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Qualitative Content Analysis in Community Health Nurses: Principles Measures Adopted Rural Areas in India

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Abstract

Qualitative content analysis as described in published literature shows conflicts opinions and unsolved issues regarding meaning and use of concepts, procedure and interpretation in primary health care. This paper provides an overview of important concepts related to qualitative content analysis; illustrations the use of concepts related to the research procedure, and proposes measure to achieve community health nurses and community health worker in rural areas throughout the steps of the research procedure. Interpretation in qualitative content analysis is discussed in light of practice aspects of community health nurses and community health worker in rural areas.

Keywords: Community health Nursing ,Credibility ,Manifest content, Qualitative content analysis, Transferability, Home visit , Principles of community ,Primary care

Introduction

Healthcare research is a systematic inquiry intended to generate robust evidence about important issues in the fields of community health nursing and healthcare settings. Qualitative research has ample possibilities within the arena of healthcare research. This article aims to inform healthcare professionals regarding qualitative research, its significance, and applicability in the field of Community health Nursing. A wide variety of phenomena that cannot be explained using the quantitative approach can be explored and conveyed using a qualitative method. The major types of qualitative research designs are narrative research, phenomenological research, grounded theory research, ethnographic research, historical research, and case study research. The greatest strength of the qualitative research approach lies in the richness and depth of the community health exploration and description it makes. In community health research, these methods are considered as the most humanistic and person-centered way of discovering and uncovering thoughts and actions of human beings[1]. Community Health research is a systematic inquiry intended to generate nursing care evidence about issues in the field of Community health and Community Health nursing care. The three principal approaches to health research are the quantitative, the qualitative, and the mixed methods approach. Qualitative information with an objective

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to solve different but related questions, or at times the same questions[2].

Overview concepts

Ensuring access to Community healthcare is a complex, multi-dimensional health challenge. Since the inception of the health care settings, this challenge is more pressing. These dimensions of access are particularly evident in rural health systems where additional structural barriers make accessing healthcare more difficult. Thus, it is important to examine healthcare access barriers in rural-specific areas to understand their origin and implications for resolution[3].

Five key themes emerged from analysis: 1) a friction exists between aspects of clients' rural identities and community healthcare systems; 2) facilitating access to community healthcare requires application of and respect for cultural differences; 3) communication between community healthcare providers is systematically fragmented; 4) time and resource constraints disproportionately harm rural health systems in the field areas and 5) profits are prioritized over addressing barriers to healthcare access in India

Need for the study

The qualitative data approximately 13.3% of adults in India did not have a usual source of community healthcare. Millions more did not utilize services regularly, and close to two-thirds reported that they would be debilitated by an unexpected natural calamity in the rural areas. Findings like these emphasized a fragility in the financial security of the total population[4]. These concerns were exacerbated by the health care when a sudden surge in unemployment increased un- and under health care modalities. Indeed, employer- health care covers close to half of total cost of illness. Unemployment linked to health care cut off the lone outlet to healthcare access for many. Health-related financial concerns expanded beyond individuals, as healthcare organizations were unequipped to manage a simultaneous increase in demand for specialized healthcare services and a steep drop off for routine revenue-generating healthcare services in the rural health care in the countryside. These consequences of the health risk of all put additional, unexpected pressure on an already fragmented community healthcare system[6].

Other structural barriers to healthcare access exist in relation to the rural–urban divide. Less than 15% of Indian healthcare resources are located in rural areas where approximately 65% of the Indian population resides. In a country with substantially fewer providers per capita compared to many other developed countries, persons in rural areas experience uniquely pressing healthcare provider shortages in rural health care. Rural inhabitants also tend to have lower household income, higher rates of disease prevalence and more difficulty with travel to healthcare clinics than urban dwellers. Subsequently, persons in rural communities use healthcare services at lower rates, and potentially preventable hospitalizations are more prevalent. This disparity often leads rural residents to use services primarily for more urgent needs and less so for routine care[8].

