Received: 26 March 2022 | Revised: 6 December 2022 | Accepted: 16 December 2022

DOI: 10.1002/nop2.1586

NursingOpen Open Access WILEY

RESEARCH ARTICLE

Stakeholders' perceptions of continuing professional development among Nepalese nurses: A focus group study

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Abstract

Aim: This study explores perceptions of Continuing Professional Development (CPD) opportunities among stakeholders in the profession of nursing in Nepal.

Design: Qualitative study using focus group discussions (FGDs).

Methods: Eight FGDs were conducted in three major cities of Nepal with nursing stakeholders including nurse managers, matrons and directors/managers of private and public nursing colleges, representatives of nursing organizations, government officials, nursing academics and practitioners from the government and private sectors. The data were analysed thematically using Creswell's six steps of analysis and the Standards for Reporting Qualitative Research (SRQR) guideline was followed.

Results: The study generated three major themes: (a) policy level including the national situation of CPD, political influence and training guided by the policy; (b) organizational level incorporating perceptions towards forms of CPD, staff shortage, poor staff retention, seniority for training, financial constraints and lack of continuity of training; and (c) individual level including motivation for training and lack of relevant training.

KEYWORDS
continuous education, CPD, midwives, Nepal, nurse, professional development

1 | INTRODUCTION

Updating skills among health care practitioners is vital for improving services and implementing evidence-based practice (WHO, 2013). University training alone is not sufficient to enable the practitioners for their whole life to deliver services because of the half-life of knowledge, which starts to decline 5 years after its attainment (Macgregor, 1975). Thus, many countries across the world have recently made the Continuous Professional Development (CPD) registries compulsory for nurses (Karas et al., 2020). CPD courses relevant to the specific area of practice help staff to maintain an acceptable standard of nursing practice (Hegney et al., 2010). However, the type of learning approach can be affected by the availability of resources, circumstances and policy guidelines of a specific country (Vázquez-Calatayud et al., 2021). CPD helps nursing professionals to keep up to date (Mlambo et al., 2021; Pool et al., 2013). CPD is defined as: '*a life-long process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice, and supporting the achievement of their career goals*'(ANA, 2011). CPD is also referred to as continuing education (CE) (Rouleau et al., 2019) and is often considered a learning framework and activities for

professional development (Gallagher, 2007). Of course, nurses' motivation and need for CPD varies at different stages of their career (Allen et al., 2019). The benefits of CPD are well documented (Allen et al., 2019; Mlambo et al., 2021), for example, it enhances knowledge and skills, self-motivation, enables strong leadership and develops positive workplace culture. It also helps to strengthen inter-professional collaboration and communication and promotes professionalism and accountability (Filipe et al., 2014). Despite the importance of CPD among nurses globally, less is known about how CPD is perceived and implemented in resource-poor countries like Nepal. Poor management of CPD is one of the key factors in compromised health services and poor leadership development among nursing professionals (Varghese et al., 2018; Wardani et al., 2021). Several studies have explored perceptions and experiences of CPD among the nursing profession in resource-poor settings (Feldacker et al., 2017; Giri et al., 2012). Therefore, this study is expected to fill the gaps of the evidence regarding stakeholders' perceptions towards CPD and its implementation in Nepal.

