

**STRATEGIES REGISTERED NURSES USE TO IMPLEMENT INTEGRATED
PRIMARY HEALTH CARE IN MASERU DISTRICT, LESOTHO**

By

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DECLARATION

I declare that the research report hereby submitted in compliance with the requirements for the degree in Masters of Social Science in Nursing to the University of Free State is my own, independent work, and has not been submitted by me to any other university. I further cede copyright of this research report in favour of the University of the Free State.

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Date

DEDICATION

This research is dedicated to the registered nurses out there who unceasingly do a wonderful job in primary health care settings to promote health, prevent illness and take care of patients' needs holistically. I salute!

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I wish to give my sincere thanks to God, who showers me with His grace so that my joy is full. I would also like to give my special gratitude to the following people, and others not mentioned, without whom I would have simply given up at an early stage of the project:

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SUMMARY

Integrated primary health care (IPHC) is a fundamental method of service delivery at a primary level of care. Registered nurses in charge and registered nurses at health centres are the main implementers of IPHC, and their main focus is to deliver a package of combined services based on each person's needs. In Lesotho, there are no documented strategies on how registered nurses implement IPHC in Maseru district, Lesotho.

The study sought to explore and describe the strategies used by registered nurses who are engaged in the day-to-day implementation of IPHC. A qualitative, exploratory design was applied and the nominal group technique used to collect data. The researcher randomly selected eight health centres where IPHC was implemented and recruited the registered nurses who had been providing IPHC for at least one year at the selected health centres. Two nominal groups were held, one with registered nurses in charge of the health centres, and another with registered nurses working at the health centres. Each group had a separate session, which was conducted by an expert facilitator who is conversant with the use of the nominal group technique.

The findings of the study are provided in the form of prioritised statements made by the participants; the statements were later arranged into themes by the researcher and checked by an expert group of nurse researchers. Four priority themes were identified. Participants indicated that they used the following four main strategies to implement IPHC, namely, organisation of services around the health centre, person-centred care, collaboration and staff capacity. The participants indicated that they organised services around the health centre by four means: service delivery through referrals to different departments within the health centre (supermarket approach), utilising available human resources, timing (providing all services needed during one visit) and documentation (proper documentation of care in registers and booklets). The registered nurses ensure that care is person-centred through giving health the relevant information. Collaboration with community structures (community health workers and health centre committees) is also practiced to implement IPHC. Lastly, staff capacity is built through attendance of frequent workshops and sharing of information among all the staff at the health centre.

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TABLE OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
CHAL	Christian Health Association of Lesotho
DHMT	District Health Management Team
DOTs	Directly Observed Treatments
HIV	Human immunodeficiency virus
HSREC	Health Science Research Ethics Committee
IPHC	Integrated primary health care
MOH	Ministry of Health
NGT	Nominal group technique
PHC	Primary health care
SIMS	Site Improvement Monitoring System
UFS	University of the Free State (South Africa)
USA	United States of America
VHWs	Village health workers
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

This chapter will start with an overview of integrated primary health care (IPHC), and continue with an explanation of the way Lesotho has adopted IPHC, and the current situation as far as its implementation strategies are concerned. The chapter will conclude with the outline of the research.

1.1 PRIMARY HEALTH CARE

This chapter will start with an overview of integrated primary health care (IPHC), and continue with an explanation of the way Lesotho has adopted IPHC, and the current situation as far as its implementation strategies are concerned. The chapter will conclude with the outline of the research.

1.2 PRIMARY HEALTH CARE

It was agreed at the Alma-Ata Conference in 1978 that primary health care (PHC) offered a global solution for the problem of providing comprehensive health services to all. The conference defined PHC 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 a cost that the community and country can afford to maintain, at every stage of their development in the spirit of self-reliance and self-determination' (WHO, 1978:5).

The Alma-Ata Declaration followed, after selective primary service delivery was implemented successfully as an emergency response to the need to eradicate smallpox and to decrease the prevalence of tuberculosis in the 1960s (Magnussen, Ehiri & Jolly, 2004:167). Although selective service delivery was successful in the case of major, specific disease outbreaks, it continued to deliver poor results in addressing the overall population-based disease burden. Comprehensive PHC became a viable option after the exponential success of projects implemented in countries, such as China, which were very poor at the time, to decrease population-based mortality rates.

The Alma-Ata Declaration was based on comprehensive service delivery; nevertheless, for financial and strategic reasons, in many instances, selective (disease-specific, focused) service provision continued to be offered. Selective service delivery, however, contributes to the fragmentation of health services. In contrast, when comprehensive

services are provided, the emphasis is on the integration of essential services and strengthening of health services overall (Collins, Hewson, Munger & Wade, 2010:3; Valentijn, Schepman, Opheij & Bruijnzeels, 2013:2).

Integrated service delivery models provide a package of care that addresses the needs of the patient holistically, instead of services that are provided selectively, or vertically. Integrated service approaches are, therefore, highly diverse, and embraced universally as “best practice” models. Integration of PHC services can also significantly enhance the quality of care, prevent duplication of services and reduce the risk of adverse events (Acharya, Maru, Schwarz, Citrin, Tenpa, Hirachan, Basnet, Thapa, Swar, Halliday & Kohrt, 2017:7; Collins *et al.*, 2010:3). In many low- and-middle income countries, including Lesotho, services have largely remained fragmented and organised according to selected health problems.

The prevailing fragmentation of care is due to an overwhelming disease burden, donor-driven care, and unclear frameworks, guidelines or indicators of PHC. A continued focus on fragmented, specialised services undermines the effectiveness and original approach of PHC to combining essential services (Valentijn *et al.*, 2013:2; WHO, 2008b:4). When health workers have to deal with an overwhelming burden of disease, it makes a focus on selective services seem to be the only cost-effective, timeous solution (Magnussen *et al.*, 2004:175).

Valentijn *et al.* (2013:2) maintain that paying attention to only prioritised diseases does not strengthen the health system; instead, this approach leaves gaps in the sustainability of health care, which should be seamless. Consequently, the prevalence of preventable illnesses has increased. Conditions, such as hypertension and diabetes, are increasing yearly despite highly specialised care (Zhang, Lisheng, Campbell, Niebylski, Nilsson, Lackland & World Hypertension League, 2016:2).

In addition to increasing prevalence of these preventable conditions, patients who receive fragmented service delivery have to visit health centres to receive different specialised services on different days for different, but related, health needs (Chen, Murphy & Yee, 2013:2451). Offering separate, specialised services results in patients having to make multiple clinic visits, each time enduring long waiting periods, with endless referrals between departments, resulting in high patient “no-show rates” for appointments (Collins *et al.*, 2010:7; Nicholson, Jackson & Marley, 2013:2).

In contrast, IPHC ensures significantly increased accessibility of services, to the benefit of patients (WHO, 2016:10). An example of this improvement is demonstrated by the study done by Neilsen (2014:149), which integrated mental health services into PHC. Neilsen (2014:149) concludes that IPHC increased accessibility and reduced stigma and discrimination, while being cost-effective. IPHC has also proven to improve health outcomes, scale up services and increase utilisation of services for sensitive health issues, such as mental health (Eaton, McCay, Samrau, Chatterjee, Baingana, Araya, Ntulo, Thornicoft & Saxena, 2011:1599).

1.3 LESOTHO BACKGROUND

Lesotho adopted the Alma-Ata Declaration in 1979 (Lesotho MOH, 2011a:14). However, by 2000 it was realised that service delivery was still fragmented and uncoordinated at the PHC level (Lesotho MOH, 2012:9). The Lesotho National Health Policy, which has been used in draft form since 2004 (Lesotho MOH, 2011a:14), is largely based on the Alma-Ata Declaration on PHC, and involves the establishment of 18 health service areas. Since 2004, processes of transition, from the 18 health service areas to 10 District Health Management Teams (DHMTs) have taken place, and today DHMTs are responsible for PHC activities in health centres at a district level.

Maseru is the most populous district in Lesotho (see Figure 1.1), with a population of 431 998 (Lesotho MOH, 2013:2). As a result, the disease burden in this district is proportionately higher than the other nine districts (Mafeteng, Quthing, Qachasneck, Thaba-Tseka, Mokhotlong, Butha-Buthe, Leribe and Berea). Sixty-eight health centres in Maseru district have been tasked with adapting the concept of IPHC.

Health centres in Maseru district vary in size and location. There are smaller health centres in rural areas and larger health centres in more urban areas. The staff complement at the different health centres also varies: Smaller centres usually have a registered nurse as the PHC provider, while the larger centres have a staff complement that includes nurses, doctors, pharmacists and laboratory technologists (Lesotho MOH, 2011a:9). Furthermore, health centres are owned by different public, faith-based, private and private-public organisations. IPHC is applicable to all the health centres. Private and private-public organisations may, however, offer more disease-specific services than public and faith-based health centres, which provide multiple services.

care and implementation of IPHC. However, registered nurses employed at the health centres report to the registered nurse in charge of the health centre. The registered nurses in charge of health centres, in turn, report to the relevant DHMT (Lesotho MOH, 2011a:35).

In 2008, Lesotho recommitted itself to the original Alma-Ata Declaration for all health centres, including the health centres in Maseru district (Lesotho MOH and Social Welfare, 2011:1). The Ministry of Health (MOH) undertook several health reforms (Lesotho MOH and Social Welfare, 2011:9; Lesotho MOH, 2012:6), which were detailed in the *National Health Sector Strategic Plan 2012-2017* (Lesotho MOH, 2012:8) and the *Lesotho PHC Revitalisation Plan 2011-2017* (Lesotho MOH and Social Welfare, 2011:37).

The reforms were designed to achieve sustainable, increased access to quality health care services, equity, and universal coverage at all levels. In order to achieve these goals, the government of Lesotho prioritised health care service delivery that integrates services as an essential facet (Lesotho MOH, 2012:9). The so-called *supermarket approach* to integrated health service delivery is informed by integrated guidelines and planning tools for this priority area (Lesotho MOH, 2011:b31).

1.4 INTEGRATED PRIMARY HEALTH CARE IN LESOTHO

As the country needs to strengthen IPHC, Lesotho placed more registered nurses in health centres during the 2000s to strengthen IPHC. The concept of integration was strongly emphasised within PHC, as one of the priority areas of Lesotho's health system. An additional layer of management has been established since 2004, with DHMTs overseeing health centres implementing IPHC.

Lesotho also published a health policy to support IPHC implementation further, the PHC revitalisation policy, in 2011. Furthermore, the MOH embarked on a plan to continuously include vertical programmes in existing IPHC at health centres and in communities (Lesotho MOH and Social Welfare, 2011:5, 21). The integration of additional services ensures that, when a new condition emerges and becomes prevalent, programmes are established and consolidated into one service delivery package for IPHC. IPHC in Lesotho, therefore, comprises the promotion of healthy lifestyles, and providing preventive and curative services at health centres. The main implementers are registered nurses at health centres, with additional management roles assigned to the

nurses in charge to ensure the implementation of IPHC (Lesotho MOH and Social Welfare, 2011:21).

However, a lack of specific implementation strategies complicates the implementation of IPHC for registered nurses. In Lesotho, like in many other countries, there is a lack of frameworks, guidelines and strategies to direct IPHC implementation (Lesotho MOH and Social Welfare, 2011:29-30; Valentijn *et al.*, 2013:4). Although Porter, Pabo and Lee (2013:516) suggest certain strategies, such as organising care around patients with similar needs, can be helpful in implementing IPHC, the WHO also documents that little is known about useful strategies for IPHC implementation (2008b:4). With no standard guide or strategies for IPHC in place, registered nurses have to improvise and practice IPHC in different ways that suit their health centres. As a result, registered nurses invent their own practical strategies for implementing IPHC.

1.5 THE ROLE OF REGISTERED NURSES IN INTEGRATED PRIMARY HEALTH CARE

In IPHC, registered nurses have largely replaced physicians, and work as consultants (Maier & Aiken, 2016:929). The main reason for this shift is the professional transformation of the nursing profession. Bodenheimer and Bauer (2016:1016-1017) explain that the nursing profession has changed, and has extended beyond the boundaries of hospital premises, into communities.

Nurses are now a diverse group of professionals, with various specialities, and they assume prominent roles in communities as main IPHC providers (Spetz, Fraher, Li & Bates, 2015:360). In providing IPHC, nurses' main focus is to promote health, prevent disease and treat general ailments. Registered nurses' scope of practice has been broadened for practice beyond the hospital setting, and to reach out to health centres and health posts, where not only curative services are provided, but also preventive and health promotion services (Dawson, Nkowane & Whelan, 2015:97). Registered nurses can now work as community health nurses or PHC coordinators, and can specialise in topics relevant to different aspects of PHC.

Extending nurses' roles has extended the health workforce and has improved the coverage of different aspects of PHC. Aspects such as health promotion and prevention have become important components of a holistic approach that can now complement curative services (Brault, Kilpatrick, D'Amour, Contandriopoulos, Chouinard, Dubois,

Perroux & Beaulieu, 2014:3). Salmond and Echevarria (2017:12) explain that it is the diversity within the nursing profession that makes nurses suitable candidates to fulfil the mission of PHC to provide an essential health package. The essential health package coincides with one of the primary values of nursing: holistic care. Holistic care, in nursing, is the art of taking care of a person beyond their physical inabilities, and to involve care of emotions and social wellness, and to consider environmental factors (Uys, 2016:45). Holistic care, like PHC, focuses on preventing diseases by addressing potential health hazards or causes; giving treatment and coping with illness; and monitoring illnesses (rehabilitative services).

The holistic view, however, means registered nurses have a bigger responsibility. The nurses' scope of practice is being extended and, if they are to deliver the require care, they have to be competent and full members of the interprofessional team, with other health professionals (Starling, 2018:53; Supper, Catala, Lustman, Chemla, Bourgueil & Letrilliart, 2015:719). Registered nurses, therefore, play a dominant role within IPHC practice.

Nurses' dominance within IPHC is also due to their large numbers, compared to other cadres of health professionals. Many more institutions train (produce) nurses than they do other health professionals (Bodenheimer & Bauer, 2016:1016-1017). In many countries, there are four times as many nurses as doctors available. In practical terms, in many countries, nurses carry the vast majority of the responsibilities for implementing IPHC. For instance, in Lesotho, there are several tertiary schools that offer nursing education, but no medical school. Hence, registered nurses outnumber medical doctors by far. It is noteworthy to reiterate that, due to staff shortages, registered nurses in charge of health centres in Lesotho are also directly involved with patient care, therefore, giving them and the registered nurses the same experiences regarding the implementation of IPHC (Stender, Phafoli, Christensen, Skolnik, Nyangu, Lemphane, Ramokhitli & Whalen, 2014:2).

1.6 PROBLEM STATEMENT

Registered nurses (including those in charge of health centres) manage the implementation of the IPHC through collaboration with community-based VHWs, health-centre-based staff and the DHMT (Lesotho MOH and Social Welfare, 2011:32). Implementation, however, takes place without the guidance of agreed-upon,

standardised implementation strategies or frameworks (Lesotho MOH and Social Welfare, 2011:3133).

Lesotho has a national policy (Lesotho MOH, 2012:40) that recommends the integration of services to improve the delivery of PHC, however, there is no formal framework with documented strategies that guides such integration in practice. In the absence of such guidelines, implementation can be done in a haphazard fashion, as the registered nurses implement IPHC based on their own understanding. This gap (unknown strategies used) hinders the optimal implementation of IPHC, while the primary level is where the majority of the population's healthcare is being delivered. Documented evidence of the strategies registered nurses use to implement IPHC in Lesotho could not be found. It is, thus, unclear how registered nurses implement IPHC.

Furthermore, little is known about how IPHC is being implemented at different health centres in Maseru district, Lesotho. Understanding the experiences of registered nurses, as the main actors, will be valuable for investigating how IPHC is being implemented. Recommendations by registered nurses could give these front-line workers a voice and might influence the implementation of IPHC as a policy and, finally, bring about the purpose envisioned by the Alma Ata Conference; hence, the need to explore the strategies registered nurses use to implement IPHC.

1.7 RESEARCH PURPOSE

The purpose of the study was to explore and describe strategies registered nurses use to implement IPHC in Maseru district, Lesotho.

1.8 RESEARCH QUESTION

What are the strategies registered nurses use to implement IPHC in Maseru district, Lesotho?

1.9 CONCEPT CLARIFICATION AND OPERATIONALISATION

Concepts are abstract versions of observable phenomena, influenced by the researcher's world experiences. Concept clarification assists in describing the focus, and defines the boundaries of the research (Bloomberg & Volpe, 2016:126). Conceptual definitions give the theoretical meanings of concepts, while operational definitions are

descriptions of how concepts will be applied in the study (Polit & Beck, 2012:129). Clarifications of the main concepts of the study will be presented in the next sections.

1.9.1 Registered nurses

A registered nurse is a professional who completed training in at least general nursing science and has the authority to practice in primary, secondary and tertiary health care settings (Lesotho Nursing Council, 2014:3). In Lesotho, registered nurses include those that have a single qualification in nursing, and nurses with multiple qualifications (Stender *et al*, 2014:1). In this study, registered nurses who possess at least a qualification in general nursing will be included, although some might hold additional qualifications. The terms registered nurse and professional nurse are used interchangeably in practice. Nurses in charge and nurses working in health centres are both registered nurses. In this study, registered nurses (including the registered nurses in charge of the health centres) who implement IPHC were included. In Lesotho, registered nurses in charge of health centres also render direct patient care (IPHC services) alongside the other registered nurses in the health centres. Both groups of registered nurses are, therefore, implementers of IPHC.