Methods

Qualitative methods were utilized for this interpretive, exploratory study because knowledge regarding barriers to healthcare access within Tripua rural health system. We chose West Tripura healthcare providers, rather than patients, as the population of interest so we may explore barriers to healthcare access from the perspective of those who serve many persons in rural settings. Inclusion criteria required study participants to provide direct healthcare to patients at least one-half of their time[9]. We defined 'provider' as a healthcare organization employee with clinical decision-making power and the qualifications to develop or revise patients' treatment plans. In an attempt to capture a group of providers with diverse experience, we included providers across several types and specialties. These included Community health worker and Community Health nurses , who worked in community health care, family health care, pediatrics, psychiatry, and urgent community health care. We also included community health workers and clinical field specialist who specialize in community behavioral healthcare provision. We recruited participants via direct field visit snowball sampling approach we opted for this approach because of its effectiveness in time-pressured contexts, such as the time bound study,

which has made healthcare provider populations hard to reach. Considering additional constraints with the community care and the rural nature of Tripura, interviews were administered and recorded function enabled. All interviews were conducted by the first author between December and March 2021.

Results

Illustrations of the use of concepts

In the following we illustrate the use of concepts and analysis procedures for two texts based on interviews and observations respectively. One rationale behind giving two examples is to show various ways to develop themes. The processes of analysis are described and shows in Fig 1-3 , Even if there description point to a linear process, it is importance to bear in mind that the process of analysis involves a back and forth movement between the whole and parts of the text.

Qualitative content analysis of an interview text

The unit of analysis in this example is interview text about experiences of heaving rural health care. The content consists of a larger study aimed at describing coping strategies related to the everyday routine in rural health care. Twenty community health nurses aged 25-59 years, participated in the study. Interviews were performed addressing various aspects of rural health challenges.

Table 1: Examples of meaning units, condensed meaning units and codes

Meaning Unit	Condensed meaning unit	Code
There is a curious feling in the head in some way, empty in some way	Curious feeling of emptiness in the head	Emptiness in the head
It is more unpredictable so tosay,you can never be sure about anything	An unpredictable and unsure situation	uncertainty

Table 2: Lack of control and struggle for regaining in community connectivity

Theme	Lack of control and struggle for regaining in community connectivity				
Category	Sensations		Actions		Cognitions
Sub-category	Unfamiliar	familiar	Unfamiliar	Familiar	Action difficulties
Codes	Route map and modification of concept mapping in community field	Logical changes in the route mapping in agencies	Rural health system health management disruption	Urge to know about connectivity in the rural health sector	In ability of thinking clear concept on rural health system with clear concepts on health

Our sample included 12 health providers do with intentive care providers in community health in the field and one in behavioral health Our participants averaged 9 years (range 2–15) as a healthcare provider; most reported more than 5 years in their current professional role. The diversity of participants extended to their patient populations as well, with each participant reporting a unique distribution of age, race and level of medical complexity among their clients in the community. Most participants reported that a portion of their patients travel up to two hours, sometimes across district , to receive care.

Theme 1: A friction exists between aspects of patients' rural identities and healthcare systems

Our participants comprised a collection of medical professions and reported variability among health-related reasons their patients seek care. However, most participants acknowledged similar characteristics that influence their patients' challenges

to healthcare access. These identified factors formed categories from which the first theme emerged. There exists a great deal of 'rugged individualism' among country side people, which reflects a self-sufficient and self-reliant way of life. The system marked a primary factor to characterize this quality. One participant explained: True country side people are difficult to treat medically because they tend to be a tough group. They don't see doctors. They don't want to go, and they don't want to be sick. That's an aspect of Montana that makes health culture a little bit difficult.

There is a real perception of a punitive nature in the medical community, particularly if I observe a health issue other than the primary reason for one's hospital visit, whether that may be predicated on medical neglect, delay of care, or something that may warrant a report to social services. For many of the patients and families I see, it's not a positive experience and one that is sometimes an uphill barrier that I work hard to circumnavigate.

Analysis of these factors suggests that low use of healthcare services may link to several characteristics, including access problems. Separately, a patient's perceived stigma from healthcare providers may also impact a patient's willingness to receive services. One participant put it best by stating.