2 | BACKGROUND

Nepal is one of the resource-poor countries in South Asia with nursing as the backbone of its health system, particularly in rural areas (MOHP, 2021; Simkhada et al., 2016). Nurses are the single largest health occupation in Nepal, as in many other countries (MOHP, 2021; Szabo et al., 2020). The 250 nursing colleges produce 5000 graduates per year and the Nepal Nursing Council (NNC) has currently over 67,509 nurses registered (NNC, 2022). Little effort has been made in Nepal to encourage CPD among nurses and there is no requirement for post-registration training. Nepalese nurses have to renew their nursing licence every 6 years with the NNC. However, there are no specific requirements of CPD in the NNC's post-registration renewal process. Even nurses who have taken time out from nursing can easily renew their licence without any evidence of additional training (Simkhada et al., 2016). Consequently, the uptake of post-registration training is haphazard (Adhikari & Melia, 2015). For example, nurses may attend any training offered in specific fields or on specific topics offered by the government or international donors (Khatri et al., 2021; Simkhada et al., 2016). Barriers such as lack of funding from employers, lack of time available due to workload, lack of staff for replacement when away for training and a centralized training system have been identified as key barriers to accessing training for nurses and midwives in resource-poor countries (Azad et al., 2020). The poor understanding of CPD provision among employer, regulators and practitioner is another challenge in Nepal. There is a need for raising awareness of formal and informal CPD opportunities to establish its provision. Nurses need to be reminded that CPD can be easily obtained informally, through, for example, reading evidence-based papers relevant to their practice, and reviewing and writing papers in their field of work. Similarly, some in-house CPD training could be developed to avoid staff absence from work to attend training outside. Often nurses' professional development opportunities and work environment in low-income countries are poor (Willis-Shattuck et al., 2008). Nursing staff often experience poor job satisfaction, being underpaid, intolerable workload and unfairness in professional opportunities, all factors leading to staff seeking work elsewhere (Dywili et al., 2013; Garner et al., 2015; Tollstern Landin et al., 2020). It is thus essential to generate contextual evidence to help policymakers and other stakeholders to develop appropriate policy guidelines for CPD opportunities in Nepal. Different countries have adopted the concept of CPD in various ways; however, in this study, CPD refers to a continuous learning process that helps to enhance knowledge and skills and develop positive work culture to ensure that they are competent in their practice (Mlambo et al., 2021; Vázquez-Calatayud et al., 2021). Therefore, this study explores the perceptions of nursing stakeholders on CPD opportunities in Nepal. This study is also the first of its kind to generate evidence on stakeholders' perception towards the CPD opportunities among Nepalese nurses in the context of a decentralized health governance structure.

3 | METHODS

This qualitative research comprises focus group discussions (FGDs) to explore the perception of CPD opportunities among nursing stakeholders in Nepal (Green & Thorogood, 2018; Groenewald, 2016). The Standards for Reporting Qualitative Research (SRQR) guideline was utilized in reporting this study (O'Brien et al., 2014).

Eight FGDs with 54 participants in total were conducted in three major cities: Kathmandu, Pokhara and Chitwan. All three cities include a large number of nursing education centres and health facilities operating from primary to tertiary levels. The study used purposive sampling (Green & Thorogood, 2018) and participants include nurse managers, matrons, directors/managers of private and public nursing colleges, representatives of nursing organizations, nursing academics and practitioners from the government and private sectors.

The FGDs were conducted face-to-face using a broad topic guide in 2017–18, in the local language and transcribed by Nepali-speaking bilingual researchers. The FGD guidelines allowed flexibility for the researcher to focus the discussion on the key issues of the broader study objectives. After participants' mapping was conducted (APK and CKS), the recruitment followed three steps, at first, the relevant participants were identified through gatekeeper, then we provided study information using a Participant Information Sheet (PIS) and an Invitation Letter. The PIS explained the benefit and potential harm of the study, and about their voluntary participation explaining they can withdraw their participation at any time during or soon after the interview. People were also assured that their names will be anonymized to maintain confidentiality and then a researcher phoned the participants to confirm their availability. After that, the participants were contacted to be formally invited to the FGD and gave consent for their participation. All eight FGDs were conducted in the local language and audio recorded while notes were taken. The principal

investigator (BS) and co-investigators (APK and CKS) conducted all the FGDs. Each FGD took 50–60 minutes. The homogeneity among participants was maintained in each FGD to reduce the inhibitors in the process discussion. The Nepali transcripts were translated into English by experienced translators, before being coded using Atlas.ti software (Scientific Software Development GmbH, 1993). We followed Cresswell's (2013) six steps of analysis for thematic analysis (Cresswell, 2013). The emerging themes were reviewed in the team to maintain quality. The data analysis started after the completion of four FGDs; no new themes were generated after eight FGDs indicating reaching data saturation (Guest et al., 2006).

Written informed consent was obtained from participants before data collection. Research ethics committee approval was obtained from the Nepal Health Research Council (NHRC) and Bournemouth University ethics committees, and all quotes are reported anonymously.

