ORIGINAL ARTICLE

EXPLORING BARRIERS AND ENABLERS OF COMPASSIONATE AND RESPECTFUL CARE IMPLEMENTATION IN PRE-SERVICE EDUCATION IN ETHIOPIA

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ABSTRACT

Background: *The health sector mainly demands a better result of health outcomes and impacts by ensuring integrated compassionate and respectful care into pre-service education that dramatically changes health workforce pride, ethics, compassion, and person-centered care. It brings high-quality healthcare systems. It is critical to building sustainable, equitable, and healthy teaching environments. Therefore, this study aimed at exploring the implementation of compassionate and respectful care in pre-service education in Ethiopia.*

Methods: *An implementation research with qualitative approach was conducted in April 2021. We interviewed 20 participants (n = 18 men and n = 2 women) and observed 18 curricula. Purposively, 8 institutions found in the two Regional States and one City Administration of the Federal Democratic Republic of Ethiopia were selected. We included 4 Higher Education Institutes, 2 Health Science colleges, the Ministry of Science and Higher Education, and the Ministry of Health. Data were collected through key informant in-depth interview, and observational checklist. Data were transcribed, translated from Amharic into English language, and coded using Open Code V.4.02 software. Thematic framework analysis was used for analysis. The codebook was developed and all the data were coded and under five main themes and two sub-themes.*

Results: *We identified relevant themes that emerged from interviewed participants. Accordingly, five main themes and two sub-themes were emerged. These were the importance of compassionate and respectful care, integration of compassionate and respectful care, barriers of CRC (internal and external barriers), enablers for compassionate and respectful care and strategies to tackle barriers. Compassionate and respectful care in pre-service education was enhanced the students' ability to engage in reflective practice, deal with clinical challenges, evaluation, and gained confidence. Internal and external compassionate and respectful care barriers in higher education was identified in the participants' in-depth interview at department level, school level, college level, and ministerial level to foster compassionate and respectful care delivery in pre-service education.*

Conclusions and recommendations: *The implementation of compassionate and respectful care which was poorly integrated in pre-service education in Ethiopia needs strong establishment for further incorporation. It is important to include it in education and a 360-degree evaluation of student's module, patient awareness about compassionate and respectful care, and high commitment of stakeholders engagement to avail of compassionate and respectful care in pre-service curricula. The sustainability of compassionate and respectful care in pre-service education should be maintained through collaboration work with Ministry of Sciences and Higher Education, Ministry of Health and Higher Education Institutions to integrate and implement in pre-service education curricula of all health science education and improve the health workforce skills through in-service training.*

Keywords: *CRC, implementation, pre-service education, Ethiopia*

BACKGROUND

The Global strategy on human resource for health Workforce 2030 clearly outlined that the health system can be improved only with health workers, and that improved health services coverage realized the right to the enjoyment of the highest attainable standard of health. This depends on health workers availability, accessibility, acceptability, and quality and effective coverage(1). A significant shift in CRC for

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health workforce is important to implement in pre-service education that provide long-term effective transformation for health care facilities in the health sector and health teaching schools to achieve better health care outcomes and high quality health services (2).

The Ethiopian Ministry of health designed implementation strategy for compassionate and respectful health care service and initiated its implementation in 2015 in all health care facilities and higher teaching institutions(2).The major strategic intervention are strengthening ethics and professionalism in pre-service and in-service education/training, strengthening health policy and healthcare system strengthening, enhance person centered care, community and stockholders engagement, and reform student selection based on their passion for health profession (8).

A lot has been done globally, continentally, and nationally to improve health care systems. Even though there is increasing scope and sophistication of healthcare, vast resources invested to it, the focuses are still failing at a fundamental level in different under developed nations of the world (10). Caring and compassion, which are the basics of care delivery and the human aspects that define it, seemed to be under strain (7).

Within the Ethiopian healthcare system, many health professionals have worked, and have been appreciated by their respective patients whom they serve. However, some health professionals considered their patients as merely 'cases.', They do not exhibit compassion and respect (6). Survey researches have shown that lack of respect, lack of compassion and lack of respect for the dignity of patients are at the heart of care failures (11). Some of the causes are frightening and the concern of many why such things can happen in a presumed "caring" society (3).Many patients get treatment that is de-humanizing and uncongenial which caused disastrous for professionals, families and failure for the health care systems(12, 13).

