ORIGINAL ARTICLE

IMPORTANCE OF IN-SERVICE TRAINING ON IMPLEMENTATION OF COMPASSIONATE AND RESPECTFUL CARE DELIVERY IN GONDAR METROPOLITAN CITY GOVERNMENTAL HEALTH FACILITIES: NORTHWEST ETHIOPIA

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ABSTRACT

Background: *Nowadays, compassion and respectful care (CRC) is not an optional, but it is a professional mandatory. However, the health work force frequently considered it as it is less important as other aspects of care. A study which was conducted in Canada showed that compassion is broadly considered as a cornerstone of quality health care delivery.*

The Ethiopian national Health Sector seemed as it underscored the importance of creating compassionate, respectful and caring health workforce as a major pillar to improve the quality of health care services. As a result the sector incorporated compassionate, respectful care in the transformation plan I. Therefore, this study aimed to determine the effect of CRC In-Service Training on Implementation of Compassionate and Respectful Care Delivery.

Methods: *A phenomenological study design was employed. We included8 key informants, and 11 in-depth interviews on leaders and health care professionals. In addition, 14 observations were made using observation checklist to verify the actual CRC practice of the health care professionals. We used an interview guide to collect data, and we used audio records of interviews which were transcribed verbatim. Coding was done using Open code software, and thematic analysis was applied to identify patterns..*

Results: *The study found that CRC in-service training has many benefits to boost capacity of HCPs, to increase satisfaction of patients and to improve service quality. However, we found that currently the health care professionals are not practicing CRC due to different barriers. According to study result, the identified barriers for CRC in-service training were: misconception of the HCPs about the training, shorter duration of training, lack of support from leaders, and shortage of resources. On the other hand, presence of well experienced trainers, allocation of adequate budget, availability of proper training hall, good mode of delivery and appropriate training contents were enablers of effective CRC in-service training. The alternative strategies suggested by participants include: conducting continuous offsite trainings, including monitoring and evaluation mechanism, and involvement of religious leaders in the training process.*

Conclusions: *Though CRC in-service training is reported as having many benefits by participants, HCPs do not practice it well because of different barriers. Accordingly, different barriers and enablers of CRC implementations were explored, and new recommendations were also suggested. Therefore, stakeholders are expected to work on these identified barriers and optimize the enablers for the effective delivery of compassionate, respectful and caring in-service trainings.*

Keywords: *Caring, Compassionate, Gondar city, In-Service, Respectful, Training.*

INTRODUCTION

In today's modern world, compassion and respectful care (CRC) is not an optional, but the health workforce frequently considered it as it is less important as other aspects of care. A study which was carried out in Canada indicated that compassion is broadly considered a cornerstone of quality health care improvement [1].Compassionate and respectful care is very important for human-centered care, and for serving patients ethically and with respect adhering

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to a professional oath. Furthermore, it also help to be a good role model for young professionals [2]. On the other hand, it requires professional pride to address the patients' innate need[3].

There are concerns that high-quality compassionate care is not consistently delivered across health and social care. Recent international literature suggested that trying to being ameliorated exacerbated the levels of patients' frailty and acuity [3].

In a well developed countries, CRC has been given attention, and it is considered as a significant source of flexibility and beneficial relationships, and as fundamental for human rights today [4].

In the Ethiopian health system, there are many health professionals who have dedicated their entire career to public service and are respected by the public they serve. However, a significant proportion of health professionals see patients as just 'cases', and they do not show compassion. In addition to this, lack of respect to patients and their families is also a common complain presented against these professionals (1). In line with this, the national Health Sector Transformation Plan (HSTP-I) has underscored the importance of creating CRC health workforce as a major pillar to improve the quality of health care services. This has led to a renewed focus on how to improve the health workforce performance including responsiveness, timeliness and patient-centeredness of health care services. To implement this CRC agenda, Ministry of Health (MoH) plan a national movement in creating a nationwide CRC movement by using standardized training documents with core competencies and course syllabus (2).

Research evidences showed that organizations that place a high priority on delivering of CRC benefit from lower staff turnover, higher retention, recruitment of more highly qualified staff, greater patient loyalty and reduced costs from shorter lengths of stay, lower rates of re-hospitalization, better health outcomes, and fewer costly procedures. Caregivers who are able to express compassion for patients, families and for each other get higher job satisfaction, less stress, and a greater sense of teamwork. Furthermore, patients who are treated compassionately benefit from improved quality of care, better health, fewer medical errors, and a deeper human connection with their caregivers [5].

Considering the benefits of providing CRC in-service training, morethan30,000 health work force is active for basic CRC training, pre-deployment CRC orientation for newly graduated health professionals, CRC orientation for the graduating class health science students, national CRC sensitization workshop in all health facilities, regions, city administrations and for the leaders at all level had been given. However; due to unknown and unclear reasons, currently provision of the CRC in-service training is ceased before a couple of years.

Motivations of health care professional to serve the clients compassionately, to build team spirit, to participate in the volunteer service were seen as a good signs that are observed following the provision of the training. However, besides these successes, there are many challenges/barriers to implement CRC effectively in the health care settings. Some of the challenges are lack of program ownership, inadequate training material's component, health professionals' misperception towards the training, insufficient training coverage for all health workforces, lack of post-training assessment, absence of continuous refreshment training, inadequate medical equipment, drugs,

laboratory regents' and poor commitment of leaders are the challenges for the effective and efficient implementation of CRC [6].

