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Challenges for Nurses in Providing Patient-Centered Care in Rural Primary Health Care Clinics in Nigeria

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Abstract

Globally, patient-centered care has become the focus of the healthcare system. It is imperative to note that during a global pandemic crisis, patient-centered care principles seek to empower partnering approaches in Primary Health Care (PHC), and have recently gained prominence in nursing practice and applied nursing research. However, nurses are faced with challenges in achieving the desired results in the PHC system. Thus, the study aimed to explore the factors that influence PCC utilization in the PHC facilities in Nigeria. A qualitative exploratory-descriptive design was used for this study. Data collection was conducted with the nurses from PHC facilities through individual interviews. Data saturation was achieved with 35 participants from 30 PHC facilities in Osun State, Nigeria, using a purposive sampling technique. All interviews were audio-recorded, later transcribed verbatim, and analyzed using the thematic analysis approach. NVivo 12 software was used for data management. The results from this study were categorized into two factors: Organizational factors and individual factors. Six themes that emerged from the study include inadequate management support, insufficient opportunities for further training, work overload and time constraints, health personnel readiness to use PCC, dearth enthusiasm for change, and poor nurses' Accountability. The study shows that nurses encountered diverse challenges in providing patient-centered care. To improve the quality of healthcare delivery in the PHC facilities, there is a need to reinforce adequate management support, education, continued training, and the internal motivation of nurses to achieve transformative health outcomes in the community.

Keywords

Patient-Centered Care, Challenges, Nurses, Primary Health Care, Healthcare Service

1. Introduction

Patient-centered care (PCC) is personalized and coordinated care given to individuals [1]. PCC is tailoring healthcare services to suit the patient's needs, by providing care for a patient beyond the disease condition [2]. PCC is a process of treating a client receiving healthcare service with respect, values, dignity and involving the individual in all planning and choices to make all decisions about their healthcare based on preferences [2] [3] [4] [5], it is a broader approach of caring for patient by looking on the whole life of the patient to guide clinical decisions [4] [6]. This is holistic care, and the strategy is related to a person's right to ask questions and complaints about their healthcare, which helps patients receive better quality of care [2]. To achieve this, healthcare workers need to know patients at a personal level and involve them in the decision-making process. This is because nobody values someone making decisions for them without involving them. Using PCC with patients gives them a sense that they are human beings with feelings and beliefs instead of objects [7].

Nursing services and the quality of healthcare delivery with PCC operation need investigation to be effectively evaluated in the health system [8]. This is because PCC is a well-recognized concept in nursing. However, in practice, it is poorly demonstrated [8]. Conceptually, PCC in nursing practice remains a concern within the healthcare system [9]. Therefore, it is essential to address barriers with nurses implementing PCC, which focused on the patient rather than diagnostic values. Westphal, Alkema, Seidel, and Chernof identified misunderstanding among nursing professionals about the concept and the process of caring as a contributing factor to the poor implementation of PCC. The way forward is for nurses to be patient-oriented by putting patients at the center of their care and avoid viewing patients from a disease standpoint [10]. Consequently, the use of PCC requires nurses to be competent in PCC's knowledge and skills to deliver holistic nursing care [9] effectively.

Understanding PCC's strategies to nursing practice will facilitate its implementation and would help nurses address [10] [11] their patient's needs [9] efficiently. The main characteristics of PCC are: Care; communication; culture; collaboration; respect; values; compassion; coordination; dignity; involvement; information and education. This healthcare strategy requires an effective partnership between the nurse and the patient to improve health outcomes, patient responsibilities to their healthcare, which enhance patient satisfaction, nurse morale, and efficiency [12].

World Health Organisation report shows that infrastructure, healthcare organization, education level, and amount of information contribute to PCC practice that promotes high-quality healthcare service delivery [13] [14]. This concept has been presented as one of the six powerful healthcare system approaches to achieve multiple reforms directed towards healthcare delivery [15].

According to Engel George, an American Psychiatrist recommended PCC as a new medical model in medicine [16]. This was due to the unparalleled care between the psychosocial and biological challenges that has been a struggle but needs

to be reconciled within human beings. Therefore, achieving evidence-based approaches to healthcare intervention is a significant challenge, leading to a discrepancy in health care across the world [17]. Although patients improved satisfaction, quality healthcare, health outcomes, reduced cost of health care, and reduction in the health care disparities have been demonstrated in developed countries [18] [19], however, in low and middle-income countries (LMICs) such as Nigeria multiple difficulties such as literacy, political instability, make PCC concept more challenging for nurses to implement, deliver and optimize [20] [21]. As a result, there has been a need to develop a holistic approach to understanding the "What", "Why" and the "How" to improve healthcare [22] [23] [24].