These days, unethical medical practice is a severe issue of the health world. The effects of unethical medical practice are wide-reaching, harming many clients who come to hospitals searching for compassionate medical services (4). The increase in a lawsuit against health professionals is an immediate and hot issue (14, 15). Health professionals have several ethical, moral, and legal obligations in their medical practice, even if there are gaps in the code of ethics (10).

There are limited studies regarding CRC implementation in pre-service education in Sub-Saharan African countries in general and in Ethiopia in particular. This study focuses on CRC practices in Ethiopian health teaching institutes, and it aimed to shed light on the implementation of CRC services. Not only these, it also tries to explore barriers and enablers in Ethiopian pre-service education system. The finding of this study is important for policy makers, health teaching institutions, development partners, health professional associations, and other stakeholders to design informed strategies and practices to move forward the CRC services agenda in pre-service education.

METHOD

Study design and settings: An implementation study with a qualitative descriptive approach was conducted from February 1/2021 to April 30, 2021.Eight purposively selected institutions in charge of designing or delivering pre-service educa-

tion, across two regional states and one city administration of the Federal Democratic Republic of Ethiopia were included in the study. From these, four Higher Education Institutes and notably four departments in each (Addis Ababa University, University of Gondar, Arsi University, Debra Tabor University), two health science colleges, and notably one department in each (St. Paul hospital millennium medical college and Debrebirhan health Science College), the Ministry of Science and Higher education (MoSHE), and the Ministry of Health (MOH) respective directorates.

Study participants: The study participants were purposively selected from the selected institutions. These were department heads, school heads, academic coordinators, directors or deans from selected universities and colleges, across the departments of Nursing, Medicine, Public health officers, Midwifery, Anesthesia, and pharmacy, and the head of selected directorates at the MoSHE and MoH.

Sample size and sampling procedure: Twenty (20) key informants were involved in in-depth interview that selected from each department depending on their position and CRC implementation experience, using a purposive sampling technique. We invited them to participate in scheduled in-depth interview through the invitation letter for volunteer key informants.

Data Collection: Both the interview guide and the observation checklist were developed in English and administered in Amharic language. The instruments were pilot tested with informants from a department and a directorate that would not participate in the sample. Interviews addressed the implementation of CRC in pre-service education, related barriers, enablers, and possible strategies to address the barriers. During interviews, audio was recorded for an average of one hour. Furthermore, undergraduate health curricula adopted by the selected departments were reviewed using an observation checklist to check for any CRC-related content and how it is integrated in the curriculum, mode of delivery, credit hour, year(s) of inclusion in curriculum and delivery.

Trustworthiness: In-depth guides were examined by qualitative research experts from the University Of Gondar, College Of Health Science in order to maintain credibility. Before the actual data collection, the data collection tool (interview guide) was pre-tested on two informant participants who will not participate in the sampling. Following a discussion with members of the research team, the tool was modified. The methodology section clearly defined the general research procedure, study setting, and study participant characteristics in order to maintain transferability. Between each question, probing interview techniques were utilized to ask more questions in order to understand the barriers and enablers of CRC implementations better. The data collectors recorded the interviews using a tape recorder and wrote field notes. Finally, the lengthy description was finished. The participants completed a member check to examine and verify the interpretations and findings in order to preserve dependability.

Data management and Analysis: The recorded interviews were transcribed and fi-

nally translated from Amharic language into English language. Data were entered and coded using open code version 4.02 software. Thematic framework analysis was used for analysis. A codebook was developed and all the data were coded and thematized. During data transcription, coding, and thematizing peer auditing was conducted frequently to minimize errors(16).The verbatim transcripts were independently checked against the audio recordings of the interviewers and further guaranteed the consistency of each interview session by analysis team. The teams also analyzed the interview adherence to the protocol and the probing questions' each transcript checked again to reduce differences between individual codes and mark out the transcript that was non-specific to CRC throughout the process. Rigors were further assured during data collection and analysis by the study team. Finally, the narrative was organized according to themes emerged.