1.9.2 Primary health care

The Alma-Ata Declaration of 1978 (WHO, 1978:5) states that PHC is,

an 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 cost that the community and country can afford to maintain, at every stage of their development in the spirit of self-reliance and self-determination.

In Lesotho, PHC involves affordable health care that is made available at community level by VHWs, and at primary health centre level by registered nurses (and midwives), assisted by nursing assistants and other allied health personnel. There is a strong element of community participation in PHC (Lesotho MOH, 2012:10). In this study, PHC will refer to services provided at primary health care level.

1.9.3 Integrated primary health care

IPHC consists of combined programmes and services delivered at PHC level. Services are comprehensive and based on the patients' needs (Collins *et al.*, 2010:36). In other words, IPHC provides health services that are patient-centred and holistic (Lesotho MOH, 2012:6). In this study, IPHC will refer to combined services provided to a patient at a health centre with limited referrals.

1.9.4 Strategy

A strategy is a method or plan chosen to bring about an achievement, goal or solution to a challenge (Cambridge Dictionary, 2019:online). "a way in which an organization carefully plans its actions over a period of time to improve its position and achieve what it want". In this study, a strategy will refer to the actions or methods that registered nurses use to execute their duties in order to implement IPHC.

1.10 RESEARCH DESIGN

Every research project requires a research design that is carefully tailored to obtain appropriate data for investigating the specific research questions (Bloomberg & Volpe, 2016:41; De Vos, Strydom, Fouché & Delport, 2011:144; Grove, Burns & Gray, 2013:195, 256). The plan that answers the research question best becomes the most appropriate design for the research (Polit & Beck, 2012:120). Researchers weigh the risks and benefits of each design and select the best one, which will yield the most accurate data that is closest to reality.

The study sought to explore and describe strategies registered nurses use to implement IPHC in Maseru district, Lesotho. A qualitative exploratory and descriptive design was selected as the appropriate design for answering the research question. A process to establish consensus was also used, so that the study's results are based on agreement by the group (Botma, Greeff, Mulaudzi & Wright, 2010:251). The nominal group technique was applied to elicit data. In this study, registered nurses participated in nominal groups to generate ideas, assign priority, and reach consensus on the strategies used for the implementation of IPHC.

1.11 RESEARCH TECHNIQUES

The nominal group technique (NGT) was used to collect data in the form of words. NGT is a structured form of inquiry that requires a small group of key informant to reach consensus about a topic. The NGT is used by researchers to ask participants in a group to generate ideas, prioritise the ideas and reach consensus in the form of discussions and voting processes (Botma *et al.*, 2010:251; De Vos *et al.*, 2011:390). The sizes of the groups were six and nine people (Delbecq, Van de Ven & Gustafson, 1975). Groups were facilitated by a skilled field worker. The initial data analysis was done by the groups, after which the researcher analysed the multiple-group data, based on the guide proposed by Van Breda (2005:4-11).

1.12 STUDY POPULATION AND UNIT OF ANALYSIS

The unit of analysis relates to the specific objects, elements, people, documents, events or specimens, whose characteristics we wish to describe or explore and from which we can collect data (Botma *et al.*, 2010:290; De Vos *et al.*, 2011:93). In this study, the unit of analysis (population) consisted of all registered nurses who provided direct IPHC patient care, as summarised in Table 1.1. Therefore, registered nurses (including those in charge of health centres) working at the 40 PHC centres that implement IPHC, constituted the population (Lesotho MOH, 2015:6). The unit of analysis was therefore (N=40) registered nurses in charge of the health centres, together with the other registered nurses (N=117) working in the 40 PHC centres (a total of 117) that implement IPHC(see Table 1.1)

Table 1.1: The population in summary

Number of health centres that implement IPHC in Maseru district	40
Number of registered nurses in charge of the health centres	40
Number of registered nurses working at the health centres	117

1.12.1 Sampling and selection

Sampling is the process of selecting, through sampling techniques, a subset of the population that will represent the accessible population (Botma *et al.*, 2010:290). According to De Vos *et al.* (2011:391), the overall purpose of the relevant sampling techniques in qualitative research is to collect the richest data. As discussed in detail in

Section 2.6, a layered approach was used, involving random selection of the health centres, where after registered nurses (including those in charge of the health centres) who met the inclusion criteria were invited to participate. For more details see Chapter 2.

1.13 EXPLORATIVE INTERVIEW

The role of explorative interviews is to create an opportunity for researchers to have a small-scale exercise of the data collection and to orient themselves to the project they have in mind (De Vos *et al.*, 2011:236). The nominal group question was pre-tested for clarity. The researcher asked two registered nurses who were not part of the main study to answer the nominal group question. This gave the researcher an indication of whether the question would be clear to participants and whether it would yield the intended data. The question was, '**What are the strategies registered nurses use to implement IPHC in your district?**' and the explorative interview indicated that no corrections or amendments were needed.

1.14 DATA COLLECTION

Botma *et al.* (2010:131) describe data collection as the formal, precise and systematic gathering of data. As recommended by Creswell (2009:173), access was negotiated by seeking permission from local gatekeepers, who were individuals at the research site who assisted with access while ensuring that participants were protected. In this study, after approval had been obtained through processes at the University of the Free State (UFS), the main gatekeepers contacted were directors at the Lesotho MOH and the Christian Health Association of Lesotho (CHAL), DHMT-Maseru and applicable health centres. All the steps followed for each of the gatekeepers will be described Section 2.8.

To reach the registered nurses in charge the selected health centres and the registered nurses employed at the selected health centres, a process of recruitment commenced. More details on the recruitment process can be found in Section 2.8. Registered nurses in charge and registered nurses who agreed to participate were provided with the schedule for the nominal group session times. On the date that was set (1 September 2017) the participants and the facilitator started nominal groups in two sessions: One for the registered nurses in charge of the health centres, and another for the registered nurses employed at the health centres. The nominal groups were conducted according

to sequential steps by an experienced facilitator, as recommended by Botma *et al.* (2010:251-253) and Harvey and Holmes (2012:190-192).

The facilitator started off by giving an introductory statement and explaining the topic of the research and its purpose. The participants all signed consent forms before the sessions. A page containing the typed question, “***What are strategies registered nurses use to implement integrated primary health care in your district?***”, was placed at each participant’s seat. The nominal groups were then conducted according to four steps, as explained in the next chapter (Section 2.8.2). The four-step process involved generating ideas, recording/writing down ideas, discussing ideas and voting on ideas. At the end of the session, the facilitator thanked all the participants for their contribution. This process proceeded similarly in both groups.

1.15 DATA ANALYSIS

After the data had been collected, it was managed, organised, and analysed, to make sense of all the accumulated information (De Vos *et al.*, 2013:59). Bloomberg and Volpe (2016:188,189) explain data analysis as an ongoing process of combining pieces of information (raw data) collected through different methods into sensible and easily comprehensible data. In this study, data was analysed in a step-by-step way, to combine the different lists of statements and to create an integrated list (Van Breda, 2005:3).

To achieve this, the researcher used Van Breda’s (2005:3-5) guidelines for multiple-group data analysis for data generated through the NGT. The six-step process includes capturing data on a computer, identifying the top five responses, doing content analysis, calculating ranks and writing the report. How data was analysed is recorded in detailed descriptions in the next two chapters, which describe the methodology and literature summary.

1.16 TRUSTWORTHINESS

Validation is a criterion for ensuring quality related to the research product (Savin-Baden & Major, 2013:475). Creswell (2009:190) describes qualitative validity as the procedures that the researcher employs to achieve accurate results. Trustworthiness is an alternative construct in qualitative research, used as a form of validity (Botma *et al.*, 2010:232; Savin-Baden & Major, 2013:475). Polit and Beck (2012:584) list the criteria

for developing trustworthiness of qualitative inquiry as credibility, dependability, confirmability, transferability and authenticity.

1.16.1 Credibility

Credibility refers to confidence in the truth of the data and interpretation thereof (Polit & Beck, 2012:585; Savin-Baden & Major, 2013:476). In this study, credibility was enhanced by using the NGT, which verifies the accuracy of data as it is being collected. In this way, the NGT allows member checking to be done during data collection. Engaging a facilitator who is knowledgeable about using the NGT also contributed the collection of trustworthy, reliable data. There was, furthermore, prolonged engagement (2-3 hours) with the participants, so that there was enough time to reach saturation. During data analysis, a review was done with expert nurse researchers to enhance the reliability of established themes. More details of each step is explained in Section 2.10.1.

1.16.2 Dependability

Dependability suggests that research findings will endure over time and conditions; the essence is whether the findings of the inquiry will replicate if repeated with the same participants in the same context (Polit & Beck, 2012:585; Savin-Baden & Major, 2013:476). In this study, dependability was enhanced through comprehensive and vivid recording of information. Detailed descriptions of all research procedures and the population involved were given.

1.16.3 Confirmability

Confirmability refers to the ability of the researcher to remain neutral during data analysis and interpretation (Savin-Baden & Major, 2013:476). Polit and Beck (2012:585) clarify this criterion by explaining that the data must represent the information the participants provided and that the interpretations of the data should not be manipulated by the inquirer. The researcher ensured that the findings reflect the participants' voices and the condition of enquiry by engaging participants to vote (reach consensus), and by giving immediate feedback to the group. The researcher followed the procedure proposed by Van Breda (2005:3), to collate the data from multiple groups and to analyse the data.

1.16.4 Transferability

Transferability refers to the applicability of findings to another setting (Savin-Baden & Major, 2013:476), and indicates the extent to which the findings will be applicable in another setting or group. In this study, transferability was enhanced by disclosure of quality-enhanced strategies and through thick, contextualised descriptions (Polit & Beck, 2012:585).

1.16.5 Authenticity

Authenticity refers to the extent to which researchers are sincere about showing a range of realities. According to Polit and Beck (2012:585), a text has authenticity if it invites readers into the experiences of the lives being described, and if it enables readers to develop a prominent sensitivity to issues being depicted.

Each criterion will be discussed further and in more detail in Section 2.10, to show how each criterion was applied.

1.17 ETHICAL CONSIDERATIONS

After obtaining approval from the School of Nursing Research Evaluation Committee of the UFS, the proposal was submitted to the Health Science Research Ethics Committee of the Faculty of Health Sciences, UFS. According to Bryman (2012:134), researchers should comply with ethical guidelines and have their proposals assessed by the ethics committees of universities. Hence, ethical approval was obtained (HSREC 43/2017 UFS-HSD2017/0327); a copy of the approval can be found in Appendix A. Subsequently, approval was also obtained from local stakeholders in Lesotho, such as the MOH, CHAL and DHMT Maseru (Appendices B, C and D).

The basic ethical principles of autonomy, beneficence and justice were honoured.

1.17.1 Autonomy

Autonomy involves the right to self-determination and full disclosure (Polit & Beck, 2012:154). Self-determination means that people have the right to ask questions, to refuse to give information and to withdraw from the study without prejudicial treatment or consequences. For full disclosure, the researcher described to participants the nature of the study, the participants' right to refuse participation at any time, the researcher's

responsibilities, and likely risks and benefits of participation (Polit & Beck, 2012:155). Participation was, therefore, voluntary. Participants could also discontinue their participation at any point, without consequences. Two participants chose to discontinue their participation due to family responsibilities.

Informed consent was based on the principle of autonomy. Informed consent means that participants had adequate information about the research, comprehended the information and had the ability to consent to or decline participation voluntarily (Bryman, 2012:138; Lichtman, 2014:146). Each prospective participant was provided with an information leaflet and the opportunity to ask questions before they were asked to complete the informed consent form (Appendix E). After participants had filled in the informed consent form, there were verbal explanations by the facilitator: She introduced the study, the nature of the research and the process of nominal groups. Eventually, participants signed the consent forms with a clear understanding of their rights regarding voluntary participation, and knowledge that they could withdraw from the study without incurring penalties.

1.17.2 Beneficence and non-maleficence

Key principles of beneficence (do your best) and non-maleficence (do no harm) were upheld. The participants had the right to be free from harm and discomfort, including the right to protection from exploitation (Botma *et al.*, 2010:20). According to Bryman (2012:136), avoiding harm means taking into consideration the possibility that the study could affect the participants negatively, either directly or indirectly. Participants' wellbeing should not be affected as a result of a research project (Lichtman, 2014:146).

In this study, in order to avoid exploitation and because the researcher was a registered nurse in charge of a neighbouring health centre, an experienced facilitator conducted nominal group sessions. The facilitator avoided unnecessary probing, adhered to time schedules and acted professionally (Polit & Beck, 2012:153). Access to research sites was obtained through gatekeepers at the DHMT (Botma *et al.*, 2010:291). As outlined in Section 1.11, to gain entry to the setting, the researcher submitted letters to the applicable sampled health centres, requesting permission to conduct the study. In this study, permission was of paramount importance, so that gatekeepers could also evaluate whether discomfort or harm could possibly result from the study.

Another measure to minimise harm was to keep the participants' identities and responses confidential. Confidentiality pertains to how the researcher manages the data that is collected, and guaranteeing that only the researcher and field worker had access to the data and the information. Data was shared by group and not by individual (Botma *et al.*, 2010:17). In other words, study participants had the right to have the information they provided kept in the strictest confidence (Polit & Beck, 2012:441). No one except the researcher, the facilitator and a group of peers had access to the data. All data was securely locked in a cabinet and kept safe.

Anonymity could not be guaranteed, as the data was collected during group sessions. Wood and Ross-Kerr (2011:45) indicate that anonymity is compromised in situations involving face-to-face interactions during group discussions. However, in this study, codes and pseudonyms were used for any identifying information, such the names of the health centres and the participants, for reporting of data.

1.17.3 Justice

The principle of justice was upheld, as the researcher treated all the participants fairly and honoured their right to self-determination, privacy and protection (Wood & Ross-Kerr, 2011:155). Registered nurses who were in charge of and those who worked in the health centres were not included in the same groups, to prevent feelings of intimidation. The researcher, as a registered nurse in charge of one of the health centres at the time, excluded herself from being part of the population. The registered nurses working in the study were also exempted from participating, because they might feel obliged to obey their manager and be hindered from the rule of voluntary initiative.

No interventions, procedures or techniques were carried out that had not been described in the proposal and the informed consent procedures (Botma *et al.*, 2010:19). The participants were also selected based on study requirements, and not based on the participants' position (vulnerability), e.g., by forcing junior members to attend the managers' group session. Participants' time was respected and the agreed-upon schedule was adhered to. Nurses who withdrew from the study were freely exempted without judgement (Polit & Beck, 2012:155). The study also gave voice to the registered nurses implementing IPHC.

1.18 OUTLINE OF THE STUDY

The rest of the study will be presented in an additional four chapters:

Chapter 2: Methodology

Chapter 3: Literature review

Chapter 4: Data analysis

Chapter 5: Recommendations

1.19 SUMMARY

In this chapter, a study overview was presented, and the research processes that were followed were explained. The background and problem statement were outlined clearly, followed by the research purpose and question. The research design and methods relevant to the inquiry of the research were identified and outlined. Lastly, the ethical principles were described and of the whole study outline presented. In Chapter 2, the details of the methodology applied in this research will be described fully.

CHAPTER 2: RESEARCH METHODOLOGY

Chapter 1 provided an introduction to the study. This chapter will provide an overview of the research methodology used in the study. The chosen methodology is embedded in the way the researcher argued for the suitability and utility of her choice of research processes, using literature to inform the argument (Henning, Van Rensburg & Smit, 2004:36; Saldana & Omasta, 2018:30). Research processes discussed are the paradigm and design of the research, how the sample was selected, data collection method used, how the data was analysed, ethical aspects considered, issues of trustworthiness that were addressed, and, finally, the limitations of the study.

2.1 INTRODUCTION

Methodology refers to the coherent group of methods that complement one another and that have the capacity to deliver data and findings that will answer the research question in line with the purpose of the study (Saldana & Omasta, 2018:30). Methodology also explains the reasons behind the selection of research processes or methods and their relevance to the field of study.

A knowledge gap was identified in relation to the strategies registered nurses use to implement IPHC in Lesotho. Through this study, the researcher had the opportunity to explore and gain insight into the phenomenon, that is, IPHC implementation, based on the participants' perspectives, through a series of steps and processes (Brink, Van der Walt & Van Rensburg, 2012:53-54; Botma *et al*, 2010:182). The research processes will now be discussed.

2.2 RESEARCH PARADIGM

Every research project is guided by a paradigm, which is the “set of beliefs and values that guide the research” (Botma *et al.*, 2010:40). There is a subtle relationship between the researcher and the research processes. Ontology, epistemology and methodology, together with methods, form a research paradigm. The ideas the researcher has about the nature of the phenomena under study comprise the term ontology (Saldana & Omasta, 2018:141). Ontology refers to what things are. Ontology, thus, refers to the interpretation by individuals about what constitutes the fact or the reality. Hence, in research, ontology is the insight the researcher has about the phenomenon.

In its turn, the way to acquire knowledge of and an explanation for the phenomenon constitute epistemology (Brink *et al.*, 2012:53-54). Epistemology refers to the way we know things. In this study, the researcher was able to gain knowledge on the implementation of IPHC by understanding the strategies registered nurses use to implement IPHC in a group of health centres in Maseru district, Lesotho.

