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Health providers' perspectives on covid-19 healthcare delivery in the public health care in Indonesia: a qualitative study

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Abstract

The corona virus disease-19 global pandemic has impacted all aspects of life, including biological, psychological, social, and spiritual well-being over the world. Due to this fact, health professionals were challenged not only to provide physical care associated with Corona Virus Disease (COVID)-19 but also psychosocial and psychological support for patients. This study aimed to describe the subjective experience of corona virus disease COVID-19 health providers in community settings. A descriptive exploratory design was used. Focus group discussions were conducted with 15 health providers in public health centres in Indonesia. The participants were recruited using purposive sampling, and data were analyzed using thematic analysis. Three themes are constructed: i) explaining primary care service provided; ii) perceiving barriers to care; iii) perceiving expectations of prospective care. Care provided in the community setting included tracing, tracking, testing, treatment, making a referral in a coordinated manner, providing support for home care, a home visit, and recording and reporting. However, inadequate knowledge and negative beliefs of patients and the community coupled with limited resources, shortage of health professionals, heavy workload, and different policies negatively impacted the quality of care. Primary health providers

deliver COVID-19 interventions along with a coordinated approach despite dealing with burdens in the community.

Introduction

The Corona Virus Disease (COVID)-19 global pandemic has impacted all aspects of life, including biological, psychological, social, and spiritual well-being over the world not only on patients but also health providers.¹⁻⁴ Many community members dealing with COVID-19 found that when diagnosed, individuals experienced shock, sadness and anger.⁵ Some community members lost their partners or families and reported that they need physical treatment and support in the form of emotional, spiritual, communication, and health education to increase their well-being.^{5,6} The literature discusses patient care needs as complicated, varied, and contextual which not only needs physical care but also psychosocial and psychological support for patients.⁷ In addition, the quality of care in healthcare systems, such as the interactions between Healthcare Providers (HPs) and patients has come under increased scrutiny.⁸ The quality of care services cannot be improved unless patient satisfaction is actively pursued and special attention is paid to patient's wants and expectations in terms of comfort as well as clinical services.⁹ Those, HPs must commit to identifying and meeting patients' psychological, physical, and other needs during the treatment process in particular, in the context of COVID-19.

Many existing studies provide a good understanding of COVID-19 and its impact on COVID from the perspective of patients and nurses. For example, existing studies have reported the impact of COVID-19 and family coping responses,¹⁰ the implementation of adaptive coping strategies associated with the stigma of COVID-19,¹¹ the challenges faced by parents during the COVID-19 pandemic, including the concepts of loss and resilience,^{7,12-14} the impact on education, teaching and learning,¹⁵⁻¹⁸ the clinical research on COVID-19 in children,¹⁹ and the challenges of nurses in caring patients with COVID-19.²⁰ Furthermore, delivering holistic care reduced patients' illness severity for COVID-19 in India.²¹ Additionally, other research addressed the readiness and response of primary care to the pandemic's COVID-19.²²⁻²⁶ Furthermore, a study from Indonesia explored challenges faced by health professional roles in hospital and Primary Care Centers settings.²⁷ However, a limited article discussed how Indonesian HPs provide the delivery of care for COVID-19, particularly in the community setting.

Healthcare providers are critical components of the healthcare system in terms of preventing and managing patient's health conditions. They may advise patients on preventive healthy lifestyle,

intervention, and treatment options based on the signs and symptoms of diseases. Therefore, exploring the perspectives of HPs delivering care during the COVID pandemic care delivery is warranted. The aim of this study was to describe the subjective experience of HPs of COVID care delivery in the PHCs. By exploring HP's perspectives and experiences. This evidence could also be used by policymakers to better understand and contribute to the development of alternative interventions to assist both patients and professionals in handling these difficult circumstances during the COVID pandemic in particular and in outbreak situations in general.

