A QUALITATIVE STUDY OF HEALTH LITERACY AND CULTURAL INFLEUNCE ON NURSING PRACTICE IN MENTAL HEALTH

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A Qualitative Study of Health Literacy and Cultural Influence on Nursing Practice in Mental Health

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CERTIFICATE OF ORIGINALITY

I hereby declare that this thesis is my own work and that, to the best of my knowledge and belief, it reproduces no material previously published or written, nor material that has been accepted for the award of any other degree or diploma, except where due acknowledgement has been made in the text.

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ABSTRACT

OBJECTIVE: Despite the critical role that health literacy plays in the provision of health services, a significant proportion of nurses have limited knowledge and experience on how to assist their patients with lower levels of health literacy. This lack of adequate understanding is due to numerous contextual factors. To investigate these factors, this study begins by exploring the perceptions and understanding that mental health nurses (MHNs) have about their patients' health literacy. It then examines how local factors, such as culture and language, shape knowledge and the adoption of strategies to deal with issues affected by health literacy in clinical practice in the Greater Accra Region in Ghana.

METHOD: This study has employed a qualitative descriptive design with the use of purposive sampling techniques to recruit 43 mental health nurses from two psychiatric hospitals in order to conduct semi-structured interviews. Six focus group discussions and three in-depth interviews were conducted amongst these nurses from October to December 2017. The data were analysed using a content analysis approach.

FINDINGS: Major findings of the study were: the experience and practice of MHNs is shaped by local cultural beliefs; MHNs interpretation of health literacy has an impact on mental health nursing practice; the practice of health literacy has to be negotiated within a cultural context. Nurses' understanding of their patients' health literacy was generally poor and this was reflected in an inadequate application of health literacy strategies in nursing practice. Nurses attributed low health literacy among patients to firstly, the cultural beliefs of their patients (which included spirituality as a cause of and a solution to mental health problems); and, secondly, the level MHNs' skills such as their communication skills and their knowledge about mental disorders. However, most of the informants reported that they believed that spirituality was a major cause of mental illness in Ghana. Some of them admitted that they avoided giving care to patients with low levels of education, strong spiritual beliefs and low socioeconomic status. These observations were exacerbated by several factors, viz, language differences between nurses and patients; limited trust in biomedical treatments, lack of materials needed for educating patients regarding relevant health care services as well as impediments related to the Ghanaian health system itself. All these factors militated against nurses' attempts to address health literacy deficits among their patients.

The implication for practice: Findings from this current study suggest that health literacy, language and cultural issues interact with each other and they affect nursing practice.

CONCLUSION: Understanding health literacy issues from a cultural perspective can assist nursing practice and health services to address the challenges that hamper care delivery by enabling them to rectify misconceptions about mental health. The findings and the framework proposed in this study can be adopted to develop interventions to improve MHNs' understanding of health literacy and that of their patients. In addition, these initial findings can be used to inform further investigation in order to examine how health literacy and cultural competence can be harmonised more extensively in nursing practices.

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LIST OF ABBREVIATIONS

MHN	Mental Health Nurses
RN	Registered Nurses
NP	Nurse Practitioners
APRN	Advanced Practising Registered Nurses
HL	Health Literacy
MHL	Mental Health Literacy
NAAL	National Assessment of Adult Literacy
IOM	Institute of Medicine
WHO	World Health Organization
AMA	American Medical Association
NVS	Newest Vital Sign
TOFHLA	Test of Functional Health Literacy
REALM	Rapid Estimate of Adult Literacy
SILS	Single Item Literacy Scale

CHAPTER 1
INTRODUCTION

1.1 Introduction

Health literacy has caught the attention of policy-makers, researchers and healthcare professionals in the last decade due to the discovery of its widespread influence on the health and well-being of the public (Nutbeam, McGill, & Premkumar, 2017; Irving Rootman & Deborah Gordon-El-Bihbety, 2008). Health literacy refers to an individual's ability to access, understand, evaluate, and communicate health information in order to promote, maintain and improve health in different settings (Irving Rootman & Deborah Gordon-El-Bihbety, 2008). It is now one of the important components of health promotion and health education. Some researchers regard it as one of the most important ways of addressing adverse health outcomes (Flecha, García, & Rudd, 2011; Nielsen-Bohlman, 2004). It is now imperative that health systems and health personnel be well-acquainted with the concept and practice of health literacy in order to ensure positive and sustained health outcomes (Nielsen-Bohlman, 2004; Irving Rootman & Deborah Gordon-El-Bihbety, 2008). Unfortunately, many health professionals, particularly nurses, who are often the primary sources of health information and health education, have been reported to have low health literacy even in high-income countries (Egbert & Nanna, 2009). The situation is even worse among mental health nurses (MHNs) and other speciality groups in many countries. Sadly, virtually no study has focused on health literacy knowledge and practice among staff in this specialised branch of nursing practice (Belinda Bruwer et al., 2011; Clausen, Watanabe-Galloway, Baerentzen, & Britigan, 2016; Lincoln, Arford, Doran, Guyer, & Hopper, 2015). Furthermore, in many developing countries, especially in sub-Saharan Africa, health literacy practice and research are virtually non-existent (Kanj & Mitic, 2009; Pleasant, 2013; Pleasant & Kuruvilla, 2008). The reasons for this lack of research in both mental health nursing and its non-existence in developing countries generally are widespread; and many of the reasons for this problem and this includes, low priority of mental health, lack of funding and an insufficient number of trained mental health professionals (Monteiro, 2015).

Using a qualitative descriptive research design, this study explores the MHNs understanding of their patients' health literacy and the way in which local elements (such as culture, language and the nature of the health systems themselves) shape knowledge and the adoption of health literacy in clinical practice in the Greater Accra Region in Ghana. Culture comprises the shared

beliefs, ideas, meaning and values acquired by individuals as members of a particular society (Nielsen-Bohlman, 2004). This study, with its focus on mental health nursing in particular, is important because the focus of research and associated clinical practices in Ghana and elsewhere has hitherto for been almost exclusively on the health literacy of patients and the public rather than on nurses per se (Amoah et al., 2017; Cormier & Kotrlik, 2009; Cornett, 2009; Egbert & Nanna, 2009; Lori, Dahlem, Ackah, & Adanu, 2014). Importantly, scant research has been done on low health literacy issues in patients, and even nurses, from a cultural perspective in spite of the fact that issues of mental health are peculiarly understood and addressed on the basis of local knowledge and features, which essentially encompass cultural issues (Asare & Danquah, 2017; Monteiro, 2015). Such local elements have an important effect on health literacy and require systematic explanation and exploration (Begoray, Gillis, & Rowlands, 2012).

1.2 Problem Statement

The prevalence rate of low health literacy among the general population ranges from 29% in the Netherlands to 84% in China (Pleasant, 2013; Sørensen et al., 2015). However, the prevalence rate of low health literacy among the general population in many African countries is unknown due to inadequate research (Kanj & Mitic, 2009; Pleasant, 2013). However, in spite of the dearth of information about health literacy in Africa generally, a recent study in one of the most populated regions in Ghana showed that only about 33% of adults had sufficient health literacy to access, comprehend and use health information in order to improve and sustain their health, or the health of their families (Amoah, 2018). This puts an additional obligation on health systems and health personnel to ensure that their patients are adequately equipped to understand health information and its application. However, the incidence of low knowledge on health literacy among nurses themselves compounds the problem, making the situation critical (Egbert & Nanna, 2009; Parnell, 2014a).

In fact, inadequate knowledge and practice on health literacy affect nurses at all levels from pre-licensure (undergraduates who are not yet licensed) to practising nurses (Alper, National Academies of Sciences, & Medicine, 2015; Coleman, 2011). Several reports show that the knowledge of the consequences associated with poor health literacy and the evaluation of patients' understanding is inadequate among nurses (Williamson & Chopak-Foss, 2015). In

many health systems, nurses play a significant role in healthcare delivery by disseminating health information, coordinating patient care services and empowering patients to take control of their healthcare (Parnell, 2014a). Without adequate awareness of the techniques and strategies for dealing with patients with low health literacy, nurses may not carry out their duties adequately (Matzke, 2007).

One of the specific problems with inadequate health literacy among nurses is that some nurses' written and spoken communication often lacks sufficient clarity and is sometimes filled with medical jargon that makes it difficult for patients to follow their instructions (Al Sayah, Williams, Pederson, Majumdar, & Johnson, 2014; Jukkala, Deupree, & Graham, 2009). Nurses are required to use plain language and to avoid the use of medical jargon particularly in written health material so that the material can be easily read and understood by all patients and relatives regardless of their health literacy levels (Edwards, 2014). Language is key to a person's social life and also mediate the attainment of cultural knowledge on various issues including health (Andrulis & Brach, 2007). Depending on an individual's culture, some words or their inherent concepts have a different meaning, or little or no meaning (Institute of Medicine, 2004). Similarly, some medical terminologies carry different meanings for individuals who are not employed in the medical field. Health professionals, therefore, must be conscious of these differences in order to ensure effective health promotion by adopting the right strategies and the appropriate choice of language to increase patients' understanding of relevant terminologies. Therefore, interventions that seek to educate patients for the purpose of understanding, accessing and using health information need also to address the issue of trust and effective two-way communication (Parnell, 2014a).

In addition to the issue of the appropriate choice of terminology in spoken and written communication, most nurses tend to overestimate their patients' health literacy levels as their assessments are often based on intuition rather than on sound health literacy screening and practice (Dickens, Lambert, Cromwell, & Piano, 2013; Egbert & Nanna, 2009; Parnell, 2014a). This assessment problem has been attributed to the unavailability of health literacy screening tools in the health system and a lack of formal and continuous training/education on how to formally screen for the health literacy level of patients (Drake, 2015; Redden, 2017; Richey, 2012). Indeed, this is even common in high-income countries. For example, a seminar report by Institute of Medicine (IOM) in the United States of America (USA) found that health professionals have limited health literacy training/education and practice to develop the skills

needed to deal with low health literacy amongst their patients. The IOM has therefore recommended that health literacy training should be incorporated in all health training schools and those of other related fields in order to promote the competence of health professionals in dealing with the problems associated with low health literacy of patients (Coleman, Nguyen, Garvin, Sou, & Carney, 2016). As a result, health literacy education is now more commonplace in the curricula of health professionals, but there is still a striking absence of it in the literature about the nursing profession (Amoakoh-Coleman et al., 2016; Hess & Whelan, 2009; Jackson, Coan, Hughes, & Eckert, 2010). Growing research provides evidence which shows that the addition of health literacy training to the nursing curriculum may positively influence the knowledge and skills that nurses have, as well as improve nurse-patient communication and education (Amoakoh-Coleman et al., 2016; Hess & Whelan, 2009; Schlichting et al., 2007). Without adequate health literacy skills and formal screening, it may be difficult for nurses to assess their patients' levels of literacy just by observing them or by using their socioeconomic status as a predictor of literacy skill (Cornett, 2009; Kasemsap, 2016; Parnell, 2014a).

The practice and application of health literacy are therefore multifaceted. In order to address the issue of low levels of health literacy and trust, interventions need to encompass three key elements, which have been termed 'the triple threat' to effective nurse-patient communication, education and case management, namely, literacy skills, culture and the linguistic demands of the health system (Health Resources and Services Administration, 2017; Ingram, 2012; Singleton & Krause, 2009). Thus, for nurses to provide effective health communication, they must be aware of their patients' *and their* health literacy, culture and language skills, and how these factors influence interaction with clients (Toronto & Weatherford, 2016). However, nature and the way in which these factors shape health literacy practice among MHNs remains unknown.

There is growing recognition that culturally diverse individuals with limited literacy skills and language proficiency, as well as ethnic minorities, older persons, and those with lower levels of education and socioeconomic status are the most vulnerable to ill health, which is aggravated by the higher rates of low health literacy among them (Andrulis & Brach, 2007; Kelly, Jorm, & Wright, 2007; Nielsen-Bohlman, 2004). The incidence of low health literacy is reported to be worse among mentally ill patients as compared to the general population (Clausen et al., 2016; Edwards, 2014 ; Galletly, Lincoln, & Arford, 2013). Interestingly, there are over 100 culturally distinct groups of people in Ghana who have diverse linguistic, spiritual and religious

backgrounds (Adjorlolo, Abdul-Nasiru, Chan, & Bambi, 2016; Akyeampong, 2015). The health literacy awareness and practices of nurses in such a context is therefore complex but critical to ensuring an informed population with regard to access to health services.

Furthermore, cultural differences between the healthcare provider and the patient lead to misunderstandings about management of the acute and chronic conditions, the treatment regimen and the severity of the condition (Shaw, Armin, Torres, Orzech, & Vivian, 2012). Culture, social and family influences shape attitudes and beliefs about health and therefore also influence health literacy. An individual's culture influences the way in which he/she communicates, understands, seeks appropriate health services, uses preventive services and makes informed decisions about health, disability and end-of-life issues (Health Resources and Services Administration, 2017; Shaw et al., 2012).

These cultural differences manifest themselves through different aspects of culture. A recent survey by Mogobe et al. (2016) showed that when health professionals are not able to communicate in a *patient's language*, for instance, it leads to ineffective communication. At the same time, the *cultural beliefs* of patients serve as a barrier to healthcare and hamper efforts to address low health literacy among patients. Similarly, another study reported that nurses' lack of knowledge about diversity in patients' *cultural values, behaviour and communication styles* and distrust/stereotype of some particular cultures contributes to poor nurse-patient communication and poor health outcomes (Huang, Yates, & Prior, 2009). Culture may also influence the importance of certain types of health information and have an impact on instructions (Nielsen-Bohlman, 2004).

Moreover, for the purpose of this research, studies on mental illness in sub-Sahara Africa report that mental health issues are too sensitive to discuss with patients and even with the public and others due to the shame and stigma associated with mental illness in many cultures. Many ordinary Ghanaians firmly believe that mental illness is caused by the existence and manipulation of witches, ancestral spirits, sorcerers, and other demonic forces (Adjorlolo et al., 2016). Just as with mental health and many other illnesses, health literacy is mediated by a person's experiences with health and disease, education, ageing, language and social interaction, in addition to the culture of the setting in which health services are provided (Berkman, Davis, & McCormack, 2010; Speros, 2011; Zarcadoolas, Pleasant, & Greer, 2006). These factors, coupled with the shame and embarrassment associated with low health literacy,

make low health literacy among patients difficult to detect and may also affect the health literacy practices of mental health nurses. Studies thus advocate for mental health nurses to contribute to creating a shame-free environment for patients in order for them to feel secure and communicate effectively about their low health literacy levels (Cornett, 2009).

In many settings, cultural diversity of both patients and health personnel is pronounced, and this may be problematic for nurses and other health professionals especially in contexts where there is little training for the professionals in this regard (Shaw et al., 2012). If unaddressed, differences in cultural beliefs about health between the patient and the healthcare provider can lead to misunderstandings, value conflicts, poor health literacy and poor health outcomes (Shaw, Huebner, Armin, Orzech, & Vivian, 2009). The challenge of addressing the needs of the culturally diverse population is a common issue expressed by many health professionals from different countries because their ability to engage in culturally competent, non-stereotyping communication with patients is undeveloped (Ingram, 2012; Shaw et al., 2009). A study by the American Institute of Medicine reported that whether consciously or not, most health professionals treat patients differently depending on their race and ethnicity (Institute of Medicine, 2004). Similarly, another study identified that race, ethnicity, and language have a major impact on the quality of patient-provider communication (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). Nurses' knowledge of a patient's cultural background is significant for effective nurse-patient communication and reduction in poor health outcomes. As a result, several institutions have advocated for nurses to be competent in providing for culturally appropriate nursing care (Health Resources and Services Administration, 2017; Hernandez, Institute of Medicine, Board on Population, & Public, 2013). This means that nurses should be culturally sensitive and be able to adapt their own beliefs and values to those of their patients to facilitate effective interaction between themselves and their patients.

However, in order to meet these requirements, MHNs should first be trained and then monitored to improve their knowledge of health literacy, and the skills and ability needed to transmit mental health information to patients and their relatives in plain and understandable language (Edwards, 2014). To achieve this goal in contexts where health literacy research and application is still new, such as in Ghana, it is important to explore the current state of the nurses' understanding of health literacy and the strategies they use to address the incidence of low health literacy amongst their patients. Moreover, from the above, it is particularly prudent

to understand how some of the contextual factors such as cultural beliefs, practices and linguistic issues shape nurses' health literacy knowledge and practice.

1.3 Research Questions

The study attempts to answer the following research questions:

1. What do Ghanaian MHNs know about health literacy?
2. How does culture and local perception about mental health affect MHNs' capacity to communicate with patients with inadequate health literacy?
3. In what ways do mental health nurses' own characteristics affect the effectiveness of communication between themselves and their patients?
4. What challenges do MHNs face in addressing health literacy in the clinical settings?

1.4 Study Objectives

1. This study aims to explore MHNs' understanding of health literacy and
2. To explore MHNs' experience in dealing with patients with low health literacy by taking into consideration various cultural and contextual factors in the Greater Accra Region in Ghana.
3. To identify ways in which MHNs' own characteristic influences their nurse-patient communication and interactions.
4. The study also attempts to find out what challenges MHNs face in their quest to address issues of low health literacy among patients in their clinical practice.

1.5 Operational Definition of Terms

The following key concepts and terms are important for the study, and they are operationally defined in this section:

a. *Health Literacy:* The individual's ability to access, understand, assess and communicate health information as a way to promote, maintain and improve health in different settings across the life-course (Irving, 2012).
b. *Culture:* Culture is defined as shared ideas, meaning, and values acquired by persons as members of a given community (Nielsen-Bohlman, 2004).
c. *Cultural competence:* The process through which health professionals continuously strives to attain the ability to effectively provide care within a cultural context of the patient and their family members (Campinha-Bacote, 2002).
d. *Mental Health Nurses:* A MHN is someone with either a diploma, bachelor's or advanced practice mental health degree who has been licenced as a mental health nurse (Health & Abuse, 2005). For this study, the person must also be involved in clinical practice.
e. *Health Outcomes:* A change in the health status of an individual, or population which is attributed to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status (World Health Organization WHO, 1998, p. 10).
f. *Mental Health Literacy*: ' Knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (Jorm, 2000, p. 182)

1.6 Significance of the study

Although several studies have explored health literacy awareness, knowledge and experience among nursing students, registered nurses, nurse practitioners and emergency department nurses (Cafiero, 2012; Cormier & Kotrlik, 2009; Knight, 2011; Torres & Nichols, 2014), no study has so far focused on specialised areas of nursing including mental health (this is demonstrated in chapter 2). This will be the first study to investigate MHNs' understanding of health literacy in Ghana. This focus is needed in order to deal with low health literacy among the mentally ill in Ghana and many African countries.

The knowledge gained from this study will help to initiate strategies for further research and the formulation of interventions that improve health literacy and the practice of it among MHNs in Ghana and many other sub-Saharan African countries. It is also anticipated that the study will contribute to generating new ideas for training MHNs in ways that will make them culturally competent to address incidents of low health literacy among their patients.

This study will help to expand the literature on health literacy issues for MHNs and nurses in general, particularly in Ghana. In the end, the study will also lay the foundation for improving the mental health knowledge of MHNs. For a country where cultural ideologies shape attitudes and perceptions on the mental health issue, this study will be of immense help in improving health literacy practices in the mental health system.

1.7 Organisation of the study

The study is organised into six chapters. Chapter 1 presents the general background to the need for a qualitative research study focusing on the MHNs understanding of health literacy in Ghana. The chapter provides the general background, problem statement, and study objectives, significance of the study and operational definition of terms which put the entire study into perspective.

Chapter 2 discusses the evolution, definitions and measure of health literacy over the years and how language and culture impact health literacy. The chapter also presents a discussion on how health literacy differs from concepts such as literacy and mental health literacy. This chapter also shows how health literacy fits into nursing practice. This chapter provides a meta-

ethnographical review of existing evidence of practising nurses' understanding of patients' health literacy and how they apply it in their clinical setting.

Chapter 3 provides information about the methodology used in this research for the selection and description of informants, the settings, data collection method and measures, data analysis and ethical consideration.

Chapter 4 presents the findings from the fieldwork to address the questions posed in this study.

Chapter 5 presents a summary of findings, the limitation of the study, recommendations, implication for nursing practice and conclusion.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

This chapter presents an overview of the major definitions of health literacy and how it has been conceptualised over the years. This chapter discusses the evolution and definition of health literacy and presents a discussion about mental health literacy. It presents a review about nurses' understanding of the concept of health literacy and explores how they apply it.

2.2 Evolution of Health Literacy

The concept health literacy was first used in 1970 by Simonds (1974) in a paper advocating for health educational materials to be written at a minimum standard easily readable by all, regardless of grade level (i.e. K through grade 12) (Ad Hoc Committee on Health Literacy for the Council on Scientific & American Medical, 1999; Simonds, 1974). Simonds (1974) was advocating for health education and emphasising how health information should be included in primary and secondary school education (Ratzan, 2001; Simonds, 1974). However, it took nearly two decades before attention was given to health literacy as a major healthcare issue (Egbert & Nanna, 2009) in itself. Widespread attention was paid to the concept when the 1992 National Assessment of Adult Literacy (NAAL) was published (Egbert & Nanna, 2009).

Health literacy which began as an evaluation of the association between poor literacy and health knowledge and behaviours has expanded to the concept of individual health literacy in self-management of health and diseases (Chinn, 2011; Nutbeam, 2000). Low health literacy has been identified to lead to frequent use of emergency services (Baker et al., 2002), higher health care costs (Weiss & Palmer, 2004), poor utilization of preventive services (Scott, Gazmararian, Williams, & Baker, 2002), and are associated with higher mortality rates (Baker et al., 2007). Currently there are numerous health literacy-related publications addressing the readability of health materials (Wolf, Parker, & Ratzan, 2017).

The term health literacy later appeared in a paper by Kickbusch (1997) and in a health promotion glossary developed by Nutbeam (1998). Kickbusch (1997) defined health literacy as the level of development of an individual knowledge, information and skills concerning health, an understanding of the social factors of health, an ability to negotiate the environment,

an understanding and deliberation of the risks of personal and social behaviour, the coping and caring skills to use the health sector, and a shift from fatalistic acceptance of health problems towards the implementation of health knowledge. The role of the health professionals in addressing patients' low health literacy received attention in the early 1990s (Lambert et al., 2014; Nielsen-Bohlman, 2004). A report by the Institute of Medicine (IOM) suggested that, health services and system placed a significant demand on patients by the level of complexity of demands imparted to an individual by a particular healthcare system (Wolf et al., 2017). However, none of the existing and new definitions fully address the role of health professionals to subdue or enhance patients and community health literacy skills.

The initial research and attention on health literacy as an issue in itself was mainly concentrated in the United States (U.S) and Canada but the concept has achieved international recognition over the past four decades (Sorensen, 2013). Internationalised research and national policies on health literacy have also appeared in Australia (Adams et al., 2009; Barber et al., 2009), the United Kingdom (Ibrahim et al., 2008), Korea (Lee, Kang, Lee, & Hyun, 2009), China (Hongwen, Qi, & Yinghua, 2016; Shen, Hu, Liu, Chang, & Sun, 2015), Japan (Ishikawa, Takeuchi, & Yano, 2008; Nakayama et al., 2015), the Netherlands (van der Heide et al., 2013), Switzerland (Connor, Mantwill, & Schulz, 2013), Sri Lanka, Jamaica, Turkey, Saudi Arabia, Serbia, Denmark and Romania (Hernandez et al., 2013). However, little is known about health literacy rates among people in Africa. To date, no national screening has been conducted in any of the 54 individual countries in Africa (World Health Organization 2013). This situation is worrying because there are still many people in the world who are illiterate. This complicates health literacy, which is linked to literacy (Sørensen et al., 2012). Current estimates by the United Nation are that there are 757 million people globally who are illiterate and an estimated 182 million of this population are from Africa (UNESCO, 2015). In Ghana, 71% of people over 11 years of age are illiterate (GSS, 2012). Possession of a basic level of general literacy is required in order to achieve an adequate level of health literacy (Kasemsap, 2016).

Although research into the field of health literacy has increased greatly over the past several decades, with currently over 1000 health literacy-related publications available, a large proportion of these studies focus on addressing the readability of health material. The focus on the contribution of the skills of health professionals and health institutions *per se* (Rudd, 2015; Wolf et al., 2017) is minimal.

2.3 Definition of Health Literacy

Despite the increased attention of researchers, policy-makers and healthcare professionals, there is a lack of unanimity on the definition of health literacy and the concept continues to have a plethora of meanings depending on the individual health field and context of reference (Osborne, 2012; Parnell, 2014b). Currently there are numerous definitions for health literacy with each providing a slightly different perspective (Egbert & Nanna, 2009; Sorensen et al., 2012). Early definitions of health literacy were based on the individual's skills and ability to read, understand, gain access to and use health information to promote and maintain good health (Parker, 2000). The definition of health literacy has progressed from an individual's ability to read health-related information, to having the skills necessary to problem solve, compute and understand health information to make appropriate healthcare decisions (Cutilli, 2005; Cutilli, 2007). However, of these definitions, the most widely cited ones include those of American Medical Association (AMA), the Institute of Medicine (IOM), the World Health Organization (WHO) (Lambert et al., 2014; Sorensen et al., 2012).

The American Medical Association defines health literacy as "a constellation of skills, including the ability to perform basic reading and numeracy tasks required to function in the healthcare environment" (Ad Hoc Committee on Health Literacy for the Council on Scientific & American Medical, 1999). These skills include the ability to read and comprehend prescription bottles. The AMA definition stresses the need for adequate functional literacy which refers to basic reading, writing and literacy skills necessary to help an individual to perform daily tasks as well as a knowledge of health conditions (Nutbeam, 2000).

The World Health Organization **(**WHO**)** expands the definition of the AMA and includes the use of information and defines heath literacy to include cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health (World Health Oranization (WHO), 1998). This definition was expanded by Nutbeam (2000) with a greater focus on health promotion, empowerment and the improvement of an individual's knowledge, skills and confidence to initiate action to improve their own health and that of the community health (Nutbeam, 1998). The definition of health literacy by Nutbeam (1998) implies that health literacy means an individual's knowledge and confidence in modifying his or her personal habits and living conditions in order to improve one's health and that of his/her community.

This definition provides a broader perspective where health literacy is seen as a key factor in health promotion and education efforts and supports communication strategies in increasing people's access to health information and capacity building (World Health Oranization (WHO), 1998).

The Institute of Medicine (IOM) also defined health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions" (Nielsen-Bohlman, 2004; Ratzan & Parker, 2000). The IOM definition has been adopted by researchers in United Kingdom, the National Library of Medicine (NLM) in the United States, the American College of Physicians Foundation, and the American Academy of Family Physicians (Egbert & Nanna, 2009; Wolf et al., 2017).

