ASSESSING THE PERCEPTIONS OF CLIENTS AND NURSES REGARDING INTEGRATION OF THE PRIMARY HEALTH CARE SERVICES, OKURYANGAVA AND WANAHENDA CLINICS WINDHOEK, NAMIBIA

A MINI THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS IN PUBLIC HEALTH

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ABSTRACT

The successful implementation of the Integrated of Primary Health Care (PHC) services is major challenge for health systems internationally. This research study aimed to explore the perception of clients and nurses regarding integration of primary health care services between the two clinics (Okuryagava and Wanaheda clinics). The study objectives were to assess the perceptions of clients regarding integration of PHC services; To assess the perceptions of nurses regarding integration of PHC Services; and suggest possible recommendations that can be adopted to improve integration of PHC Services based on the perceptions of Clients and Nurses. The research was conducted using qualitative research methodology. The study used an interview guide to collect data through in-depth interviews. A total of 20 participants who include both nurses and clients were purposively sampled. Data is presented using the thematic approach while content analysis was used to analyse data. Research results show that integration of PHC services has improved relationship between nurses and clients, integration of PHC services is convenient, integration of PHC services enhances competence and PHC makes nurses assessment of clients made easier. On the other hand, integration of PHC services has led to the mixing of services that do not go along, it prolongs time a client is served, integration of PHC services does not resonate with the structure as well as the resources of the clinics and stigmatises clients. On the basis of the findings, it is recommended that there is need for resources, consultation rooms and instruments to be addressed so as improve the integration of PHC services at the clinics. If more infrastructure could be provided it would ease the problems that the nurses are currently facing. The study recommends that there is need to restructure the processes of the PHC provision at the clinics as the current ones seem to be out of sync with the available resources. The study suggests that immediate actions towards patient-centred care are necessary in order to operationally integrate all provided services and existing functions of the PHC system at the clinics. Participants were also of the view that health policymakers should adopt an evidence-based action plan that ensures and safeguards patient-centeredness, comprehensiveness, sound coordination, and continuity of services at the clinics.

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ABBREVIATIONS

ANC	Antenatal Care
ART	Anti-Retroviral Treatment
AU	African Union
HIV	Human Immune Virus
MMR	Maternal Mortality Ratio (MMR)
MoHSS	Ministry of Health and Social Health
ODA	Official Development Assistance
PHC	Primary Health Care
SRH	Sexual Reproductive Health
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Acquired Immune Deficiency Syndrome Programme
UNICEF	United Nations International Children Emergence Fund
WHO	World Health Organisation

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DEDICATION

I dedicate this thesis to my sons, Miracle & Memoriam. May this thesis inspire you to believe that no dream is too big to achieve. I also dedicate this thesis to my parents for their strong belief in education.

DECLARATION

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CHAPTER 1: INTRODUCTION

1.1 Introduction

This chapter covers the background of the study, research problem, briefly describes the area of concern that this study has investigated, as well as the research objectives. Also, it provides definitions of key concepts, significance of the study, delimitations, and limitations of the study. Finally, the chapter gives the structure of the thesis and a summary that highlights the key issues discussed under each of the subsections.

1.2 Background of the study

Integrated health service delivery is an approach of combining health services required by the users (clients) in order to increase overall efficiency of the health system and patient convenience (patient-centered integration).[1] World Health Organisation (WHO) defined integration of primary health care services as referred to the "organization and management of health services so that clients receive a comprehensive continuum of preventative and curative services they need, when they need it, in ways that is user-friendly to achieve the desired results and provide value for money."[1] For the *user*, integration means health care that is unified, and easy to navigate (one room, one nurse, one client).

Users want a co-ordinated service which minimizes both the number of stages in an appointment and the number of separate visits required to a health facility[1]. They want health workers to be aware of their health as a whole (not just one clinical aspect). In short, clients want continuity of care. Integration for the providers means that separate technical services, and their management support systems, are provided, managed, financed and evaluated either together, or in a closely coordinated way. It aims to increase health service utilization by increasing accessibility and availability of all health care services at Primary Health Care (PHC) level[1].

Recent years have realized a dramatic rise in funding for single-disease or population-group-specific programmes, such as Malaria, TB, HIV and AIDS, Family Planning, Antenatal Health Care Services, immunizations, and polio eradication. For example, funding for HIV and AIDS as a share of total health Official Development Assistance (ODA) has climbed from less than 10% in the 1990s to around 30% currently[1]. There are concerns about potentially adverse effects on less well-funded health priorities, thus question remains why not integrating all primary health care services if they share almost same features? In addition to the latter, health services face resource restraints of specific concern are human resource shortages in low-income countries, resource allocation and availability is a matter of concern as well[2].

Globally, there is growing evidence of appreciation by most policy makers and stakeholders of the importance of integrating HIV and Sexual Reproductive Health (SRH) with the rest of primary health care services. Some countries claimed that SRH/HIV integration reduces the number of return visits by clients, reduce HIV-related stigma, reduces waiting time for clients in the facility, reduces workload for health care providers, cut costs, and improves the overall quality of services provided to clients[2].

One of Namibia's long-term goals has been and it is still to improve the welfare and health of individual as well as families. This is done through the provision of acceptable, accessible, equitable as well as affordable quality health services[3]. HIV has been identified as one of the national priority diseases and the link between HIV and Sexual Reproductive Health (SRH) services, that were identified some years back., Various organization such as WHO, UNFPA, UNAIDS and AU have been working together with the country to develop a strategy that can strengthen the link between HIV and SRH and integrate it with all other Primary Health Care

Services. Prior to the implementation of the identified strategy which is integration, a baseline assessment study was conducted by MoHSS with technical support and financing from the United Nations Population Fund and joined United Nation program on HIV and AIDS (UNAIDS) country offices in Namibia, to establish the current status of integration in Namibia and also to direct the MoHSS on the way forward regarding integration[3].

In Namibia inequality, accessibility, availability of health care services, long waiting period and stigmatization were the most drivers to the implementation of PHC services integration. The piloting of integration in Namibia was done in the selected seven health facilities; Epako clinic, Hakahana clinic, Nau-Aib clinic, NAPPA, Okankolo clinic and Khomasdal clinic, in 2013[4]. In the one- stop-shop different each nurse will be responsible for all Primary Health Care Services such are; Family Planning, Immunization, Antenatal Care, HIV, Health education, Screening (adults & children), postnatal care, parameters, wound dressing, and dispensing of some medications.

1.3 Problem Statement

Namibia has been providing the HIV and Sexual reproductive health in silos during the past two decades, with high fragmentation. As a result of this, quality and efficiency of services in Primary Health Care has been compromised and the cost of services has been a challenge. Furthermore, media (radio, newspaper, social media) have been reporting complains from clients about long waiting period at public health facilities, unavailability of some health care services, poor quality health care services, inequality and inequity in health care services provision[1].

The researcher also observed some clients complaining at public health facilities, about long waiting period, language barriers, too much referrals to different points of care. All – in- all

the previous points are supported by a pre-assessment study conducted at Epako clinic by UNFPA and MoHSS which indicated that, before integrations HIV Client use to suffer stigmatization alone, because clients use to get medications at ART clinic, the assessment further added that a Clinic was always flooded and patients and the nurse productivity were low (1.6), the study also indicated that before integrations clients would stay almost 5hours waiting and another 45minutes in consulting room[6].

Since the implementation of integration in Namibia there is no much evidence documented on the perception of clients and Nurses regarding integration and the progress apart from the feedback from the seven piloted facilities which are: Epako clinic, Hakahana clinic, Nau-Aib clinic, NAPPA, Okankolo clinic and Khomasdal clinic. The results show that at these seven facilities most of the service providers were satisfied with the integration of other services. Furthermore, they reported that they prefer offering all services, including HIV testing, in the same room, instead of referring to another room at the same facility.

Although some clients showed that they are satisfied, there are still some who complain about the longer waiting periods. For example, those who only visit clinics to collect medicines for chronic illnesses are required to wait for a very long time instead of just collecting their medication and go back home. The findings indicated that there is challenge experienced in integrating TB and HIV with the rest of primary Health Care Services[5]. This research sought to explore the perceptions of both nurses and clients regarding integration.

1.4 Purpose of the study

The purpose of this study was to explore the perception of clients and nurses regarding integration of primary health care services at Okuryagava and Wanaheda clinics

1.5 Objectives

The study objectives were as follow:

- To assess the perceptions of clients regarding integration of PHC services
- To assess the perceptions of nurses regarding integration of PHC Services
- To suggest possible recommendations that can be adopted to improve integration of PHC Services based on the perceptions of Clients and Nurses

1.6 Significance of the study

The outcome of the study is important to the Ministry of health and social services and policy makers to inform them on how users (who are the clients) and the providers (Nurses) perceive the integration of Primary Health Care services and help them to decide on whether to continue with integration, do adjustment or to discontinue. This study may also be of beneficial to the whole government at large and can also be used by other country who may also be interested. In addition, future students who may want to conduct the research on the same or related topics may use the study to add to their knowledge. Hypothetically, the implementation of the study recommendations may minimize the stress levels experienced by nurses and clients.

Integration of Primary Health Care Services is important both to clients, Nurses and to the entire Ministry of Health at Social Services at large. Integration can better ensure the universal access to health care services and information that every individual need to make a healthy choice. In addition to the latter, Integration as a biggest program in Southern African have been said to have supported the development of several policies as well as program delivery instrument, these include the current operating guideline for HIV and Sexual Reproductive Health (SRH).

The research is significant because it suggests how clinics can align clinical, managerial and service user interests, and to improve coordination of care for patients, in particular those with long-term conditions (chronic diseases), also reduce the number of staff turnover, reduce the waiting period and increase nurses' productivity.

1.7 Limitation of the Study

Limitations of the study refer to the barriers or influences that are beyond researcher's control[8]. Participants may have lacked transparency in explaining some of the issues concerning the integration of Primary Health Care due to the confidential nature of the organisational culture of clinics. Due to time constrains, the study was only conducted at Okuryangava Clinic and Wanaheda Clinic. Therefore, the results of the study may not be generalizable to other health centres. The research did not have control over the information the participants may have chosen to give or withhold. However, the researcher ensured that the participants were sensitised about the importance of undertaking the study. The study was conducted during Covid-19 induced restrictions. This affected the manner in which sampling was done.

1.8 Delimitations

These are choices and boundaries that the researcher set for his/her study[8]. The study only targeted the clients aged 18years and above that are willing to participate. All nurses who were available and willing to participate were included to participate in the study. The study was strictly conducted at Okuryangava and Wanaheda clinic but other clinics.

1.9 Structure of the thesis

Chapter one provides a general introduction to the study. It focuses on the background of the study, statement of the problem, purpose, objectives, significance of the study, limitations, and delimitations. Chapter 2 focuses on literature review. In this chapter information from a

variety of sources is reviewed and gaps are outlined. This chapter also underscores the methodological limitations. Chapter 3 explains the methodology and methods as well as the procedures and techniques that were adopted by the researcher as well as the justification for their use in the research Qualitative research methodology was applied to the study. Chapter 4 presents and analyses the results of the study and implications of the findings are also underscored. Chapter 5 outlines the conclusions made with reference to the results of the study. Conclusions are made based on the objectives of the study. The chapter also makes recommendations for practice and for future studies.

1.10 Summary

This introductory chapter presented the background for the study. It provided brief information on motivations for conducting the present study and what influenced this researcher to put the topic on the map. In this first chapter, the background of the study, statement of the problem, purpose of the study, objectives of the study, significance of the study, limitations and delimitations of the research were presented. The next chapter is focuses on literature review.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The purpose of the literature review is to deepen the theoretical framework of the research and to acquaint the researcher with the latest development in the area of the study (Kamhozo, 2018). Overall, this chapter analyses and synthesises relevant empirical studies, which aimed to answer the research questions as well as provide research-based evidence to support this research topic. The literature review focused on the overview of PHC approach and integration; history of integration of Primary Health Care services; Global trends in PHC Integration; desired outcomes and results; as well as on challenges of integration. Furthermore, the health care system of Namibia and its commitment to care and equity, the implementation of integration of PHC were also reviewed.