4 | RESULTS

The FGD analysis identified various issues in terms of CPD opportunities and the professional development of nurses and midwives in Nepal. Themes are organized into three levels which are presented here, each built up from several sub-themes. The first is policy level: (a) national situation around CPD; (b) political influence and (c) training guided by the policy. The second is organizational level: (a) perception towards forms of CPD; (b) staff shortage; (c) poor staff retention; (d) seniority for training and (e) lack of continuity of training. The third is individual level: (a) motivation for training and (b) lack of relevant training.

4.1 | Policy level

The findings of this study indicated that there is no policy on CPD for nurses/midwives. It has been recognized that existing political circumstances, training opportunities and priorities could influence the CPD provision and policy formulation.

4.1.1 | National situation around CPD

Participants considered the National Health Training Centre (NHTC) under the Department of Health Services as the only accrediting body while the NNC was viewed as the accrediting body for nursing degrees. Most thought that professional training in Nepal is haphazard in organizations with or without accreditation. A government official raised the issue of current training and suggested how it could lead to CPD and the need for accreditation and policy to guide CPD implementation.

> There are different divisions except NHTC provides certain training like mental health and appreciative inquiry… But still, not all training is accredited…everything should one-door policy. Training is all conducted by NHTC and that is what actually should happen.
>
> Government Officials.

However, nursing college managers indicated professionals should have a key role in designing policy. A nurse manager stated that nurse practitioners' participation in the policy development could benefit CPD development.

> A nursing representative should be there in policy planning, budgeting and the division of the planning committee. At present, there is no nursing representative in planning. So, nursing should participate at the policy level and nurses should not be treated as a second class [dosro darja] in every area.
>
> Managers nursing college/hospital.

In addition, some academics stressed that the current renewal of nursing registration at NNC is only a formality. The NNC does not require nurses to have undergone professional development training or to evidence job experience at the time of renewal of nursing registration.

> There is nothing like this many credit hours of [=CPD]. There is no such requirement, so we also do not worry about that.
>
> Academics private nursing education.

Some recalled that the NNC required an experience letter at the time of renewal in the past.

> NNC used to ask for an experience letter where we worked but now it does not even ask for an experience letter. Once she is registered, there is a condition to be licensed no matter if she does not work, or works as a housewife or does not do any professional work and engages in business.
>
> Academics public nursing education.

4.1.2 | Political influence

The majority of participants in all FGDs mentioned that political interference, corruption and bias were major challenges to CPD. Political influence was seen as a particularly important factor in degrading the quality of nurse education. Political influence has played an important role in terms of higher education than developing CPD provisions to benefit many nurses. More attention is given to a few nurses who had political links to go abroad for training. For example, a participant claimed that the selection of candidates for higher study abroad is unfair and not transparent as nepotism is common among government officials.

> Sending nurses for advanced study by the Ministry of Health should be transparent. I have heard that there are quotas for advanced nursing studies but ministry staff send their relatives for higher study to Bangladesh and China.
>
> Nurses working in public hospital

Moreover, some participants noted the difference between staff with and without political influence, as nurses with access to political power could be transferred sooner or avoided going to remote rural places altogether. For the following example, it is important to know that Skilled Birth Attendant (SBA) training has been promoted in Nepal since 2006, training that is often funded and delivered by international donors. The issue of having political connections adversely impacted the quality of services in remote health facilities; one participant highlighted this with an example around SBA training:

> Let's say a person received SBA training. That person is hired in the birthing center. But if that person has political influence then she will return to [=more desirable place]…then a person who does not have SBA will conduct the delivery (remote/rural is less desirable institutions to work).
>
> Nursing professional organisation.

Matrons commented that staff working for the ministry got priority for the training and private sector staff were only placed in training by chance. Typically, selection criteria for training were not followed, as an ineligible staff was sometimes chosen for training. Others were repeatedly selected for the same training if they had political links.

> There is bias in the selection criteria. Staff from lab technicians, AHW [Auxiliary Health Worker], CMA [Community Medicine Assistant] are sent to training organized for nurses. They [training organizer] send staff close to them… Another thing is repetition; the same nurse keeps on coming for the same training… Ministry officials themselves try for the places.
>
> Matrons public/private hospitals.