This form of epistemology was based on the interpretive theory of knowledge. The interpretive theory is a philosophical approach that seeks to make meaning of reality (De Vos *et al.*, 2011:8; Henning *et al.*, 2004:19; Scotland, 2012:11-12). In this way, knowledge is acquired by understanding the information (data) provided by the participants. There are several forms of inquiry within interpretive theory, among which phenomenology, ethnography, and hermeneutics.

In conclusion, the philosophical assumptions above are in line with the methodology and methods that form a coherent whole and which are expected to yield the desired data. The research design and technique used will be explained in Section 2.3 and 2.4 respectively.

2.3 RESEARCH DESIGN

Research design is the plan for conducting a study that addresses the research question. When conducting the study, there are no strict rules, instead, researchers choose methods, techniques, tools and sampling methods that are in coherence with each other (Bloomberg & Volpe, 2016:151; De Vos *et al.*, 2011:268). Other authors simplify the definition of research design, as identifying what the study seeks to find, and what the best possible way to do so is. Hence, all the decisions the researcher makes in planning the execution of a study makes up its design.

In the social sciences, studies usually have qualitative, quantitative or mixed designs. Quantitative researchers are concerned with concepts and their measurement, whereas qualitative researchers focus primarily on words that describe what people say or do, or how they may feel about those particular concepts (Saldana & Omasta, 2018:144-146). In mixed method designs, a combination of the two types of designs are used. Within mixed method designs, it is important that the purposes of doing research are achieved. Research is done for the purposes of exploration, description or explanation of a certain phenomenon (Brink *et al.*, 2012:53).

In this study, the main purpose was to explore and describe the strategies used by registered nurses for IPHC implementation. Exploratory studies are carried out “when a researcher examines a new interest or when the subject of study itself is relatively new” (Bell, 2011:42). In this study, a qualitative exploratory and descriptive design was used to obtain data in the form of words. Little is documented about the phenomenon. The researcher intended to immerse deeply into inquiring and describing the strategies registered nurses use to implement IPHC in Maseru district, Lesotho.

Botma *et al.* (2010:251) explain that several qualitative strategies or techniques can be applied to collect data, through observation, group discussion, and interviews. For this study, a group technique was chosen. The study used the NGT to document information in the form of words and descriptions provided by the participants. The NGT is a structured small group discussion that aims to achieve consensus on the topic under discussion. This consensus group technique is based on the general agreement reached by the participants in the group(s). Consensus on strategies that registered nurses use to implement IPHC was reached through a sequence of steps, and by passing through the phases of the NGT (Botma *et al.*, 2010:251).

2.4 RESEARCH TECHNIQUE

The NGT was originally developed in the 1970s as an organisational planning technique. The technique is a creative strategy for generating ideas where individuals work in the presence of one another; with this technique there is no dominance or interference, which could occur in other brainstorming groups (Delbecq & Van de Ven, 1974:472). Nominal groups involve four phases: 1) Participants generate ideas individually without discussion and write them down, 2) Participants share their ideas in a round-robin feedback session, 3) Participants clarify the ideas, and 4) Participants vote and rank the ideas according to their relative importance – the group members reach consensus (Botma *et al.*, 2010:251.; Delbecq *et al.*, 1975). The study benefited from the strengths of this technique.

2.4.1 Strengths of the nominal group technique

Delbecq and Van de Ven (1971:492) state that, when using the NGT, the quality of ideas generated individually is high in regard to creative empowerment. The NGT enhances creative, thoughtful ideas, which are generated and written down individually

(Boddy, 2012:7; Delbecq & Van de Ven, 1971:470; Harvey & Holmes, 2012:190). During this phase, there is silence in the group, and people use the right sides of their brain, which stimulates creativity. Therefore, a response from each group member is assured. The NGT allows participants to fully immerse themselves in the task through heightened concentration (Botma *et al.*, 2010:251). The “round-robin procedure (each member around the table present their own ideas without discussion)” allows each participant a fair opportunity to share their ideas. The effect is enhanced ownership and satisfaction amongst the participants (Delbecq & Van de Ven, 1974:610).

The NGT has been used successfully to elicit health care priorities, ranked by order, as agreed upon by participants (McMillan, Kelly, Sav, Kendall, King, Whitty & Wheeler, 2014:1). In this study, the NGT was used to identify and rank, by priority order as agreed upon by registered nurses, the strategies they use to implement IPHC. This technique was found to be advantageous; the strategies used were not only identified, but also ranked by the participants. Hutchings, Rapport, Wright and Doel (2013:492) refer to “relative importance of consensus made”. Attention is focused more on those items that, in the participants’ view, have priority.

The NGT was used to avoid the problem of dominant views, which sometimes arises with other types of group discussions, where views of less dominant participants may be disregarded (Hutchings *et al.*, 2013:492). This happens because, in most groups, participants find it more comfortable to react to someone’s opinion, than to generate their own.

Lastly, the NGT is an effective way of collecting data because the participants do the first level of analysis themselves. Using the NGT, therefore, assures that participants receive feedback immediately, within the course of the session, thereby saving time. Data was gathered within two to three hours and results were readily available by the end of the sessions. The technique is also fairly simple, and can be done by a facilitator with some training (Van Breda, 2005:2).

2.4.2 Limitations of the nominal group technique

Although the NGT was the preferred technique, it had some limitations. The fixed time schedule was inconvenient for some of the selected participants; neither did the time commitment of the nominal group sessions suit all participants (Boddy, 2012:12).

Two nominal group sessions were held on a Friday. The group session for the registered nurses in charge took place in the morning, and the group session for registered nurses working at health centres in the afternoon. The times were fixed and each registered nurse was asked to attend the group session applicable to their position, whether in charge of the health centre or working in the health centre. This request was made to protect the participants from possible intimidation by more senior colleagues, however, it limited their choice regarding time of attendance. Participants could, therefore, not choose which group session they wanted to attend, and this lack of choice affected the attendance of group sessions, because some participants were unable to attend at the specified times. Moreover, two participants from the registered nurses group left the session before they could vote, due to family commitments. This limitation had been explained during the recruitment process.

When using the NGT, participants can deal with only a limited range of issues at a time, thereby restricting the type of information that can be gathered (Islam, 2010:148). Cross-fertilisation of ideas may be constrained and the process may appear mechanical and rigid (Boddy, 2012:11; Sample, 1984:online). Hence, the process may result in a lesser degree of knowledge sharing amongst participants, compared to other group techniques. Participants were, therefore, informed about the format of the nominal group and what to expect during the group session. This information was given verbally and in writing before the group session started and participation was voluntarily, as participants had the option to withdraw from the study at any time.

Although nominal groups are effective for generating many good-quality ideas, evaluation (clarification) of the ideas may be compromised at the beginning of the group session. One of the rules is to state from the onset that participants should not clarify their ideas before the appropriate step – some participants might find this frustrating (Boddy, 2012:8). Delbecq and Van de Ven (1971:475) explain that, in nominal groups, early evaluation of ideas may create a fear of criticism. In this study, an experienced nurse researcher facilitated the groups. She explained the nature and procedure of the NGT as part of the introduction to the group sessions.

2.5 UNIT OF ANALYSIS/POPULATION

The unit of analysis can be individuals, groups, organisations, programmes, events or processes, which researchers can observe, describe or explain, and from which they

collect data (De Vos *et al.*, 2011:93). Whatever the basic unit, the unit of analysis involves all the elements in which the researcher is interested (Polit & Beck, 2010:306). According to De Vos *et al.* (2011:93), the choice of the unit of analysis (population) happens automatically at the problem-identification stage, as it becomes clear to the researcher. In this study, the unit of analysis (population) was all registered nurses (N=40) in charge, and registered nurses (N=117) working in health centres that implemented IPHC. The details of the population were described in Section 1.11 (Lesotho MOH, 2015:6).

2.6 SAMPLING

Sampling is the process of selecting a part of the population/unit of analysis to represent the accessible population, through sampling techniques. Researchers often sample because of economic and practical reasons (Botma *et al.*, 2010:290; Polit & Beck, 2010:307). However, in qualitative research, sampling is done so that rich data can be gathered to provide meaning, and to explore realities. Thus, according to Polit and Beck (2010:307) it is important to consider who would provide informative data that will heighten the researcher's understanding of the phenomenon under study; the intention is not to generalise the data gathered in relation to the concept. In this study, it was important to check who was most likely to provide rich data. Sampling was, therefore, done in line with the purpose of the study, considerations of credibility, and feasibility of the study within the available time and resources (De Vos *et al.*, 2011:391).

Only health centres implementing IPHC formed the population. To achieve the selected number of participants, random sampling of the health centres was used. Random sampling gives an equal opportunity for selection to the whole set of the unit of analysis. Though this approach is not a requirement in qualitative studies, but can be used (Bryman, 2012:416). The registered nurses implementing IPHC at the selected health centres were then recruited. However, in order to acquire rich data from participants, the researcher used inclusion and exclusion criteria to ensure participants had had adequate exposure, as described.

The inclusion criterion was as follows:

- Registered nurses in charge and registered nurses with at least one (1) year experience of implementing IPHC.

The exclusion criterion was the following:

- Registered nurses in charge and registered nurses with less than one (1) year experience of implementing IPHC.

Although the health centres were not the specific population, their names were used in a layered approach to selected eight (8) health centres to be included in the study. As stated in Section 1.16.3, the researcher, as one of the registered nurses in charge of a health centre at the time, was excluded, as were all registered nurses who worked under her supervision. This means that, although the health centre where the researcher worked formed part of the 40 centres that implemented IPHC, participants from this centre were not selected to participate. As a result, in order to identify the sampled nurses, one health centre was excluded from the study, giving 39 health centres to select from. The names of the 39 health centres were put in a hat and drawn randomly. The first eight (8) health centres drawn were the ones registered nurses in charge and registered nurses were recruited from.

Table 2.1: Number of registered nurses recruited

Rank	Number recruited
Registered nurses in charge	8
Registered nurses	12

The registered nurses in charge and registered nurses working at the health centres were invited to participate and divided into two groups: one for the registered nurses in charge of the health centres (Group 1) and the other for registered nurses working at the health centres and who were not in charge (Group 2). Hence, separate groups were formed for registered nurses in charge of the centres and those working in the health centres, to avoid possible intimidation of participants by colleagues. A detailed description of the characteristics of each group is given in the section on data analysis (Section 4.2).

Data saturation was achieved between the two groups; the information was mostly similar, with a few nuances (Botma *et al.*, 2010:290). Some of the information had the same meaning, but was expressed in different words. The researcher reached this

conclusion after checking the data closely and observing various similarities in the data collected from the two groups (see Tables 4.1 and 4.2).

2.7 EXPLORATIVE INTERVIEW

An explorative interview is meant to test if the nominal group question will elicit the intended or relevant data from the participants. The intention is to test the feasibility of the study in terms of the willingness to participate, if the time available is enough, and if questions can be answered and produce the data needed (Botma *et al.*, 2010:291; De Vos *et al.*, 2011:394).

In this study, the question was pre-tested by posing it to two registered nurses who were not part of the main study, so that it could be clarified and modified, if necessary. Although the question was not asked in a formal nominal group session, the way the registered nurses responded to the question, “What are the strategies registered nurses use to implement IPHC in your district?”, made the researcher confident that the nominal group question was clear and that the study was feasible. The question was not altered after the explorative interview.

2.8 DATA COLLECTION

Data collection is the process the researcher follows to gain entry into the research setup, clarify the role of stakeholders, accumulate data, and protect the rights of the participants (Botma *et al.*, 2010:291). After receiving approval from the UFS Health Sciences Research Ethics Committee, HSREC 43/2017 (UFS-HSD2017/0327), permission was requested and obtained (see letter in Appendix A) from all the gatekeepers (Botma *et al.*, 2010:291):

- The director general at the MOH and the director PHC, Lesotho: A letter describing the purpose of the study was submitted to the director general, MOH, who issued a letter of approval (Appendix B).
- The director, CHAL. The letter of approval is attached as Appendix C. CHAL management wrote letters and telephonically informed their health centres (two of the eight selected) about the arrival of the researcher for recruitments at their facilities.

- DHMT Maseru district, Lesotho. The letter of approval is attached as Appendix D. The district health manager informed the health centres included in the study by text message about the visits to the health centres.
- Applicable health centres: The researcher visited the randomly selected health centres (both for government and CHAL) to request permission and to allow for further recruitment in addition to the nurse in charge.

Upon arrival at the health centres, the registered nurses in charge of the health centres were given the letters of approval from the MOH and CHAL. For government-owned health centres, the counter-signed letter by the district manager was presented whereas for CHAL facilities the approval letter from CHAL management was handed in.

The registered nurses in charge of each health centre then gave verbal permission to invite registered nurses working at the health centres to be involved in the study. Depending on how busy they were, they either arranged a small meeting with the registered nurses to introduce the researcher, or accompanied the researcher to different departmental sections to make introductions.

After introducing herself and explaining that she was allowed to carry out the study, the researcher asked the registered nurses individually to participate in the study. The background of the study was explained, and an indication given of the date, time and the hall to be used for group sessions. It was explained that there would be two group sessions. The session that would commence in the morning would be for the registered nurses in charge, and the afternoon session would be for the registered nurses working in the health centres. The main reason for this distinction was to avoid any possible intimidation by the higher ranked registered nurses in charge of the health centres. As mentioned in Section 1.3, both of these groups were directly involved in the implementation of IPHC, however, they did not have the same rank. Information leaflets were issued. Some participants declined to participate.

After the process of recruitment of participants, a hall was arranged at a central location where the group discussions commenced as tabulated below.

2.8.1 Nominal group technique setup and arrangements

A hall was booked at a central health centre. As recommended by Delbecq and Van de Ven (1971:473), the arranged hall was at a quiet place that allowed participants to

concentrate. The hall was cleaned and a large table was placed in the center of the room; enough seating was provided to accommodate the participants (see Figure 2.1).

Equipment available included flip chart paper, markers and small cards. Every seat had a bottle of water, consent forms and an information leaflet. Each participant was also provided with a pencil, plain writing paper and five voting cards. The flip chart pages were pasted on the walls, high enough for participants to see.



Figure 2.1: Photo of the nominal group setup

2.8.2 Conducting nominal group discussions

The first group, which consisted of registered nurses in charge, started at 9:30 and continued to 12:00. Six (6) of the eight (8) (75.0%) registered nurses in charge of the health centres had voluntarily agreed to participate and attended the group session. For the group of the registered nurses that work at the health centres, nine (9) of the 12 (75.0%) members recruited started their group session later on the same day, at 14:00, and their session lasted until 16:00. However, out of the nine (9) registered nurses who participated in the second group session, two left early, before the end of the group, to attend to family responsibilities.

The facilitator started by welcoming every participant to the nominal group session. She introduced the study, and explained its purpose and value. Other information included

explaining that the study had ethical approval from the UFS and permission from authorities at the MOH. General rules of confidentiality were clarified (Harvey & Holmes, 2012:191). The processes involved in the nominal group were explained, with the aim of making every participant relax and feel comfortable with the group (Delbecq & Van de Ven, 1971:473). There was time for questions. Consent forms, which were placed by each participant's seat, were completed before the nominal group session commenced.

2.8.3 Nominal group technique processes

Four distinct stages were followed in conducting the nominal groups.

2.8.3.1 Generating ideas

An open-ended question was asked: ***'What are the strategies registered nurses use to Integrate Primary Health Care (IPHC) in your district?'*** In each group, the participants were asked to write ideas on a piece of paper, each idea separately. They were given 10 to 15 minutes to generate ideas individually. After participants had finished writing down their individual ideas, the round-robin stage commenced.

2.8.3.2 Sharing ideas (round robin)

Participants were invited to share their ideas in a round-robin fashion. Participants took turns to provide their ideas. No criticism or clarification of ideas was allowed in this stage of the process. All responses were written on flip chart pages, even those that appeared to have similar meaning, for all participants to look at and read. After all the participants had had the opportunity to share all their ideas, the next stage commenced.

2.8.3.3 Rating/ranking

All the ideas were then discussed and clarity was provided on how the group understood each idea. This process was highly interactive, and involved lengthy elaboration by the group members. Elaboration was done in such a way that participants were free to give input without personalising the ideas. Discussion points were summarised under each idea. While the points were being discussed, some of the statements, which had similar meaning, were consolidated into one point with a single meaning as judged by participants. Statements were merged simultaneously within the discussions, until all were distinct points (see Appendix G Column C of the table). After the discussions ended, the participants had the opportunity to group similar ideas

together by achieving group consensus (Botma *et al.*, 2010:253), after which participants voted on the relative importance of the ideas.

2.8.3.4 Voting

Each participant was given five voting cards on which they could rate their top five ideas separately, from five – the most highly favoured idea – to one, the least favoured. The data, at this stage, became more structured, as the group participants sorted, mapped, voted and checked the results of the vote based on the ideas they had generated (Boddy, 2012:15). At the end of this stage, each group had identified the five most favoured ideas. The participants were satisfied with the partial analysis they had achieved through prioritising and voting. The participants expressed their appreciation of the immediate feedback of the group session.

After the nominal group sessions, the facilitator thanked all the participants for their time and input. They all had refreshments, they were reimbursed for their transport expenses, and left.

The data analysis discussed below will show how partial analysis by the participants was achieved and how the researcher continued with other steps to conduct a final analysis.

