ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

SCHOOL OF NURSING AND MIDWIFERY

POSTGRADUATE PROGRAM

CHILDBIRTH SERVICE QUALITY IN PUBLIC HOSPITALS OF SHASHEMENE TOWN, SHASHEMENE, QUALITATIVE STUDY 2023.

BY: ROBA GEMECHU MUMICHA

A RESEARCH THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER IN MATERNITY AND REPRODUCTIVE HEALTH NURSING.

JUNE 2023

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APPROVAL SHEET

This thesis by Roba Gemechu was accepted in its present form for examination as satisfying thesis requirement for the degree of masters in maternity and reproductive health nursing.

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STATEMENT OF DECLARATION

By my signature below, I honestly declared that this research thesis on childbirth service quality of Shashemene town is my own work and all the sources that I have used indicated and acknowledged by means of complete references. I have followed all ethical principles of research in the preparation, data collection, data analysis and completion of this thesis. All scholarly matter that is included in the thesis has been given recognition through citation. I affirm that I have cited and referenced all sources used in this document. Every effort has been made to avoid plagiarism in the preparation of this thesis. This thesis is submitted in partial fulfillment of the requirement for a graduate degree from the Addis Ababa University at College of Health Sciences, School of Nursing and Midwifery, Department of Midwifery. The thesis is deposited in the Addis Ababa University Digital Library and is made available to local, national and international scientific community. I solemnly declare that this thesis has not been submitted to any other institution anywhere for the award of any academic degree, diploma or certificate. Brief quotations from this thesis may be used without special permission provided that accurate and complete acknowledgement of the source is made. Requests for permission for extended quotations from, or reproduction of, this thesis in whole or in part may be granted by the Head of the Department or all advisers of the theses when in his or her judgment the proposed use of the material is in the interest of scholarship and publication. In all other instances, however, permission must be obtained from the authors of the thesis.

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LIST OF ABBREVIATIONS AND ACRONYM

ATSMOL: Active third stage management of labour

BEmONC: Basic and Emergency Obstetric and Neonatal Care

EDHS: Ethiopian Demographic Health Survey

EmONC: Emergency Obstetric and Neonatal Care

FHR: Fetal heart rate

FMOH: Federal Ministry of health

IDI: In depth interview

KII: Key informant interview

MMR: Maternal mortality ratio

NRFHP: Non-reassuring fetal heart beat pattern

PNC: Postnatal care

QoC: Quality of Care

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ABSTRACT

Background: Medical care accessibility and availability are both essential but insufficient for enhancing mother and neonatal health outcomes. In fact, they are not guarantees of more service utilization or higher satisfaction among clients. The quality of care a woman receives during pregnancy, childbirth, and postpartum affects her health, the health of her baby, and her likelihood of being cared for in the future. The study was aimed to explore childbirth service quality in public hospitals of Shashemene town, Shashemene.

Methods: A qualitative exploratory research design was conducted from February 30 – march 30 at public hospitals of shashemane town. Purposive sampling was employed to recruit women and hospital staff who fulfill the inclusion criteria for in-depth interview, key informant interview and observation. Women on Labour, mother who received labour and delivery care and staff in managerial position were study participants. The total participant for in-depth interview, observation of care and key informant interview were 12, 6 and 3 respectively. Both observation and interview were conducted using semi-structured guide. Data were audio recorded, transcribed verbatim and imported to ATLAS.ti 9 software for coding and analysis assist. Thematic data analysis were used for categorizing and interpretation of data.

Result: The finding revealed the quality of childbirth service at facility. Which includes inadequate human and physical resource like number of staff, room and bed, cleanliness of room. In addition, provision of care is not inline to developed guideline; for example painful procedure, partograph use and inadequate labour follow-up. Moreover the finding from women's perspective were strengthen the study finding in relation to communication and relationship with care providers which is explained as poor, undignified and disrespectful care were experienced by mothers.

Conclusion and recommendation: The study identified many challenges and experience on quality of care related to childbirth service from both care providers and mothers. Prioritized financing on infrastructure, supportive staff supervision and capacity building on compassionate and respectful care for staff should be considered to enhance quality of service.

Key words: Childbirth service, Quality of care, mother's, care provider, qualitative, Ethiopia

1. INTRODUCTION

1.1. Background

Increased focus on quality care during childbirth can quadruple the return on outcome by reducing maternal and neonatal deaths and preventing stillbirths and future disabilities. An estimated 3 million mothers and newborns die each year, and the number of stillborn babies can be saved by improving access and expanding quality care during pregnancy, childbirth and the postpartum period. The quality of childbirth care in a health care facility reflects the available physical infrastructure, supplies, management and adequate human resources along with the knowledge and skills to deal with pregnancy and childbirth. Although this is a normal physiological, social and cultural process, complications that require immediate life-saving action may occur. World Health Organization (WHO) concept of quality care defines a well-functioning health care system structure with competent and motivated health care workers as a prerequisite for the delivery of quality health care (1-3).

In 2017, approximately 295,000 women died from pregnancy- and childbirth-related causes worldwide, with sub-Saharan Africa accounting for 66% of the global burden(4). There are approximately 2 million stillbirths, of which 50% are stillbirths during delivery and 98% of worldwide neonatal deaths and stillbirths occur in sub-Saharan Africa and Asia. Ethiopia has one of the highest maternal mortality rates in sub-Saharan Africa. Despite the decline in Maternal mortality ratio (MMR) (from 600 in 2011 to 412 per 100,000 live births in 2016) and increased number of skilled health care providers (from 33% in 2011 to 62% in 2016), the significant decrease in unskilled deliveries or home deliveries and the increase in institutional deliveries were not notable. For example, births at institutions increased from 26% in 2016 to 48% in 2019, while births at home decreased from 73% to 51% over the same period (5-7).

A holistic approach is needed to ensure uninterrupted, high-quality maternal care in a health care setting. Communities need to be empowered to demand high quality services including well-functioning referral and transport mechanisms. Qualified and motivated teams must be available in facilities with essential medicines and supplies, and in a supportive environment,

that promotes evidence-based, client-focused, and respectful birth care services. Also, facility management and administrative systems with in-built accountability are needed (2).

1.2. Statement of the problem

The quality of care a woman receives during pregnancy, childbirth, and postpartum affects her health, the health of her baby, and her likelihood of being cared for in the future. A systematic review of previous research found that perceived poor quality of care during childbirth in a health facility and fear of discrimination are some of the major barriers to giving birth in a health facility(2).

