Health workforce perspectives of barriers inhibiting the provision of quality care in Nepal and Somalia – A qualitative study

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ABSTRACT

Objective: In this paper settings from Nepal and Somalia are used to focus on the perspectives of healthcare providers within two fragile health systems. The objective of this study was to describe barriers inhibiting quality care in Nepal and Somalia from a health workforce perspective.

Methods: Data were collected through 19 semi-structured interviews with healthcare providers working in healthcare facilities. Ten interviews were conducted in Nepal and nine in Somalia.

Results: Various structural barriers inhibiting the availability, accessibility, and acceptability of the quality care were similar in both countries. Barriers inhibiting the availability of quality care were linked to healthcare providers being overburdened with multiple concurrent jobs. Barriers inhibiting the accessibility to quality healthcare included long distances and the uncertain availability of transportation, and barriers to acceptability of quality healthcare was inhibited by a lack of respect from healthcare providers, characterised by neglect, verbal abuse, and lack of competence.

Conclusions: Inequality, poverty, traditional and cultural practices plus the heavy burden placed on healthcare providers are described as the underlying causes of the poor provision of quality care and the consequential shortcomings that emerge from it. In order to improve this situation adequate planning and policies that support the deployment and retention of the healthcare providers and its equitable distribution is required. Another important aspect is provision of training to equip healthcare providers with the ability to provide respectful quality care in order for the population to enjoy good standard of healthcare services.

Background

Human resources for healthcare are essential in achieving health-related sustainable development goals (SDGs), and are integral to universal health coverage [1]. Universal health coverage emphasises the fundamental importance of the health and wellbeing of all people. Universal health coverage is thus about ensuring that all people get equitable access and use of the quality healthcare services they need without experiencing financial hardship [1,2].

If health-related targets are to be achieved, health systems will have to be strengthened to deliver a wider range of essential health services. Hence, health systems need to directly address and work towards universal healthcare, including sexual, reproductive, maternal and newborn health, and gender equality [3]. In combination with available health sector policies or reforms, universal health coverage can only be achieved if there is a sufficient number of healthcare workers and available medicines [4].

Compelling evidence shows that a higher number of healthcare providers such as doctors, midwives, nurses, and auxiliaries has a positive effect not only on access to healthcare but also on health outcomes [5]. As many of the SDGs clearly impact on the healthcare workforce and its ability to provide quality care [6], the provision of
quality care requires equitable access to the right combination of educated, skilled and motivated healthcare providers [5,7] who need to be equitably distributed to where they are most needed within a functioning health system [8,9]. Alongside this, wider issues of equality that affect quality care, such as gender, race, and socio-economic status need to be addressed [6]. Heathc systems all over the world are struggling to keep up with the demands placed on them, which in turn places additional demands on their healthcare providers in delivering quality care [10]. Healthcare providers are the key to realising the potential of improved quality care [11]. In this paper, settings from Nepal and Somalia are used to focus on the perspectives of healthcare providers with regards to barriers inhibiting the provision of quality healthcare in Nepal and Somalia. Both these countries are located in regions with low per capita expenditures on health; South Asia 3.55% and Sub-Sahara Africa 5.15% of the national Gross Domestic Product (GDP) [12], and experience difficulties in meeting the healthcare needs of their populations [13,14]. One challenge that has been identified is the underestimation of the ability of both countries’ health systems to enable the healthcare providers in providing quality care [11,15]. Consequently, unless this specific challenge is targeted, efforts made by supporting healthcare providers in Nepal and Somalia who can meet the needs of the population will have little effect. Identifying challenges in preparing a workforce fit for providing quality care can help in setting policy priorities [4]. Until now, scientific papers have only discussed the health system or the facilities, or the health workforce of these countries [1,2,16,17]. In health systems such as those found in Nepal [18] and Somalia [19], the perspectives of healthcare providers are fundamental to understanding the challenges faced in providing quality care and to strengthening these healthcare systems. This has therefore been deemed an important area of research but has, however, scarcely been investigated in these countries. In order to close this gap, the aim of this study was to describe barriers inhibiting quality healthcare in Nepal and Somalia from a health workforce perspective.