2. Overview of Primary Health Care Approach and Integration

Primary health care was defined as "essential health care based on practical, scientifically sound methods, made universally acceptable to individuals and families, at a cost that they can afford."[15] It is a key element in the health delivery system. [15] The origins of PHC emanate from the failure of a WHO malaria eradication programme in the mid-1950s,[16] which was a vertical approach to the management of the disease. Vertical health approaches were targeted at a specific disease, usually by the developed world into developing countries,[17] and were characterized by the transplantation of the Western hospital based health care system with little place accorded to preventive strategies. By the mid-seventies there had been a number of attempts to implement more comprehensive approaches to health care provision, including the "barefoot doctor" in China, [16] the Pholela health project in South Africa in the early 1940s [15,16] PHC was conceptualised as a significant socio-political shift in health care paradigms. Emphasis was based on more equitable, appropriate and effective responses to the basic health needs of the world's populations. It presupposes an inter-sectoral, collaborative and

people-centred approach to health care delivery, community involvement and empowerment and is closely linked to community development objectives. [17]

The term 'integration' has been used in a variety of ways by the population and health sectors over the past decades. Early in the 1970's, descriptions of integrated services echoed the aspirations of Alma Ater, comprehensive, inter-sectoral services whose objectives were closely tied in with development objectives. Integration was not just about primary care services, but was seen as a key to the primary health care approach. For example, United Nations International Children Emergence Fund (UNICEF) put forward one of the first plans from an international agency to move away from a narrow vertical approach in the 1960's and 1970's.

Implicit in UNICEFs early approach was integration of health services across all sectors related to development, not just within the health sector. Apart from a few landmark pilot projects in the late 1970's (included in this review), this comprehensive development-oriented approach was seldom adopted.[16] It was plagued by logistical barriers to getting cooperation between sectors, and lack of measurable short- and medium-term indicators. The strategy of selective primary health care (SPHC) was popularised by a paper presented at Knowles Bellagio meeting and then published in 1979 in the New England Journal of Medicine.[17] Although targeting main sources of mortality and morbidity with known feasible treatments, SPHC was intended as an interim strategy, which, it was argued, in itself would help development.

However, SPHC generated considerable controversy. A special issue of the journal Social Science and Medicine was brought out, to try to clarify some of the issues; for example, some argued in this forum that selective interventions, as epitomised in initiatives such as

UNICEFs GOBI-FF campaign, actually undermined community participation and empowerment, which form the basis for PHC[15, 16].

The disagreements reflected confusion or contradictions over the relative importance attached to the primary health care approach to delivery versus importance of the actual services themselves. While the decade of the 1980s became characterised by donor-programmes run completely separately from the host countries public health service, and run separately from one another, with project-specific lines of authority and accountability, the 1990's saw a shift back to some of the original integration aspirations, with some important modifications. The motivation for integrated services differs between different groups. In a World Health Organisation (WHO) report addressing the topic, it is promised that integration avoids wastage and duplication of effort.[17]

Women's health advocacy groups on the other hand, see integration as supplying a wider range of services than would be provided in biomedical approach health care alone, and easier access for marginalised or vulnerable groups.[16] According to Htay[17] an integrated service is firmly linked to the development of a district health service. Integration implies multipurpose clinics; multi-purpose staff; overlapping of levels (e.g. primary and outreach functions from hospitals); planning of programmes that have many objectives and include other sectors, and budgeting that reflects this; information systems that track inputs, services delivered and health status; training courses that are general rather than specialised; and supervisory visits that deal with all aspects of the service. In addition, an integrated service has in place the existence of mechanisms to bring together different health care providers (e.g. health committees); a close relationship between health centres and the district hospital; and joint efforts across sectors.[17]

Despite this vision of an integrated service, the urgency of the HIV and AIDS epidemic in many developing countries, has meant that current efforts towards integration have come to mean simply adding new functions such as HIV and AIDS prevention or treatment of STDS to existing vertically-run services, most commonly MCH-FP programmes. Recent reviews have focused solely on the integration of MCHFP with STD services.[15,16] In general, recent guidelines and documents on integration focus on the advisability and means for bringing together specific services previously run separately, but to date most guidelines have lacked a health systems approach. In particular, factors necessary for the successful implementation of an integrated service have been paid scant attention[15]. Further, there is no consensus as to how to measure the performance of integrated programmes. Among the donor community, this lack of approved indicators has been a disincentive for integration.[17]

2.3 History of Integration of Primary Health Care services

Primary health care (PHC), the model for global health policy[16], was introduced by the World Health Organization and the United Nations International Children's Emergency Fund (UNICEF). It reaffirmed the WHO definition of health in 1946 "a state of complete physical, mental and social wellbeing, and not merely an absence of disease or infirmity", and was declared by the conference at Alma Ata in 1978 as the means of achieving Health for All by the year 2000. [15,16.17]

From the late 1980s to mid-1990s the interest on silo system delivery of health care in the United States, Canada, Australia, United Kingdom as well as other Western European countries started to decrease, different countries start showing interest in comprehensive care/ integration ("one client, one health care provider and one room)[9]. For many years the health care system has focused on improving integration between the organizations and level of

care. Integrating the health care services has been a greater concern to improved health care delivery.

The integration strategy which has persisted today was driven by the long waiting period and time spent by clients and health care facilities, the efficiency of health care services, the availability of health care services and most notably which increased interdependencies at different levels the introduction of managed care in US which It is broadly believed that the greater configuration and interaction achieved through integration enhances quality of quality of care, efficiency and patient satisfaction, however there is general lack of consensus on what is integration on what is integration. In addition, evidence begin to merge in mid 1990s that successfully integrating policy, staff, funding as well clinical processes require substantial investment that may result in improved quality of care[9].

2.4 Theoretical Framework

Primary health care is a broad term describing an approach to health policy and service provision that includes both services delivered to individuals (including patient pathways) and the general population. [19] Primary Care (PC) refers to "family doctor-type" services delivered to individuals, whereas some frameworks [19,20] use PC to assess PHC components. The adopted operational integration model for this study was based on the Donabedian approach, [21] combining the basic PHC principles presented by Starfield [22] and the chronic care model [23]. Following a systematic literature review, the dimensions of PHC as reported in the work of Kringos and colleagues, [24] were selected as the most appropriate. According to Kringos and colleagues, [20] PHC is viewed as a complex system comprising three levels: (a) structures, (b) processes, and (c) outcomes. [20] Each level is composed of dimensions encompassing a range of key attributes/features

2.5 Desired outcomes of integration

According to WHO, many benefits are claimed for integration of PHC services, they can be cost-effective, client-oriented, equitable and locally owned[10]. Cost -effectiveness is considered in the sense that it's efficient to share resources than to have them devoted to a specific program. Furthermore, effectiveness is based on the idea that makes sense to deal with whole person (plus his or her family) rather than focusing separately on just one health problem or condition for individual[10].

WHO pointed it out that of Integrating Primary Health care services have reduced stigma in HIV, TB and mental illness patients, instead of patient going to the ART or mental clinic, they simply just go in the same room where everyone is going for any condition. Furthermore, one study explained that integration improved access to health care services, availability of health care services, instead of getting only one service because, there is shortage of staffs, every service is now available in each room per patient. This same goes to affordability. The study indicated that integration also improve long waiting period[11].

2.6 Global Trends in PHC Integration

The concept of integration has received a lot of attention in the literature, although its definition and scope vary across settings. [18] The World Health Organization (WHO) has defined integrated care delivery as "the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system" [18]. Literature supports the premise that integration results in better health outcomes and minimises overall healthcare costs. [19] Main benefits include patient orientation, equity, quality, accessibility, efficiency, continuity of care, and cost-effectiveness. The first integrated care models were introduced during the

1980s in the USA[22]. Those models focused on chronic disease and care provision according to patient needs [5]and significantly influenced developments in other countries.

The Netherlands and the United Kingdom (UK), both countries with strong primary healthcare (PHC) systems and gatekeeping, have adopted integrated approaches to link health promotion and disease prevention to disease management and self-management support [22]. Electronic prescribing, integration of pharmacies within healthcare units, comprehensive training of healthcare professionals (HCPs), use of community resources, and an accessible referral system with optimised patient flows in multidisciplinary centres, have all contributed towards reduced healthcare costs and more efficient reallocation of resources [17,18].

In 2006, the last wave of healthcare reforms in the Netherlands focused on sustaining the successful innovations of previous decades. Strong emphasis was given on improving information technology (IT) services, coordinated and comprehensive chronic care and optimum utilisation of community resources [23]. In the UK, the "Quality and Outcomes Framework (QOF)" considered as best practice the adoption of electronic records and other measurable variables that facilitate quality monitoring and benchmarking data [23]. These best practices are crucial in ensuring sound resource allocation, especially in countries with highly burdened healthcare systems and less developed PHC, such as Greece[23]. Therefore, such experiences could guide countries with fragmented systems towards effective reforms in optimising unit and patient-level integration and introducing standardised processes.

An added benefit could be the provision of valuable information for evidence-based policy in terms of allocating or reallocating resources at system level. Having been subjected to a harsh austerity period, Southern European countries share similar healthcare system characteristics and challenges in PHC service delivery [23]. In 2000 and 2008, Greece and Spain exhibited a rapid expansion of public spending, while in Italy and Portugal the trend was moderate [24].

Despite restricted coverage of PHC services, Italy has achieved a high degree of system integration and an effective way of managing public funding and private healthcare expenditure [24]. Nevertheless, the lack of standardised processes and protocols for patient pathways, as well as for addressing the needs of patients with multiple morbidities, represents an important commonality for all these systems.

During the last thirty years, Greece has attempted to strengthen its national health system (NHS), by expanding and standardising PHC, initially in rural, and more recently in urban areas. Despite efforts and an intense debate lasting more than 15 years, Greece is still lacking a sustainable, evidence-based integrated model. As a result, integration still remains a largely neglected issue in the country's health policy agenda [24]. The existing socio-economic hardships inflicted by the prolonged financial austerity, as well as the recent refugee and migrant crisis, render the need for healthcare reform urgent.

Moreover, the country's rapidly aging population, along with the high incidence of mental health disorders [25] and the growing burden of chronic diseases, [26] necessitate immediate actions towards an integrated, multidisciplinary network of well-coordinated and cost-effective services. Lack of integration can result in fragmentation of care and poor health outcomes, [23] as well as in problems related to funding, planning, effectiveness and operation of the healthcare system [24]. Substantial healthcare budget cuts and prolonged delay of major reform are jeopardising the NHS, putting it at risk of becoming unsustainable and ultimately, obsolete [26].

Failing to achieve immediate policy and structural changes to this direction, could increase the risk of potential NHS collapse with numerous adverse consequences [25]. Thus, it is vital to develop and implement policy well-aligned to a strategic vision towards integrated PHC. This

can be a challenging and arduous process, considering that it requires major NHS reform along with changes in organisational culture [25].

2.7 Health Care System in Namibia

Namibia is one of the largest and least populated countries in Southern Africa. With an estimated population of 2.2 million living in an area the size of France, close to 50 percent of its citizens live in urban centers, resulting in a low population density in rural areas [25].

After Namibia gained independence from South Africa in 1990, its healthcare delivery system reflected a traditional medical model, focused mainly on hospital-based and curative services [26]. Health outcomes were generally poor, and income inequality in Namibia was extreme, as was inequity in access to health services[14,15]

2.7.1 Commitment to care and equity

In response to the situation, the newly formed independent government of Namibia made a commitment to health as a fundamental human right, and to integrating racially divided communities into one health care system. Within a few years, the national leadership at the Ministry of Health and Social Services (MoHSS) began reforms to focus on transitioning to a system based on a central role for primary health care (PHC) [27].