Ethical considerations: All components of protocol and methods were approved by the University of Gondar Ethical Review Board (V/p/RCS/05/680/2021). A support letter was also obtained from the Ministry of Health to collect the data from each institution. Written informed consent was taken from key informant participants. Confidentiality of participants was secured using identification number codes to protect disclosure. The collected data have been anonymized throughout the research process.

RESULT

From twenty key informants, eighteen were male and two were female, and age ranging from 26 to 52 years old. Their professional background was nursing, public health officer, anesthesia, medicine, midwifery and pharmacy.

The findings were illustrated in the five themes found. They included: the importance of CRC, integration of CRC, barriers, enablers for CRC, and strategies to tackle the barriers which were drawn from both the interviews and the observation checklists. The findings were directly related with the designed research objectives and national CRC strategy implementation.

The importance of CRC: The relevance of CRC was highlighted from the result obtained with some implications for CRC provision in pre-service education. It is indicated that CRC integration in pre-service education health curricula is important for establishing a strong CRC and professional ethics in higher educations.

The informants described that the CRC is one of the most core competencies of healthcare professionals who tried to develop the CRC and patient-centered care attitude for their students in their curriculum. Additionally, participants described CRC as the center of keeping dignity, humanity, and developing a sense of feeling for clients during skill lab-based and clinical or human simulation practices.

"CRC is philosophy of health professionals view towards their patients and how do they provide health care through compassionate care, [good]

relation and based on their needs in keeping with the right and dignity of patients…"(Anesthesia Department Head)

"… [CRC] is health professionals' feeling about their [patients'] pain and about delivering professional care." (Medicine School Head)

"CRC is about how professionals especially health care providers should give care, respect patients, giving successful and acceptable care." (Public Health Department Heads)

"Only getting medicine can't cure clients, but also it needs respect and compassionate service. Beyond the medicine, compassionate and caring service can develop trust to take the medicines appropriately. Even though they did not get comprehensive health service practice, patients show progress when they are treated well."(College Dean)

Key informants from selected universities and colleges generally agreed that healthcare providers should respect, provide acceptable care with a positive attitude (compassion, respect, humanity and develop trust for clients) which are different from taking medicine. CRC is an important medical component that all health care providers, instructors, and students should use as a guide for their professional ethics, responsibility, and duty to fulfill the standards of treatment, psychological therapy, and which engaged clients in the decision of health care practices.

Integration of CRC: The principles of CRC are currently integrated with nursing, midwives, and anesthesia undergraduate curricula. All students who are taking theoretical skill lab, and clinical attachment participate in the teaching and learning process, and evaluated.

"In every attachment in clinical practice, the students are evaluated for the medico-legal ethical principle that governs the students' attitude, behaviour, respect to a human being, human dignity and privacy, preference and decision making for the patients. Additionally, the course contains the responsibility and duty that expected from one profession including consent form before any procedure that we checked our students during clinical attachment through the observational checklist" (Midwifery Department head)

The curriculums contain professional ethics, respectful maternal care, human-centered care, and principles of the CRC which are aimed at patient-centered care and professionalism.

"*In fact, previously the CRC was not integrated into the curricula except few points which were integrated with professional ethics module directly or indirectly. we integrated them during course delivery. For example, respectful maternal care is provided in the module. We evaluated students' attitudeabout respect, compassion, and professionalismduring clinical evaluation."* (Midwifery Department head)

On the other hand, currently,CRC training is not integrated in medicine, pharmacy, and public health curricula. Yet, professional ethics and its principles are taught and share CRC values. A representative from one of these departments noted that:

"*Instead, there is a professional ethics principle in the curriculum that indirectly contains CRC. For me, CRC is applying ethical principles which came after learning professional ethics. and after students acquired knowledge of ethical values, believes, norms, and philosophy of their profession."*

Barriers: According to the data collected, there were many factors and challenges to integrate and implement CRC in pre-service education according to the national CRC strategies. The challenges were categorized into two levels::internal and external challenges. Internal challenges are challenges which are related to instructors' CRC skill gaps, lack of clinical role model, short time allocation for ethics and CRC and lack of conducive teaching environment. The external challenges include: stakeholder involvement and lack of collaboration with MoH.