Having a good connection with the trainer also gave priority access:

> If I am close in relation to the trainer, then I can receive training even twice. I can receive all the training. But if I am not close to them then I get obstructed.
>
> Managers nursing college/hospital

4.1.3 | Training guided by the policy

The findings suggest that the availability of training is determined by government policy and availability of the funding, and support from bilateral/multilateral organizations rather than the needs of practitioners. From the perspective of some government staff, the training set-up worked quite well. Participants who have long experience in the government health system often have a more positive opinion about training opportunities than others. One nurse with nearly three decades of experience explained:

> I worked in a pediatric hospital … in the operating theatre so I received OT (operating theatre) training. But when I went to the remote area, BNMT (Britain Nepal Medical Trust) sent me to a southern hospital to receive BEOC (Basic Emergency Obstetric Care) training. … I was sent to receive CAC (Comprehensive Abortion Care) training. I mean to say that the government provides all the training that is required.
>
> Nurses working in government hospital.

However, there was the view that the government's training should also be open to staff in private health facilities. Many argued that training should be based on needs rather than being limited to the government staff to enhance the overall quality of health services. A member of the nursing professional organization stated a lack of support for private practitioners as the policy is aimed at supporting government staff only.

> NHTC…provides training to government staff but does not involve non-government staff. Government staff receives training twice, thrice, four times, or even five times but private staff does not get the opportunity of training…If any new training is going to be conducted then government tries to involve all the staff from the government level but the private organization is not included at all.
>
> Nursing professional organization.

Government officials also acknowledged that training is mainly focused on government staff and staff in private facilities lacked training opportunities. Even worse, some government staff might receive the same training several times while private organizations were not even informed about the training although they were willing to pay. In addition, one participant stated that the government policy mainly focuses on maternity care-related training and other specialties received no training.

> Training programmes are conducted to prevent prenatal and postnatal death and others. Training on breastfeeding is being conducted by staff from the Ministry of Health and Population. But there is no training for the medical and surgical ward.
>
> Government officials.

Also, managers of nursing colleges highlighted that training of temporary staff may result in wastage due to contracts not being extended and low retention rates. Since SBA training was such a policy

priority due to its foreign funding, SBA training became a vehicle for nurses to find work on a maternity ward and even to get additional allowances. A nurse manager explained the situation around SBA and her experience as:

> According to government policy, rotation and ward shifts are done within two years... We will have to work in any ward in hospitals in Nepal, either the maternity ward or surgical ward. This is a reason why staff in the surgical ward also demands SBA training... They can work in maternity if they receive SBA training. Also, there is the provision of incentives in the maternity ward. Our salary is not enough, and staff sees that maternity staff gets incentives, but surgical and medical staff do not.
>
> Managers nursing college/hospital.

Nursing academics stated that the government has added inappropriate weightage to SBA training when counting marks for staff promotion. The SBA training equated with a postgraduate degree in nursing, which is wrong, a postgraduate academic degree is more than just training.

> Nursing professional organisations...even INGOs (international non-governmental organisations) demand SBA because they will have to take staff to remote areas. They demand SBA as a must. Next is, it takes two years to study for Masters in Nursing but the evaluation of a Masters in Nursing and SBA training gets the same marks for promotion which is not fair.
>
> Academics public nursing education.

Many FGD participants also reported that most training is commissioned by the government and centrally organized in the capital city. If the CPD policy is to be introduced, it should decentralize the training. A manager from the hospital highlighted that centralized training discouraged nurses from outside the capital to attend:

> While receiving training, travel allowance and daily allowance (TADA) provided by the government is not adequate for us to go to Kathmandu and stay in a hotel during the training. We also do not have any relatives in Kathmandu. Training is not decentralised ...
>
> Managers nursing college/hospital

4.2 | Organizational level

The organizational-level theme focused on how nurses are supported for professional development at different levels of institutions both in the public and private sectors. These findings suggest perception towards types of professional development training, human resources, financial situation and opportunity for training are contributing factors to CPD development at the organizational level

4.2.1 | Perception towards forms of CPD

FGD participants mentioned that recognized training and conferences organized by various organizations such as the Nursing Association of Nepal, Kathmandu University, NHRC, and specific hospitals could lead to CPD. Few also mentioned that seminars and international conferences could carry credit hours for CPD. Academics from a nursing college reported that it was mostly academics who attended conferences.