1.1. Challenges Facing Implementation of Patient-Centered Care

PCC has been observed to defy a series of incremental changes. In the last two decades, phenomenal theoretical development emphasizes the quality of PHC with healthcare facilities practices [25] [26]. There is a need for leadership skills compared to authoritarianism. This quality can be achieved by expanding the clinical focus from single patients to more proactive population-based, particularly for the chronic and terminally ill patients and the kind of preventive services being offered [27] [28]. Additionally, Nurse-patient relationships should shift and lean towards a relationship-centered partnering to achieve patient-oriented goals compared to adherence to clinical guidelines [29].

Another area posing a challenge to PCC is technological changes and incorporate them into the PHC system to benefit nurses and patients. New technology is more complicated and is time-consuming to implement than most organizations and healthcare managers envisioned. Technical support is practical; for example, the case of electronic medical records (EMR) is marketed as a tool for entering and storing medical records. However, it has been shown to require a complicated workaround and sometimes becomes extremely difficult and awkward to activate [30] [31]. Technological changes also require a redefinition of the work process before implementation, thus floundering in practice redesign.

1.2. Cost Implications of Patient-Centered Care

PCC's implication in reducing the total cost of primary health care is still a subject of debate [32]. The reduction of healthcare costs remains unanswered, although there is growing evidence of a favourable impact of PCC achieving the triple aims of population health, improved care experiences, and lower cost of health care [33] [34].

Based on the available literature, there is a strong basis to recognize the benefits of PCC model implementation in a broader context to reap its benefits [35] [36]. However, there is no study that can conclusively prove the efficacy of the PCC model in the healthcare system. The available literature in this area will provide a framework for understanding how best the PCC model can be implemented effectively in different environments and how it could be measured and evaluated.

PCC's potential impact on the cost of care remains unclear and debatable

since the cost is not explicitly the goal of PCC [35] [37]. In fact, PCC may increase the cost of care, especially in the short-term, as it employs greater preventive care use. Fortunately, this short-term increase in the cost of care is offset by the large decrease in acute care use which is linked to poor access to early primary health care. In other words, PCC focuses on the "upstream" in the whole care process. For instance, the PHC clinic visits, provision of preventive care and comprehensive chronic care, and care coordination to reduce the "downstream" emergency department visits and acute admissions [34]. It is imperative to note that most of the research findings covering PCC's cost implications tend to focus on value achieved from PCC implementation as a model in the PHC. Few studies have documented direct cost to deliverance and PCC implementation to medical practice functions [38].

1.3. Primary Health Care System in Nigeria

Quality healthcare services are essential to the population in Nigeria. The Nigerian healthcare system is divided into three-tiers: Tertiary level, secondary level, and PHC level [39]. All these tiers are involved in all aspects of the healthcare system functions: Stewardship, financing, and service provision. In terms of operations, the tertiary level operates from the federal ministry of health (FMOH), the secondary level operates from the State ministries of health (SMOH), and the PHC which is at the grassroots operates from the local government health care (LGHC). Also, the local government sustains the PHC facilities in the communities [39] [40]. According to the World health organization, the key to the achievement of health for all, as identified in the international Alma-Ata Declaration of 1978 is PHC [41]. However, Nigeria is yet to attain health for all in spite of the fact that several years have passed. PHC was adopted in Nigeria in 52 local government areas (LGAs) during Olikoye Ransome-Kuti between 1986 and 1992 as models. As the population health outcomes improved, PHC was then extended to all the LGAs [42]. From literature, there are approximately 30,000 PHC facilities across the 36 states in the Federal Republic of Nigeria [43]. Out of these PHC facilities, only 20% are functioning well [43] [44]. Moreover, a strong PHC improves the management of non-communicable diseases (NCDs), reduce mortality from NCDs, reduce infant and under-five mortality, reduce maternal mortality, and increase life expectancy at birth [45].

