ORIGINAL ARTICLE

EXPLORING THE IMPACTS OF DIVISION OF LABOUR ON THE IMPLEMENTATION OF COMPASSIONATE, RESPECTFUL AND CARING HEALTH PROFESSION IN FELEGE-HIWOT SPECIALIZED HOSPITAL, AMHARAREGIONAL STATE, ETHIOPIA

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ABSTRACT

Background: *Creating Compassionate, respectful and caring (CRC) health professionals (CRC) is very important to build a sustainable, equitable and healthy future for all divisions of labour and service delivery in their respective practices. The aim of the study was to explore the impacts of labour division in Felege-Hiwot specialized hospital on CRC implementation.*

Methods: *A phenomenological study design with purposive sampling, observational and document review data collection techniques was used to explore the impacts of division of labour on CRC implementation, and to explore barriers and enablers of division of labour among health workforces in Felege-Hiwot Specialized Hospital from March 15 to 30, 2021 by three well experienced data collectors. Twenty-seven participants were interviewed in the study. Patient participants were interviewed at exit time. Audio recording and field notes were taken from key-informant interviews and patient exit in-depth interviews. A thematic framework analysis was applied for data analysis.*

Results: *Based on the data analysis, six themes were investigated; labour division, workflow, and enablers of labour division for CRC implementation, effects of labour division on CRC implementation, barriers of labour division, and strategies to improve labour division. The result indicated that the labour division has direct influence on CRC implementation. Poor workflow, excessive workload, weak departmental and professional integration, limited administrative motive were identified. These in turn brought lack of motivation on health care providers, delay of service, weak patient -care provider relationship. Providing training, preparing and updating guidelines, promoting good role models, working on motivational activities for staff, strengthening professional skills, and regular supportive supervision were the most recommended solutions to improve division of labor status and CRC implementation.*

Conclusion: *According to the findings of this study, excessive workload, inadequate infrastructure, lack of responsibility, absence of supportive supervision and weak administrative issues were identified barriers for proper division of labour and CRC implementation. This study also highlighted the need for having clear scope of practice and work description, increasing integration among professionals and departments, managing hospital work flow, balancing patient flow and number of care providers, and increasing administrative motivations to implement CRC services properly.*

Keywords: *Division of labor, compassionate, respectful and caring*

BACKGROUND

Compassionate, Respectful and Caring (CRC) service to patients is an indication of being ethical, keeping the professional promises, and being a model for young professionals and students. It is a practice that requires individual professionals who identify their profession and take pride in helping patients. Compassionate, respectful and patient- centred care is a first priority in our efforts to improve quality and equity in service delivery (1).

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Ethiopia has set CRC as one of the transformation agenda to be implemented in the first growth and transformation plan (HSTP I) to achieve big goals to improve equity, coverage and utilization of essential health services, improve quality of health care and enhance the implementation of capacity of the health systems(2).

The Federal Ministry of Health (FMoH) of Ethiopia is trying to implement compassionate, respectful and caring services for the last five years to facilitate person-centered and patient preference morbidity and mortality prevention (2, 3). Currently, the FMoH is developing HSTP II to graduate Motivated, Competent and Compassionate (MCC/CRC) services deliverer professionals in a consistent and coordinated way as one of its priority transformation agenda to be achieved by the year 2030 (4).

According to WHO recommendation, human resource for health is considered as a critical component of the health system in integration with other developing transformation agenda. A long with the number and distribution of health workforce, the effectiveness of human resource for health is a key indicator in Ethiopia. Recently, Ethiopia has 273,601 heath workforces employed in different public health facilities out of which181,872 (66.5%) are health professionals, but the remaining 91,723 (33.5%) are administrative staffs (4).

Among the health professional, categories, nurses, health extension workers and midwives accounted the highest percentages with 59,063 (21.59%), 41,826 (15%) and 18,336 (6.71%) respectively(4). In fact, the majority of Ethiopian healthcare provision is twisted on promotion, prevention, curative and rehabilitative care with low quality and patient preference (4).