Material and Methods

An Exploratory-Descriptive Qualitative (EDQ) design was used to explore the subjective experience of HPs of COVID-19 care delivery in community settings. The design was appropriate because it allowed the researchers to contextualise how the participants perceived their activities, environment, and role within the context of the study and provided a picture of what naturally occurred. Exploring the experience of HPs is beneficial to contextualize their insight and perspectives on how they dealt with COVID-19 healthcare delivery associated with their roles, barriers, challenges and hopes.

This study was conducted in Surabaya, East Java, Indonesia from April to June 2022 due to Surabaya being the top five COVID-19 transmission in Indonesia after West Java and Central Java.²⁸ In Public Health Centres (PHCs), 15 HPs were enlisted using purposive sampling. Purposive sampling was the method used for participant recruitment based on a set of predetermined inclusion criteria. The inclusion criteria for purposive sampling include HPs (physicians, nurses, nutritionists, midwives) involved in the COVID-19 healthcare delivery program, working in PHCs, and being willing to take part in the study. The most appropriate strategy for descriptive qualitative research was purposeful sampling, and this sampling should allow the researcher to capture and describe the phenomena in a variety of situations. The procedure of recruiting participants began with contacting the head of PHC. The head of the PHC then notified the COVID coordinator at each local institution. The researcher then informed the recruitment process based on the inclusion criteria. The researcher handed over the research project brief, consent form, and FGD guidelines to the COVID coordinator. Prospective participants who wanted to participate in the study contacted the researcher if they had any questions or required more information about the research activities. Prospective participants who decided to participate in the study provided informed consent, and the FGD time contract was scheduled in accordance with their agreement. All responders agreed that the FGD would be held in the meeting room in the afternoon after work hours. Furthermore, this study included two PHCs from different locations that were chosen because they have a high case

rate and more representative of the work area, such as higher population density, more diverse socioeconomic variations in the community, or serve as a referral center for the surrounding sub-districts.

Focused Group Discussions (FGD) and note-taking were utilized in this study to collect data. The goal of the FGD was to gather information regarding the care process, activities, obstacles, and issues. This study conducted two FGDs in which each group consisted of 6-10 respondents, including a moderator and a note-taker. The author initially provided predetermined questions. The initial questions of FGD included perspectives, insight, experiences, job activities, and behaviour related to the provision of COVID-19 care. During a FGD, the author began by asking FGD participants questions based on the listed questions provided, then narrows the topics to keep the discussion more focused. If the author wanted additional information about a participant's response, the moderator asked her/him to elaborate. FGDs were audio recorded, and note-taking was obtained to record key points of information and to keep track of what topics have been covered and asked next.

Once data were collected, the author requested a transcription service be used to transcribe the audio speech to written text after the service signed a confidentiality agreement. There are no special requirements for analysing qualitative data. Thematic analysis, as recommended by Braun and Clarke,²⁹ was used in accordance with EDQ. Braun and Clarke present a detailed, six-phased, step-by-step guide to conducting thematic analysis,²⁶ including familiarization of data, generation of codes, combining codes into themes, reviewing themes, determining the significance of themes, and reporting findings. This study achieved theoretical saturation when there were new theoretical insights identified in the data analysis. After completing two FGDs interviews, three themes were constructed, after which no new information was being yielded. Figure 1 below illustrates the implementation of EDQ:

Rigour

An EDQ involves credibility, authenticity, criticality, and integrity in developing the scientific rigour of the study.³⁰ This study ensures credibility and authenticity in several ways. Credibility refers to how the researcher has achieved familiarity with the topic and how the research provides sufficient evidence to support the researcher's claims.³¹ The inclusion of 15 HPs from various healthcare settings ensured the study's credibility, resulting in meaningful data that reflected the participants' daily lives. In addition, the researcher has been involved in a COVID-19 project since 2021, and her involvement has built her experience and knowledge of COVID-19. This study double-checked its accuracy using an audio interview when the authors received the typed transcript

from the transcriber, maintaining meaning and enhancing the credibility of the results. A qualitative technique used to establish credibility and trustworthiness is member checking or participant validation. However, sharing the findings with research participants has a more traditional connotation because credibility implies establishing the truth of the research study's findings.³² Additionally, throughout the study, the researcher used her professional knowledge and experience as a tool to understand and interpret the data. The researcher was conscious and self-reflective of the meanings assigned to the participants' experiences, beliefs, actions, and past and present experiences enhancing reflexivity that is consistent with EDQ.³³ Authenticity takes context into account by addressing additional intrinsic naturalistic criteria.³⁴ To achieve authenticity, this study first obtained fully informed consent from respondents and inquired about all participants using transparent procedures.