Usually, at the PHC level of the healthcare facilities, the objectives are not clear and sometimes may not have been formulated [46] [47] [48]. Thus, PHC needs to be evaluated particularly healthcare service delivery [46]. In addition, only one doctor serves in the whole local government area in leaving the majority of the PHC clinics which are located in the rural areas under the care of the nurses and community health workers in Nigeria [49]. Also, poor healthcare policies are imperatively affecting the availability of effective quality healthcare service delivery in the PHC facilities, causing serious challenges encountered in some of the communities and the country at large [50] [51]. In terms of accessibility and availability of manpower, most rural PHC facilities in Nigeria function

below standards [49] [52]. Hence, using a simple intervention model as a guide to promote healthcare and prevent diseases may be missing in most of the PHCs in Nigeria. The nurses' knowledge and judgment at the PHC in using patient-centered care principles in the PHC facilities will evaluate participation. This approach will be of great value since the experience is from the grassroots. The objective of this study is to explore the factors that influence PCC utilization in the PHC facilities in Nigeria.

1.4. Aim

This study's aim was to explore the factors that influence PCC utilization in the PHC facilities in Nigeria. The findings of this study would help to improve the quality and effectiveness of healthcare services delivery in rural PHC facilities. Also form a part of recommendations to improve implementation of PCC strategies in the federal Republic of Nigerian PHC health system.

2. Research Methods

2.1. Research Design

A qualitative exploratory-descriptive design was conducted to understand the reality of PCC concept from the perspective of the nurses working in the rural PHC facilities, and to explore PCC implementation. This helps to give a better understanding and more insight into social phenomena of interest [53]. Hence, it allows the researcher to generate an in-depth understanding of the PCC concept in PHC from the nurses' perspectives in the context of the Nigerian healthcare system.

2.2. Research Settings

The study was conducted in 30 PHC facilities located in Osun State, Southwest, Nigeria. Osun state is one of the states in the Southwest, with its capital in Oshogbo and a population of 4,705,589 [54]. Southwest was purposefully selected from the six geopolitical zones in Nigeria, while Osun state was randomly chosen from the six states in the zone through the ballot. Osun State is divided into three Senatorial Districts: West, Central, and East. These districts are further subdivided into two zones each. Osun West: Ede and Iwo zones; Osun Central: Oshogbo and Ikirun zones and Osun East: Ilesha and Ife zones. These zones comprise of 30 local government areas, 621 PHC facilities with 1101 nurses working in the three districts [55]. The study was conducted in all three districts. The local government and the PHC from these three districts were selected randomly after listed all the PHC and the LGAs separately in a sampling frame.

2.3. Research Participants

A purposive sampling method was used. The participants for this study comprised nurses who work in rural PHC as a community health nurse. This was based on the assumption that this group of nurses are capable of improving the

quality and health outcomes of the people through implementing the PCC concept during healthcare service delivery.

2.4. Inclusion and Exclusion Criterial and Recruitment Process

The following inclusion and exclusion criteria were considered in selecting participants who participated in the study:

1) Participant must be a registered nurse working in the rural PHC. 2) The nurse has had at least one year of experience working in the PHC community 3) Be involved daily in the nursing care providing direct healthcare service to the people; 4) Indicate willingness to participate in the study; 5) Must be employed by the government as a PHC nurse. Other nurses who did not meet the above criteria were excluded in this study.

Nurse administrators and chiefs in each LGAs PHC were contacted via phone, letter and research information sheet for introduction of the research topic and to gain access to participants. Participants that met the criteria were purposely selected. Both verbal and written consent were gained from each participant who voluntarily participated in this study. Participants were recruited through the PHC facilities where the study took place.

2.5. Data Collection

The interview guide questions used for this study were developed by both authors (AL and EM). The interview guide questions were further reviewed and validated by a third reviewer who screened the content of the instrument before data collection. The two researchers contributed equally to the study. The interviews were conducted in English language, and were audio-taped with the permission of the participants. Each interview lasted between 25 and 40 mins. The data collection for the study reached saturation with population size of 35, and this sample size was based on the principle of data saturation [56] that follows the process of gathering and analyzing data until it reaches a point of no new idea or information is observed. The nurses who participated in the study comprised of seven males and 28 females nurses who had varied nursing qualifications and years of working experience as shown in **Table 1** below. Field notes along with taped recording were taken during data collection to ensure that the researcher do not miss out on any vital information.