Method

Study design

This study is based on individual interviews with healthcare providers (nurses, midwives, doctors, health assistances, and auxiliary nurses) in healthcare facilities in Nepal and Somalia. The term “healthcare facility” in this study refers to any healthcare facility ranging from community to referral hospitals. Semi-structured interviews were analysed using content analysis [20]. The study followed ethical principles for research [21] and was approved by the Nepal Health Research Council, Reg. no 21/2014, and the Department Ethics Committee on March 6, 2016, in Somalia.

Setting

Nepal is a low-income country with a population of nearly 30 million. Vast social and geographical disparities exist in health indicators and health services. With its three ecological zones – mountain, hill and Terai (lowland) – the disparities in the access to and utilization of healthcare services between the 126 multi-ethnic groups are significant. There is no universal healthcare system providing free healthcare to all citizens, although this is a national priority. Life expectancy for males and females is 68 and 71 years respectively, with a low ratio of skilled attendance at birth – 56% – and a high maternal mortality ratio of approximately 732 maternal deaths for every 100,000 live births [18].

Somalia is a post-conflict country with a population of around 14 million. There are large disparities in access to and utilization of healthcare services between urban and rural populations. The health system is described as inadequate, unfair, and fragmented, with highly privatized services, and low levels of central governance at all levels. Life expectancy for males and females is 53.5 and 57 years respectively, with a low ratio of skilled attendance at birth – 33% – and a high maternal mortality ratio of approximately 732 maternal deaths for every 100,000 live births [19]. Although these two countries are different in terms of setting; Somalia as a post-conflict country and Nepal as a low-income country, both countries face major challenges in delivering a good healthcare service. It is crucial to understand the challenges and facilitating factors from the perspectives of healthcare provider.

Participants and sampling

Study participants in Nepal were recruited from community clinics, district and referral hospitals; five were from the Kathmandu Valley and five from hill and mountain regions. Three categories of healthcare providers were identified: (1) medical doctors, (2) auxiliary nurse-midwives, and (3) healthcare assistants. Study participants in Somalia were recruited from two tertiary level hospitals. Three categories of healthcare providers were identified: (1) medical doctors, (2) nurses, and (3) midwives. Purposeful sampling [22] was used for recruitment of participants in both countries. This sampling technique was used to ensure a representation of gender, level of facility that participants worked in, and representation of urban and remote areas. The inclusion was based on the following criteria: clinically active healthcare provider, working in government healthcare facilities, and aged 18 years or older. Participants were recruited with the permission from the clinic/hospital directors, and invited to participate through face-to-face by the co-author (AJ) in Nepal, and by the co-author (JM) in Somalia. All participants who were invited agreed to participate. Characteristics about the participants are illustrated in table 1.

Data collection

A semi-structured interview guide (Additional file 1) was developed in English to respond to the study aim, and thereafter translated into the local languages. The Dalarna University mentors (KE, UB, CPN, and FO) trained the research team in each country to ensure consistency in the recruiting, questioning, and piloting between the two contexts, as well as training on critical self-reflection about one’s own biases, preferences and preconceptions. The co-author (AJ) conducted ten in-depth interviews in Nepal in January 2014, and the co-authors (MK, AAI, JM, and FS) conducted nine in-depth interviews in Somalia, in March 2016. The translated interview guide included questions relating to (i) implementation of healthcare, (ii) experiences of daily work, and (iii) factors effecting people seeking healthcare. The interview guide was pre-tested by the co-author (AJ) with one nurse from Nepal and the co-author (MK) with one nurse from Somalia. Minor changes were made, thus the pretested interviews were included in the analysis. All interviews lasted between 30 and 60 min and were conducted with the

Table 1

Characteristics of participants from Nepal and Somalia.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>14</th>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>5</td>
</tr>
<tr>
<td>Age range</td>
<td>23–60</td>
<td></td>
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<tr>
<td>Median</td>
<td>40</td>
<td></td>
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<tr>
<td>Healthcare providers</td>
<td>Medical Doctor</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Auxiliary Nurse-Midwife</td>
<td>3</td>
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<tr>
<td></td>
<td>Healthcare assistant</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Nurse</td>
<td>1</td>
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<tr>
<td></td>
<td>Midwife</td>
<td>4</td>
</tr>
<tr>
<td>Academic qualification</td>
<td>Diploma</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Bsc</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Master’s</td>
<td>6</td>
</tr>
<tr>
<td>No of years within the profession</td>
<td>1-5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>6–10</td>
<td>8</td>
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<td></td>
<td>&gt; 20</td>
<td>3</td>
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participants’ written consent. Data collection was continued until the interviewees sensed to have reached data saturation. The interviews were audio-recorded and took place at a location chosen by the participants, typically in their workplace. In Nepal, four interviews were conducted in English and six through an interpreter, and in Somalia they were conducted in Somali. Any parts conducted in a language other than English were translated and transcribed into English by a professional interpreter/translator.