Internal barriers: Selected informants listed many internal challenges that limited the implementation of the CRC in higher education. The main challenges include: instructors' skill gap on CRC, lack of conducive working environment, lack of focus in contents of professional ethics in curricula and shortage of CRC role model in clinical care practice from the senior staff. The anaesthesia department head stated it as follow:

"Starting from the beginning, the CRC limitation may be because of instructors' skill gaps who deliver the professional ethics that shape the student as a role model. They [health care providers] are working in a very hazardous and stressful working environment which bring compassionate fatigue, burnout and hesitate to provide the CRC accordingly."

A nursing department head described the insufficiency content of professional ethics as follow:

"To tell you the truth, I have the opportunity to teach professional ethics to both undergraduate and postgraduate students. While I come to undergraduate curricula professional ethics, I think it is not sufficient. It only contained 3% weight of the module time"

In the same way, the midwifery department head described that barrier from the instructors and students, practical sites, and a problem with hospital space and lack of timely curriculum revision.

"There are barriers from both students and instructors. While the students are not 100% involved according to the professional ethics requirement, the instructors have a gap on CRC to show practicum on the patient simulation as a role model. Even the environment is not suitable to provide in the practice site. The hospital staffs are not motivated to show real respect and compassion on clinical practice as a role model. In the same way, there is an overload of the students, and there is lack of good governance. Likewise, there is no timely curriculum revision."

External barriers: The informants mentioned that there are external challenges for the CRC implementation in the higher education curricula. There is lack of stakeholder involvement since they were not working collaboratively to influence its implementation. Anaesthesia department head and school of pharmacy head revealed that:

*"MoSHEas an organization does not allow compromising the time duration.. On the other hand, our opportunity to incorporate CRC in the professional courses is very limited. So, their (MoSHE) authorities' rigid position on time duration is the main challenge." (*Anesthesia Department Head)

*"There is no a stakeholder who came to us to work on CRC… We reported this to the responsible body and trainers. They provided training only for on jobs staffs. They said sorry, and they promise to organize training but they did not make it practical. We told, and we convinced our students that a few days of training would not improve their practical skill in the expected level." (*School of Pharmacy head)

A participants from the school of medicine head described that MoH's irregular follows ups in pre-service education is one main challenge for incorporating the CRC in the curricula.

"*The main factor is that we have not taken the initiative to start, and there is no order from responsible bodies like MoH. That is why we haven't started yet"*

Most of the participants mentioned that the difficulty to have curricula is due to tight time and CRC training skill gaps in pre-service education. In addition, the participants stated that the curriculum development was not done by right professionals.

Similarly, the midwifery department headexplained it as: "*The curriculum development is mandated by MoSHE and MOH which is a hindrance for us to make timely revision. We have three types of curricula, However, as mentioned above, the curricula development is not done by the concerned professionals which made bias among the different courses For example, there was no time to incorporate professional courses like professional ethics, CRC, and professional care practice that need more time, but they contained life-saving procedures."*

In the same way, the nursing department head added similar points: *"---lack of CRC is affecting the quality of health care delivery because we are dealing with life. The allocation of inappropriate time and the tight time that we have make a difficulty to have curricula, to implementCRC, and to include professional ethics., As a result ,we have no room to revised 20% of the curriculum"*

Enablers for CRC: The participants agreed on CRC integration and implementation in pre-service education of health curricula. The informants' willingness and motives enable to integrate and implement CRC in pre-service education of health curricula. Awareness creation, religious values, giving training, and collaboration work with stakeholders were some of the positive factors for CRC integration and implementation in pre-service education.