Qualitative interviews were conducted with a purposefully selected sample of 18 participants in UK who explained their professional attitudes and approaches, organization and leadership, as well as training and education as main barriers to implement compassionate care. Specifically this study is categorized in three themes: traditional practices and structures; stereotypical attitudes from professionals; and factors related to the development of person-centered interventions [7].

Facilitators included organizational factors such as leadership and training as enabling attitudes and approaches by professionals. Trained project managers, patients taking an active role in research and adaptive strategies by researchers all helped person-centered care delivery [7].

Moreover, according to a study conducted in 35 US hospitals and health systems, engagement of professionals was identified as a major problem to deliver companionate and caring practice where as large teaching hospitals which tend to have more consulting physicians who may not be engaged and may not see patient experience compassionate care shared priorities. Communication and interpersonal skills training work well for younger physicians. Lack of visible support from the CED, and from other senior leaders was also raised as a major barrier to implement compassionate healthcare practice [2]. In the same, another study which was carried out in London, England viewed that clinical staff lacked sufficient time to demonstrate a compassionate approach, and it was generally agreed that strong leadership was required to ensure a consistent compassionate approach from all staff within a healthcare organization [3].

Likewise, studies which were conducted in Ethiopia showed that an average number of service users (42.9 to 48.8%) received both compassionate and respectful health care services [8], and only 59% of hospitals delivered respectful care [9]. Moreover, workload and inadequate supplies were listed as the major contributors to low compassionate and respectful care[10]. Cognizing the aforementioned gaps, the FMOH Ethiopia incorporated compassionate and respectful care in the HSTP. Despite considering these healthcare services in the second growth and transformation plan, less emphasis is given on measuring its progress when HSTP is coming to an end. Even though compassion is an important ethical foundation of all healthcares, it is an international priority of health care profession. In our country Ethiopia, there is little understanding about the status of effective implementation. Therefore, this study aimed to explore the possible benefits, barriers, and enablers, and to inform appropriate strategies for effective implementation of CRC in-service training and its application in the clinical set up.