Even though health is influenced by a complex interaction of physical, social, economic, cultural and environmental factors, health care should be safe, effective, timely, efficient, equitable, and person-centered. So, to fulfil these dimensions, health workforces can take the lion's share to improve the health literacy of patients, the quality of care and health outcomes indifferent health care deliveries. Based on this fact, provision of motivated, competent and compassionate health care benefit patients on treatment adherence, the healing process, care satisfaction, and it helps to develop timely health-seeking behaviours. Similarly, compassionate and respectful care provision helps health workforces to have lower depression rate, elevated work satisfaction, lower burnout, and more diligent technical care.

The 2016Ethiopian national human resource for health (HRH) strategic document indicated that the proportion of health workforce in Ethiopia was 1.63 per 1000 people. This is below the WHO's minimum recommended of 2.3 health workers per 1000 people (3). Participants who involved in the study which was conducted in Tigray reported that there was significant increases in the number of deliveries which indicated the sharp increase in preference for facility-based delivery. However, there has not been a parallel increase in the number of staff to give these delivery services(5). In some studies, the result further showed that delivery caseload is negatively associated with quality of care. Similarly, delivery service providers who had high numbers of deliveries were found to be less likely to provide quality of care (6).This was further corroborated in studies done in Malawi (7) and other sub-Saharan African countries (8, 9). This can contribute a lot for significant inequity in workloads division for staff in different facilities and different units within the same facility.

Generally, CRC is important to build a sustainable, equitable and healthy future for all division of labour services delivered in their practices. However, the amount of evidence on the current practice in Ethiopia is scanty.

METHOD

Qualitative approach: A phenomenological study design was used to explore the effects of division of labour on CRC implementation and on barriers and enablers of division of labour. We used a phenomenological approach to get an in-depth information from the real work experiences of the health work force (HWF) team practice on CRC implementation, and from the sprit (social relationship) teams to improve CRC implementation. The reason to use phenomenological approach was that it is used to gather in-depth information and perceptions through in-depth interview, observation and KI interview from the research participants. The phenomenological approach is very useful for understanding subjective experiences, gaining insights into people's motivations and actions. Phenomenological methods are particularly effective in bringing the workforce experiences and perceptions of individuals from their own perspectives.

Context: The research was carried out at Felege-Hiwot Specialized Hospital. It is found in the capital city of Amhara Regional State, Bahir Dar, which is 565 km far away from the capital city of Ethiopia, Addis Ababa. It was established in 1963 as the district hospital, and it was upgraded to referral hospital in 1994. The hospital has Surgery, Medical, Paediatrics, Obstetrics and Gynaecology, Psychiatry, Dental, and Orthopaedics units with both outpatient and in-patient departments and follow-up departments.

Sampling procedures: In the current qualitative study, Health workforces in Felege-Hiwot Specialized Hospital from medical director, CRC focal person, Planning officer, Quality officer/director, Pharmacy, Laboratory, Card office, Emergency, Nursing and Midwifery, Labour/MCH department coordinators, data clerk and recording officers were study participants. Purposive sampling technique was used for this study. Similarly, a purposive sampling technique was used to select patients for exit in-depth interview after completing all their health care services. The authors included the patients at the exit time for integrating patients' feeling on CRC service in the hospital and care givers' experience on CRC implementations for their patients. The study participants' in-depth interviews and KII were eighteen which were taken from different units and nine from patients.

Data collection tools and techniques: The interview guideline, semi-structured questionnaire and observation checklist (English & Amharic version) were prepared and pre-tested at the University of Gondar comprehensive specialized Hospital which has a similar setup. This was done to check & modify data collection tool, and so to include in the actual study. During pretesting, a tape recorder and handwritten notes were the main sources of data recording. After the pre-test, some modification was done on the tool before we started the actual data collection. Three data collectors who graduated in masters of public health and nursing, and who have good experience of qualitative data collection were recruited & oriented for a half-day to enable them have a common understanding of the tools. Actual data collection was held from March 15, 2021 to March 30, 2021. The data collectors were assigned to conduct key-informant interview, in-depth interview and observation of the

work flow, departmental layout with work integration, scope of practice and all the actual existing division of labour and CRC implementation according to the checklist.