In consistent with high levels of mortality and morbidity, worldwide evidence is emerging to show that the care process itself is dehumanized in many parts of the world (8). There is evidence of dissatisfaction with services as a result of a shortage of basic necessities such medicines and other supplies, a lack of dedication by the majority of staff, poor food quality, and unclean physical environments (9, 10). The major concern is, there was emerging evidence that shows insufficient care and concerns about the quality of care are causing delays and non-use of services by women and their families. Recent studies show that progress in reducing maternal mortality in Sub-Saharan Africa has been lagging due to inadequate quality of healthcare, a scarcity of human resources, limited access to crucial health technologies, including equipment, medications, and supplies, as well as financial barriers for the provision of safe delivery care (5, 11).

Numerous studies have revealed that the standard of care in Ethiopia falls below of what the WHO recommended (12, 13). According to a study conducted in various areas of Ethiopia, just 15.6, 9.3, and 10.7% of health facilities attained the satisfactory level of quality in terms of input, process, and output requirements, respectively (14). And according to a study on Quality of Care surveys carried out in 19 Ethiopian hospitals with the highest volume of deliveries, substandard quality of care is found at all hospital levels and across all types of caregivers (15). Studies conducted on emergency obstetric and neonatal care(EmONC) in Ethiopia revealed that the quality and accessibility of EmONC were much below what considered the recommended level, which increases the risk of maternal and neonatal mortality (12). Poor QoC is one of the

variables that leads to low service uptake and has been cited as a major reason why women either do not receive services at all, accessed late, or face avoidable adverse consequences (13).

Even though the Ethiopian Federal Ministry of Health (FMOH) attempted to increase access to health services, hospital-based labor and delivery care is a top priority, and maternal services have been provided at cost-free, but secondary to poor quality care in the facility some women are giving their back to the service once experiencing it (16-19). Different studies have tried to assess quality of delivery service provisions, using some domain of quality care (16, 20-24) in health facilities of different parts of the country and reported that the qualities are suboptimal. The general quality of childbirth services in Ethiopia, particularly in the study area, is not widely investigated, despite the fact that it is crucial for the improvement of mother and child health outcomes and its utilization. Therefore, this study aimed to explore and in-depth understanding of overall childbirth service quality in public hospitals of Shashemene town, Shashemene, 2023.

1.3 Significance of the study

The study were assessed the quality of childbirth services at selected public hospitals by using the overall quality components based on the Hulton and colleague's framework. Therefore, this study would provide full picture of quality of childbirth care services at public hospital's in Shashemene town.

Moreover, the study were used qualitative approach that would have able to get detail information on childbirth service quality by involving care provider and management staff on facility care provision and mothers experience on childbirth quality service. Therefore, the finding of this study will add to the existing body of knowledge on improving quality of childbirth service in Ethiopian public health facilities.

In addition, policy makers and different stakeholders will use the findings of the study in designing and develop intervention plan as it provides a baseline data, which may help them for improving childbirth service quality in the study area. Moreover, researchers will explore more about the childbirth service quality of public hospitals in Shashemene, Ethiopia

2. LITERATURE REVIEW

2.1. Introduction

This chapter presents a review of literature on the quality of institutional childbirth service in Ethiopia's public hospitals. It takes into account regional and global studies that are relevant to the study's topic, which is the overall quality of childbirth care provided by public health facility. The literature review discussed the concept of quality of institutional childbirth service according to Hulton and colleges updated framework to assess quality of institutional childbirth service. The reviewed concept includes the quality of human and physical resource, practice in provision of standardized care and client experience of quality institutional childbirth service. Improving health outcomes and lowering preventable mortality and morbidity among women and their newborns require high-quality care for women during pregnancy, delivery, and the postpartum period.(25, 26). It is also the likelihood of obtaining ongoing care in the future to improve universal health coverage(27, 28). Even though significant advances in coverage and access to maternal health services have been noted in Ethiopia, changes in quality of care have lagged (16, 29, 30). This shows that if the quality of care is poor, expanding facility delivery may not be sufficient to lower mother and neonatal mortality (31, 32).

2.2. Provision of care

2.2.1. Human and physical resource

This broad term included, physical resources, which implies general infrastructure including water and electric power, and human resources that are adequate, well trained, inspired, and well supervised health and non-healthcare professionals(33). In low- and middle-income nations, access to water and electricity, as well as lack of transportation and communication to the referral hospital, affected quality of intrapartum care. In sub-Saharan countries, 60% of hospitals lack electricity (34), ambulances, and dedicated phone lines(35) and there aren't enough beds for women and their newborns, they have to share beds or the floor (9). According to the standard, just 54% of health facilities in Uganda have maternity beds, whereas in Kenya, 7.4% of national and 1.0% of district hospitals have delivery couches. All of these indicate that

delivery rooms were not conducive to provide safe and women friendly care service (36, 37). Another component that is necessary for providing high-quality intrapartum care is medical equipment and supplies. Studies on the perceptions of healthcare professionals regarding the quality of maternity care in Tanzania, Nepal, and Ethiopia show that many respondents complained about the lack of necessary equipment and supplies (38-40). Additionally, according to many studies conducted in Ethiopia, it is difficult to provide high-quality care when there is a lack of important medications, supplies and equipment, ambulance not arriving in time (41-43).

Every postpartum and intrapartum woman should be monitored by trained healthcare personnel, according to WHO recommendations (25). In a research conducted in Tanzania, Ethiopia, and Uganda, it was found that the number of healthcare professionals was only half of the minimum required number that their number is not proportional to the volume of patients and inadequacy of capacity building mechanism and low salary were identified. This condition brings insufficient support of the laboring mother owing to exhaustion, increase workloads of the healthcare professional, sleeping during the night, lack of motivation and satisfaction to the healthcare professional on their job, unfriendly behavior towards women and colleagues (38, 44-46).

2.2.2 Adherence to standard care

The results of a direct observation study on the intrapartum care given to 161 women in a crowded tertiary hospital in Sub-Saharan Africa reveals suboptimal adherence to local and international guidelines on timely care, including monitoring the woman's vital signs, FHR (Fetal heart rate), and labour progress(44). Almost Similar findings from research conducted in northern Ethiopia and Tanzania describe providers were not performed fetal heart rate monitoring and blood pressure uniformly, temperature and respiratory rate is rarely measured (16, 44, 47).

The key findings of the study done in tertiary hospitals of sub-Saharan Africa were lack of continuity in care, lack of support and respectful care, reflected by a notable absence of communication, privacy, and support at the time of childbirth (44). Lack of privacy is the

primary issue during labor and delivery, according to a research conducted in the Hadiya zone (48). The study done in Arbaminch and Shambu town also suggested over one-fifth of mothers were encountered physical and verbal abuse in the form of verbal insulting to even hitting or pinching during labor and delivery in health facilities(49, 50)

According to WHO guideline every women has the right to access care free from harmful and ill-treatment (25). However multiple comments from clinical observation on respectful maternity care of five African countries and study done in India shows administering uterotonic drug prior to delivery, use of fundal pressure, routine episiotomy, and suturing of episiotomies or tears without anesthesia were identified harmful procedures during delivery(51, 52).