The prominence of PHC in these reforms is reflected in the vision of the MoHSS National Directorate for Primary Health Care Services “to translate and oversee the implementation of health policies and programs as an integral part of the health care delivery network based on the strategy and philosophy of primary health care” [28]. This vision is being realized through both horizontal integrations of public health and curative care services, as well as integration across multiple system levels from community health workers to health centers and district hospitals."

Additional efforts have been undertaken to integrate traditionally siloed programs such as HIV and AIDS, malaria, and tuberculosis into PHC. With the support of UNFPA, the MoHSS has remodeled PHC service delivery from a parallel, fragmented model towards a comprehensive, integrated, and patient-centered approach. For example, a pilot project conducted at Epako Clinic in Gobabis integrated sexual and reproductive health services with HIV services in a model known as "one nurse, one patient, one room." Preliminary results from that pilot project suggest that this integration reduces patient waiting times, improves nurse productivity, and reduces stigma and discrimination against those seeking HIV-related services [29].

Reflecting this model of integration, primary health care in Namibia is centered on four pillars:

- Health promotion;
- Disease prevention;
- Curative services; and
- Rehabilitation services [29]

As the country began the transition towards a system focused on primary health care, Namibia faced the challenge of ensuring equitable and quality healthcare for all. It attempted to address inequity through strategies including the redistribution of health care resources based on measured differences in communities [22, 23, 24]. In order to provide effective PHC services, the healthcare reform included the decentralization of responsibilities and decision-making to the local communities [25]. In 1994, thirteen regional health management teams were created to plan and manage all local PHC services and facilities [26]. These teams were responsible for managing district health management teams as they sought to operationalize a primary care approach. This decentralization facilitated more equitable distribution of critical

resources. For example, the regional health management team in the capital city of Windhoek used data to identify inequities in staffing related to increased demand and subsequently drove reallocation to poorer communities [27].

2.7.2 Mobile clinics and community outreach expand access

Recognizing the need for further action to reduce inequities in access to basic health services, a public-private partnership between the MoHSS, PharmAccess, and USAID SHOPS program implemented the Mister Sister mobile clinics in 2008 to enable better access in three rural regions[28]. The clinics aim to improve geographic access and equity by targeting poor rural communities and other vulnerable populations, including pensioners, orphans and vulnerable children [30]. The mobile clinics are designed to provide high-quality, person-centered care with a focus on comprehensiveness and continuity. Unlike traditional mobile clinic models which focus on acute care, the Mister Sister mobile clinics provide a range of services in line with the primary health care model, including routine immunizations, diagnosis and treatment of routine communicable diseases, management of minor trauma, testing and follow-up treatment for chronic diseases, voluntary counseling and testing for HIV, antenatal care, and health education [23]. Each mobile clinic includes a team comprised of a registered nurse, enrolled nurse, and a driver to help with administrative tasks. If a patient cannot be treated by the mobile clinic, they can be referred to the nearest public health facility.

Recognizing the importance of being able to provide more comprehensive care for non-communicable diseases, Mister Sister plans to have a physician available in each clinic on a quarterly basis [25]. The mobile clinics collaborate with rural employers and farmers to provide PHC to the targeted communities. The majority of local employers (80 percent) are willing to contribute to the financing of their employees' health services, in part through these clinics [26].

The Mister Sister mobile clinics have had considerable success in expanding effective coverage, particularly for the most vulnerable. Within a group of children followed over time, statistically significant declines were seen:

- Anemia declined from 1.9 percent to 0.5 percent
- Incomplete immunizations fell from 6.5 percent to less than one percent
- Parasitic infections dropped from 16.9 percent to 0.2 percent.
- Even more impressive improvements were seen among orphans: the rate of incomplete immunizations dropped from 25% to 0, and parasitic infections dropped from 22.7% to 0 [22].

Coordinated by regional health management teams, the MoHSS also provides community outreach services, including comprehensive medical outreach, eye campaigns, and clinic outreach services. Teams of doctors, dentists, and ophthalmic clinical officers visit primary care clinics in a district catchment area to expand access to these critical services. Additionally, primary care clinics conduct outreach activities within their home communities, including immunization, family planning, HIV rapid tests, antenatal care, and management of chronic diseases. New public private partnerships are also expanding access to services through outreach activities to rural communities with multidisciplinary teams of private and public doctors.

2.7.3 Health improvement results

Since independence, Namibia has shown a strong commitment to primary health care and achieved significant improvements in effective health coverage. Total health expenditure has increased from 6.2 percent of gross domestic product in the mid-1990s to 8.9 percent in 2014 [18].

Even in the face of one of the highest rates of HIV in the world, Namibia achieved 90 percent coverage with antiretroviral therapy among eligible individuals in 2012. HIV infection rates among pregnant women have declined from their peak of 22% in 2002 to 14% in 2013 [18]. Additionally, tuberculosis prevalence has declined from 1407/100,000 in 2000 to 655/100,000 in 2012 [18]."

Service delivery coverage has also improved. In 2013, 87 percent of women delivered in a facility, went up from 75 percent in 2000 to 85 percent in 2013 and 79 percent of children with diarrhea were treated with oral rehydration therapy or increased fluids [18]. Namibia has made significant progress towards reducing preventable mortality, including:

Under 5 mortality rate declined from 74 deaths per 1,000 live births in 1990 to 50 in 2013; Maternal mortality ratio declined from 320 deaths per 100,000 live births to an estimated 130 deaths per 100,000 live births over the same period [18]; Infant mortality decreased from 50 deaths per 1000 live births in 1990 to 35 deaths per 1000 live births in 2012[18].

- Namibia health worker
- CDC Global/Creative Commons
- Ongoing and emerging challenges

These improvements notwithstanding, Namibia still faces a number of challenges to providing equitable, person-centered primary health care. HIV prevalence is still the 6th highest in the world. Similar to many other countries, Namibia is now facing a growing burden of non-communicable disease, which accounted for 43 percent of deaths in 2014 [19]. Reflecting its commitment to strengthening PHC, Namibia included measurements of blood pressure and fasting blood glucose for the first time in their most recent demographic and health survey [19]. In the 2013 DHS reported that almost half of the population between the ages of 35 and 64 years (44 percent of women and 45 percent of men) had hypertension or

were on medications for hypertension. Diabetes is also a growing challenge, with 7 percent of the population having elevated glucose or already taking medications [18].

Additionally, inequity remains a pressing challenge for Namibia overall. In 2010, Namibia had one of the highest income equalities in the world [18], which is reflected in the lingering disparities in health access and outcomes seen across income groups, races, and geographic locations. For example, in 2013 18 percent of women in the lowest wealth quintile had an unmet need for family planning, compared to only 7 percent of women in the wealthiest quintile [18]. Similarly, infant and under-five mortality rates in the wealthiest quintile in Namibia (22 deaths per 1,000 live births and 31 deaths per 1,000 live births, respectively) are less than half of that of the poorest wealth quintile (51 deaths per 1,000 live births and 67 deaths per 1,000 live births, respectively) [18].

Namibia has developed a vast health care system to meet the geographic spread of its population, which requires a focus on integration and coordination across its tiers. Namibia has four tiers in the public health system: 1150 outreach points, 309 health centers, 34 district hospitals, and four intermediate and referral hospitals. The growing health care demands are complicated by a workforce shortage, as well as gaps in management capacity [18]. Reflecting human resource and other supply side shortages, the public sector is unable to respond to all needed care including specialized services. Some progress has been made through the creation of public-private models to increase the private sector coverage from its current level of 15 percent.

Notably, the Namibian government remains committed to ensuring universal access to primary health care for all its citizens. In the 2010-2020 National Health Policy Framework (NHPF) [30], the government of Namibia renewed its commitment to primary health care and the key principle that “All Namibians have the right to enjoy good health through access to

primary care and referral level services according to need" [30]. The NHFP set forth a strategy to expand and ensure equitable, quality PHC through a multi-sectoral, integrated model of delivery.

2.7.4 Challenges of integration

Despite the discussed desired outcome or advantages of integration, there are also some challenges. The study conducted in Kenya 2010, mostly focused on the integration of Non-communicable diseases with HIV indicated some of the problems experienced by Kenyans during integration such as frequent staff turnover, and space constrains for additional services[11]. In addition, the study further reveals that some countries especially developing countries where the wider health system does not function well, it makes no sense to change a separate health service or program which works well and integrate it with others. The same study reveals that there are concerns that allocation of financial resources to health priority may be reduced with integration[11].

Another qualitative study done in Uganda on the integration of Mental health disorders with Primary Health care services shows that there was limited appreciation of integration and what it means, the findings shows that some healthcare managers could not afford to train all the health care workers on mental illness and some nurses are not comfortable with integration to integrate. Besides, a negative attitude towards mental health and mental disorders was noted to play a significant role[12].

2.7.5 Integrated Primary Health Care Services in Developed versus Developing countries

Although some individual countries see integration of Primary Health care services as a burden, there is strong evidence from the electronic database of UK countries[13]. The study that was conducted by [13] in UK showed that new models of integrated care may enhance

client's satisfaction, perceived quality as well as increase access to Primary Health Care services. The same study done in UK strongly support that outpatient appointment and waiting time have reduced, all this signifies the benefits of integration in developed countries.[13]

Not all developed countries find it easy to integrate the Primary Health Care services. Some countries specifically Australia experience challenges of lack of clear and consistent policy directions across different departments. Moreover, challenges related to poorly integrated service planning as well as difficulties in accessing coordinated multidisciplinary and multi-sectoral care most especially for chronic conditions are also experienced. This reflects a weak linkage between different Primary Health Care services.[14]

Namibia is one of the developing countries that have been faced with high mortality and morbidity rate, stigmatization have been high in developing countries, long waiting period and accessibilities of Primary health care services have been challenges[14]. Global fund revealed that these challenges can be addressed through integration. The study also showed that the provision of integrated services increased the uptake and coverage of health care services.

The system review of integration in Low-middle income country from 2006, identified three types of integration, the first integration was on communicable diseases with Immunization, Family planning, TB and HIV treatment. The second integration replaced the previous separate services (e.g. providing the sexual transmitted infection (STI) testing and treatment within family planning services rather than separate infectious disease clinic.

The third integration focuses in all the Primary Health Care Services delivered in one room, by one nurse to one specific client.[14] All- in –all comparing integration of Health care services in Developed and developing countries indicated that; Integration in developing

countries has tended to concentrate more on specific clusters of health services for specific population at the service delivery level-frequently in response to donor priorities as well as responsibility requirement, on the other hand integration of developed country focused on managing and coordinating multiple/wider range of health care services including those outside health care system.[14]

2.8 Empirical Studies

There is growing consensus that Greece should work towards operational integration by allocating resources in a cost-effective and quality-assured manner.[27] This is considered a challenging task due to the lack of data on current integration levels and the requirements of PHC units [28]. In addition, key performance indicators for processes should be developed and adopted in order to establish sustainable integrated care models. [26]

The study by Tejada-Tayabas et al, [28] attempted to map the current integration levels and processes within the Greek PHC units, as well as to develop the optimum processes that should guide the national operational integration model. Interestingly, despite the widespread budgetary and human resource problems, integration among home care provider units scored at higher levels. A recent SWOT analysis of home healthcare service operations identified a lack of an integrated institutional framework as a major deficit.[41]

The pivotal role of nursing in case managing home care recipients and improving quality of life can be instrumental in integrating services and achieving seamless care [41,42]. Yet, policy makers in Greece have failed to recognise existing evidence. Given the reported high level of operational integration, this study provides further support in the direction of expanding home care services led by nurses or social workers. Viewed as an action call to health policy makers, as well as healthcare institutions and professional organizations, to cover a larger

proportion of the urban population in need of community-based and home-based skilled nursing care, the study tools can provide evidence and further guidance in that direction.