Sometimes, families assume that I didn't want to see them because they will come in for follow up to meet with me but end up meeting with another provider, which is frustrating because I want to maintain patients on my panel but available time and resource occasionally limits me from doing so. It could be really hard adapting to those needs on the fly, but it's an honest miss. When a patient arrives for a healthcare visit and experiences this frustration, it may elicit a patient's perceptions of neglect or disorganization. This 'honest miss' may, in turn, exacerbate other acceptable-related barriers to care.

Theme 2: Facilitating access to healthcare requires application of and respect for cultural differences

The biomedical model is the standard of care utilized . However, the state comprises people with diverse social and cultural identities that may not directly align with conceptions of health and wellness concept of government of India. Approximately 11.5% of the Tripura population falls within an ethnic minority group. 6.4% are of Christians, 65% are of bengalis. Cultural insensitivity is acknowledged in health services research as an active deterrent for appropriate healthcare delivery. Participants for this study were asked how they react when a patient brings up a cultural attitude or behavior that may impact the proposed treatment plan. Eight participants noted a necessity for humility when this occurs. One participant conceptualized this by stating: When this happens, I learn about individuals and a way of life that is different to the way I grew up. There is a lot of beauty and health in a non-patriarchal, non-dominating, non-sexist framework, and when we can engage in such, it is really expansive for my own learning process.

Facilitating factors to react to cultural attitude/ behavior that does not align with treatment path

Consensus among participants indicated that the use of these protective factors to promote cultural sensitivity and apply them in practice is not standardized. When asked, all but two participants said they had not received any culturally-based training since beginning their practice. Instead, they referred to developing skills through "on the job training" or "off the cuff learning." The general way of medicine, one participant remarked, was to "throw you to the fire." This suggested that use of standardized cultural humility training modules for healthcare providers was not common practice. Many attributed this to time constraints.

Individual efforts to gain culturally appropriate skills or enhance cultural humility were mentioned, however. For example, three participants reported that they attended medical conferences to discuss cultural challenges within medicine, one participant sought out cultural education within their organization. Participants described these additional efforts as uncommon and outside the parameters of a provider's job responsibilities, as they require time commitments without compensation.

Theme 3: Communication between healthcare providers is systematically fragmented

Healthcare is complex and multi-disciplinary,

and patients' treatment is rarely overseen by a single provider. The array of provider types and specialties is vast, as is the range of responsibilities ascribed to providers. Thus, open communication among providers both within and between healthcare systems is vital for the success of collaborative healthcare. Without effective communication achieved between healthcare providers, the appropriate delivery of healthcare services may be become compromised. Our participants noted that they face multiple challenges that complicate communication with other providers. Miscommunication between departments, often implicating the health Department (ED), was a recurring point noted among participants. One participant who is a primary care physician said:

This concern was highlighted with a specific example from a different participant:

I have been unable to troubleshoot instances when I send people to the primary health centers with a pretty clear indication for admission, and then they're sent home. For instance, I had an older fellow with pretty severe chronic kidney disease. He presented to another practitioner in my office with shortness of breath and swelling and appeared to have newly onset decompensated heart failure. When I figured this out, I sent him to the ER, called and gave my report. The patient later came back for follow up to find out not only that they had not been admitted but they lost no weight with outpatient dialysis. I feel like a real opportunity was missed to try to optimize the care of the patient simply because there was poor communication between myself and the primary health care.

In some cases, communication breakdown was reported as the sole cause of a poor outcome. When communication is effective, each essential member of the healthcare team is engaged and collaborating with the same information. Some participants called this process 'rounds' when a regularly scheduled meeting is staged between a group of providers to ensure access to accurate patient information. Accurate communication may also help build trust and improve a patient's experience. In contrast, ineffective communication can result in poor clarity regarding providers' responsibilities or lost information. Appropriate delivery of healthcare considers the fit between providers and a patient's specific healthcare needs; the factors noted here suggest that provider-provider miscommunication can adversely affect this dimension of healthcare access.

Theme 4: Time and resource constraints disproportionately harm rural health systems

Several measures of system capacity suggest the healthcare system in the Tripura under-resourced. There are fewer health care providers and hospital beds per capita compared to most comparable states , and the growth of healthcare provider populations has stagnated over time. Rural areas, in particular, are subject to resource limitations. All participants discussed provider shortages in detail. They described how shortages impact time allocation in their day-to-day operations. Tasks like patient intakes, critical assessments, and recovering information from diseases take time, of which most participants claimed to not have enough of. There was also a consensus in having inadequate time to spend on medically complex cases. Time pressures were reported to subsequently influence quality of care. One participant stated.