Theoretical Framework

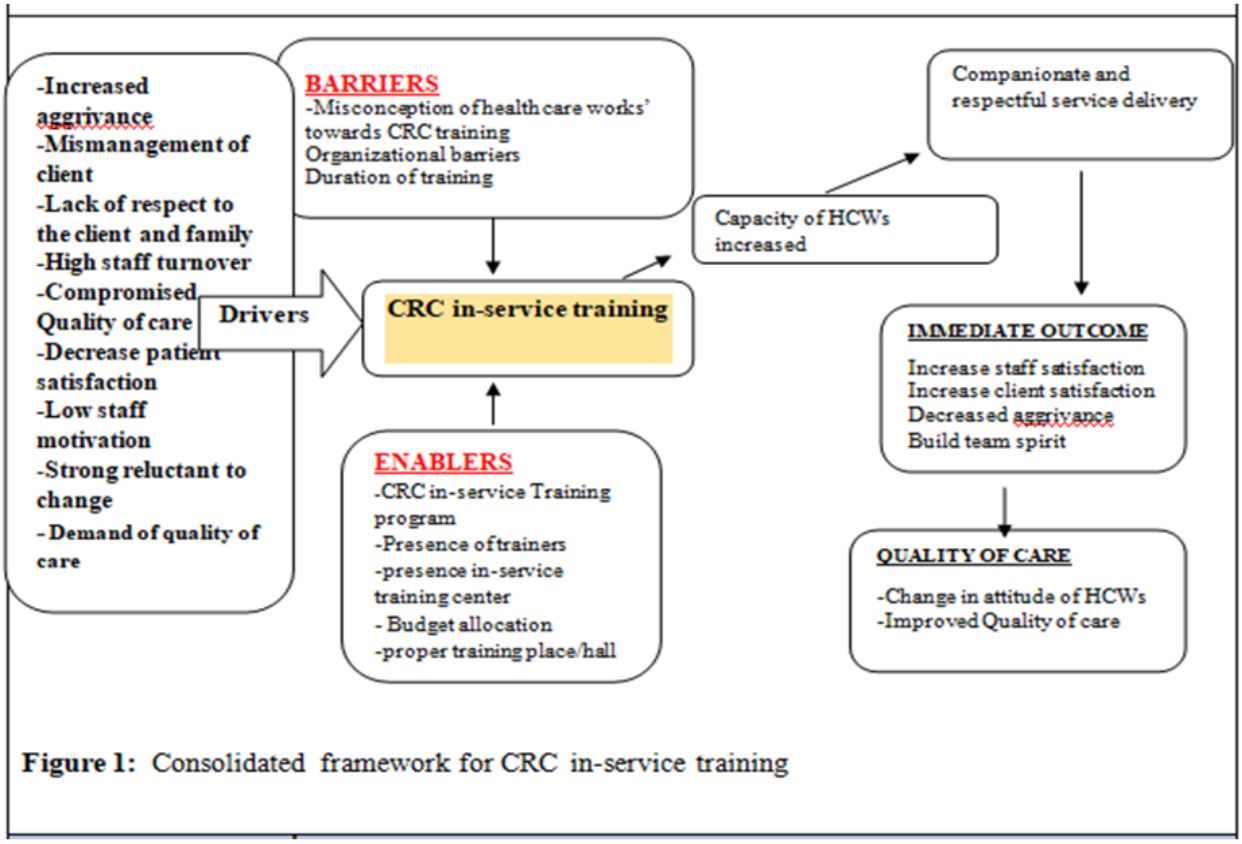

Figure 1: Consolidated framework for CRC in-service training

METHOD

Study setting: The study was conducted at Gondar metropolitan city in "Amhara" Regional State North West, Ethiopia. The city of Gondar is located 747 km from Addis Ababa, the capital of Ethiopia. Gondar metropolitan city administration is administratively divided in to six sub-cities. The city also has a total of 36 Kebeles (25 urban and 11 rural kebeles). According to information obtained from the ´woreda health office of the city, the total population of the Gondar metropolitan city is 333,432 out of which 173,206 are women, but 160,226 are men. The city has one governmental comprehensive specialized referral hospital, eight health centers, fourteen health posts, two private hospitals and forty private clinics. There are about 1396 health professionals (medical doctors, nurses, midwives, pharmacy, laboratory technologists, and others) who are working in these health institutions. Among these health professionals, 1049 are working in Gondar University comprehensive specialized hospital. The study was conducted from December 2020 to June 2021.

Study design: This study employed a phenomenological study design to elicit in-depth information from the active work force experience of HCPs after they took CRC in-service training on CRC implementation and CRC in-service training effects on the quality-of-care delivery.

Study population and eligibility criteria: All health professionals who took CRC training and working in the selected health facilities of Gondar city were the study population. The CED/medical director and matron of the hospital, head of the eight health cen-

ters and HCP who took CRC in-service training at Gondar city health facilities were also included. However, HCPs who received their CRC training from other health institution and those who have work experience of less than six months were excluded.

Sample size and sampling procedures: A total of 19 participants were recruited for the study. Though we determined the initial sample size, the final sample size for this study was determined based on the level of information saturation. Information saturation was checked with redundancy of ideas and when there are no new emerging ideas in the consecutive interviews.

The study participants were recruited using purposive sampling technique to get maximum possible variation aimed to capture a range of experiences and demographic. we conducted in-depth interviews (IDIs) to eleven health care professionals who had received CRC in-service training, and we interview8 key informants including CED/Medical director and heads of health centers with semi-structured interviews.

Data collection, analysis and management

Data collection: After reviewing relevant literature, an interview guide was developed for in-depth and key informant interviews by a team of researchers who are from different disciplines including human resource and behavioural science experts. Additionally, a non-participant observation checklist was also prepared by the team of researchers. The English version of the data collection tool was translated to Amharic language for data collection. The interview guide was reviewed by domain experts (experienced professionals in human resource management, behavioural science and qualitative research) and refinement has been done accordingly.

The key informant and in-depth interview guide were piloted out of the study area. Based on the inputs from the pilot test, the interview guide was revised for actual data collection.

Actual data collection was carried out by trained data collectors who were involved during the pilot testing. The data collectors interviewed the study participants in their respective health facilities, and they gave them detail information about the purpose and procedures of data collection. Finally, the interviews to the actual study participants were held in separate rooms at health facilities. Convenient environment was created for the data collection to keep the privacy of the study subjects.

During interviews probing questions were asked to participants to explore the issues in-depth. Each KI and in-depth interview were recorded using voice recorders with each participant's permission and detailed hand written field notes of each session had been taken at the time of each in-depth interview.

Data management: The interview was conducted in prior selected areas which were free from disturbance and noise. The interviewer clearly explained the objective of the study to reduce intentional over and under estimation of the findings. Essentially, confidentiality (protecting participants' identifiers) and security (using passwords to protect disclosure to third party) were ensured. Major personal identifiers like: name, mobile number, email address and photo were not taken. Instead, ID number was given for each participant to link all related variables.

Data quality assurance: The objectivity of the data was checked through continuous, accurate, and proper treatment of all stages of the study and clarity of the research method. To ensure data quality, fre-

quent investigation of the data (transcription of the data and investigating it until the main themes' concerns obtained) was held.

For this particular study, the authors used cross checking of transcripts and translations as part of data quality assurance. Moreover, only the teams of investigators have accessed the data for analysis.

Data management and analysis: Data from KI and in-depth interview were captured using voice recorders, and from each day field notes was transcribed by the team of three researchers who have Masters and PhD qualifications. The translated data were cross-checked with the audio file to ensure its proper transcription and translation. The team of researchers read the translated data repeatedly to understand the concept and related meanings of the data.

Coding was done using open code software version 4.03to identify related patterns. The coding was done by the team of three researchers (with qualifications of Masters and PhD) independently. Then, codes which have similar pattern were merged to identify themes from the data. During analysis, modification on existing codes and themes were made based on the information from subsequent interviews. Finally, thematic analysis was conducted to identify major themes that helped to answer the research question.

Ensuring trustworthiness : In order to enhance the rigor of this particular study, certain strategies were applied. In this study, detailed description of the study setting and participants was done. All data were transcribed every day to reduce recall bias and translated into English. Notes from interviews and observation were also expanded immediately into organized manner.