> The nursing association organizes a national conference every three years. We have reported presentations and classes on continued nursing education (CNE), paper presentations, and research report presentations.
>
> Academics public nursing education.

Nursing practitioners from the private hospital stated the need for organizational-level collaboration to develop CPD and form of CPD that could be assigned to a different organization to succeed in the long term.

> That should be from the organizational level where we are working. There is a nursing council, so it should be initiated from the nursing council's level and the Government of Nepal...The Government of Nepal should provide the training. If it is related to nursing, then it should come through the nursing council. And if we have to update everyday knowledge and there may be something like we have been working on but we may be forgetting many things; such things can be initiated through organization's level.
>
> Nurses working in private hospital.

Moreover, nurse practitioners stressed the need for mandatory training on renewal to create pressure on the organization.

> If certain hours or a certain number of CNE or training is mandated before renewal then it would be compulsory to all. Even the organization would also get pressure and think that ward sisters in their hospital would also get the training.
>
> Nurses working in private hospital.

Some practitioners working in government hospitals voiced the need for in-house training for sustainability. One nurse stated that training needs should be assessed for professional growth.

> There should be a training department in every hospital. Then there should be analysis of which training is required to whom, … There should be a plan, and proposal for the rotation of staff and for the sustainability of training and if we can support that then only the nursing profession can move forward.
>
> Nurses working in public hospital.

4.2.2 | Staff shortage

Some academics stated that staff keen to go on training could not go for it due to lack of backfill which stopped organizations from approving leave. Academics in private nursing education stated that they were not able to attend training because of inadequate staffing:

> Despite the personal interest, we are not able to go for training because of the limitation of staff. Some of our friends were sent for training only after trying for one year. It is also difficult to leave the job… Some nurses are not able to receive CPD even if they are interested. Institute is not able to approve leave of two and half months because of a shortage of staff.
>
> Academics private nursing education.

4.2.3 | Financial constraints

Many reported that cost was a barrier for staff in private organizations, and organizations are reluctant to fund staff training due to high costs. However, a participant demanded training for private sector staff at reasonable costs:

> The government sends their staff to take SBA training free of cost. But there are some staff from the private sector also. The private organization should pay around Rs.40,000 (=US$ 400) for the training. Sometimes, they [NHTC] invite us either by an individual or interpersonal relations saying that we are conducting training, one participant has dropped out so you can come if you want to. But…we have to pay around Rs.40,000 (US$400)…This is the reason why private sector staff has limited training and training seems focused only on government staff. But training should be given to private organizations as well.
>
> Academics private nursing education.

Conversely, from a professional organization's perspective, this was understandable as nurses are often mobile and may not stay long in one area, in which case the investment in them is lost when they leave.

> The organization will not pay for the training if there is no job retention…because of high turnover in the private sector, there is no training at all.
>
> Nursing professional organization.

Although the majority wanted financial support from their employers, some stated that nurses were even ready to pay for their CPD. One academic stated that she even funded herself as certain training would help her in her career progression and professional development.

> We (nurses) should also be ready to spend on our training and professional development. I received about three training by self-payment. I went through my own initiation, not from the campus… We will never progress if we blame the organization for everything… If we can spend on other things then why do not we spend on training and professional development?
>
> Academics public nursing education.

> Similarly, academics also acknowledged the benefit of the training towards their promotion. The organization does not send us for training. The reason for me to go for the training is … I will be promoted in the future.
>
> Academics private nursing education.

Some suggested that direct cost is not the only reason for not attending specific training, but other factors such as leave approval and unpaid leave were sometimes major barriers:

> We do not get leave even if we want to go for the training …If I want to receive ICU (Intensive Care Unit) training then I will have to pay around NRs.35, 000 (=US$ 350) and take a leave of one month. So in this case, I do not get the salary of one month and instead, I will have to pay for the training which is problematic for us…In private organizations, they do not let us go for training even if we want to pay ourselves.
>
> Matrons public/private hospitals.