WHO practical post-partum guidelines recommended, all mothers and newborns should receive postnatal care in the facility for at least 24 hours after birth(25). However, different studies revealed that postnatal care is inadequate or below the standards. According to a study from India(52) postpartum stays for the majority of women ranged from 6 to 10 hours during daytime deliveries and up to 24 hours in cases of late-night deliveries. And immediate postnatal care utilization was 13.5% from the finding of study conducted in Nepal (39). According to a study in Swaziland, only 44.9% and 26.6% of mothers had their temperatures and pulse rates measured after childbirth (53). Blood pressure, temperature, and uterine tone were measured in 58.5%, 65%, and 45.5% of the cases in Ethiopia's Tigray region, respectively (54).

According to WHO (2018) partograph is one of the methods to prevent complications and help healthcare professionals diagnose and manage a problem. Moreover, it improves quality of care and its outcome(25). The utilization of partograph was 98% and 32.4%, respectively, according to a WHO, grading study carried out in Bangladesh (55) and Cameron (56) however, the interpretation or plotting of the partograph is inaccurate and was not plotted accurately. Different studies carried out in different regions of Ethiopia showed, only 10.1%,25% of the facilities had used partograph effectively in Amhara and Tigray regions of Ethiopia respectively (16, 23) Which shows partograph use is not yet implemented adequately. On another hand, even if there was good figure usage, some of them had used it inaccurately (57).

2.3. Mother’s perspectives on childbirth quality care

Every mother wants and expects healthcare facilities to provide care of the highest standard ranging from a humanistic approach like compassionate and respectful care to medical care with a supportive structural environment like adequate skilled personnel, drug supply, infrastructure, and a clean hospital setting. This shows both aspects of quality childbirth care have an impact on perceived quality of the mother at intrapartum care, particularly the interpersonal behavior of the care provider. Different study in Ethiopian study found that woman’s interactions with healthcare providers and facilities had an impact on their decision to seek care (58-60). Therefore, Understanding how mothers feel about their treatment is crucial because it affects how often they would use the facility's services in the future. Mothers who felt the facility's quality was high were more likely to use it again (61, 62).

There is negative perception towards the quality of care provided. Study done in Tanzania showed that lack of supplies and cost of transportation services, made mothers to negatively perceive quality of care at public facility (47). Another qualitative study conducted in Malawi explored healthcare providers' unethical behavior and the inconsistent availability of medical supplies affected mothers' perceptions of quality care (8).

For acceptance and future use of the service, a mother's own opinions on the delivery care service are crucial. According to a study conducted in Nigeria and Malawi, women find it difficult to interact with healthcare providers due to language issues, and nurses' impolite communication styles including "shouting" and "talking badly" (63, 64).

The study from eastern Ethiopia and Guinea(65, 66) shows that certain healthcare providers make distinction in care among patients based on their social class and place of residence. The other finding shows that the healthcare provider didn't give adequate information, companions were not permitted to enter labor and delivery room, and the laboring mothers were felt abandoned and alone in room because there was no one there to comfort and support them (30, 48). Therefore, assessing maternal experience of care gives a better idea of to improve quality of care and increase utilization of service.

2.4. Concept and framework of Childbirth service quality

There are multiple points of view to the quality of care (QoC) concept. WHO defines quality of care as "the extent to which health care services offered to specific patients and populations to improve expected health outcomes." To accomplish this, health services must be "people-centered, safe, effective, timely, efficient, and equitable"(67). and the Institution of Medicine defined quality of care (QoC) as "the extent to which health care services offered to specific patients and populations maximize the likelihood of timely and appropriate treatment for the purpose of obtaining intended outcomes that are in accordance with the current professional knowledge"(68).

In order to provide a definition applicable in the context of maternal health services, Hulton and colleagues modified the aforementioned definition of quality of care. The concept also takes into account effective and timely access as well as reproductive rights, thus "the extent to which health care services offered to specific patients and populations maximize the likelihood of timely and appropriate treatment for the purpose of obtaining intended outcomes that are in accordance with both the current professional knowledge and uphold basic reproductive rights"(69).

This definition allows quality to be separated in two parts. The quality of the provision of care within institution and the quality of the care as experienced by users. It identifies five elements related to provision of care and four elements related to mother's experience of care as shown below in the conceptual framework of the study. This study used the concept of quality in childbirth service from Hulton and colleges framework and some elements of the component were used as part of predetermined code on the analysis part of the study results.

Provision of care

1. Human resources
2. Infrastructure
3. Equipment, supplies and medicine
4. Clinical practice
5. Referral and networks of care

Experience of care

1. Human resources
2. Infrastructure
3. Equipment, supplies and medicine
4. Respect, cognition and equity

Figure 1 Conceptual framework to assess childbirth service quality (69)

3. OBJECTIVES

3.1. General objectives

- To assess childbirth service quality at public hospitals of Shashemene town, Shashemene, Ethiopia 2023.

3.2 Specific objectives

- To examine quality of clinical care process provided by health personnel at public hospitals of Shashemene town
- To explore childbirth service quality from women's perspective at public hospitals of Shashemene town
- To describe human and physical resource quality to conduct childbirth services at public hospitals of Shashemene town

4. METHODS AND MATERIALS

4.1. Study setting and periods

The study was conducted in Shashemene town. The town was located in Oromia region, 248 kilometers from Addis Ababa. Founded in 1903 E.C. Shashemene town had a total population of 393,035 people in 2021, of which 43,234 were women's in the reproductive age group, according to the 2021 Shashemene town health bureau report. The town had 5 health centers and 2 public hospitals(70). The study was conducted at both public hospitals of the town. Those facilities provide maternity services such as Basic Emergency Obstetrics and newborn Care, antenatal care, delivery, and postpartum care. Shashemene comprehensive and specialized hospital, serves at referral levels, 300 delivery were monthly reported and total of 3 functional delivery coach and 16 beds were available at labour and delivery unit. Melka Oda general hospital were attend averagely, up to 400 delivery in a month and a total of 3 delivery coach and 17 beds available at Labour and delivery unit as a data from archives of each hospital. The study was conducted from February 25 to March 25, 2023.

4.2. Study design

A qualitative study by using exploratory research design was conducted. The purpose to use this design was to gain opinion that helps to have deeper understanding on quality of childbirth care at selected hospitals from different perspectives.