2.6. Data Analysis

All interviews were audio-recorded and transcribed verbatim. Thematic analysis approach was used to analyze the data according to Braun and Clarke [57]. The transcriptions were read numerous times to familiarize ourselves with the information gathered and to ensure that the participants' constructions are well captured. NVivo 12 software was also used for data management. The organization of the codes was based on relevant information identified from the data. Then, cleaning of data was done and codes were developed into themes and sub-themes as guided by thematic analysis [58] [59].

Table 1. Sociodemographic and clinical characteristics of the participants.

Participants code	Gender	Age	Year of working experience	Educational level
P01	F	31	02	RN, BNSc
P02	F	30	10	RN, BNSc
P03	F	37	11	RN, BNSc
P04	M	33	10	RN, MSc
P05	F	37	11	RN, BNSc
P06	F	35	10	RN, BNSc
P07	F	40	11	RN, RM
P08	F	30	6	RN, BNSc
P09	F	38	10	RN, BNSc
P10	F	34	06	RN, BNSc
P11	M	30	11	RN, BNSc
P12	M	33	12	RN, RPHN
P13	F	40	16	RN, BNSc
P14	F	40	15	RN, RM
P15	M	42	17	RN, BNSc
P16	M	35	15	RN, BNSc
P17	M	40	12	RN, RM & RPHNN
P18	F	38	15	RN, RM
P19	F	39	16	RN, BNSc
P20	F	33	12	RN, RM
P21	F	39	15	RN, RM
P22	F	41	15	RN, BNSc
P23	F	30	12	RN, RM
P24	F	38	15	RN, BNSc
P25	F	45	18	RN, BNSc
P26	M	41	15	RN, RM & RPHNN
P27	F	50	18	RN, RM & RPHNN
P28	F	39	15	RN, BNSc
P29	F	35	12	RN, RM
P30	F	42	18	RN, RM & RPHNN
P31	F	41	12	RN, RM & RPHNN
P32	F	48	26	RN, RM & RPHNN
P33	F	61	25	RN, RM & RPHNN
P34	F	59	31	RN, RM & RPHNN
P35	F	48	19	RN, BNSc

RN: Registered nurse; **RM**: Registered Midwife; **BNSc**: Bachelor of nursing science; **RPHNN**: Registered Public health nurse and **MSc**: Masters of nursing science.

2.7. Trustworthiness

The term rigor or trustworthiness is used to explain the validity and reliability in

qualitative studies [60] [61]. This refers to the rigor of the data and the degree to which a researcher could influence the readers that the study is worthy [62] [63]. The four criteria that qualitative researchers considered in maintaining the trustworthiness of the study, as proposed by Guba [64], are employed in this study [65]. These include credibility, dependability, conformability and transferability [65].

Credibility: It refers to the accuracy with which the data provided by the participants were interpreted [63] [66]. To ensure the credibility of this study, individual interviews were adopted to obtain information from the participants. The researcher spent adequate time with the participants in order to understand them better and gain insight into the phenomenon under study and their experiences during data collection. Each interview lasted for 25 to 40 minutes per participant. However, data saturation was ensured. Field notes were taken that noted gesture and other non-verbal cues. All interviews were audio- recorded for further analysis. *Confirmability*: This is the extent to which data collected from the participants was analyzed objectively such that if another researcher examined the same data, they would get the same results [62] [63]. The result of this analysis is not biased but a neutral reflection of the interpretation of the data obtained from interviewed participants that was audio-recorded, transcribed verbatim and coded. The interpretation of the data followed a peer debriefing with a few colleagues to ensure objectivity. *Dependability*: This refers to the stability and consistency of data obtained and the extent to which this data is dependable over time under different conditions. To ensure reliability, an inquiry audit was adopted to estimate the dependability of the results of the study through an inquiry audit and replication of research. *Transferability*: Is the ability of the research findings to be applied to a similar situation and still yield similar results. This is the extent to which the findings and analysis can be applied to another similar research situation elsewhere [60] [67]. Thus, transferability in this study was ensured by providing adequate data description, study setting, and socio-demographic characteristics of the participants. This could enable the public to evaluate the applicability of the data to other contexts.

2.8. Ethical Approval and Consent to Participate

Approval for this study was obtained from Nigeria research body, Osun State Primary Health Care Board Research Ethic Committee and the University of KwaZulu-Natal Humanities Social Sciences Research Ethics Committee with Protocol reference number: HSS/1772/018D. Participants' participation was voluntary; participants provided both written and verbal consent for their participation. The confidentiality of this data is maintained by assigning a pseudo name to each participant. Lastly, no identity of the participants is revealed in this research.