Data collection was started from observation then to in-depth interview, and finally to KI interview. Audio recording and field notes were taken from key-informant interviews and patient exit in-depth interviews.

Each interview lasted for about 25 to 50 minutes. No interview was refused by any of the selected participants. Data saturation was reached when participants began repeating the same responses replayed by interviews.

Data Analysis: The audio and field notes taken from in-depth interview, key-informant interviews and from observation were transcribed in Amharic language and translated in to English by investigators. A list of codes were initially developed from the interview guidelines and observation checklist to be used for transcripts analysis. Repetitive readings of each transcript were done by the research team and codes were generated from plain text data. All transcripts were coded and themed using Open Code software version 4.02, and they were analysed thematically.

Techniques to enhance trustworthiness: In order to enhance trustworthiness of the qualitative research, certain strategies were applied in this study. Triangulation data was used to check information on the same issue. The collected information was transcribed in each data collection day to reduce recall bias, and translated into English. Notes from interviews and observations were also organized immediately. The data collected using the three techniques were triangulated during interpretation. The researchers kept records during the process of conducting the research as it will be undertaken for audit trail at later time to review different aspects of the research. Extensive description of the setting and the participants of the study was presented. In addition, detailed description of the findings with adequate evidences was provided in the form of quotes from participants' interviews.

Ethical Approval and Informed Consent Process: Ethical clearance letter was given from Institutional Review Board (IRB) of University of Gondar. Similarly, supportive letters were given from medical director of the hospital. The supportive letter was submitted at the same time in case if it needs to have permissions from the head of the departments before starting data collection. Copies of supportive letter and ethical clearance were held at hands of the data collectors throughout the data collection period.

Informed written consent including consent to quote participants was given from each respondent. The respondents' confidentiality was maintained by excluding their names from the interview and key-informant interview audio records.

RESULT

A total of 27 participants were interviewed. Among these, 16 were males while the remain were females. Out of this patients, nine were from patients, but the other18 were from health care workers such as from matrons, pharmacist, laboratory, medical card office medical director, nurses, midwife, planning director, CRC focal person, quality director, emergency team leader, triage team leader, MCH directorate and liaison officer one from each. Six main themes were investigated from the content analysis of qualitative research. These were: (1) Workflow,(2) Labour divi-

sion,(3) Enablers of labour division on CRC implementation, (4) Effect of labour division on CRC implementation, (5) Barriers of labour division, and (6) Strategies to improve labour division. Direct quotes from transcripts are provided to illustrate these themes.

Hospital work flow: The hospital work flow considers both service direction indicator and office layout. Participants from patients and health work force reported that the hospital work flow is not comfortable for patients. The finding of the study revealed that participants have common understanding on the following points: layout is not convenient and accessible for new and illiterate patients, the distance between service units are far apart, no individual is assigned to provider information and show direction, and no system is established to link each department. The work flow is explained by the participants as follows:

> *"The layout is not clear. Even I cannot seethe direction clearly, and people may consider me as unwillingness to show or to tell where it is. This seems as deliberately done to confuse patients in the organization. I remember one time when our patient was broken on his leg while he was searching for the laboratory unit in the night. This case scenario was presented at management meeting. After that, we tried to reduce patient confusions to get the service by preparing direction indicators."*

Similarly, one of the participants who was working at the liaison office assured the absence of good work flow which is a challenge for CRC implementation at the hospital. The participant explained it as follow:

> *"Generally speaking, it is more challenging to get the service from different units because its layout is not convenient and accessible for new and illiterate patients. The distances b/n each service units are far apart, and it is not easy to get departments in the hospital. ... patients can get service units after exhaustive search, and after the ask different individuals since there is no assigned individual that can indicate service units and support patients to facilitate their trial to their illness treatment"*

In contrast to the above point, some of the patients replied on the improvement of office layout, and the presence of service direction indicator sat the hospital. A 40 years old patient explained the improvement of workflow in the hospital as follow:

> *".... securities of the hospital show the directions where to go, and where an emergency department is. Furthermore, there is emergency triage at the get of the hospital which is supportive to indicate directions besides the emergency units."*

Division of labour: Health systems require skilled health care work forces for any demanding task to increase CRC deliveries. This requires division of labour which included workload distribution, professional and departmental integration, and professional skill mix, scope of practice and job description. According to the participants' view, absence of guide line, low supervision, high patient flow, irresponsiveness, professional complexity, and low number of health care work forces are the factors which affect the division of labour.