Triangulation of data collection methods was used to elicit information about the same issue using key informant interview, in-depth interview and observation. In addition, the data which were found from the three methods were triangulated during interpretation to enhance credibility. Moreover, detailed description of the findings with adequate evidences was provided in the form of quotes from participants' interviews.

Ethical considerations: Ethical approval for this research was given from the University of Gondar Ethical review Board with Ref.No-V/P/ RCS/05/678/2021. Similarly, written informed consent was taken from key informant interview and in-depth interview participants. As a form of participant checking, participants were given the opportunity to review draft reports / articles / summaries of our reports.

RESULT

Demographic Characteristics: In this study, we conducted interview to 8 key informants and 11in-depth interviews to leaders and health care professionals.Moreover,14 observations were made using non-participant observational checklist to verify the real CRC practice of the health care professionals on the clinical area. Most of the study participants were male, and 42% of them were age greater than 40 years.Similarly,47.4% of them had a work experience of 5-10 years (Table 1)

Table 1: Socio-demographic characteristics' of study participants

Variables	Category	Freq (n)	Remark
Sex	**Male**	**14**	
	Female	**5**	
Age	20-30 years	5	
	30-40 years	6	
	≥ 40 years	8	
Work experience	5-10 years	9	
	10-20 years	2	
	≥20 years	8	

Current practice, barriers and enablers of implementation: From the analysis of key informant and in-depth interview data, five themes were emerged. These themes were: Perceived benefits, barriers, enablers, training outcome and new strategies/ recommendations of CRC in-service training.

Main theme 1: Perceived benefits of CRC in-service training: CRC has multiple benefits for the health work force in general, and since CRC is an essential element for health care providers, it builds a positive environment and intimacy among health care professionals, patients, and families.

Sub theme 1: Benefits to the health care professionals: In these sub themes, we tried to explore the perceived benefits of CRC in-service training from different dimensions as: capacity, satisfaction, communication, recognition and punctuality dimensions.

Boosting the capacity of health care professionals as a benefit of CRC in-service training: One of the main benefits of CRC in-service training is boosting the capacity of HCPs in terms of knowledge, attitude and skill, making being compassionate and improving approaches to a patient. Many of the participants agreed that: training always up grades the existing attitude, knowledge, skill and the ways the health care professional approaches to his/her patients. So, it enables the service providers to provide a better service.

This idea is supported by a midwife who is working in X health center, and he/she described it as:

> *First, from a professional point of view, the professionals can provide non-discriminatory service/treatment in a way that satisfies patients with equal love and humility.*
>
> *It is also useful for professionals to be equipped with sufficient knowledge and to see themselves, and to create good understanding for their customer.*

Communication as a benefit of CRC in-service training: Communication is more important specially whenever there is a team work. It is useful to improve HCPs' patient communication and active listening of the patients' concerns and complains. Most of the health care professionals agreed that they build a good friendship, and they started working in teams with effective communication. Furthermore, they explained that they started listening to patients' complaints. As a result, client relationship with the clinician is getting better, and this brought long-lasting result.

This is supported by a nurse who is working in X health center:

> *We are beginning to listen to people's complaints especially we started to accept what they complain as appropriate which previously complaints were not accepted from our clients. Now it is important to listen to people because listening is one of the importance of CRC.*

Similarly this is supported bya nurse professional who is also working in X health center.

> *Taking training is very important After taking the training practice, we get much satisfaction from some people. Even without saying any word, but just by showing the direction, some people say thank you and left out. Medicine alone is not necessarily curable to patients' sickness, but mainly approach matters. When we honor ourselves, we have to honor and loved our patients too. As far as I can see in practice, it is also important for*

the professional, to be happy when he/she received praise and respect. Even thanks and respect are in front of the professionals. When someone is positive, and has good behavior, people want to be examined by him/her. This, of course, sometimes bring unreasonable pressure.

Satisfaction of HCPs from CRC in-service training: Satisfaction of HCPs is described when ever: they are honored, satisfied by being compassionate HCPs, when they start to provide quality and non-discriminative care and whenever they get mental rest. Majority of the health care professionals described that as a professional we are honored and satisfied specifically when we are being compassion and provide effective and qualified care to their clients.

This is supported by a nurse professional who is working in X health center. …stated it as:

It gives better satisfaction to the health professionals because whenever the customers are satisfied, we are also satisfied.

Similarly this is supported by a health officer who is working in X health center as:

The benefit of CRC in-service training for the HCPs is that whenever they get the training's full service that is going to be delivered effectively, and when it gives us a good mental satisfaction.

Sub-theme 2: Benefits of CRC in-service training to the patients/clients: Under this sub theme, the benefits of CRC in-service training are described in terms of patient satisfaction, trusting the HCPs, improved their health outcome and gain economic benefits.

Patients' Satisfaction from CRC in-service training: The majority of the health care professionals agreed that when they take CRC in-service training, the patients get the following benefits patients are properly treated, there will be great satisfaction of the care that they rendered, so that we believe that our patients get quality of care and they trust us. As a result, their health status will be improved, and later on when they come back to the health facility, they will come before health situation get complicated. So, their health-seeking behavior is increased. This is supported by the in-depth interview given by a nurse professional:

This is also approved by an in-depth interview given by a health officer who is working in health center as:

If they [patients] got CRC service, the psychological treatments will start there, but the medical one will be next. Our community who live around us will apply the proverb of 'kefetfitufitu.' Therefore, from this stand, our client will get good psychological satisfaction.