Ethical consideration

This study was equipped with ethical approvals from the Indonesian health research ethic committee (No. 2495/KEPK, 7 April 2022). The primary researcher provided sufficient and appropriate information about the study allowing participants to have a complete understanding and meaningful choices. The primary researcher respected that HPs had the autonomy to make their decisions, participate in this study voluntarily, and withdraw at any time if desired. All data formats and respondents' identities were kept confidential and anonymous using codes. All participants were willing to participate and give consent voluntarily. The participants' details are presented in Table 1.

Results

The results begin with an overview of the HPs' profiles. Table 1 presents the profiles of HPs. Fifteen HPs participated in FGDs, consisting of 8 males and 7 females. The number of FGDs was established based on objectives, HPs diversity, number of HPs delivering COVID-19 care at the PHC, and data saturation principles to ensure a dynamic yet controlled discussion. Different HPs involved in FGDs include three physicians, four Nurse Practitioners (NPs), two midwifery, three environmental public health professionals, and each Information Technology (IT) man, pharmacist, and radiologist working across 2 PHCs. HPs' ages range from 20 to 40 years, and everyone has received education and training about COVID-19 care during pandemic, such as contact tracing, swab COVID test, COVID surveillance, reporting and recording.

Through the data analysis process, three themes are constructed. The three themes are i) perceiving primary care service provided; ii) perceiving barriers to care; iii) perceiving expectations of prospective care. Each of these themes is shown in Figure 2.

Perceiving primary care services provided

The first theme recognizes that HPs perceived delivering COVID-19 care in the PHCs to promote patients' health. The care provided in PHCs includes tracing, tracking, testing, treatment, making a referral in a coordinated manner, providing support for home care and a home visit, delivering health education to enhance psychosocial well-being associated with stigma, and recording and reporting. The majority of HPs reported that the management of COVID-19 care and services in PHCs in the City of XX adheres to the mayor's directives, including COVID-19 surveillance and making referral hospitals.

The majority of HPs reported that to stop the spread of COVID-19, the local government used multisector engagement and coordination among HPs, communities, and non-commissioned law enforcement personnel (known in Bahasa as Bintara Pembina Desa or Babinsa), a neighbourhood head, and a subdistrict head. In addition to multisectoral collaboration, most of the HPs detail how PHCs treat self-isolated patients, provided care for hospitalised patients in PHCs, and refer COVID-19 patients with severe signs and symptoms to the hospitals. First, HPs explained that PHCs provided basic interventions for patients who have mild signs and symptoms. HPs discuss how they give primary care to hospitalised patients in PHCs by administering oxygen to those whose SaO₂ levels have been proven to be below 90%, providing COVID-19 medicine packages based on specific clinical symptoms, and regularly monitoring on patients' status. If the patient experiences worse results, HPs then will refer her or him to the hospital for further care and treatment:

“...// we give primary care here like oxygenation and asymptomatic therapy until the patient's condition is stabilized, but if her/his condition is getting worse, we called several hospitals because back time, it was really hard to find a room due to all hospitals were so full of COVID patients” (GP)

In addition to the provision of self-isolated patients, most of the HPs explained that they conducted a case investigation, registered the patient's data in the regional and national COVID-19 database systems, provided a COVID-19 test, medication, support, a home visit, and hospital referrals for the ones who had worse problems. As a COVID-19 tracker, a nurse stated:

“...// we give COVID medication following the Government’s standard and other medicines based on the patient’s signs and symptoms and then send all medicines to a patient at home using “Gojek” service (is such an App that serves online transportation). In the first wave of COVID-19, we also gave isolated patient or confirmed patients with herbal drinks, boiled eggs, food, and multivitamin supported by the local government” (A nurse)