Existing literature has revealed a wide range of parameters that contribute to poor integration, including absence of an interoperable IT system with standardised flows, unequal distribution of equipment, staff and other resources [29]. Tejada-Tayabas [28] study supports previous findings indicating that the lack of standardised processes and evidence-based guidelines widens the gap between theory and practice among PHC units[23]. Therefore, there is a negative impact on continuity, coordination, comprehensiveness and quality of PHC services for all patient categories [30]. A systematic review by Tejada-Tayabas [27] suggested that effective IT systems constitute a core element for operational integration within PHC [24].

IT systems promotes patient centeredness and facilitates communication between healthcare professionals and patients (e.g., follow-up, patient training and active self-management) [19,20,21]. Reform of the Greek healthcare system during this intense austerity period, should be guided by best practices from other countries, adjusted according to current findings [22]. The theoretical model by Walker et al [22] coupled with the Chronic Care Model is strongly recommended by Krespi et al [30] and other researchers [28,29,23]. Greece could become a case study for highly burdened healthcare systems aiming to streamline operations and achieve sustainability.

[55] findings suggest that integrating HIV care with primary care services does not negatively affect individual patients and may offer some benefits that extend beyond the health system level to the individual patient. Assessment of the patient-level effect suggests that patient satisfaction remained high and that integration did not heighten perceived stigma in a study carried out by [49].

Furthermore, research findings also show that clients perceive that the privacy, confidentiality and equitable treatment for those with TB and HIV was being eroded by stigma attached to them due to the fact that they have to receive their treatment outside the main structures. The results of this present study are indicative of the fact that most nurses perceive the integration of PHC services as causing discomfort to a particular group of patients receiving care at the health facility due to the possibility of other people finding out one's HIV status.

Before and after integration, patients generally agreed that care was provided confidentially and equitably regardless of HIV status although women expressed increased discomfort with receiving care at integrated clinics. In rural Kenya, other investigators from our group have found that overall client satisfaction with integrated HIV services among pregnant women is associated with satisfaction with administrative staff, satisfaction with health professionals, and convenient wait times and encounters with a receptionist.[55]

Overall, [44] findings suggest that despite the challenges involved in integrating HIV care into routine health care, it is possible to pursue integration without significant disruption of patients' experience, and in fact with some benefits observable even within a 12-month period. Our finding that patient satisfaction remained high with integration may be evidence that the restructuring required to achieve the system-wide benefits of integration [44] does not result in patient dissatisfaction.

[24] established that clients and nurses perceive that the integration of primary health services prolongs the time that one is served or serves the clients. Most participants indicated that integration of health services is time consuming as a nurse spends more time with a client. [24] also found that a client has to do everything including screening and dressing in one room and as a result more time is taken. [26] also expressed the same views on the basis that they

spend more time in a queue waiting for a nurse to finish with the another client before they can get served.

[14,18,25] found that the integration in developing countries is mainly on communicable diseases with Immunization, Family planning, TB and HIV treatment. This integration is widely seen as replacement of the previous separate services (e.g. providing the sexual transmitted infection (STI) testing and treatment within family planning services rather than separate infectious disease clinic.[45,42,41].

[42,41] findings reveal that patients/clients perceive integrated primary health services as facilitating the mixing of people who are sick and those that are not for example a key issue raised on this matter is that people who come for family planning are often mixed with outpatients. A study by [33] supports this finding as it established that integrated PHC services mixes services that might otherwise conflict.

[42,41] argue that nurses encounter various challenges in trying to prioritise the clients whom they should serve first. Research findings revealed that it is difficult to serve clients on a first come first serve basis because if one client comes for family planning and another comes for ANC it would be unethical for them to neglect a pregnant woman regardless of the fact that a client who came for family planning came earlier.

2.9 Chapter Summary

In a nutshell, the literature review for this study has discussed the literature that shapes the study, Perceptions of Clients regarding integration from different studies, perceptions of health care workers regarding integration, comparing integration in developing countries with developed countries, history of implementation of integrations of Primary Health Care Services in Namibia. The next chapter focuses on research methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The preceding chapter focused on literature review and conceptual framework of the study. This chapter focuses on the methodological aspects of the study. Gupta and Gupta[31] stated that "research methodology is way to systematically to solve the research problem." This chapter describes research approach, research design, research instruments, population, sampling, data analysis and research ethics.

3.2 Research Approach

Qualitative research approach was used in this research due to its ability to provide rich and detailed information about the integration of health care services in Namibia. In that regard, qualitative research provided a platform to interpret data objectively and allowed the researcher to gain insights about the nature of Primary Health Care Services.

The qualitative approach is useful in contemporary social settings and it gave a better understanding of the situation, from the participants' perspective and obtain first-hand information on the phenomena.[32] Furthermore, the qualitative approach enabled the researcher to examine the experiences of the participants. Moreover, the qualitative approach provided the requisite insights regarding interpreting the study findings and putting them into perspective.

The purpose of qualitative research is to describe variation in a phenomenon or situation through the use of an unstructured and flexible methodology, and analysis is done in non-quantifiable form. The researcher made use of qualitative research to get an in depth analysis of the subject matter that is perceptions of nurses and clients regarding the integration of PHC services. [33], [34], [35], concurred that the advantage of qualitative research is that it ensures obtaining actual and direct experience from the participants which gives valuable and

meaningful information. On the same note, Chang et al [36]and Kugler [37] agreed that information gathering in qualitative studies is flexible, subjective and in depth.

3.3 Research design

Without a definitive research design, this research would have been untrustworthy and unreliable. That is why it was significant for the researcher to articulate the plan how the information would be gathered. Research design as defined by [38] denotes a blueprint followed in the process of collecting and measuring data. In this research, research design denotes the steps that the researcher followed in carrying out the research. The researcher used exploratory case design.

In this research, an exploratory case design was implemented and was found appropriate to collect data regarding new phenomena, when there is less literature. Exploratory research is a study design that a researcher can adopt to enquire about a research problem when the researcher has no past data or only a few studies for reference. This is because an exploratory research design as a tool can enable one to understand an issue more thoroughly.

3.4 Research instruments

According to Torri [39,] a research instrument is a tool that enables the researcher to gather relevant data. The researcher used an interview guide. to get more information through interviews. The interview guide was semi structured containing two sections; the first section was to get demographic characteristics of the participants and the other section for the questions.

The researcher also used a voice recorder as an instrument of data collection. Field transcript sheets were also used to make field notes. The study employed semi structured interview schedules to collect primary data. Studies by Jha and Rathi [40,] Palmer et al [41] and Harilall and Kasiram [43] used semi-structured interviews thus the researcher opts for this data collection

instrument to allow the researcher to probe and delve deep into the views, opinions and experiences of the participants. Permission was sought from participants to record interviews with the aid of a voice recorder.

3.5 Population

Target population denotes a total number of entities from which the sample is drawn by the researcher.[44] The population for this study were all the patients and Nurses who are served and serving at the two facilities, Okuryangava and Wanahenda clinic. The catchment population of Okuryangava Clinic is 51 021 and it is manned by 11 Nurses.

3.9.1 Inclusion criteria

This study only included clients from the age of 18 who were available and willing, who came either for treatment, immunization, family planning, dressing, postnatal care, Antenatal care, follow up of chronic medications (ARVs, diabetic medication etc.) and dressing. Because they are adults and they can reason on their own. Only those that can understand English and Oshiwambo will participate. All nurses at the two clinics who are willing and available were part of the study.

3.9.2 Exclusion criteria

Children below the age of 18 are excluded from the study, severely sick and mentally ill were excluded in the study. Clients who do not understand English, Oshiwambo were excluded, because the researcher can only speak those two languages.

3.6 Sampling

This research used non-probability sampling. The participants were selected using purposive sampling techniques since only certain members of the population hold information. The researcher used purposive sampling technique because in purposive sampling, the researcher

uses a wide range of methods to locate all possible cases of a highly specific and difficult to reach population. Purposive sampling technique denotes a kind of sampling which is designed for the selection of specific cases within a population.[44]

This sampling method helped the researcher to target only prospective participants who have the information needed by the researcher in this case those who are aware of integration of Primary Health Care Services. This sampling technique is important as it enables the researcher to reach the targeted sample quickly. A total of 20 participants were selected. The two clinics Okuryangava and Wanahenda clinic were selected purposively based on the volume of the clients as well as the location.

All clients/patients aged 18 years old and above who were present at the two clinics on the date of data collection and who were willing to participate were conveniently sampled to form part of the sample size. The total catchment population was approximately 89 054 (Okuryangava 51 021 & Wanahenda 38 033). Since the number of nurses is few all of them who were available and willing to participate were part of the sample size. They were selected on the basis that they were directly involved with one nurse one room setting. Although the researcher's plan was to conduct 40 interviews, data was collected until saturated. The level of saturation was reached at 20 interviewees.

3.7 Data Collection Procedure and Data Collection Methods

The study was ethical cleared by the human subject research ethics committee (HREC) at UNAM. Thereafter, the researcher sought permission from the Ministry of Health and Social Services as well as permission from the nurses in charge of the two clinics where the study was conducted. After permission was granted, participants were then selected using purposive sampling technique. The researcher explained the study purposes and what was

expected from participants. Furthermore, the researcher obtained informed consent from participants before she commenced with data collection.

The researcher conducted in-depth interviews, wrote down the responses and probed to get more clarity on the responses. The targeted participants were asked to answer questions, without necessarily divulging their identities if they wished to do so. Upon completion of data collection, responses were evaluated. For unforeseen circumstances, the researcher made copies and stored them in a lockable drawer in her office.

The researcher used interviews to extract information as regards the integration of primary health services in Namibia. This method was chosen because it is flexible as it allowed interesting points to be followed by the researcher[45]. [39] views an in-depth interview as a purposeful conversation between two people that is directed by one in order to get information. In-depth interviews are one of the most common qualitative method of collecting data because they are very effective in giving a human face to research problems.

In- depth interviews were useful in getting information, face to face, from the individual key informants. This means that by carrying out in-depth interviews in this study it enabled the researcher to gather information about the topic. The study used interviews with selected participants on purpose to give participants the freedom to answer the questions in their own words. Interviews were used by the researcher because they enabled the researcher to follow points of interest and participants had the liberty to respond to interview questions using their own words thus making the study original.

The researcher made use of face to face interviews because they enabled her to get information relevant to the study. Appointments were made with the management so as to allow them to be interviewed when they were free and to increase the response rate.

Interviews were scheduled to last for a period of 40 minutes for each respondent as a way of managing time.

However, face to face interviews proved to be time consuming as some respondents were not readily available at scheduled times which resulted in the interviews taking more time. More time was also taken as participants explained the issues and this was useful to the study as more information was provided.

3.8.1 Pilot study

Pilot study is defined as a small-scale version or dummy of the actual study. The researcher can identify and address some problems during pilot study by obtaining information for improving the entire project, re-assessing the feasibility of the study and also making adjustment to the instrument[6].With this study pilot study was conducted at Maxuilili and Robert Mugabe clinic. No changes were made.

3.9. Data analysis

The aim of data analysis of qualitative data is to infer into patterns, ideas, and explanations to understand or simplify the data discovered[46]. Torri [39] argues that qualitative data are organised materials to generate the meaning towards the research questions. Data that emerged from the research were thematically presented. Data was analysed through content analysis. In this study data was analysed and presented by giving the textual report of shared views, opinions and experiences of the experts who participated in the study. Data were interpreted and discussed in comparison to information gathered in the literature review. The researcher analysed data by the use of content analysis.