Scope of practice and job description: Participants stated that scope of practice and job descriptions are distributed for each discipline based on the new labour division and salary scale which enable the staff to accomplish their identified jobs properly. Accord-

ing to the document review, scopes of practices of each health work forces are properly developed and available at human resource management office. The document explicitly contains not only the scope of practices, but also the responsibilities. The samples which were taken from individual profiles of pharmacy, nursing, midwifery, laboratory and medicine confirmed the presence of scopes of practices and their responsibilities.

A gynaecologist who was working at maternal and child health confirmed the presence of scoping practice and responsibilities of each health work forces as follow:

> *"This is a labour ward which has different units. The units are divided as labour unit, high risk postnatal and delivery units. Professionals assigned in each unit with appropriate division of work at day time and night as well as weekends with duty in a balanced proportion. We monitor the professionals by providing activities for each assigned unit like follow up of postnatal cases. That means the activities are counted and shared to the responsible person in each unit."*

In opposite to the above participant's description, some participants said that there are a lot of unspecified job descriptions and work mix ups among different professions in the hospital. A nurse who works at emergency unit described the unspecified job descriptions as follow:

> *"…In case of job description, there is confusion. For example, the porter is taking patients, and he/she is transferred to other units, but some type of patients who have fracture, who need oxygen, who recovered from anaesthesia and patients who have other serious cases should be supported either by a porter or other professionals is not explained. Some activities like blood sample and transfusion are done by nurses, physicians and midwifes which is sometimes a cause for conflict even though sharing tasks are common among health professionals*."

Departmental integration: Some of participants agreed that there is a good departmental integration and communication between departments to facilitate patient service activities by using feedback, formal reporting systems, and integrating service units at one area. A fifty years old gynaecologist explained the presence of good departmental and service integration to increase patient satisfaction in the following way.

> *"Our department has its own laboratory and pharmacy service near to our service unit since our care unit serves emergency cases and it arranged the services to customers in a way it enable them to get without delay. This service integration b/n departments is arranged to provide facilitated services to customers. So, I can say that there is service integration and appropriate department layout in maternity ward".*

One the other side, some participants explained the absence of departmental integration. A 33 years old man who has three years work experience in medical card office explained the patient flow and departmental integration status as follow:

> *"… Service integration is very poor, but client flow is highest in our hospital. We have communicated with different departments, and some units tried to help our job. However, others units are not voluntary to help us rather they put patients' card on shelf. This affects our services. Most of the time, the relationships b/n staffs are good since there are young staffs in our hospital"*

Workload Distribution: According to patients and health work force, the imbalance between recruited health care workers and patient flow, low professional mix, budget, and administrative motive are the causes of excessive workload distribution.

A 55 years old patient who has 5 times history of visiting the Felege-Hiwot referral hospital (FHRH) enlightened it as follow:

> *"There are no voluntary staffs who can be called randomly, and who can help the patients in prioritizing them according to their severity. No porter is voluntary to inform us where he is going by calling our name. In addition, the patient flow is high as compared to card officers, and it is not proportional since the hospital is used as referral for large number of population. We understand that the number of card officers should be increased "*

A pharmacist who has12 years work experience in hospital explained the workload distribution status in the hospital as follow:

"Even though all professionals come to the hospital, or some lately or totally absent, there is unequal man power of pharmacists with patient flow in the hospital. ..... Even based on the new reform, the workload distribution is not shared to health workers equally to each personnel. If we see the standardized guide, a single pharmacist in referral hospital can serve forty -five to fifty -five patients per day averagely fifty. But the reality is in our hospital is completely different from this. One pharmacist serves more than hundred patients per day. So, in our hospital, the proportion of pharmacist to patient served per day is above the standard."