A midwife also mentioned that HPs need to keep an eye on the patient's health throughout their illness and recovery. Through her experiences, she explained that she observe the patient's condition for at least ten days. To do this, she is more likely to use the WhatsApp app and occasionally make house visits. Most of the HPs (nurses, midwives, and doctors) indicated that to reduce COVID-19 transmission, they were required to conduct case investigations and contact tracing. A COVID coordinator nurse explained that as a contact tracer, he must locate and keep track of 30 people who have interacted with a confirmed COVID-19 patient. After that, he must register all confirmed COVID-19 patients in the COVID-19 database system, including the patient's demographic, treatment, comorbidities, and medical history. He also frequently conducted a patient home visit. The results of this study have demonstrated how HPs offered primary COVID-19 care and support for patients in the community. The COVID-19 care and support provided in the PHCs comprised of tracing, testing, treatment (3T), nutritional and motivational support, referral, reporting and recording (3R), and a home visit.

Perceiving barriers to care

The second theme identifies barriers to effective care. Most HPs reported overarching factors that negatively influence the provision of optimal care for confirmed COVID-19 patients. These factors included inadequate knowledge and negative beliefs of patients and communities, limited resources in the settings, shortage of HPs, heavy workload and policies response to COVID-19, which always changes. According to participants’ perspectives, the HPs perceived two components that would reduce the optimal quality of COVID-19 care in community settings. The two components are i) individual factors and ii) organizational factors.

Individual factors

Individual factors represent an internal factor and are classified into experience, knowledge, attitude and beliefs. In this study, most of the HPs reported that patients in the community had different experiences associated with COVID-19. According to HPs, some patients had negative experiences and values related to COVID-19, such as losing their friends, feeling ashamed and self-stigma. For example, due to self-stigma, patient refused a HP for a home visit. A nurse who is a COVID-19 coordinator states:

“...//When we visited a confirmed COVID-19 patient at home, we were rejected...//...a patient experienced fear and had psychological distress besides suffering from physical illness. My patient was self-isolated at home, and was isolated by her neighbour. Not only that, but a patient also scolded us to visit to her house”(A nurse, a COVID coordinator)

Furthermore, a doctor participant indicated that the legislation for burial a dead body from COVID-19 in the City of Surabaya that the deceased body must be buried apart from a mass graveyard. Furthermore, the deceased body COVID-19 must be handled by HPs wearing adequate Personal Protective Equipment (PPE). However, the doctor discovered that the relatives of COVID-19's deceased body rejected the rule and procedures. In this case, the doctor approached the local police for family persuasion and negotiation. Furthermore, the doctor participant explained that some families living with COVID-19 were more likely to be isolated from their neighbourhood. A midwife claimed that shame and rejection in the community were common during the first wave of COVID-19. Some people's behaviour in the community has altered as a result of their level of education and experience. They helped isolated neighbors or family members by supplying food and other necessities.

Organizational factors

Organizational factors encompass all aspects of COVID-19 care in the PHC setting. The examples of organizational factors are human resources, teamwork management, coordination, communication, and government policies. According to the majority of HPs, they were mandatory to provide care services to COVID-19 patients; however, they faced many issues. For example, HPs were more likely to work overtime and work overload, which caused them to be exhausted and burned out. Not only that, but HPs often lack knowledge, experience, and practice related to COVID-19. For example, some HPs reported that they still monitored confirmed COVID's patient conditions through WhatsApp even though they were also self-isolation at home. Additionally,

some of the HPs explained that back in time they worked insecure due to limited PPE. They often wore plastic bags or raincoats to replace the dress. A midwife states:

“... at the first wave peaked at COVID-19, the protective equipment was limited. We wore a raincoat or plastic bag to protect ourselves from droplets and the transmission of other infections in the public area during tracing and COVID testing” (A midwife, a COVID tracer).