The Canadian Expert Panel on Health Literacy defines health literacy as the ability to access, understand and evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the course of life (Irving Rootman & Deborah Gordon-El-Bihbety, 2008). This definition expands and explicitly highlights the importance of different health context in providing comprehendible health information and services to patients. Health literacy changes over life course due to differing health information processing demands and changing skills level of individuals. Effective health literacy according to the Canadian Expert Panel needs to start in early childhood and needs to be continued and progressive by building on knowledge and experience gained throughout life course (Irving Rootman & Deborah Gordon-El-Bihbety, 2008).

Berkman et al. (2010), identified health literacy as a shared responsibility of the individual, health professionals and the healthcare system in his definition of health literacy as "dependent upon individual and system factors, which also include the communication, knowledge, and culture of both the professional and lay person, the context as well as the demands of the health care and public health system. This definition by Berkman et al. (2010) incorporated the aspect of the culture of both the professional and lay persons as this is crucial in understanding the factors that underlines an individual beliefs and attitude towards certain conditions(especially mental illness) and seeking medical help and is this is in line with ecologically framed conceptual model of Nutbeam (2008) who appraise the role of language, culture, and social capital in the definition of health literacy.

A systematic analysis by Sørensen et al. (2012) deviated from the concept of health literacy as a skill set and defined health literacy as " linked to literacy and entails peoples' knowledge and competence to access, understand, appraise and apply health information in other to make judgement and take decisions in everyday life concerning healthcare, disease prevention, and health promotion to maintain or improve quality of life during the life-course. This definition of Sørensen Kristine et al. (2012) is different from other definitions of health literacy as it incorporate key components of public health such as healthcare, disease prevention and health promotion as areas where individuals and groups have to be informed and it identifies 12 dimensions of health literacy and relate it to the capacity to assess, understand and apply health information in the domains of the healthcare sector.

Similarity in the characteristics of the IOM, AMA and WHO definitions is their emphasis on the individuals' ability and skills to obtain, process and understand health information and services needed to make informed health decisions (Sørensen et al., 2012). Current discussions pertaining to the role of health literacy have reported that the concept goes beyond individual skills and includes the interaction of the individual's skills with the demands of the healthcare system and the society. This notion was captured in the CEPH definition of health literacy which will also be discussed in relation to the other three widely cited definitions (Irving Rootman & Deborah Gordon-El-Bihbety, 2008). Sharma, Branscum, and Atri (2014), suggested that health literacy is a multi-faceted effort and a partnership effort of the health institutions (healthcare system and health training institutions) and the media can be mounted to improve health literacy. The health institutions can assist by creating health information that can be easily understood by patients and general population. Also, by training health professionals on how to address the population's low health literacy, and by making the health system easily navigable.

2.3.1 Limitation of the Various Definitions

Definitions identify the main focus of concern and provide variables for analysis, set parameters for inquiry and shape measurement tools (Pleasant et al., 2016). The obvious complication with the above definitions is the conflicting and lack of consensus on the exact meaning of health literacy as a concept among researchers, health professionals and policy

makers (Pleasant et al., 2016; Sorensen et al., 2012). All the above definition centres on the individual skills or ability. However, growing research has recognized that health literacy is not solely based on an individual characteristic but includes both the system demands and complexities as well as the skills and abilities of individual and health professionals (Parker & Ratzan, 2010; Pleasant et al., 2016). All these definitions did not incorporate the role of the healthcare professionals and the health system. Definition of health literacy should incorporate the multidimensionality of health literacy and give an explanation of the variety of settings and role of the healthcare professionals. The definition should be tangible, tested and health outcomes specified or outlined.

The AMA definition did not address health literacy's relationship with social interaction, verbal communication and the capacity to act (C. Speros, 2005). These deficits were incorporated into the definitions WHO when they broadened the concept of health literacy by incorporating social skills of the individual (Alper Joe & Rapporteur, 2016; C. Speros, 2005). Nutbeam (2000) expanded the concept and linked it to patient empowerment but underscored the importance of the health system or contexts. The IOM definition captured the significance and shared responsibility of the various sectors (health system, education system, and culture/society), and that the healthcare system carries significant but not the entire responsibility for improvement (Nutbeam, 2000; Parker & Ratzan, 2010; Parnell, 2014b; Wolf et al., 2017). Although the IOM definition noted that health literacy is a shared function of social and individual factors, it did not explicitly include the role of health professionals *per se* in that shared function in their definition. The IOM also did not specify the implication of health literacy over the course of individuals' life and this was well captured in Canadian Expert Panel's definition. The CEPH's definition highlight the primacy and complexity of health literacy in promoting health across the lifespan but this definition also did not explicitly include the role of the healthcare professional.

There is therefore a need for a new definition of health literacy that incorporates the multidimensionality of the concept and a new level of consensus among researchers, healthcare professionals and policy makers on the components of this definition. In conclusion, to effectively address issues of low health literacy among the general population, there is a need to identify a sound definition that illustrate the pathways to informed health actions.

2.4 Health literacy and Literacy

Literacy is the understanding, evaluation, and use of, or engagement with, written text needed for individuals to participate in society in order to achieve their goals and to develop their knowledge and potential (Parnell, 2014b). Although literacy and health literacy are related, it is imperative to note that general literacy and health literacy are two distinct concepts (Galletly et al., 2013; Sørensen et al., 2012). There is ongoing discussion among researchers about the exact nature of the relationship between literacy and health literacy (Irving Rootman & Deborah Gordon-El-Bihbety, 2008). Some researchers argue that health literacy is nothing more than literacy within a health context whilst others are of the view that they are entirely separate concepts (Berkman et al., 2010; Pleasant et al., 2016; Irving Rootman & Deborah Gordon-El-Bihbety, 2008). However, it is important to note that a basic level of general literacy is required to obtain adequate health literacy. Health literacy is based on the notion that both health and literacy are critical for everyday survival (Gillis & Quigley, 2004). The next section will give a brief description of literacy as a concept on its own.

Literacy is generically taken to mean a person's reading and writing skills. Literacy refers to an individual ability to read, write and speak in English, and solve problems at levels of proficiency necessary in daily activities on the job and in society, to achieve one's goals, and improve one's knowledge and potential (Parker, 1999). Literacy is also used with reference to one's knowledge of a subject matter such as financial literacy, computer literacy, information literacy, cultural literacy and health literacy. General literacy is sometimes referred to as the foundation of education and includes reading, writing, speaking, listening, and calculating (numeracy). These components are interrelated (Nielsen-Bohlman, 2004).

However, literacy expectations are centred on an individual's ability to recognise and pronounce words and develop of the skills needed to understand text and obtain new information (Carolyn Speros, 2005). According to Doak and Root, literacy skills in relation to health grew during the 20th century as public health campaigns used marketing methods to promote information in order to stop the spread of tuberculosis and polio (Zarcadoolas et al., 2006).

However, the attention of the media, policy-makers and researchers was drawn to the literacy skills of individuals when the results of the United States of America's (U.S.A) National Adult

Literacy Survey (NALS) revealed the magnitude of the problem. The survey revealed that approximately half of the population of the USA of the age of 16 and above had inadequate functional health-related literate (Kirsch, 1993; C. Speros, 2005). These findings were an indication that half of American adults had difficult reading and were unable to perform simple mathematical calculations needed to perform everyday tasks (Speros, 2005). Currently, several national surveys have been conducted and reports reveal that inadequate health literacy rates among the general population is high and this includes Canada (60%), Europe (European Health Literacy Survey HLS-EU) (50%), in China (94%) (Hernandez et al., 2013; Lambert et al., 2014; Quaglio et al., 2016; Irving Rootman & Deborah Gordon-El-Bihbety, 2008; Sørensen et al., 2015).

Functional illiteracy is defined as existing if an individual cannot engage in all activities in which literacy skills is required for effective functioning in society and to enable him to contribute to his/her community's development (UNESCO, 1978; Vágvölgyi, Coldea, Dresler, Schrader, & Nuerk, 2016). The distinction between literacy, illiteracy and functional illiteracy remains unclear, therefore an operational definition of the differences of these terms to date remains unclear (Vágvölgyi et al., 2016). There is therefore a need for a clear distinction between these terms.

2.5 Health literacy and Mental Health Literacy

Mental health literacy (MHL) is a concept that has risen from the domain of health literacy and was coined by Jorm et al. (1997). MHL is an important component of mental health service utilization and mental health outcomes (Kim, Lee, Lee, Simms, & Park, 2017). MHL is defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182). This definition was later refined to include; knowledge of how to prevent a mental disorder; recognition of disorders when developing; knowledge of effective self-help strategies for mild to moderate problems; and first aid skills to help others (Jorm, 2012). The definition of MHL has been redefined to be consisted with the evolving construct of health literacy (Kutcher, Wei, & Coniglio, 2016). Currently MHL has been defined as: understanding mental disorders and their treatments, decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management

capabilities) (Kutcher, Bagnell, & Wei, 2015; Kutcher & Wei, 2014). This definition provided by Kutcher et al. (2015) extended Jorm's definition to include the concept of stigma which has historically been addressed differently (Corrigan & Rao, 2012; Kutcher et al., 2016). It acknowledge the fact that there is an interrelationship between MHL and various types of stigma (Kutcher et al., 2015; Kutcher et al., 2016). Lack of knowledge regarding mental health is regarded as a drive of negative attitudes (prejudice) which in turn also affect their discrimination of mentally ill patients (Kutcher et al., 2016).

However, despite these redefinitions of MHL, the construct is yet to be content specific as a main domain of health literacy. Health literacy has expanded its construct to apply to individual's ability to develop and apply health literacy skills in everyday situations and across one's lifespan (Irving Rootman & Deborah Gordon-El-Bihbety, 2008). Most of the studies conducted on MHL do not measure all the components of mental health and do not use assessment tools of adequate psychometric properties (O'Connor & Casey, 2015; Wei, McGrath, Hayden, & Kutcher, 2015). Also, studies on MHL are often related to specific mental disorders and adopts the diagnostic vignette approach which was initially used by Jorm (Kutcher et al., 2016). Using this vignette approach alone cannot measure the entire domain of MHL. In addition, existing studies on MHL do not consider mental health promotion and neglects an individual's skill to differentiate mental disorders from a mental health promotion and even everyday stressors. Interventions tailored to promote MHL a not yet contextually sensitive and not specific to population groups (Kutcher et al., 2016). Therefore, MHL cannot be used for general discussions about health literacy on the broad health conditions.

Again, studies on MHL often focus on university students and older population and less focus on practicing health professionals, educators, younger populations and other unique populations (Kutcher et al., 2016; O'Connor & Casey, 2015). The construct of MHL is yet to focus on the role of mental health professionals and the mental health system in promoting adequate MHL. There is therefore the need for MHL construct to be informed and shaped by current developments in health literacy and not treated separately from health literacy. According to the IOM, health literacy is achieved when a patient seeking health information and services, skills and expectations meet the expectations and skills of health professionals communicating health information and providing services (Institute of Medicine, 2004). The concept of MHL needs to integrate the role of health professionals in promoting MHL among

patients and general population. Due to limitation in the construct of MHL, this study uses the main domain of health literacy to address mental health nurses' knowledge, understanding, experiences and challenges of promoting adequate health literacy among their patients. The construct of health literacy was therefore deemed as more appropriate and suitable to address the study aims and objectives particularly considering that health literacy is still a new concept in many developing countries.

2.6 Nurses' Awareness and Knowledge of Health Literacy issues in clinical practices

2.6.1 Introduction

Health literacy practice is defined as the patient-centred protocols and strategies that minimize the negative consequences of low health literacy. Health literacy practice is a promising approach to improving a patient's health outcomes (Barrett & Puryear, 2006). However, reports show that assessing and addressing patient health literacy issues are not routinely adopted by health care professionals within the clinical settings just as the literature review this chapter has discussed (Castro, Wilson, Wang, & Schillinger, 2007; Schwartzberg, Cowett, VanGeest, & Wolf, 2007; Turner et al., 2009). A review was conducted to synthesize existing evidence of nurses' understanding of the concept of health literacy and explore how they apply it (Ho & Chiang, 2015; Noblit & Hare, 1999). The aim is to give some understanding of the concept and issues relating to the meaning of health literacy and its adoption among practising nurses in different contexts. This chapter helps to identify responses to these questions from existing literature:

i. What does health literacy mean to nurses?
ii. How do nurses assess patients' health literacy?
iii. What practices do nurses adopt to enhance patients' health literacy?
iv. What are the barriers that nurses encountered when promoting health literacy among patients?

2.6.2 Design

This review adopted the meta-ethnographic approach of Noblit and Hare (1999) to synthesize knowledge from published qualitative studies. The focus of meta-ethnography is on the development new interpretations of concepts, in particular, rather than on the accumulation of information (Walsh & Downe, 2005). To generate an in-depth understanding of nurses'

knowledge on health literacy, the steps involved in the meta-ethnography were utilised to analyse each paper repeatedly by comparing and contrasting reported findings from these studies (Britten et al., 2002; Campbell et al., 2011; Merten et al., 2010). Meta-ethnography requires the reciprocal translating of qualitative findings from one study into the outcomes of another to derive interpretive explanations and understanding. In this review, different qualitative studies ranging from qualitative descriptive to phenomenology were synthesised. This was done to promote cross-comparison of studies and facilitate the identification of similarities and differences in the reported findings from the included studies (Walsh & Downe, 2005).

2.6.3 Methods

2.6.3.1 Search Strategy

An electronic search of seven databases was undertaken to identify relevant primary empirical qualitative and mixed method articles for the review. The seven databases included: PubMed, CINAHL, MEDLINE via Ovid & EBSCOhost, ProQuest Dissertation and Thesis, Science Direct, British Nursing Index and PsycINFO. These databases were scoured for articles on nurses' understanding and awareness about health literacy published between January 2000 to August 2017. Many of the terms in the Medical Subject Headings were used either separately or together to search the databases and journals. A modified search filter was used to identify qualitative and mixed method design articles. Search terms used included: nurses, nursing skills, health literacy, health education, understanding, awareness, communication, knowledge, teaching, teach-back, perception. In addition, a search of the interlibrary service of The Hong Kong Polytechnic University was done to determine published and unpublished theses/dissertations. The last stage of the search activity consisted of an ancestry search through the reference lists of all selected papers to identify other relevant articles. In all cases, whenever full texts of articles were unavailable, authors were contacted to obtain full texts.

2.6.3.2 Inclusion and Exclusion Criteria

Studies included in this review were primary empirical studies, including both qualitative and mixed-method studies. No restrictions had been placed over the host country, even though the studies could have been dissertations. Articles were required to have been written in English and published from January 2000 to August 2017. However, studies that focused on nursing students and health professionals other than practising nurses were excluded. Student nurses

were excluded because the primary objective was to focus on the current situation of nurses' knowledge, experience and practice with regard to health literacy. Studies that use quantitative methods or were editorial papers or commentaries were also excluded. Before undertaking this review, the resources of the Cochrane Library, the Joana Briggs Institute Library of Systematic Reviews and CINAHL were also scoured, but no published or on-going systematic review of this topic was found.

2.6.3.3 Search Results

The search strategy yielded 167 results. Firstly, titles and abstracts, and 122 articles that did not focused on nurses' knowledge of health literacy were screened and removed. Some 25 duplicated articles were removed. Based on the inclusion criteria, another 14 studies were removed because they were quantitative studies, editorial and commentary papers. Six studies were retained for further data extraction (Al Sayah et al., 2014; Malloy-Weir, Begoray, & Tatlock, 2016; Matzke, 2007; Redden, 2017; Richey, 2012; Toronto & Weatherford, 2016).

2.6.3.4 Data Extraction and Synthesis

The initial approach was to include both qualitative and mixed method studies in the review. However, as the six studies identified were all qualitative papers, the stages recommended by Noblit and Hare (1999) to guide data extraction and synthesis in this meta-ethnography were applied. All the studies were thoroughly and independently studied to identify key themes in each study, and to draw comparisons between studies through the process of reciprocal translation. Reciprocal translation is a process that involves examining critical similarities, differences and contradictions between studies (Ho & Chiang, 2015; Noblit & Hare, 1999). Comparison of themes identified in each of the six studies were made. Study 1 was compared with study 2, then study 3, until all six studies were examined. Data synthesis began with reciprocal translation, and this involved translating constructs from individual studies by arranging them in chronological order. All the papers were nursing articles. Two reviewers (AOK, AYML) read each paper, and agreed on the index paper published by Richey (2012), from which the first set of themes were identified. An index paper is a paper/article that captures the essence of specific topics of a study. The remaining articles were compared with the preliminary themes. Contradictions between studies were examined and explained using

the first and second order constructs which expressed the synthesised interpretation through written words.

2.6.4 Results

Only qualitative papers were identified without any mixed method papers. The six studies represented the views of nurses from two countries (four studies were from the United States of America, and the other two were from Canada) and included data from 64 participants. Participants were interviewed in face-to-face mode (Matzke, 2007; Redden, 2017; Richey, 2012), handwritten narrative (Toronto & Weatherford, 2016), telephone interviews (Malloy-Weir et al., 2016) and audio recordings of nurse-patient encounters (Al Sayah et al., 2014) as part of individual interviews. Five studies were conducted in urban settings while one remaining study took place in a rural setting. The earliest paper was published in 2007, and the latest in 2017, with the majority of the studies (n=5) published within the last five years.

The majority (n=5) of the studies (Al Sayah et al., 2014; Matzke, 2007; Redden, 2017; Richey, 2012; Toronto & Weatherford, 2016) targetted registered nurses, while one focused on public health nurses (Malloy-Weir et al., 2016). Five studies explored nurses' understanding, perception and experience of low health literacy issues among patients (Malloy-Weir et al., 2016; Matzke, 2007; Redden, 2017; Richey, 2012; Toronto & Weatherford, 2016). The one remaining study examined nurses' application of health literacy in their communication, their use of medical jargon and the impact of health literacy when nurses provide patients with education (Al Sayah et al., 2014). Out of the six studies, four studies (Malloy-Weir et al., 2016; Matzke, 2007; Redden, 2017; Toronto & Weatherford, 2016) addressed the barriers that impeded nurses' teaching and communication with patients.

Two central themes emerged from the reciprocal translation and synthesis, and this included nurses' understanding and assessment of patients' health literacy, and barriers to address the incidence of low health literacy among patients.

2.6.4.1 Theme One: Nurses' understanding and assessment of patient's health literacy

In analysing the data, it was discovered that nurses have limited understanding of health literacy regarding awareness, knowledge and the skills needed to assess and address issues of health literacy among patients. From the reviewed studies, nurses' understanding of patients' health literacy encompasses knowledge about health care needs and how to interpret information given by healthcare providers; and how to read books or information found on the internet. Nurses have adopted various ways of addressing issues affecting patients with low health literacy. From this analysis five sub-themes were identified. They included:

a. Nurses' awareness of patients' health literacy;
b. The meaning of health literacy to nurses;
c. Techniques used by nurses to assess patients' health literacy levels;
d. Consequences of low health literacy;
e. Communication strategies used by nurses to improve patients' understanding of health information or treatment regimen.

2.6.4.1.1 Nurses' awareness of patients' health literacy

The majority of the nurses working in rural and urban communities contended that health literacy was a relatively new and unfamiliar concept to them (Matzke, 2007; Redden, 2017). Place of work did not appear to influence nurses' familiarity or understanding of health literacy as nurses in both urban and rural communities were unfamiliar with the concept.

> "*… I remember we did an information literacy class; you know we focused more on patients, teaching materials for patients, and things like that; Never heard of health literacy" (Matzke, 2007, p. 51).*

> *"I have to be honest; this is the first time I have heard the term health literacy…" (Redden, 2017, p. 66).*

2.6.4.1.2 Meaning of health literacy to nurses

Nurses provided different definitions of health literacy (Malloy-Weir et al., 2016; Matzke, 2007; Redden, 2017; Richey, 2012). None of the nurses appeared to understand the concept of health literacy completely. Definitions for health literacy most often cited by nurses focused on the functional dimensions, for instance, patients' ability to obtain and understand health information or instructions (Malloy-Weir et al., 2016; Matzke, 2007; Redden, 2017; Richey, 2012). However, a significant number of registered nurses (4 out of 7 (Richey, 2012) and 4 out of 15 (Redden, 2017)) defined health literacy as part of nurse-patient communication, and more specifically, how nurses explained medical terms in plain language for patients to understand. Nurses also tried to connect the concept of health literacy with holistic nursing, patient teaching and patient education. In many instances, nurses had to guess the meaning of health literacy, and this highlighted the lack of training and unfamiliarity with the term.

> *"By the way… patients understand the care that they're receiving. You know, the tests that they're doing to them… the discharge instructions that go home with them. Just understand their overall … what their process is and what they need to do to care for themselves" (Richey, 2012, p. 74).*

Other nurses also expanded their understanding of health literacy to include the communication between a nurse and a patient or even nurses and doctors.

> *"It can even be communication between nurses and a patient, patient-doctor, nurse-doctor" (Richey, 2012, p. 42).*

2.6.4.1.3 Techniques used by nurses to assess patients' health literacy levels

Although nurses were aware of their responsibility in assessing a patient's health literacy levels, none reported that they had used a valid health literacy assessment tool. Most nurses assessed patients' health literacy based on their intuition (getting the feeling that patients are of low health literacy according to the patient's enquiries during communication) (Malloy-Weir et al., 2016; Matzke, 2007; Richey, 2012; Toronto & Weatherford, 2016).

> *"I will ask a question so that I get their level of understanding … rather than me just telling them again, I want to hear it in their words … That is also where you will pick up on their comprehension" (Malloy-Weir et al., 2016, p. 3).*

Nurses also without adequate assessment perceives patients with high educational status as possessing ‘adequate level of health literacy.

> *“You do that on every admission, and it is part of the admission form and while you are admitted …. How high in school did you go … That sort of thing” (Matzke, 2007, p.63)*

2.6.4.1.4 Consequences of low health literacy

Nurses were aware of the challenges patients and their relatives faced when they tried to obtain health information and maintain health status. According to nurses, low health literacy affects the ability of patients to read and understand health information and make informed choices about their health (Malloy-Weir et al., 2016; Matzke, 2007; Richey, 2012; Toronto & Weatherford, 2016).

> *“When I asked him if he ever had diabetic education information … he said ‘yes’ and showed me the resources he had. All were written in English. It turned out that even though he spoke English fairly well, he did not read English” (Toronto & Weatherford, 2016, p. 10).*

> *“I think it’s huge … if somebody doesn’t understand something completely, how can they make an informed decision about it ... I think it’s huge to know how your patient learns and how they process things, to know if they’re getting it and if they do understand the decision that they’re making” (Richey, 2012, p. 46).*

Nurses reported that low health literacy affected patients’ level of self-efficacy and often caused them shame and embarrassment, which in turn affected their ability to openly ask questions about their health or communicate with nurses (Richey, 2012; Toronto & Weatherford, 2016).

> *“I think some people cover it up very well and are afraid to speak up for things that they don’t understand because they might think that somebody would think that, you know they’re stupid or uneducated … So I think most often you can tell, but not always” (Richey, 2012, p. 84).*

> "*My mother-in-law, for example, … she'll call with questions all the time, but she'll let her health go because she just doesn't have the confidence … and she says she feels stupid every time she calls, because she doesn't know what she's talking" (Richey, 2012, p. 47).*

Nurses reported that low health literacy affects patients' ability to take their medications as prescribed or make proper use of their treatment regimen (Malloy-Weir et al., 2016; Matzke, 2007; Richey, 2012; Toronto & Weatherford, 2016).

> *"…. I remember an elderly black man … he had asthma, CHF and was hypertensive and a little overweight … And we gave them an aminophylline suppository and gave him instructions on how to use it, written instructions, but did not tell him that it had to be inserted rectally … when he came back he said it didn't help and it was uncomfortable because it was too hard for him to swallow … I had no idea that people would not understand how to take their medicines … don't assume that patients understand what we tell them" (Matzke, 2007, p. 58).*

2.6.4.1.5 Communication strategies used by nurses to improve patients' understanding of health information or treatment regimen.

Nurses adopted various techniques in communicating with patients with low health literacy and in helping them to understand health information. The use of diagrams, speaking in plain language (devoid of medical jargon), observing body language, tailoring consultations to suit the patient's literacy level, referral of patients to trustworthy sites, use of peer educators, use of written information and hands-on techniques were the most commonly used strategies by nurses to communicate effectively with patients. Clarification and checking for patients' understanding were conventional approaches adopted by nurses to ensure that information conveyed to patients was understood.

> *"I am verbally going through things, but I am having them read it, and when it comes to hands-on, I will do a hands-on opening a birth control package. Making sure they handle it, understand what to do, or what type of birth control they have chosen. So*

actually, it would be tactile, verbal, and reading the written word with us" (Malloy-Weir et al., 2016, p. 3).

Using peer educators to improve understanding was one of the strategies that nurses often used to enhance patients' knowledge of health information and services.

> *"Having the youth speaking to youth (peer educators) is what has been a great bonus so that they understand that it isn't just us in the field. It's their fellow peers that are in there talking this talk, making it acceptable to discuss sexual health and sexually transmitted infections and so on. So, I think it's making sure that they understand they are getting some of that education and learning from their peers. And that has been a great bonus … regarding communicating with them" (Malloy-Weir et al., 2016, p. 3).*

One study examined nurses' communication skills by audio-recording of nurse-patient encounters and identified that nurses never checked patients' understanding (81% never used) nor asked patients if they understood the information conveyed (42% never used). Medical jargon and mismatched language were often used in most encounters (Al Sayah et al., 2014).

2.6.4.2 Theme Two: Barriers to address incidence of low health literacy among patients

Nurses reported a variety of factors (individual, institutional, societal/cultural, and provider-related obstacles) that hindered their abilities to address patient' low health literacy. There were four sub-themes:

a. Patient-related factors
b. Nurse-related factors
c. Institutional factors
d. Societal and cultural associated factors

2.6.4.2.1 Patient-related factors

At the patient level, nurses reported a population patient-range that was particularly challenging when providing health information. These included: poor socio-economic status, educational background, uninsured, racial and ethnic minorities, specific age groups (older adults and adolescents) and individuals with limited English proficiency. These individuals were considered as high-risk groups for low health literacy and deemed to be the most challenging groups for providing health information and services.

> *"The young and elderly population often present challenges with communication; for example, teens do not offer their full attention … during consultation whereas the elderly often have hearing and vision impairment or just do not understand correctly" (Redden, 2017, p. 77).*

> *"Because I work in a place with a population that speaks a different language than myself, I have no real experience to talk about (Toronto & Weatherford, 2016, p. 11)."*

Individual patient characteristics, like avoidance behaviour and cultural beliefs, were reported as a barrier to nurse-patient communication (Malloy-Weir et al., 2016; Toronto & Weatherford, 2016).