Data analysis

The audiotaped transcribed interviews were analysed by MB, KE and FO, using inductive qualitative content analysis inspired by Elo and Kyngas [20]. The analysis was performed in several steps. The first step aimed to gain a sense of the transcripts by answering the question: What are the barriers inhibiting the provision of quality healthcare in Nepal and Somalia? This involved the authors reading the transcripts several times. In the second step, meaning units corresponding to barriers inhibiting the provision of quality healthcare in Nepal and Somalia were identified. Thirdly, after the meaning units were compared for similar content, they were coded. Fourthly, as the analysis progressed with the continuous comparison of the codes for similarities and differences, the codes were clustered into three emerging categories: “Limited availability of providing quality healthcare”, “Constrained accessibility to providing quality healthcare”, and “Poor acceptability for providing quality healthcare”. To ensure a standard approach to each step of the analysis, the authors applied a self-critical approach throughout the analysis process, which allowed for alternative descriptions and/or interpretations of the data until consensus was reached. An example of the analysis process in given in Table 2.

Results

Limited availability of quality healthcare services

The availability of quality healthcare services was limited to the insufficient numbers of healthcare providers in Nepal and Somalia. As a result, the healthcare facilities were only open for a few hours each day, which had a negative impact on the provision of healthcare services. According to the healthcare providers, availability of quality healthcare services could be ensured if there was an adequate payment system of their salaries, and not as the current situation, were they were forced to hold multiple jobs in order to receive a regular salary.

The healthcare providers in both countries also reported limited availability of medicine due to corruption at hospital management level, even though medicine was supplied to hospitals free of charge. One participant from Nepal stated: The government provides medicine but the hospital management puts all the money in their pockets. Patients are forced to buy the medicine in the pharmacy instead (Healthcare provider from Nepal #2).

Despite facing these barriers, it was described how they had developed systems that provided quality care in both countries. For example, one healthcare provider from Nepal had organised a ultrasound instrument and a portable power pack so pregnant women in the community could be examined. It is a great feeling when you are helping patients (Healthcare provider from Nepal #7). Another healthcare provider from Somalia described how she had mobilized private funds to support women with fistula complications.

Moreover, study participants from Nepal reported how some of the healthcare providers could not speak to patients in their language due to shortage of translators. This, however, was not the case in Somalia, as all healthcare providers spoke the national language. In Nepal, language barriers led to communication problems between healthcare providers and people in the local communities. This was expressed as Here it is difficult... These people speak Tibetan and I have no knowledge of it at all. I only speak Nepali and some English. In some parts of Nepal, people only speak their local language... (Healthcare provider from Nepal #10).

Constrained accessibility to quality healthcare services

Even if there are days with enough healthcare providers, people may not be able to access the healthcare services because of different constraints. Accessibility to healthcare services at a community level was affected by the inhabitants’ financial and education levels, regardless of cast in Nepal and clan in Somalia. The healthcare providers described the accessibility to healthcare services as being affected by distances to the healthcare facilities. As a result, people in communities far away from healthcare services either waited too long before seeking care or utilized the shaman or traditional birth attendants in Nepal and traditional healers or traditional birth attendants in Somalia.

When utilizing traditional birth attendants, women gave birth at home. Because of the long distances to healthcare facilities, women often arrived in bad condition when pregnancy and childbirth complications arose. As one healthcare provider from Somalia stated: They come from far away and it can take days to reach a healthcare facility, they are held at home and often delayed at home and the woman and child might die during the journey (Healthcare provider in Somalia #4). In addition, when they reached the healthcare facility, study participants from both countries stated that healthcare providers were not always accessible, which affected the provision of care negatively.

In both countries, the limited access to vehicles and ambulances to transfer emergency cases from healthcare facilities in the communities to referral hospitals added to the barriers inhibiting quality healthcare services. There are no vehicles to transfer the pregnant women and it can take days to find a car (Healthcare provider in Somalia #6). High cost and limited access to vehicles were common reasons for delays in women reaching a hospital even if they were referred there by a healthcare provider at the healthcare facility.