4.2.4 | Poor staff retention

Most participants also reported a high staff turnover and poor retention, especially in the private sector were barriers to access the training. Despite the training information sent to private organizations, they had to think twice before sending staff on the training.

> Even if a private organization knows about the training… organization thinks, 'What benefit will my organization have from this training?' After all, my staff might leave the job tomorrow.
>
> Nursing professional organization.

Participants reported better job security, higher salary level, better institutional reputation and lower workload as major pull factors for seeking other jobs, resulting in a high turnover. This mismatch between the institutional and individual staff interests discouraged training in private facilities.

> Even if the organization pays for the training, staff may leave the job in six months. If an organization pays NRs.50,000 (=US$ 500) and staff leave the job then the organization has no benefit. …the organization may also think of not giving training anymore.
>
> Academics private nursing education.

4.2.5 | Seniority for training

Many of the participants highlighted that seniority in the position played an important role in accessing the available training. According to a nurse manager, training was provided based on seniority, although they argued that training should be based on need:

> Let's say I work in the orthopedic so orthopedic training is essential for me. But what I can do with SBA training if I were just selected for that training based on my seniority…
>
> Managers nursing college/hospital.

Participants emphasized that the notion of seniority was dominant in the government sector while considerations around job retention, the willingness of staff, training needs and availability of training were prioritized in the private sector, although seniority still played a role:

> Perhaps seniority matters in the government sector. We do not consider just seniority in our private and medical college. We focus on the staff with high job retention.
>
> Academics private nursing education

4.2.6 | Lack of continuity of training

Most FGD participants reported that even if organizations initiated training, they were not able to continue. Some emphasized that there was no continuity in government refresher training, which helps explain the staff's unfamiliarity with the CPD concept. Reasons for discontinuation of training included lack of human resources/funding and internal disputes. They mentioned that some had not been in training for decades. Most participants pointed to unfair treatment around professional development, a lack of updated records in the government system and a lack of human resource policies in the health care system. A participant with a long employment history commented:

> There should be the management of refresher courses for staff. Actually, the Government of Nepal does that but there is no continuity. It is a need to have refresher training in a certain time interval. For instance, I received certain training and if there is no refresher then how can I have up-to-date knowledge? This relates to other training as well. Like, I received … training in 2003. Many things have been updated after then but we do not have any refreshments.
>
> Managers nursing college/hospital.

4.3 | Individual level

The findings suggest that CPD for nurses/midwives is influenced by individual motivation, and the availability of the relevant training to meet the need of the individual.

4.3.1 | Motivation for training

Participants mentioned that there is a general perception that nurses want to get training or seek work experience to go abroad.

> Nurses try to get training and go abroad. There will be international recognition for those who have worked in a good institution and received training from a good institute…
>
> Matrons public/private hospitals.

Some participants from professional organizations stated that low payment of nursing staff was a demotivating factor for not attaining training.

> There are many differences between government and private-sector employees; I would like to talk about a staff nurse. Staff nurses in government organizations get a salary of NRs 24,000 (US$240) per month. However, nurses in the private sector are first hired as a volunteer and even if they give a salary, it is just NRs. 7000/month. How can be they motivated for the job?… A nurse to complete her PCL level nursing education spent six or seven lakhs rupees on average…she either gets no payment at the beginning or just paid around NRs.7000/month which is much less than the payment of an office assistant…
>
> Nursing professional organization

4.3.2 | Lack of relevant training

Participants cited that some nurses seek training that is or at least seems irrelevant to their post. They thought that reasons for receiving unnecessary training include increasing the scope of one's job, promotion and the job rotation system, e.g.:

> Rotation policy. If a member of staff has not received any training during her duty in a specific ward then she is not shifted to another ward.
>
> Managers nursing college/hospital.

FGDs with professional organization representatives and private college academics indicated that government-paid TADA increased the individual's expectation for financial support to attend training. However, they also acknowledged nurses should not be tempted to do irrelevant training simply for the allowance.