Theme 5: Profits are prioritized over addressing barriers to healthcare access in the health department in India.

The Indian healthcare system functions partially for-profit in the public and private sectors. The government provides funding for national programs such as Medicare, but a majority of Americans access healthcare through private employer plans. As a result, consumer rates influence healthcare access. Though the rate of the uninsured has dropped over the last decade through expansion of the Affordable Care , it remains above 28 percent. Historically, there has been ethical criticism in the literature of a for-profit system as it is said to exacerbate healthcare disparities and constitute unfair competition against nonprofit institutions. One participant shared their views on how priorities stand in their practice.

Eight participants echoed a similar concept, that addressing barriers to healthcare access in their organizations is largely complicated because so much attention is directed on matters that have nothing to do with patients. A few other participants supported

this by alluding to a "cherry-picking" process by which those at the top of the hierarchy devote their attention to the easiest tasks. One participant shared an experience where contrasting work demands between administrators and front-line clinical providers produce adverse effects:

Discussion

This study explored barriers and facilitators to healthcare access from the perspective of rural healthcare providers in Tripura. Our qualitative analysis uncovered five key themes: 1) a friction exists between aspects of patients' rural identities and healthcare systems; 2) facilitating access to healthcare requires application of and respect for cultural differences; 3) communication between healthcare providers is systematically fragmented; 4) time and resource constraints disproportionately harm rural health systems; and 5) profits are prioritized over addressing barriers to healthcare access in India. Cultural competence is achieved through a plethora of trainings designed to expose providers to different cultures' beliefs and values but induces risk of stereotyping and stigmatizing a patient's views. Therefore, cultural humility is the preferred idea, by which providers reflect and gain open-ended appreciation for a patient's culture.

Implications for Practice

Perhaps the most substantial takeaway is how embedded rugged individualism is within rural patient populations and how difficult that makes the delivery of care in rural health systems. We heard from participants that stoicism and perceptions of stigma within the system contribute to this, but other resulting factors may be influential at the provider- and organizational-levels. Stoicism and perceived stigma both appear to arise, in part, from an understandable knowledge gap regarding the care system. For instance, healthcare providers understand the relations between primary and secondary care, but many patients may perceive both concepts as elements of a single healthcare system. Any issue experienced by a patient when tasked to see both a primary and secondary provider may result in a patient becoming confused. This may also overlap with our third theme, as a disjointed means of communication between healthcare providers can exacerbate patients' negative experiences..

Implications for Future Research

It is important for future health systems research efforts to consider issues that arise from both individual- and system-level access barriers and where the two intersect. Although mental health did not come up by design in this study, future efforts exploring barriers to healthcare access in rural systems should focus on access to rural healthcare. In many rural areas, Tripura included, rates of suicide, substance use and other mental health disorders are highly prevalent. These characteristics should be part of the overall discussion of access to healthcare in rural areas. Optimally, barriers to healthcare access should continue to be explored through qualitative and mixed study designs to honor its multi-dimensional stature.

Ethical clearance: Ethical clearance taken from Institutional Ethical clearance committee before going to the study.

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Conflict of Interest: There is no conflict of interest for the study

Conclusion

The divide between urban and rural health stretches beyond a disproportionate allocation of resources. Rural health systems serve a more complicated and hard-to-reach patient population. They lack sufficient numbers of providers to meet population health needs. These disparities impact collaboration between patients and providers as well as the delivery of acceptable and appropriate healthcare. Our qualitative study explored rural healthcare providers' views on some of the social, cultural, and programmatic factors that influence access to healthcare among their patient populations. We identified five key themes: 1) a friction exists between aspects of patients' rural identities and healthcare systems; 2) facilitating access to healthcare requires application of and respect for cultural differences; 3) communication between healthcare providers is systematically fragmented; 4) time and

resource constraints disproportionately harm rural health systems; and 5) profits are prioritized over addressing barriers to healthcare access.

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