4.3. Study participants, recruitment and sampling

Three groups of population; women who gave birth and admitted at postnatal ward for at least 4 hours, facility administrators who had been working in that position for at least 6 months and care provider serving during labor and delivery were study population. Purposive sampling method was employed to recruit the participants who fulfill the inclusion criteria and are able to offer detailed information. Twelve Women who received labour and delivery care, three Hospital administrators and six mother on labour were total study participants. However, the number of participants were determined by information saturation, which is the point at which no new data were revealed in terms of fresh information, themes, or coding. At the conclusion

of each interview day, the data were reviewed for the presence of codes or categories and the necessity of additional interviews in a preliminary manner in order to ensure saturation. After having similar ideas repeated, the recorded data were no longer generating new code. Data saturation was assured after tenth interview and two interview were added to ascertain that saturation have reached.

4.4. Eligibility criteria

4.4.1 Inclusion criteria

The study included the following women and health care providers

- Women who attend labour and delivery at selected public hospitals.
- Mothers who gave birth vaginally, and admitted in postnatal ward.
- 18years and above, and gave informed consent to participate.
- Hospital staff with at least 6months in managerial position related to labour and delivery service.

4.4.2 Exclusion criteria

- Mothers with known psychiatric problems
- Mothers who had stillbirth for the current birth
- Severely ill at time of data collection.

4.5. Data collection method

In-depth interviews and key informant interview

Face-to-face individual interviews with a semi-structured interview guide were used to collect the data. Afaan Oromo and Amharic translations of open-ended questions were included in an interview guide. To determine if the research questions will result in sufficient responses, two volunteers who are not among the primary participants and who meet the established eligibility criteria were used. Following this pilot interview, the interview approach and questions were modified. The principal investigator conducted the interviews in Afaan Oromo (for majority of cases) and Amharic in a quiet and private place in each facilities. Interview was held in free postnatal room for mothers while selected key informant were interviewed at their office. The

interview was audio recorded with the participants' verbal consent and written notes were taken to preserve the original accounts of the participants' responses and to verify the participants' explanations by referring back to the original answers. Each interview session lasted 20–35 min. Each day's interview session ended with a verbatim transcription of the answers that had been recorded on audio, and kept with field notes in Microsoft Word format.

Observation

An observation guide was used to assess clinical care process of health care providers toward provision of labour and delivery service. Observations of the entire labor and delivery care process; from the admission process, through observation of the active first stage, second stage, third and fourth stage of labor was held. Simultaneously observation of how suitable were the infrastructure and basic equipment's and drugs at labour and delivery ward to provide quality service was held.

An observation guide is adapted from WHO maternal and newborn health standards of care and BEMONC manual guide (71, 72). The investigator take notes, while taking part in this activity both during and after observations. The process of collecting data at each facility began with a formal introduction to the medical directors and the head of labor and delivery at each hospital, during which the goal of the study and a brief explanation of the data collection plan were explained. Then followed by ward tour for familiarization with staff and layout of facility. Prior to data collection, informed verbal consent were obtained from each relevant staff. One or two observations were made without being formally recorded in order to reduce the inherent biases of observation on provider behavior (the Hawthorne effect). However, there is always the chance of researcher bias because behavioral observations are subjective in nature.

Care providers were guaranteed that data collection would be anonymous, and individual performance would not be disclosed or published. Laboring women who attend the facility to give birth were purposefully approached and informed verbal consent was obtained (in some cases), before starting observation. There were no refusals, but in two instances, women had to be dropped from the process of observation because they were taken to emergency OR, due to NRFHP (Non-reassuring fetal heart beat pattern). Each observation lasted about 2 – 6 hours.

4.8. Method of data analysis and processing

Analysis of the data were started simultaneously with data collection and emerging ideas and new question was added throughout data collection. Data were thematically analyzed by combining inductively emerged codes and priori code (from conceptual framework). Data from audio recording were transcribed verbatim concurrently with data collection in a language of interview (Afaan Oromo and Amharic). Transcribed verbatim was translated from Amharic and Afaan Oromo to English. Afterwards data were checked by qualitative experts for consistency between transcripts and audio recording. Data were coded line by line after imported to Atlas ti9 software including finding from observation notes, to aid the process of coding. Primarily the principal investigator carried out coding and then main advisors revised and checked for clarity and consistency of the code. All 36 codes were divided into subthemes based on their similarities and differences. Themes were created from sets of related sub-themes. Then, the views shared by respondents was used as quotes to support the points to be made in the study. Participants were recognized in the presentation of findings by a code given to their interview and quotations as participant - Participant and number from 1-12 according to the number of recording, and Case – for case observation, KII- key informant interview, IDI-In-depth interview were assigned as method of data collection held with participant.

4.7. Trustworthiness

Trustworthiness is the ability of researchers to convince participants and themselves that the investigation's results were direct, truthful, or reliable. Pre-test was done to determine the trustworthiness of the instrument before the main study, and after that, the interview method and questions were adjusted.

Credibility: Several techniques were taken to ensure the report's credibility, including familiarizing with the study environment before data collection and building relationships with significant participants like labor and delivery attendants. The investigator had taken advanced training on qualitative research study including data collection and method of analysis. The other was Method triangulation and continuous discussion throughout the research process with advisors' and other staff who have experience in qualitative study.

Transferability: A thorough explanation of the study area, methods, and results were given in

order to assure the transferability of the research findings to similar settings.

Dependability: The initial technique was an audit trial to ensure dependability. An external auditor evaluated and confirmed the study's conclusions and asked clarification for any adjustments that had been made. Secondly saved audio records of participant interviews, notes during observation and from the interviews, and verbatim transcriptions were kept, in order to cross check the process and maintain consistency in the interpretations.

Conformability: During the interview, field notes were made to preserve conformability. In order to minimize bias during data collection, coding, and analysis, the researcher reflected on and took prior personal experience and expectations into consideration. The other technique was to confirm that the data interpretation accurately reflected the participants' own words rather than the researchers' opinions or views by using the participants' own words from interview transcripts.

4.8. Operational definitions

Provision of care: Reflects key elements of the care given by the hospital, such as the strength of their physical and human resources, the quality of their referral networks, and the use of evidence-based, nationally and internationally accepted practices for the care of women.

Experience of care: Women's views of the human and physical resources, their comprehension of the situation, the respect shown to them, their sense of dignity and equity, and the emotional support they receive throughout hospital labour and delivery care.

Human resource: Refers to morals and job satisfaction of staffs, management style, and population based staffing ratios, nature and frequency of staff training.

Infrastructure: Covers general hospital infrastructure including water and electricity supply

Clinical process of care: Refers childbirth care provided in accordance with internationally recognized, evidence-based practice from admission to discharge.