> It is fine even if the government manages just lunch and accommodation. In government, the situation has become like a requirement of money even to move a step. The system has degraded… They do not come in the training if the government does not provide that TADA.
>
> Nursing professional organization.

Academics also acknowledged that TADA should not be the motivating factor to seek further training.

> Nurses should be conscious of their training needs and they should also search for training for their skill development…TADA should be removed. Institutions should manage to provide leave for training because we will face difficulty if an organization does not provide leave. But sometimes we also should dare to take leave and go for training for our development because that is for our development… There will not be development by waiting for TADA. So, we should become self-motivated.
>
> Academics private nursing education.

Most participants knew of staff who had been offered a job without relevant training, and one spoke of her current work:

> I started working without any training in oncology…I knew nothing about chemo handling, chemo preparation, and patient preparation. I was totally clueless. I knew that chemo was psycho toxic, it caused hazards to the health of patients and personnel … I prepared and handled chemo with these naked hands, and naked eyes, without a mask, and gloves.
>
> Matron private/public hospital.

However, some managers acknowledged that nurses' ability without training is common practice.

> We have skilled birth attendants who have conducted delivery very well for 2–3 years but actually, they have not received SBA training.
>
> Managers nursing college/hospital.

5 | DISCUSSION

The themes identified in the focus groups can be separated into three interrelated levels (policy, organization and individual). CPD was very much talked about in terms of formal training, while self-directed learning, journal clubs or shadowing more experienced colleagues was seldom mentioned (Filipe et al., 2014; Mlambo et al., 2021). Most training was perceived to be around maternity care (Ross et al., 2013) and SBA gained high emphasis on the FGDs. Over the past decades, Nepal has increased the number of deliveries attended by SBAs (Karkee et al., 2021), although SBA-trained staff does not meet the minimum WHO standards (Rajbhandari et al., 2019). This may be due to either lack of skilled trainers or participants having limited opportunity to practice during training (Azad et al., 2020; Rajbhandari et al., 2019).

The participants often mentioned the influence of politics, nepotism and corruption, for example, most of the training is prioritized for nurses working for government institutions, especially senior staff. Corruption in South Asia is a barrier to health workers' development and delivering quality health services (Naher et al., 2020). Lack of staff to backfill and the cost of travel to often centralized training were burdens for private organizations and individuals, as reported previously in Nepal and the Republic of Congo (Bogren et al., 2020; Shrestha et al., 2010). The unsupportive organizational system, insufficient work-related security and inadequate preconditions hindered the uptake of CPD (Bogren et al., 2020; Shrestha et al., 2010). In this study, there is a concern about why private organizations are not supportive of their staff accessing CPD. They were mainly worried about staff leaving in a short period of time. This is a short-sighted approach as appropriate CPD improves the quality of care and staff retention (Price & Reichert, 2017). The worry about staff leaving is linked to Nepal's history of migrant workers (Simkhada et al., 2018), while the demand for nurses abroad has led to a booming nursing education industry in Nepal (Adhikari, 2010).

The only accrediting body for professional development training in Nepal is NHTC which provides training, training sites, training curriculum and certification that is similar to the Australian College of Nursing, the country's only accrediting body to offer 'endorsement' (Ross et al., 2013). Other accreditation models, e.g. in the UK, recognize a wide variety of organizations as providers of nursing and midwifery CPD (Karas et al., 2020). Although there is a regulatory body (NNC) for registration for nurses and midwives, there are no mandatory requirements for the licence renewal process (NNC, 2022). However, the renewal process for nurses and midwives in the neighbouring and resource-poor countries requires mandatory CPD (MOH, 2020). For example, India requires 150 credit hours for every 5 years, Ghana requires 10–20 points yearly depending on nursing roles, South Africa

requires 15 CPD points per year, Zimbabwe requires 12 credits hours per year and Kenya 20 CPD points per year (MOH, 2020).