A midwife explained that HPs must be prepared to adapt and adjust for local and national policy responses to COVID-19 at all times. Most of the HPs stated that they were reliable and communicative when it came to organising COVID care in community settings. HP's capacities, resources, policies, coordination, and communication have all been identified as organisational elements that influence optimal and successful COVID care quality.

Perceiving expectations of prospective care

Different HPs express their expectations on how to improve COVID-19 care in community settings to prepare for future pandemics. According to participant's insight, COVID care quality can be improved at the individual, organizational, policy, and community levels. A doctor, for example, explains that, in addition to the availability of resources, communication and coordination among HPs, as well as multi-sectoral collaboration, play a crucial role. Furthermore, a nurse and COVID coordinator states:

“Training and capacity for HPs are essential, as are treatment management, case investigation building and trace management. Also, COVID socialization for communities is required due to the stigma associated with COVID” (a nurse, COVID coordinator).

Furthermore, other HPs argue that work incentives should be maintained in order reward to reward their work. During the conversation, a nurse said that the first time, HPs worked overtime without thinking about financial incentives; nonetheless, they recognized that they earned their incentive a few months later.

Discussion

During COVID, HPs in this study followed national and local health directives on testing, tracing, and treatment (3Ts). HPs in the PHCs intended to provide comprehensive COVID-19 care including both medical and non-medical therapies in a coordinated manner; However, the care was sub-optimal due to several burdens that negatively influence optimal COVID care in community settings. HPs appear to confront contextual and interconnected difficulties, such as insufficient resources, a shortage of health professionals, a demanding workload, and policies. Furthermore, no training was provided to HPs on how to utilise adequate Personal Protective Equipment (PPE). Similarly, an Indonesian hospital-based study found that the majority of HPs who cared for COVID patients experienced physical and mental exhaustion due to the limited number of qualified HPs and equipment available at the hospital.³⁵ In Iran, HPs concurred that the lack of nurses and the absence of PPE posed difficulties for COVID-care nurses.

Inadequate patient education and societal stigma, in addition to a lack of HP capacity, policies, and procedures, led to sub-optimal quality of care and fragmentation of care in this study. This situation is similar to other study findings in Indonesia, which show that patient factors and social stigma contribute to poor health outcomes among Indonesian children living with human immunodeficiency^{36, 37}. For example, social stigma from the wider community caused Indonesian children with human immunodeficiency virus to be judged, which often resulted in social rejection or isolation because the community did not have adequate information and knowledge on HIV infection, prevention, and transmission.³⁷ During the COVID era, social stigma may result from the community's lack of knowledge about COVID, its transmission, and its prevention. Nonetheless, this is no longer the case as a result of the government's implementation of health protocol policies to control the spread of COVID. This policy has changed since the government implemented the health protocol policies to control the spread of COVID. Even though the incidence of COVID has decreased, increasing the number of HPs and enhancing their capacity are essential for enhancing care holistically and patient outcomes. In addition, the healthcare system must be prepared and responsive to the outbreak through the use of technology, comprehensive care and support interventions, and community empowerment.

This is supported by Community-based interventions, management interventions, social and economic factors, the readiness of hospitals and health centres, and a related environmental factor are the five primary factors that influence the responsiveness and preparedness of the health system in the face of the COVID epidemic. Bamir (2023) supported that there are five main factors affecting the health system's responsiveness and readiness in the face of COVID epidemic that are community- based interventions, management interventions, social and economic factors, the readiness of hospitals and health centers, and related environmental factor.³⁸