Main theme 2: Barriers of CRC in-service training: The trainees' perspective, organizational, duration of training and mode of delivery of the training frequently mentioned barriers explained by the study participants.

As understood from the study participants' interview, trainees' perspective was the leading barrier for the CRC in-service training program. The trainees' perspectives are described as miss conception of the health care professionals about the training, behaviors of trainees, and number of trainees per training.

Many of the interviewed health care professionals believed that training doesn't bring changes specifically from compassionate, respectful and caring point of view. So, this miss conception is considered as a barrier for the CRC in-service training.

This idea was supported by an interviewee who is a nurse professional in X health center:

> *When it comes to CRC, I don't think it will come by training. Frankly, I think other alternative should be considered.*

The study participants also explained the increased number of participants per training session as a result of which there is presence of side talks which are the barriers of CRC in-service training program. The presence of side talk while the training was on, can significantly caused for lack of interest from the facilitator, and this may impact the way the trainers delivered their session. He explained that:

> *In my training place, it is very difficult to say that the training is comfortable since sometimes it was like a mare overcrowded on the field. When we were trainees, there were many people. The condition of the chosen number of participants were not favorable for a training size. some individuals were talking side by side, and the person who is facilitating the training said that there is an interest problem on the training.*

Organizational barriers of CRC in-service training program is the second leading barrier next to trainees' perspective barrier. These organizational barriers happened when there is unfavorable training hall, improper training site/place, and presence of noise and shortage of staffs. Therefore, to achieve the desired outcome of the CRC training has to be given in a place where the trainee get focused, just like in a better place with no disturbance around and in appropriate hall.

This idea is supported by a laboratory technologist who works in X health center as:

> *As you know, the CRC training needs much focus.. Therefore, this kind of training has to be given in a better place. For example, this kind of training has 'aemeronyemiseresirnegerallew' and believe that this kind of training should not be considered as a simple orientation.*

The third leading CRC in-service training barrier commonly raised by the study participants was the duration of the training. Many of the study participants stated that because of the short duration, they do have difficulty to cover the topic so that they couldn't get better understanding or a clear picture of CRC. Because of difficulty to talk about the included facts, the trainers hurry to cover the topics. This short duration of the training and its impact is supported by an interview given by a nurse professional. He stated it as:

> *The shorter the time, the less comfortable it is to talk about facts included in the training. Therefore, in a short time, bulky trainings should not be given.*

Another nurse professional also stated that if the duration of the training is shorter,, it is difficult to consider the contents in depth. The study participant stated that…

> *Except trainings which prepared for few days, you will improve, but in trainings which prepared for few days, it is not possible to address many things in depth.*

On the contrary, few study participants stated that if the training was too long, it needs to be adjusted.

One of the nurse professional who participated in the study described the problem with longer duration of the training as:

> *The training had been given for around 7 days, and it's very long, CRC should not took that long duration of time because there would be so many repetitive things which challenge to be focused.*

Main theme 3: Enablers of CRC in-service training: In the current study, different enablers were identified. These enablers were considered: when there are competent trainers involved in the training, adequate budget is allocated, appropriate hall which has no disturbance around, proper and relevant training contents with good modes of delivery. In this regard, many of the participants agreed that the presence of seniors who are well experienced, ethically role models, assigning trainers who have good approaches were the possible enablers of effective CRC in-service training.

A 32 years old man who is a HCPs explained this as:

> *If the coaches in particular were good, they would make you feel happy and relaxed. The fact that it was given by them [seniors] shows that the training was given due attention and the delivery was also pleasant. It tells us the real importance of CRC.*

A 30 years old woman who is a HCPs also explained how the trainers' experience and understanding of both the HCPs as well as the patients feeling were considered as the enablers of the CRC in-service training.

She stated that:

> *The coaching staff has long years of experience, and it has seen many hospitals for many years and has seen the feeling of the staffs and patients in depth. Therefore, they are really good.*

The other mostly shared idea of the study participants about the enablers of the CRC in-service training is the modes of delivery that the trainers use during the provision of the training.

This is evidenced by a nurse professional's explanation:

> *More, we had a lot of discussion and we learned a lot from what everyone was talking about what happened.*

Main theme 4: Practices of CRC on the clinical area: In this theme, presence of practice is considered when the trained health care professionals are applying CRC on a daily basis without interruption showing kindness, respect and began to communicate verbally and non-verbally. Participants who were interviewed about their daily practice of CRC in the clinical area, or if not, they were also asked to explain their reasons of failure to practice. From the interviewed trained health care professional, some of them explained practicing CRC in their clinical area in a daily basis.

This daily application of CRC is evidenced by-

> *A nurse professional who is working in X health center stated that:*

But in our observation, while they are providing care to the patients in the clinical area, many of them fail to practice. Even though some of them apply CRC daily in the clinical area, the majority of the health care professionals fail to practice on a daily basis., The most shared reasons for this (for not applying CRC in the clinical area) are: workload, health system and shortage of resources.

During the in-depth interview, the health care professionals were also asked to state their reasons why they do not practice CRC daily after they took the training. Many of them replied workload as a reason that hinders them to practice CRC on a daily basis. In the current study, presence of workload is considered when they [HCPs] are working beyond their capacity, inadequate staff members and when there is high patient flow.