2.9 DATA ANALYSIS

Bloomberg and Volpe (2016:188, 189) explain data analysis as an ongoing process of combining pieces of information (raw data) that was collected through different methods, into sensible and easily comprehensible data. Data analysis is the process of organising and managing the data collected (Bryman, 2012:13; Lichtman, 2014:317). Blaikie (2010:24) explains analysis as reducing the bulk of raw data into interpretive meanings. The data was analysed in two phases.

2.9.1 First phase of data analysis

The participants assisted with the first phase of analysis during the nominal groups. During data collection, the participants had clarified and ranked all their statements in order of priority. In NGT, the first phase of analysis occurs as participants interpret and merge statements that have the same meaning, as explained in Section 2.8.3.3. The

researcher analysed the ranked strategies from the groups further using the guide proposed by Van Breda (2005:1-4) to integrate the list of statements from the different groups. Six steps were used. The data set and subsequent calculations can be found in the tables in Appendices F, G and H.

2.9.2 Second phase of data analysis

Thereafter, the researcher analysed the data according to a six-step procedure described by Van Breda (2005:10-11). During the second phase, the researcher identified themes through content analysis. She also engaged peers (a group of expert nurse researchers) to review the themes and make suggestions.

2.9.2.1 Step 1: Capture data on a computer

The data that had been collected was captured in an Excel spreadsheet. At this stage, the researcher did not need statistical knowledge and did not have to execute calculations; however, a basic knowledge of spreadsheets was mandatory. The two groups' data was entered into the horizontal columns headed A to F.

2.9.2.2 Step 2: Identifying the top five statements

The researcher arranged each group's set of statements according to the importance assigned to each statement by the group, and then identified the five most important statements of each group. Next, the data was sorted in ascending order, per group. The individual scores assigned by participants were summed in Column A; then, all the scores were divided by the number of participants in the group, to calculate the average score of each statement. The data was sorted in descending order, by the average score. The top five statements for each group could now be identified from the average scores.

2.9.2.3 Step 3: Content analysis of data

The researcher grouped the individual statements that had been collected into themes or categories by means of a content analysis process. In qualitative research, content analysis is done to reduce large amounts of data and to group data into distinct themes and categories (Polit & Beck, 2012:268). Van Breda (2005:3) states that, in the NGT,

content analysis is done by grouping statements with similar meanings together to form a theme.

The researcher familiarised herself with the statements by reading them repeatedly before deciding to which theme they belonged. Some themes were merged into one, if they contained overlapping meanings, and some were separated during the process, until each theme was distinct from the others. Each theme was given a number and its definition was attached. In order to ascertain if all the statements had been categorised, the researcher studied the list of statements and made sure each had a corresponding theme (Appendix F/G/H, Column B of the table).

2.9.2.4 Step 4: Confirm content analysis

Van Breda (2005:7) and McMillian *et al.* (2014:14) concur that researchers can confirm the themes derived through content analysis processes. During this step, peer review can lead to changes and the reduction of themes, to make the themes more distinct. In this study, a small group of nurse researchers assisted the researcher to confirm and reduce the themes. The group consisted of a professor of nursing, a PHC expert, the nominal group facilitator and the researcher. Separate copies of the statements and themes were printed and provided to each nurse researcher. The study background was explained and the nominal group question was stated. The researcher then described each theme and its definition. The nurse researchers then independently read each statement and decided which theme they would associate with it. The themes were then discussed until consensus was achieved.

2.9.2.5 Step 5: Calculating combined ranks

The researcher then determined the relative importance of each theme, based on the average score, determined by the participants' votes (described in Section 2.9.2.2) and which yielded the prioritised list of themes. See Appendix I.

2.9.2.6 Step 6. Reporting the nominal groups' findings

The themes that were identified are described and interpreted in Chapter 4.

2.10 TRUSTWORTHINESS

The study's trustworthiness was ensured by adherence to Lincoln and Guba's (cited in Polit & Beck, 2012) principles of credibility, transferability, dependability and confirmability. Authenticity as cited by Polit and Beck (2012:596) was also applied in the study.

Certain measures were undertaken throughout the research process to improve rigor and enhance the reliability of the findings. De Vos *et al.* (2011:365) believe that, in qualitative research, like in quantitative research, researchers need to apply measures that evaluate the "truth value" of the study. In qualitative research, truth value is known as trustworthiness (Polit & Beck, 2012:596).

Validity and reliability are rigorous processes in quantitative research, while qualitative studies can be judged or evaluated according to trustworthiness, based on the argument that there can be multiple accounts of social reality (Bell, 2011:44; Bryman, 2012:390). The trustworthiness of the study was addressed using the following criteria: credibility, transferability, dependability, confirmability and authenticity (Polit & Beck, 2012:595).

2.10.1 Credibility

Credibility relates to the accuracy with which the researcher interpreted the data provided by the participants (Bryman, 2012:390). Bell (2011:44-45) suggests that credibility of findings can be established by ensuring that the research is carried out according to the standards of good practice. In this study, the participants voluntarily provided ideas with the help of a facilitator, who was a nurse researcher with a PhD and extensive prior experience of conducting nominal groups, and of working in remote, low-income areas). Hence, the study findings rest upon the facilitator's credibility.

Researcher's credibility: In qualitative studies, the researchers (facilitators) are the main data collection instruments in the research process. The researchers are involved in all the aspects and steps, including data collection and data analysis, of the research process (Polit & Beck, 2012:596). In this study, an expert facilitator was entrusted with facilitating the nominal group sessions until consensus was achieved. The decision to make use of an expert facilitator was made so that the researcher could bracket her

influence on data collected; this was necessary, as she was a registered nurse in charge of one of the health centres in Maseru.

Member checking: As Polit and Beck (2012:566) suggest, “member checking can be carried out in an ongoing way as data are being collected”. When using other techniques, researchers usually have data transcribed, and refer back to participants to check if the meanings derived are accurate. In this study, the use of NGT allowed for member checking during data collection. The participants received instant feedback and had an opportunity to clarify their response (statements) and confirm their concrete meaning. Member checking heightens trust in the credibility of the data collected.

Prolonged engagement: Credibility increases when the researcher spends long periods of time with the participants and when findings are believable from the participants’ perspective (Plooy-Cilliers, Davis & Bezuidenhout, 2014:258). The researcher should invest sufficient time to collect data, to gain an in-depth understanding and to test for distortions in the data. Prolonged engagement also builds trust and rapport with participants, which, in turn, makes it more likely that rich, accurate data will be obtained (Polit & Beck, 2012:589). The nominal group session lasted for two to three hours, to allow enough time for data collection. The researcher also familiarised herself with the collected data. She read statements over and over with their elaborated explanations before commencing with data analysis.

Peer review and debriefing: An expert group, consisting of the nominal group facilitator, an expert PHC nurse, a professor of nursing research and the researcher, reviewed the themes during the data analysis. These peers helped to match the statements with the themes during this stage of the analysis, to recheck and confirm that the researcher understood and interpreted the participants’ accounts in a reliable fashion. Nonetheless, it remained the researcher’s responsibility to interpret the data. In this study, data analysis and interpretation was done before a comprehensive literature review (Chapter 3) was done, to enhance the reliability of the data interpretation.

2.10.2 Transferability

Thick descriptions: Qualitative research typically involves an intensive, in-depth study of a small sample of individuals who share certain characteristics, in contrast to quantitative studies, which are much broader (Bryman, 2012:392; Plooy-Cilliers *et al.*, 2014:258). Hence, qualitative findings tend to be oriented to contextual uniqueness and

the social aspect being studied. It is mandatory in qualitative studies that researchers produce thick descriptions, which could make transferability of findings possible. Transferability is, therefore, the ability of a reader to judge if the findings can be applied to a similar situation (Plooy-Cilliers *et al.*, 2014:258). In this study, thick and vivid descriptions are provided to explain who was involved in the study, and how data was collected and analysed. This may enable other researchers to assess the applicability of the study in their own contexts.

2.10.3 Dependability

Thick descriptions: Dependability refers to the integration that takes place between data collection, data analysis, and possible theory generated from data (Plooy-Cilliers *et al.*, 2014:259). The criterion of dependability is based on “auditing” of research records. Dependability suggests that research findings will endure over time and in different conditions. The essence is whether the findings of the inquiry will replicate if the study is repeated with the same participants in the same context (Polit & Beck, 2012:585; Savin-Baden & Major, 2013:476). To enable the assessment of dependability research conditions and processes (research methodology: technique, sampling and data collection steps), should be outlined in detail. Should the same processes be applied, the findings should be the same.

Descriptions of how data was collected and analysed improve the chance that, if the same participants were to participate in a nominal group session, during the same time period, again, the findings would probably be the same if the steps are followed as described. In this study, dependability was enhanced by describing fully the research methodology, the design, sampling procedures and processes undertaken for NGT steps.

2.10.4 Confirmability

Confirmability refers to the ability of the researcher to remain neutral during data analysis and interpretation (Savin-Baden & Major, 2013:476). Polit and Beck (2012:585) clarify this criterion by explaining that the data must represent the information the participants provided and that the inquirer must not manipulate the interpretations of the data. Confirmability is concerned with the researcher ensuring that her personal values or theoretical inclinations do not influence the collection and interpretation of the data.

The data collected must support the findings and interpretation of the researcher. Should anyone else analyse the data collected, they must come to similar conclusions as the primary researcher (Plooy-Cilliers *et al.*, 2014:259). In this study, confirmability was enhanced through engaging a skilled facilitator, participants through using NGT, peer review and debriefing.

Peer review and debriefing: The researcher is a registered nurse and was, at the time, in charge of a health centre implementing IPHC. For the purposes of confirmability and to enhance bracketing, she engaged a facilitator during the process of data collection and confirmation of the final analysis. Moreover, during data analysis, peers were involved in the content analysis process. They associated the statements with the definitions provided. In this way, the researcher enhanced the likelihood that other researchers would reach the same conclusions. The data is available in Appendix H.

2.10.5 Authenticity

Authenticity, as explained in Section 1.12.5, is one of the measures of trustworthiness, which is applied to enhance the reliability of data (Polit & Beck, 2012:585). In this study, thick description were done to enhance authenticity. Group members wrote down their individual ideas, shared their ideas and clarified topics in a group, before the topics were classified and consensus was reached by voting. Elaboration of the processes took place earlier in this chapter, in Section 2.8.

Table 2.2: Summary of strategies to ensure trustworthiness

	Strategy	Applicability to the study
Credibility	Researchers' credibility	<ul style="list-style-type: none"> • The group sessions were facilitated by a skilled field worker • Confidence was acquired through her experience and shared credentials coupled with familiarity with NGT.
	Member checking	<ul style="list-style-type: none"> • Through probing and matching statements, participants verified the meaning of data during data collection
	Prolonged engagement	<ul style="list-style-type: none"> • Time allocated for the group sessions was enough 2-3 hours • The engaged facilitator gave time to reach every step while using NGT technique (participants had trust in her) • The researcher also familiarized herself with data collected over time to understand it
	Peer review and debriefing	<ul style="list-style-type: none"> • Peers were asked to participate in explorative interview • A group of experts were engaged in content analysis
Transferability	Thick descriptions	<ul style="list-style-type: none"> • Descriptions about the methodology, population, sampling , data collection steps • Participants gave strategies with in depth explanations and elaborations
Dependability	Thick descriptions	<ul style="list-style-type: none"> • Descriptions about the methodology, population, sampling, data collection steps and procedures followed in using NGT were explained to enhance dependability
Confirmability	Peer review and debriefing	<ul style="list-style-type: none"> • During explorative interview and during data analysis, peers were engaged to assist in feasibility of the study and content analysis
Authenticity	Thick descriptions	<ul style="list-style-type: none"> • Elaborations and descriptions were done that would engage readers on the research processes and findings

2.11 ETHICAL CONSIDERATIONS

Ethical considerations refer to all the measures the researcher took to protect the participants in the study. According to Bryman (2012:134), researchers should comply with ethical guidelines and ensure that the research study does not have any

detrimental effects on participants. As outlined and discussed in Section 1.13, the following ethical principles were observed: autonomy (informed consent), beneficence, non-maleficence (confidentiality) and justice (research responsibilities). These principles were considered from the proposal stage and were carried out throughout the research process.

At the beginning of this research process, the proposal was evaluated by a research review committee at the School of Nursing and further assessed by the HSREC of the UFS. Once approval had been received through UFS processes, the same proposal was submitted to the MOH ethics committee and CHAL for review. During data collection, provisions in the proposal were honoured. The selection process of participants involved fair sampling, without any conflict of interest, with the purpose of gathering rich data. To avoid discomfort and intimidation, managers and the staff working at the health centres were allocated to different groups. Furthermore, nominal groups were conducted by an expert facilitator, participants signed consent forms, data was kept safe in a locked cabinet and participants were not penalised for withdrawing from the study.

2.12 CONCLUSION

In this chapter, the methodology applied to this study was described. This included the research paradigm, research design, research technique, sampling, data collection, and data analysis. Moreover, trustworthiness was explained and ethical considerations tabulated. The methodology chapter in this study was done before a full literature review was undertaken. In this study, the literature was reviewed after data analysis, although the literature background is presented before data analysis to aid with the flow of the document.

CHAPTER 3: LITERATURE BACKGROUND

After the data analysis process had been completed, as described in the previous chapter, the researcher reviewed some literature relevant to the study. The researcher aimed to explore literature to provide a background to the phenomenon of PHC. Chapter 3 will, therefore, serve as background for the study and provide an introduction to the data analysis (De Vos *et al*, 2011:93). Polit and Beck (2012:66) argue that engagement with literature is not a one-step chapter of the research, but an evolving process that continues throughout all the chapters. Some literature will, therefore, also be referenced in Chapter 4.

This chapter contains information on the initial approach, philosophy, and implementation of PHC, including the challenges experienced. Next, the need to refocus on IPHC will be explained, with attention to the different aspects that need to be integrated.

3.1 INITIAL APPROACH AND PHILOSOPHY OF PRIMARY HEALTH CARE

PHC as a health care approach and philosophy was launched in 1978 at a World Health Organization (WHO) conference. The Alma-Ata Declaration resulting from the conference advocated for “health for all”, and considered PHC as an approach that could improve the health of every citizen through access to basic health care (WHO, 1978:16-17).

The WHO recommended the approach for both developed and underdeveloped countries. Health is a complex component of human life and a major task to maintain, regardless of the economic status of the country. Countries, therefore, gathered at the Alma-Ata Conference to plan how to address the ever-increasing disease burden in their communities.

The original idea was to make sure that all countries were capable of providing a minimum standard of care to everyone at community level, to ensure good health. Health was declared as a human right. Apart from access to an essential package of health care services, the services also had to be acceptable to persons in need and had to the best to address their needs (with available resources). PHC, as approach, set out to no longer merely treat disease and illness, instead, it would focus on health:

prevention, promotion and rehabilitation (Booth, Hill, Moore, Dalla, Moore & Messenger, 2016:3; WHO, 1978:2).

The underlying philosophy of PHC is based on values of equity, solidarity and social justice (Association of Registered Nurses of Newfoundland and Labrador, 2012:1; WHO, 2008a:14). PHC is person-centred, and requires each person to be actively involved in their own health. As explained by Goodwin (2016:1-4), equity in PHC means everyone is given the same opportunity to access essential health services, namely, “promotion, preventive, curative and rehabilitative care”. Solidarity involves all the people in a community, together with stakeholders, supporting each other in order to fulfil the mission of PHC. Social justice, on the other hand, pertains to observing people’s culture and delivering care in a way that is fair and acceptable to them. Therefore, the whole theoretical basis of PHC rests on the belief that basic care is for everyone, involves everyone and should be delivered through methods that are acceptable to communities.

As an approach, PHC is seen as the entry point to access health services. The principles that underline PHC as approach include,

accessibility of services within a reasonable geographic distance, public participation to ensure communities are active partners in their health, collaboration from a variety of sectors involved in ensuring health, comprehensive service delivery that enables communities to increase control and improve their lives, and use of resources and technology that are acceptable to communities (WHO, 1978:37-43).

3.2 IMPLEMENTATION OF PRIMARY HEALTH CARE

Since the Alma-Ata Declaration, PHC has been adopted and adapted in both developed and underdeveloped countries. However, different countries implement PHC at different rates (WHO, 2008b:2). Most developed countries were able to commit the money and other resources needed to implement PHC rapidly. Resources, such as health centres, health workers, equipment and drugs, where it was available, played a vital role in the success of PHC (Kringos, Boerma, Bourgueil, Cartier, Dedeu, Hasvold, Hutchinson, Lember, Oleszczyk, Pavlic & Svab, 2013:743). However, in many underdeveloped countries that experienced challenges relating to the availability of the necessary

resources, implementation has been slow or compromised. Exceptions were Cuba, an underdeveloped country, and the United States of America (USA), a developed country.

In Cuba, PHC has been very successful. Since the introduction of PHC, mortality rates have reduced significantly and, despite the country's low economic status, quality of life has improved (Magnussen *et al.*, 2004:170; Rao & Pilot, 2014:3). After implementation of PHC the infant mortality rate in Cuba declined from 23 to 7 per 1 000. People also started living longer, with the average life expectancy increasing to 78 years. Cuba invested less in secondary and tertiary level care and, instead, more resources were channelled to PHC activities. Champion and Morrissey (2013:297-298) commend Cuba for the drastic measures it took and the outstanding results of its strong PHC system.