During the COVID pandemic, HPs are more likely to provide a variety of care and support to patients, despite their heavy workload and shortage of HPs. HPs must comprehend the physical, psychological, social, and spiritual care requirements of their patients in order to provide holistic care. According to the American Holistic Nursing Association, holistic care aims to heal the patient as a whole while taking into account their physical, emotional, and spiritual preferences.³⁶ Treating a whole patient is a basic tenet of holistic care that enhances health outcomes.³⁹ Hence, HPs are required to focus on the whole individual needs covering physical, emotional, social and spiritual preferences leading to empower patients in their health and wellness. To do so, HPs in particular, nurses should recognize and provide individual patient care by considering their social and cultural preferences and respecting the humanistic view of patients resulting in optimal patient outcomes and satisfaction.⁴⁰ For example, nurses could develop their therapeutic potential when they provide care for patients, provide complex interventions including medication, education, communication, self-care and complementary treatment, and treat the patients based on openness, equality and mutuality.⁴¹ In addition, a best practice from India on holistic COVID care and management in the hospital shows that HPs provide five components to support a patient's full recovery from COVID. These five elements are a healthy and nutritious diet, music therapy for relaxation, yoga and exercise therapy, productive engagement, and AYUSH medicine, a combination of medication and traditional herbs to boost the patient's immunity.²¹ HPs would be challenged to address all patient's complex needs and preferences, although they deal with high work pressure that negatively affects their psychological well-being.⁴² Holistic care has been shown to be a comprehensive approach that must be provided not only to COVID patients but in all care delivery contexts.

Limitations of the study

The results of this study can not be quantified and generalised due to the limited sample size. However, in a qualitative study, a small number is acceptable because there are no guidelines for defining the number of participants in qualitative studies and the study reaches saturation. Hunter (2019) suggests that the average sample size for exploratory-descriptive research appears to be 15.⁴³

Implications

Individual and organisational problems impede COVID care in the community. Understanding these barriers has far-reaching implications for developing and enhancing techniques for providing holistic care or care for the whole person, not only for COVID patients in community settings but for all patients in community settings or in hospitals, with the aim of enhancing patients' health outcomes. HPs, in particular, nurses should provide holistics comprehensive care interventions

including both medical and non-medical intervention. Therefore, HPs, particularly nurses, must learn how to improve interdisciplinary communication and coordination, as well as how to carry out complex interventions based on the needs of the patient.

Conclusions

HPs experienced sub-optimal holistic care due to individual and organizational factors. HPs frequently felt physical and psychological exhaustion. Despite the obstacles, HPs are committed to delivering COVID care with the help of the local government through multisectoral coordination and communication. Several strategies are suggested to improve the delivery of COVID care, including enhancing the capacity of HPs, the health workforce, resources, incentives, and policies, and implementing COVID health education initiatives in the community.