This was supported by an in-depth interview given to

the head of the X health center, and he explained as:

> *From September to December, patient flow becomes very high as a result of which there might be irritation. As a result, one HCP is expected to give service more than s/he is expected.*

Shortage of the HCPs is also expressed as a reason for not practicing CRC in the clinical which is supported by a female nurse professional like this:

> *Patient flow and the number of health care professional do not much; patients are more and professionals are few in number. So, to implement CRC, this has to be adjusted and corrected.*

The next reason explained by the study participants was lack of support and attention from the heads/ leaders. This is supported by one of the heads of the X organization. He expressed in this way:

> *Because of the absence of attention from the higher level management, now we are moving back to our previous trend.*

One of the midwives professional also described it as:

> *I believe that there are many problems related to the service delivery. However, the availability of good governance helps us to solve problems.*

The third reason for which was explained by the study participants not practicing CRC on daily basis was shortage of resources. Resource in the current study is considered when there is complain of the HCP about the shortage of inputs like medication and laboratory reagents that potentially hinder to apply CRC.

One of the study participants who is a laboratory technologist described the shortage of resource and its implication on practice as:

There is a shortage of inputs. For example, as a lab technologist, I have to do all the tests at my room. So, all the necessary inputs have to be fulfilled first.

This is supported by a pharmacy technician who is working in X health center.

Main theme 5: New strategies/Recommendations for effective implementation of CRC in-service training: In this theme, both the health care professionals and the key informants were also interviewed to express their view about the CRC in-service training, and about it can be effectively delivered. The most commonly suggested recommendations from the participants were: the importance of delivering this training frequently for all health care professionals, conducting the training as an offsite or onsite based on their advantage and disadvantages, the importance of including monitoring and evaluation mechanism, and the involvement of religious leaders in the training process.

Many of the study participants emphasized on the importance of giving frequent training and making it accessible to all HCPs preferably without interruption.

One of the nurse participants stated that:

> *If everyone is trained, the service would be improved well, but if someone who is trained but works with the untrained, there is no change. Hence, everybody should take CRC in-service training.*

The second proposed recommendation which was raised by HCPs during the in-depth interview was the importance of including monitoring and evaluation soon after giving the CRC in-service training, and the requirement of ongoing follow-up to check whether or not an individual brings change.

The importance of including monitoring and evalua-

tion to see the change is well explained by a health officer like this:

> *So, it is good for the experts to check whether the health care professionals bring change within the training or not.*

Other male laboratory technologist also conceptualizes the importance of monitoring and evaluation as part of the CRC in-service training:

> *As I told you earlier, it may change if you are being monitored and evaluated.*

The third most suggested recommendation for the effective application of CRC in-service training raised by the participants was the place where the training is conducted either in an offsite or onsite. With only slight difference nearly the same proportion of the interviewees recommended offsite training by considering the following advantages:

> *The health care professionals really refresh and see new things that helps them to attend the training attentively, taking training without doing routine activities make us to obey the norms so that we can actively engaged without interruption. Generally, offsite training is good and inspirational for the health care professionals.*

This suggestion is supported by explanation given by a nurse professional:

> *If the training is also given in an offsite, firstly the employee refreshes and sees new things and can follow the training attentively.*

However, nearly a similar proportion of the interviewees also recommended onsite training by justifying the financial advantage and possibility of giving the training to many health care professionals, and the comfort that they get from the training when it is being around the residence area.

This was also suggested by one of the pharmacy technician:

> *Financially, it's good if training is given a near place. I do not go far. So, I am comfortable because I am close.*

DISCUSSION

Compassionate and respectful health care service is the current attention of health care system all over the world because it is a means to improve and keep quality health care service not only in the current, but also in the future. Respondents in all governmental health institutions of Gondar metropolitan city who participated in this research reported the benefits of CRC in-service training, the barriers of CRC in-service training, the enablers, and the practice of HCPs. In addition, possible recommendations about the way how CRC in-service training has to be delivered were proposed to improve the future in-service training provision modalities. As their significance becomes increasingly recognized in enhancing quality patient care, wellbeing and overall quality of life, compassion and compassionate care are be coming as a competency that healthcare providers are expected to have[11].

Many of the participants in the current study agreed that training always changes the existing attitude, knowledge, skill and the way the health care professionals should approach to their patient. A study conducted with mixed-methods in North She was stated similar benefits of CRC in the qualitative components that the presence of CRC training reduces health care professionals' burnout, increases loyalty and respect for the clients, better adherence to medical advice and treatment plans, reduced malpractice, accelerated healing processes, create better relation-

ships between clinician and clients, and improved health care quality [12]. This is because once the HCPs updated themselves and get KAP, they can do a lot of activities related to the patient as well as to themselves.

Many of the participants in the current study agreed that training always changes the existing attitude, knowledge, skill and the way how the health care professionals approach to their patient so as to provide better service, and they described its importance to shapes their personality. This is also supported by a study which was conducted at Maharashtra which stated that trained health workers' perceptions of the training confirmed the gain in knowledge, and the participants strongly assured that they acquired a significant amount of knowledge which they illustratively indicated a change ranging from three- to six-fold from what they possessed before the training [13].

Therefore, addressing and developing HCPs' capacity for compassion is supported by providing organizational support and professional training [14].