Content analysis is defined by Torri [39] as a method of analyzing the content or information. The researcher analysed data by the use of content analysis. As Kugler [37] argues, content analysis can be used to analyze texts. The results of the research were analyzed so that

significant interpretations could be made. This allowed the researcher to reach an informed conclusion on which this study and other subsequent studies could be based. Qobadi et al [48] outlines the steps in the data analysis. The initial plan in data analysis is planning for the recording of information. The researcher used a schedule in guiding the planned interviews. The next step involves data collection and preliminary analysis. This was followed by management of the data using file folders, index cards or computer files.

After completing the process of reading and writing memos, the researcher generated categories, themes and patterns. The next process entailed the identification of common themes and trends. The next step was coding of the data and a coding scheme to the identified themes and categories using key words and numbers. This researcher considered the extent to which the available data answered the questions about what was required

3. 10 Research Ethics

The ethical approval to conduct the study was obtained from the University of Namibia, Human Research Ethics Committee (HREC). In addition to that, further permission ethical clearance was obtained from National Health research department of the Ministry of Health and Social Services. The study proposal was presented to the Khomas Regional Directorate in order to obtain a permission authorization to conduct the study in the two clinics. All ethical issues were fully explained to the participants and were enforced during the research.

The researcher explained the purpose of the study, arranged the interview and discussion dates, asked the participants to sign consent letters before interviews and discussions. Approving that they were taking part in the study voluntarily and had understood what the study questions were all about. Other important ethical issues that were considered are participant informed consent; whereby clients were given informed consent to the researcher

that they accept to participate in the study. The participants were assured of their human right that should be protected, such as: privacy, anonymity, confidentiality, autonomy, beneficence, and justice.

Privacy, Anonymity and confidentiality

The researcher made sure that participants' real names were not mentioned; therefore, each participant had a code assigned to him or her. Participant's identities were protected in such a way that not even a researcher will be able to link a subject with her data. Data collected was kept confidential and not to be made available to anyone, except when it will be published.

Beneficence

The participants were informed that their physical well-being would be protected and that they have the right to protection from discomfort and harm. Furthermore, the researcher made it clear that there is no direct individual benefit for participating in the study, but the study findings will be submitted to MoHSS and may be used to improve the service of the entire population.

Autonomy

All the participants were informed that participation in the study is voluntary and they could withdraw or choose not to answer any of the questions without any effect. During the study the researcher ensured that participants expressed themselves without interruptions.

Justice

Fair selection of study participants was assured and also the participants during the study had equal treatment, no discrimination of race, level of education, employment status, religion etc. Participants were selected for reasons directly related to the research problem but not because they were readily available. Participants have right to fair selection and treatment.

The researcher made it clear that selection of participants is done fairly and the participants were given equal and fair treatment during the study, no discrimination against race, level of income, level of education or religion.

3.11 Chapter summary

In summation, this chapter focuses on the methodological aspects of the study. This chapter described research approach, research design, research instruments, population, sampling, data collection procedure, data analysis and research ethics. The next chapter focuses on the presentation of research data.

CHAPTER 4: RESULTS AND DISCUSSION

4.1 Introduction

The chapter provides an overview of the research findings. This chapter presents research findings and analyses data with regards to the perceptions of clients and nurses regarding integration of the primary health care services with reference to Okryangava and Wanaheda Clinics. Data presentation and analysis is done in this chapter in a bid to answer the research questions from the research findings. The data comes from the interviews that were conducted. The purpose of the study was to explore the perception of clients and nurses regarding integration of primary health care services between the two clinics (Okuryagava and Wanaheda clinics). The qualitative data acquired is presented in thematic form and content analysis was used to analyse data.

4.2 Demographic Characteristics

This section presents the demographic characteristics of the participants who were interviewed in this study. A total of 20 participants were interviewed in this study. The participants included registered nurses from both Okuryagava and Wanaheda clinics and walk in patients who visited the clinics at the time of data collection. 5 nurses were purposively sampled from either clinic. 5 clients were also selected from either clinic to participate in the study. Of the 20 participants interviewed, 13 were female while 7 were male. The participants ages varied from 19 years to 62 years. 2 had primary education, 6 had secondary education and 12 had tertiary education. Of the 20 participants, 14 were employed and 6 were unemployed.

4.3 Findings

This section presents the results of the study in relation to the research objectives. The section also analyses how the research results and the key themes that emerged from the research contrasts and compares with findings from the previous researches. This section also shows how the research results can support the theoretical framework outlined in chapter 2. The interview questions were open ended to encourage meaningful responses from the interviewees. This technique provided the researcher with the opportunity to obtain qualitative data in a manner that has the benefit of providing an overall question and focus for the interviewer, yet also providing the interviewees with the opportunity to express their views. The interviews each lasted for about 45 to 50 minutes and were conducted at the facilities were the participants were found by the researcher.

The findings are analysed and points of interest are presented in verbatim. Pseudo names were given to the participants to protect their identities. thus they were named from Participant 1 (P1) to Participant 20 (P20). To ensure the accuracy of the analysis of the data, the researcher prepared summaries of his interpretation of participants' responses and gave them to each of the interviewees for review and validation.

Eight themes were identified from study findings. They are listed in table 4.1 and are further detailed below:

4.4 Themes

Theme No	**Theme**
Theme 1	Integration and improved relationship between nurses and clients
Theme 2	Convenience of integration
Theme 3	Integration of PHC services enhances competence
Theme 4	The mixing of services that do not go along
Theme 5	Integration is prolongs time a client is served

Theme 6	Integration does not resonate with the structures as well as the resources of the clinics
Theme 7	Integration and stigmatisation of clients
Theme 8	The need for resources, rooms and instruments should be addressed

Theme 1: Integration and improved relationship between nurses and clients

An interesting finding that emerged from the study is that the integration of primary health care services is perceived by both nurses and clients as a catalyst for an improved relationship between nurses and clients. The results of the present study indicate that the integration of primary health care services enables the nurses to know their patients as well as knowing what is wrong with them. Moreover, the results show that regular clinic visits by clients often build good nurse-client relationships with the nurses who serve them. Participants said,

> *Integration of primary health care services has a benefit of enhancing the relationship between nurses and patients which is good for the recovery of patients because you understand them personally. This explains why my relationship with the clients has improved since the introduction of integration of primary health care services.* (P1; P2).

Another interesting finding that emerged from the study is that clients perceive that the integration of primary health care services has greatly transformed the knowledge of nurses with regards to their clients wellbeing because more time is spent with them in a consultation room and this gives them ample time to build a rapport. Participant 3 had this to say,

> *"This new system of obtaining health services at one place whereby you have one nurse attending to you as well as getting all services in one room is good because as you get all the services on one point you spend more time with the nurse and consequently improves the relationship you have as well as the care."*

Findings also reveal that the integration of primary health services promotes a good relationship between the nurses and patients since the integration of primary health care is patient centred during consultation time. This then enhances communication between the nurse and the patients in most cases. This is demonstrated in the follow up sessions in which one can get attended by the same nurse who attended them the first time they came to the clinic with an ailment. Moreover, the results of the study suggest that the nurse-patient relationship in terms of patient training also improves especially training that relates to the self-administration of drugs through injections or tablet medication. Participant 5 said,

> *"My relationship with patients has improved since the introduction of integration of primary health services because I can easily identify patients who come for follow up visits especially those whom I would have served the first time they visited the clinic. This can enable me to speak freely or be able to communicate them and advise them comprehensively on how to administer injections or take their medication."*

Participant 6 said,

> *"The integration of primary health services facilitates an improved relationship building between us and the nurses especially when we come for follow up visits. You develop a good relationship when see the same nurse who served you the first time you came. It's also easy for that nurse to quickly understand you and ask you on how you are improving."*

Participant 4 said

> *"In general, the relationship builds up and in most cases the people you deal with are the same."*

Participant 3 said

"You can make an assessment regarding whether they are getting better or worse. It builds a good relationship with clients."

A critical part of the findings that emerged from the study is that the integration of primary health care services is perceived by both nurses and clients as a catalyst for an improved relationship between nurses and clients. This finding corroborates previous studies by [26,28] which established an improved relationship between nurses and clients as a result of the integration of PHC services at clinic levels. The results of the present study further indicate that the integration of primary health care services enables the nurses to know their patients as well as knowing what is wrong with them. Moreover, the results show that regular clinic visits by clients often build good nurse-client relationships with the nurses who serve them. [14,36,51] suggest that the provision of integrated services increases the uptake and coverage of health care services as well as the relationship between nurses and clients.

Findings also reveal that the integration of primary health services promotes a good relationship between the nurses and patients since the integration of primary health care is patient centred during consultation time. A study by [25] established that the integration of PHC services enhances communication between the nurse and the patients in most cases given the follow up sessions in which one can get attended by the same nurse who attended them the first time they came to the clinic with an ailment.

Theme 2: Convenience of integration

The results of the study indicate that the integration of primary health services has led to convenience of service delivery. An interesting finding that emerges from the data is that the integration of primary health services is convenient for patients since they do not need to walk around. Most of the participants perceived the integration of primary health services as a time saving method through which the clients can get served. Participants suggested that the

movement of the clients/patients is reduced and one can acquire all the service in one room. The data from the present study suggests that the outpatients' appointments as well as the time that one have to wait has reduced which is a benefit which both patients and nurses claimed. Participant 8 said,

> *"I see the integration of primary health services as convenient because you don't need to walk around and it saves us a lot of time and you can be attended on all at once. I also perceive that the integration of primary health services is convenient because every service is now available in each room per patient."*

Research findings further show that the provision of an integrated primary health services is convenient to both patients and nurses because of the easiness of coordination of services for all patient categories. In other words, the results of the study suggest that the integrated primary health services allow the comprehensive and quality of services in each room per patient. Participant 10 said,

> *"The good thing about the integration of primary health services is that it is convenient because the wastage of time is avoided and it reduces the duplication of our efforts in expediting treatment to diverse patients. Therefore, in my opinion I think it leads to quality treatment with a sense of urgency."*

Participants perceive that integrated primary health services makes health service delivery convenient because time wasting is reduced as one nurse can attend to one client at a time and thus all services such as mass recording and temperature recording are done at one place. Findings also show that the participants perceived that the integrated primary health services are convenient as processes such as immunisation are done efficiently as vaccines are kept in the same room. Participant 9 said,

"Immunisations are a bit of time consuming but with integrated primary health services they are administered in conveniently."

Participant 6 said,

"Integration has its good and bad sides. It cuts movement on the part of the patient. Before integration the patient could wait for a long time to get a service. The patient could be sent to the injection room to be injected but now one person can administer all the services in one room."

[52,53,17,18] concur that the integrated services are thought to increase the access of women and vulnerable groups to health care as all health needs can be met at a single visit. For example, women bringing children for health care can have their own health needs addressed at the same time, saving the expense, time and inconvenience of a further visit. The findings of this study are supportive of this because they indicate that the integration of primary health services has led to convenience of service delivery. An interesting finding that emerges from the data is that the integration of primary health services is convenient for patients since they do not need to walk around. Most of the participants perceived the integration of primary health services as a time saving method through which the clients can get served.