3. Results

The themes generated from this study are tabulated in **Table 2**. These are in-

adequate management support, insufficient opportunities for further training, work overload and time constraints, health personnel readiness to use PCC, dearth enthusiasm for change, and poor nurses' accountability. A summary of these themes and the sociodemographic of the participants are provided in Table 1 and Table 2 below.

Details of these themes and sub-themes are presented as follows:

Theme 1: Inadequate management support

The following two sub-themes emerged under this theme:

a) Poor remuneration and lack of incentive.

b) Unavailable practice guide and standard of practice.

1) Poor remuneration and lack of incentive

Participants reported that their welfare was not being taken into consideration at all. As a result, they were not motivated to deliver quality healthcare services to the community because they are poorly treated by the government. Nurses expressed that the government must first make them happy and comfortable by paying their salaries and incentives in a timely manner. Additionally, the PHC facilities were not well equipped and therefore required a complete improvement from the government to strengthen the healthcare system. This would in turn enhance the quality of healthcare services. The following is an excerpt from the audio recordings:

Table 2. Summary of the themes and sub-themes.

(a)

Pseudonym	Frequency	Working experience	Academic Qualifications		Percentage (%)
			R.N., BNS	RN, R.M. and RPHN	
P1-P9	9	2 - 10 years	8	1	25.7
P10-P11	15	11 - 15 years	7	8	42.9
P12-P31	7	16 - 18 years	1	6	20.0
P32-P35	4	19 - 31 years	0	4	11.4

(b)

Category	Themes	Sub-themes
Organisational factors	Inadequate management support	Poor remuneration and lack of incentive Unavailable practice guide and standard of practice
	Insufficient opportunities for further training	
	Work overload and time constraints	
Individual factors	Health personnel readiness to use PCC	Need for self-discipline and interest Dissatisfaction and discouragement of staff
	Dearth enthusiasm for change	
	Poor nurses' accountability	

"*Advocacy, if they pay us very well we will implement it. Good remuneration is necessary because the welfare of the health personnel matters. You see the staff are not well taken care of, our welfare is poorly attended to so we can't do better. I want to say that the nurses—the comfort of nurses—should also be taken into consideration* (*Nancy*)."

"*If the government do not participate enough to improve the remuneration of the staff in the healthcare centre there may be a challenge. A lot of constraints, a lot of compromises, we have from the government—from financing to human resources person, resources…most of these facilities you are seeing, we are not being supplied with anything. So most of the time we have to improvise…I think that is still a factor we can look into—incentive and encouragement* (*Iyabo*)."

2) Unavailable practice guide and standard of practice

An unavailable practice guide and the standard of practice emerged as important, from the participants' narrative in this study. Even though healthcare services were provided to patients in the community, the nurses reported that policies, standards of practice and practice guides which are key in delivery of high quality healthcare services in PCC, were lacking. The nurses stressed the need to improve PHC facilities by providing an evidence-based working practice for nurses. These strategies would enhance effective PCC implementation leading to improve the healthcare outcome to the community. Below are the excerpts from the interviews:

"*The challenge I see is the need to provide a written document…it could be in form of poster that could be pasted on walls to remind somebody working, so when you are working you look and it reminds you of something* (*Rose*)."

"*The design doesn't actually allow for total client-centered care in such a way…things are muddled up together, we are addressing a lot of people together at the same time, such that we are not really client-oriented in our healthcare service* (*Mary*)."

"*Then looking at the challenges we might say our knowledge bases are not the same so that might be a limitation to patient centered care in the primary health care system in Nigeria* (*Kola*)."

Theme 2: Insufficient opportunities for further training

The participants reported insufficient opportunities for further training as one of the barriers to to upgrade themselves and meet up with global standard of carin. It was observed that PCC knowledge and skill are associated with effective implementation to improve the quality of nursing healthcare service in the rural areas. The nurses revealed the importance of training to acquire knowledge on the PCC concept as an asset to be given from the government to professional nurses even after they have been employed in the healthcare system. Participants expressed that failure to keep updating with current knowledge, skills and learning through seminars, workshops and conferences is a contributing factor to the poor PCC implementation. The extract below from the transcript is evidence:

"*There is no empowering people for knowledge…If government can provide*

something like a workshop or seminar I think that can help again to achieve patient-centered care, because if we are not orientated towards patient-centered care even we nurses might not do it the way we ought to do it, but if we are all orientated, if we know it and are familiar with the components, the approaches then we can do something (*Wole*)."