> *"They (African Americans) will reject food recommendations of the dietician and have family members bring in high fat and salt (soul) food; some patients do not believe in American medicine" (Toronto & Weatherford, 2016).*

2.6.4.2.2 Nurse-related factors

In a study, several participants reported that nurses' perceptions or assumptions about a patient's health literacy contributed to the poor understanding of their patients' needs (Toronto & Weatherford, 2016). Nurses' reported that lack of training on health literacy is one of the obstacles for them to address issues of low health literacy (Redden, 2017; Toronto & Weatherford, 2016).

> *"… All of that has to do with health literacy, but I don't know because it is not something I was ever trained on" (Redden, 2017).*

2.6.4.2.3 Institutional factors

Nurses reported a variety of obstacles in their practices: inadequate resources and lack of health literacy education/training were seen by nurses to influence their ability to address issues of low health literacy. Limited time allocated to attend to patients, the complexity of a health care system and lack of interpreters in clinical areas affected nurses' ability to identify who had low health literacy (Malloy-Weir et al., 2016; Toronto & Weatherford, 2016).

> *"They did not speak English, and no translator was available, and lack of time when using interpreters" (Toronto & Weatherford, 2016, p. 11).*

> *''She was unable to read English, and I was unable to provide any written materials in Spanish'' (Toronto & Weatherford, 2016, p. 11).*

Health literacy includes various skills needed to navigate the healthcare system, including print literacy (reading and interpreting written information), oral literacy (speaking/ efficiently listening), and numeracy (applying quantitative information). Individuals with low health literacy may have trouble with even basic health-related tasks, such as completing medical history or insurance forms. One nurse participant recounted the difficulty a patient with low health literacy faced in navigating the health system.

> *''I told him the steps he needed to follow, and he rarely did so, citing the complexity of navigating the system'' (Toronto & Weatherford, 2016, p. 11).*

2.6.4.2.4 Societal and cultural associated factors

Nurses reported that overarching cultural meaning of disease competed with medical language and health concepts. Rural health cultural beliefs and practices influenced the patient's lack of understanding of healthcare teachings and compliance to treatment. Nurses reported that rural community patients preferred home remedies to treating conditions and this limited their health-seeking behaviours. Some nurses encountered patients who had utilized folk remedies and expressed their concern for the adverse effects of this treatment on the health of patients.

> *"I have seen that quite a few of patients think that old home remedies are the best things next to medicines…" (Matzke, 2007, p. 69).*

"Rural people have less intelligence, and they are just different, and you need to repeat the information over and over again because sometimes the rural people don't question their health" (Matzke, 2007).

2.6.5 Discussion

This review contributes to developing a thorough picture of how nurses understand health literacy, how they react, and the barriers they face in addressing incidences of low health literacy among patients. Across all the articles in this review, we found that nurses' awareness of health literacy was low, and the meaning they ascribed to health literacy was unclear. However, most of their definitions were closely aligned with patients deficits. This may partly be due to the lack of consensus on the universal definition of the term, or the evolving nature of the concept of health literacy in literature (Nutbeam, 2008; Pleasant et al., 2016). Therefore, it was not surprising to find that the majority of nurses in the reviewed studies indicated that they had not heard of the term 'health literacy'. When nurses were asked to define health literacy, they described or reported a variety of meanings, which was conflicting. The majority of the nurses were not able to provide a complete definition of health literacy (Malloy-Weir et al., 2016; Matzke, 2007; Redden, 2017). Some described health literacy as something related to a patient's ability, while others attributed health literacy to nurse-patient communication. From these nurses' perspectives, health literacy is not well defined, and this reflected the diverse meanings of health literacy to nurses (Pleasant et al., 2016; Sorensen et al., 2012). This may eventually affect nurses' actions in clinical practices.

There was a concomitant lack of consensus over the definition among nurse practitioners. Some nurses conceptualised health literacy as a problem arising from their patients' inabilities and not as an issue relating to the abilities of health professionals. In the reviewed studies, the majority of informants reported patient-related factors (socio-economic status, educational and racial/ethnic background and English proficiency) as barriers to addressing low health literacy. Few mentioned nurse-related factors, which further demonstrated their weak understanding of the concept. Nurses bear the responsibility of patient teaching and education, and as such, assessment of patient health literacy levels. They are also responsible for directing patients to

credible sources of health information. These are all critical health literacy skills they need to possess.

Although some nurses were not aware of health literacy, they asserted that they had learnt how to meet a diverse range of patients' needs in patient education in nursing schools (Matzke, 2007; Richey, 2012). When asked how they addressed this, nurses mentioned using various communication techniques to improve a patient's understanding. However, Al Sayah et al. (2014) found that nurses never checked patients' understanding and used inappropriate language and medical jargon in nurse-patient communication. These findings highlighted the discrepancy between what nurses said and what they did in actual practice. Other practical approaches that may be useful include: asking open-ended questions; using visual representations like graphs and figures to make health information comprehendible; and limiting information to two or three main points (Koh & Rudd, 2015; Parnell, 2014b). Nurses can adopt these recommended approaches to address issues of low health literacy.

The majority of the informants were able to identify a number of barriers to addressing the issue of health literacy in clinical practices, and social and cultural factors (patients' beliefs and values about health and treatment) that stood out to be significant in interpreting a patient's ability to understand health information. Nurses in both urban and rural settings reported the challenges imposed by different cultures beliefs and values on patients' health literacy. Compliance with medication/treatment and health-seeking behaviours can be affected by strong belief in folk remedies, and the difference in cultural practices/beliefs/languages between nurses and patients. Multiculturalism and limited English proficiency could be a barrier to convey health information to patients (Mogobe et al., 2016), and this was witnessed in nursing practices. When nurses are not able to communicate in the patient's language, quality of care can be adversely affected. Understanding this barrier allows nurses to find ways to resolve the problem. Medical translators are employed in many health centres to help to promote effective communication between nurses and patients. The question is whether nurses in different contexts are aware of these medical translator services to make use of them in their nursing practice. Perhaps, nurses can begin to make a difference in practice by integrating cultural and linguistic concerns in communication when they deal with culturally diverse patients.

Several health literacy educational tools have been developed by various institutions across the globe (such the United States' Centers for Disease Control and Prevention & Institute of Medicine) to provide health professionals with the fundamentals of health literacy and practical steps to apply health literacy principles and strategies in their daily clinical practice (Howard, Jacobson, & Kripalani, 2013; Leung, Lou, Cheung, Chan, & Chi, 2013). It is high time that health systems adopt and adapt some of these resources.

2.6.6 Limitation of the review

There are some limitations to this meta-ethnographic review. Firstly, the search was limited to studies published in English and it is possible that relevant articles written in other languages may have been overlooked. Secondly, the study designs of all reviewed articles were limited to qualitative, exploratory, descriptive and phenomenological studies. Thirdly, the reviewed papers reported the health literacy knowledge and experience of 64 nurses and this may not have represented the knowledge and experience of all nurses across different settings and specialities. This caused this review to be over-represented by general nurses, and as such, the rich contextual subtlety of health literacy may be missing. Various interventional tools exist to promote health literacy in the clinical setting; however, these findings indicate that adoption of these health literacy tools by nurses may still be low. Further studies should be conducted to examine if these available tools are known to nurses and what hinders their adoption by nurses within the clinical settings. Lastly, the majority of the papers included in the review were from two high-income countries, United States of America and Canada, and findings may be specific to these contexts and may not reflect the knowledge and experience of all nurses. Therefore generalizability of the data is limited and should be inferred with caution.

2.6.7. Implication for Practice and Research

The findings showed that nurses were unfamiliar with health literacy and had limited understanding of the assessment of patient's health literacy. Therefore, there is a need for nurses to assess patients' health literacy when providing health education and this should be incorporated in routine clinical practice. This area should be developed as the target for professional development in nursing. Educational institutions and healthcare organisations could share the responsibility of health literacy at both pre-registration and post-registration

levels. The stigma associated with low health literacy can impact nurses' spoken communication with patients and therefore their patients' ability to benefit from health services. There is a need for nurses to offer non-judgemental culture-sensitive care to promote a positive healthcare experience and outcome.

Evidence from this review shows that research on nurses' awareness and knowledge about health literacy is still in its early stage of development leading to practice change. Therefore, more studies will be needed to understand and address health literacy knowledge and practical issues in nursing, as well as patients in all healthcare settings. The most prominent deficiency in health literacy skills among nurses was the lack of training in the use of assessment tools of health literacy. Further research must be carried out to assess the effect of formal training of health literacy on the efficiency of nursing practices and patients' outcomes.

There is a need for more studies to examine existing health policies and identify how health literacy might fit into current practices. Such studies will prepare policy-makers to select the right approach to address health literacy knowledge deficiencies among nurses and other health personnel. Again, the fact that the majority of the papers included in the review were from two high-income countries calls for more studies in other contexts, particularly low-income countries to help identify similarities and differences about the issue of nurses' health literacy skills, practices and barriers. None of the studies attempted an interventional approach to health literacy. Interventional studies can be conducted to understand and address the scope of health knowledge gaps and barriers faced by nurses in their attempt to address the incidence of low health literacy. Such an approach would help to identify contextually relevant interventions and policies.

2.6.8 Conclusion

The findings in this review call for the attention of health policy-makers, nursing educational institutions, nursing researchers and hospital administrators to collaborate to address the gaps in health literacy knowledge of nurses. If nurses, who are the advocates, surrogates and educators of patients, have limited health literacy skills, the majority of efforts geared towards improving low health literacy among patients may be futile. As most studies have identified, even people with adequate literacy can also suffer low health literacy at one point, and without proper communication skills among nurses, health information may be confusing for patients to understand. These findings show that there is a need to improve the health literacy skills of nurses and interventions such as 'Ask me 3' and 'Teach-Back Method' have been endorsed by the American Association Foundation to promote better nurse-patient communication (Ferguson & Pawlak, 2011). According to the Institute of Medicine (2004), health literacy involves the alignment of patient abilities with the demands of the health system and the skills of healthcare providers. Equal attention needs to be paid to patients' health literacy abilities and that of nurses' health literacy skills by health administrators, nursing educators and researchers.

2.7 Conceptual Framework for the study

The conceptual framework adopted for this study was based on the health literacy model by the Institute of Medicine (IOM). According to the IOM model health literacy reflects a broad conceptual understanding of health literacy which stresses the need for shared responsibility in improving each individual's health literacy through the shared responsibility of the educational system, the healthcare system as well as the society (Nielsen-Bohlman, 2004; Ratzan & Parker, 2000). This means that health literacy is dynamic and dependent of various factors including the current medical problem, the health profession and the health system (Baker, 2006). According to IOM, health literacy is the bridge between the individual's literacy skills and abilities, on the one hand, and the health context, on the other. Within the framework, literacy is regarded as the foundation of health literacy and is the active mediator between the individual and the health context. The various sectors that constitute to health literacy, as shown in Figure 1 below, are culture and society, the healthcare system and the education system. These factors

help provide researchers, clinicians, public health professionals and policy-makers with the necessary interventions to solve problems of low health literacy (Nielsen-Bohlman, 2004). The IOM's model describes how a person's health literacy skills are influenced by factors such as the health system, the educational system, and culture and society (Parker, Ratzan, & Lurie, 2003).

2.7.1 Health System (Mental Health System)

The health system includes a range of environmental circumstances relating to health such as the health professionals, the media, government agencies as well as the available facilities (Nielsen-Bohlman, 2004; Parnell, 2014b). Health literacy within the clinical settings occur when the skills and ability of the individual is aligned with the health system demands and complexity (see Figure 1) (Landi & Hernandez, 2011).

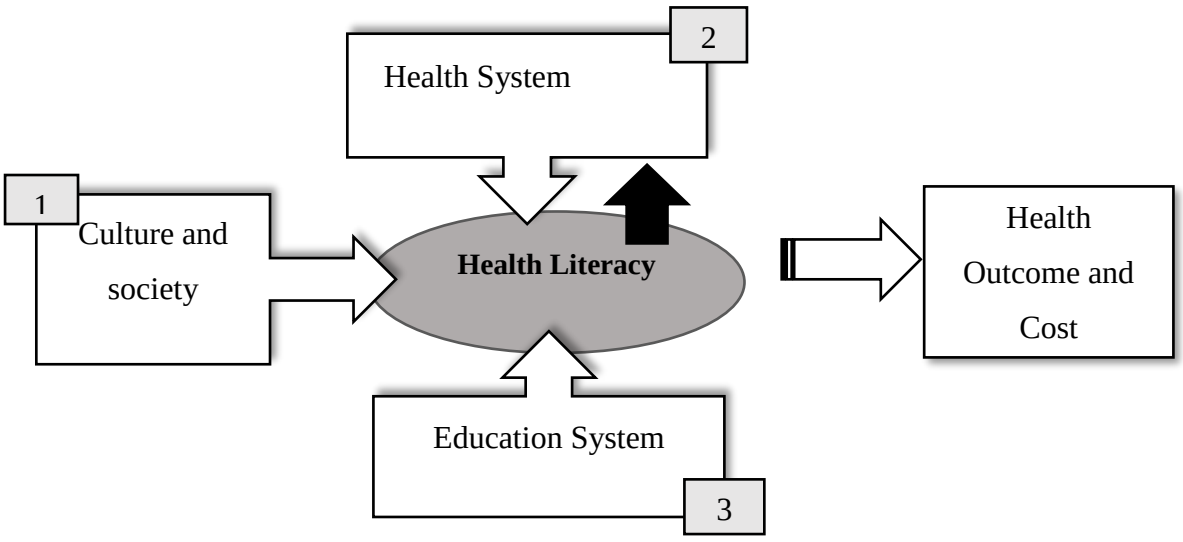

Figure 1: Conceptual Framework of the study

Source: Nielsen-Bohlman, L., Panzer, A., Kindig, D.A. (Eds.), 2004. Health Literacy: A Prescription to

The health system is comprised of individuals working within the mental healthcare system and includes public health agencies, clinical mental health professionals, both private and public clinics, those in psychiatric clinics, health regulatory bodies including accreditation

boards, educational institutions and health researchers. However, in sub-Saharan Africa there is high structural and systemic barriers due to inadequate number of mental health professionals, inadequate healthcare infrastructure and financial difficulties (Monteiro, 2015; Roberts, Mogan, & Asare, 2014). Government institutions throughout the continent has neglected mental health and focus instead more on communicable diseases such as tuberculosis and malaria (Monteiro, 2015).

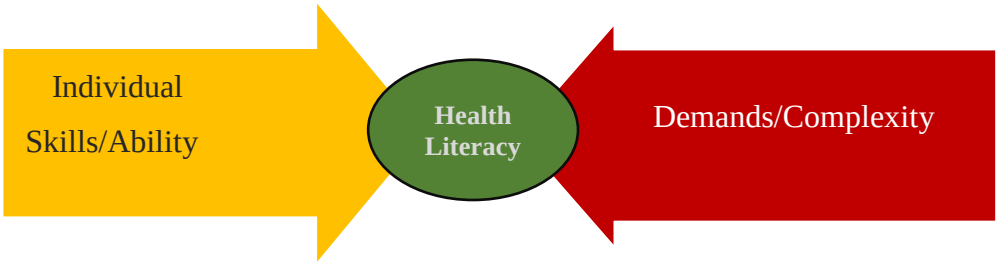

Figure 2: Health Literacy Framework

Source: Parker (2009)

However, research indicates that 30% of the global population suffers from one form of mental disorder but up to two-thirds of populations do not receive adequate treatment. In Ghana, a report by the World Health Organization (WHO) estimated that about 98% of the 2.5 million people suffering from mental illness do not receive the needed treatment (Roberts et al., 2014). This affects health literacy levels of people because one of the key ways of gaining adequate health literacy skills relates to ability to access care and utilization of available health services (Nielsen-Bohlman, Panzer, & Kindig, 2004).

Ghana is classified as a lower middle-income country (LMIC) by the WHO. However, the country's mental health system fails to meet any of the average statistics with regard to mental health care (Bartlett, 2016). Ghana's mental health system faces issues of limited infrastructure, poor and scarcity of mental health facilities and insufficient mental health professionals, which has been identified to contribute to this treatment gap (Opare-Henaku & Utsey, 2017; Roberts et al., 2014). The low priority of mental health issues in Ghana can also be seen from the fact only about 1.4% of Ghana's total health budget goes to mental healthcare (Roberts et al., 2014).

The available mental health facilities are plaque with overcrowding, health and sanitation hazards (lice, tick infestation, and scabies abound) (Burler, 1997).

Moreover, given the fact that Ghana has only three mental health hospitals as compared to the estimated 45,000 traditional healers and church facilities available for the treatment of mental disorders, it is not surprising these traditional healers and churches are the first point of call and most preferred by families (Barke, Nyarko, & Klecha, 2011; Roberts et al., 2014). Access to mental health services is very limited as the only three hospitals in the country are in the urban centres and southern part of the country. Traditional/ spiritual healers often exist predominantly in the rural areas of the country (Sundh & Roslund, 2012). Research among mental health professionals in Ghana indicates that lack of knowledge about appropriate place to receive mental health services was a major contributory factor to poor utilization of avialable mental health services by patients and families (Barke et al., 2011). This situation may in turn influence patients' access to credible information on mental disorders.

The IOM has found that health literacy affects the effective communication between healthcare providers and patients within the health contexts and this has an effect on health outcomes and status (Nielsen-Bohlman, 2004; Parker & Ratzan, 2010). The scarcity of mental health resources, limited knowledge about mental illness has been identified as a significant contributory factor to low utilization of mental health services among mentally ill patients (Barke et al., 2011). Coupled with these health and sanitation issues, there is overcrowding in these mental health institutions(World Health Organization, 2011) and there is over reliance on mental health nurses for provision of health services (Roberts et al., 2014). Given the fact that in these three government hospitals there are only 18 psychiatrists, 1,068 registered mental health nurses, 72 community mental health officers, and 21 social workers (Roberts et al., 2014). This insufficiency of human resource may partly be the reason why the balance of treatment for mentally ill patients in Ghana is too strongly focussed on medication rather than psychosocial interventions and prevention(Roberts et al., 2014). As this imbalanced nurse-patient ratio implies that mental health nurses' ability to provide patient-centred care, assess and promote adequate health literacy among patients may be hindered. This also implies that

health education on effective ways to promote and prevent mental health disorders is rarely done.

2.7.2 Culture and Society (The Ghanaian Society and Culture)

Culture, according to the IOM report, is the shared ideas, meaning, and values acquired by people as members of a given society (Nielsen-Bohlman, 2004). An individual's culture influences the way that individual interacts with the healthcare system and the meaning he or she assigns to health conditions (Nielsen-Bohlman, 2004). Within the health system, culture does not include language and vocabulary alone but the definition and meaning attached to health and illness concepts, an individual's utilization of the healthcare system and his or her interaction with healthcare professionals. Culture provides a lens through which people understand or give meaning to health-related information and make decisions about health choices. Each person is influenced by cultural, social and familial interaction, and this influences the way in which each one deals with the world around him or her.

Understanding and knowledge on mental health vary from culture to culture (Choudhry, Mani, Ming, & Khan, 2016). Asians attribute causes of mental illness to traditional and/or spiritual and psychological factors instead of biogenetical causes (Wong, Xuesong, Poon, & Lam, 2012). In Africa mental disorders are believed to be caused by possession of evil spirits, witchcraft and the handwork of supernatural forces and a result of one's own doings (drug abuse) (Ganasen et al., 2008; Opare-Henaku & Utsey, 2017). In Ghana religion and spirituality are strongly associated with the cause and treatment of mental illness and play a critical role in mental health care (Bartlett, 2016; Quinn, 2007; Sundh & Roslund, 2012). Ghanaian cultural beliefs influenced notions of causes of mental illness and care of the mentally ill patient (Opare-Henaku & Utsey, 2017). In Ghana, there is the recognition of the role of multiple factors such as genetics, substance abuse, poverty, and trauma as causes of mental illness (Human Rights Watch, 2012; Opare-Henaku & Utsey, 2017). However, most Ghanaians holds the notion that mental illness is a *retributive* and/or a *spiritual* illness. This belief encourages pluralistic health-seeking behaviours among patients and families who utilize hospitals, prayer camps,

herbalists, and traditional healers. It is estimated that 70% of the families of mental health patients prefer herbal and or spiritual treatment over orthodox (Sundh & Roslund, 2012). These are not surprising because, Ghanaians are extremely religious. It is estimated that about 71.2% of the population are Christians, 17.6% have Islamic faith and 5.2% are traditionalists (Bartlett, 2016). However, a significant number of the population practice traditional beliefs alongside Christianity or Islam. The basis of the traditional beliefs form a significant part of Ghanaian culture and everyday normative practices (Bartlett, 2016).

The early 1920s saw a surge of Christian prayer camps which sought to treat chronic conditions and mental disorders in Ghana. A report by the Human Right Watch indicates that these charismatic and Pentecostal churches believed in the power of miracles, consultation with angels and spiritual healing (Human Rights Watch, 2012). There are over thousand (45,000) of these prayer camps throughout the country (Barke et al., 2011) and a survey of 10 faith-based clinics revealed that in total, these facilities treated 1253 mentally ill patients in a year (Bartlett, 2016; Human Rights Watch, 2012). However, these facilities operates outside government health system regulations and without supervision by any trained mental health professional (Bartlett, 2016; Opare-Henaku & Utsey, 2017). Investigations into the practices of these prayer camps have exposed extreme human rights violations and abuse to the mentally ill. Overcrowding, poor sanitation, chaining of patients to trees inside and outdoors, detention against one's will and denial of food and shelter are conditions mentally ill patients are subjected to in these camps (Bartlett, 2016). Unfortunately for the mentally-ill, some of these conditions (poor sanitation, involuntary detention and lack of medications) are also found in government mental health hospitals.

There are different traditional religions in Ghana and some share common beliefs, values and practices whilst others are different. The belief in spirituality and direct physical blessings and punishment from the gods is common to the majority. A product of this belief is the perception that mental illness is a possession by evil spirits. This is why mentally-ill patients are sent to spiritual healers for treatment instead of psychiatric hospitals (Bartlett, 2016; Opare-Henaku & Utsey, 2017).

An individual's native language, gender, race, socioeconomic status and ethnicity along with media influences such as advertising, marketing, and news publishing and the internet as sources of information are the various factors that influence a person's health literacy rates (Nielsen-Bohlman, 2004; Parnell, 2014b). English is the official language of Ghana but there are over 50 to 100 different local dialects (Roberts et al., 2014). This means that the health system have to be sensitive to language differences (World Health Organization, 2011). The situation is even more complex because, literacy rate in Ghana is low. The literacy rate in Ghana is 67.3%.

The above complications are part of the reasons why the IOM framework also highlighted that disparities within the health system arise as a result of cultural diversity (Ratzan & Parker, 2000). It is argued that addressing the culture of individual patients helps promote patient-centred care. More specifically, health information such as doctors' instructions, medications, and brochures that are based on scientific medical concepts may be barriers to achieving effective levels of health literacy. This is more prevalent where English is a second language, and where traditional Indigenous beliefs about illness prevail (Vass, Mitchell, & Dhurrkay, 2011).

2.7.3 Education System (Mental health nursing Education System)

In Ghana, only 3% of undergraduate training for medical doctors is devoted to mental health, and 10% of training for State Registered Nurses (SRNs) is devoted to mental health (Roberts et al., 2014). Studies show that the balance of treatment for patients have been strongly focussed on medication rather than psychosocial interventions and prevention. Presently, there are no degree or advanced programs designed for mental health professionals. Training of nurses are at the diploma level (Roberts et al., 2014). To make things worse, practising nurses often do not receive refresher courses to enhance their skills. For example, the Ghana Health Service reported that no primary health mental health professionals received refresher training in mental health in 2011 (World Health Organization, 2011). Furthermore, opportunities for postgraduate training for mental health professionals is very few. These imply that majority of

nurses may be practising without adequate knowledge on modern trends in mental health care. This lack of training may influence their services and ability to address health literacy issues among mentally ill patients and family.

2.8 Health Literacy and Mental Health Nursing

Mental health nurses are interdisciplinary treatment-team members and are well positioned to deliver a wide range of recovery-oriented services. Mental health nurses play a crucial role in patient education. It is therefore imperative to prepare nurses to be well equipped to face and address the challenges of low health literacy within clinical settings. However, several studies have reported that, nurses including other health professionals are unaware about health literacy issues among their patients (Matzke, 2007; Redden, 2017; I. Rootman & D. Gordon-El-Bihbety, 2008). A survey of nearly 700 healthcare professionals and policy makers reported that 30% of health professionals were unaware of the term health literacy (I. Rootman & D. Gordon-El-Bihbety, 2008). Similarly, a study to evaluate nurses' interpretation of health literacy reported that majority of nurses were unfamiliar with the term health literacy, had limited knowledge on health literacy and were unaware of available health literacy assessment tools (Matzke, 2007). Without adequate awareness and understanding about health literacy, nurses will not be cognizant of the direct impact that they have a patient's level of health literacy during each patient encounter (Speros, 2011).

Various studies acknowledge the importance of including effective health literacy strategies and assessment skills in mental health nursing as low health literacy has a great impact on effectiveness of current nursing practice (Knight, 2011; Lincoln et al., 2008). However, studies show that the majority of nurses have limited knowledge about health literacy and will benefit from educational training on health literacy to improve their skills as the systematic review demonstrated earlier in the chapter (Cafiero, 2012; Knight, 2011; Redden, 2017).

It has however been reported that mental health professionals including mental health nurses have the same negative attitudes towards mentally-ill patients as the public do (Nordt, Rössler, & Lauber, 2006). With these stereotypes against mentally-ill patients, it poses an aggravated challenge for the mentally-ill patient to seek health information or clarification from mental health nurses (Nordt et al., 2006). This in-turn affects their nurse-patient communication and relationships. Mental health nurses therefore have to change their personal beliefs and attitudes and be culturally sensitive to patients' beliefs before informing or educating patients about their conditions (Edwards, 2014). This is because patients can sense such insensitivities in health personnel. For instance, a study conducted in Canada reported that the majority of participants reported unwillingness to seek help for mental ill-health issues and reported that fear of denial, or fear of being judged by mental health professionals, deter them from seeking help (Bourget & Chenier, 2007). Such attitudes of mental health professionals coupled with mentally-ill patients' fear of being criticized or discriminated against deter them from asking questions or clarification from health professionals. This further impairs their ability to understand health information leading to adverse health outcomes (Knight, 2011). Because of this, many studies advocate for nurses including mental health nurses to be empathetic and apply patient-centred care in dealing with patients with low health literacy (Cornett, 2009; Parnell, 2014a).