In the current study, most of the health care professionals agreed that effective communication helped them to build good friendship and encourage them working in teams. As a result, they started listen to patients' complaints so that client relationship with the clinician is getting better. Hence, they bring long lasting result. This is supported by another study that described the important of communication for effective teamwork. As it is clearly known health care outcomes depend not only on the medical skills and knowledge of the physician, but also on his or her effective communication and emotional support [15]. Therefore, effective communication and active listening of the clients concern has paramount importance[16].

Many of the study participants in the current study explained that CRC in-service training increases HCPs satisfaction. They said that as a professional they are honored and satisfied specifically when they are being compassion and providing effective and quality of care to their clients. This suggestion is also supported by a mixed method study conducted in the north Shewa, Ethiopia[12].

In the current study, many of the health care professionals agreed that when the HCPs are taking CRC in -service training, the benefits to the patients are many. These includes: patients are properly treated, there will be great satisfaction of the care that health professionals rendered so that they believe that their patients get quality of care and they trust them, because of trust they start to adhere to any intervention be it medication, counseling or any other treatment. Therefore, their patients' health status got improved, and their health seeking behavior is increased as a result which they come back to the health facility before they their health got complicated. Similar benefits of satisfaction as a result of CRC in-service training is reported by a study which was conducted in North Shewa Oromia region [12]. This is because compassion is very important in the health care system, and it is a deep awareness of the suffering of others. It is not only the awareness that is important to the health professionals, but also it is the great attempt to alleviate the suffering. Hence if the health care professionals are compassion and apply the definition of compassion, the patients are going to be satisfied as long as they are treated compassionately [17]. In addition to this, the end outcome within the category of forging a healing alliance was to come to an in-depth understanding of the person, allowing HCPs to address a person's multi-factorial needs in a personalized manner [18].

What we can learn from the available literature is that the barriers to implement CRC vary across countries though there are some common barriers. However, in the case of barriers of CRC in-service training, there is no study conducted in the globe. Hence, exploring the barriers of CRC in-service training in Gondar city governmental health institutions have a paramount effect for researchers, policy makers, leaders and health professionals to overcome the challenges and make the CRC in-service training more smooth and effective.

From the study participants' in-depth interviews, trainees' perspective was the leading barrier for the CRC in-service training program. The trainees' perspectives also described as miss conception of the health care professionals about the training. Behaviors of trainees, the number of trainees per training as well as the presence of side talk while the training was on progress were some of the barriers.

Misconception of the HCPs was explained as a barrier of CRC in-service training. This might be because of HCPs engaged in their routine work schedule, and they are not always open to take trainings. This misconception on the training might also be due to the interrupted training given to the health care professional in the study area. Most of the time, the training is given once, but it is not updating periodically. On the other hand, some of the experienced health care professionals say that training is not a one -time event it rather it has to be an ongoing process. The other possible justification could be professionals have to justify training expenses by providing how much it pays or considering training as a business [19].

The other barrier of CRC in-service training in the current study was the number of training participants per session. Many trainees per session could hinder the way they communicate, and it limited the time for discussion as well as sharing their experiences. In addition to this, there was side talk that potentially disturb others.

A similar reason was justified in the principles and methods of training guideline which stated that if too many people are talking at once, the receiver may be unable to select between transmissions [20].

Organizational barriers of CRC in-service training program is the second leading barriers next to trainees' perspective barrier. This is also reflected in a study conducted in Northwest England which acknowledged that healthcare environments can impact significantly on the aspect of practice. The management must create resources for those who are fond of studying especially in the workplace [21]. In a qualitative exploratory study which was conducted in Iran, organization is also reflected as a barrier for being compassionate. In this study, the HCPs stated that their organization did not compel them to show compassion[14].

According to the current study, the majority of the health care professionals failed to practice CRC on a daily basis. The most shared reasons for failure of practicing CRC were workload, health system (lack of support from heads) and shortage of resources. In a study which was conducted in UK, similar barriers were reported that may hinder compassionate and respectful care practices [22]. Similarly another study which was conducted in north Shewa, Oromia region, explained workload as a barrier for changing theory in to practice [12].

It is well known that leadership can play an important role in an organization to bring a change in multi

-factorial ways. However, sometimes they are also considered as barriers for some practices. In the current study, during an in-depth interview, participants were asked their reason for not applying CRC in the clinical area. Many of the participants commonly mentioned lack of support from the head greatly influenced to practice CRC. This is supported by a mixed method study which was conducted in Ethiopia [12].Similarly, this is also supported by another study which was conducted in US hospital that described lack of visible support from the CED and other senior leaders was also raised as a major barrier to implement CRC[23]. Therefore, to deliver CRC in the clinical are a effective, leaders are expected to do a lot in motivating health care professional, and they are essential for enabling the workplace environment and continuing CRC in health care facilities[12].

The third leading CRC in-service barrier commonly responded by the study participants was the shorter duration of the training. In the current study, many of the study participants stated that very few days a reallocated for the CRC in-service training. In this regard, participants might not achieve the learning outcomes stipulated in the guideline so that their practice to the clinical set up might be somewhat compromised. In addition to this, the care provided may be of a little compromised. The possible justification for the shorter duration of the CRC in-service training and its impact on application of CRC in the clinical area is because some experts suggest that time in the courses is critical aspect of achieving the learning outcomes. However, adequate course durations give teachers the time to facilitate the comprehensive learning of the required knowledge and practical skills to trainees'. Generally, there is a strong support for the notion that course durations of appropriate length for the qualification concerned do play a part in achieving high-quality outcomes in the qualifications of interest [24].