"*In terms of the technicality aspect of it, we might say Nigeria is still backward in the sense that when you are looking at the competence of the staff, the quality of service delivery to a client…we need more, adequate knowledge about patient-centered care* (*Kabirat*)."

"*…the knowledge and the skills can hinder the utilisation of the patient-centered care concept…I want to say lack of knowledge about the client-centered care…you can't practice what you don't know…you are not aware you will not be able to use it* (*Kudira*)."

Theme 3: Work overload and time constraints

Work overload and time constraints emerged as a theme from the data. Participants reported excessive workload as one of the major hurdles to implementing PCC in the healthcare service in PHC settings. It was further mentioned that nurses faced a lot of physical and psychological stress due to the shortage of nursing staff in the PHC system. In addition, the nature of the environment and the workload made the quality of their nursing health care to be poor and the patients were not allowed to make decisions in the care process. This means that the current working environment in the rural PHC setting is not conducive for nurses to practice PCC. Related interview extracts below are evidence:

"*Bureaucracy or let me put it that way, that is, if there are too many things to be done…If you have a lot to do like you have over* 50 *clients and it's only you. If you have enough hands you can easily practise PCC…if we have facilities and if it is not that the work is so much that five people are supposed to do it and only one person is doing it, definitely if there is division of labour, definitely nurses will adopt the method, it is a very good method and it will help nurses to know their patient better if there is improvement in the health system…* (*Eunice*)."

"*There is an average amount of clients we are expected to see in the health facility, for example in the immunisations section let me use that as a standard, we are expected to see just about* 30 *or* 40. *Just a facilitator, as I am expected to see* 15 *so if we are only two we are expected to see* 30 *people effectively but do you know we have people coming in tons of about* 80 *daily*? "*So for an individual if the work load is bulky and we are busy, it may not be easy for us to follow PCC approaches and practise it* (*Winnie*)."

"*If we nurses must practise this concept—our timing is very important because honestly we have a very large number of patient to attend to within a short period of time* (*Mary*)."

Theme 4: Health personnel readiness to use PCC

Health personnel readiness to use PCC emerged as a theme with two subthemes as follows:

a) Need for self-discipline and interest;

b) Dissatisfaction and discouragement of staff.

1) Need for self-discipline and interest

Participants identified lack of self-discipline, interest and laziness as some of the hurdles to the Implementation of PCC. It was further reported that for the PHC system to implement PCC, it would be crucial for nurses to develop enthusiasm with self-discipline in order not to continue undermining its potential to improving the quality of health care. The quotes below are a reflection:

"*Laziness on the part of we, the nurses, to engage with patients…Interest is also important, some may not have interest in it like that…so lack of interest is a factor…* (*Jide*)."

"*Lack of enthusiasm at work due to some level of frustration. We get less pay from government…frustration is on your mind, and you can't do some things that ordinarily you have knowledge of doing…So, you approach the patient poorly when patient comes to you and you tell him go and sit down first* (*Kemi*)."

2) Dissatisfaction and discouragement of staff

Several participants who reported dissatisfaction and discouragement of the staff during interviews further expressed that underpaying rural nurses coupled with lack of incentives, lack of work balance, limited opportunities for career development and poor management of PHC resulted in poor healthcare service delivery. All these were mentioned to contribute to nurses' dissatisfaction and discouragement. As a result, delivery of quality healthcare services using PCC was negatively impacted. These extracts below are evidence:

"*…It is a good strategy which should be implemented because with that you know the specific health care need of the client however, there is no motivation for us to use all these concept, the nurses are frustrated and so the practice has been the same, is still the same in the nursing management aspect…* (*Chuks*)."

"*I know that many people are not happy due to poor management of our PHC system and so there is poor resistance when you talk to the nurses about changing their routine of practice for improvement and patient benefits…* (*Yemi*)."