In the same way, the college dean stated that CRC national transformational agenda was possible because of the incorporation of social values and norms, religious values of the community, and because the participants who were engaged in human care were role models."*It [CRC],which designed as a transformation agenda,encompasses religious values, social values, norms, role models, people who engaged in humanity support,."*

Professionals' inner passions were also important enabling factors for CRC integration and implementation in pre-service education. The nursing department head narrated it like this:

"*We haven't faced interruptive internal challenges yet. Our staffs are young, and they are motivated to do new thing. So, they like changes. There is a good commitment or willingness.As much as possible, I tried to integrated by providing a passionate way of transferring inner senses of professional knowledge, by rising different case scenario, and by assigning clinical experienced professionals who are skilled to solve an ethical dilemma."*

Giving recognition for role models was also one of the enabling factors to integrate and implement CRC in pre-service education of health curricula. School directors and department heads explained role model recognition as one of the enabling factors for CRC

integration and implementation in pre-service education.

"*Actually, in the past time, the CRC agenda was concerned only to health care facilitators who provide training, and who are role models at the hospital level including social values. However, providing recognition for the health care workers is a very recent practice."* (Nursing School director)

"*There is an initiation of selecting role models who are exampleries in their behaviour, ethics and education at university and hospital-levels for the staff, and for the students. The initiation also included providing recognition for the health care workers and students who are nominated as CRC ambassadors."* (Midwifery Department Head)

Strategies to tackle barriers: The study participants suggested possible strategies to solve CRC implementation barriers in pre-service education. Most of them mentioned the following strategies: stockholders engagement, collaboration work, commitments, narrowing skill gaps by training academicians, empower students' skills and knowledge by incorporating CRC competencies in the health curricula.

Participants from the Ministry of Science and Higher Education described that CRC is important if it is integrated from the lower grade level education (elementary school to university) which makes CRC concept effective nationwide

"When a work is done individually, it may not be effective. On the contrary, CRC concept awareness and working collaboratively with stakeholders horizontally and vertically make it more effective. We are working at the university level, but this should be done starting from the lower levels. If we do this at the lower levels, we may not see the current challenges in the nation."

In addition, integrating CRC in pre-service education by identifying the gaps on evidence-based research activities and uniform delivery of the CRC training in pre-service education benefits the students, health workforce, and the community.. The nursing school director explained the importance of CRC integration in the following way:

"For the future, training has to be given uniformly for all students. The academic trainer should provide cohesive integration with the pre-service education. It is better to involve an academician in the integrated training for the academician may raise research questions, and he may identify the gaps that hinder the implementation of CRC. In fact, CRC takes a long time to bring changes on the students and health care providers to be more compassionate and respectful".

Similarly, a participant who is nursing department head recommended possible strategies to solve CRC implementation barriers. For instance, CRC is effective if it has its own course module, and this is advantagefor the health care providers to save their clients' life timely.

"In general, [to overcome the challenges], the curriculum must contain ethical principles, compassion, and respectful caring because one of the three competencies is an attitude which can be explained through the provision of compassionate and respectful care approaches to the clients during client care."

Similarly, anaesthesia department head proposed possible strategies to avoid barriers by integrating CRC module though out the year, and this advan-

taged the students to save their clients' life.

"Integrating CRC in the curriculum has many advantages. Clinical care is directly related to immediate human life. If we don't care for the patients immediately, we are going to lose patients' life. The profession itself is also a high-risk profession. Therefore, professionals must have compassionate and respectful skills which have an advantage for the health care providers."(Anesthesia Department Head)

Likewise, other study participants suggested possible strategies to bring an impact on CRC implementation in pre-service education. These included: stakeholders' engagement and commitments which have a great impact on CRC implementation.

*"When a curriculum is designed, it needs government involvement, community, and individual commitment…especially great focus expected from the MOH. We have recommended integrating CRC with health ethics and legal medicine module." (*Medicine School Head)

Observation: The implementation of CRC in pre-service education was depended upon curricula contents and hours allocated for the module. A pre-service in-depth interview analysis alone is not accepted as conclusive evidence of CRC implementation. Curricula observation is also important for content analysis. Therefore, all current curricula used in pre-service education were observed for CRC including the year of integration, element of CRC, course credit, assessment and evaluation mechanism, and presence of teachers guide.