The accessibility to quality care in both countries was impeded by financial constraints meaning that the patients have to cover the cost of things such as health assessments, laboratory tests, medication, blood transfusions, food, etcetera. This was explained by a healthcare provider in Somalia who stated: They (the women) don’t have money to cover their medical expenses, especially women in rural areas. They have animals but no money (Healthcare provider from Somalia #2). Hence, the patients’ conditions often worsen at the facilities, and in some cases even result in death, due to financial constraints.

Poor acceptability for providing quality care

People’s poor acceptability of healthcare providers was linked to a lack of respectful care. It was stated that people chose not to consult with healthcare providers due to shortcomings in their care and their ignorant behavior. Neglecting danger signs and maternal complications were barriers inhibiting care for women’s needs. Some healthcare providers from both countries believed that women were sometimes put

<table>
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<tr>
<th>Mening unit</th>
<th>Code</th>
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<td>They come from far away distance which can take day and half day to reach health facility, they are held at home and there is delay at home and the woman and child might die during travelling</td>
<td>Long distances to reach healthcare</td>
<td>Constrained accessibility to quality healthcare services</td>
</tr>
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</table>
at risk because of neglect and poor attitudes during pregnancy and childbirth. One healthcare provider from Nepal described a colleague who had lost her temper when dealing with a patient. Another healthcare provider from Somalia stated that she knew several healthcare facilities where she would never take her family members because of the bad attitude of the staff towards the patients. The healthcare providers in both countries believed that bad attitudes were part of the working culture and would be hard to change.

There are hospitals where I would never take my family members (Healthcare provider from Somalia #3).

Health services need to be respectful, of medical ethics, culturally appropriate and gender sensitive, but gender discrimination and inequalities contributed to poor acceptability for providing quality care. From both Nepal and Somalia, it was reported that women could not visit health facilities without their husband’s consent. In Nepal, husbands, according to cultural practice, have the authority to speak to healthcare providers on behalf of their wives. This is not the case for women in Somalia, who have the authority to speak for themselves. As a result of this, healthcare providers in Nepal did not always receive accurate information on women’s health conditions, thus care of good quality was not always provided. This contributed to poor acceptability of care.

Surgical procedures such as cesarean sections were not an accepted intervention in the Somali community due to a lack of trust in performing such interventions. For women to undertake such procedures, oral consent was required from a male relative. This was a barrier for many pregnant women: As one participant stated: Misconceptions regarding cesarean sections delay oral consent from women’s male relatives and put women in labour at risk (Healthcare provider from Somalia # 9).

Healthcare providers from both countries talked about patients from a holistic viewpoint. One healthcare provider from Nepal expressed: Professional care is so important. It is not just medication, it is so many things; mental, physical, economic, social... everything! (Healthcare provider from Nepal # 1). In contrast, a lack of competence and an inability to provide respectful care was reported in both countries. Healthcare providers sometimes gave the wrong treatment. One healthcare provider from Nepal stated that she had seen a colleague administer a double dose of blood pressure medicine. Moreover, workplace conflicts in both countries stopped healthcare providers from providing respectful care. Participants stated that there was no difference between government and private healthcare facilities in this regard. Thus, conflicts inhibited the provision of respectful care.

Discussion

This interview study has identified similar barriers inhibiting the provision of quality healthcare linked to availability, accessibility, and acceptability in Nepal and Somalia. The barriers inhibiting healthcare providers were similar in both countries and can be linked to the health systems and low levels of universal health coverage. As seen in the results of this study, as well as in other research [16,17], the status of the studied countries was the most disadvantaged when it came to availability, accessibility, and acceptability and of the provision of quality healthcare. The population did not benefit from the healthcare they had the right to benefit from [16].

Healthcare providers from both Nepal and Somalia faced barriers that inhibited the availability of quality healthcare due to their attempts to balance the available resources, while workers were overburdened with multiple concurrent jobs. The lack of health financing in addressing availability, and subsequently acceptability, can be seen as a lack of national planning which hampers efforts at all system levels [17]. We agree with other researchers [23,24] that it is a concern that having multiple concurrent jobs may jeopardise the availability and the accessibility of healthcare providers as well as the quality of services and therefore put the attainment of universal health coverage goals for sustainable development in jeopardy.