Low health literacy of mentally-ill patients is very debilitating, but the lack of adequate health literacy skills of mental health nurses makes the problem even worse. Several studies have concluded that health literacy education and training should be incorporated into the nursing curriculum and nursing practice (General, Prevention, & Promotion, 2006; Koh & Rudd, 2015; Parnell, 2014a). In view of these observations, mental health nurses should also target patient education with standard psychiatric evaluation procedures, paying attention to the cultural appropriateness of information that avoids the use of psychiatric terms and is written or spoken in plain and simple language. This needs to be done so that instructions and treatments may be given to patients in a manner that is comprehensible to all patients regardless of their health literacy levels (Clausen et al., 2016; Edwards, 2014). Studies show that with increased formal assessment of health literacy, patients should receive written information appropriate to their reading level or, if needed, should be able to obtain additional help from mental health nurses.

2.9 Summary of Chapter 2

Evidence supports the contention that low health literacy is an epidemic that needs to be addressed by health professionals including nurses due to its profound impact on the health care system and patient outcomes. It was identified that to date, there is a lack of consensus about the definition of health literacy. However, in addition to various definitions and the accompanying measures to deal with health literacy issues, only some of the definitions have been extended to incorporate the interaction with individuals, the health literacy skills of professionals and the norms, policies and practices within the health system/ institutions and the society in general. Researchers should consider a definition that emphatically incorporates the role and health literacy skills of nurses and health institutions to effectively improve access and understanding of health information materials and empowerment of the individuals to be active participants in their health (Rudd, 2015). Nonetheless, since this study is focused on addressing mental health nurses understanding of health literacy in clinical section.

CHAPTER 3
METHODOLOGY

3.1 Introduction

This chapter describes the study design that was used to explore the understanding that MHNs have of the health literacy of their patients, with special reference to language and culture. The description includes the selection of informants, sampling strategy; and the setting in which the study was conducted. Other sections include the data collection instruments and procedures, data analysis and ethical considerations.

3.2 Study design

This study employed a qualitative descriptive research design for the following three reasons: First, little is known about MHNs' understanding of health literacy and how they deal with health literacy issues among their patients and their relatives. Second, existing studies have not specifically linked health literacy and cultural elements in clinical nursing practice. More specifically, this study explores how MHNs' characteristics and their understanding of health literacy is linked to cultural elements in Ghana. Third, to improve mental health nurse-patient communication in culturally diverse healthcare settings, an empathetic understanding of MHNs' voice is essential for developing complex and contextually-specific research-based interventions.

This qualitative descriptive study is grounded in the principles of naturalistic inquiry and was chosen to follow the post-positivist paradigm (Henderson, 2011; Ryan, 2006). This choice was based on a preference for staying close to the data and to provide a rich description of mental health nurses' understanding of health literacy and that of their patients (Colorafi & Evans, 2016; Polit & Beck, 2008). Moreover, a qualitative research design provides deeper insight into how people (in this instance, mental health nurses) make sense of their daily experience in a way that cannot be fully addressed by quantitative research methods. Quantitative methods (i.e., positivism) tend to provide predetermined questions and limit respondents to elaborate sufficiently on the phenomena of interest (Leedy, 2013). In this regard, a quantitative design

was deemed inappropriate because I wanted to collect rich and in-depth narrative experiences rather than measure the numerical index of health literacy knowledge and experiences of the nurses (Leedy, 2013). Post-positivism appraises the experiences of informants as experts with regard to their opinions and perspectives on a subject matter (Tracy, 2012). Moreover, since qualitative methods are not as precise as quantitative research techniques, the construct of the research questions relied, in part, on the researcher's personal experience and skills as a mental health nurse in Ghana to construct a vital qualitative interview guide (Shank, 2006). More detail of the post-positivist paradigm will follow in section 3.2.1.

Qualitative descriptive design focuses on descriptive validity, whereby diverse investigators agree on the accuracy of an event being fully described in everyday language. As such, there was no attempt to manipulate or interfere with the normal unfolding of events. This design also allowed for alteration of the conceptual framework in the process of the study when deemed necessary (Colorafi & Evans, 2016). The design was appropriate because the study was geared at assessing the retrospective and current situation of health literacy understanding of particular health personnel (i.e. mental health nurses). The approach is also adequate to ascertain and analyse the cultural and linguistic factors that influence knowledge and practice of health literacy in clinical settings.

3.2.1 Post-Positivism Paradigm

According to Lincoln and Guba (1985), a paradigm is a set of beliefs that deals with ultimate principles and represents the worldview from a viewer's perspective. The study adopted a post-positivism paradigm to underpin this study due to its ability to emphasise meanings and support social concerns (Henderson, 2011; Ryan, 2006). Samdahl (1999) described post-positivism as research that uses qualitative data with the belief in the significance of subjective reality but does not abandon tenets of conventional positivism. Postpositivist research is of the notion that research is broad and not limited to theory or practice alone but rather the incorporation of theory and practice (Ryan, 2006). This study focused extensively on the practical aspects of

concepts such as health literacy and culture by relying on the clinical experiences of the nurses (i.e. the informants in this study).

3.3 Data Collection and Processing

In this section issues concerning the sampling techniques, sample, data collection procedures and a pilot study are discussed.

3.3.1 Study Settings

Ghana is a middle-income nation located in Sub-Sahara West Africa's Gulf of Guinea and sharing borders with Togo to the East and Cote D'Ivoire to the west and Burkina Faso to the North (Adjorlolo et al., 2016; Fournier, 2011). Ghana is a heterogeneous society with more than 46 different ethnic groups and between 50 and 100 languages and dialects spoken by the various ethnic groups (Adjorlolo et al., 2016). English is the official language in Ghanaian and universally used in all levels of the educational system (Roberts et al., 2014). Estimated literacy rate as of 2010 in Ghana was 71% (Arthur-Mensah & Alagaraja, 2018).

Mental Health Nurses who participated in this study worked in two out of the three government teaching psychiatric hospitals in Ghana (Ofori-Atta, Read, & Lund, 2010). To ensure anonymity the two chosen hospitals will be referred to as Hospitals A & B. These hospitals employ most of the mental health nurses and provide mental health nursing training to students since they are the only two teaching psychiatric facilities in Ghana. MHNs constitute the majority of the human resources working in the only three government psychiatric hospitals in Ghana (Roberts et al., 2014). Among the present staff strength, there are only 18 psychiatrists, 31 medical doctors (not specialised in psychiatry), 19 psychologists, 21 social workers, 4 occupational therapists and 546 other mental health workers (medical assistants, auxiliary staffs, health assistance, professional and paraprofessional psychosocial counsellors) (Roberts et al., 2014). The number of mental health professionals is inadequate and place heavy reliance on mental health nurses for most direct service provision (Jack, Canavan, Ofori-Atta, Taylor, & Bradley, 2013; Roberts et al., 2014). The total number of nurses in Ghana per 100,000

population is 5.19 with 0.48 mental health nurses per bed in mental health hospitals (Agyapong, Osei, Farren, & McAuliffe, 2015; Roberts et al., 2014).

There are an estimated 2.4 million Ghanaians with mental health problems. Of them only 2.8% received treatment in 2011(Roberts et al., 2014). Both psychiatric hospitals (namely, Hospital A and hospital B) are clustered in the coastal areas (Agyapong et al., 2015). These two hospitals are the most accessible to the public and therefore receive the most significant number of patients from all parts of the country including the neighbouring countries in West Africa (Ofori-Atta et al., 2010). The bed capacity in the three government hospitals ranges from 250 to 800. However, all the hospitals are overcrowded as patients have been found to sometimes sleep on the floor due to insufficient beds and wards (Jack et al., 2013; Roberts et al., 2014).

3.3.2 Sampling method

Purposive sampling was used in selecting informants. Purposive sampling entails recruitment of the informants who fit the parameters of the study objectives and research questions regarding their qualification, understanding and experiences (Bryman, 2015; Tracy, 2012). Purposive sampling may take the form of maximum variation approach by which a researcher handpicks a sample of informants based on specific characteristics the informant possesses (Bryman, 2015; Creswell, 2011; Oppong, Kretchy, Imbeah, & Afrane, 2016; Tracy, 2012). This approach is useful for situations where the need to reach a targeted sample quickly and the need for sampling proportionality is not a concern (Creswell, 2014; Tracy, 2012). I chose a purposive sampling technique to intentionally select registered MHNs who have experience in nursing and assessment of mentally ill patients. The informants were purposively selected to ensure maximum variation in the sample regarding their nursing ranks, the years of experience, gender and the speciality unit. These speciality units included Out Patient Department (OPD), chronic ward, geriatric wards, female/male general wards, children ward, psychological unit and rehabilitation unit where nurses work in the hospital. The selection criteria for recruiting nurses for the study comprised of two inclusion criteria: 1) Only registered mental health nurses (RMHN) with at least two years working experience in mental health nursing were considered; and 2) Permanent staff from the two psychiatric hospitals.

Thus, exclusion criteria were: 1) mental health nurses without any clinical experience; 2) part-time or temporary status in the two institutions (including those who were not attached to a particular service unit).

Consistent with purposive sampling, key informants, such as nurse managers/administrators with upper-level managerial experience were also thought of as useful and having in-depth mental health nursing experience. As such, they were also purposively recruited to add their rich experience on culture and health issues affecting mentally ill patients and nursing care. It was believed that their managerial roles in the health sector were likely to provide them with unique perspectives. The criteria for inclusion were only registered mental health nursing managers with at least 2 years' experience working in the mental health nursing administration; and permanent staff from the two hospitals. Thus, exclusion criteria were: 1) mental health nurses who were not nurse managers, 2) mental health nurse managers who were rotating at the nursing administration at the time of data collection.

3.3.3 Sample size

According to Morse (2000), the quality of the data is linked with the number of samples selected in a study and the research method used. Morse (2000) further elaborated that, to obtain the richness of data required for qualitative analysis using semi-structured interviews, one needs at least 30 to 60 samples of informants. Therefore, I planned to recruit 40 to 50 informants for the study. This was to assist produce a rich description of informants experience and that of their opinion of Ghanaian cultural beliefs regarding mental illness.

There is no consensus about the adequacy of sample size in qualitative studies; instead qualitative researchers propose that sample size should guided by the nature of the topic, the quality of the data, the study design, or by the concept of "saturation" and what Morse (2000) described as "shadowed data" (Mason, 2010; Oppong, 2013; Sandelowski & Barroso, 2007). An important issue associated with sample size in qualitative research involves assessing whether a sample is too small or too large to support claims of having achieved either informational redundancy or theoretical saturation (Bryman, 2015; Lincoln & Guba, 1985;

Sandelowski & Barroso, 2007). However, Sandelowski (1995) simplified this confusion by stating that adequate sample size is ultimately dependent on an experienced qualitative ressearcher's judgement in evaluating the quality of data/information collected and how thoroughly it addresses the research problem (Sandelowski, 1995). As such, qualitative researchers are encouraged to produce what Geertz (1973) described as "thick description" which implies a rich account of the details of a culture.

However, the exact number of informants to be included was also based on the relationship between the sample size and data saturation with strategies specific to the purpose of gathering rich and thick data to reduce the risk of data redundancy. Sample size estimation of this study was based on the principle of data saturation. In this study, data saturation was reached when I realised that there was enough information to replicate the study and the ability to obtain additional new information had been attained; moreover further coding was no longer feasible (Fusch & Ness, 2015; Guest, Bunce, & Johnson, 2006; O'reilly & Parker, 2013). The emphasis of this study's analysis was to produce rich and thick data (quantity) descriptions of the experiences of the informants.

3.3.4 Recruitment of Sample

The in-service coordinators of the hospitals provided me with an approval letter which authorised me to conduct the research and also served as letter of introduction. The approval letter from the hospital administration, the study's information and informed consent papers were shown to the ward/department managers at each unit. Ward-in-charges (a nurse who is in charge of a ward) were approached in their respective wards/departments, and permission sought to recruit their nurses as potential informants. The ward managers later introduced me to the potential informants before recruitment. This approach was to encourage dialogue and trust between me and the potential informants in order to facilitate a relaxed environment for sharing ideas during the interview sessions. Informants were recruited with the help of a research assistant and in-service coordinators (one each) in the two hospitals.

3.4 Data Collection Methods

The data collection took place from October to December 2017. Focus group discussion (FDG) and individual in-depth interviews with experienced nurses were the primary data collection method (Bryman, 2008a). Primary data collection is self-constructed data that has been put together through a researcher's own endeavours and have not been subjected to any kind of manipulation (Amoah, 2013; Bryman, 2015). The FDG and in-depth individual interviews were complementarily used during the fieldwork. Each method was used to gather data from two different groups of MHNs. Thus, the FGD was used to gather data from MHNs in the various departments whilst in-depth interviews were conducted with nurse mangers/administrators. MHNs working in the various departments in these two hospitals outnumbered nurse administrators and as such it was difficult to interview the latter as part of an FGD. In addition, due to the busy schedule and time-constraints of nurse administrators, it was deemed more appropriate and practical to have an individual in-depth interview with each of them instead of an FGD. However, using these two approaches complemented each other. The in-depth individual interviews were conducted with nurse managers individually to confirm information gathered from MHNs in the focus group sessions. MHNs' self-reported experience, practice and knowledge of their patients' health literacy formed the basis of discussion. All the FGDs and the in-depth individual interviews were with key-informants and took place on the premises of the two hospitals. The FDGs took place in the two of the hospitals' conference rooms, while the individual interviews with nurse managers took place in their offices. The FGD sessions lasted approximately an hour and a half while the in-depth interviews lasted for 50 minutes each.

3.4.1 The interview Guide

A semi-structured interview guide (see Appendix I) was used to interview the informants. The interview guide was developed from a comprehensive review of the literature on health literacy (Ingram, 2012; Matzke, 2007; Redden, 2017). This is to aid the researcher to gain more information on the research questions by not restricting the response of the respondents unnecessarily with regard to the issue that is being discussed. The questions chosen for the purpose of this research centred on the knowledge of the key informants with respect to health

literacy, health literacy practices in their hospitals and measures put in place to address issues of low health literacy and culture. These questions were chosen to enable the researcher to gather more information about the research questions without restricting the respondents unnecessarily regarding the issue at hand. Also, the use of the semi-structured interview guide was to enable informants to express themselves freely within the confines of the research problem (Bryman, 2008a). The interview guide explored various aspects of the informants' experiences regarding the research objectives. Some of the interview questions were:

1. What do you understand about health literacy?
2. On a typical workday, how do you assess the health literacy of patients you see?
3. How may culture and local beliefs about mental health affect your ability as a mental health nurse to assess or address health literacy?
4. Can you tell me about how low health literacy impacts the health of mentally ill patients?
5. What resources do mental health nurses need to address issues of health literacy at your workplace?

3.4.2 Pilot study

Before the actual data collection, two different pilot tests were conducted. The initial pilot test was done with students and staff of the School of Nursing of The Hong Kong Polytechnic University. Among the informants was one expert qualitative nurse researcher; two renowned nursing researchers and five PhD students. This pilot helped me to practice my interview skills and also to test the consistency, accuracy and flow of the interview guide. During the process, anomalies with the interview guide and interviewing skills were addressed. Some of the improvements included making the interview questions concise, and the need for the interviewer to probe more fully after every question to elicit more and in-depth information from informants.

The second pilot test took place in Ghana with informants who were from a similar background to that of the target group. I conducted the test with five MHNs who were on leave at the time

of data collection. This test was to identify issues about the applicability of the interview guide to the settings and in addition to check for environmental and practical interference, which might affect the quality of audiotape-recording during the interviews. The interviews took place in a meeting room of the Hospital A's nursing quarters, which is on the same premises as the hospital. The focus group lasted for one hour and forty-five minutes. The informants attested to the clarity of the questions after the session. However, they proposed a few changes to the demographic characteristics of the informants whom I will approached to participate in the main research. The demographic changes included information about the ethnicity of informants and the names of the various departments. The suggestions of informants in the pilot test was considered before the actual data collection. This pilot study helped to improve the interview guide tremendously.

3.4.3 Focus Group Discussion

Focus group discussions (FGDs) generate empathy and understanding from different people. They create awareness that goes beyond simple preconceptions and promotes understanding of the social and cultural influence of the phenomena being investigated or studied (Amoah, 2013; Moule, 2015). FGDs also help to generate new knowledge through interactive discussions. The FGD method was chosen due to its ability to produce a considerable amount of relevant data on a specific topic as well as help to identify ways in which MHNs collectively understand and construct meanings about health literacy (Bryman, 2015). This approach explored the complexities of health literacy and how it is affected by local precepts about mental illness in the eyes of MHNs. By having different categories of nurses, the FDG helped to even acknowledge how health literacy was understood and adopted by different kinds of nurses in every session.

The authorities in both hospitals helped to arrange meeting rooms for the FGDs. The majority of the MHNs signed up willingly for the FGDs in each hospital after the first contact with them, while the remaining requested a day to check their work schedules. However, there were some whom I had approached who declined to participate because of their busy schedules and because of their reticence in being involved in a group discussion with other colleagues.

Six focus groups were conducted with one moderator and a research assistant in the two hospitals. At Hospital B, each group comprised six informants, and the sessions lasted between one hour and twenty minutes and two hours. While the number of informants may be considered to be small, Bryman (2015) suggests that smaller groups for focus group discussion are sometimes better for effective moderation of the discussion. Therefore, in this study an estimated number of eight MHNs in one focus group was deemed to be appropriate. Moreover, researchers suggest that focus groups are more productive when the length of time used to elicit information is not too short (Holloway & Galvin, 2016; Maxwell, 2012; O'donoghue, 2006; Tagbor, 2011). The focus group sessions last approximately an hour and a half each.

As stated above, some informants voluntarily signed up for the study at the first contact. Because others were busy at the time, some ward managers proposed to leave a sign-up sheet, information letter and an informed consent sheet on their ward for informants to sign up during their free time. I retrieved all recruitment forms/lists from respective departments and assigned the informants into three initial groups. These groups were chosen on the basis of their nursing rank and the units/departments in which they worked. The three groups created in this way comprised of ward nurses (group 1), the out-patient department/rehabilitation unit (group 2) and the ward-in-charges (group 3). The ward-in-charges were deemed to have the highest rank and experience and were placed in the same group while the remaining informants were grouped according to their units or department. The idea was to foster an atmosphere of familiarity that would encourage the informants to discuss and share their views spontaneously and frankly.

Before each session began, informants were asked to choose a fictitious name for themselves so as to ensure their privacy and provide them with a sense of confidentiality. However, although adequate information was gathered, it was noticed that among the groups of ward nurses (comprising of male and females), cohesiveness or familiarity was lacking. Some the informants were observed to be shy and reluctant to communicate freely. I approached the individual informants after these sessions, and they suggested that a group which comprised informants of the same rank would be preferable, and they would be more comfortable talking openly with others of the same rank than with informants of various ranks.

Based on this observation, there was a deliberate change in the recruitment strategy from the use of ward settings to group allocation based on nursing rank. This composition of the groups was to ensure that the power structures in the hospitals could not intimidate informants. This change prevailed for the other interview sessions and all those at the Hospital A; informants were allocated to the staff nurses and senior staff nurses' group, nursing officers' group and the ward-in-charges group. The conference room of the hospital was used for all the interviews. All the sessions at Hospital A lasted for one to two hours. I repeated the need to adhere strictly to the principle of confidentiality with regard to all information shared during the focus group sessions.

Due to language differences (mother tongue informants), all the FGD were conducted in English and audio-recorded all interviews with the informants' permission. During the focus group discussion sessions, the emerging themes were scrutinised more fully to gain a richer understanding of the informants' views. Brief notes were taken during the sessions and included the recording of significant issues and observations made during the interviews that had led to further questioning in order to explore specific issues more deeply. This note-taking was carried out by the research assistant.

3.4.4 Key informant (In-depth) interviews

As series of key informant in-depth individual interviews were organised for nurse administrators to triangulate the findings from the group interviews, and to gather further information to enrich the data. Guest et al. (2006) carried out a systematic analysis of their data and identified that, "a sample of six interviews may be sufficient to enable development of meaningful themes and useful interpretations" (Guest et al., 2006, p. 78). The sample size for the key informant in-depth interviews were based on this recommendation (Guest et al., 2006). Therefore, the plan was to recruit six key informants for this study. I conducted the in-depth interviews after the focus group sessions. This revealed some unclear ideas from the FDGs that needed to be clarified and investigated more fully.

In-depth interviewing is a process by which a researcher conducts an intensive interview with a small number of informants to explore their knowledge or views on a particular subject/situation or phenomenon (Boyce & Neale, 2006; Bryman, 2015). The individual in-depth interviews were conducted with the nursing administrators to identify and examine their subjective views and experiences of how local perception about mental health (including culture and language) shape nurses' practices and knowledge on health literacy.

At Hospital B, nurse managers reported that, due to their busy schedules, they will not be able to participate in the study. However, one nurse manager agreed to join the ward managers in their FGD. Nursing administrators signed up at the hospital A after they were approached in their offices where they were informed about the study. The interview dates were scheduled according to the availability of the informants. The appointments made with all informants were cross-checked to avoid scheduling conflicts. All the informants filled in demographic sheets before the interview. The interviews were conducted in English and were audio-recorded with the informants' permission. Each interview took approximately 30 to 50 minutes. Conversation with the key informants centred on mental health practices with regards to health literacy and how issues of culture, language and health literacy were addressed in their hospitals.

3.4.4.1 Challenges encountered during recruitment

There were numerous challenges during the field work that are worth mentioning for the sake of replicability. The preliminary problem faced was the recruitment of informants for the study at the two hospitals. During the period of data collection, most of the MHNs were on leave and as such only a few nurses remained on the wards/units. The initial plan was to gather information from all six nurse administrators from the two hospitals, but I was able to interview only three. This was because, at Hospital B, two of the nursing administrators were on leave and the remaining two had to attend workshops during the period of data collection. However, one nurse manager later joined the ward in-charges focus group making the total number of nurse mangers four as shown in table 2. Due to the busy schedules of the hospital's nursing administrators, it was necessary to use individual interviews instead of the FDG to gather data

from the informants. The assignment of informants into the different groups based on their nursing rank proved to be helpful in fostering a free flow of opinions and in-depth discussions among the informants. The interview with the nurse managers also provided in-depth insight into how tensions arising from cultural background and health literacy could be addressed within the healthcare settings. One nurse manager joined the in-charges focus group at the Hospital B.

Even though many nurses signed-up for the discussions, some could not attend due to a shortage of nurses and time constraints within the departments. In view of this, scheduling interviews was more difficult than had been anticipated as those who signed up were on different work shifts. Finding a time that suited all the informants was problematic. Nevertheless, tactful involvement of all informants through social media (WhatsApp group) helped solve the issue because informants were able to see through this public forum which times were most likely to suit everyone else.

Apart from the difficulty encountered in finding times that suited all informants/participants, another difficulty that had to be overcome was the issue of the unfamiliarity of some of the informants with qualitative research. While some informants expressed concerns about paraticipating in discussions that were new to them, the majority of the informants were used to quantitative research. This initially discouraged some of them from joining but this problem was resolved with further information about the study and through my existing connections, who proved to be useful in assisting with the process of recruitment.

3.5 Data Analysis

As stated earlier, all the interviews were transcribed (in-depth and focus group) verbatim within 24 hours after each session ended. This was done to ensure familiarity with data when the researcher had the freshest memory of the contents of the audiotapes. This also provided an opportunity to identify gaps in data and ask unanswered questions in the next interviews. Audiotapes were listened to several times to ensure accuracy and to rule out any missing words or unclear wording. NVivo software 11 was used for data storage, organisation and to support

data analysis. NVivo managed the large amounts of data. In addition, the program helped to keep track of ideas and memos that captured a detailed description and aided in linking similar codes together. The program also helped to create a visual image of the data.

The actual analysis was carried out using a process of content analysis (Krippendorff, 2004). Content analysis is a research technique used to produce replicable and valid inferences from data to the contexts of their use (Krippendorff, 2004). An inductive content analysis approach was used for interpretation of the data. The inductive content analysis involves open coding, creating main categories and sub-categories (Krippendorff, 2004). Using inductive analysis helped to describe and quantify the information gathered by reducing the huge amount of data into fewer categories. The data analysis process was complex.

Two independent researchers read each transcript (first with the focus groups transcripts and then in-depth interview) several times to grasp the content and capture the essential features of the answers and to promote trustworthiness. A coding book was generated through the efforts of two people (I and another researcher). The coding process was guided by the research aims and objectives. The codebook was used to aid in the coding process. Table 1 below highlights the coding process and how sub-categories, categories and themes were identified from the individual and focus group transcripts.

The reason for using open coding was to capture key codes from the informants' exact wording rather than basing the codes on the researcher's assumptions or preconceived ideas/views. The codes generated from the transcripts formed the coding scheme for generating categories (Drisko & Maschi, 2015; Hsieh & Shannon, 2005). The purpose of the coding was to develop new knowledge and fully address the study's research questions (Drisko & Maschi, 2015).

A codebook structure was developed to document the progression of theme identification after each set of two focus group interviews. Newly created codes were also added to the codebook and necessary changes made to the existing ones. Attention was paid to the frequency at which new codes were added after each focus group interview and this was to document the relative rate at which thematic expression across groups changed over time. We stopped data collection

after five focus groups (two in Hospital A and three in Hospital B) were conducted in each hospital to examine the data.

In the first phase of the analysis, we started with data from the Hospital B and analysis the first focus group discussion conducted. We also checked for a code has high rate of repetition across informants based on the research questions answered. We kept adding one group after the other until we completed all three focus group transcripts. To ensure the same code was not applied in the next focus group transcripts, I created an audit trail updating record of codes generated from each set of focus group transcripts. I analysed the responses from each group and assessed whether the same question elicited a different code from a particular group discussion compared with the third group. After the first two focus groups were conducted, data from hospital A were also added. To ensure data has indeed saturated, I conducted another focus group to verify if any new thematic expressions would be generated. However, no new codes were generated and therefore the data was deemed to be saturated. Therefore, for this study, data collection ceased when I realised that no new information was forthcoming, and all interview questions have been exhaustively answered.

An effort was made to ensure that each generated code was relevant and close to informants' wording or exact words and could be modifiable (Drisko & Maschi, 2015). The use of a second person in the coding process was necessary to ensure validity of the findings and the procedure (Brod, Tesler, & Christensen, 2009; Rubin & Rubin, 2011). A comparison between the codes generated from the two independent researchers was drawn, and disagreements were resolved through discussion and re-examination of data. Both independent researchers reached consensus. I then independently reviewed the identified codes and deleted tautological codes while we grouped similar codes. The codes identified were then recorded and developed into categories with the help of the NVivo software. The preliminary categories were generated based on their similarities and differences. The coding process was repeated until saturation was reached.