In contrast, in the USA, although its economy is one of the largest in the world, PHC is not successful. Rao and Pilot (2014:3) report that the USA spends 13% of its gross domestic product on healthcare per capita, compared to 7% in Cuba. The USA has, however, not been able to achieve cost-effectiveness in relation to reducing its mortality rate. The USA family medicine programme, which was meant to be population-based, is unable to provide equitable, affordable PHC to all citizens (Andersen, Davidson & Baumeister, 2014:47; Ventres, 2013:53). The USA's health system remains heavily focused on secondary and tertiary, specialised care.

Furthermore, after the Alma-Ata Declaration, some countries adopted PHC as a result of pressure to assume responsibility for giving all citizens an equal chance to access basic care (Peltzer, Williams, Kowal, Negin, Snodgrass, Yawson, Minicuci, Thiele, Phaswana-Mafuya, Biritwum & Naidoo, 2014:1). It was expected of each country to implement it by means of acceptable methods, in light of available resources and in a way that is most cost-effective. Approaches to implementation differed in relation to the human resources deployed. Most countries started to utilise community health workers, also known as VHWs, at the forefront of service delivery, to engage with their communities and persuade them to take part in their own health decisions and treatment measures (Andersen *et al.*, 2014:47). In turn, the VHWs referred persons, when needed, to PHC facilities, where other health workers with additional skills could assist them.

Due to the varied pace of implementation in different countries, 40 years after the Alma-Ata Declaration was signed, PHC, on a global level, is still not delivering projected

outcomes consistently (Rao & Pilot, 2014:2). In some countries, PHC is still not accessible to everyone, has low coverage and does not include all aspects of PHC. Services, such as promotion, prevention, treatment and rehabilitation, have not yet been fully integrated into one package everywhere. There are, however, commonalities regarding the positive impact of PHC implementation, which cut across developed and underdeveloped countries.

3.3 CHALLENGES EXPERIENCED WITH PRIMARY HEALTH CARE IMPLEMENTATION

PHC faces challenges regarding implementation. despite the existence of established policies to support it. Some challenges have been mentioned, for example, inadequate funding, infrastructure and resources. The most noticeable challenge at the health systems level is ever-increasing, concurrent, fragmented service delivery and a lack of standardisation (Valentijn *et al.*, 2013:3).

As discussed in Section 1.2, PHC can be undermined by the fragmentation of care, as driven by large donor-funded projects and an uncontrolled burden of disease. PHC is also largely unstandardised.

To date, PHC has had very few comprehensive implementation frameworks or guidelines. There is a need for standardised, tabulated, systematic procedures (Valentijn *et al.*, 2013:2) for implementation. In the absence of standardised protocols across settings, PHC implementation remains subjective and, sometimes, misguided (Goodwin, 2016:2). The WHO (2008b:3-4) warns that the absence of standard guidelines for implementation has the potential to derail the initial vision of PHC.

The need to be able to measure the impact of PHC poses a further challenge. Due to a lack of standardised indicators to measure the progress and success of PHC implementation, the conviction that PHC results in improved care remains unfounded; thereby, creating more room and opportunity for fragmented service delivery. The end results of fragmentation are suboptimal care to the very poor, and an increase in care costs due to duplication (Ahgren, 2014:53; Valentijn *et al.*, 2013:2). This effect necessitates an urgent response, to revive the initial PHC vision of comprehensive care (Bhutta, Ali, Cousens, Ali, Haider, Rizvi, Okong, Bhutta, & Black, 2008:972). As explained earlier in this chapter (Section 3.1.4), comprehensive care involves a range of health services that are made available to persons in a packaged manner. Hence, the

term integration emanates from the comprehensiveness of PHC (Rovere, Fuks, Bertolotto, Bagnasco & Jait, 2017:267). However, Valentijn *et al.* (2013:2) comment that even the term integration has ambiguous definitions, hence, the differences evident in practice.

Despite the challenges experienced, PHC continues to be the approach recommended by the WHO for basic health service delivery. In 2008, the WHO published a progress report on PHC, *Primary Health Care: Now More Than Ever*, which contains a review of the impact of PHC. In the same year, the Ouagadougou Declaration, with its emphasis on the integration of PHC, was pronounced at the Conference for Primary Health Care and Health Systems in Africa (WHO, 2008b:1). The intention of the Ouagadougou Declaration was to serve as a renewed call to renew the vision of PHC implementation, specifically, to emphasise the original concept of comprehensive (integrated) care that was embedded in the approach to PHC of the Alma-Ata Declaration, 30 years ago before Ouagadougou Declaration.

3.4 REVISION OF PRIMARY HEALTH CARE DELIVERY

The call for a renewed focus on PHC was made in order to counteract increasingly fragmented service delivery that appeared to hamper PHC progress (Bhutta *et al.*, 2008:972). The original concept of PHC, which contained an integrated philosophy and approach, was being distorted and overshadowed by highly specialised care, which does not facilitate continuity, comprehensiveness, coordination and PHC at the centre of a health system. As a result of this deviation from the concept of PHC, the intended outcomes of PHC, of achieving global health goals, were not being achieved.

The initial goal of PHC, to achieve “Health For All” by 2000, was not accomplished. Neither were the global goals set out in a set of Millennium Development Goals, which were meant to be attained in the period between 2000 and 2015. Bitton, Ratcliffe, Veillard, Kress, Barkley, Kimball, Secci, Wong, Basu, Taylor and Bayona (2017:567-568) emphasise that the focus of different health goals at the Conference for Primary Health Care and Health Systems in Africa, unfortunately, encouraged a fragmented, disease-specific approach to PHC, rather than integrated services. The current global health focus is on attaining the Sustainable Development Goals by 2030; there are 17 goals and 169 targets (Pogge & Sengupta, 2015:3).

One of the primary Sustainable Development Goals is attaining universal health coverage. Universal health coverage entails the principles of PHC that strive to distribute health care evenly, to reach everyone. For improved accessibility of health services, PHC services must be equitable (fair), and medicines must be affordable (Bitton *et al.*, 2017:566). De Andrade, Pellegrini Filho, Solar, Rígoli, de Salazar, Serrate, Ribeiro, Koller, Cruz and Atun (2015:1) emphasise that the universal health coverage mandate matches the initial aim of the PHC that had been declared in 1978. Like universal health coverage, PHC was meant to offer cost-effective care that can be accessed by everyone. The essence, of including preventive and health promotion, makes it possible to avoid a focus on sick people, instead, focusing on the wellness of the general population. The renewed call for universal health coverage, therefore, emphasises the underlying need identified by PHC to integrate services (Schmidt, Gostin & Emanuel, 2015:1). To achieve universal health coverage, it is, therefore, important to focus on the aspects of integration of PHC.

3.5 INTEGRATED PRIMARY HEALTH CARE

IPHC is defined as a coordinated service package at first contact of care that suits the needs of an individual at a particular time and place best (Valentijn *et al.*, 2013:7). The service package includes health promotion, health prevention, and curative and rehabilitative services (WHO, 1978:11-12; WHO, 2008a:2). This form of integrated care is fundamentally important, because it emulates the concept of health itself.

Health is explained according to a holistic view that does not only focus on physical inability, but which involves the psychological aspect of humanity within the societal context. Schmidt *et al.* (2015:1) believe that, through its principles of comprehensiveness and a combination of essential services, IPHC responds to the demands of optimal health for everyone. The WHO (2008b:2) calls for revitalising PHC through a focus on IPHC, as a significant approach to attaining “Health For All”, despite the challenges involved.

IPHC, just like PHC, aims to strengthen the whole health system. For integration to take place at PHC level, the whole health system is required to transform. The core determinants are population and persons (Valentijn *et al.*, 2013:7). As all levels of care turn their focus to people, the whole system becomes strengthened towards one target – what service user needs. Strengthening health systems is simplified by Valentijn *et al.*

(2013:1-9) in the Rainbow Model of Integrated Care (RMIC) for PHC. The model states that there is a form of integration applicable to all dimensions/levels of care, which is founded upon population and persons.

PHC operates within clinical integration. Clinical integration is “the coordination of person-focused care in a single process across time, place and discipline” (Valentijn, Boesveld, Van der Klauw, Ruwaard, Strijs, Molema, Bruijnzeels & Vrijhoef, 2015:2). The needs of a person are addressed by health workers using shared guidelines and protocols. Health workers then use these protocols to deliver services coherently and according to patient needs by a joint service at PHC level (WHO, 2008b:5). IPHC is, therefore, responsible for delivering coordinated services at first contact of care, based on persons’ needs.

3.6 CONCLUSION

This chapter described the origins of PHC, how it is implemented, and what necessitated a renewed focus on the concept of integration. The next chapter will begin to address the gap described in Chapters 1 and 3. Chapter 4 will document some of the strategies utilised by registered nurses who implement IPHC in the Maseru district of Lesotho.

CHAPTER 4: DESCRIPTION OF FINDINGS

4.1 INTRODUCTION

The previous chapter detailed the methodology used in the study. Data collected by means of the NGT will be presented in this chapter. Data were collected to answer the research question:

What are the strategies registered nurses use to implement integrated primary health care in your district?

4.2 PARTICIPANTS' DEMOGRAPHIC DATA

As suggested by Van Breda (2005:8), demographic data may be included in the research report to analyse participants' characteristics. In this study, demographic data was of importance, in order to rule out the role of gender and experience of participants. Two sets of data were collected, one for each groups of participants. Group 1, comprised of the registered nurses in charge of health centres, and Group 2, of the registered nurses working in the health centres. The characteristics of each group are tabulated in Table 4.1.

Table 4.1: Demographic data of participants in Group 1

Invited	Participated	Gender	Age range (years)	Experience (years)	NGT time
8	6	Men 1	32-55	Men 3	09:00-12:00
		Women 5		Women 5, 6, 7, 7, 18	

As reported in Table 4.1, some of the nurses who had been invited were not able to attend the data collection sessions. Recruiting was done two weeks prior to data collection day, which was on 1 September 2017. Doing recruitment two weeks before the day gave participants time to reschedule their duties. However, due to unforeseen circumstances, two of the nurses in charge could not participate, leaving six participants. One of the six participants was provided with transport. The other five participants were reimbursed for their transport expenses. Refreshments were served after the session. The group session lasted three hours.

The group consisted of more women (n=5; 83.3%) than men. The nurses in charge were also older than those of Group 2 (32-55 years, median 37.5 years) (see Table 4.2).

Group 1's members had extensive experience, with more than two thirds of them (n=6, 83%) having been in their positions for more than half a decade (median 6.5 years).

The demographic data of the participants was not surprising. The gender distribution corresponds with the Lesotho nursing PHC placement, which indicates that nursing is a woman-dominant profession (Lesotho MOH, 2014:8). Nurses in charge are older and have more experience than other nurses. Due to a shortage of nurse clinicians in Lesotho, registered nurses who hold Bachelor's degrees are considered for management positions (managing health centres) after two years of work experience, and those with diplomas in nursing, after five years (Stender *et al.*, 2014:2). The NGT session for Group 1 was conducted in the morning, to enable nurses in charge to return to work as soon as possible.

Demographic data for Group 2 is presented in Table 4.2.

Table 4.2: Demographic data of participants in Group 2

Invited	Participated	Gender	Age range (years)	Experience (years)	NGT time
12	9	Men 2	28 – 36	Men 3, 3	14:00-16:00
		Women 7		Women 3, 3, 4, 5, 6, 6, 7	

Group 2 consisted of registered nurses who provided direct patient care at eight health centres. The group comprised nine participants from the 12 nurses who had been invited to participate. Participation was voluntary. Two members left the discussion before they could vote, due to family commitments.

This group also comprised a majority of women (n=7, 77.8%). The registered nurses were slightly younger (28-36 years, median 31 years) and had less experience (3-7 years, median 4 years) than the nurses in charge of health centres. The participants of Group 1, however, all had more than one year of experience and were directly involved in implementing IPHC at their respective health centres. The session for Group 2 lasted for two hours.

The nominal group question mentioned in Section 4.1 was posed; the participants responded to the question and provided data, which will be analysed in the next sections.

4.3 DATA ANALYSIS PROCESS

During the important stage of data analysis, the researcher processed and organised the large amounts of raw data that had been provided, and reflected on the participants' perspectives (Babbie, 2007:378; De Vos *et al.*, 2011:399-400). In this study, data was in the form of multiple statements, which were partially analysed by participants (Phase 1) and later interpreted by the researcher (Phase 2). The process to ensure that the interpreted data reflected the participants' viewpoints and social reality was described in Section 2.3.

4.3.1 Phase 1

The first phase of data analysis coincided with the data collection in the nominal group discussions. Participants in each group combined statements that had the same meaning during the discussions. A full description of the NGT and how the data was analysed by participants was given in Section 2.8. Consensus was reached and the participants voted for the strategies they used. The statements and scoring, by group, are reported in Tables 4.3 and 4.4.

4.3.2 Phase 2

The steps for analysing multiple sets of data according to Van Breda's guide was followed (as described fully in Section 2.9):

- Capture data on a computer
- Identify the top five statements
- Do content analysis
- Confirm content analysis
- Calculate ranks
- Report the nominal groups' data

4.3.2.1 Capturing data on a computer:

Data collected from participants (statements and scores) were entered onto a spreadsheet, after which the second phase of data analysis was done by the researcher and a group of nursing researchers. A detailed description of the second phase of data analysis was given in Section 2.8. Table 4.3 (Group 1 data) and Table 4.4 (Group 2 data) report on the statements and scores allocated by the participants and then processed by the researcher.

4.3.2.2 Identifying the top five statements

The researcher tabulated individual score ratings and calculated the total score for each statement. These scores were then summed and divided by the number of participants who had participated in the NGTs, to obtain averages. The “top five” statements (far right columns in Tables 4.3 and 4.4) are based on these calculated averages.

Table 4.3: Group 1 data: Statements and scores

Group	Statements	Scores	Totals	Average	Top 5
1	Patient information of service availability	4, 5, 5	14	2.3	1
1	Organises services based on available human resource	4, 5, 4	13	2.2	2
1	Internal referral and accompanying patients to different service points by RNs and other staff members	5, 3, 2	10	1.7	3
1	Triage, screening, start with main complaint and attend to other needs afterwards	1, 3, 2, 3	9	1.5	4
1	Combining TB/HIV/PMTCT services, e.g., ART corner that incorporates other services	4, 1, 2	7	1.2	5a
1	Establish community links with community health workers for continuity of IPHC at home	2, 4, 1	7	1.2	5b
1	Utilise patient flow plan and assign other staff to help	2, 4	6	1.0	
1	Use of appointment system that favours more services to accessed in one clinical visit	1, 1, 3, 1	6	1.0	
1	Include spiritual uplifting in daily routine of giving IPHC	5	5	0.8	
1	External referral to other facilities for services that the health centre cannot offer	5	5	0.8	
1	In-service training and mentorship for capacitation on IPHC	3, 2	5	0.8	
1	Partial integration done when full IPHC services are not possible to render	3	3	0.5	

Legend: HR – human resources; Dr – doctor; TB – tuberculosis; RN – registered nurse; PMTCT- Prevention of mother to child transmission; PITC - Provider initiated testing and counselling; ART – antiretroviral therapy; HIV – Human immunodeficiency virus.

Similarly, Group 2 prioritised their statements, which are reflected in descending order based on their scores and averages in Table 4.4.

Table 4.4: Group 2 data: Statements and scores

Group	Statements	Scores	Totals	Average	Top 5
2	Provide health education of services offered in the health centre	5, 2, 5, 5, 5, 1	23	3.3	1
2	Monitoring and evaluation	3, 4, 1, 5	13	1.9	2
2	Use supermarket approach to implement IPHC	4, 1, 4, 3	12	1.7	3
2	Timing of all services to be provided all at once: and one-stop-shop	5, 3	8	1.1	4a
2	Appoint patients based on the needs to be provided	3, 2, 3	8	1.1	4b
2	In service training conducted to nurses to increase competence in practicing IPHC	2, 4, 2	8	1.1	4c
2	Refer to departments and staffing, which determines the type of service that can be offered	4, 2	6	0.9	5
2	Community participation, which assist with informing the health centres about patients' needs	4,1	5	0.7	
2	Include staff in plan and budget for easy identification of resources needed for IPHC	5	5	0.7	
2	Referrals and linkage systems to hospitals or other non-governmental organisations for further assistance	1, 1, 2	4	0.6	
2	Proper documentation to identify patients' needs	4	4	0.6	
2	Health centre staff help with patient flow to different service points	1, 3	4	0.6	
2	Follow up village health workers for continuity of IPHC at home and make proper referrals	3	3	0.4	
2	Form clubs/groups of patients with same health needs, e.g., adolescents	2	2	0.3	

Some statements that were mentioned by the participants of Group 2 were not voted for, namely, performance appraisals and entertainment of staff. These statements were not included in Table 4.4.

To turn the prioritised statements into usable information, the researcher had to make meaning of and interpret the data, hence, she performed content analysis. The

researcher merged the statements that had similar meanings into themes by reading and rereading the statements (De Vos *et al.*, 2011:402), thereby identifying eight themes.