Similarly, the excessive work load is common at night than at day time. A 40 years old nurse who was working at emergency department described it as follow:

> *"Nowadays, the work load distributions for along and middle level professionals are relatively normal since they have two work shift schedules. However, the numbers of senior specialists are still limited, and they are not regularly presented to treat referral cases in the hospital.*

How work flow and labour division affect CRC implementation: The most commonly identified factors affecting CRC implementation are limited and ambiguous division of labour and workflow. Participants answered that there is high patient flow, unclear job description and scope of practice, absence of information provider office at the gate, and week departmental integration system affects CRC implementation.

One of the senior internists who has been working for 15 years in the hospital clarified how work load affects CRC implementation as follow:

> *"... in practice, as an example within 8hrs, a physician expected to see 35 patient's at day time in the OPD, but he is expected to see more than 80 patients at night time. Therefore, it is very difficult to examine properly and treat the patients according to their requests. In addition, it is difficult to give follow ups appropriately. These overburdened work load distributions with scarce manpower and poor motivational factors directly affect the implementation of CRC".*

Likewise, a 30years old female who is working at emergency unit clarified the effect of man power, absence of clear direction indicators, and improper implementation of job descriptions as indicated below:

"... besides shortage of staffs, the burdens of emer-

gency unit staffs are due to personal initiatives, poor institutional administrations, and coordination problems affects family and patients CRC implementations.

A health care worker who is working at quality care office also explained how patients face a problem due to unclear workflow as follow*:*

" ...the current departments' name and number is very unclear even I cannot identify them easily especially it is difficult to patients at night time. Some patients may spend the whole night searching without getting the service."

Enablers and barriers of labour division for CRC implementation

Enablers: The majority of the participants from health work forces agreed that having professional skill mix, updated guideline manual, professional relationship, presence of responsibility, proper administrative issues, good knowledge and adequate infrastructures are enablers of division of labour for proper implementation of CRC.

A participant who was working at midwifery and nursing department clarified his agreement regarding updated guideline and professional skill mix as follows:

> "*The first priority issue is organizations should develop their own updated working guidelines based on the national protocols which used for leveling scope of practices and division of labor. Additionally, having staffs who specialized indifferent fields, and who have skill mix ups to support each other, and to improve the service provision* are some of the good enablers."

In addition, a participant who is working in the laboratory department explained his agreement on having a professional relationship for health care services and patient satisfaction as:

> "*When there is high workload in lab units, any professional working in laboratory units is expected to share that loaded unit and supports them. As FHRH Lab department, the professional is not to be restricted in their assigned unit only since health delivery is a team work. If one professional is absent from his assigned unit, other professional may substituted him, and perform his activity to reduce delayed patient service."*

Barriers: Most of the respondents agreed that excessive workload, inadequate infrastructure, lack of responsibility, weak team integration, absence of supportive supervision and weak administration as major barriers for proper division of labour and CRC implementation.

One of the participants who was working on quality office directorate responded his agreement on excess work load as:

"The national expected work load standard for nurse states that one nurse should serve for six patients, but in practice, one nurse is serving more than eleven patients. We understand that such work load among staffs possibly affect the implementation of compassionate and respectful care delivery for patients."

Additionally, other participant who work in radiology department also expressed his agreement on the impact of inadequate infrastructures on CRC implementation as:

"In radiology department, there is shortage of medical equipments to serve the large number of patient who came from different service units and as referral cases, and who came at the same time. Large number

of patients flow to this materially scarce infrastructure service units. This makes even communicating patients properly impossible for the service deliverers. Unable to care because of the allocation of adequate time breaks CRC implementation."

Strategies for implementation of division of labour: In the current qualitative research finding, the participants recommended possible strategies to improve the implementation of division of labour and CRC. The most common strategies listed by the participants were: providing training, developing and updating guideline, promoting good role models, working on motivational activities for staff, strengthening professional skill mix, and providing regular supportive supervisions.

"…there should have professional skill mix from different disciplines or specialties, education opportunity should be facilitated for staffs, provision of motivational activities for staffs, availability of PPE, drugs and infrastructures, facilitating supportive and motivational activities for staffs, might be alternative strategies for proper implementation of CRC".