Theme 5: Dearth enthusiasm for change

Dearth of enthusiasm for change was reported by the participants during the data collection stage. It was also reported that the majority of the nurses were resistant to change. This prevalence among nurses was identified as a concern regarding PCC implementation. This is a potential consequence that contributed to the ineffective use of PCC. However, the readiness of the nurses to embrace change would enhance the healthcare outcome of the patients and improve healthcare service because nurses as individuals can promote PCC. These changes have the potential to increase the readiness to change among nurses and influence organisational interventions to promote PCC and the well-being of the healthcare providers which would inevitably lead to the high quality healthcare services needed. The extract below asserts this:

"*I have seen what it could be so I know that many nurses are resistant to change that is the very first thing…there is this challenge of people not ready to*

change (*Ade*)."

"*If you want to change the whole world you cannot change the whole world but you will realise that you, yourself, need to be changed—that's where to start…* (*Mariam*)."

"*Human beings naturally are resistant to change. The challenge I foresee is in the ability of the nurses to change their practice from what we have been practising since* (*Yinka*)."

Theme 6: Poor Accountability of the nurses

Participants reported on professional Accountability. It was expressed as taking responsibility for action by upholding the holistic standards on quality healthcare service of patient care as well as maintaining competency. The nurses further stated that it was important to ensure that the patient's interest was always considered first through collaboration and involvement in the decision making process. The nurses earned the patient's trust by sharing their thoughts willingly. The extract below is the evidence:

"*I'm saying that using a client centered approach will help to take the possible preventive measure…nurses will benefit in the sense that when you do something very well you feel good about yourself, that you have done this very well. You know that it helps you to feel fulfilled at the end of the day* (*Detan*)."

"*Primary health care facilities will be a better patronised place, if the community sees that the nurses respect and value their involvement in their work* (*Elizabeth*)."

4. Discussion

This study identified key of the negative factors influencing the poor implementation of PCC in rural PHC facilities. These factors include inadequate management support, insufficient opportunities for further training, work overload and time constraints, health personnel readiness to use PCC, dearth enthusiasm for change, and poor nurses' Accountability.

The PHC nurses during the interviews frequently mentioned work overload; insufficient opportunities for further training; inadequate management support and unavailable practice guide and standard of practice. This shows that these four particular factors are the key challenges that are hampering nurses' effective implementation of PCC in the PHC facilities. Study conducted in other settings on PCC identified high work load, time pressure as common barriers to implementing PCC [68]. This is identical to the findings in our study. Flagg argued that majority of the nurses are more task-oriented due to work overload, whilst less focused on the patient. Whereas, other studies revealed that the challenges of less involvement with the patient could largely be as a result of the dearth knowledge of PCC concept [69]. Hence, in-service training for rural PHC nurses is essential for effective and competent PCC implementation. Our study revealed that improved living and working conditions, better remunerations and continued training of the rural PHC nurses would help to contribute to providing quality healthcare in rural PHC setting in Nigeria. In addition, accountability,

evaluation, Innovations in healthcare service delivery and government increasing expenditure on health were also identified as some of the major factors that could help to improve the nursing care practice [70] [71].

Esmaeili, Ali Cheraghi and Salsali study identified lack of holistic view of the nurses about PCC; unsupportive organisational system and lack of motivation to be major barriers to implementing PCC [72]. Although, their findings are similar to our findings. However, participants from this study expressed a good understanding of PCC during interviews which suggest that nurses have a holistic view about PCC but poorly demonstrated due to lack of motivation, work overload and support from the organisation. It was revealed also that majority of qualified nurses end-up leaving rural PHC due to lack of motivation inform of good remuneration and incentive, and poor working conditions. These factors affect the nurses negatively leading to poor demonstration of PCC approaches in delivering healthcare services to patients. Therefore, organisational support could assist to improve the challenges facing the rural PHC nurses and advanced nursing care practice. The implication to nursing practice is that delivery healthcare service is evidence-base and up-to-date.

Globally, it may seem simple to integrate PCC into the PHC system for service delivery in rural areas; however, the complexity involved in the integration of PCC into the Nigerian healthcare system is revealed in this study. 89% of the PHC nurses still hold patients' care as a way of showing that they are experts in health care [73] [74]. This study found this to be a threat to the conventional way of organizing healthcare delivery services around patients' need for better health outcomes. This is because nurses often bear sole responsibility for patients in the rural PHC setting which leaves them with many responsibilities. Therefore, there is need for a change and transformation to increase high quality healthcare service delivery. This can be achieved by implementing evidence-based evaluation for caring for patient, improved quality of activities, development of team-based care, practice management changes engaging patients in new engagement strategies, and the use of information systems [75].