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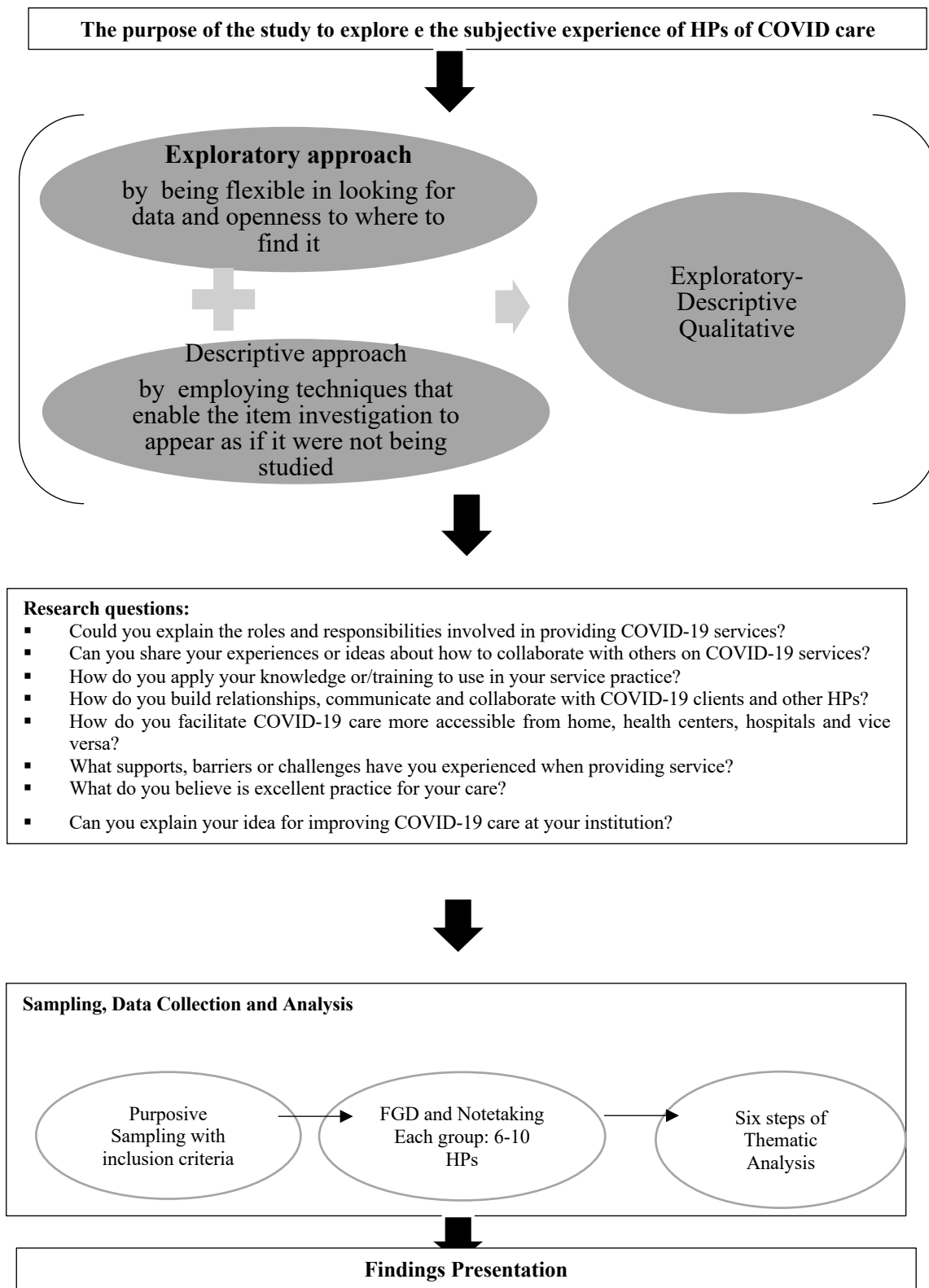


Figure 1. Exploratory-Descriptive Qualitative in This Study

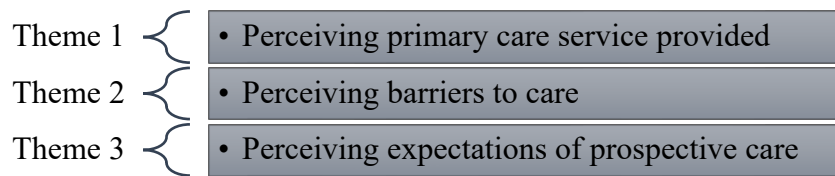


Figure 2. The perspective of COVID-19 health care delivery in the community setting

Table 1. Health providers' profile.

Health providers' profiles	n
Roles of health providers working in Public Health Centres (PHCs)	
Physicians	3
Pharmacist	1
Nurse Practitioners (NPs)	4
Midwifery	2
Environmental public health professionals	3
Information technology (IT) man	1
Radiologist	1
Health provider's qualifications	
Diploma of Midwifery (D3, D4)	2
Diploma of Nursing	3
Bachelor of Nursing	1
Bachelor of Medicine + GP	3
Bachelor of Public Health	3
Bachelor of Informatics	1
Diploma of Radiology	1
Bachelor of Pharmacy	1
The age range of health providers	
20-40 years	11
≥ 40-60 years old	4
Gender	
Females	8
Males	7
COVID-related training	

Health providers' profiles	n
Contact tracing	10
Swab COVID-test	4
Reporting and Recording	4
Surveillance	2
Waste management training	2

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Conflict of interest: there is no conflict of interest.

Data availability statements: the data underlying this study are not publicly available due to respondent privacy issues.

Declaration of generative AI and AI-assited technologies: no AI or AI-assisted technologies were used in the production or content of this study.

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