Childbirth services: - Refers to service provided during labour and delivery including immediate postpartum and newborn care.

Technical aspects of care: - Refers to nationally/internationally recognized midwifery skill used during management of labour, delivery and immediate postpartum care.

Mothers/women: - are individuals who use labour and delivery service in public hospitals. Mothers and women are used interchangeably in this study.

Women friendly care: - Services that are acceptable to the woman: Considers their rights, their emotional, psychological, and social well-being, and ensure good interpersonal communication and empower the women(71).

4.9. Ethical considerations

The study was started after full approval and Ethical clearance to conduct this research was obtained from the Research and Ethical Review Committee of the School of Nursing and Midwifery, College of Health Sciences, Addis Ababa University. Administrative Permission was granted after written request was made to participating public hospitals. Before participants signed the consent form, which was written in Afaan Oromo and Amharic, the researcher ensured that participants were understood the information given by using the language of the choice and at the level of their understanding. After informed written consent obtained from all participants, the right to refuse answer for few or all question is valued. The voluntary nature of participation in this study was underlined. The following steps were taken to ensure anonymity and confidentiality; participants received guarantees that all information they provided would only be used for the purposes of the study. The researcher took measures to ensure that the raw data collected were secure and password-protected, that names of participants were not recorded in study documents, and that data were published in a way that could not link or identify the participants with the information.

4.10. Dissemination of Study Findings

The findings of this study will be submitted to the School of Nursing and Midwifery at Addis Ababa University's College of Health Sciences. Finally, attempts will be made to publish portions of the research findings in reputable local and/or international journals. Workshops and seminars will also be used to disseminate the findings.

5. RESULTS

5.1. Basic characteristics of participants

The total numbers of participant were 21 in number, including mothers who received a care and admitted to postnatal (N=12), hospital staff (N=3), and six observation was held by principal investigator. The mean age of mothers was 27, ranging from 22-34 years. Among the mothers 10(83%) of them were housewife in occupation, and 9(75%) of them had primary and above course in their educational status.

Table 5. 1 Socio demographic and obstetrical characteristics of mother's (care receiver) participated in in-depth interview (N=12)

Participant code	Age	Gravidity	Parity	Marital status	Educational status	Occupation
Participant #01	22	II	II	Married	Elementary	Housewife
Participant #02	24	II	II	Married	High school	Housewife
Participant #03	28	IV	III	Married	Illiterate	Housewife
Participant #04	24	II	II	Married	Elementary	Merchants
Participant #05	30	VI	VI	Married	Illiterate	Housewife
Participant #06	34	V	IV	Married	Elementary	Housewife
Participant #07	23	II	II	Married	Degree	Accountant
Participant #08	26	III	III	Married	High school	Housewife
Participant #09	30	V	V	Married	Elementary	Housewife
Participant #10	26	IV	III	Married	Elementary	Housewife
Participant #11	25	III	III	Married	Elementary	Housewife

Participant #12	32	VI	V	Married	Illiterate	Housewife

5.2 Emerged themes

Main finding of the study includes presentation and descriptions of the finding from observation of clinical process of care, interview of key informants on general infrastructure and human resource of hospitals and mothers perspective on childbirth service quality. There are three main themes with a total thirteen subthemes. Quality of provision of care encompasses human and physical resource aspects of care and Clinical process of care. Under human and physical resource, There is four subthemes namely: - infrastructural status, human resource factors, equipment and supply issue, referrals and networks of care. Clinical process of care constitutes technical care, safety and precaution, partograph use and women friendly care. A group of repeating ideas such as human resource impression, infrastructural impression, equipment and supply, interpersonal care, dignified and respectful care were organized under quality of care experienced by users. Themes and subthemes of finding with their descriptions for each domains of quality are summarized under table 5.3 bellow.

Table 5. 2 Themes and subthemes with its description identified through interviews and observation of childbirth service quality at public hospitals of shashemane town.

Themes	**Subthemes**	**Codes**	**Description**
Clinical process of care	**Technical care**	Admission	Staffs are not well-prepared necessary instrument and patients before procedure.
		Standards of care	Some procedures are not well-followed national/internationally recognized guideline.
	Infection prevention	Hygiene	All staff were vaccinated against Hepatitis, however there is poor handwashing and waste disposal practice before and after procedure

		Use of PPE	Partial use of glove and other PPE identified throughout care observation.
	Partograph use	Incomplete and Inaccurate plot	Partograph is not timely started, incomplete and retrospectively filled and plotted by estimation.
	Women friendly care	Companionship	One partners (women) is allowed during labour, but no one is allowed at the time of delivery.
		Privacy	Privacy were partially insured during physical examination, however no unnecessary exposure of women's body
		Mistreatment	Physical and verbal abuse, not to allow preferable position and food intake by some of the staff.
Human and physical resource	**Human resource factors**	Staff development	Staffs felt inadequate training and educational opportunities.
		Staff motivation and satisfaction	Not motivated and satisfied staff by their job, due to case over flow and payments for their work
		Staff number inadequacy	The numbers of staff is not retained in appropriate numbers per case flow
		Payment issue	The salary and other duty payments are not paid on time
	Infrastructure status	Room status	The room was well ventilated but not adequate and well-cleaned toilets and shower room
		Utility service	There is interrupted availability of electricity and water
	Equipment, supply and medicines	Inadequate equipment's and supply	Unmatched numbers of equipment's and supply per case flow.

		Availability of drugs	Emergency drugs are available, but some antibiotic and NS are rarely available
	Referrals and networks of care	Referral system	No outgoing referrals, but there is poor communication with referral among facility
		Networks of care	Service providers communicate with each other between services and levels of care.

Mother's perspective of childbirth service quality	**Staff related**	Staff adequacy	Unmatched number of care provider with number of case flow
		Staff competency	Service given by incompetent students
		Gender preference	Some of clients think men's are better, 'they try to understand and cooperate with you'
	Infrastructure, supply and medicine impression	Supply and medicine	Participants report shortages of beds, blankets and sheets. They got drugs and other supply for free
		Hygiene condition	Feeling of discomfort by cleanliness of the room and delivery couch.
	Technical aspects of care	Neglected care	Staff refused and delayed to care clients, and not to give proper attention.
		Harmful procedure	Painful stich, fundal pressure and unsupported perineal were some of the experienced problem.
		Labour Follow up	Participants complained of the staff visited them only, when they call them or during delivery.
		Post-natal visit	Participants were visited only while they were going to be discharged.
	Social support	Companionship	Patients responded that, family is not constantly stay, staff will send them outside.
	Interpersonal care	Poor communication	Difficulty of communication due to language barrier with care providers and clients

		Emotional support	Clients report there is variation among care provider some continually support and encourage and others not.
	Abusive and disrespectful care	Verbal abuse	Clients bothered when care provided yelled, insulted (even their family) and made them not to scream.
		Physical abuse	Doing painful procedure and make the clients not to move during delivery by hitting on the thigh or attach forceps on it.
		Discrimination	Client perceived knowing some staff, being from urban, being well-dressed make them specially treated.
		Privacy issue	Patients feel discomforted during p/e due to number of students, no screen is used, and sometimes even door is opened.