4.3.3 Content analysis

In order to consolidate the findings, content analysis was applied (definition provided in Section 2.9.2.3). The researcher familiarised herself with data collected. Statements were read and reread to understand the meaning. The process of grouping statements with similar meaning then commenced. A theme was attached to each group of statements, and eight themes constructed. They are tabulated in Appendix F. Van Breda suggests that confirmation of derived themes can be reviewed, as an optional step, to enhance the distinctiveness of the themes. The researcher decided to invite a group of peers to review the themes.

4.3.3.1 Confirming data analysis

As described in Sections 2.10.4 and 2.9.2.4, the researcher engaged a team of experts who were well acquainted with both the concepts of IPHC and NGT processes to assist with data analysis. The group of peers consisted of three people and the facilitator. The background of the study was given to the group by the researcher, and the NGT and NGT question asked. This information also was handed to each peer for easy reference. The researcher also shared the drafted themes. Then, silently and individually, each person was given the opportunity to agree or disagree with the statements and make suggestions according to their own understanding.

After each one of them had worked through themes, they discussed derived statements. Finally, the team agreed on amending the themes to only four distinct ones. Furthermore, one theme was divided into four sub-themes. Table 4.5 shows the four themes and Table 4.6 lists the sub-themes agreed upon by the group.

4.3.4 Combined ranking (relative importance of themes)

At this point, the data from both groups were combined. All statements were assigned to a theme. The total scores, averages and top five statements were calculated and clearly tabulated. Van Breda (2005:7) names/denotes this stage as “quantitative analysis” of

data. At the end of this stage, the themes were arranged according to their relative importance to the entire set.

Although McMillan *et al.* (2014:17-18) describe a more recent method for nominal group data analysis for large amounts of data, they still consider the seminal work of Van Breda's data analysis (2005) to be useful. Van Breda's process for analysis of data from multiple groups is suitable when the researcher combines the entire data set into one group. However, when researchers deal with large amounts of data and many sets of data with many themes, they have to prioritise the themes, so that only the themes with the highest scores are used to answer the research question. However, if data is manageable and only needs to be combined across a small number of groups, Van Breda's method of analysis is ideal. The researcher, therefore, used the data analysis method described by Van Breda (2005:6-10) for this study's data.

In order to combine the whole set of data, Group 1 statements and Group 2 statements were combined into one set of data (Van Breda, 2005:7-8) by means of the quantitative steps described below. The main reason for this step is to rule out the relative importance of each theme. The statements were then all typed in the spreadsheet with scores and each statement attached to a theme and averages (see Appendices G and H, and illustration below).

Sort by:

- Column B (theme) first, in ascending order; and
- By Column F (Top 5), in descending order,

After this stage, statements with the same theme were grouped together for the entire set of data with distinct themes. Then, the themes were ranked and Columns A to H created.

- Column A: Themes were typed, e.g., 1 Person-centred care.
- Column B: The frequency of each theme was determined by counting how many prioritised statements appear in the top five of each groups' statements.
- Column C: Statements for each group.
- Column D: Scores for each statement.
- Column E: Average in relation to the entire group.

The themes were ranked using the same procedure that was used for the statements. Table 4.5 lists the final ranking, and shows the relative importance of the theme

Table 4.5: Final themes that emerged from the data

<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>	<i>E</i>	<i>F</i>	<i>G</i>	<i>H</i>
Theme	Top 5 (1)	Top 5 (2)	No. 1	No. 2	Average (1)	Average (2)	Final rank
2. Organisation of services around the health centre	8,0	4,0	16,0	4,0	1,1	4,0	12,0
1. Person-centred care	2,0	3,0	2,0	3,0	2,8	1,0	7,0
4. Collaboration	1,0	1,5	5,0	2,0	0,7	3,0	6,5
3. Staff capacity	1,0	1,5	3,0	1,0	0,9	2,0	4,5

Column B: Top 5 (1) indicates the number of statements prioritised in relation to the combined statements. For example, Organisation of services around the health centre had eight statements that were in the top 5.

Column C: Top 5 (2) represents the ranked number of each theme based on top 5 (1).

Column D: No. 1 represents how many times each theme was voted for.

Column E: No. 2 represents the ranked number of each of themes 1, 2, 3 and 4.

Column F: Average (1) displays the average calculated by averages of statements divided by number of statements.

Column G: Average (2) gives average ranking of each theme.

Column H: Final rank gives the sum of column top 5 (2), Number 2, and average 2.

From the data above, organisation of services around the health centre is the relatively most important theme across both Groups 1 and 2. There more prioritised statements (eight) by the participants with many statements (16) for the entire set of data. It is noteworthy that person-centred care has a high average score. The explanation for the high average is linked to the high scores assigned to its statements, in Appendix G/H. High scores do not show the relative importance of the entire set of statements; it means a theme was voted for by relatively few participants, yet they assigned it a higher vote/rank. The purpose of establishing the relative importance is to analyse the themes across the combined data set, beyond calculated averages. Sometimes, a theme can have a high number of statements, and very few that were prioritised. For example, collaboration has five statements attached to it, however, only one was prioritised. Hence, as encouraged by Van Breda (2005:10) and McMillan *et al.* (2014:6), the themes were compared to determine their importance to the combined groups.

Organisation of services around the health centre was the most important, and staff capacity the least favoured amongst the four themes.

4.4 DISCUSSION OF THEMES

The discussion in this section focuses on the themes that were consolidated during data analysis. There were four main themes for the data collected, and the themes were consolidated as follows: (A) *Organising services around the health centre*, (B) *Person-centred care*, (C) *Collaboration* and (D) *Staff capacity*. Organising services around the health centre was, furthermore, divided into sub-themes, as some statements could be placed further. The subgroups for (A) Organising services around the health care are: (A1) Service delivery, (A2) Human resources, (A3) Timing, and (A4) Documentation.

Table 4.6: Themes tabulated

Themes	Sub-themes
(A) Organisation of services around the health centre	(A1) Service delivery
	(A2) Human resources
	(A3) Timing
	(A4) Documentation
(B) Person-centred care	-
(C) Collaboration	-
(D) Staff capacity	-

The sub-themes pertaining to organization of services (just like themes) were arranged in order of importance by using averages and the strength of each in relation to the whole group's votes, as shown in Table 4.6. A full description of the steps used to calculate the top 5, number, average and final mark is given in Appendix I.

Table 4.7: Sub-themes of Theme A

Theme	Top 5 (1)	Top 5 (2)	No. 1	No. 2	Average 1	Average 2	Final rank
A1 Service delivery	3,0	4,0	6,0	4,0	2,8	4,0	12,0
A2 Human resources	2,0	2,5	4,0	2,5	0,9	2,0	7,0
A3 Timing	2,0	2,5	4,0	2,5	0,7	1,0	6,0
A4 Documentation	1,0	1,0	2,0	1,0	1,3	3,0	5,0

The discussion below will be arranged by the main themes and sub-themes in sequence of relative importance. The more statements attached to a theme, the greater the relative importance of that theme to the participants. In this study, the strategies registered nurses used to implement IPHC are identified as ways to execute IPHC. Under each theme and sub-theme, strategies identified were tabulated. Moreover, under the discussion of each theme, prominent examples of statements (strategies discussed) made by participants (*“in quote format”*) will be provided and reference to related literature will be given. In some statements (strategies discussed), additional quotes are provided to elaborate. These elaborated explanations originated during the nominal group discussions (a stage of data collection, explained in Section 2.8.3.3), when the participants were given the opportunity to clarify their statements. Also, as the whole set of data was combined, the discussions of both Group 1 and Group 2 will be discussed jointly.

4.4.1 Theme A: Organising services around the health centre

Organising PHC services around patients' needs is not a new concept. Porter *et al.* (2013:516-517) emphasise that PHC services involve a variety of multiple services. One strategy for providing a range of multiple services to a person is to organise primary care based on groups of persons with similar needs, or based on the competences of the staff available. The participants felt strongly about the need to organise services to implement IPHC.

Organisation of services around the health centre was indicated as the most dominant and a highly favoured strategy for the implementation of IPHC by both groups. The participants highlighted four areas that can be organised to implement IPHC.

4.4.2 Theme A1: Service delivery

Various services are delivered in PHC settings (Booth *et al.*, 2016:3). These services focus on health promotion, disease prevention, and acute and chronic care. Service provision includes family planning, mother and child health, outpatient department, adolescent clinic, under-five clinic, and antiretroviral treatment. Registered nurses deliver care in these multiple settings. Discussions by participants suggested that, in order to serve persons at the health centre, they had adopted a “supermarket approach” as a strategy.

“Use supermarket approach to implement IPHC.” (Participants Group 2)

Sibiya and Gwele (2009:35) conducted a grounded theory study to describe IPHC in South Africa, and they describe how registered nurses understood the meaning of IPHC. The registered nurses compared IPHC to a supermarket, where patients who require more than one service were seen by different nurses located in different consulting rooms. According to Sibiya and Gwele (2009:35-36), the supermarket approach to IPHC provision entails the provision of multiple services under one roof, with various service points (rooms). The participants in this study indicated that they referred persons in need of services that these nurses could not provide in that particular cubicle to the next room (service point) within the centre (under the same roof), where the person’s needs could be addressed, and so on, until all the person’s needs had been addressed. The registered nurses also mentioned that, in order to practice the supermarket approach, they do internal referral of the persons so that they can access integrated services.

“We internally refer patients so that they access services in one day in different service points which are under one roof.” (Participants Group 2)

Apart from internally referring patients to different service points, Group 1 participants also mentions that they combine related services to serve persons at the same time.

“Combining ART/TB/PMTCT in one room.” (Participants Group 1)

“Include spiritual uplifting in daily routine of IPHC.” (Participants Group 1)

Providing care to persons with interrelated needs has been documented, and proven to be possible if additional services are incorporated into an existing programme, like the integrated care for diabetes mellitus or hypertension (Mohan, Seedat & Pradeepa,

2013:6). In this strategy, services are integrated in one room, rather than sending the person to the next room for further services. An example is a person receiving antiretroviral treatment in a certain room, and also being screened for possible prevalent opportunistic infections, such as tuberculosis. If the person is found to have active tuberculosis, the registered nurse will initiate tuberculosis treatment in the same room during the same consultation (Churchyard, Mametja, Mvusi, Ndjek, Hesselning, Reid & Babatunde, 2014:247). Another relevant example involves antenatal care. If a pregnant woman is found to be infected with HIV, she will access the antiretroviral treatment in the antenatal clinic, without having to visit an antiretroviral treatment clinic (Lesotho MOH, 2016a:17). Several examples were mentioned by participants:

“No up and down. If a patient complains of cough, we give everything there: there is a dispensary pharmacy without referring them to OPD”
[outpatient department] (Participants Groups 1 and 2)

Registered nurses in Group 2 described both the so-called supermarket approach and one-stop shop (providing all services in one room), and they allocated more votes to the supermarket approach. This means that registered nurses acknowledge both strategies, but preferred to address persons' needs through short referral trips within the health centre, instead of offering all the services in one room.

Nurses tasked to manage the health centres as well as provide care (Group 1) provided a further level of prioritising the persons visiting the health centre and the persons' needs through triage.

“Triage, screening and starting with the main complaint, and attending to other needs afterwards” (Participants Group 1)

Triage involves the systematic assessment of persons presenting at the centre, followed by prioritising persons based on their needs, and attending to the persons with more serious needs first (Hitchcock, Gillespie, Crilly & Chaboyer, 2014:1533). The participants described the process of triage used in health centres every day. When people arrived, the nurses did triage. Those presenting with emergencies and those with coughs were attended to first.

“Coughers first, they do not wait along with others. Emergencies are given priority and casualty patients” (Participants Group 1)

“There are also rooms spared for screening services. All patients who come for service are screened for HIV and vital signs” (Participants Group 1)

“We screen for signs of TB [tuberculosis], and give provider initiated testing and counselling. In special room for vital signs we screen for blood pressure, blood sugar level, and signs of malnutrition” (Participants Group 1)

“Registered nurse ask the patient for their main complaint. The patient might not be precise but eventually disclose the main reason for the visit” (Participants Group1)

“Ask the patient: Patient start at minor complaint, beat about the bush then later chief complaints come out. Service is then based on patient’s need”(Participants Group 1)

Triage and screening processes are used to ensure timely, holistic care. Hitchcock, *et al.* (2014:1533) found that a process of triage and screening allowed persons to receive the care they needed beyond the main reason they came for care. Often, someone will complain about a certain thing that made them seek help, but during triage and screening, more health concerns will be identified. Triage and screening enable the registered nurse to identify additional services that are needed, which can then be incorporated into the planned care (Churchyard, *et al.*, 2014:248).

Another important aspect of service delivery that the participants discussed, was the flow of patients.

“Utilize patient flow plan and assign other staff to help directs patients to different service points” (Participants Group 1 and 2)

The registered nurses, as administrators of IPHC, use patient flow as a strategy to ensure all the services needed by a person are provided on a particular day. Persons are directed to the relevant service points after the triage and screening processes. The flow of persons within the centre can be adjusted, based on the allied health staff available on the day. Participants indicated that a specific staff member is responsible for directing patients to the different service points. This coincides with the information

given by Group 2 on the supermarket approach and referring a person to various service points within the health centre.

“The security officers register patients on arrival and issue tickets. They even would call out patients by name on who must get to the consultation room/service point” (Participants Group 1)

Participants indicated that even auxiliary (non-medical) staff assisted with patient flow direction. During this process, a staff member, even a security officer, directed persons at reception. Persons were directed to rooms labelled with signs and posters. The management of patient flow ensured the integration of services.

“Patients start at reception: they are directed where to go, and are prevented from missing services” (Participants Groups 1 and 2)

Participants discussed the role human resources play in the implementation of IPHC, and this was identified as the second sub-theme of the main theme, Organising services around the health centre.

4.4.3 Theme A2: Human resource

In order for services to be integrated, health personnel have to work hand in hand with each other to address persons' needs (Hilty, Rabinowitz, McCarron, Katzelnick, Chang, & Fortney, 2017:244). Sibiya (2009:196) argues that integrating services places a greater demand on registered nurses in relation to the various skills and professional knowledge needed. A sufficient number of primary health nurses are needed to address issues, such as access to health care and patient waiting time (Igumbor, Davids, Nieuwoudt, Lee & Roomaney, 2016:1).

“Organizes services based on available human resource which are placed in various departments” (Participants Groups 1 and 2)

“Partial integration when full IPHC services are not possible to render” (Participants Group 1)

Available registered nurses and other health centre staff need to work in collaboration in order to address patients' needs sufficiently (Rissi, Gelmon, Saulino, Merrithew, Baker & Hatcher, 2015:34-35). Participants confirmed that services are rendered on the basis of whether registered nurses and other health workers are available to provide a service

on that day. In some centres, there are additional health workers, such as doctors and HIV counsellors, to whom registered nurses can refer patients. The presence of other cadres of health workers enable the registered nurses to interconnect with others and refer the person within the health centre, to another health worker in a different room.

“We refer to the appropriate human resource: the specific person who is able to do what the patient need such a doctor or a counsellor”

(Participants in Group 1 and 2)

Another aspect that was mentioned relates to utilising human resources in a specific way to provide services to groups of persons that may be difficult to reach or that may have very specific needs. Examples discussed were the male and adolescent clinics within the health centres. At “male clinics”, registered male nurses are allocated to provide health services specifically tailored for male visitors. In the case of adolescents, services are provided separately and at specific times on weekdays, and on weekends, to enable adolescents to attend school. The timing of service delivery is, therefore, also important in IPHC.

4.4.4 Theme A3: Timing

PHC comprises a range of services that assists patients who report with multiple illnesses (Lesotho MOH, 2016b:23). The participants explained that services are clustered, to ensure that the person can access different services during one visit, to save time and spare the person multiple visits in a month.

“Timing of all services to be provided all at once described as one-stop-shop.”

(Participants Group 2)

Participants in Group 2 viewed integration of services as referring to the accessibility of health services in a cluster (e.g. HIV-infected persons). They mentioned consulting people in a “one-stop shop”. This means timing of all services needs to be provided within one consultation. In order to group the services,

“Use of appointment system that favours more services to be accessed in one clinical visit” (Participants group 1)

“IPHC saves time: all services are given once at the same place. It saves time for both patients and staff” (Participants Group 2)

Some authors argue that integrating services prolongs consultations, as a multitude of services are provided on the same day. Others argue that providing multiple services eliminates the need for multiple visits by the same person on different days, thereby saving time in the long run (Richards, Bower, Chew-Graham, Gask, Lovell, Cape, Pilling, Araya, Kessler, Barkham, Bland, Gilbody, Green, Lewis, Manning, Kontopantelis, Hill, Hughes-Morley & Rusell, 2016:1). The aspect of timing also extends to the scheduling of persons' follow-up visits.

“Use of appointment system that caters for multiple service delivery”

(Participants Groups 2)

Registered nurses explained that they use appointment books and electronic tablets with “com.care” software to schedule persons' next visits. The electronic system automatically sends a short message (SMS) reminder to the person three days before the appointment date. The booking system enables registered nurses to improve planning for related services that will be needed for a person on a specific day.

“Some chronic illness patients, such as who have TB [tuberculosis], HIV, and hypertension are linked to other related activities, such as drawing blood for tests. For instance, a woman who comes for antenatal clinic will have her HIV testing the same day” (Participants Group 2)

The same system is used to identify persons who had missed their appointments and who need to be traced. In addition to the appointment systems, care records also influence IPHC implementation.