DISCUSSION

Organizational workflow and division of labour which includes workload distribution, professional and departmental integration, professional skill mix, scope of practice and job description have a significant impact on CRC implementation in health care setting. Findings of the present study reveal that such care has been compromised by either workflow or labour division attributes.

Health care organizations have often the responsibility to design, or redesign its workflows to be more efficient and effective(10, 11).The current study indicated that the organizational service layout is not suitable for clients. Being inaccessible and absence of information and direction provider at the gate of the organization caused for the clients to be exhausted and failed getting the service on time. This was mainly happened due to weak administrative issues, lack of responsibility, and in adequate infrastructures to facilitate client service. A previous study also indicated that the poor workflow causes working process delay and interruption(10, 12).This is also supported by observational data analysis findings in which there were some posters at each office and some direction indicators which are not visible for the clients.

A division of labour refers to the allocation of tasks that are divided between or among groups in the care work force on the basis of skill, education, job classification, and it means that the work have boundaries, are highly regulated, and are formalized(13). The present finding showed that though the distribution of job description and scope of practice for each staff was performed, there is unspecified job descriptions and work mix up among different professions which is cause conflict. This affects the proper implementation of CRC in the hospital. Studies conducted on health care revealed that the presence of unclear description of scope of practice creates considerable role confusions among professionals which challenged them in differentiating their roles. This role confusion created tension in the workplace., lack of trust among professionals, and ineffective teamwork. As a result, patients fail to get timely service, proper care, and they become unsatisfied (14, 15).

Excessive workload occurs when an employee assigned too many tasks to do in a period of time. This excessive workload increased the stress level that directly affects the time to care of the health care

professionals for their patients(16, 17). In this study the researchers found that health care workers have high work load in the hospital. Especially, the high workload is significantly observed at card office, emergency, pharmacy, laboratory and radiology departments. The patient participants indicated that there is imbalance between patient flow and health care workers that affect getting timely service and proper care from service providers. The influence of high work load on patient respectful care was supported by previous findings (17-19). The previous studies revealed that the overburdened workload increased burnout, decrease health care providers' motivation and finally failed to give proper patient care service. The possible reasons for high workload might be administrative problem, lack of budget, high patient flow, and minimal professional skill mix.

Health care providers agreed that positive relationship among the different health professionals and integrations across departments is the pillar to increase compassionate and respectful care implementation. The current study participants noted that departmental integration is not well organized, and professional relationship is not good as it is expected to facilitate patients' properly service. A study which was conducted in Japan health care institute supported this finding in which departmental and professional communication and collaboration is not in the expected level. As a result, health care providers do their own work without communication and collaboration (18). The possible barriers for this finding might be unstructured workflow, weak administrative motivation, and lack of supportive supervision.

In the current qualitative research finding, participants explained that identified workflow structure and labour division problem and their consequence negatively affected compassionate and respectful care delivery. This can be addressed by providing training on professionals' scope of practice and job description, developing and updating guidelines, promoting good role models, working on staff motivational activities, , strengthening professional skill mix, and applying regular supportive supervision.

Limitation of the study: Our study has some limitations. First, we could not include perceptions of health workers and patients across different regions of Ethiopia. Secondly, we incorporated only the opinions and perceptions of the health workers and patients. However, we attempted to minimize bias by collecting data from various types of health care providers and patients.

CONCLUSION

According to the findings of this study, we found that there was improper labour division and poor CRC implementation. High workload, inadequate infrastructure, lack of responsibility, absence of supportive supervision and weak administrative issues were barriers for proper division of labour and CRC implementation. This study also indicated the need for having clear scope of practice and job description, increasing positive integration among professionals and departments, managing hospital work flow, balancing patient flow and number of care provider, and increasing administrative motivations to implement compassionate, respectful and care service properly.

Abbreviations:

CRC: compassionate respectful and care

FHRH: Felege-Hiwot Referral Hospital

HWF: Health Work Force

FMoH: Federal Ministry of Health

Declarations

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Author's contribution: DA, MB, EG and BT conceived and designed the study, participated in the data collection, performed analysis and interpretation of data, drafted the paper, and revised the manuscript. All authors read and approved the final manuscript.

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