Theme 3 Integration of PHC services enhances competence

Research findings suggest that the integration of PHC services enhances the competency of nurses. What emerges from the study as interesting is that with integration the nurse has to know how to administer every health service and they are thus required to possess high

proficiency in doing their jobs. In this regard, findings show that most nurses have improved their competency on the job. Participant 3 had this to say,

> *"With integration there are both benefits and disadvantages. With integration you learn a lot of things. With regards to competency, I am now competent as compared to before the introduction of integration of primary health services.*"

Other participants also highlighted the fact that they now know about certain services that they knew little about or were inexperienced to perform that need to be done on patients. Participant 2 said,

> *I have learnt a lot of things such as war wash out. If it was not for integration, I would just refer that to dressing but now I am competent in that area because it is my duty to offer that service.*

Participant 7 said,

> *"Our competency has increased because nurse assessment of clients made easier."*

Participant 1 said,

> *"With regards to competency there is difference now. Competency has improved because it reminds us of all the things that we have to do as nurses"*

Besides the fact that most of the participants indicated that they are now competent with regards to their service delivery, a few participants said that their competency have been the same. Participant 4 said,

> *With or without integration our competency remains at the top level. In our case we do delegation of tasks and we rotate so we are still exposed to every services that a nurse should undertake.*

Theme 4: The mixing of services that do not go along

Research findings show that participants particularly nurses perceive the integrated primary health services as a problem because it includes the mixing of services that do not go along. Research findings reveal that patients/clients perceive integrated primary health services as facilitating the mixing of people who are sick and those that are not for example a key issue raised on this matter is that people who come for family planning are often mixed with outpatients. This then makes it difficult for nurses when they are serving their clients because they have to multi task. Participant 7 said:

> *"The main pitfall of the integrated primary health services is that it mixes the sick people together with those who are not sick but come for other health services such as family planning."*

Participant 15 said

> *"There is mixing of service that do not go along for example the mixture of ANC and screening can take a lot of time. Depending on the service being sought can take up to 10 minutes and ANC can take up to 40 minutes if it's the first time. In essence, there are some services that can be offered together and there are some that cannot and it inconveniences us who come for family planning."*

Another key interesting finding that emerged from the study as it relates to the perceptions of clients regarding that integrated primary health services is that sometimes clients are kept waiting in queues and yet they require different services from those that are sick. Participant 13 said:

> *"Sometimes we come here take family planning pills and you have to be in the same queue with everyone who came for treatment. I feel that this mix up is not fair and services should be provided separately."*

Findings show that nurses encounter various challenges in trying to prioritise the clients whom they should serve first. Research findings revealed that it is difficult to serve clients on a first come first serve basis because if one client comes for family planning and another comes for ANC it would be unethical for them to neglect a pregnant woman regardless of the fact that a client who came for family planning came earlier. Participant 8 said that,

> *"We encounter challenges in prioritising the patients between the old people and the pregnant women because all the clients are mixed up as a result the services that we offer do not go along."*

Participant 10 said

> *"I think it's not working at all because I believe that there are some services that can be integrated, for example, ANC should be taken out."*

The results of this study also indicate that There were a lot of services offered before. Those who were coming for family planning would go straight to family planning section where they would not have to wait for long. Participant 4 said,

> *"Prioritising old patients and pregnant women can make those who have come for family planning to spend the whole day at the clinic instead of at least 20 minutes."*

Another critical finding is that the integration of primary health services is perceived by nurses as a problem because it includes the mixing of services that do not go along. This finding diverges from previous studies by [14,18,25] which found that the integration in developing countries is mainly on communicable diseases with Immunization, Family planning, TB and HIV treatment. This integration is widely seen as replacement of the previous separate services (e.g. providing the sexual transmitted infection (STI) testing and treatment within family planning services rather than separate infectious disease clinic.[45,42,41].

Research findings reveal that patients/clients perceive integrated primary health services as facilitating the mixing of people who are sick and those that are not for example a key issue raised on this matter is that people who come for family planning are often mixed with outpatients. A study by [33] supports this finding as it established that integrated PHC services mixes services that might otherwise conflict.

Findings show that nurses encounter various challenges in trying to prioritise the clients whom they should serve first. Research findings revealed that it is difficult to serve clients on a first come first serve basis because if one client comes for family planning and another comes for ANC it would be unethical for them to neglect a pregnant woman regardless of the fact that a client who came for family planning came earlier.

Theme 5 Integration is Prolongs time a client is served

The results of the study indicate that clients and nurses perceive that the integration of primary health services prolongs the time that one is served or serves the clients. Most participants indicated that integration of health services is time consuming as a nurse spends more time with a client. Research results show that a nurse has to do everything including screening and dressing in one room and as a result more time is taken. Participants also expressed the same views on the basis that they spend more time in a queue waiting for a nurse to finish with the another client before they can get served.

Participant 5 said,

> *"Work overload is a challenge especially when you are understaffed and everyone has to come to your consultation room. You will end up being overworked especially given the fact that you spend a lot of time with a patient and yet you have a lot of patients to serve."*

The prolongation of time emerged as a key finding in this study in which case the time for patients at the clinic is made longer than necessary because the system takes only one patient at a time and one nurse. The nurse is expected to administer every health service to the patient hence it takes more time to serve a client. Participant 17 said,

> *"We come here expecting to spend more time because you are served by one nurse during the entire process of receiving treatment from the clinic. If you need dressing the nurse has to attend to you as well. As a result, you spend more time here."*

Research findings further brings to light the fact that since there is one nurse one patient in a consultation room and that all the services are centralised at one place it takes time for the nurse to serve the client because there is no specialisation but the services offered by the nurse are relative from patient to patient. To substantiate this Participant 8 said,

> *"It is time consuming for example, child temperature, length, screening all that take a lot of time if it's being done by one person. People outside will begin to complain or even shout at you that you are slow"*

Research results also show that institutional factors also aid in the elongation of time that clients may spend at the clinic. Moreover, the nature of the job that the nurse does per single client is also key and it determines the time spent in acquiring a health service. Participant 9 said,

> *"Integration leads to work overload which prolongs time for serving a client for example in a day we might receive about 60 clients and since we have two rooms for consultation it means per day a nurse may serve 30 clients and thus takes a lot of time."*

Participant 6 said,

"Looking at the figure of 30 patients it's a lot for a single nurse. Moreover, there are a lot of registers that needs to be filled. The work becomes too much because there is also need to look for instruments that you need to use for each client."

Participant 5 said that, *"when nurses are on leave or going for their studies it creates problems because we cannot rotate but we just have to serve all the clients by ourselves."*

Participant 19 said,

"There are normally a lot of patients to be served so integration of PHC services leads to the delay of clients. We normally take close to 3 hours before we are served and these longer periods feel us uncomfortable as we are sick."

Participant 20 said,

"Integration leads to prolonged time we spent here as clients. The clinic receives over 50 clients and since they have only two rooms for consultation it means per day a nurse may serve a lot of clients and they often get exhausted making even worse because they end up delaying"

The results of the study indicate corroborate the findings of [24] who established that clients and nurses perceive that the integration of primary health services prolongs the time that one is served or serves the clients. Most participants indicated that integration of health services is time consuming as a nurse spends more time with a client. [24] also found that a client has to do everything including screening and dressing in one room and as a result more time is taken. [26] also expressed the same views on the basis that they spend more time in a queue waiting for a nurse to finish with the another client before they can get served.

Theme 6 Integration does not resonate with the structure as well as the resources of the clinics

The findings of the study suggest that integration of PHC does not resonate with the structure as well as the resources of the clinics. Given the structure of infrastructure as well as the resources available for nurses, it was established that the resources available are out of sync with the provision of integrated PHC services at the clinics.

Findings reveal that the instruments needed by each nurse in a consultation room are inadequate as they have to share particularly the special instruments. Research results indicate that the number of rooms for consultative purposes are insufficient which translates to the prolongation of time spent because only 3 consultation rooms are functional and yet some nurses may be redundant at that time. Participant 6 said,

> *"Integration would have worked best if we had resources, rooms and the needed instruments. Integration of primary health services does not fit our health system in Namibia because we don't have enough rooms and resources needed to implement it."*

Participant 7 said,

> *"It's just not working because of the number of patients we receive daily and we don't have enough rooms to handle them. Integration places the burden of too much workload among nurses"*

Participant 10 said,

> *Personally I think it is not working because there are many factors that were not considered. In terms of the structure of the clinic and the resources available one can say that it is not working. Sometimes there is shortage of staff.*

Participant 8 said,

> *"We have only 3 consultation rooms and we are a lot of nurses. We have people who come for family planning and yet they should be served in the same few rooms that we have and this creates a problem for us."*

The effect of integrated care on inadvertent disclosure bears further investigation. Overall, [44] findings suggest that despite the challenges involved in integrating HIV care into routine health care, it is possible to pursue integration without significant disruption of patients' experience, and in fact with some benefits observable even within a 12-month period. Our finding that patient satisfaction remained high with integration may be evidence that the restructuring required to achieve the system-wide benefits of integration [44] does not result in patient dissatisfaction.

Theme 7 Integration and stigmatisation of clients

Research findings show that the integration of PHC services stigmatises other patients. The clients' perceptions of stigma at the clinics indicated that those with diseases such as Tuberculosis were stigmatised as they have to receive treatment in a container far away from others. Furthermore, research findings also show that clients perceive that the privacy, confidentiality and equitable treatment for those with TB and HIV was being eroded by stigma attached to them due to the fact that they have to receive their treatment outside the main structures.

The results of this present study are indicative of the fact that most nurses perceive the integration of PHC services as causing discomfort to a particular group of patients receiving care at the health facility due to the possibility of other people finding out one's HIV status.

Participant 16 said that,

It evident that there is stigmatisation. There are containers outside for those with TB which shows that clearly discrimination of some of the patients.

Participant 1 said,

You need to do classification of patients in front of everyone and this stigmatises those with TB

However, some of the participants refuted the fact that integration of PHC services has led to stigmatisation. They argue that even before the integration of PHC services some patients were not mixed. Participant 7 said,

I have never observed stigmatization. Even before the integration of PHC services those with non-communicable diseases were not mixed with those communicable or infectious diseases.

The clients' perceptions of stigma at the clinics indicated that those with diseases such as Tuberculosis were stigmatised as they have to receive treatment in a container far away from others. [55] findings suggest that integrating HIV care with primary care services does not negatively affect individual patients and may offer some benefits that extend beyond the health system level to the individual patient. Assessment of the patient-level effect suggests that patient satisfaction remained high and that integration did not heighten perceived stigma in a study carried out by [49].

Furthermore, research findings also show that clients perceive that the privacy, confidentiality and equitable treatment for those with TB and HIV was being eroded by stigma attached to them due to the fact that they have to receive their treatment outside the main structures. The results of this present study are indicative of the fact that most nurses perceive the integration of PHC services as causing discomfort to a particular group of

patients receiving care at the health facility due to the possibility of other people finding out one's HIV status.

Before and after integration, patients generally agreed that care was provided confidentially and equitably regardless of HIV status although women expressed increased discomfort with receiving care at integrated clinics. In rural Kenya, other investigators from our group have found that overall client satisfaction with integrated HIV services among pregnant women is associated with satisfaction with administrative staff, satisfaction with health professionals, and convenient wait times and encounters with a receptionist.[55]

Theme 8: The need for resources, consultation rooms and instruments deficiencies should be addressed

Research findings show that participants were of the view that there is need for resources, consultation rooms and instruments to be addressed so as improve the integration of PHC services at the clinics. If more infrastructure could be provided it would ease the problems that the nurses are currently facing.

Research findings also reveal that there is need to restructure the processes of the PHC provision at the clinics as the current ones seem to be out of sync with the available resources. Participants said:

> *I feel that there are certain services that need to be taken out such as ANC because it takes a lot of time* (P1)

Participants believe that immediate actions towards patient-centred care are necessary in order to operationally integrate all provided services and existing functions of the PHC system at the clinics. Participants were also of the view that health policymakers should adopt an evidence-based action plan that ensures and safeguards patient-centredness, comprehensiveness, sound coordination, and continuity of services at the clinics.

The findings of the study suggest that integration of PHC does not resonate with the structure as well as the resources of the clinics. Given the structure of infrastructure as well as the resources available for nurses, it was established that the resources available are out of sync with the provision of integrated PHC services at the clinics. Findings reveal that the instruments needed by each nurse in a consultation room are inadequate as they have to share particularly the special instruments. Structures are needed that will enable the disparate parts of primary health care to function as a system.