4.4.5 Theme A4: Documentation

Documentation of patient care was identified as an important tool to motivate and enhance implementation of IPHC. Registered nurses use records (registers and patient cards, booklets and monthly reports) to ensure proper practice of IPHC. Alkouri, AlKhatib and Kawafhah (2016:103) claim that documentation, as a concept in nursing, is an essential principle of quality assurance, and a way to measure the effectiveness of care.

Registered nurses confirmed this notion in IPHC practice. Participants mentioned that proper documentation in registers and patient cards assisted them in their IPHC practice.

“Proper documentation that helps to identify patients’ needs” (Participants Group 2)

“Proper documentation help monitor patients’ care, reduce repeated services and assist in budgeting” (Participants Group 2)

Participants also stated that proper documentation is a form of communication amongst health centre staff, and enhances the process of monitoring and evaluation of IPHC. By checking all the registers and booklets used in health centres, integration can be monitored and evaluation of the data can inform major decisions, such as budgeting, and can provide insight into IPHC progress.

“Monitoring and evaluation” (Participants Group 2)

“Monitoring and evaluation ensure quality improvement when carrying out IPHC assessment. For instance, Site Improvement Monitoring System, which identifies patients in registers and ensures IPHC” (Participants Group 2)

Although it was not intended as a specific strategy for IPHC, the MOH in Lesotho implemented standardised registers and patient cards that combine related programmes into one (Lesotho MOH, 2011b:33; Lesotho MOH, 2016c:22; Lesotho MOH, 2016a:23).

An example given by participants was the Site Improvement Monitoring System (SIMS), which ensures that documents and records are assessed to ensure continuation of care through different departments at health centres. The SIMS enables registered nurses to measure the integration of services across departments that make up PHC services.

4.4.6 Theme B: Person-centred care

The concept of person-centred care is clarified in a framework by McCormack and McCance (2016:39). The authors base the concept on nurses’ experiences of caring for older persons. The approach involves forming and fostering therapeutic relationships between care providers, service users and others people who are significant to them in their lives. The approach is underpinned by values of respect for persons, individual rights to self-determination (respect for the right to choose), mutual respect and understanding. Moreover, it is enabled by a culture of empowerment that fosters continuous approaches to practice development (McCance & McCormack, 2016:39).

The person-centred care theory advocates for health professionals to be mindful of the “persons’ values and beliefs, shared decision making and providing holistic care” (Booth *et al.*, 2016:4; McCormack & McCance, 2016:54-60). For shared decision-making to take place, nurses have to give health information to patients, so that the patients can decide about their own health solutions. The registered nurses and managers identified health education as one of the great enablers of IPHC.

*“Health education and patient information on services offered in the health centre”
(Participants in Groups 1 and 2)*

Health education sessions are conducted daily to give information about services available to the persons and to link patients to various departments. Other authors refer to the same aspect as health literacy. Castañeda, Giacinto, Medeiros, Brongiel, Cardona, Perez and Talavera (2016:190) explain that health literacy refers to the extent to which individuals are able to make sense of health information that influences their decision-making. Assisting a person to increase their health literacy, therefore, enables the person to take responsibility for their own health needs and make informed decisions (Valentijn *et al.*, 2015:8).

To ensure that the health education session is optimally effective, it is done in the mornings, as part of the general information delivered to persons present at the centre. Group sessions are supplemented by individual sessions in the consultation rooms, as well as small group sessions with persons who present with the same health concerns. Participants indicated that the information sessions were intended to:

- Raise awareness of various PHC services that were available and how they are integrated; and
- To direct patient flow, in order to optimise access to the integrated services.

The registered nurses believed that providing information on IPHC made persons aware of the availability and accessibility of different services as a whole. Participants agreed that it was helpful when persons knew where to obtain services and where to queue to access a package of services. This knowledge also reduced the number of clinic visits per person per month.

“It reduces patients’ concern and misunderstanding of services. When patients are knowledgeable of services provided, it decreases unnecessary visits to the clinic” (Participants Group 1 and 2)

Participants also revealed that access to information is a way of marketing PHC services. This argument aligns with the original idea of PHC, to involve persons in their own health promotion efforts. Dinh, Bonner, Clark, Ramsbotham and Hines (2016:211) agree that giving health information contributes significantly to health promotion. In this study, registered nurses reported that they marketed IPHC through word of mouth, and by handing out take-home information flyers.

“This strategy markets our services to patients. The patients will also know on which queue to be at that will take them their relevant service point” (Participants Groups 1 and 2)

Participants not only indicated that the persons in need of health services were engaged, but also reported that IPHC implementation requires collaboration from several additional stakeholders, who are not necessarily within the health centres.

4.4.7 Theme C: Collaboration

Collaborating with stakeholders at the community level has been a principle of PHC since its origin (Lund, Tomlinson & Patel, 2016:2-3). It appears that, in the Maseru district of Lesotho, collaboration is not only a principle, but also a strategy for implementing IPHC (Valentijn *et al.*, 2015:11-12). Participants referred to the same concept and agreed that IPHC cannot be executed solely by registered nurses. Various stakeholders must be engaged to implement various aspects of IPHC. The first sector the registered nurses engaged with was the communities they served.

Registered nurses liaise with different community leaders (chiefs, community counsellors and non-governmental organisations) for IPHC practice. The Lesotho MOH (2016b:33) emphasises that community leaders are the cornerstone for mobilisation, health promotion and better understanding of illness in the context of their society.

“Maintain community links with community health workers for continuity of IPHC at home/for meeting patients’ needs and identifying new illnesses”(Participants Group 1)

A group that was identified as instrumental to IPHC implementation is the VHWs. VHWs are community members who have been selected to receive formal training on comprehensive care. They act as the first contact with PHC, as they are based in communities, where they assist individuals and families (Abdulraheem, Olapipo &

Amodu, 2012:3; Rifkin, 2014:99). In the Maseru district of Lesotho, VHWs work primarily to link patients with the health centre (Lesotho MOH, 2016b:54).

Participants explained that they could engage these VHWs to follow up persons in the community and assist persons by providing services, such as the directly observed treatment (DOT) system that is used to increase adherence to medication. When they use DOTs, VHWs dispense medications to patients and make sure they swallow it while they are being observed. VHWs also carry out screening procedures in the community and, when needed, refer persons to health centres.

“VHWs screen patients at their place of residence and refer them to the health centre if need be. The patient is given a referral form that they will present at the health centre” (Participants Groups 1 and 2)

The same process applies when a person defaults on their treatment: A VHW can refer someone to be fast-tracked when they present at the health centre. VHWs also carry out screening activities, such as weighing children under the age of five, and referring them to health centres if they are found to be below normal weight. VHWs also inform health centres of the needs and preferences of the community.

“Community participation for informed IPHC and engagement of community in decision making” (Participants Groups 1 and 2)

Through community participation processes, such as health centre committees and VHW meetings, communities can make suggestions on IPHC and give feedback about aspects important to communities. Communities are, therefore, involved in decision-making, planning, care and monitoring of IPHC (Lesotho MOH, 2016c:54; Macinko & Harris, 2015:2178). In addition to VHWs and health centre committees, the participants declared that community leaders are an important vehicle that eases IPHC implementation.

“They are the most informed personnel who know the kind of care that would be most acceptable by the communities. They also communicate with them in the way that they will understand” (Participants Group 1 and 2)

Participants also expressed a need for collaboration with stakeholders outside the immediate community they served.

“External referrals, referrals and linkage systems” (Participants Groups 1 and 2)

“External referral to other facilities (health centres, hospitals and NGOs) for services which the health centre cannot offer” (Participants Group 1)

The referral system available within the healthcare system is seen to be key, and enables persons to access holistic care in various settings. Referrals can be done within community structures, such as the health post, and to external collaborators at the secondary and tertiary levels of the health system (Abraham, Erika, Mohammed, Fetene & Bradley, 2015:1).

In order to meet people’s needs, the registered nurses who participated in the study explained that they collaborated with other stakeholders who are not part of the health centre, or even health departments. For instance, in the health sector, they refer patients to higher levels of care, such as a hospital, depending on patients’ conditions. Referrals can also be made to other departments, such as X-ray, psychological support, social development, and the police. Literature shows that collaboration with allied stakeholders is a key element of IPHC. As mentioned by Valentijn *et al.* (2013:4), patients can be referred down, to VHWs, horizontally, to other facilities at the same level, or vertically, to facilities at a higher level. Access to a comprehensive package of care beyond the health centre enhances the provision of holistic care, to ensure that all the health-related needs of people are met.

4.4.8 Theme D: Staff capacity

Sibiya (2009:195) indicates that IPHC demands highly “multi-skilled” registered nurses who can handle the comprehensive nature of IPHC. Health professionals have to stay up to date with an ever-increasing burden of disease, which leads to evolving health care challenges (Mars, 2012:1). Participants discussed their need for updated information. One strategy that was mentioned that could ensure that health professionals receive timely updates, was in-service training.

“In-service training and mentorship for capacity building on IPHC”
(Participants Groups 1 and 2)

Participants reported that capacity-building workshops were offered frequently to help them to expand their knowledge. They appoint one of them to attend the workshop, and

the nominee then, upon his/her return, gives feedback and disseminates information to the others.

“In-service training assists in gaining new knowledge and/or sometimes aims at refreshing the already existing knowledge. At times, it is useful in identifying challenges and re-planning. If new information needs to be shared, we gather nurses together, to disseminate information helps in empowering IPHC” (Participants Groups 1 and 2)

Mars (2012:1-2) and Sibiyi (2009:195) believe that the initial formal education undergone by registered nurses is not enough to enable them to meet the changing demands of IPHC. Gaining further knowledge and experience improves the skills and competence necessary for IPHC. Constant supervision by PHC officers can ensure the standard levels of competency and quality of care are maintained.

Participants indicated that registered nurses at health centres receive periodic supervision and are mentored by staff from the MOH and its partners. During these visits, monitoring tools and reports that are available are checked, data is verified and IPHC emphasised. As it is being emphasised, quality of IPHC competence is promoted.

“MOH and partners checks that care is done in line with MOH policies and guidelines” (Participants Groups 1 and 2)

4.5 CONCLUSION

From this chapter, the researcher concludes that all participants had extensive experience of the phenomenon under study; all of them had been practicing IPHC for at least three years. The first phase of data analysis was done by participants and the second by the researcher. The themes that emerged during the second phase of analysis were confirmed with the aid of a team of peers.

The findings of the study resulted in four main themes relating to the way registered nurses implement IPHC. The main strategy was *organising services* around the clinic through available human resources, services delivered, timing and documentation. The other strategies constituted *providing person-centred care*, *collaboration* with relevant stakeholders and *building staff capacity*.

The next chapter will conclude the study by giving recommendations. Chapter 5 will also give the researcher's reflection.

CHAPTER 5: RECOMMENDATIONS

The following recommendations were compiled from the findings of this study. The researcher believes that the information will contribute to improving the implementation of IPHC in Lesotho's health systems.

As the findings suggest, registered nurses and nurse managers do have strategies they use for IPHC implementation, even though they differ in relative importance. As Van Breda (2005:10) indicates, the more statements that are given for a certain theme, the more the theme is likely to be prioritised over the others. Most of IPHC implementation is carried out through organising services around the health centre. Although most of the recommendations were based on organisation of services, other themes were also considered and commented on.

5.1 IMPLICATIONS OF AND RECOMMENDATIONS BASED ON THE STUDY

In this final chapter, the researcher will make recommendations applicable to practice, policy development and implementation, nursing education and further research. The chapter will conclude with a brief reflection by the researcher.

5.1.1 IPHC practice

In this study, the researcher documented strategies that are used by some registered nurses in the Maseru district of Lesotho to implement IPHC. Strategies that could be considered by other health professionals implementing IPHC in a similar setting, include:

- Organise IPHC around health care. Professionals should plan service delivery to integrate services under one roof within the health centre through referral to different service points staffed by relevant health personnel (so-called supermarket approach). As participants mentioned, relevant human resources must be placed in each department or at each service point. Non-medical staff members can also play a vital role.
- Document the persons' cards and registers completely and properly, as it is one of the major strategies for implementing IPHC and monitoring and evaluating it.

- Use registers and patient cards for easy identification of persons' needs, and for meeting these needs.
- Do triage and screening of persons' needs as another way of combining services. Systematic screening and triage means assisting persons who are coughing or those who have an emergency first, thereafter, provide screening during consultations. Attend to all a person's concerns (person-centred care), starting with the main complaint.
- Give health information for marketing and promotion of IPHC.
- Collaboration means there should be a clear referral system of patients to service providers within the health centre, and to outside the health centre.
- Engage stakeholders/establish community links to support IPHC by engaging traditional leadership and empowering VHWs, thereby widening the reach of the IPHC team.
- Expand staff capacity, conduct in-service training, which could be an effective strategy to improve IPHC implementation. Nominate a staff member to attend external capacity-building opportunities and to return with feedback; this approach limits staff absenteeism while allowing the group to access the updated knowledge.

5.1.2 Policy development and implementation

In relation to the organisation of IPHC services, the researcher recommends organising services around service delivery. Policy-makers can implement consolidated guidelines to encourage the supermarket approach. All resources (especially human resources) needed to implement a supermarket approach must be considered. Even though the participants voted for a supermarket approach, and preferred to refer persons from one department to another, they also mentioned that, due to a lack of human resources, they sometimes practiced partial integration. Deploying adequate staff to each health centre will, therefore, enable daily integration of services. For example, a mother who brings a child for vaccines can be given family planning advice and receive a full consultation if she is ill on the same day. Adequate human resources are essential for IPHC implementation.

In relation to staff capacity, human resources deployed for IPHC should receive adequate support. The MOH should ensure human resources have the relevant,

required competencies. Registered nurses confirmed, when they reported on their strategies, that ongoing in-service training events ensure proper IPHC implementation. A scheduled plan for IPHC capacity-building activities should be scheduled and coordinated by the IPHC overseers (DHMT).

5.1.3 Nursing education

Registered nurses who participated in the study reported that they rely on in-service training to improve implementation of IPHC. This feedback may be the result of initial formal training of nurses not being sufficient to prepare nurses for the evolutionary changes that characterise the care involved in IPHC. It is important that nurses are trained by means of a competency-based curriculum, so that future nurses are competent and can meet the increasing demand for IPHC.

5.1.4 Further nursing research

This study sets the stage for further research regarding IPHC in Lesotho. Further research can expand the exploration to beyond the strategies registered nurses use to implement IPHC, to focus on developing a framework for IPHC in the Lesotho context.

The other prominent gap in knowledge that this study identified relates to developing standard IPHC guidelines (not selective programmes) or standard operating procedures that clearly outline strategies that can be used for IPHC implementation at the health centre level.

5.2 LIMITATIONS OF THE STUDY AND GAPS THAT REMAIN

Although the study succeeded in answering its research question, there are limitations associated with its findings, and the gaps that remain should be considered in the future.

The researcher formed part of the population and, hence, had to apply bracketing measures (by engaging a facilitator), which limited her experience in relation to conducting group sessions. Moreover, although measures to achieve bracketing (engaging a facilitator, excluding her own health centre and doing rigorous data interpretation) were applied, the researcher, as the nurse in charge of one of the health centres, could unknowingly have influenced the interpretation of the results.

Due to time and budget constraints, the NGT was the technique preferred for eliciting data to answer the research question. However, given another opportunity to repeat the same study, the researcher would include the use of journal-keeping by registered nurses, so that they could document every strategy as they implemented it. Doing so would assist with triangulation of methods and, hence, provide more reliable findings.

The nominal group schedule was binding and not flexible enough to give participants a choice regarding the session they could attend. Nurses in charge were supposed to attend their own session, while registered nurses also were obliged to group in their own session. The nominal group sessions were conducted on a Friday, which meant a clash for some of the participants, who had conflicting family responsibilities and travel obligations at the onset of the weekend.

Lack of literature for IPHC was a limitation. The concept of IPHC and PHC are used interchangeably by most writers. Embedding IPHC in the original definition of PHC leads to the emphasis on integration seeming vague and ambiguous.

During data collection, anonymity of participants could not be guaranteed, as they participated in face-to-face discussions with the facilitator.

The researcher was of the opinion that data saturation was achieved after engaging with the data provided by the two groups. One of the examiners believed that conducting another group would have helped to confirm this. At the time, considering the overlapping themes, the discussion with the expert group and the scope of a Magister study, the researcher did not consider conducting further groups.

5.3 RESEARCHER REFLECTION

At the beginning of the researcher, I was a nurse in charge of a health centre where IPHC was implemented. During the last months (after data collection), the researcher was transferred, and by the end of the study I was working as a manager at the DHMT for community health. I both implemented and managed services at health centres for the last eight years. IPHC is one of the approaches I am fond of, and I totally believe it is dependent on nurses' competencies. IPHC can also improve our clients' satisfaction and health.

Having to deal with IPHC during my research process has given me invaluable insight into the concept. I now have a deeper understanding of the phenomenon, both globally

and regionally. This knowledge has fuelled my passion to conduct further research on IPHC in the future.

However, learning how to conduct research is a humbling process, with experiences of anger, impatience, and even sometimes wishing I had chosen another modular course. Nevertheless, being familiar with the research processes and vernacular brings pride that no one can take away from me. It takes enormous courage to write and rewrite, and then delete passages, and then to search and finally restart the writing. It felt as if I was going around in circles, infinitely. It is also noteworthy to document that I lived in a very remote area of Lesotho (Haseng), where internet access was scarce, while I conducted this research project. It sometimes made conducting research taste sourer than a lemon.