This study revealed that financial constraint was a significant barrier to CPD. A comparable study from low- and middle-income countries noted that the lack of financial support, distance from training sites and motivational, physical, attitudinal and structural factors were key barriers to CPD (Azad et al., 2020; Bwanga, 2020). Many nurses self-fund training when organizational financial support is not available (Bogren et al., 2020). However, lack of funding is the ultimate barrier to seeking CPD, as structural barriers in the organization often discourage nurses in resource-poor settings (Mlambo et al., 2021). An unsupportive environment coupled with negative organizational cultural practices has long-term adverse effects on staff motivation (Bogren et al., 2020; Mlambo et al., 2021). Previous studies established some deterrents for CPD which included a lack of time available due to workload and the absence of replacement staff (Khatri et al., 2021). In our study, most participants indicated unsupportive organizational behaviour which stopped nurses from attending CPD. Our study showed that nurses acknowledged the importance of CPD, and at the same time noted the lack of accessible CPD training and centralized training as barriers, as also reported in Africa and other developing countries (Azad et al., 2020; Bwanga, 2020).

Also, our study suggests that regular monitoring and assessment of nursing and midwives' professional development both in public and private health institutions can help prevent brain drain, high staff turnover and strengthen the relevance of nursing in society and help improve the health care system to deliver high-quality health services. Furthermore, this study also highlights the need for the mandatory CPD provision for the renewal of nurse and midwives' licences in Nepal. Therefore, the importance of policy-driven value of CPD, and then a widespread understanding of the different ways CPD can be understood, accessed and/or delivered, is needed to enhance uptake of CPD with the ultimate aim to improve the quality of nursing care in Nepal.

5.1 | Limitation of the study

Three authors have a nursing professional background and therefore it is difficult to completely rule out the subjective influences of their previous professional experiences on the data collection and analysis process. However, we have minimized the chances of such subjectivity by involving researchers from non-nursing backgrounds at all stages of this study. The critical reflexivity and cross-validation of results among co-investigators were performed to mitigate the impact of previous experience on the data analysis (Probst, 2015).

6 | CONCLUSIONS

The barriers to CPD identified at policy, organization and individual levels are interrelated. Nurses were found to give priority to maternity training because of the benefits associated with it. The participants often mentioned political influence on the nursing profession. Examples reflecting such political influence were most of the training being prioritized for nurses working for government institutions and senior nurses. Nurses also identified barriers to receiving CPD which included staff shortages in the organization when nurses were away on training and cost, not just the cost of a training module but also travel and backfill when the CPD training was centralized. Organizations did not support staff because of the fear of trained staff leaving the job, especially if they feared that staff wanted training to increase their chances of migration. Therefore, this study suggests reviewing the current provision and practices of post-registration training to motivate nurses and midwives in their current jobs and prevent them from migrating abroad. There is an urgent need to map the existing provision of professional development training which are available on ad hoc basis and the need to introduce compulsory CPD based on the need to enhance the knowledge and skills to improve nursing care in Nepal.

6.1 | Implications for nursing policy

It is time for policymakers to introduce the CPD provision as a mandatory requirement for the renewal of nursing and midwifery licence in Nepal. Health policymakers and educational developers should consider reported barriers such as resource constrain, the practice of seniority, continuity of training, staff retention, political influences, etc., and facilitators such as policy provision, decentralization, relevant training, organization support, etc. when introducing compulsory CPD in Nepal.

ACKNOWLEDGEMENTS

We thank all participants for their enthusiasm, Deena Giri for data collection, and Bournemouth University for funding.

FUNDING INFORMATION

This study was funded by Bournemouth University.

CONFLICTS OF INTEREST

The authors have no conflict of interest.

ETHICAL APPROVAL

Ethical approval was obtained from the Nepal Health Research Council (NHRC) and Bournemouth University Ethics Committee. The participation was voluntary and all participants' were informed about the study purpose and ensured confidentiality of their data.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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How to cite this article: Simkhada, B., van Teijlingen, E., Pandey, A., Sharma, C. K., Simkhada, P., & Singh, D. R. (2023). Stakeholders' perceptions of continuing professional development among Nepalese nurses: A focus group study. *Nursing Open*, *00*, 1–11. https://doi.org/10.1002/nop2.1586