Implementing PCC in PHC could solve a lot of healthcare-related problems such as poor health outcomes, cost of service, and spread of communicable and non-communicable diseases among others if the healthcare personnel are well motivated and equipped to use PCC. Nurses are discouraged and dissatisfactified due to organisational factors causing fatigue midway to the implementation phases of PCC by these healthcare providers. Patel, Jaen, Stange, Miller, Crabtree and Nutting reported similar findings [76]. This shows that poorly integrated PCC in PHC healthcare facilities could also be a major contributing factor to the increase in communicable diseases and non-communicable diseases in the nation, and the readiness of the healthcare personnel to use PCC is seen to be at the mercy of the organisational responsibilities to the healthcare workers. According to World Health Organization (WHO), approximately 400 million people worldwide received poor quality health care. In addition, there is unequal improvement in the healthcare system service [77] [78]. This is despite the ef-

forts of the international collaboration on health regulations to strengthen health systems in low- and middle-income countries [21] [23].

PCC implementation is still a challenge in nursing practice despite policy makers' and government endorsements of PCC. Although these findings revealed some of the challenges facing nurses in the implementation and practice of PCC, it is observed that some of these challenges emanated from both the organisational and individual levels.

It is essential to emphasize the importance of Accountability of the nurses as part of the healthcare service delivery in the rural PHC [79]. Accountability is a key component of nursing. That is, nurses should be held accountable for their own decisions and actions. In addition, governments should pay much attention to the dimension of healthcare in PHC facilities and nursing [80] [81]. Dignity and compassion should be emphasized and driven by the growing concern within the nursing fraternity. This would help PHC regain what it has "lost", as its quality has been inconsistent across different countries, regional divisions within countries and even globally [82].

In addition, Accountability is a personal responsibility that nursing professionals should embrace as a continuous service to themselves and to their patients [83]. Conversely, this study identifies poor nurses' Accountability as another hindrance to implementing PCC. This suggests the importance of incorporating these skills in the training and work environment during in-service education which could help to improve PHC nurses. In addition, since nurses do not work in isolation within the healthcare system but with other disciplines, there is a need for inter-disciplinary teamwork. This collaboration drive is further encouraged by the WHO framework for action on inter-professional education and collaborative practice as reported by [84], for effective delivery of the PCC concept in the healthcare system. A comprehensive service by partnering with patients, their families and friends needs to be incorporated in the nursing care to offer high quality healthcare service that would lead to better outcomes [85]. It is therefore recommended that nurses should take responsibility for their actions towards patient health care outcomes and encourage nurse-patient trust in order to improve quality healthcare using the PCC approach. This will provide further protection for the institution, the nursing profession and the patient from unsafe practices. Thus, these barriers should be broken for nurses to effectively operationalised PCC concept.

Strength and Limitation

Even though this study involved direct observation in the reality of nursing care practice in the PHC setting, it was not without limitations. The main limitation is that perception from the other healthcare professionals and the patients under care at the PHC were not investigated. It is therefore recommended that further studies be done to include other healthcare professionals and patients in the PHC system.

5. Conclusion

There is a need to revolutionize the healthcare service in PHC. The study identified poor motivation and support system, work overload, resource constraint, and lack of training as barriers facing nurses to implement PCC. PCC transformation requires support, motivation, time, effort, and the availability of resources for an effective transitional period. On the basis of our findings we, therefore, recommend the use of PCC, the need to reinforce adequate management support, training programs to upgrade the nurses, and internal motivation. This will help to enhance the nurses' knowledge and skill, boost their morale to improve the quality of healthcare delivery in the PHC facilities as well as health outcomes.

6. Abbreviation

PHC: Primary Health Care; **PCC:** Patient-centered care; **LGAs:** Local government areas; **WHO:** World Health Organization; **LMICs:** Low and middle-income countries; **NCDs:** Non-communicable diseases; **LGHC:** Local government health care; **SMOH:** State ministries of health; **FMOH:** Federal ministries of health; **EMR:** and Electronic medical records.

Authors' Contributions

A.L. conceptualized the paper, and prepared the manuscript draft, and Dr. E. M.M read and reviewed final draft of the paper. This manuscript is a part of a bigger study which is a doctoral thesis project. Dr E.M.M. supervised and provided guidance in the study and the completion of this manuscript. Both authors have read and agreed on the final versions of the manuscript to the published.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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