After open-coding, subcategories were identified and grouped as generic categories and then consolidated into the main theme based on their underlining meaning. These groupings were necessary to ensure that all the categories were entirely separate and there was no, or little similarity, or empirical overlapping between them (Bryman, 2015; Krippendorff, 2004). Each category was named using the content characteristics. This process was continued until all the relevant information had been well categorised. A detailed description of how categories were condensed into sub-categories and then main themes is shown in Table 1 below. Lastly, to ensure the validity of the data analysis process, the themes and the categories created were subjected to a review by an independent scholar (who is an expert in qualitative research) to ensure the validity of the analysis.

3.6. Researcher's positioning for Reflexivity as part of Rigour

A researchers' awareness of his or her status (whether as an outsider or an insider) to the people he or she is researching enables him/her to understand his/her informants' experience as authentically as possible. Positioning oneself either as an insider or outsider is a strategy that a researcher has to employ to be able to conceptualise research observations and interpretation of findings objectively (Amoah, 2013; Cloke et al., 2004; Tinker & Armstrong, 2008). A researcher can share similarities and differences with his or her informants in various ways: age, ethnicity, religious beliefs, gender, social status/class, personality and sexuality (Cloke et al., 2004; Tinker & Armstrong, 2008). Several qualitative experts have argued that a researcher's position, either as an insider or outsider, can influence interpretation of findings. "Outsider" researchers are usually criticised for their failure to understand or accurately represent informants' experiences while insiders are viewed as overlooking the significant differences within as well as between groups due to their familiarity with the group (Tinker & Armstrong, 2008). During the data collection, a memo was developed which became part of the data analysis. It included reflective notes and insights about what was learnt from the data. Thus, new data was collected and simultaneously added to the initial analysis during the field study through reflexive-note taking to buid up a comprehensive record of the interviews .

It is therefore imperative for a researcher to set aside any prejudgement, values, and beliefs before conducting interviews with research informants. For this reason, I therefore reflected on my own knowledge and experiences to be able to position myself in an impartial position during the entire study. I had practised as a registered mental health nurse in the Hospital A for six years prior to undertaking this study. Therefore, I have had the opportunity to care for culturally, linguistically and economically diverse patients within the mental health institution. I have encountered an infinite number of patients who I believed had low health literacy. At the time I had not received any education or training to equip me to address issues of low health literacy.

Against this background, it was vital that I considered the effects that my personal views and life experiences could have on the response and behaviour of my informants, and how I understood their experiences. While I was primarily a researcher, I positioned myself as both an insider and an outsider through the research process. Hence, I do agree with Tinker and Armstrong (2008, p. 54) that "researchers are always both insiders and outsiders in every research settings, and are likely to oscillate between these positions as they move in and out of similarities and differences". Drawing from this, being an insider made me part of the social group (mental health nurse), and this helped me to completely and accurately understand the informants' experiences during the data collection phase. I shared some similarities with the informants' characteristics regarding the nursing profession. However, I also shared some differences with informants regarding ethnicity, language, age, gender, religious beliefs and knowledge about health literacy. On the one hand, positioning myself as an insider helped me to be able to relate easily to the informants during the recruitment stage. It also made it easy for informants to be more open in sharing their ideas, experiences and challenges with me as I was able to gain their trust with little effort.

Table 1: Coding Process

Subcategories	**Categories**	**Themes**
➢ People belief mental illness is caused by spirits ➢ People belief mental illness is caused by witchcrafts and curses ➢ The belief that mental illness is a punishement for wrong doings/sins from the gods ➢ Highly educated also believe spirits cause mental illness	Mental illness has a spiritual cause	The experience and practice of MHN is shaped by local cultural beliefs
➢ Herbal/spiritual centers are always the first source of mental healthcare ➢ People belief traditional herbalist and spiritual doctors cure mental illness faster than mental health hospitals	Ghanaians prefer herbal/spiritual treatment instead of standard care.	
➢ People stigmatised against mentally ill patients ➢ Family members always abandon mentally ill relatives due to fear of societal stigma ➢ People don't want to associate with the mentally ill patients ➢ Other nurses even refuse to take care of mentally ill patients in general hospitals ➢ Other nurses stigmatise against MHNs	Ghanaians stigmatise and have negative attitude towards mentally ill patients	
➢ MHNs beliefs concerning mental illness ➢ MHNs perception of mental health patients as a whole	Some MHNs shared in the local cultural beliefs towards mental disorders	
➢ The impact of culture on mental health nursing practice	Local cultural beliefs influence nursing practice	

➢ HL is patients knowledge and skills concerning their health. ➢ HL is MHNs' skills and responsibility regarding patients' health ➢ HL is nurse-patient communication ➢ Patient HL as dependent on MHNs HL ➢ Only MHNs can possess adequate HL	MHNs have different understanding of health literacy	MHNs interpretation of health literacy has an impact on nursing practice
➢ No assessment of patients HL ➢ HL assessed based on patients' cultural beliefs ➢ MSE used as measure of patients HL level ➢ HL assessment is based on nurses' assumptions ➢ Patient characteristics used as a measure of their HL level	Lack of Institutional requirement to assess patients' HL	
➢ Use of patients' beliefs to educate patients about mental illness ➢ Key identifiers of patients understanding ➢ Use of sign language , plain language, geatures and drawing to communicate with patients	Routine strategies adopted by MHNs in dealing with patients' low health literacy.	
➢ MHNs must possess cultural competency skills ➢ Cultural competence should be part of nursing curriculum	MHNs need cultural competency skills to break down cultural myths & practice	The practice of health literacy has to be negotiated within a cultural context
➢ Nurses need to involve community leaders in mental health education to address low HL Language difference between patients and nurses is a barrier to effective nurse-patient communication ➢ Diverse societal expectation impinged on nursing care ➢ Patriarchal cultures in Ghana influence who a patient listens to. ➢ Certain cultural taboos makes it difficult to talk about certain issues in patient education. ➢ Multiple social issues like poverty is an influence on patients' health seeking behaviour	Language and certain social issues act as impediment to nursing practice and the need to involve of community leaders in health education	

➢ Lack of health materials to use in patient teaching ➢ Lack of priority for health literacy issues in the mental health settings ➢ Lack of ample time for patient teaching or health literacy assessment ➢ Geographical location and number of mental health facilities in Ghana ➢ MHNs need to possess adequate health literacy skills ➢ Need to address HL of both nurses and patients	The institutional practice towards patient education and the need for MHNs to receive health literacy training	
➢ Integration of satndard care and spiritual care	MHNs strategy to integrate standard care with alternative treatment in the care of mentally ill patients	

On the other hand, by remaining calm during the interview sessions and data analysis process, I was conscious of my role as a researcher. I made sure not to allow any personal bias or knowledge to interfere with the data collection and analysis. My insider position was only used during the preliminary stages of the fieldwork and did not inform my interviewing skills and judgement of informants' views or responses. Thus, I positioned myself as an outsider during the data collection and analysis phase by making sure that I did away with prejudicial opinions, considered myself to be a blank slate concerning issues surrounding health literacy within the setting. I, therefore, tried as much as possible to minimised informants fear of being judged and asked questions in a manner that portrayed my role as a researcher. This was done using an audit trail with an expert in qualitative research who helped to review the research procedure and the interview guide. I also tried to make informants adopt the position of experts by encouraging them to tell me about their own experiences and practices with patients with low health literacy.

I tried to be reflexive throughout the process. Reflectivity is the process of self-critical introspection of oneself as a researcher (Bryman, 2015). Reflectivity during data collection induces self-discovery and allows a researcher to gain new ideas concerning the research questions. By interacting with informants within the group I evaluated continuously through self-reflection and the use of my research assistant as my chief critic. This helped me to improve on subsequent interactions in the next focus group sessions. Although I shared a similar professional background and other characteristics with some informants, I made efforts to ensure that I was critically reflective of my role as a knowledge seeker within these two hospitals.

3.7 Rigour/ Trustworthiness of Study

Lincoln and Guba (1985) have proposed ways to establish rigour and trustworthiness in qualitative study and includes credibility, dependability, confirmability, and transferability. In the next sub-secitons, these approaches are elaborated in terms of how they were adopted for this study

3.7.1 Credibility

Credibility refers to the accuracy of the researcher's account of the interview and the description of the participants' experiences gathered during data collection (Koch, 2006). Efforts were made to ensure that the interpretation of the phenomena represented those of the informants and not of the researcher in order for the data to be saturated (Holloway & Galvin, 2016). I achieved this by providing informants with a preliminary account of findings after the interviews and this is refered to as respondent validation. Informants confirmed that the preliminary findings represented their views. This was done to ensure that findings generated from the interview corresponded with the experinece and perspective of the informants (Bryman, 2008). Also, the study design, method, as well as research question, were based on a systematic review of literature on health literacy as well as expert reviews. The interview guide was carefully designed, and pilot-tested twice to suit the settings of informants. I also conducted the group discussions in such a way that I was able to reduce ambiguity or misinterpretation by constantly asking informants to clarify their views. To establish the credibility of the process of analysis, two independent coders read each transcript (first with the focus groups transcripts and then in-depth interview) several times to grasp the content and capture the essential features of the answers and to promote trustworthiness.

Moreover, it is argued that a researcher's self-awareness (reflexivity) is essential in their bid to ensure credibility and could be achieved through the recording of fieldwork experience in a journal (Guba & Lincoln, 1989; Koch, 2006). In this study, I kept a record of all observations and information gathered throughout the fieldwork in a field notebook to supplement tape recordings. I paid attention to informants' mannerisms, which included body language and tone of message delivery. These helped to gain a deeper understanding of the informants' experiences as they described them to me. Furthermore, the research procedure was enriched by triangulating different data gathering methods (in-depth interviews and focus groups) and maximum variation of informant sources (use of various ranks of MHNs, interviews with MHNs, ward managers and nursing administrative staffs). This strengthened the credibility and provided comprehensive information of each MHN's perspective of the influence of culture on patients health literacy and nursing care.

3.7.2 Dependability

Dependability refers to the minimisation of idiosyncrasies in interpretation. This means that the interpretation gathered from informants should be consistent and theoretically inclusive across all informants, and thus not contradictory (Amoah, 2013; Koch, 2006). An experienced nurse educator and a qualitative researcher were consulted to examine the methodology and interpretation of findings for coherence. In this process, the researcher and the team were able to explicitly reflect on theoretical, methodological and analytic decisions made throughout the study. More specifically, the external audit enhanced confirmation of the team's rationale and dependability of their analytical decisions.

3.7.3 Confirmability

Confirmability is the extent to which findings derived from a study were derived by consensus of the research team's interpretation and reflect participants' ideas and experiences rather than the researchers' perspectives (Gatrell & Elliott, 2014; Polit-O'Hara & Beck, 2006). As analytical patterns developed, they were explored during data collection for whether they "rang true" with other informants, including key informants. More specifically, this triangulation of data supported confirmation of the interpretations in that three nurse managers and five other informants provided feedback to ensure confirmability of interpretations.

3.7.4 Transferability

Transferability or applicability is the appropriateness of the research findings to the actual (outside/naturalistic) study area (Amoah, 2013; Guba & Lincoln, 1989; Koch, 2006). Even though this was the first study to examine MHNs' understanding of the concept of health literacy and the impact of cultural perceptions on patients' health literacy and nursing care in Ghana, the informants showed characteristics which represent findings from studies conducted in the United States (Matzke, 2007; Redden, 2017; Toronto & Weatherford, 2016) and Canada (Malloy-Weir et al., 2016). In other words, how the findings 'fit' in the context of the broader understanding of health literacy and culture will be discussed. In addition, raw data quotes that exemplify the interpretation of the researchers will be presented in the findings chapter for readers to assess transferability.

3.8 Ethical Considerations: Protection of Human Subjects

Ethical approval was sought from the Hong Kong Polytechnic University (Reference Number: HSEARS20171011006). I also requested the permission and consent of the two hospitals' directors to conduct a study in their facilities. An approval letter was given by the university (Appendix VII) and a confirmatory letter from the two hospitals (Appendix VI). I also sought informants' consent before recruiting them into different focus group sessions and in-depth interviews. An informed consent form and the introductory letter were given to eligible informants before embarking on any form of interview. Emphasis was placed on voluntary participation and the fact that each informant could withdraw from the interviews whenever he or she felt uncomfortable without having to give a reason. Effort was also made to ensure informants felt comfortable in all circumstances by requesting their permission to audio-record interview sessions.

They were assured that any information shared would be treated with absolute confidentiality; that the results would be used for academic purposes only; and that the audiotapes would be kept in a locked locker at the primary researcher's office and would be destroyed after the research was complete. A sample of the Information Sheet and Consent Form is attached in Appendix III & IV respectively.

3.9 Summary of Chapter 3

This chapter sought to give a detailed description of the study design, setting, sample and sampling techniques, data collection and analysis procedure of this study. Positioning of the researcher in the analysis as part of the rigor was described. Ethical considerations in the process of data collection and data analysis/interpretation were highlighted. The next chapter presents the findings of the study.

CHAPTER 4
FINDINGS

4.0 Introduction

This chapter presents the findings of the study. As stated in the introduction to the study, the aim was to explore mental health nurses' (MHNs') knowledge and practical experience of, as well as challenges to, the health literacy of patients in their clinical settings. Therefore, as stated previously, the research question that the study addressed was: What do Ghanaian MHNs know about patients' health literacy and how does culture and local perception about mental health affect their capacity to communicate with patients with inadequate health literacy? An in-depth understanding of culture and health literacy and how they impact health and disease are important for health professionals including nurses to enable them to meet the individualized needs of mentally ill patients and to provide culturally sensitive care.

The analysis of the findings concerns the MHNs' knowledge of health literacy as a concept and their understanding of patient's health literacy from their lived experiences. In line with the objectives of the study, the chapter subsequently focuses on how local precepts about mental health (including culture and language) shape the nurses' practices and knowledge of health literacy in the context of nurse-patient interactions. At the outset, the chapter begins with a presentation of the informants' demographic characteristics, and the presentation of findings which have been discussed under three main themes. The verbatim quotes of informants were used to illustrate how categories emerged from the data and further developed into themes requiring verification for the purpose of establishing reliability and trustworthiness. The themes that emerged from the data addressed issues of culture, language, health literacy and traditional/herbal and alternative mental healthcare. The final part of the chapter presents a description of a conceptual framework which was developed from the study's findings and a summary of all the findings.

4.1 Demographic Characteristics of Participants

A total of 43 informants were interviewed in six focus groups. Of these 43 informants, 30 were female and 13 were male. However, for practical reasons during the field study, an average of seven informants was included in each focus group interview. Forty informants were interviewed. The remaining three informants were interviewed individually. Of the six groups,

Group one consisted of four males and two females; Groups two and three each consisted of three males and three females each; Groups four consisted of six females and one male; Group five consisted of three males and five females while Group six comprised of only females (refer to Table 3). Table 2 summarised the characteristics of the study's informants. Moreover, an additional three individual interviews were carried out with nurse managers/administrators. Thus, a total of 43 nurses of various ranks and qualifications were interviewed.

Informants' education ranged from diploma to advanced nursing degree level. Participants worked in various departments ranging from the out-patient department to nursing administration. There was also considerable diversity of ethnicity amongst informants, who were from six different ethnic groups (Akan, Ga, Dagomba, Guan, Dagaati, and Ewe). The ethnic composition of informants was consistent with Ghana's ethnic distribution where Akans dominate as the largest ethnic group (La Ferrara & Milazzo, 2017; Opare-Henaku & Utsey, 2017).

Table 2: Characteristics of Informants in the Study

Demographic Characteristics		Frequency	Percentage
Location	Hospital A	25	58.1
	Hospital B	18	41.9
Gender	Male	13	30.2
	Female	30	69.8
Age	20-30 years	12	27.9
	31-40 years	26	60.5
	41-50 years	5	11.6
Ethnicity	Akan	23	53.5
	Ewe	7	16.3
	Ga	7	16.3
	Dagomba	1	2.3
	Guan	2	4.7
	Dagaati	3	7.0
Departments	Out-patient department	6	14.0
	Female ward	19	44.2
	Male ward	9	20.9
	Rehabilitation Unit	5	11.6
	Nursing Administration	4	9.3
Level of Nursing education	Diploma	28	65.1
	Bachelor's in nursing	13	30.2

	Advanced (masters+) degree	2	4.7
Years of Nursing Experience	2-10 years	11	25.6
	11-20 years	22	51.2
	21-30 years	7	16.3
	30 and above	3	7.0
Nursing Rank	Staff Nurse	1	2.3
	Senior Staff Nurse	16	37.2
	Nursing Officer	17	39.5
	Senior Nursing Officer	4	9.3
	Principal Nursing Officer	1	2.3
	Nurse Manager	4	9.3
Total number of participants		**43**	100

Table 3: Characteristics of Focus Group Session and Individual Interviews

Interviews		Number of Informants	Gender	
			Male	Female
Focus Group Discussion Sessions	Focus Group 1	6	1	5
	Focus Group 2	6	3	3
	Focus Group 3	6	4	2
	Focus Group 4	7	1	6
	Focus Group 5	8	3	5
	Focus Group 6	7	-	7
Individual Interviews		3	1	2

4.2 Findings from the Study

Three main themes were identified from the data and this has been illustrated in figure 3 below.

1. The experience and practice of MHNs is shaped by local cultural beliefs.
2. MHNs interpretation of health literacy has an impact on nursing practice.
3. The practice of health literacy has to be negotiated within a cultural context.

4.2.1 The experience and practice of MHNs is shaped by local cultural beliefs

Informants had in-depth knowledge of the cultural beliefs, norms and practices about mental health and illness among their patient population. Informants across all six focus groups reported various instances in which cultural beliefs among their patients and even the nurses themselves influenced health-related knowledge and practices. These observations are shown in the following subthemes:

1. Mental illness has spiritual causes.
2. Ghanaians prefer herbal/spiritual treatment instead of standard care.
3. Ghanaians stigmatise and have negative attitudes towards mentally ill patients.
4. Some MHNs share in local cultural beliefs towards mental disorders.
5. Patients' characteristics has an influence on nursing care.
6. Local cultural beliefs influence nursing practice

4.2.1.1 Mental illness has a spiritual cause

Informants mentioned that most of their patients, and the society in general, held 'magico-religious beliefs' about mental illness. In general, mild mental health conditions such as depression were attributed to weak personalities, while critical mental conditions were attributed to witchcraft and curses.

> *Even with depression, people think it is only people who are weak that suffers from it, and as an African or Ghanaian depression is not in our culture and only white people suffer from it. … Can you believe that?* (Nana Akua, female, nursing officer).

> *Mostly they believe* [that mental illness] *is a curse, sin or wrongdoing against a god by their ancestors, family or themselves for which they are being punished. … A wrong deed against someone is believed to result in mental illness* (Eric Frimpong, male, Senior Staff Nurse).

> *Mental health is mostly associated with spirituality. … I can say that about eight out of every ten patients admitted have been to churches or prayer camps before coming to the hospital for treatment. Anytime someone exhibits behaviour far from normal, the first place of contact is the church or mosque, depending on the religious affiliation, to seek spiritual guidance. … The hospital is the last resort when they don't get results* (Nana Akua, female, Senior Staff Nurse).

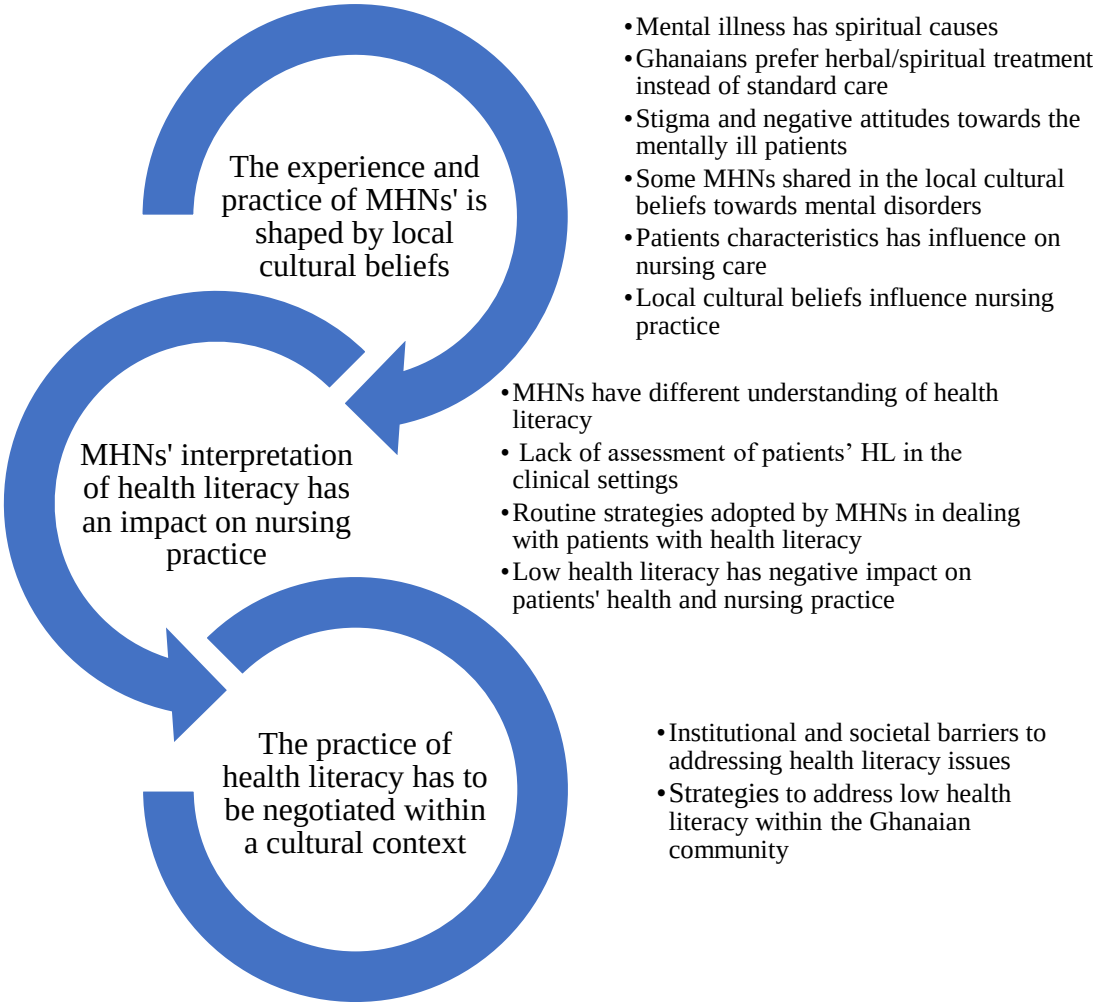

Figure 3: Summary of Themes and Sub-Categories Identified from the Data

According to some informants, the knowledge that patients and family members have about mental health and illness is what Ghanaian cultural beliefs portray it to be. A biomedical concept of mental disorders was unknown to patients. Some informants noted that:

> *To me, Ghanaian cultural beliefs are the cause of the low knowledge levels about mental health in Ghana. …Until we can change this belief system, it will be difficult to address issues of poor attitudes and knowledge about mental* health (Dako, male Senior Staff Nurse).

> *Most of our patients and their relatives don't know about mental health, and their knowledge of mental health is centred on what culture depicts it to be. … To me, almost all of our patients' population and their relatives have little knowledge of mental health* (Adwoa, female. Senior Staff Nurse).

To explain how substantial the influence of local culture and practices is on mental health issues, some of the informants maintained that gradual cultural transition has made people informed about their health and attitudes towards mental illness. From informants' perspectives, people are now becoming better informed about mental health conditions and noted that:

> *Averagely they do have enough knowledge. … Gone are the days when people did not have access to information about mental health, and so the way people treat mentally ill patients when they have challenges was not the best. … Now things are changing. We see things in a different way and relatives now understand and are becoming more caring towards patients* (Del, male, Nurse Manager).

4.2.1.2 Ghanaians prefer herbal/spiritual treatment instead of standard care

Informants reported that in accordance with their patients' cultural beliefs, mental health care is mostly sought from herbal or traditional healers, and psychiatric hospitals are mostly the last resort.

> *They always say that it is an evil spirit that is causing their mental condition … that is always what they say. So most of the time when they are mentally ill, they take them to the prayer camps, and they chain them and beat the hell out of them saying they are beating out the evil spirits and when this approach is not working that is when they bring them to the mental hospital. And others too I will not blame them they just don't know there is a mental hospital that can be able to take care of their relatives and help recover. So, in the community, people always inform them that there's a fetish*

priest here who can help us so they go and give their relatives or friends to them and when they are not able to cure them, they look for alternatives and eventually in the search come here (Ama Afrah, female, Nurse Manager).

The preference for herbal/spiritual treatment according to the informants causes most of their patients to seek referral against medical advice.

For referral against medical advice, is normal in our hospital settings because the community members are expecting magic from us (Dupsy Serens, female, nursing officer).

When you are nursing a patient with a mentally ill diagnosis like psychosis and the relatives come in to tell you that (in spite of) *all the medication you are giving to him or her they do not see any improvement. So, they think it is a spiritual curse as a nurse you can't do anything about it than to discharge the person against medical advice* (Akosua Mansa, female, nursing officer, Ward in-charge).

4.2.1.3 Ghanaians stigmatised and have negative attitude towards mentally ill patients

From the perspective of the informants, Ghanaians stigmatised and discriminated against mentally ill patients and as such ignored these patients and dissociated themselves from the sick. This situation according to the informants has led to a huge burden on the mental health system as most people have abandoned their relatives in the hospitals.

Some relatives even deny their relation to their own family. One lady came with her brother and told us they were distant cousins, and when the patient became stable he told us that it was his sister who brought him to the hospital. But on the other hand, when it is a physical illness they show a lot of passion and interest in their relatives' condition, but with mental illness, they don't want to have any association. They dread societal stigma as in Ghana when you have a history of mental illness nobody marries from that family or associates with you (Dako, male, Senior Staff Nurse).

People are ignorant about mental health, and … they discriminate and stigmatise against the mentally sick and even totally neglect them… Family members don't care and don't want any association with them. Come to the wards, and you will see cases that have been here for more than 10 to 20 years; they have all been abandoned by their relatives. Some have recovered and had nowhere else to go and therefore, they have become government properties. The challenges that low health literacy impose on mental health nursing is enormous (Gifty Osei, female, Senior Staff Nurse).