In the current study, one of the enablers was the presence of well equipped, efficient and role model trainers. This is in line with a qualitative exploratory study which was conducted in the northwest of Iran teachers as role models[25]. Nurses, especially newly graduated nurses, discussed that they considered their teachers behavior as a model for themselves within clinical settings. In this study, nurses identified positive role models as a key factor that facilitate compassion practice, and they try to demonstrate how role model influenced their compassion for their patients [14].

In this study, healthcare providers suggested that continuous CRC training is advisable for all health care professionals. The first one is continuous training on CRC is advisable for all health care professionals. It is generally accepted that education and training can have an impact on the attitudes, knowledge, skills and potentially on the behaviors of those who take part. Thus, it is often assumed that continuously providing training to the professionals in quality improvement is beneficial [26]. Research suggested that continuous training in quality improvement can improve health professionals' skills and knowledge, and this is associated with improvements in care processes[27].

Another recommendation suggested by the participants was conducting the training as an offsite. One of the benefits of preparing training in an offsite is that the trainees will have an opportunity for social networking with other trainees from other organizations as well as they can share a very good experience. This enables them to get benefits bilaterally to achieve the training's objectives. Since individuals

are more likely to complete training because of no work pressure, preparing training in an offsite is effective, and the probability of applying on the clinical set up is high [28].

The third suggested recommendation is incorporating monitoring and evaluation mechanism in the training. The majority of the study participants recommended that monitoring and evaluation should be given after the training since it helps to check exactly whether the program is on right track to continue, or whether changes may be needed in the mean time. It identifies the gap and tries to fill the gap as soon as possible. Despite the importance of monitoring and evaluation, in most of the cases, monitoring and evaluation were not given after the training to see the final outcome of the training [29].Evidences also showed that continuous monitoring and evaluation is recommended [30].

Similarly, the study participants recommended the involvement of religious leaders as a good strategy while planning training. Religious leaders especially in compassionate training provide guidance to the followers of that particular religion. So, they can clearly play a vital role in leading, inspiring, guiding and directing their people. In addition to this, religious leaders have the opportunity to raise awareness and influence attitudes, behaviors and practices so that they can shape social values [31].

Another recommendation proposed by the study participants was allocation of adequate budget for the training. For the continuity of the practice in health care facilities, at least every health care professional has to take the training. To facilitate this adequate budget is required. The training budget helps an organization to assess and forecast short- and long-term skill and knowledge gaps. Therefore, planning the best resource allocation and monitor its effectiveness and continuity is very important[32]. The last strategy recommend by the study participants was considering the training place and appropriate hall while planning training. The training hall plays a vital role in the success of every program [33].

Strength and limitation of the study: The issues are described in detail and in depth and also there was a possibility of examining how the HCPs really practiced CRC. However, there could be a possibility of recall bias, since some of the health care professionals took the training before 5 years.

CONCLUSION AND RECOMMENDATION

The study found that CRC in-service training has many benefits to the HCPs, to the patients and to the organization. However, during our observation, HCPs failed to practice because of different barriers. The common reason for the failure of providing CRC on a daily basis were workload, lack of support from leaders/heads and shortage of resources. The presence of competent trainers, adequate budget, and proper training hall, good mode of delivery and appropriate contents were described as possible enablers of CRC in-service training.

Trainees' perspectives, Misconception of HCPs about the training, shorter duration of training, and organizational related issues were the explored potential barriers for effective implementation CRC in-service training. So, the responsible bodies are expected to work on these identified variables for the effective delivery of compassionate, respectful in-service training.

In general, the Ethiopian Federal Ministry of Health

and Ministry of science and higher education has to give due emphasize to CRC in-service training continuity by integrating within the pre-service training curriculum and designing appropriate policy to reduce HCPs workload.

Abbreviations

CED: Chief Executive Director; CRC: Compassionate Respectful and Caring; HC: Health Center; HCP: Health Care Professional; HCPs: Health Care Workers; HSTP: Health Sector Transformation Plan; IDI: In-depth Interview; KII: Key Informant Interview

Declarations

Consent to Participate: Study permission was given at all levels and informed consent was taken from each of the study participants.

Data Sharing Statement: The data on which these findings were developed could be available upon a reasonable request.

Conflicts of Interest: The authors declare no conflicts of interest.

Funding: This study was supported by the Alliance for Health Policy and Systems Research. (Alliance) The Alliance is able to conduct its work thanks to the commitment and support from a variety of funders. These include long-term core contributors from national governments and international institutions as well as designated funding for specific projects. For the full list of Alliance donors, please visit:https://ahpsr.who.int/about-us/funders.

Author's Contribution: FS, ZM, MK 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.

ACKNOWLEDGEMENT

We extend our gratitude to the Federal Ministry of Health for their commitment and support throughout the initiative, and to all stakeholders contributing their time to participate in the study. We thank the University of Gondar for coordinating the initiative, and Marta Feletto for providing technical guidance and support through research protocol and manuscript development.

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