[34] The current reform process suggests that these may be politically achievable for the first time in many years. Taken as a whole, the recommendations from the interim report from the National Health and Hospitals Reform Commission [35] and the Primary Care Task Force [36] contain all the main elements that will be required: management through a single level of government, guidance from a national primary health care strategy, regional organisations to coordinate service planning and voluntary patient registration with general practice to strengthen the relationship between patients and their general practitioners.

The reports also point to other elements that will contribute to more coordinated primary health care: more flexible approaches to program funding, payments to service providers that relate to prevailing chronic and complex conditions rather than single episodes of care and better infrastructure for supporting care coordination, such as shared information systems could then facilitate the adoption of more integrated models of care.

4.5 Conclusion

This chapter clearly presented the research findings and discussed the findings against the existing PHC literature and the theoretical framework employed in the study. From the findings, it is evident that integration and improved relationship between nurses and clients, integration is convenient, accelerates competence, PHC makes nurses assessment of clients

made easier. On the other hand, PHC has led to the mixing of services that do not go along, it prolongs time a client is served, it does not resonate with the structure as well as the resources of the clinics and stigmatises clients.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The previous chapter focused on presentation of findings and discussion. This chapter outlines the key results of the research and the conclusions with the aim to respond to central questions that were raised in chapter 1. This chapter also focuses on the recommendation of the research based on the findings presented in chapter 4. After the summary of key findings is outlined, conclusions and recommendations are made with reference to the findings. The emphasis is on the opinions of the participants for this research project. The objectives that guided this research are as follows:

- To assess the perceptions of clients regarding integration of PHC services
- To assess the perceptions of nurses regarding integration of PHC Services
- To suggest possible recommendations that can be adopted to improve integration of PHC Services based on the perceptions of Clients and Nurses

5.2 Summary of findings

Research findings show that that integration of PHC services is complex. Findings underscore the need for a multifaceted approach to integration of PHC services which entails ensuring that they are indeed effective. The competing dissertations around integration of PHC services provide an opportunity to examine the effectiveness of integration of PHC services at Okryangava and Wanaheda Clinics. The integration of PHC services at Okryangava and Wanaheda Clinics evade the realities of the needs of the clients. The integration of PHC services at the Okryangava and Wanaheda Clinics thus miss the systematic and institutional aspect of the needs of the patients that are manifest in the inefficient health service delivery.

The first objective of the study was to assess the perceptions of clients regarding integration of PHC services. Findings show that nurses perceive that integration of PHC services has improved relationship between nurses and clients, integration of PHC services is convenient, integration of PHC services enhances competence and PHC makes nurses assessment of clients made easier. On the other hand, clients said that integration of PHC services has led to the mixing of services that do not go along causing inconveniences for them. Clients perceive PHC as time consuming as it prolongs time a client is served. Moreover, integration of PHC services does not resonate with the structure as well as the resources of the clinics and stigmatises clients.

The second objective of the study was to assess the perceptions of nurses regarding integration of PHC Services What also arose as a key finding in this research is that integration and improved relationship between nurses and clients, integration is convenient, accelerates competence, PHC makes nurses assessment of clients made easier. On the other hand, PHC has led to the mixing of services that do not go along, it prolongs time a client is

served, it does not resonate with the structure as well as the resources of the clinics and stigmatises clients.

The third objective of the research was to suggest possible recommendations that can be adopted to improve integration of PHC Services based on the perceptions of Clients and Nurses. Findings show that Research findings show that participants were of the view that there is need for resources, consultation rooms and instruments to be addressed so as improve the integration of PHC services at the clinics. If more infrastructure could be provided it would ease the problems that the nurses are currently facing.

Research findings also reveal that there is need to restructure the processes of the PHC provision at the clinics as the current ones seem to be out of sync with the available resources. Participants believe that immediate actions towards patient-centred care are necessary in order to operationally integrate all provided services and existing functions of the PHC system at the clinics. Participants were also of the view that health policymakers should adopt an evidence-based action plan that ensures and safeguards patient-centredness, comprehensiveness, sound coordination, and continuity of services at the clinics.

5.3 Recommendations of based on the Study

While the PHC practices are well documented, substandard practices continue to strive in Namibia. Therefore, discovering areas of PHC improvement remains a pressing area of inquiry. Based on research findings and taking cognizance of the need to ensure effective PHC management, the following recommendations are made to MoHSS:

Recommendations to the government

- Education, recruitment and retention of adequate staff, improving the clinical and population oriented performance of the primary health care system.

- Establishment of a performant primary health care service integrated in the cluster health system.
- Organisation of health systems in an inter-sectoral network, with cross links to environment, economy, work and education at the different institutional levels, and with use of a bottom-up approach (inter-sectoral action for health), involving civil society

Recommendations to the nurses

- There is need to fully to separate ANC from PHC as well as Family planning.

5.4 Areas for Future Study

The scope of this thesis was quite broad and aimed to assess the nurses and clients' perception regarding the integration of PHC services. The researcher suggests that further studies should be carried out on the effectiveness of the strategies put in place to manage the integration of PHC services. Further research is required to give more highlights on the issue of Health Information System (HIS) integration in Namibia.

It could prove of much help to study areas such as the other parts of routine HIS, as well as, the national level, which was not included in this study. The national level is important to consider especially in a hierarchal system such as in Namibia to explore interest and motives towards integration.

Wider scope study of the health system might come up with results of further exploration of potential challenges and opportunities for system integration. It would be interesting to explore the practice on other professions since talent management is now a global trend.

5.5 Conclusions

Overall, the study draws the conclusion that integration improves relationship between nurses and clients, integration is convenient, accelerates competence, PHC makes nurses assessment of clients made easier. On the other hand, PHC has led to the mixing of services that do not go along, it prolongs time a client is served, it does not resonate with the structure as well as the resources of the clinics and stigmatises clients.

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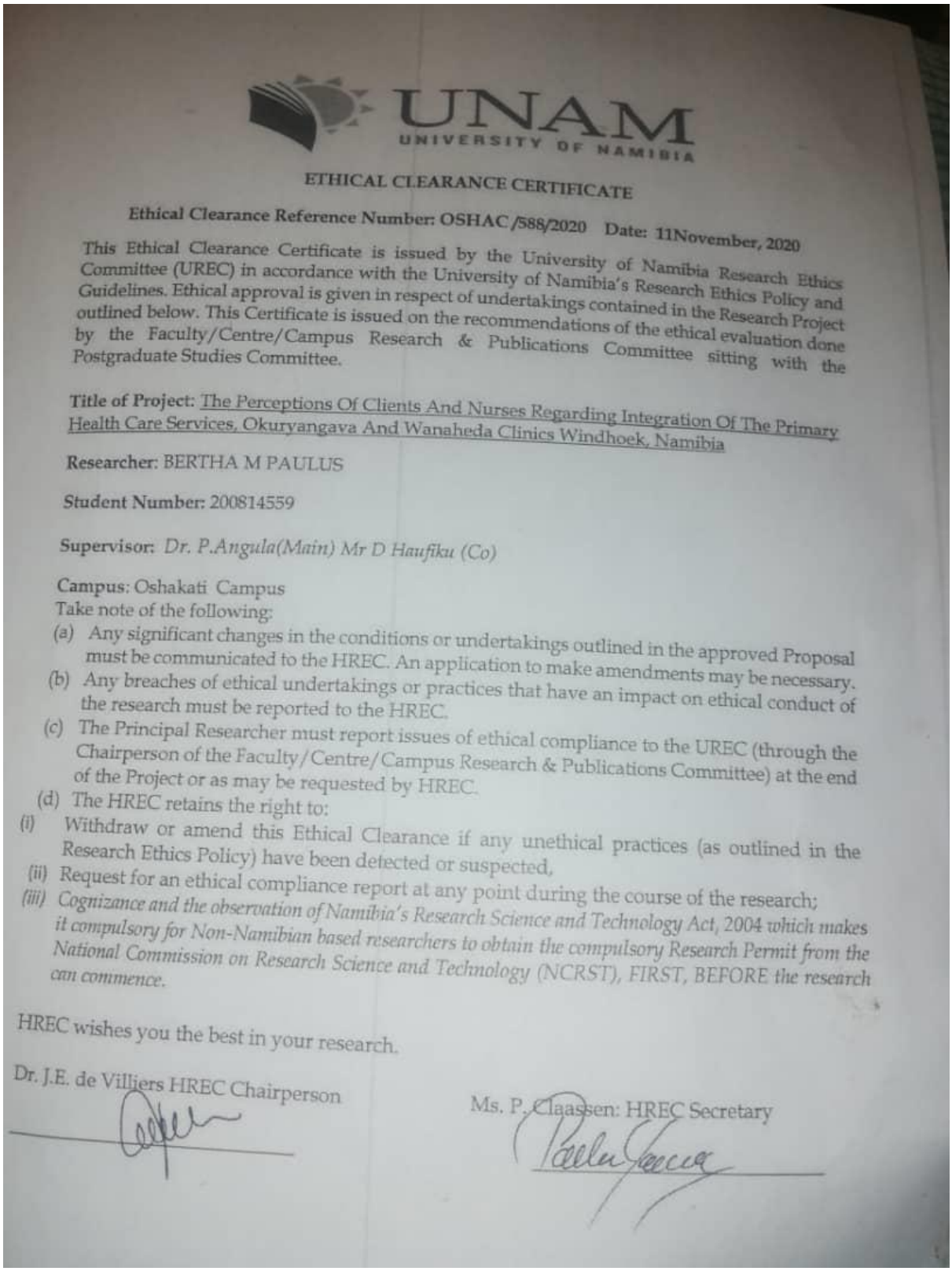
ANNEXURE 1: ETHICAL CLEARANCE



UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: OSHAC /588/2020 Date: 11November, 2020

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: The Perceptions Of Clients And Nurses Regarding Integration Of The Primary Health Care Services, Okuryangava And Wanaheda Clinics Windhoek, Namibia

Researcher: BERTHA M PAULUS

Student Number: 200814559

Supervisor: *Dr. P.Angula(Main) Mr D Haufiku (Co)*

Campus: Oshakati Campus

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the HREC. An application to make amendments may be necessary.

(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the HREC.

(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by HREC.