Let me highlight the cultural issues that affect mental health nursing. Because people attach evil spirit to psychiatric conditions, there is a strong stigma attached to mental illnesses in Ghana. Due to these beliefs, families don't want to accept their son, daughter, father or mother who is suffering from a mental condition. Due to this, they don't want to have any conversation about mental illness. So, when educating them, they don't even want to listen (Naana Dartey, female, nursing officer).

Also, the negative attitude towards the mentally ill was not only directed at the mentally ill persons themselves, but also towards their community members, extended family members and even mental health professionals. Informants reported:

The stigma is even among health workers. At ceremonial functions at which one introduces himself/herself as a mental health nurse, people start to stare differently at us and think it is not a right profession (Aku, female, Senior Nursing Officer, Ward in-charge).

The stigma attached to mental illness is significant. They think even when they bring them here they are wasting money. Most of the family members do not understand mental health conditions as such they do not involve themselves in their relatives' care. On my ward, there are several patients who since admission have never received a visit from any relatives. Due to ignorance and the perception that mental illness is caused as a result of a curse or wrongdoings, no one wants to be associated with a mentally ill person even if they (the mental patient) *are their daughter or son just for fear of being stigmatised themselves* (Ann, female, nursing officer, Ward in-charge).

A client who was brought here that comes from a different home (i.e. a rented apartment just for the patient to stay alone) other than the family home even when she was on review. The family was shy to send her back to their family home again so rented a place for her to stay because they thought her condition was contagious. This girl suffers from epilepsy, and in Ghana, most people believe epilepsy is a communicable disease and as such do not want to stay close or be associated with a sufferer of the condition (Afia, female, nursing officer, Ward in-charge).

Informants reported that stigma towards mentally ill patients was not only from the general population; even nurses in other specialties do the same.

There are countless occasions where general nurses have to discriminate against mentally ill patients and even mental health nurses (Joke, female, Senior Staff Nurse)

> *Most nurses at the general hospitals, when they get to know that you are from the psychiatry they will try to stigmatise such patients. I once took a patient to Ridge hospital, and this patient was supposed to be hospitalised there for further observation and management, but the nurse on duty there told me they couldn't take care of the patient and that one of the nurses from our facility … the mental health nurses on the ward should come and nurse the mentally ill patient. I told her we were just two staff nurses and one enrolled nurse on duty taking care of 123 patients, but she insisted no. So, we have to be running shifts in that hospital until our patient was discharged back to this hospital. And this is just one of the numerous cases … the general nurses even don't know much about mental illness not to talk of even Ghanaian lay persons* (Grace Afua, female, nursing officer, Ward in-charge).

Mental health is an area that has received minimal attention by most Ghanaians. Some people normalise mental conditions, and some perceive certain mental conditions as alien to the African or Ghanaian population.

> *Almost all mental illness. Even with depression, people think that only people who are weak suffer from it, and as an African or Ghanaian depression is not in our culture, and only white people suffer from it. Can you believe that?* (Nana Akua, female, nursing officer).

> *Stigma is one of the challenges. Society shuns them, and they also withdraw from society. The patients lose their jobs and don't have any source of income ... It makes the patients regress more. When an individual is going through emotional and psychological stress, they don't get support from family members. In our communities being stress emotional is a stereotype as being a weak person so people can't even openly discuss their emotional problems especially for men. I think that is the reason why suicide cases became rampant* (Gifty Osei, female, Senior Staff Nurse).

Other informants reported that societal stigma towards mentally ill patients were as a result of negative images portrayed in the main stream media about mental illness. Low knowledge on mental illness extends to media personnel as well.

> *The media always portrays a negative image of mental illness wherein every movie, music video and documentaries; mental illness is caused by evil spirits, curses from the gods, money rituals and drug addiction. None of them creates mental illness as a medical condition caused by trauma, even untreated medical cases. We need the media to be also well informed about mental health. They all possess low levels of mental health literacy… is there a word like that?* (Kwaku, male, nursing officer).

4.2.1.4 Some MHNs shared in the local cultural beliefs towards mental disorder

As stated earlier, the notion that spiritual forces caused mental illness was also held by some of the nurses themselves, despite their biomedical training and clinical experiences. Many of the informants did not hesitate to admit that they shared similar cultural and religious beliefs with some of their patients, and this was observed in both hospitals.

> *The reasons why spiritual aspects cannot be ruled out* [of mental health issues] *is that there is evidence in the Bible, so we cannot tell people in our education these things do not exist. … The fact that evidence is* in *existence doesn't mean it does not exist. Personally, I also believe demons can cause a mental disturbance* (Sey, male, Ward in-charge)

> *I believe some conditions can be caused by spiritual forces, but then because of my education in nursing, I also think some diseases have neurological causes. There was this client who came to the OPD, and during the assessment, he verbalised that he went for money rituals, and he was supposed to do some rituals for the fetish priest, but he wasn't able to fulfil that requirement. … So, when he came, he was hallucinating though and behaving in an unusual mannerism like he was in a shrine. This was a classical spiritual case, but because he was already in the hospital, I told them to continue with the medical treatment, but the relatives should also consult a strong pastor at home who will help cure him faster* (Ahemaa Kusi, female, Senior Staff Nurse).

> *Yes, some conditions can be seen as spiritual. You just can't explain the pathophysiology of it. We don't do CT or MRI scans here, so we can't explain the causes. So what people can't explain physically, we only assume caused spiritually. Especially with puerperal psychosis, epilepsy and dementia* (Deborah Bruce, female, Senior Nursing Officer, Ward in-charge).

Despite these surprising observations, a significant number of the informants believed in the biomedical explanation to mental health and illness. Some confessed their nursing training had changed such inclinations from 'magico-religious' to biomedical beliefs:

> *Before becoming a health worker, I thought the same about the cause being more spiritual than scientific, but as I became more knowledgeable, my thought changed as well as the care I render to patients. … The care I give now is more medical oriented because I know more about mental health. We are bound by ethics of the profession* (Eric Frimpong, male, Senior Staff Nurse).

Thus, even those who adhered to the biomedical explanation to mental health still held onto some elements of the spirituality of the condition as they related their understanding about the ethics of their profession:

> *I don't believe mental illness is a spiritual problem because with medications they get better. ... I cannot refer someone to see a spiritualist ... If the relatives insist on seeing a spiritualist; I advise them to let the patient continue with the medications while they see the spiritualist* (John, male, Senior Staff Nurse).

> *We encourage them to keep their belief while we the health professionals render care in every aspect possible. ... We let them know the health professionals are religious as well and so there is no harm in taking medication and then seeking spiritual help* (CDH, male, Principal Nursing Officer, PNO, Nurse Manager).

4.2.1.5 Patients' characteristics has an influence on nursing care

Some informants were of the view that the cultural beliefs, norms and practices of their patient population made it difficult for them to develop the means for improving their patients' understandings.

> *It affects our interaction with patients. It's challenging getting people to understand that mental illness is not communicable. … Let me share my experience with you. A woman brought her son to the hospital at my previous ward; she told us that prayer camps were her first choices that she was considering and that hospitals were her last option. She was looking for an influential spiritual person to deal with the problem until someone told her about bringing the son to the hospital. Even when you educate her about the son's condition, she still tells you it is spiritual. In this situation, I just do more of education, but she still would not accept it. Her son recovered, and he was discharged. After the discharge, I learnt she took her son to Nigeria to see a prophet* (John, male, Senior Staff Nurse).

> *This is a significant issue that indeed affects our work as mental health professionals. We try our best to educate the ones that come here, or we meet in churches and our family. Most people do not know about mental health. It does affect our communication with them. They are fixed on their beliefs, so it is difficult getting them to believe the medical aspect of the illness. You have to spend time in educating them* (Maxwell, male, Senior Staff Nurse).

The informants reflected that the relationship between patients and mental health professionals operated in the form of power relations where patients accepted whatever the doctors said and

did not ask questions. One informant reported that some of their patients have limited trust in mental healthcare and health professionals.

> *Ghanaians don't ask doctors about the name of their condition or even ask questions. To many, the doctor knows best, so they don't question anything, and due to the nature of consultation and vast numbers of inpatient at the OPD daily, doctors have little time to educate patients or their relatives. We only have three hospitals in Ghana taking care of the 25 million Ghanaians. You can just imagine the massive burden on these hospitals. Time to provide adequate information patients is little* (Karen, female, nursing officer)

Informants also reiterated that patients with low health literacy are 'difficult to educate' and as such mental health nurses often shied away from interacting with these patients. They sought assistance from the relatives and friends of these patients in order to discuss the conditions of their mental health patients because they assumed the relatives and friends would have higher literacy levels.

> *With the educated relatives it is easier because they understand the information we give them. If people don't have a basic understanding about their condition... With this kind of poor attitude, mentality and ignorance, it will take a lot of time and devotion to educating them that's why with the limited time. I will go for the relative with adequate or good educational background to educate them and save time (Josephine Sam, female, Nurse Manager).*

Other informants perceived that most Ghanaians were more concerned about their physical illness and neglected their mental health due to societal beliefs and perceptions about mental illness. This according to informants makes their nursing care very challenging.

> *They believe mental illness is caused by evil spirits, curses that might have caused the person to be mentally unstable. And then the kind of signs and symptoms with mental conditions like aggression, nobody wants to keep the person at home. Meanwhile, when you look at the physical illness like when someone has hypertension, everybody shows concern and like even to accompany the person to the hospital and even at times to visit the person two times a day. People go at dawn to stay in hospital premises to visit their relatives at 6 a.m., but with mental illness issues, nobody wants to take this patient to the hospital and even when they do never visit and abandon them here* (Dako, male, Senior Staff Nurse).

Our patient population and the entire Ghanaians do not show any interest in learning about mental health issues. Sometimes they will have adequate health literacy and know how to Google for information on their physical health issues but will not do same for mental health. To Ghanaians, if they are not smoking cocaine or marijuana and they have not offended any witch nor have a witch in their family, mental health is not their concern (Akua Serwaa, female, Senior Staff Nurse).

It makes work complicated when it comes to weaning them from their beliefs. The sick themselves don't even want medical attention, so it is difficult to help them. This has caused huge cases of mental illness within the communities that are yet to be sent to the hospital. You cannot roam the major streets in any city in Ghana without coming across at least five mentally sick lying by the street side. Family members don't care and don't want any association with them. Come to the wards, and you will see cases that have been here for more than 10 to 20 years they have all been abandoned by their relatives. Some have recovered and had nowhere else to go and therefore, they have become government properties. The challenges that low health literacy impose on mental health nursing is enormous (Gifty Osei, female, Senior Staff Nurse).

There was a time we were going to a church to give education on mental health. They decided they were no longer giving us their time if we were not going to talk about the physical illness, so the media should help. Also, the government should pay attention to mental health and address the issues (John, male, nursing officer).

4.2.1.6 Local cultural beliefs and practices influence nursing practice

The multiple cultural positions and compromises had implications for nursing practice and delivery of healthcare in general. This was reflected in their caregiving and health education to patients as some informants reported:

I am trying to say we also do believe it … Let me say I also believe some mental conditions are spiritual, and as Christian, I know there are evil spirits out there that cause certain mental illnesses. … So, I often try not to tell them [patients and their relatives] *that they are wrong or right with their beliefs. Being a Christian, I know it is possible for some conditions to be caused by evil spirits* (Josephine Sam, female, Nurse Manager).

As the previous findings indicate, prevailing socio-cultural practices and beliefs influence the way participants approach patient care and education. For instance, one informant reported an incidence where even nurses referred patients to see traditional/spiritual healers:

In Ghana, we have about 53 different dominant cultures and other non-dominant cultures … As nurses, our culture influences the way we interact with patients. I have

met patient relatives who told them a nurse advised them to take their relatives to see an herbalist (Dako, male, senior staff nurse).

I believe some conditions can be caused by spiritual aspects and then because of my education in nursing, I also think some diseases have neurological causes. There was this client who came to the OPD and doing the assessment, he verbalized that he went for money rituals, and he was supposed to do some rituals for the fetish priest, but he wasn't able to fulfil that requirement. So, when he came, he was hallucinating though and behaving in an unusual mannerism like he was in a shrine. This was a classical spiritual case, but because he was already in the hospital, I told them to continue with the medical treatment, but the relatives should also consult a strong pastor at home who will help cure him faster (Ahemaa Kusi, female, senior staff nurse).

Other informants mentioned that such directives emerged from their cultural or religious values, which frown upon specific mental health conditions (alcoholic psychosis and substance abuse) and as such they neglect these patients and do not provide nursing care to patients suffering from such conditions.

I personally sometimes have instances where my cultural background influences the way I interact with patients. ... In my religion, we frown on addiction to alcohol and because of this, drunkards are not respected. As a result of this, I didn't even regard drunkards as sick people so, because of that, I usually avoid them and accuse them of their bad behaviour. So, during my first two years working as a mental health nurse, I usually avoided the substance abuse patients and focused all my attention on those with other conditions (Mr Love, male, nursing officer).

Personally, I am thinking we all encounter this situation often within our nursing practice where our own cultural belief influences the way we treat or nurse our patients. I mostly advise patients based on own belief system not on medical grounds. Sometimes we can't just help it. I asked a patient to pray for her daughter as her symptoms seemed unusual. It was not ethical, but sometimes we can't just help it (Akua Serwaa, female, senior staff nurse).

One informant hinted that only a few mental health nurses check for the patients' understanding during patient education or teaching; while the majority does not check.

I have observed nurses give health information and never check if the patients understood what he said. We always say I have given the information ... if they did otherwise sure is up to them. (Mrs. Cardinal, female, nursing officer).

4.2.2 MHNs' interpretation of health literacy and its impact on mental health practice

Data from the interviews reflected that health literacy conveys a different meaning to MHNs. Institutional culture and attitudes towards patient education and institutional requirements have affected the health education performance of MHNs. Notwithstanding, MHNs were able to describe routine practices that they adopted to deal with patients with low health literacy. These observations are shown in the following subthemes:

1. MHNs have different understanding of health literacy
2. Lack of assessment of patients' health literacy in the clinical setting
3. Routine strategies adopted by MHNs in dealing with each patient's health literacy.
4. Low health literacy has negative impact on patients' health and nursing practice.

4.2.2.1. MHNs have different understanding of health literacy

The informants ascribed different meanings to health literacy. Across the six focus groups, participants expressed unfamiliarity with the concept. They defined health literacy as something that has to do with a person's (lay-person) knowledge on health and health conditions as these statements show:

> *It means knowing much information about your health. In a situation of a lay-person, it will be how much they know about their health and how to take care of themselves at home* (Akua Serwaa, female, nursing officer).

> *It is you knowing your health and the particular care you should give to it. It is how best an individual know is when it comes to health knowledge about various health conditions and how best to treat or manage when affected. And it could be mental… physical health. … having an overall knowledge of issues that affect one's health* (Grace Afua, female, Ward in-charge).

Other informants described health literacy as related to the skills and responsibility of mental health professionals and as a communication between the nurse and patients:

> *The ability to communicate in a way that brings understanding between the nurse and the patient. … How we as health professionals help patients to understand their condition and manage themselves effectively with the good discharge plan. …How we*

can make them understand medical terms and how to take their medication as prescribed (Nana Akua, female, nursing officer).

It's the ability to communicate effectively about health issues… how we can make patients understand various health conditions and how to prevent them (Maxwell, male, Senior Staff Nurse).

Thus, some informants believed while health literacy was about patients, it was dependent on the health professionals' health literacy. MHNs' lack of sufficient or updated information on health issues, neglect of their teaching roles/responsibility, failure to give quality information to patients were seen as some contributory factors for low health literacy among mentally ill patients and their relatives:

Mental health nurses in this hospital don't take their time to give them quality information on their health that will prevent them from coming back in a worse relapsed state … So, it's partly mental health nurses fault patients have limited knowledge of mental health issues (Mr Love, Male, Nursing Officer).

I am saying if we possess adequate health literacy, we will have sufficient knowledge of the topic on which we want to educate the patient; we will do a better job at communicating this information to the patient than when we are not knowledgeable about the issue. So, health literacy should be detailed knowledge of the topic at hand for the health worker, and information understanding and action-taking by the patient (Kwaku, male nursing officer).

However, some of them refuted the overconcentration of health literacy as something that relates to patients alone. This group argued that health personnel could also have low health literacy:

Everyone is talking about the health literacy of the patient. What about health literacy of us nurses? Sometimes nurses don't understand what they read, or the topic at hand and they give wrong information to the patients. … We also need to look at our health literacy too. Majority of patients go home with false information provided by nurses which leads to devastating effects. … We must take a critical look at our literacy level ... So, we have to address health literacy of both the patient and the mental health nurse (Kwaku, male, nursing officer).

I think the main issue is the way as mental health nurses we communicate health information to our clients. Knowing is very different from instilling the knowledge to others (Dako, Male, Senior Staff Nurse).

Consistent with how health literacy was defined, adequate health literacy was seen as pertaining to health professionals only and not to lay people or patients. This was because the opinions of both the patients and the public contradicted the biomedical principles they held dearly:

> *Health literacy correlates with educational literacy so most people will not know about health when they have not had any form of education in health. Apart from nursing, medical or other allied health students, no other courses teach people about their health. Even in the primary and secondary schools, we have not informed anything about our health, especially mental health. If we have no education concerning our health, we won't know anything. So as Ghanaians we are not health literate* (Maxwell, male, Senior Staff Nurse)

> *No, they* [patients and the public] *don't have adequate health literacy … because health literacy, especially about mental health issues is just with the mental health professionals. … This is because our native values just don't want to know or have anything to do with mental health. … Because of our belief system and what they associate with mental health, they don't know about mental health but just have societal myths about psychiatric disorders*... (Dako, male, Senior Staff Nurse).

4.2.2.2 Lack of assessment of patients' health literacy in the clinical setting

Assessing a patients' level of health literacy is based on the patients' cultural characteristics. In fact, the majority of the informants argued that their patients were highly religious and dedicated to their cultural values. This, as shown earlier, made them associate mental illness with spirituality, which they considered to be a cause of low health literacy and ignorance about mental health illness:

> *Most often the patients have some way of thinking and how they understand mental health is different from what we know as health workers. At times because of culture and traditions they see mental health differently and so to me most Ghanaians have low health literacy. …Until we can change this belief system, it will be difficult to address issues of low health literacy* (Ann, Female, Nursing Officer, and Ward in-charge).

> *I will say Ghanaians don't have adequate health literacy, especially concerning mental health issues … You realise most people don't understand information concerning mental conditions. Even when well explained to them, you realise because of the cultural beliefs they have, it is difficult for them to fully agree with us on the information we are relaying to them*... (Deborah Bruce, female, Senior Nursing Officer, Ward in-charge).

> *Most of our patients and their relatives don't know about mental health, and their knowledge of mental health is centred on what cultural practices depict it to be. To me, almost all our patient population and their relatives have low health literacy when it comes to mental health. I can't just think of one particular case, but … they have no information about mental illness* (Adwoa, female OPD, Senior Staff Nurse).

Consistent with how health literacy was defined, its assessment within clinical practice was based on each patient's level of general awareness of mental disorders, as this scenario indicates:

> *I assess patient's health literacy based on their knowledge about health issues most importantly their condition. … I start by asking them basic questions about mental illness, and when the patient is not able to give me information about their health, then I know this patient does not understand anything about their health, which then tells me that they have low health literacy* (Ahemaa Kusi, female, Senior Staff Nurse).

To a greater extent, a patient's health literacy level according to this practice was based on their level of education. One informant reported that patients with higher educational status have a higher knowledge of mental disorders than those with lower levels of health literacy:

> *In most cases, people with higher educational status like a degree know a little more than those without any form of education* (Lisa, female, Senior Staff Nurse).

Other assumptions about health literacy and education also had to do with whether a person is living in a rural or urban community. Rural residents were seen as having low literacy and in effect had low health literacy. One informant shared that:

> *Countless of our patients and their relatives have low health literacy especially those coming from the rural areas. Most of the rural folks cannot read and write, and as a result, they lack any knowledge of mental illness. They mostly hold strong cultural beliefs about mental illness* (Linda, female Senior Staff Nurse).

However, a contradictory opinion indicated that this approach was not a reliable way to ascertain patient health literacy as the experience of other informants showed:

> *A man, who is well educated, came in with his mother. According to the man, his mother had been behaving abnormally at home. The woman leaves the house and cannot find her way back home; and was caught naked roaming the neighbourhood at dawn. …His wife had also been visiting a certain pastor on a regular basis who told her; her mother-in-law was a witch and the cause of her barrenness, so they took his mother to the*

pastor. After one of the long visits, his mother's symptoms even got worse …So a friend he convinced him to bring her to our unit. Even when we tried to let him know his mother's condition is a common mental disorder and not spiritual, he was still insisting it was (Gifty Osei, female, Senior Staff Nurse).

Despite the above explanations to health literacy approaches, quotes from informants infer that conscious assessment of health literacy was not a part of clinical practice as an urgent request for specific and detailed procedures produced inconsistent revelations. Indeed, at the Hospital A setting, some informants opined that assessment of patients' health literacy was not carried out at all:

By the definition of health literacy and my understanding of the term, I don't think as mental health nurses we do assess a patient's level of health literacy in our hospital. Most of the time we don't evaluate them but just go ahead with our health education … We only take health education as a routine procedure that needs to be done with; we just start teaching without knowing who the listeners or patients are … when we finish our education, and we later ask the patients "do you understand?" and they respond yes, then we think our job was well done. …We don't take a step further to know their literacy rate, or whether they genuinely understand by asking them questions about what we taught them ... in the majority of cases, we just go ahead with our nursing care and don't assess patients' health literacy (Mr Love, Male, nursing officer).

In fact, some informants admitted that most nurses do not assess patients' health literacy levels but only assume that their patients possess adequate health literacy.

We as nurses have to know our patient's knowledge level and specify our approach for each patient. But we always assume that as far as the person has entered our hospital, he/she knows everything about their health or is well-informed. We often assume our patient literacy rate on their health. And because of our assumptions we often give basic education and do not go in-depth to educate our clients and their relatives (Naana Dartey, female, nursing officer).

Others referred to the examination of the patients' insights into their conditions using the mental state examination procedure. According to the informants, this was one of the usual approaches used to examine their patients' health literacy rates:

What I do on the ward is to first assess for their insight, which I usually have follow-up questions like what medication do you take, how much dosage are you taking and how do you handle side effects of the drugs. So, when I asked about this thing it gave me a fair idea about the patients' health literacy and based on that, I educate them (Dako, male, Senior Staff Nurse).

However, contradictory opinions were raised by informants (ward nurses' group) where some of them were of the impression that mental state examination was not conclusive to determine the health literacy rate of patients. This was what some informants had to say:

> *I think what we mostly do here is to assess patients' insight into their conditions but not to assess their health literacy level* (Mr Love, male, nursing officer).

> *With mental state examination, insight is just one of the criteria that are used to getting a diagnosis for the patient. We ask various questions that lead us to know their knowledge or insight into their mental condition. It does not fully assess health literacy but is a step to help us know what the patients know and educate them appropriately* (Kwaku, Male, nursing officer).

4.2.2.3 Routine strategies adopted by MHNs in dealing with each patient's health literacy

To communicate with patients with low health literacy, the informants reported that they used a range of techniques in their daily practices to improve patient understanding and efficiently communicate.

4.2.2.3.1 Materials used in patient education/teaching

Informants reported that to improve patients understanding of health information, they resort to using the experiences of other patients and resources including scenarios, movies, documentaries and wall posters in their patient teaching.

> *I use illustrations such as drawing to explain health conditions to patients. There are times I use audio-visuals on my laptops to educate clients and their families. I often download videos on various mental conditions just to assist with my education. Because throughout my nursing experience, I realised the patients learn more and can remember easily when audio-visuals are used. I give articles to those who can read to help them understand their conditions better* (Mr Love, male, nursing officer).

> *Sometimes we use other patients who show significant signs of improvement are used as examples in teaching and encouraging them. There is a group session on the ward called group therapy, and within the session, we introduce other patients with similar conditions to them. This is to assure the patient that his condition can be improved and also to relieve their anxiety level (*Ann, female, nursing officer, ward in-charge).

Other informants reported using plain terms or simple language, illustrations and use of a patient's native dialect to transmit important information:

Sometimes I use layman terms or shorten the words, so the patient can understand. For example, a drug like haloperidol we shorten it to Haldol, so the patient can easily remember or understand. Illustrations or demonstrations also help to improve their understanding (Ann, female, nursing officer, ward in-charge).

4.2.2.3.2 Use of patients' beliefs to educate patients about mental illness

Informants reported using patients' spiritual beliefs as a means of explaining the cause of mental illness, and one ward nurse reported that:

Ghanaians are very religious, and it affects the causes of mental illness. I observed acute cases brought to the out-patient department (O.P.D). Most of the time they come in with a Bible in their hands either preaching or praying ... so they think that mental illness is spiritual ... What I usually say is that the spirit has caused disorder in the brain which affects the physical aspect of the person so when you take your medication as prescribed, you will get well (Tobio, male, senior staff nurse).

4.2.2.3.3 Techniques used by nurses to assess the patients' level of understanding

Informants shared the fact that they check each patient's level of understanding using various techniques such as asking questions, the patient's verbalisation, gaining feedback and observation of the patient's mannerisms during and after interactions.

Most patients show signs of gratitude when they truly understand what you said. Most often the patient and relatives respond by saying "thank you aunty Nurse and I wish I have had this education earlier; it will have helped me a lot". With this kind of declaration, you will know the education went well (Linda, female, Senior Staff Nurse, APH).

... For some, I ask them whether they understand what I said, and some other patients just smile, and from that, you can tell whether they get what you are saying or not. .... Sometimes when you look at their faces you realise nothing you said went into their heads. They didn't just understand so I will look at their faces or whether they nod in agreement or disagreement (John, male, Senior Staff Nurse).

4.2.2.4 Low health literacy has negative impact on patient's health and nursing practice

Despite the different meanings ascribed to health literacy, informants also mentioned the adverse effects that culture and low health literacy have on their patients' health and nursing care.

> *We discharge these patients, and they go home, because they don't understand and know what is wrong with him, they (family members) flare up and misinterpret it and bring this patient back to the hospital. These patients do not need re-admissions again what they need to do was to take action to calm these patients. But they always bring these patients back again and bringing these patients back to the hospital is not only putting pressure on the nurses but also on resources. This leads to frequent hospitalisation because they don't have an understanding of the condition and they don't know what to do in times of simple crises. Their beliefs and lack of understanding do affect our nursing practice* (Mr Love, male, nursing officer).

> *It doesn't build the patient's self-confidence. When people have low health literacy, it predisposed them to low self-esteem, and they just let people treat them anyway. And this is the primary reason why patient default and do not come for review because they are afraid and not self-aware that even with their condition, they can still function adequately within their communities. It also prolonged recovery for that person as the family don't know much about the condition and are also not ready to help. The relatives do not have much information, so it also prolongs recovery rate* (Naana Dartey, female, nursing officer).