We observed that most of the curricula did not incorporated CRC in their department curricula, but a few departments integrated the CRC in their curricula. On the other hand, all departments integrated the professional ethics module in their curricula including the principle of ethics, respect for clients, patient right, responsibility and duty of healthcare providers and code of professional ethics.

In the current curricula of anesthesia department, CRC content is sufficiently incorporated which contains concepts of compassion, respectful and dignified care, mindfulness, humility, principles of compassionate care. Additionally, the module contains qualities of compassionate care, elements of compassionate care, professionalism and professional ethics, threats of compassion and respectful care, and mitigation mechanisms to address the threats.

In addition to the content of CRC in the module, we observed the mode of CRC delivery in pre-service education. It included interactive lecture and discussion, role-play, case study, bedside teaching, portfolio, clinical simulation, video show, demonstration (at skills lab and basic sciences lab), guided clinical practice, problem-based learning cases, interprofessional learning experience in the clinics, and community practice, and seminar presentations. All integrated CRC modules were credited and integrated into each course module.

Together with the mode of delivery, we have observed methods of assessment and evaluation of students. The module contains formative and summative assessment methods. The formative assessment contains drills, essay exams, quizzes, and practical tests (direct observation of skills), structured feedback reports, oral exams, portfolios, and other assessment methods. The summative assessment on the other hand contains progressive assessment (Objectively

Structured Clinical Examination and Structured Oral Examination). We also observed that there is no teachers guide for CRC reference.

DISCUSSION

The informants shared their experiences, proximities knowledge, skills, and practices of CRC, and their role as the implementers of CRC integration to CRC implementation in pre-service education. , This was very useful perspective to assist the development of CRC in academic environments. In addition to sharing their insights on the importance of CRC in pre-service education, participants also emphasized the berries of CRC implementation across the different internal and external dimensions, integrations, enablers, and strategies to solve the barriers in which challenged their curricula development.

Our research findings demonstrated that the implementation of CRC in pre-service education is useful in all healthcare undergraduate training programs because of its attribution for continuous professional development across the entire healthcare settings. In addition, demonstrating CRC in pre-service education is core for developing competency-based practice, for improvement of quality of care by improving the culture of the organization, equip the students, and enhance person-centered care. Different studies indicated that integration of CRC in pre-service education was the best instrument in engaging the students in bedside clinical practice, educators in peer-based learning and sharing of ideas, developing effective communication and client- centered care, and better awareness of CRC and professional ethics in their professional practice (17-20)

In the last five years, implementation of the CRC services strategy has faced multiple challenges. For example, attribute and passion-based selection of students has not been actualized; curricula in teaching health facilities are not harmonized, ethical competencies are inadequately defined and implemented in health curricula. In addition, there is lack of role models in teaching and practical sites, and there is poor commitment to improve the curricula and teaching-learning processes by stakeholders. Adding together, service users are poorly aware of CRC services, there is a poor monitoring and evaluation system for CRC implementation, and clinical practice as well medical ethics and professionalism and simulations centers are not well designed to address CRC principles in an ethical manner (14).

However, in most developing countries, CRC in pre-service education is less practiced by middle managements, students and ward-level frontline health care workers (21, 22). We found that most of the study participants described that the CRC course module is not integrated with higher education curricula. As a substitute, it contains the professional ethics which contain the principle of CRC, including responsibility, autonomy, justice, dignity, humanity, professional code of ethics that the students developed a sense of feeling for clients during skill lab-based and clinical or human simulation practices. Research evidences suggested that supporting the students by junior and senior staffs to avail of CRC and person-centered care course is a key step to embracing and sustaining change and promoting patient -centeredness (23, 24).

The barriers related to CRC in pre-service education emerged in two significant categories: internal and external barriers. Internal barriers identified for CRC delivery in pre-service education were related to lack of available resources, shortage of time, and CRC

training support, instructors' skill gap on CRC, lack of conducive working environment, lack of recognition, and few focuses in contents of professional ethic in curricula, and shortage of CRC role model in clinical care practice. The other sub-them barriers are external barriers that included insufficient stakeholders involvement, and curricula development is not expert-based. Similar findings were reported as lack of available resources, shortage of time, and lack of supporting multi studies done in United Kingdom (UK) (21, 24, 25). Conversely, awareness creations, maintaining religious values, social values and norms, recognition of role models, provision of CRC training for instructors, and collaboration work with stakeholders are enabling factors for CRC implementation in pre-service education. This was supported by previous finding in a mixed-methods study (6).