Now, I am a learned professional who knows that acknowledgements are more than a mere list of names and words, but genuine expressions of gratitude from a researcher's heart. I have learned to depend on others to help me when I am vulnerable and face dire desperation.

5.4 CONCLUSION

In this chapter, recommendations for implementers, policy-makers, nursing education and further research were given. The recommendations are based on the findings (strategies) of the study. The limitations of the study were also identified and the gaps that remain were mentioned. The researcher believes that, if these recommendations could be considered, IPHC implementation could be improved.

The researcher also reflected on the learning curve she endured and on the personal experience she gained throughout the whole research process.

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APPENDIX A: APPROVAL LETTER FROM HEALTH SCIENCE RESEARCH ETHICS COMMITTEE



IRE nr D000624C
REC Reference nr 230408-011
IORG0005187
FWA00012784

31 May 2017


MS MP POSHOLI
C/O MS M WILKE
SCHOOL OF NURSING
IDALIA LOOTS BUILDING
UFS

Dear Ms Posholi

HSREC 43/2017 (UFS-HSD2017/0327)
PRINCIPAL INVESTIGATOR: MISS MAMONAHENG P POSHOLI
SUPERVISOR: MARISA WILKE, SCHOOL OF NURSING
PROJECT TITLE: STRATEGIES REGISTERED NURSES USE TO IMPLEMENT INTEGRATED PRIMARY HEALTH CARE IN MASERU DISTRICT, LESOTHO.

1. You are hereby kindly informed that, at the meeting held on 30 May 2017, the Health Sciences Research Ethics Committee (HSREC) approved this protocol after all conditions were met.
2. The Committee must be informed of any serious adverse event and/or termination of the study.
3. Any amendment, extension or other modifications to the protocol must be submitted to the HSREC for approval.
4. A progress report should be submitted within one year of approval and annually for long term studies.
5. A final report should be submitted at the completion of the study.
6. Kindly use the HSREC NR as reference in correspondence to the HSREC Secretariat.
7. The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act, No. 61 of 2003; Ethics In Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 58; CDMS; ICH-GCP-E9 Sections 2-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

Yours faithfully


DR SM LE GRANGE
CHAIR: HEALTH SCIENCES RESEARCH ETHICS COMMITTEE



APPENDIX B: APPROVAL LETTER FROM MINISTRY OF HEALTH



Ministry of Health
PO Box 514
Maseru 100

REF: ID96-2017

Date: 24 July 2017

To
Miss M. Posholi
Masters in Nursing candidate
University of Free State, SA

Category of Review:

- Initial Review
 Continuing Annual Review
 Amendment/Modification
 Reactivation
 Serious Adverse Event
 Other _____

Dear Ms. M. Posholi,

RE: STRATEGIES REGISTERED NURSES USE TO IMPLEMENT INTEGRATED PRIMARY HEALTH CARE IN MASERU DISTRICT, LESOTHO

This is to inform you that on 18 July 2017 the Ministry of Health Research and Ethics Committee reviewed and APPROVED the above named protocol and hereby authorizes you to continue the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:


- Protocol
 English & Sesotho consent forms
 Data collection forms in Sesotho
 Data collection forms in English
 Participant materials [insert types, versions, dates]
 Other materials: CVs of the study team members
This approval is **VALID** until 23 July 2018.

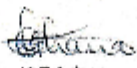
Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date.

All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at: rcumoh@gmail.com (or) 22226317.

Sincerely,


Dr. Nyone Letsie
Director General Health Services


Mrs. V. T. Lehana
Co-chairperson NH-IRB

APPENDIX C: PERMISSION LETTER FROM CHRISTIAN HEALTH ASSOCIATION OF LESOTHO



Christian Health Association of Lesotho

P.O. Box 1632, Maseru 100, Lesotho

Telephone: +266 2231 2500, Fax: +266 2231 0314

e-mail: chal@lcsuff.co.za

28th August 2017

Ms Mamonaheng Posholi

P.O. Box 418

Maseru, Lesotho

Dear Ms Posholi,

Re: Permission to conduct a study on the strategies Registered Nurses use to implement Integrated Primary Health Care (IPHC) in Maseru District CHAL Health Centres

With this letter you are given permission to continue with the study thereon in CHAL health centres as per the subject above. However, kindly observe the following as related conditions.

- 1) Brief introductory session of the study to the Health Centres (H/C Manager and Nurse in Charge) upon arrival.
- 2) The findings/report of the study should be shared with CHAL upon completion.

Hoping for your understanding and cooperation in the matter.

Yours sincerely,

Lebohlang Mothae (Ms)
Executive Director

APPENDIX D: PERMISSION LETTER FROM MASERU DISTRICT HEALTH MANAGEMENT TEAM



Ministry of Health
PO Box 514
Maseru 100

REF: ID96-2017

Date: 24 July 2017

To
Miss M. Posholi
Masters in Nursing candidate
University of Free State, SA

Category of Review:

- Initial Review
- Continuing Annual Review
- Amendment/Modification
- Reactivation
- Serious Adverse Event
- Other _____

Dear Ms. M. Posholi,

RE: STRATEGIES REGISTERED NURSES USE TO IMPLEMENT INTEGRATED PRIMARY HEALTH CARE IN MASERU DISTRICT, LESOTHO

This is to inform you that on 18 July 2017 the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the above named protocol and hereby authorizes you to continue the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:


- Protocol
 - English & Sesotho consent forms
 - Data collection forms in Sesotho
 - Data collection forms in English
 - Participant materials *[insert types, versions, dates]*
 - Other materials: CVs of the study team members
- This approval is **VALID** until 23 July 2018.

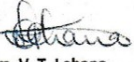
Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date.

All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at rcumoh@gmail.com (or) 22226317.

Sincerely,


Dr. Nyane Letsie
Director General Health Services


Mrs. V. T. Lehana
Co-chairperson NH-IRB

Noted 18/08/17
NG [Signature]

APPENDIX E: INFORMED CONSENT SAMPLE

CONSENT TO PARTICIPATE IN RESEARCH

You have been asked to participate in a research study regarding the strategies registered nurses use to implement Integrated Primary Health Care in Maseru district, Lesotho.

You have been informed about the study by Mamonaheng Posholi. You may contact Mamonaheng Posholi at +26 658 697 421 at any time if you have questions about the research or if you are harmed as a result of the research.

You may contact the Secretariat of the Health Sciences Research Ethics Committee (HSREC) of the Faculty of Health Sciences at the University of the Free State (UFS) at telephone number +27 51 405 2812 if you have questions about your rights as a research subject.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to terminate participation during the study.

If you agree to participate, you will be given a signed copy of this document as well as the participant information sheet, which is a written summary of the research.

The research study, including the above information, has been verbally described to me. I understand what my involvement in the study means. I voluntarily agree to participate in the group discussion. I also undertake to keep the discussions held during the group confidential.

Signature of Participant

Date

Signature of Witness

Date

Signature of Facilitator

Date

PARTICIPANT INFORMATION SHEET

Study title: Strategies registered nurses use to implement Integrated Primary Health Care in Maseru district, Lesotho.

Greetings. I, Mamonaheng Posholi am doing research about the strategies registered nurses use to implement Integrated Primary Health Care (IPHC) in Maseru district, Lesotho.

Research is just the process to answer a question. In this study I want to learn more about the strategies registered nurses use to implement IPHC in Maseru district. The study will be of value to participating registered nurses by providing them the opportunity to share information regarding the strategies they use to implement IPHC. The study will also provide some information on IPHC that policy makers, DHMTs and other stakeholders might find useful. Improved IPHC could ultimately improve access to health care and in turn patient outcomes. This study might also form the basis of further research towards a framework for IPHC implementation in Lesotho.

Invitation to participate: I am inviting you to participate in this research study.

What is involved in the study: My study is a qualitative study that aims to collect information through group discussions. A nominal group discussions will be conducted by a facilitator from the University of the Free State (UFS). The discussions will be held at the quiet place suitable for brainstorming to generate ideas. The group will be asked a question. Participants can then think, name and discuss their ideas. At the end the group participants can decide which of the ideas discussed are the most important to the group. The group discussions will be conducted in English. Registered nurses with more than a year's experience of implementing IPHC at health centres in Maseru district from randomly selected health centres will be invited to participate in one of the group discussions for the study.

Risk: There are no risks involved in participating in the study.

Benefits There are no personal benefits to be gained from the study.

Participants will be given pertinent information on the study while involved in the study and after the results are available.

Participation is voluntary, and refusal to participate will involve no penalty or loss of benefits to which participants are otherwise entitled; any participant may discontinue participation, at any time, without penalty or loss of benefits to which the participant is otherwise entitled.

Reimbursements: There will be some reimbursement for participants' travel expenses to attend the group discussions. Snacks will be served after the discussions.

Confidentiality: Participants involved in the same group discussion will participate as a group. No information shared in the group will be reported by individual. The results agreed upon by the entire group will be reported on by group. Your identity will not be shared outside the group. Personal information may only be disclosed if required by law. Persons that may inspect research group records for quality assurance and data analysis include my supervisor or authorised persons from the Ethics Committee. If results are published, this may lead to group identification.

Contact details of the researcher: Mamonaheng Posholi, phone +26 658 697 421, or email at neneposhie@gmail.com for further information/reporting of study-related concerns.

Contact details of HSREC at UFS: Phone +27 51 405 2812 for reporting any complaints or problems you have with the study.

APPENDIX F: STATEMENTS WITH FIRST THEMES

Column A	Column B	Column C	Column D						Column E	Column F	
Group	Theme	Statement	Scores						Average	Top5	
1	1. Involvement of other stakeholders	Establish Community links with community health workers for continuity of IPHC at home	2	4	1					1,2	X
1	1. Involvement of other stakeholders	External referral to other facilities for services which the health centre cannot offer	5							0,8	
2	1. Involvement of other stakeholders	Community participation which assist with informing the health centres on patients' needs	4	1						0,7	
2	1. Involvement of other stakeholders	Referrals and linkage systems to hospitals or other non-governmental organisations for further assistance	1	1	2					0,6	
2	1. Involvement of other stake holders	Follow up village health workers on continuity of IPHC at home and proper referrals	3							0,4	
2	2. Documentation of patients information in registers	Monitoring & Evaluation	3	4	1	5				1,9	X
2	2. Documentation of patients information in registers	Proper documentation that identifies patients' needs	4							0,6	
1	3. Referrals of patients within the health centre	Organizes services based on available human resource	4	6	4					2,3	X
1	3. Referrals of patients within the health centre	Internal referral and accompaniment of patients to different service points that offer IPHC	5	3	2					1,7	X

2	3. Referrals of patients within the health centre	Use of supermarket approach to promote/give user-friendly services	4	1	4 3							1.7	X
2	3. Referrals of patients within the health centre	Deliver services depending on functioning departments and staffing pattern	4	2								0.9	
1	4. Directing patients' flow	Triage, Screening, Start main complaint and attend to the rest afterwards	1	3	2	3						1,5	X
1	4. Directing patients' flow	Have patient flow plan and assign other staff to help	2	4								1,0	
2	4. Directing patients flow	Staff assist with patient flow to different service points	1	3								0,6	
1	5. Combination of various health services	TB/HIV/PMTCT/ART corner that incorporates other services	4	1	2							1,2	X
1	5. Combination of various health services	Include spiritual uplifting in daily routine of giving IPHC services	5									0,8	
2	5. Combination of various health services	Timing of all services to be provided all at once	5	3								1,1	X
2	5. Combination of various health services	Appoint patients based on needs to be provided	3	2	3							1,1	X
1	5. Combination of various health services	Use of Appointment system that favours more services to be accessed on one clinical visit	1	1	3	1						1,0	
2	5. Combination of various health services	Form clubs/groups of patients with same needs e.g adolescents	2									0,3	
1	6. IPHC awareness of available services	Patient's information on service availability	4	5	5							2,3	X
2	6. IPHC awareness of	Provide health education on services	5	2	5	5	5	1				3,3	X

APPENDIX G: TOP 5 STATEMENTS PER GROUP

Group	Theme	Statement	Scores							Average	Top5
1	Person-centred care	Patient's information on service availability	4	5	5					2,3	X
1	Organisation of services (HR)	Organizes services based on available human resource	4	6	4					2,3	X
1	Organisation of services (HR)	Internal referral and accompaniment of patients to different service points within the health centre by RNs and support staff	5	3	2					1,7	X
1	Organisation of services (Service delivery)	Triage, Screening, Start main complaint and attend to the rest afterwards	1	3	2	3				1,5	X
1	Organisation of services (Service delivery)	Combining TB/HIV/PMTCT e.g corner that incorporates other services	4	1	2					1,2	X
1	Collaboration	Establish community links with Village/community health workers for continuity of IPHC at home	2	4	1					1,2	X
1	Organisation of services (Service delivery)	Have patient flow plan and assign support staff to help	2	4						1,0	
1	Organisation of services (Timing)	Appoint patients based on needs to be provided	1	1	3	1				1,0	
1	Organisation of services (Service delivery)	Include spiritual uplifting in daily routine of giving IPHC	5							0,8	
1	Collaboration	External referral to other facilities for services which cannot be offered at the health centre	5							0,8	
1	Staff capacity	In-service training and mentorship for capacitation on IPHC	3	2						0,8	
1	Organisation of services (HR)	Partial integration done when full IPHC services are not possible to render	3							0,5	
2	Person-centred care	Provide health education on services offered in the health centre	5	2	5	5	5	1		3,3	X
2	Organisation of services (Documentation)	Monitoring & Evaluation	3	4	1	5				1,9	X

APPENDIX H: STATEMENTS WITH THEMES

Group	Theme	Statement	Scores							Average	Top5
1	4. Collaboration	Establish Community links with community health workers for continuity of IPHC at home	2	4	1					1,2	X
1	4. Collaboration	External referral to other facilities for services which the health centre cannot offer	5							0,8	
2	4. Collaboration	Community participation which assist with informing the health centres on patients' needs	4	1						0,7	
2	4. Collaboration	Referrals and linkage systems to hospitals or other non-governmental organisations for further assistance	1	1	2					0,6	
2	4. Collaboration	Follow up village health workers on continuity of IPHC at home and proper referrals	3							0,4	
2	2. Organisation of services (Documentation)	Monitoring & Evaluation	3	4	1	5				1,9	X
2	2. Organisation of services (Documentation)	Proper documentation that identifies patients' needs	4							0,6	
1	2. Organisation of services (HR)	Organizes services based on available human resource	4	6	4					2,3	X
1	2. Organisation of services (HR)	Internal referral and accompaniment of patients to different service points within the health centre	5	3	2					1,7	X
1	2. Organisation of services (HR)	Partial integration done when full IPHC services is not possible	3							0,5	
2	2. Organisation of services (HR)	Deliver services depending on functioning departments and staffing available	4	2						0,9	
1	2. Organisation of services (Service delivery)	Triage, Screening, Start main complaint and attend to the rest afterwards	1	3	2	3				1,5	X
1	2. Organisation of services (Service delivery)	TB/HIV/PMTCT/ART corner that incorporates other services	4	1	2					1,2	X
2	2. Organisation of services (Service delivery)	Use supermarket approach to promote/give user friendly IPHC services	4	1	4	3				1,7	X
1	2. Organisation of services (Service delivery)	Have patient flow plan and assign other staff help	2	4						1,0	

APPENDIX I: RELATIVE IMPORTANCE OF THEMES AND SUB-THEMES

Themes:

<i>Column A</i>	<i>Column B</i>	<i>Column C</i>	<i>Column D</i>	<i>Column E</i>	<i>Column F</i>	<i>Column G</i>	<i>Column H</i>
Theme	Top 5 (1)	Top 5 (2)	Number 1	Number 2	Average 1	Average 2	Final rank
2. Organisation of services around the health centre	8,0	4,0	16,0	4,0	1,1	4,0	12,0
1. Person-centred care	2,0	3,0	2,0	3,0	2,8	1,0	7,0
4. Collaboration	1,0	1,5	5,0	2,0	0,7	3,0	6,5
3. Staff capacity	1,0	1,5	3,0	1,0	0,9	2,0	4,5

Sub-themes:

<i>Column A</i>	<i>Column B</i>	<i>Column C</i>	<i>Column D</i>	<i>Column E</i>	<i>Column F</i>	<i>Column G</i>	<i>Column H</i>
Theme	Top 5 (1)	Top 5 (2)	Number 1	Number 2	Average 1	Average 2	Final rank
2.3 Service delivery	3,0	4,0	6,0	4,0	2,8	4,0	12,0
2.2 Huma Resource	2,0	2,5	4,0	2,5	0,9	2,0	7,0
2.4 Timing	2,0	2,5	4,0	2,5	0,7	1,0	6,0
2.1 Documentation	1,0	1,0	2,0	1,0	1,3	3,0	5,0

APPENDIX J: LETTER FROM LANGUAGE EDITOR

Declaration

22 January 2019

Hester Sophia Human
PO Box 86602
Eros
Windhoek
Namibia

Student: Momonaheng Posholi

Dissertation: Strategies registered nurses use to implement integrated primary health care in Maseru, Lesotho

I confirm that I edited this dissertation and audited the references. The student accepted or rejected proposals for changes.



+264 813 359 120 | hettie.human@gmail.com