4.2.3 The practice of health literacy has to be negotiated within a cultural context

In the previous sections, informants acknowledged the pivotal impact of cultural beliefs and language on the health literacy of mentally ill patients. Informants also reported daily strategies they employ to address issues of low health literacy among patients. In this section informant mentioned some issues and challenges they face within the mental health institutions and society which serves as impediment to nursing practice. Despite the apparent difficulties informants face in integrating health literacy into clinical practices, many of them acknowledged the potential usefulness of incorporating health literacy and cultural competence skills in nursing practice. Informants also acknowledge ways to address health literacy issues within the Ghanaian cultural context. This acknowledgement was observed in the various strategies they suggested for purposes of promoting health literacy. Issues raised include:

1. **Institutional and societal barriers to addressing health literacy issues**

a. Limited resources and challenges within the mental health hospitals

b. Language and certain social issues act as impediments to nursing practice

c. Lack of health literacy training and continuous education for MHNs.

2. **Strategies to address low health literacy within the Ghanaian community**

a. There is a need to involve community leaders in health education.

b. MHNs need health literacy training

c. MHNs need cultural competency skills to break down cultural myths and practices.

d. The need for government and policy makers to provide funds for the mental health system

e. MHNs strategy to integrate standard care with alternative treatment.

4.2.3.1 Institutional and societal barriers to addressing health literacy issues

4.2.3.1.1 Limited resources and challenges within the mental health hospitals

Health materials play a crucial role in health literacy as reading and writing were the skills the nurses first considered when they thought about patient health literacy. However, informants at both hospitals reported that their facilities did not provide them with any materials for patient education.

> *'Talking therapy'. That is what we use. We have no written material for patient teaching, so we rely on our knowledge on mental health conditions to educate patients* (Ann, female, nursing officer, Ward in-charge).

> *We don't have any materials for educating our patients. We only teach them with the little knowledge we gain from school. There are no leaflets, pamphlets or anything to educate them. And to me, that may be one of the reasons why it is challenging to teach them for them to understand. So, imagine if the nurse also knows little or is not conversant with current knowledge, the information given will not be adequate for patients to understand. So, some nurses shun from health education because they know little* (Deborah Bruce, female, Senior Nursing Officer, Ward in-charge).

> *Most cases we just leave it like that and manage the symptoms. The hospital hasn't made any provision for language interpreters even though they are aware of this challenge* (Linda, female, Senior Staff Nurse).

In fact, others attributed the lack of priority for health literacy issues to congestion and lack of ample time to systematically conduct health literacy assessments:

> *Comparing the service delivery model, when shifts end and the huge numbers of old and new cases at the OPD, it will be difficult even to assess patient's health literacy and to even talk of educating them. The time allocated for each patient is limited, so the only thing we can do is to reassure and inform them of the diagnosis and medication* (Kwaku, male, nursing officer).

4.2.3.1.2 Language and social issues act as impediments to nursing practice

Ineffective communication that related to language differences was reported in all the six focus groups and individual interviews conducted. Informants said that their patient population was not limited to only Ghanaians but also extended to neighbouring francophone countries (Ivory Coast and Togo):

> *The other issue with health literacy is language differences. In our setting, we deal with patients from different ethnic groups, and as such, they speak different languages. Because most of the mental health nurses here are not bilingual, it becomes difficult when we meet a patient who cannot speak any of the languages we understand* (Adjoa Mansa, female, nursing officer)

> *Because we are surrounded by francophone countries, we do get a lot of patients who can only speak French but we the nurses cannot speak this language. … Even with our local dialects we also have challenges. I remember we had this patient who only speaks 'Frafra' and none of the nurses on my ward understands such dialect. And because of this, there was little we could do to assist this patient, especially with health education. So language affects our nursing practice here, but nothing is done about it.* (Grace Afua, female, nursing officer, Ward in-charge).

Language differences between the MHNs and their patients were addressed through the use of various strategies by informants:

> *We resort to using other mental health nurses from other wards we know can speak the same language that this patient speaks. And in other cases, if we don't find anyone, we use hand gestures to depict what we want to tell them (*Adwoa Mansa, female, nursing officer, Ward in-charge).

> *Some wards have deaf and dumb patients and are difficult to communicate with. In this institution, there is no mental health nurse trained to communicate in sign language. There is one patient on my ward who is deaf and dumb, and mostly we use diagrams*

and hand gestures to communicate with them (Afia, female, nursing officer, Ward in-charge).

However, some informants commented that the use of sign language was only feasible with a simple instruction like eat, sit or take medication; but the ability to effectively communicate to the patient and educate them about their health conditions was hampered by language differences. This often resulted in poor health outcomes:

> *The language barrier to me is the major cause of frequent relapse cases and re-admission. … We keep nursing these patients, and they return to us again as health education did not go well* (Adramak, male, nursing officer, Ward in-charge).

The inability of informants to transmit proper health information and do so effectively was also viewed from other social expectations such as respect for the elderly. The following summarises this observation:

> *There is the issue of the language barrier and the age of the person. In our context here, we don't need to use some words for the elderly person, so nurses will have to know the cultural background of that patient and relatives too. It is a whole lot of issues* (Dako, male, Senior Staff Nurse).

Social issues that influence nurses' health literacy practice

Moreover, many Ghanaian patients face multiple social issues that are often overwhelming and compete with health issues for attention. Poverty-related to low income was seen as a pressing issue that influences patients' health-seeking behaviour:

> *Though health literacy has not yet gone far, most families have challenges with money and cannot access health services. More so the country has only three psychiatric hospitals which are all in the south. It will be difficult for those in the northern part of Ghana to bring their sick regarding money* (Sey, male, senior nursing officer, Ward in-charge).

> *Mental health is yet to integrate into the NHIS (National Health Insurance Scheme) which is a big problem because most relatives do not have the means to afford the bills when their sick is admitted or buy drugs even when discharged* (Afia, female, Ward-in-charge).

Some informants reported the situation of the only three available mental health hospitals in the southern part of Ghana as a contributory factor in patients' decision-making regarding mental health care as they had to travel long distances to seek care.

A lot. People in the northern sector when they start seeing specific behaviour with their relatives, and they do not know what to do since the psychiatric nurses are made to practice as general nurses. They have to bring their sick to the south because this is where the mental health sources are. They mostly find solace in what the religious personnel's say. Accessible to mental health care is also compromise and this affect patients' decision concerning help-seeking (Aku, female, senior nursing officer, Ward in-charge).

Some informants also reported that in some patriarchal cultures in Ghana, males might make decisions for females. As such most patients did not heed the advice of nurses but based their choices or decisions solely on their husbands:

I remember as a student nurse, I had to nurse this Muslim patient who had to deliver and hadn't shave her pubic hair and she told me her husband told her not to shave... We told her because of infections she needs to shave, … But she insisted unless her husband agreed she wouldn't allow us to shave her. Even in that pain, can you imagine that? So, we called the husband and told him the situation, even with that we had to do a lot of explanation before he agreed. So yes, cultural beliefs affect nursing practice a lot and even the patient's condition. In a northern region where this woman resides, married women cannot make any decisions even about their health without their husband's consent. … Every decision must come from the husband even with blood transfusion (Dupsy Serens, female, Ward in-charge).

Furthermore, according to some informants, cultural issues (taboos) hinder their nurse-patient communication and as such their ability to give appropriate health education. It was identified to be forbidden to mention the reproductive organs in some cultures.

In our cultural settings, we can't pronounce certain part of the body like the vagina or penis by their local names. We refer to them as 'your something'. …What is that? (Naana Dartey, female, nursing officer)

Socio-cultural attributes also impinged on several aspects of caregiving, and one informant from one of the senior nurses' focus group shared her personal experience in this regard:

…A patient I nursed didn't want that a simple haircut should be done for him by a female. No matter how hard you try your best to persuade he would not agree unless you look for a male to do that. … It is our duty as nurses to respect the culture of the patient before taking a decision, but it is sometimes too difficult (Deborah Bruce, female, Senior Nursing Officer, Ward in-charge).

4.2.3.1.3 Lack of health literacy training and continuous education for MHNs affect nursing practice

The lack of knowledge on how to assess and address issues of health literacy can be inferred from the fact that MHNs in these two hospitals had not received any health literacy training nor continuous education on current nursing practices.

> *Most mental health nurses are not health literate themselves. … Some have not attended any training programs to update their knowledge on health and it's not our fault; we hardly have the opportunity for in-service training to educate us on current trends in mental health and not until recently I mean last year, there was no degree program for mental health nurses we only had a diploma. So, the majority of mental nurses still have old information on mental illness* (Nana Akua, female, Senior Staff Nurse).

> *No, not specifically to train them on health literacy but we look at the general conditions they are lacking the necessary skills to manage them and then we get a facilitator to educate them and also train them on nursing skills used to manage such conditions. But specifically, on how to solve issues of low health literacy I will say no* (Ama Afrah, female, Nurse Manager).

4.2.3.2 Strategies to address low health literacy within the Ghanaian Community

4.2.3.2.1 There is a need to involve community leaders in health education

To facilitate effective mental health education some of the informants emphasised the importance of going to patients' environment and involving opinion leaders within their communities to address the issues related to the patients or community's cultural beliefs:

> *With these cultural issues, nurses need to go into these communities, talk to the opinion leaders and the chiefs and learn more about their culture. …It is only when nurses are able to convince these opinion leaders on the negative influence of certain cultural beliefs on the health of the community members that we can actually solve these issues of spirituality and mental illness. If the chiefs and leaders are convinced, that is when they will together with mental health nurses, educate these people about the negative impact of certain cultural practices on the mental health of community members. And sometimes even the chiefs who serve as volunteers in educating their community members* (Ama Afrah, female, Nurse Manager).

*Resources should be put in place to help liaise with the community nurses and the community elders. As community elders do not assist community mental health nurses in their health promotion exercise, it makes it difficult for nurses to gain access to community members. Without health education on psychiatric disorders within the community, the fight against low mental health literacy will be ineffective (*Dako, male, senior nursing officer).

4.2.3.2.2 MHNs need health literacy training and skills

However, some of the informants stated that, for health literacy issues among patients to be adequately addressed, MHNs need to possess health literacy skills.

I am saying if we possess adequate health literacy, we will have sufficient knowledge on the topic we want to educate the patient on, we will do a better job at communicating this information to the patient than when we are not knowledgeable on the issue (Kwaku, male, nursing officer).

Not just the cultural competence skills but also health literacy skills. Just like me even with my level of education, don't know much about this health literacy issues. And I think it will be best if nurses especially us mental health nurses have these two skills to help us address these issues of low knowledge which have resulted in negative opinions and stigma towards the mentally sick patients in our country. If we know how best to educate Ghanaians by addressing some cultural beliefs that surround mental health, I think we will go a long way in promoting mental health knowledge among Ghanaians and most importantly our patients. And these skills will also help us to be more efficient in our nursing care (Ama Afrah, female, Nurse Manager).

We need to train mental health nurses on health literacy. Today is my first time of hearing and discussing this issue, and it will be appropriate if we are trained on it. For me, mental health nurses need to be trained how to handle patients with low health literacy and how to be health literate ourselves (Tattoo, female, nursing officer).

In acknowledging the practicality of this approach, some of the informants stated that for health literacy issues among patients to be adequately addressed, mental health nurses need to possess both health literacy skills and cultural competency.

Not just the cultural competence skills but also health literacy skills. … Just like me even with my level of education, don't know much about this health literacy issue. And I think it will be best if nurses especially us mental health nurses have these two skills to help us address these issues of low knowledge which has resulted in negative

opinions and stigma towards the mentally sick patients in our country. If we know how best to educate Ghanaians by addressing some cultural beliefs that surround mental health, I think we will go a long way in promoting mental health knowledge among Ghanaians and most importantly our patients. And these skills will also help us to be more efficient in our nursing care (Ama Afrah, female, Nurse Manager).

We need to keep learning on how best to be culturally competent and also at the same time possessing good health literacy skills (Mr Love, male, nursing officer).

4.2.3.2.3 MHNs need cultural competency skills to break down cultural myths and practices

Some informants acknowledged that when MHNs possess adequate knowledge about the various cultural beliefs and practices of their patients, it will assist them to develop effective ways of breaking down cultural myths and thereby making way for proper health information delivery.

If you are a nurse and you are going to give health education in the community, you should know their taboos, values and all those things as those can assist us, nurses. When we are teaching we will know which issues to discuss, and they will also be able to understand better. A nurse cannot just get up and start informing them that this cultural practice or belief is not good, but as mental health nurses, we need to first get their opinion and reasons for the beliefs, taboos and practices. And if we are able to tell them why we think their practice can affect the physical and mental health. That will help them to change (Ama Afrah, female, Nurse Manager).

I think as health professionals we need to develop adequate knowledge of the cultural beliefs and practices of the ethnic groups within our hospital settings. With adequate knowledge of practices that contradict scientific pathophysiology of the various conditions, we then develop strategies to breakdown these cultural myths and practices. We need to develop some creative ways to address these cultural issues (Naana Dartey, female, nursing officer).

The issue here is their understanding of their health. To these people a mental health issue is a spiritual condition and so should be treated as such. Until we as mental health nurses help to educate these people otherwise, this issue will never be stopped. I know there are a lot of people who don't know how to read or write and so can't look up about mental illness but what about the well-educated ones who hold similar beliefs? So, until we learn ways to help people understand better through health education, nothing will be solved. We can't solve their low literacy if we don't deal with their cultural ideologies of mental health (Lisa, female, Senior Staff Nurse)**.**

There have been several occasions where family members have complained of the inappropriateness of nurses in communicating with them. … We need to have adequate cultural competency skills (Dako, male, Senior Staff Nurse).

4.2.3.2.4 The need for government and policy makers to provide funds for the mental health system

Some informants mentioned the need for government to subsidise cost of mental health, or possibly integrate mental illness into the national health insurance scheme (NHIS) to increase access to health services.

The government should subsidise the cost involved in mental health care, so patients can afford mental health treatment (Karen, female, nursing officer).

Financial support is needed because we need to charge less for the patient's expenses so that they can afford mental health since it's now expensive. Mental health is not included in NHIS, and so it is expensive. If it is possible the hospitals will need translators to eradicate the issue of language barrier (Kwame Aboagye, male, nursing officer).

The first thing is financial support and also access to health information for the patients especially those with language barrier issues. Equipment needed to carry out health care should also be available or provided (Del, male, Ward-in-charge).

Some of the informants attributed the lack of materials and resources in the mental health system to the low priority given to mental health by policy-makers. As such, some of the participants suggested that policy-makers should provide their mental health facilities with the materials needed for patient education.

We need health material to help us do more patient education as currently, we don't have these in our hospitals. Those in authority, stakeholders and health policy makers should understand and have interest in mental health. When they do the avenue for health education will be opened. Leaflets should be made available so that after health education it can be given (Gifty Osei, female, Senior Staff Nurse).

Low health literacy also on the part of non-specialists can affect health policy formulation and implementation because the people formulating the policies do not even know or have adequate mental health literacy. So they don't see the importance of mental health as such they won't formulate policies that will improve mental health.

And this lack of understanding influences their approach to mental health issues. The government has entirely neglected the mental health sector, renovations go on every day at the various hospital, but nothing has been done for mental health since 1901. You can just testify by having a look at our structures (Mr Love, male, nursing officer).

Policymakers should consider mental health first. Something can be done at the policy level because trained mental health nurses after school are posted to facilities to work, but there are no resources to work with, so they end up working as general nurses. Though the policy states every hospital should have psychiatric nurses the logistics are not in place (Ann, female, Ward-in-charge).

4.2.3.2.5 MHNs' strategies to integrate standard care with alternative treatment in the care of mentally ill patients.

Some informants highlighted the importance of integrating the cultural beliefs of patients into mental health care services. They considered both patients' cultural beliefs and their own beliefs to be significant factors in the healing process.

In some of the facilities we have a chaplaincy for the hospital, and it's a must. So, if the chaplaincy is effective, it'll help in the spiritual aspect of caregiving for the individual. This will help keep the patients in our hospital and prevent them from seeing the spiritual healers outside (Belinda, female, Senior Staff Nurse).

The belief of relatives is one part of the treatment and to get the families to cooperate we need them to come to an understanding with us. By accepting their beliefs, they feel respected and have become part of the treatment. We try to see if what they do has a positive effect on the patient or not, so they are allowed to pray, so long as it does not disturb others. If there's a need for them to bring anointed articles, they are permitted to so long as there are no active ingredients that will interrupt drug action. In instances where patients are to be sent to prayer camps, we advise them against that because of the patient's condition, so we try to reach a common ground of understanding for them to leave the patient on the ward (Sie, male, nursing officer, Ward in-charge).

It will be of great help if we learn to integrate spirituality into our nursing practice. So, if a patient is a Christian and believes praying will help them recover faster, we should incorporate their culture into our care for him/her and allow the person to pray. We will just need to make sure it doesn't affect the beliefs of other patients. Same applies if the patient is a Muslim, I will allow them to go to the mosque and pray or pray in the ward if that is what he/she prefers. But I will ensure my cultural beliefs do not infringe

on the cultural beliefs of the patients during patient teaching. I will rather encourage the patient to do whatever he/she believes in (Linda, female, Senior Staff Nurse).

4.3 Summary of Chapter 4

The findings from the study add to the literature on the limited understanding of knowledge, experience and practice of health literacy in the nursing profession. MHNs in this study have shown limited understanding of health literacy and expressed unfamiliarity with the concept. MHNs' perceptions about health and matters of healthcare, including mental health, have been shaped by their own cultural and religious beliefs, values, norms, practices and language. However, from the findings, we became aware that the cultural and religious factors were more influential in health literacy matters. The informants' approaches to mental nursing care were often determined by the underlying cultural and religious doctrines of, not only patients and their relatives, but also those of the nurses themselves. The findings also showed that approaches to mental health care are also affected by culture of the institution itself.

CHAPTER 5
DISCUSSION AND CONCLUSION

5.1 Introduction

This chapter discusses the findings and reflects on how mental health nursing practices should accommodate these findings. The chapter also discusses the limitations of the study, and suggestions for future research. The final part of the chapter is the conclusion of the entire study.

5.2 Discussion

This section highlights and discusses the findings of the study. The key findings of the study include:

1. The experience and practice of MHNs is shaped by local cultural beliefs.
2. MHNs' interpretation of health literacy has an impact on nursing practice.
3. The practice of health literacy has to be negotiated within a cultural context.

5.2.1 The experience and practice of MHNs is shaped by local cultural beliefs

Findings from the current study illustrate the effect that Ghanaians' cultural beliefs have on the general populations' understanding of mental illness. The narratives of the nurses revealed that their patients perceive mental illness as having two causes: one is spiritual and the other, sociocultural (Opare-Henaku & Utsey, 2017). The sociocultural aspect relates to the belief that misfortune arises from a person's wrongdoing and/or curses from the gods. On the other hand, the spiritual belief is seen as the factor associated purely with mental health conditions and not with other health conditions (Asare & Danquah, 2017). In Ghana, conditions or ailments that are challenging to explain or not clearly understood are generally attributed to spiritual causes (Asare & Danquah, 2017; Opare-Henaku & Utsey, 2017). An explanation for this strong belief about spiritual causes of mental illness may be related to the low prioritisation of the delivery of services for mental health, lack of evidence-based assessment and treatment of mental illness in Ghana, and limited research into mental illness (Asare & Danquah, 2017; Monteiro, 2015).

According to the nurses, the usual first choice of treatment for mental illness for many people in Ghana is spiritual/traditional herbal practice with Western medical practice (such as

psychiatry and psychology) as the least preferred choice. Ghanaians consult mental health hospitals only when spiritual/traditional herbal practice has failed to treat the symptoms of mental ill health. This preference for spiritual/herbal treatment may be due to the understanding of mental illness that individuals (i.e., the patients themselves and their families) share with these spiritual/herbal healers (Ae-Ngibise et al., 2010). Due to these beliefs, many people avoid interaction with mental health nurses and other mental health providers, and this means that mentally ill people may lose an opportunity to increase their knowledge of the biomedical approach to mental health knowledge, care and treatment (Lincoln et al., 2015).

Furthermore, even when people utilise the services of mental health hospitals, they simultaneously consult spiritual/herbal healers. It is therefore recommended that mental health nurses should understand lay conceptions of mental illness and be culturally sensitive to mental health issues. During the narrative, the nurse informants asserted that spirituality can help patients to cope with a wide range of illnesses and stressful events and provide them with a sense of hope (Krause, 2010). With a sense of hope, patients are motivated to adhere to treatment regimens and psychological therapies (Asare & Danquah, 2017).

Given the cultural beliefs and perceptions about mental illness in Ghana, the nurses reported that there is a great deal of social stigma attached to mental illness. Consequently, it is not uncommon for the locals to neglect, abandon and dissociate themselves from mentally ill patients, their families. This attitude even extends to health professionals. The idea that mentally-ill patients have been cursed is in itself stigmatising (Opare-Henaku & Utsey, 2017). Perception of the curse being transferred to other people who may engage with these patients may account for the reason why most people want to dissociate from the mentally ill. This situation, according to MHNs, has placed a huge burden on the mental health system as most patients who happen to be admitted into its facilities are often abandoned by their relatives. Given the huge importance of family in the Ghanaian culture, it is not farfetched to assume that neglect by family members may cause further emotional distress.

Negative portrayal of mental illness by the media was reported to exacerbate the societal stigma against mental illness. In general, according to this current study data, Ghanaians often avoid

any form of discussion, or accept any form of health education related to mental health. This may account for the low level of knowledge about mental health because Ghanaian understanding of mental illness is shaped by cultural beliefs and practices, which extend beyond their literacy or educational levels (Izione, 2014). It is possible that patients with limited literacy may be more sensitive to this social stigma and as such may be the reason why patients try to hide or avoid seeking mental health care. This may partially account for or explain why, despite the estimated 2.4 million Ghanaians living with mental illness, only 2% received appropriate treatment in hospitals as of 2011(Roberts et al., 2014).

Although MHNs are expected to uphold biomedical belief in their clinical practice, the majority of the informants reported on many occasions that their cultural beliefs and practices overshadowed their medical training and influenced the way they approached patients with regard to care and the delivery of information to them.

Health literacy affects the health outcomes of patients at three critical points of (1) access to healthcare, (2) the interaction between patient and healthcare professionals and (3) patients' self-management of chronic diseases (Mogobe et al., 2016; Waite, Paasche-Orlow, Rintamaki, Davis, & Wolf, 2008). This implies that efforts to promote mental health seeking and knowledge will be impaired because informants admitted that there were various occasions on which they advised a patient to seek spiritual/herbal treatment instead of seeking mental health services. This finding casts doubt on whether scientific education about the causes of illness is able to eliminate local spiritual beliefs and practices relating to mental health. Some informants in this study supported this view and admitted to being influenced by their own cultural beliefs in their nursing practice. However, a significant number of informants indicated that scientific education could transform cultural beliefs and perceptions about mental illness. These informants believed that scientific education had helped to transform their own ideas. However, even though some informants attest to this, there is a cause to believe their allegations of transformation relate to the ethical obligations that have shaped their beliefs and practices in their capacity as professionals, and not to a change in their personal cultural beliefs, as the findings indicated.

The nurse-patient relationship in Ghana and many developing countries operates at the level of authority where patients do not ask questions but perceive health professionals to know the best (Mogobe et al., 2016). Despite this relationship, MHNs face many difficulties in helping patients to understand the biomedical concepts of mental illness and health. Most informants indicated that when cultural beliefs and practices are a concern, there is little that can be done to change patients' beliefs. However, the findings revealed that the inability of informants to successfully translate biomedical concepts of mental illness into plain/simple terms for their patients t was a more significant challenge than cultural beliefs (Singleton & Krause, 2009). Many medical terms, ideas and medical jargon easily be translated into or explained in another language (Coleman, Hudson, & Pederson, 2017; Singleton & Krause, 2009). Issues of cultural assumption, beliefs and practices cannot be effectively addressed if nurses intentionally avoid discussing or are reluctant to translate information in patients' native dialects.

Sometimes the local cultural norms even have an effect on which patients or family members are likely to listen and whom to speak to within the clinical settings. These cultural preferences influence patients' listening and speaking practices in nurse-patient clinical encounters (Singleton & Krause, 2009). Moreover, consistent with the findings from previous studies (Paasche-Orlow & Wolf, 2007; Redden, 2017), informants perceived patients with low health literacy as difficult to care for because of the length of time and effort required to assist them in their ill health. This explains why some of the MHNs reported that they shied away from educating these patients. While this may be understandable, it further explains why despite several efforts, health literacy levels continue to be low among patients and remain unaddressed by nurses (Egbert & Nanna, 2009). Therefore, equalities about health in Ghana may be far off from being achieved if MHNs do not address these health literacy issues (Flecha et al., 2011). Adequate education and the economic levels of patients not only increase the ability of individuals to access and use health information and services appropriately, but they are also critical for patients' health and overall well-being (Amoah, 2018; Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; Glymour, Avendano, & Kawachi, 2014).

5.2.2 MHNs' interpretation of health literacy has an impact on nursing practice

In this study, it was apparent that the majority of mental health nurses were unfamiliar with the term "health literacy" and they ascribed different definitions to the concept. Informants guessed the meaning of health literacy and defined the concept in terms of the lay-person's health literacy and the MHN's health literacy. However, the majority of the informants did not refer to a patient's ability to obtain, process or act on health information to make informed medical decisions in any way. This showed their limited understanding of patients' health literacy. Research suggests that nurses' capacity to understand patients' limitations in the health information (poor health literacy) may play a critical role in providing patient-centred care (Egbert & Nanna, 2009; Irving Rootman & Deborah Gordon-El-Bihbety, 2008).

In this current study informants believed that nurses also possess low health literacy and that the ability of nurses to understand and communicate mental health related information to patients is crucial in promoting adequate health literacy (Berkman, Davis, & McCormack, 2010; Parnell, 2014). This assumption is incorrect as health literacy is an achieved level of knowledge or proficiency that depends on both an individual's own capacity (and motivation to learn) and that of the health professionals or factors within the health system factors that provides the care (Baker, 2006; Kickbusch, Pelikan, Apfel, & Fsouros, 2010; Parnell, 2014a; World Health Organization 2013). It does not rest solely on nurses as informants suggested. Moreover, several surveys prove that even well-educated and highly experienced nurses may themselves possess low health literacy and that health literacy is mostly dependent upon the current context or situation of an individual (Nielsen-Bohlman, 2004; Parnell, 2014). In spite of their expertise, health professionals may also experience a surprising inability to understand certain medical terms (Parnell, 2014). However, findings from this current study suggest that even within nurses' own expertise, nurses can also possess low health literacy unless their knowledge and information is updated regularly.