In addition, CRC in pre-service educational institutions may have a positive result, but there is also evidence that workplace culture, effective communication, and team relations as role models play key roles (26). The CRC in pre-service education should include knowledge and skills for health care students to engage in self-compassion and compassion for others. Particularly, health care workers demonstrated and provide person-centered care including all health dimensions of care, develop their own wellbeing's, resilience, and supportive environment that learned from role model leaders (27). It is important to notice that health care wellbeing and supportive environment are also considered to have a positive impact on client-centered care delivery which developed during theoretical and clinical course practices and cultured from the senior (28).

Health professionals have ethical, moral, and legal obligations in their medical practice even if there are gaps in the implementation code of ethics. A study indicated that the general practice of the code of ethics among medical doctors in Addis Ababa was found to be low (14).The majority of informants described that CRC is best if it has its own course module. Students should select their department based on their passion and attributes stockholders engagement, collaboration work, and commitments, addressing skill gaps by giving training for academicians, empower students' skills and knowledge by incorporating CRC competences in the health curricula. This approach may offer a useful structure to develop a strategic approach to the promotion and development of CRC in pre-service education that has a positive and sustainable impact on students at all levels. Especially, MoSHE and MOH have mandated to integrate CRC in the curriculum to bring the quality of health care delivery.

The strength and limitations of the study: The strength of this study is that it is the first study to explore the implementation of CRC in pre-service education developing like Ethiopia. The phenomenology approach supported broad description and allowed in-depth exploration of the different modules of curricula in various departments witnessing the curricula content and extracting the information from pedagogical experts. The limitation of the study was that most of the discussion part was compared with the qualitative report conduct on developed countries.

CONCLUSION AND RECOMMENDATION

The integration of CRC was poorly implemented in Ethiopian pre-service education. Even though the integration of CRC in pre-service is education cru-

cial, internal and external factors affect the implementation of CRC at large. Additionally, CRC in pre -service education has a positive effect on theoretical and clinical practices, and it improved instructors' inner motives, but it was not well integrated into curricula except in Anesthesia department. There are positive supplements on pre-service education in terms of professional ethics, caring for patients and preserving patient privacy. Given the positive outcomes which are related to CRC in pre-service delivery, from the findings of this in-depth interview, we conclude that it is important to integrate CRC in the pre-service education curricula for health sciences students who emphasize both for self-compassion and delivery of CRC and person-centered care.

The findings also indicated that integrating of CRC in pre-service education can enhance the long-term impact of health workforce satisfactory outcomes for provision of person-centered care, a conducive healthcare environment, and better organizational culture. The sustainability of CRC in pre-service education should be maintained through collaboration work with MoSHE, MoH and Higher Education Institutions to integrate and implement in pre-service education curricula of all health science educations and improve the health workforce skills through in-service training.

Abbreviations: CRC- Compassionate, respectful and caring, CPD- Continuous professional development, GTP- Growth and transformation plan, HCWs- Healthcare workers, HRH- Human resource for health, HSTP- Health sector transformation plan, HWF- Health workforce, MoH- Ministry of Health MoSHE- Ministry of science and higher education, UK-United Kingdom and USA-Unite States of America.

Declarations

Ethics approval and consent to participate: All components of protocol and methods were approved by the University of Gondar Ethical Review Board. A support letter was also given from the Ministry of Health to collect the data from each institution. Written informed consent was taken from key informant participants. Confidentiality of participants secured using identification number codes to protect disclosure. The collected data kept secret throughout the research process.

Consent for publication: Not applicable.

Availability of data and material: The datasets generated and/or analyzed during the current study were not publicly available. Sharing of data was not included in the approval from the ethics committee but is available from the corresponding author on a reasonable request.

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