(d) The HREC retains the right to:

(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,

(ii) Request for an ethical compliance report at any point during the course of the research;

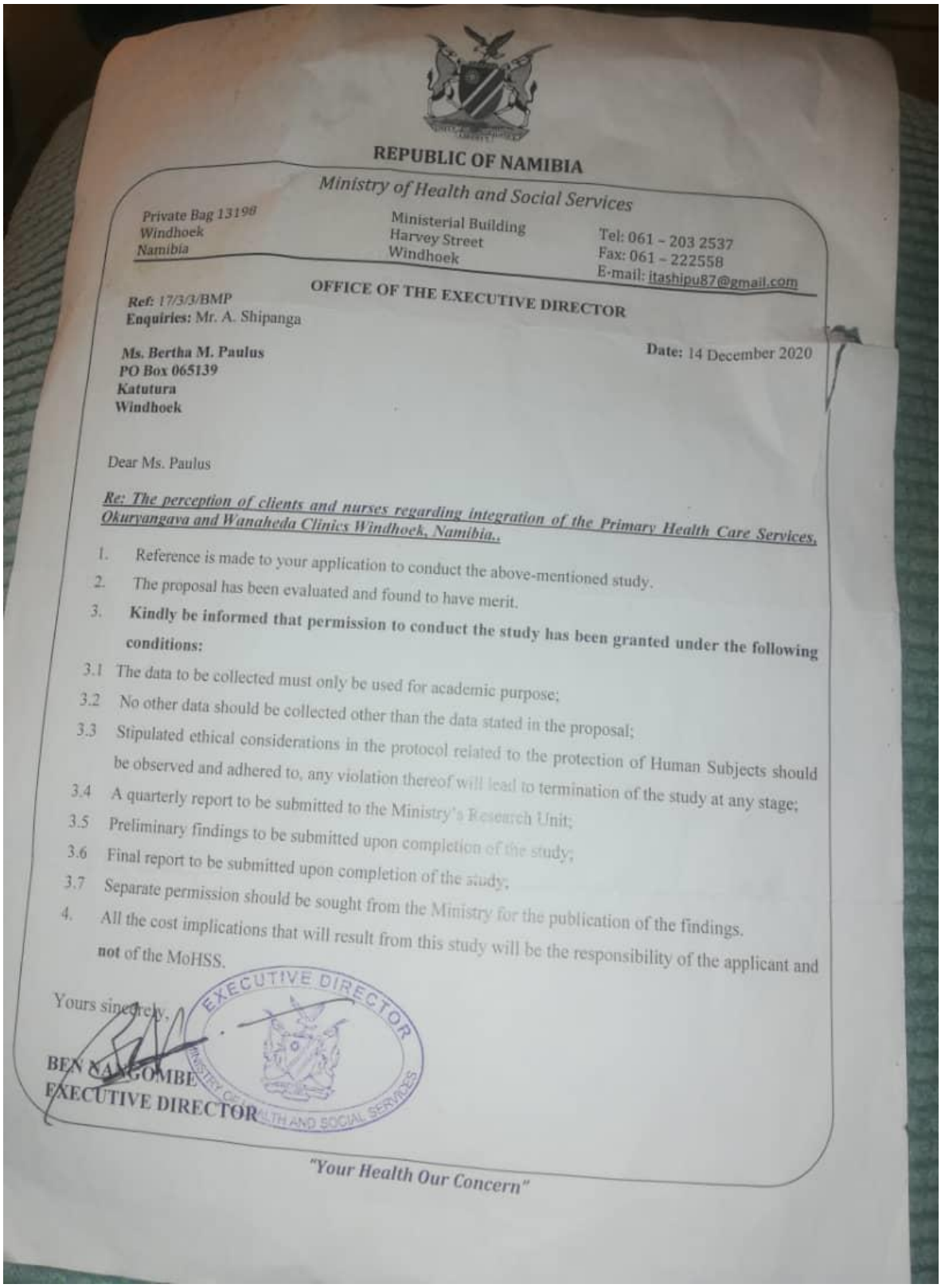
(iii) *Cognizance and the observation of Namibia's Research Science and Technology Act, 2004 which makes it compulsory for Non-Namibian based researchers to obtain the compulsory Research Permit from the National Commission on Research Science and Technology (NCRST), FIRST, BEFORE the research can commence.*

HREC wishes you the best in your research.

Dr. J.E. de Villiers HREC Chairperson

Ms. P. Claassen: HREC Secretary

ANNEXURE 2: PERMISSION TO CONDUCT THE STUDY



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2537
Fax: 061 – 222558
E-mail: itashipu87@gmail.com

OFFICE OF THE EXECUTIVE DIRECTOR

Ref: 17/3/3/BMP
Enquiries: Mr. A. Shipanga

Ms. Bertha M. Paulus
PO Box 065139
Katutura
Windhoek

Date: 14 December 2020

Dear Ms. Paulus

Re: The perception of clients and nurses regarding integration of the Primary Health Care Services, Okuryangava and Wanaheda Clinics Windhoek, Namibia..

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purpose;
3.2 No other data should be collected other than the data stated in the proposal;
3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
3.4 A quarterly report to be submitted to the Ministry's Research Unit;
3.5 Preliminary findings to be submitted upon completion of the study;
3.6 Final report to be submitted upon completion of the study;
3.7 Separate permission should be sought from the Ministry for the publication of the findings.

4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

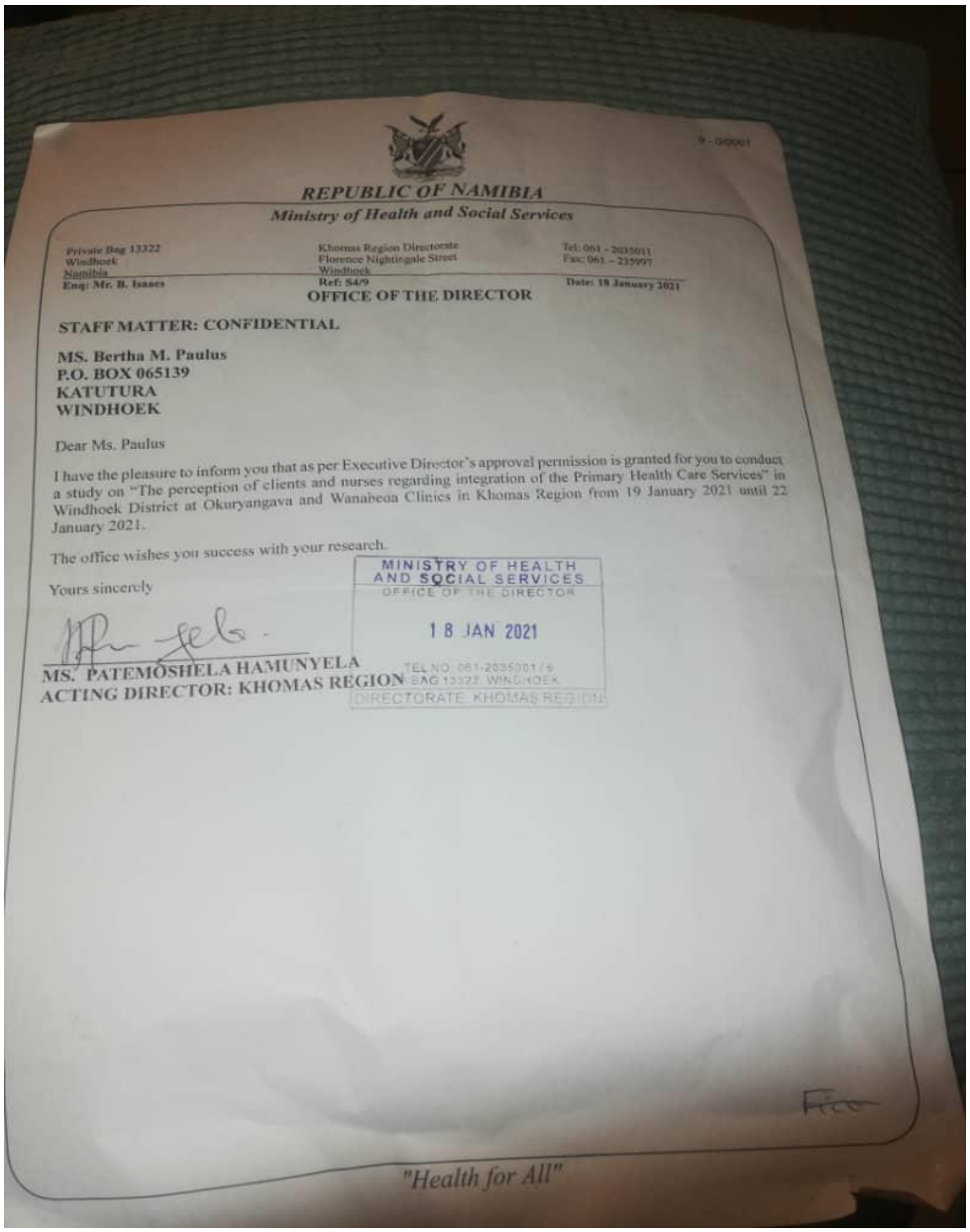
Yours sincerely,

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

BEN NANGOMBE
EXECUTIVE DIRECTOR

"Your Health Our Concern"

ANNEXURE 3: APPROVAL



REPUBLIC OF NAMIBIA
Ministry of Health and Social Services

Private Bag 13322
Windhoek
Namibia
Enq: Mr. B. Isaacs

Khomas Region Directorate
Florence Nightingale Street
Windhoek
Ref: 54/9

Tel: 061 - 2035011
Fax: 061 – 235997
Date: 18 January 2021

OFFICE OF THE DIRECTOR

STAFF MATTER: CONFIDENTIAL

MS. Bertha M. Paulus
P.O. BOX 065139
KATUTURA
WINDHOEK

Dear Ms. Paulus

I have the pleasure to inform you that as per Executive Director's approval permission is granted for you to conduct a study on "The perception of clients and nurses regarding integration of the Primary Health Care Services" in Windhoek District at Okuryangava and Wanaheda Clinics in Khomas Region from 19 January 2021 until 22 January 2021.

The office wishes you success with your research.

Yours sincerely

MINISTRY OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE DIRECTOR
18 JAN 2021
TEL NO: 061-2035001/9
P BAG 13322, WINDHOEK
DIRECTORATE: KHOMAS REGION

MS. PATEMOSHELA HAMUNYELA
ACTING DIRECTOR: KHOMAS REGION

"Health for All"

ANNEXURE 4: CONSENT FORM

Assessing the perception of Clients and Nurses regarding the integration of Primary Health Care services, Wanahenda and Okuryangava Clinic, Windhoek, Namibia.

My name is Bertha M Paulus. I am studying towards Master's in Public Health degree at UNAM. As part of the requirements for the fulfilment of the degree, I am conducting a research on the perceptions of Clients and Nurses regarding the integration of Primary Health Care services, Wanahenda and Okuryangava Clinic, Windhoek, Namibia

The information gathered through this interviews will be useful in an effort to compile a research project on the perception of Clients and Nurses regarding the integration of Primary Health Care services, Wanahenda and Okuryangava Clinic, Windhoek, Namibia.

Participation in this component of the research is voluntary. In addition, information provided will be treated as confidential, and will only be used for the purposes of the study. Your participation or non-participation will not result in any disadvantage to you.

ANNEXURE 5: INTERVIEW GUIDE
University of Namibia

School of Nursing and Public Health

Title of the research: Assessing the perception of Clients and Nurses regarding the integration of Primary Health Care services, Wanahenda and Okuryangava Clinic, Windhoek, Namibia.

Items Required

- Print out of research Proposal
- Pen (Blue or black)
- Tape/Video recorder
- Writing Pad
- Comfortable place

1 Introduction

- Greet the participants and introduce myself.
    - My name and surname
    - My work place
    - Clearly explain the purpose of the study and that it is voluntary
    - Obtain the verbal consent from the participant him/herself
    - Explain to the participant that the results of the study will strictly only be used for the stated purpose.

1 Find out the age of the participant (age category) and the address.

2 With the Semi-structured interview researcher will ask Open-ended question and if necessary probe focusing on the objectives of the study.

A. Clients questions

The main question (In client's friendly language)

What are your views or opinions about receiving multiple health care services at one point of care?

(Things to probe: duration at the facility, benefits, difference in comparing to the past, availability of services, availability of nurses, communication and language barrier, relationship-build up)

Thank you for taking your valuable time to participate in this interview.

B Nurses Question

Tell me your perception on Integration of Primary Health Care Services?

(Things to probe: Competency, benefits, challenges, experience, duration of consultation, difference in comparing to the old system, relationship-build up)

Thank you for taking your valuable time to participate in this interview.

ANNEXURE 6: SAMPLE OF INTERVIEW TRANSCRIPT

What is your age?

Answer

26

What are your views or opinions about receiving multiple health care services at one point of care?

Answer

Integration of primary health care services has a benefit of enhancing the relationship between nurses and patients which is good for the recovery of patients because you understand them personally. This explains why my relationship with the clients has improved since the introduction of integration of primary health care services.

How long have you served at this facility?

Answer

3 years

Any challenges competency, benefits, challenges, experience, duration of consultation, difference in comparing to the old system, relationship-build up?

We have only 3 consultation rooms and we are a lot of nurses. We have people who come for family planning and yet they should be served in the same few rooms that we have and this creates a problem for us. I feel that there are certain services that need to be taken out such as ANC because it takes a lot of time.