5.2.1 Theme 1: Provision of care: Clinical process of care

This theme includes four subthemes emerged from observation of care process and interview of key personal (staff). Namely technical aspects of care, safety and precaution, partograph use and women friendly care.

Subtheme 1: Technical aspects of care

The first Observation of the process of care starts with how was the admission of the patient and readiness of the staff. There was a uniform admission process among both facility. First, the laboring women were taken to the triage room for the preliminary physical examination. Women's were asked why she came for and when did labour starts immediately before any procedure. They were admitted to the labour ward or allowed to walk outside the room based on the finding of the examination. The first physical examination include vaginal examination (cervical dilatation, position of the fetus, membrane condition)) and check for contraction.

History were taken simultaneously with vital sign measurement using CTG machine. The vital sign measurement include BP, PR for mothers and presence of FHB using manual fetoscope. Temperature is not measured even once, but seen recorded on history sheet. Regarding examination during admission, the note was observed:

"Midwives ask client why she came for, and then told the client to wait on the couch for a few minutes, after around 10 minutes, he (care provider) came back with gloves. Then, assess clients cervical status per vaginal examination and after history taken she was told to make a walk in front of the room and if tired, to use a bed" ***(Case #01)***

"General wellbeing is assessed, vital sign (BP, PR) for mothers and FHR is measured while clients was admitted to labour ward. Contraction is not measured, but written on patient card through estimation. Vaginal examination is done to assess for cervical dilatation, membrane condition, station and position of the presenting part" ***(Case #01)***

After admission, many of the mothers were seen walking, sitting on the floor and laying on the bed. Labour progress and maternal and fetal condition is assessed if clients complained or increased labour pain and contraction, limited to only performing cervical dilation exams once (within the first hour) to a maximum of four times before giving birth. Most of the delivery was assisted by staff and one or more students. In some cases oxytocin (1ml is administered to running NS fluid to shorten 2nd stage of labour, which is one of observed malpractice during labour. During delivery of the head, perineal support is not given in some of the cases. Almost in all cases tear is sutured without any analgesia. Assistant administered oxytocin immediately after delivery of the baby. However the assessment for complete removal of placenta were not made. Uterine massage and examination for perineal tear and laceration were simultaneously applied.

'History taken include present pregnancy condition like, if she remember her LNMP, danger sign, history of ANC follow up, duration of labour. Which is not complete history. Monitoring the progress of labour was relied on cervical dilatation exam. Most of the times healthcare providers were assessed the progression of labour, when the woman experienced more persistent pain or contractions.' ***(Case #02)***

"Contraction is not measured for full minutes (10), estimated after a few minutes of count and women's reaction to the labour pain. Moreover, it's not registered on partograph or patients card in every visit of the patients." ***(Case #03)***

"They were administered uterotonic agent (oxytocin 1ml) to running NS fluid prior to delivery for shortening second stage of labour. The providers did not supported the delivery by providing perineum support and results in perineal tear. Care providers were not comforted to use ant pain while suturing tear site. Which makes the procedure painful." ***(Case #02)***

In majority of cases, immediate newborn care consists of clamping and cutting the cord, cleaning the mouth and nose, wiping and covering the baby with a towel from the woman's family, and weighing the infant was done simultaneously. Immediate skin to skin contact is not performed during observation period. In the absence of any further complications, women are permitted a total of 6 hours in the postnatal unit. It was not common practice to provide immediate postpartum care, which includes assessing vital signs, giving antibiotics, and checking for uterine.

"For delivered newborns, the birth weight was immediately recorded. Immediate Skin-to-skin contact was not established. Assistant Attendants put the baby under warmers and give immediate care, which is limited to clamp and cut the cord, cover the baby with a towel and weight recording. They kept her (women) under observation in the delivery room over the couch for 15 to 30 minutes after delivery." ***(Case #06)***

"After women is transferred to postnatal room, they told her to call them if there is any problem. However, no one is visited back then for vital sign record, administering antibiotics and palpating the uterus or for any postpartum counseling" ***(Case #05)***

Subtheme 2: Infection prevention practice

There was rare application of infection prevention technique during or after procedures for patients and for them self. Even though all care providers had been vaccinated against hepatitis. There was partial use of personal protective equipment; single surgical glove is used throughout delivery of the baby and placenta. Poor handwashing, mostly before procedure. Appropriate disposal of used gloves and blood and other fluid were not appreciated. One of the study participants quotes and observed case supported as follows

"We don't have enough protective equipment, and there are problems with using as much as we have. There are identified waste disposal facilities, but the use of professionals is very low. All received hepatitis vaccine. HIV prophylaxis is also available to those who need it" ***(KII)***

"…However, there are carelessness among our professionals in taking protective precautions for all clients." ***(KII)***

"No hand washing using soap or alcohol hand rub before examination and uterus is explored using the glove used during delivery for perineal and vaginal lacerations" ***(Case #04)***

Subtheme 3: Partograph use

In almost all cases, partograph were not used as a decision tool in the management of labour progress, maternal and fetal condition. Labour progress is limited to cervical examination. Whether inaccurately plotted or incomplete and retrospectively filled. Which is acknowledged by the following noted observation.