The unfamiliarity and lack of knowledge of patients regarding health literacy issues implies that the tendency for mental health nurses to apply strategies to improve patients' health literacy in clinical practice is limited. In fact, findings from this study attest to this. Many of the informants reported rarely assessing patients' health literacy. However, when they do it is based on assumptions rather than objective measurement or use of available health literacy

screening tools (example the REALM, TOFHLA, BRIEF, NVS). These tools have been reported to be effectively administered in clinical settings in circumstances in which time and personnel are limited (Haun, Valerio, McCormack, Sorensen, & Paasche-Orlow, 2014). Moreover, the assumption of the informants that patients and people from rural settings all possess low health literacy demonstrates prejudice and stereotypical attitudes. This prejudice was demonstrated by nurses' attitudes, such as ignoring or avoiding opportunities to educate or even nurse, patients with high spiritual connections and low health literacy. This highlights the concern that mental health nurses sometimes show a lack of empathy for these patients and in so doing perpetuate the stigma associated with patients in their care. Although the use of characteristics, such as educational level, socio-economic status, rural dwellings, is a quick way to identify patients with low health literacy (in a system that is over-burdened with patients), it has the tendency to result in misleading results and may cause nurses to interact ineffectively with patients (Parnell, 2014). Surveys have indicated that the average person reads several grades lower than their actual number of school years completed (Parnell, 2014; World Health Organization 2013).

Techniques employed by informants to assist patients with low health literacy, such as repetition of instructions or information, the use of illustrations or sign language, asking questions, audio visuals, group therapy, or asking patients to repeat instructions given them (teach-back) to check for their level of understanding, are consistent with findings from other studies conducted among nurses (Macabasco-O'Connell & Fry-Bowers, 2011; Redden, 2017; Richey, 2012). These techniques, although reported to be effective, may not be effective in addressing patients' low health literacy when used alone. Strategies such as creating a trustful environment to encourage patients to ask questions, and the use of patient education materials written at a 5^{th}-grade level or lower may help matters (Macabasco-O'Connell & Fry-Bowers, 2011; Parnell, 2014). It has been shown that merely asking patients "Do you understand?" does not prove that patients actually do understand, as observed through studies on patients' self-reported understanding (Castro, Wilson, Wang, & Schillinger, 2007). This has been attributed mainly to patients feeling ashamed or embarrassed and not wanting to admit their deficiencies even if they are well-educated and literate. (Parnell, 2014). This finding is similar to findings in this study where informants reported that patients with limited English language proficiency and knowledge about mental conditions often feel shy and embarrassed to admit so.

5.2.3 The practice of health literacy has to be negotiated within a cultural context

Systemic factors, which include availability of resources, the characteristics of health professionals, their communication skills, their knowledge of health and culture, have all been identified as having an impact on the promotion of health literacy application in clinical settings (World Health Organization 2013). In this study, a lack of health materials for the education of patients and the inadequate knowledge of nurses about current mental health topics were viewed as a major challenge to overcoming the problem of communication. Teaching materials and web-based resources (such as health literacy for public health professionals) (Control & Prevention, 2010) are important approaches that are valuable in overcoming low levels of health literacy (Mogobe et al., 2016). Although teaching materials have been identified as effective in improving health literacy, crucial attention should be paid to the verbal communication of nurses in a challenging setting like Ghana's mental health system where health education materials are not often available.

Nurses in this study reported a lack of health literacy training and education as such and suggested incorporation of health literacy training as an integral part of clinical nursing continuous education. The majority of the informants assigned the responsibility of improving health literacy of patients to nurses in spite of the cultural barriers that may exist between them and their patients but failed to highlight the role of nurses in mental health care settings in particular. MHNs comprise the largest segment of the mental health service workforce and health literacy training will assist them to address the increasing challenges of low health literacy in their diverse clinical settings. Studies indicate that patients with low health literacy often avoid asking questions, are often confused, frustrated, and often make excuses when asked to read printed materials and often feel shy to disclose their low health literacy status. This often makes it difficult for nurses to detect patients with low levels of health literacy without proper assessment. Therefore, teaching nurses the skill of health literacy assessment is crucial to ensuring patients' health literacy is properly detected and not based on nurses' assumptions (Egbert & Nanna, 2009; Wittenberg, Ferrell, Kanter, & Buller, 2018). This current study supports the need for building nurses' communication skills in the area of health literacy.

According to the informants, the nature of the Ghana mental health service system does not permit ample time for nurse-patient interactions. It was not surprising that informants proposed

a separate unit to be set outside for psycho-education during general out-patient clinic sessions. This, according to informants, will give patients the opportunity to ask questions pertaining to their health, and nurses more time to educate patients and address low health literacy issues.

The next critical factor had to do with how nurses can apply the principles of health literacy to meet the needs of a diverse range of patients all speaking different languages in their clinical settings. Issues of language and communication were considered as part of health literacy and a health system factor (Egbert & Nanna, 2009; Mogobe et al., 2016). This is because language differences between nurses and their patient populations was a cause for significant concern as it influenced nurse-patient communication and reduced patients' ability to understand health information fully (Parnell, 2014). As specified by Rudd "Health literacy happens when patients, or anyone on the receiving end of health communication, and providers, anyone on the giving end of health communication, truly understand one another" (Rudd, 2007, p. 176).

Although the informants adopted some strategies to address the language differences between themselves and their patients, the strategies were not sufficient to improve effective nurse-patient communication and teaching. Verbal communication was the only mode of interaction for health education between mental health nurses and patients as written materials for patient teaching is unavailable. The use of untrained, bilingual staff, patient relatives and friends as interpretation, have been reported to lead to a significant number of errors (Izione, 2014). Even in settings where a language interpreter is used to promote understanding, cultural issues were reported to interfere with the effectiveness of communication between patients and mental health nurses (Singleton & Krause, 2009). There is an urgent need to address language differences between patients (and their relatives) and MHNs as this may deter patients' willingness to seek health care services and information (Baur, 2010). In the absence of professional language interpreters in the health system, the effect of language on health literacy practice and knowledge will be increased.

The majority of informants believed that integrating health literacy into community mental health practice through a liaison with community leaders is crucial given the ethnic, religious and linguistic diversity of Ghana's demography. In Ghana different ethnic groups or cultures have different ways of communicating either through words, body language and gestures. In

addition, there are norms about what is appropriate to be discussed (Asare & Danquah, 2017; Opare-Henaku & Utsey, 2017; Parnell, 2014). This means that it was common for the meaning of words to vary from culture to culture. In addition, informants advocated that community leaders should become involved in health education. This will assist in increasing awareness of the meaning of certain words within an ethnic/cultural group. In this study, informants faced many challenges in gaining access to community members and knowledge of appropriate words to use during mental health education and collaboration with community leaders was seen as necessary in the quest to promote health literate communities (Parnell, 2014). From a public health perspective, an individual's health can be improved when health literacy is tackled from a societal or community level (Freedman et al., 2009; Parnell, 2014a). This will in turn assist community health nurses to be cognizant of the diverse cultural beliefs and practices, provide patient-family centred care and education, which is pivotal to optimal mental health care. From the informants' perspective it was noted that being cognizant of cultural beliefs and in possession of adequate health literacy skills was pivotal for nurses to improve patient mental health outcomes.

The majority of the informants believed that policy-makers do not prioritise mental health education and care as they do not allocate funds for the materials/resources needed for mental health education and training. These resources according to nurses will enable them to provide effective mental health education to patients in various communities. Provision of health materials written in different Ghanaian languages was also proposed by informants and advocated as a platform through which to educate the Ghanaian populace about mental health.

Incorporation of traditional medicine into Ghana's clinical practice has been identified as the safest and fastest way to provide effective care (Amoah et al., 2017). The integration of traditional/spiritual healing with Western medicine emerged as a critical focal point of discussion, as mentioned in section 6.2.1. Although their views are not different from the World Health Organisation, which wants to integrate Traditional Medicine (TM) within national health care systems (World Health Organization, 2013) and also the Ghana Health Service, (GHS, 2007; MoH, 2007), it may be difficult due to inadequate research to explore how these elements can be integrated so as to promote health literacy of both MHNs and their patients. Moreover, Ghana's mental health system may not be ready to ensure effective implementation of health literacy even within the mental health sub-system as many materials and resources,

including screening tools to promote health literacy, are not available. This is supported by Nielsen-Bohlman, Panzer, and Kindig (2004) who argue that the health system is an important mechanism for providing the services and facilities to promote health literacy among the patient population.

5.3 Implications for Practice

This study highlights the challenges faced by MHNs in the mental health system and how health literacy, culture and language impact their nursing practice. It encourages nurses to utilise health literacy and develop cultural competencies to facilitate efficient patient-centered care and promote equity in their care delivery. The findings have the following implications for the practice:

- There is a need for a critical attention to paid to the health literacy knowledge and skills of nurses. It is important to provide nurses with a program/training that is culturally sensitive and adapts the health literacy concept to their practices. It will be important for MHNs to provide culturally competent care to address the communication needs of patients with regards to language preference, which falls into the realm of providing patient-centred care. According to the findings, mental illness was perceived as having spiritual connotations, so nurses need to develop a measure to provide nursing care to these patients in a manner that is aligned with patients' belief system. Such an approach will help to promote the use of evidence-based strategies that assess patients' health literacy as part of every patient's plan of care, and routine nursing practice is needed in the health care system.

- There is a need for a cross-institutional collaboration between practitioners, researchers and policy-makers to provide a credible source of educational materials which will be easily comprehended by all regardless of literacy rates.

- The study showed that MHNs spend little time and effort to educate patients and their relatives. However, because knowledge is power, nurses have the key professional and ethical responsibility of conveying health information to patients. It is crucial to convert medical jargon into plain language to increase patients' understanding. Therefore, the

sole goal of interaction with patients is to empower patients to access, understand and act on health information for optimal health. There is also a need for nurses to allocate adequate time for their patients to ask questions about their health. Furthermore, MHNs are encouraged to adopt teaching strategies that meet the needs of all patients regardless of their literacy rates, socioeconomic statuses, cultural and linguistic backgrounds. This is to promote equity in care delivery among all patients.

- To achieve the above goals, researchers, healthcare professionals and managers should work collaboratively with policy-makers to provide opportunities to build a community in Ghana that is health literate by strengthening the capacity of MHNs. For practising MHNs, there is a need to implement and evaluate professional continuing education and training programs that will increase health literacy awareness and the skills of nurses.

- Finally, efforts must also be made by researchers and practitioners to integrate the body of evidence of health literacy research into clinical practices. Recognition and the addressing of issues facing patients with low health literacy through nurses' daily interactions will not only improve health outcomes but empower patients to apply new information.

5.4 Recommendations for Future Research

Further research is suggested in the areas of nursing education, practice and administration to improve health literacy knowledge and practice among MHNs in Ghana and similar countries. Based on the findings, the following are suggested for consideration of future health policies and practices to improve nurses' health literacy practices and health outcomes for the patients in Ghana:

- Future studies should focus on how to measure and apply health literacy, cultural competence and access to language services within the mental health care system. Such a study can help to improve access to understandable and actionable health information for the patients.

- There is a need for research on continued identification of verbal communication and patients teaching techniques that can increase health literacy and promote health outcomes in the clinical settings.

- There is a need for an interventional study which aims at developing teaching and assessment materials about health literacy that provide guidance on health education about diagnosis, follow-up appointment, medication adherence and self-management, and which are tailored to the patient population's culture and language. Such interventional studies could also be developed to examine ways of improving and incorporating health literacy into clinical practice in mental health care.

- A comparative study of nurses from diverse fields can help throw more light on how important contextual factors such as culture affect health literacy in nursing care across diverse healthcare settings.

- Future studies could examine the research questions by a mixed method research approach and possibly a multi-regional study, and across various health professionals. Using a mixed method design may expand knowledge on the impact of culture on health literacy among practising MHNs through statistical inferences.

- There should also be investigations into the intention of nursing administration to use health literacy strategies as part of clinical practice. This study's findings imply that MHNs are highly motivated to learn and adopt health literacy strategies. However, a study of the nursing administrations can explore how nurses' intention can be incorporated into actual routine practice. Future studies can also examine what facilitates or impedes the adoption of health literacy strategies from an administrative perspective.

5.5 Limitations of the Study

This section provides an overview of the possible weaknesses of the study with regards to its conception, methodology, findings and interpretation.

- Due to limited access to other MHNs in Ghana, the purposive sample of 43 informants from two hospitals may not represent health literacy experience and practice of other MHNs in different regions. However, some of the findings in this study are consistent with results of research conducted in different settings among other nursing specialities and health professionals. Thus, although, the findings may only reflect the perception and lived experience of MHNs in Accra, Ghana, they are still important to other settings in low-income countries.

- Health literacy is still a relatively new concept with multiple definitions. Hence, it is easy to imagine that the concept might have differently meanings across different disciplines of the healthcare profession. Along with this line, little is known about the impact of health literacy on different types of providers (nurse practitioners, psychiatrists, psychologists, and social workers) within the mental health care system. The findings of the present study view from MHNs only therefore, future studies should extend to other nurses in different specialties.

- Moreover, the study relied on the recall abilities of participants. It is thus based on selective memory and due to the limited opportunities in focus groups to share their experiences, only selected experiences were shared. Therefore, informants may or may not have remembered some important experiences.

Despite these limitations, this study, to the best knowledge of the researcher, is the first to describe MHNs' understanding of health literacy and how local precepts about mental health influence mental health nurses' understanding of the concept, and its implication for nursing practice. It is, therefore, an important starting point in this research area and the setting.

5.6 Conclusion

The study focused on how culture and its elements, such as language, affect health literacy in nursing practice. It highlights that to date; health literacy remains an unfamiliar concept to MHNs. The study shows that aspects of the culture of both patients and nurses serve as a barrier and sometimes facilitate health literacy knowledge and practice particularly concerning

decisions about health-seeking behaviour and use of traditional and complementary/alternative healing methods in mental health nursing practice.

While health literacy and cultural competence have sometimes been treated as separate concepts in nursing practice and health educational literature, this study empirically demonstrates the overlapping nature of these two concepts in nursing practice, and the need for nursing educators and health systems to develop a unified approach to address health inequalities using a common training curriculum. That is, social epidemiologists and health educators need to work in unison to develop contextually relevant tools, training strategies and resources that incorporate health literacy and local cultural elements to help reduce health disparities, enhance nursing practice and improve patients' overall health outcomes. According to the study, understanding health literacy from cultural perspectives can help to address the challenges in care delivery and rectify misconceptions about mental health, which are prevalent in places such as Ghana and even among MHNs. In fact, some MHNs demonstrated support and preference for culturally-induced approaches to addressing mental health issues despite their biomedical training. These findings represent a call for more to be done for MHNs to improve their awareness and knowledge of their local cultural practices and those of the patient populations they serve in order to ensure efficient healthcare delivery.

However, this may be difficult to achieve because many health facilities and training institutions in the study area face several challenges, including limited materials and tools for assessing and incorporating health literacy in clinical practices, and a lack of interpreters, which impede the ability of nurses to recognise and address the incidence of low health literacy among patients. In light of these challenges, there is a need for nurse-specific interventions which aim to boost the capability of MHNs to apply health literacy in their practice by taking their local culture, existing relevant policies and strategies on health education, as well as other system-wide weaknesses into consideration. Such an approach will help to improve the efficacy of the service delivery of MHNs and enhance the health outcomes of patients by empowering them through effective nurse-patient encounters irrespective of cultural and linguistic differences. It is suggested that MHNs and other health professionals should reflect on health literacy, language and cultural issues not as neatly co-occurring elements, but rather as an amorphous affiliation which occurs in different ways and degrees, for different patients.

APPENDICES

Appendix I

Interview Guide (Focus Group Discussion)

Understanding of Health literacy

1. **What do you understand about health literacy?**
    a. **Prompts:**
    b. What does health literacy mean to you?
    c. Can you tell me how you know about health literacy?
    d. Think back and describe to me when you heard about health literacy?
    e. Describe "red flags" that signal when a patient may be having problems about health information understanding.

2. **Are you required to assess the health literacy of patients you see in your workplace?**

3. **How may culture and local beliefs about mental health affect your ability as a mental health nurse to assess or address issues relating to health literacy?**
    a. **Prompts:**
    b. Can you describe some cultural practices and beliefs about mental illness?
    c. In your experience, how do such beliefs affect your communication with patients?
    d. How may your own beliefs about mental health influence you in terms of willingness to educate the public or discuss mental health information with patients?
    e. In cases where you do not speak a common language with patients, what means of translation do you use?

4. **What resources do mental health nurses need to address issues of health literacy at your workplace?**
    a. **Prompts:**
    b. How do you know the materials are at the level easily understood by patient/relatives /caregivers?
    c. On a typical workday, how do you assess the health literacy of patients you see?
    d. Can you tell me more about your experience in educating a patient with low health literacy?

5. **Can you tell me about how low health literacy impact the health of mentally ill patients?**
    a. **Prompts**:
    b. What challenges do mentally ill patients and their families with low health literacy face?
    c. Do you think health literacy may affect patient's decisions about their health care?

Appendix II

Interview Guide (Individual In-depth Interview)

Understanding of Health Literacy

1. What do you understand about health literacy?

2. On a typical workday, how do you assess the health literacy of patients you see?

3. How may culture and local beliefs about mental health influence mental health nursing or care?

4. What resources do mental health nurses need to address issues of health literacy at your workplace?

5. Can you tell me about how low health literacy impact the health of mentally ill patient?

Appendix III

Demographic Data

Impact of Language and Culture on Health Literacy and Mental Health Nursing: Perspective of Mental Health Nurses A Qualitative Study.

Researcher: Adwoa Owusuaa Koduah
Fictitious Name of Participant: _____
Date: _____

Demographic Information

1. Gender:
    a. Male [ ]
    b. Female [ ]

2. Age
    a. 20- 30 years [ ]
    b. 31-40years [ ]
    c. 41-50 years [ ]
    d. 50 years and above [ ]

3. Nursing School attended
    a. Pantang Nursing Training College [ ]
    b. Ankaful Nursing Training College [ ]
    c. Others please specify _____

4. Year you entered the nursing school _____

5. Level of Nursing Education
    a. Diploma in mental health nursing [ ]
    b. Bachelor of science degree in nursing [ ]
    c. Advanced degree/master's degree in nursing [ ]

6. Ethnicity
    a. Akan [ ]
    b. Ewe [ ]
    c. Ga [ ]
    d. Dagomba [ ]
    e. Others please specify _____

7. What language(s) do you speak? Check all that apply:
    a. English [ ]
    b. French [ ]
    c. Asante Twi [ ]
    d. Akuapem Twi [ ]
    e. Fante [ ]
    f. Ewe [ ]
    g. Ga [ ]

h. Dagaare [ ]
i. Hausa [ ]
j. Dangme [ ]
k. Nzema [ ]
l. Others please specify_____

8. Years of nursing experience (excluding basic nursing training)
   a. 2-10 years [ ]
   b. 11-20 years [ ]
   c. 21-30years [ ]
   d. 30years and above [ ]

9. Nursing Rank
   a. Staff nurse [ ]
   b. Senior Staff Nurse [ ]
   c. Nursing Officer [ ]
   d. Senior Nursing Officer [ ]
   e. Principal Nursing Officer [ ]
   f. Nurse Manager [ ]

10. Number of years working in your current workplace?
   a. 1 – 5 years [ ]
   b. 6 – 10 years [ ]
   c. 11- 15 years [ ]
   d. 16 years and above [ ]

11. Which department are you currently working?
   a. Out-Patient Department [ ]
   b. Female ward [ ]
   c. Male ward [ ]
   d. Paediatric ward [ ]
   e. Nursing administration [ ]

12. What is (are) the primary language(s) of your patients' population? Check all that apply:
   a. English [ ]
   b. French [ ]
   c. Asante Twi [ ]
   d. Fante [ ]
   e. Ewe [ ]
   f. Ga [ ]
   g. Akuapem Twi [ ]
   h. Hausa [ ]
   i. Dangme [ ]
   j. Nzema [ ]
   k. Dagaare [ ]
   l. Others please specify_____ ***Thank you.***

Appendix IV

Information Sheet

THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學

Project title: Mental Health Nurses' Understanding of Health Literacy: A Qualitative Study in Ghana

You are cordially invited to participate in a study conducted by Adwoa Owusuaa Koduah, MPhil student under the supervision of Dr. Angela Leung and Dr. Justina Liu, Associate Professors in the School of Nursing of the Hong Kong Polytechnic University respectively. This study attempts to explore mental health nurses' understanding of patient's health literacy in the Greater Accra Region in Ghana, and how cultural elements in Ghana, and local perception about mental health are in relation to mental health nurses' understanding of patient's health literacy.

If you agree to participate in this study, you will share your understanding of health literacy in a group discussion. A moderator will conduct the discussion, and the session is expected to last for approximately one and half hours. You will be asked a series of questions to share your experiences in the presence of the other participants. The entire session will be audiotaped to facilitate analysis of the data gathered during the interview.

It is anticipated that you will not experience any risks for participating in the study. You may however, be uncomfortable about specific questions. However, you are free to quit the interview at any time if you find the line of questions uncomfortable. Reasonable steps will be taken to protect your privacy and the confidentiality of the information you share during the group discussion by ensuring that, issues discussed in the group remain only among participants. Only the researcher of this study will have access to the raw data records and supervisors of this study will be provided with transcriptions of your narrative. The digitally recorded group interviews and subsequent transcribed data will be electronically stored in a password-protected computer in a password-protected file, only accessible to the researcher. Additionally, you will be allowed to use a fictitious name to ensure your anonymity in transcription and data analysis. Also, no personal identifiers will be obtained. Again, you have

every right to withdraw from the study before or during the interview session without penalty of any kind. All information received will be used for academic purposes only and destroyed after study is complete.

There are benefits to participating in this study for you as a nurse. The discussions will be an opportunity for participants to learn more about health literacy and its application in nursing and mental health practices. This will enhance the work of participants while ensuring better health services for patients.

If you have any complaints about the conduct of this study, please do not hesitate to contact Miss Cherrie Mok, Secretary of the Human Subjects Ethics Sub-Committee of The Hong Kong Polytechnic University in person or in writing (c/o Research Office of the University or email: cherrie.mok@), stating clearly the person and department responsible for this study. If you would like more information about this study, please contact Adwoa Owusuaa Koduah telephone number: +2332458 or via email: adwoa.o.koduah@ . Thank you for your interest in participating in this study.

Principal Investigator
Angela YM Leung, PhD
Associate Professor
School of Nursing

Appendix V

Informed Consent

THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學

Project title: Impact of Language, Culture and Health Literacy on mental health nursing: Perspective of Mental health nurses. A Qualitative Study in Ghana

I _____ hereby consent to participate in the captioned research conducted by Adwoa Owusuaa Koduah under the supervision of Dr. Angela Leung & Dr. Justina Liu.

I understand that information obtained from this research may be used in future research and published. However, my right to privacy will be retained, i.e., my personal details will not be revealed.

The procedure as set out in the attached information sheet has been fully explained. I understand the benefits and risks involved. My participation in the project is voluntary.

I acknowledge that I have the right to question any part of the procedure and can withdraw at any time without penalty of any kind.

Name of participant _____

Signature of participant _____

Name of researcher Adwoa Owusuaa Koduah

Signature of researcher _____

Date _____

Appendix VI

Approval Letter from Pantang Hospital

PANTANG HOSPITAL

OUR CORE VALUES:-
* Recognition of diversity
* Equal treatment
* Confidentiality
* Professionalism
* Compassion
* Teamwork

Address:P.O Box LG-81 LEGON-ACCRA
website: www.pantanghospital.gov.gh
Email: info@pantanghospital.gov.gh
Tel: +233 (0) 30 3972 321
+233 (0) 30 3972 322

8th November, 2017.

My Ref. No: MHA/PH/GF.82
Your Ref. No: .....

The Centre Director (Centre of Gerontological Nursing)

School Of Nursing

The Hong Kong Polytechnique University

Dear Dr. Leung,

PERMISSION TO CONDUCT RESEARCH BY MS. ADWOA OWUSUAA KODUAH

Your letter dated 25th October, 2017 refers.

We are pleased to inform you that **MS. ADWOA OWUSUAA KODUAH** has the permission of our institution to collect data for her research titled: **"Mental Health Nurses' Understanding of Health Literacy: A Qualitative Study in Ghana".**

We hope she fulfill the ethical measures outlined in her proposal.

Thank you.

Yours faithfully,

PHILIP ABEPUORING
(IN-SERVICE TRAINING COORDINATOR)

FOR: HOSPITAL DIRECTOR
PANTANG HOSPITAL

APPENDIX VII

Approval Letter from Accra Psychiatric Hospital

THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學

FACULTY OF HEALTH AND SOCIAL SCIENCES
SCHOOL OF NURSING
護理及社會科學院
護理學院

ACCRA PSYCHIATRIC HOSPITAL
P. O. BOX 1305, ACCRA
01 NOV 2017
RECEIVED

Prof. Alex Molasiotis
RN, BSc, MSc, PhD
Angel S.P. Chan Lau Professor in Health and Longevity
Chair Professor of Nursing and Head of School
Director of WHO CC for Community Health Services

莫禮士 教授
劉陳小寶健康延年教授
護理學講座教授及學院主任
世界衛生組織社區健康服務合作中心總監

25th October, 2017

To whom it may Concern

Dear Sir/Madam,

INTRODUCTORY LETTER

This is to introduce Ms. Adwoa Owusuaa Koduah, who is an MPhil candidate at the School of Nursing, The Hong Kong Polytechnic University. She is undertaking her fieldwork for her MPhil dissertation which is entitled: *Mental Health Nurses' Understanding of Health Literacy: A Qualitative Study in Ghana.*

We will be very grateful if you could assist her with the information/data she will need for her study. If you have any complaints about the conduct of this study, please do not hesitate to contact Miss Cherrie Mok, Secretary of the Human Subjects Ethics Sub-Committee of The Hong Kong Polytechnic University in person or in writing (c/o Research Office of the University or email: cherrie.mok@polyu.edu.hk), stating clearly the person and department responsible for this study.

Yours sincerely,

Angela YM Leung, PhD
Associate Professor
Centre Director (Centre of Gerontological Nursing)
School of Nursing, the Hong Kong Polytechnic University.

School of Nursing
The Hong Kong Polytechnic University
Hung Hom Kowloon Hong Kong
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E alex.molasiotis@polyu.edu.hk T (852) 2766 6396 F (852) 2330 5149
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