The healthcare providers from both countries reported facing barriers inhibiting the accessibility to quality healthcare, and meeting the healthcare needs of the population. The long distances and the uncertainty of the accessibility of transport were described as limiting access to healthcare providers at facility level. For example, decision to refer did not necessarily result in referral to a higher-level facility. This made people instead utilize the services provided based on traditional and cultural practices [25,26]. Long distance and the uncertainties of being able to reach health facilities and professional care can be seen as a failure of a health system. Our results emphasise the importance of a health system’s ability to provide quality healthcare, and with the reality of citizens turning to traditional care, the health system is further weakened in its attempt to provide healthcare services. Clearly, investments in human resources for healthcare [2] need to take into account the shortage and distribution of educated and skilled healthcare providers to enable the accessibility to quality care and thus improved health outcomes.

Both Nepal and Somalia reported barriers inhibiting the acceptability of quality healthcare. Significantly, healthcare providers from both countries recognised that a lack of respectful care characterised by neglect, verbal abuse, and a lack of competence among healthcare providers. An interesting finding was that the healthcare providers could find fault in other providers’ care, but did not describe that they took responsibility for providing poor care themselves. Healthcare providers’ disrespect could therefore be considered being a serious barrier to the acceptability of care. The lack of respectful care and competence can be linked to other studies Nepal [27] and Somalia [28] raising the concern about women’s vulnerability to accessing care not only of the lack of respect from healthcare providers, but because of the compulsory consent required from husbands or family [29]. On the other hand, as described above [27,28,30], the consent can be seen as a protection from harmful care at facility level where the man is taking his responsibility as the head of the family in a patriarchal society. Our findings echo research from low- and middle-income countries where women experienced mistreatment, neglect, verbal abuse by care providers, particular around the time of birth [31,32], and where inhumane and undignified care was a serious impediment to the acceptability of care [17]. A consequence of these attitudes and behaviours identified in our study is that people choose not to seek care or women choose to give birth unattended or with only the support of traditional and cultural practices. These findings put forward the need for the availability of a culturally appropriate and educated workforce with the aim of gaining trust in communities enabling maximum improvement in health outcomes. Moreover, another barrier inhibiting access to quality care in Nepal was communication. Nepal has 126 different ethnic groups, each with their own language and customs [18]. This makes it difficult at times for service providers to communicate with the population seeking care [33]. According to the participants in this study, this, in combination with poverty and low education levels, meant that both women and men had restricted opportunities to receive quality healthcare.

One limitation of this study was that part of the study was conducted in 2014, and it can be argued that some data is outdated. However lifeworld experience and perceptions do not get outdated [34]. It is although important to tell when data were gathered for the readers to judge transferability of the descriptions. The study was based on a small and purposive sample [22]. Recruitment from different categories of healthcare providers and health facilities captured various experiences and views relating to the aim. Individual interviews enabled comprehensive exploration of the healthcare providers’ different experiences and views. It can be argued that a limitation was that the interview guide did not elicit ideas from the healthcare providers about how some of the problems and gaps that could have been addressed; however, some of the participants had some creative solutions to the issues they faced. Another limitation was that some of the interviews
needed to be translated, which may have resulted in a loss of depth. This was minimized by using an interpreter, and there were no obvious inconsistencies in the data between the two countries. The multi-cultural research team from high- and low-income countries. The multi-cultural research team has enriched the analysis with their interpretations drawn from expertise.

Conclusion and clinical implications

The study showed that healthcare providers from Nepal and Somalia participating in this study were not sufficiently supported and equipped to provide quality care to the people they served. The lack of available healthcare providers affected the provision of quality of care. Even if healthcare providers were available, the long distances and the uncertainty of access to transport were barriers to the provision of quality care. Thus, some people used the services provided based on traditional and cultural practices. The poor acceptability of care was characterised by lack of respect in care in terms of neglect, verbal abuse, and lack of competence and ability among healthcare providers. These were serious barriers to the acceptability of care.

In order to improve this situation, we therefore suggest to: (i) strengthen policies to support the deployment and retention of the healthcare providers and its equitable distribution; (ii) design and accelerate in-service training in respectful care, (iii) build public engagement and advocacy to gain confidence and trust in the healthcare services provided. Finally, we suggest future implementation research beneficial for the population to enjoy good standard of healthcare services.

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Appendix C. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.srhc.2019.100481.

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