"*…midwives started recording after few hours of admission to the labour ward, however, none of the providers were seen maintaining partograph or other records of the progress of labor and instead relied on cervical dilation exam."* ***(Case #03)***

"There is attached partograph on patients card, is not started while she enters active phase of labour. Started plotting of partograph in the middle of her labour follow-up. and finally filled after delivery of the baby retrospectively. The incomplete plot of partograph were only included cervical dilatation, contraction, FHB, vital sign measurement (BP, Pulse)." ***(Case #01)***

Subtheme 4: Women friendly care

The non-technical care provided to the women is categorized under this theme. Which includes how care is compassionate, companionship and if any verbal and physical restrains happen to laboring mothers. Generally in most of cases, the care is not women-friendly; Communication problem, rude and offensive word, push or hit women on the thigh, lithotomy position only, separate mothers from the companion is some of the noted way of care. As observer noted below:-

"Midwife ask women why she came for, and then told her to wait. There were no greetings or explanations of what was going to occur to her. There is a one-way communication from care provider which is like 'be on your side', 'push down', 'open your leg', otherwise the clients is not interested to talk much." ***(Case #04)***

"During the initial examination, the laboring mothers were accompanied by at least one companion (woman), who stayed with them throughout the labor stage. In a few instances, women were left unattended and alone for longer than 15 minutes before to delivery. Otherwise, no family member is permitted to accompany the woman during 2nd stage of labour" ***(Case #01)***

*"… Although there were screens in the labor rooms, they were not being used to protect patient privacy from other patients. However, there is no noticeable physical or emotional support. During the labour and delivery process, attendants and assistant staff physically and verbally abused women. For example, pulling or pushing the woman to adjust her position on the delivery couch; yelling at her or slapping her on the thigh when she does not seem to follow the instructions given by the provider; or telling her to go to another hospital if she is not willing to follow the provider's guidance. Many midwives favor the lithotomy position for delivery, and the women were allowed to be in that position.***" (Case #02)**

5.2.2 Theme 2: Human and Physical resource

Subtheme 1: Human resource factors

Based on the interview of hospital staff the study found that the number of staff is inadequate per case flow, even if there is training and educational opportunities they felt inadequate. Low motivation and satisfaction due to the numbers of case, less recognition/support from managements of the hospital and payments are not satisfactory.

"There are occasional opportunities for education and training. They give it to one midwife a year, and without that... There is also occasional training on basic procedures like abortion, BEMONC and F/P." ***(KII)***

"As our hospital, I believe that the number of patients and of care provider is below the required ratio to provide standard and satisfactory services" ***(KII)***

"We deliver over four hundred deliveries a month, but the budget and staffing are the same with other general hospitals with monthly report of less than two hundred." ***(KII)***

"Professional satisfaction is at a low level, related to caseload, which means that even one case in the maternity ward can make you very busy. Moreover, the salary we paid is not a satisfactory in addition to the current situation of market inflation." ***(KII)***

"Every employee wants to leave here, if they get an opportunity. No one likes and does the job over here including me. I wish I could go to the health center. Because I need some rest" ***(KII)***

During interview of mother's, one women has said the same idea with above quotation

"I think the staff were not comforted while they do this job. So far, the woman who was giving birth to me, was talking to herself looking at my blood, 'icc why if God hadn't made me a doctor'." ***(Participant #10, IDI, 26 years)***

"… Otherwise, there is nothing like rewards and promotions for whom performed well in his job" ***(KII)***

The reports from one facility shows there is recognition, but there is no consistency. The other is issue of payments; which is not satisfactory and timely paid.

"There is recognition, thanksgiving, etc. although not continuously… a recognition of each other as best performer at the end of the year." ***(KII)***

"Almost salary is regularly paid on monthly basis, even if it's not that much satisfactory. But, night duty is not paid on time. As health professional, what we got is just to survive, not enough to save, so we need to be paid on time." ***(KII)***

Subtheme 2: Infrastructure status

From the finding of interview and observation most of infrastructure issues such as lack of adequate room and space for laboring mother, cleanliness and availability of toilets and shower

service, electricity and water availability, cleanliness of the room were barriers to the provision of quality childbirth service.

During observation there is over crowdedness and unpleasant smell in the room, which makes the room vulnerable to be odor and inadequate space as field notes taken by observer;-

"The maternity unit in facilities had a common ward for prenatal, as well as postnatal women. Post-natal room is not in a short distance from the delivery ward. The room is well ventilated by window but it is not regularly cleaned, and have unpleasant smell."

The most challenging problem to provide quality care provision is interrupted availability of water and power supply, water is not connected to toilet and shower room, which even care provider is challenged by; as evidenced below

"The main problem is that, we don't get water as we need…in our facility sometimes at night electricity would be cutoff, there is generator but the technicians working from the generator will not give you an immediate response when you ask." ***(KII)***

"There must be toilet in each room as of guideline, but in our setup, they(clients) leave their room and go to the distant place to urinate. There is no functional shower house connected to the water." ***(KII)***

Subtheme 3: Equipment, supply and medicines

This study identified unmatched numbers of equipment's and supply to the number of clients admitted for service through interviewing care providers. There was partial availability of drugs; mainly emergency drugs.

"The amount of beds we have and the number of deliveries are not the same, as a delivery ward we have 17 beds, including postnatal, high-risk and labour room. But there are times when we give birth to twenty people in one night." ***(KII)***

"We have never run out of emergency medicines like oxytocin and magnesium sulfate, but gloves, NS, some antibiotics and syringes are rarely available… there is 7 complete delivery

sets, as well as vacuums, other materials are also available and functional but it's too less when we compare it to the number of cases." ***(KII)***

Subtheme 4: Referrals system

One of the hospitals are referral level and the other one is general hospital. The facility has liaison office and assigned personnel. There is also functioning telephone for communication. However, the health facility from where mother is referred make poor communication with the referral unit.

"This is something that challenges us a lot. We have assigned one midwife to the liaison room for referral linkage. However, while they send clients from the health center, no one will call and inform us; they simply refer and leave her here. And if there is a bed problem, OR is occupied and we have shortage of blood, while we call to the kuyyara (referral) hospital to send the client; they didn't accept us." ***(KII)***

5.2.3 Theme 3: Mother's perspective of childbirth service quality

From the analysis of in-depth interview held with mothers on childbirth service quality, this theme with four broad subthemes were emerged. Namely; staff related, infrastructure and medicine and supply impression, technical aspects of care, interpersonal care, and dignified and respectful care.

Subtheme 1: staff related

Some of the participants had highlighted the students were incompetent to give service, and they were not happy on service given by students.

"…There are too many students; they don't have a satisfactory answers and understanding of what you ask" ***(Participant #01, IDI, 22 years)***

(…In addition, they all (students) want to touch your body (vaginal examination) seeing from one another." ***(Participant #04, IDI, 24 years)***

Some other women explained that, there is inadequate number of staff available at facility during the nighttime.

"I came here yesterday night at 6:00 hrs. When I arrived there is many other women on labour, but only one care provider, I don't know if it was because of holiday. Didn't think he only is adequate to give a care for all." ***(Participant #10, IDI, 26 years)***

Most of care recipient women stated that if the care provider has good attitude and skills to serve, their sex is not a matter for them.

"I've got service by both of them, they assisted me in good manner, I'm not worried about their sex if I got a good approach and service…" ***(Participant #05, IDI, 30 years)***

However, some of the clients think men's are better, they think they (men's) try to understand and cooperate with them.

"… The women (laboring) behind my bed said to me 'you are lucky you met a man, during the night time some women played to us and made us crying, those men's are better'." ***(Participant #05 IDI, 30 years)***

Subtheme 2: Infrastructure, supply and medicine impression

Women's reported that there is no access of toilet and shower in the room; if available, they were not functional. Many of the mothers use pad in the room, it gives unpleasant odor for the class and it is discomforting to stay in.

"There is area for shower and a toilet but there is no water. I don't know if water is not available as a whole town…" ***(Participant #09, IDI, 30 years)***

"… There is no toilet in this room; it is very difficult to get out in the sun in the early days of birth… so we use 'popo', some of the women's leave under the bed, and it gives unpleasant odor" ***(Participant #11, IDI, 25 years)***

All participants reported unavailability of blankets and sheets. Most of them accessed drugs and other supply in the facility for free, few of the ordered supply is unavailable in the inside the facility.

"…but there is no blankets and sheets over bed, we bring ours from the house. But for someone who doesn't have extra blankets and sheets; I don't know what they do." ***(Participant #07, IDI, 23 years)***

"I would not say there was a shortage of equipment and medicines. My husband told me as we got many of ordered drug inside facility, and a few was brought outside the facility" ***(Participant #09, IDI, 30 years)***

"…Related to medicine, not much prescribed for me, but we got inside facility the amount prescribed for free." ***(Participant #06, IDI, 34 years)***

Most of the women feel discomforted by cleanliness of delivery room and couch. Care providers make them to sleep on couch with blood and stool, and they have limited option to refuse care.

"Their service conditions are good, but a little bit the cleanliness of their room is very uncomfortable, they make you lie on bed with blood, and also the smell of the room is not pleasant" ***(Participant #01, IDI, 22 years)***

"…the problem was the cleanliness of the coach and bed, there is blood, and some other thing on the coach, while you go over there to give birth. i didn't say no because Im in restless labour pain" ***(Participant #05, IDI, 30 years)***

Subtheme 3: Technical aspects of care

Most interviewed mothers frequently mentioned that the staff visited them only, when they call them or during delivery. Even some of them complained as they gave birth on the bed without any of care providers assistant.

"They do not follow much during labor; I called them myself and made them look at me…" **(Participant #06, IDI, 34 years)**

"They did not be there with you, they talk to each other in their room, I got angry and asked them to call my mother … but Finally, I gave birth on the bed at labour ward by myself." **(Participant #10, IDI, 26 years)**

The other problem during clinical care was refusal or delayed to give care for clients. Which some of mothers were disappointed at, they were asked for card if they don't have follow up at the facility they were not allowed to get care, and some of care provider was not permitted to give appropriate support and attention to them in proper time and way.

"I came here last night after health center workers told me to go .... When I was to enter here almost the baby was about to come out, he asked 'where is your card?', … They repeatedly told me to go and give birth right there at our health center." ***(participant #08, IDI, 26 years)***

"…when we called and tell her, that labour was going hard for me, she said 'we were eating something', I even finished the labor on labour room bed. Then finally, thank God, I gave birth peacefully." ***(Participant #10, IDI, 26 years)***

"I don't know whether it's lack of understanding or lack of knowledge, while they support us, they don't pay attention to people, it seems not a matter to them. They only focus on the way to deliver baby as soon as possible." ***(Participant #01, IDI, 22 years)***

The other finding of the study under technical care provided for mother was, painful procedure and unable to provide necessary support while care provider assist during delivery of the baby. The statement of the mother is highlighted as follows:-

"…when he was about to stitch the tear, he stitched me without any pain killer… when I said please give me something relieve the pain, he said 'we wouldn't give it to this little thing'." ***(Participant #02, IDI, 24 years)***

"One of her assistant tried to push the baby down from the top of my abdomen using her arm, which is so painful; finally, I refused, saying, 'you hurting me leave me alone'." ***(Participant #12, IDI, 32 years)***

"…again when the baby comes out I heard that little support will be given around the private area, but he did nothing to me, and later on when I asked him if there is a tear on my body, he said it was your baby not me" ***(Participant #02, IDI, 24 years)***

Mothers referred immediate post-natal visit by midwives as, they saw staff while they came to send them home after they (clients) were transferred to the postnatal ward. They call and tell them (staff) if any postpartum complication happens. Otherwise, no one look their status and make a repeated check of vital sign.

(…they (care provider) make very poor follow-up for people, and no one comes to check on you unless your family call them for you. For example they brought me here after I gave birth and no one came to check my status." ***(Participant #09, IDI, 30 years)***

"After delivery they bring the baby to you, they tell you to give a breast, and then no one turns to look at you" ***(Participant #02, IDI, 24 years)***

"…While I am in postnatal room, they bring one women after she gave birth, they left her here in the bed and no staff came back afterward. Later on she look tired and complained that she was bleeding, family called the staff … afterwards many doctors came in, blood was given and she survived." ***(Participant #01, IDI, 22 years)***

Subtheme 4: Social support

Even though family accompany is one of evidence-based care to improve quality of labour and delivery service, some of the mothers mentioned that care provider did not permitted family members to be with them or not allowed to constantly stay with them. Most of research participants explained as follows:-

"The attitude of some professionals is not that much good, they don't let family come to you unless they told them to bring something …" ***(Participant #03, IDI, 28 years)***

"During labour they make my family to come inside at the time I need them otherwise they make them stay outside…" ***(Participant #06, IDI, 34 years)***

Some of the mothers stated that one person is allowed during labour time; however, they make them outside while they took her to the second stage unit for delivery of the baby.

"… They allowed one person (mother) from my family to come in and stay with me. When it is time to give birth, they made her go and wait outside." ***(Participant #04, IDI, 24 years)***

Subtheme 5: Interpersonal relationship

Effective communication with compassionate care and emotional support create good childbirth experience for mothers. Difficulty of communication due to language barrier with care providers and clients, angriness and poor information exchange were the main finding of the study. In-depth interview participant expressed their way of communication with care provider and how they (care provider) were compassionate while they provide service as follows:-

"…he ask her why didn't you tell me that. They do not understand each other, she speak afaan Oromo, and he speak Amharic." ***(Participant #07, IDI, 23 years)***

"…They came and looked at me with something like a hearing aid on my abdomen and left, but they did not even tell me anything about that" ***(Participant #06, IDI, 34 years)***

"The angriness of the health professionals is a big problem. For example, when I was giving birth, we were upset. Their facial expression and way of asking to do something had no any politeness" ***(Participant #01, IDI, 22 years)***

Clients report that emotional support gives strength during labour pain and any painful procedures. However there is variation among care provider, some continually support and encourage and others not.

"…if they gave something to forget the pain. If not, I think it would be nice to tell people to be patient and stay strong." ***(Participant #04, IDI, 24 years)***

"The one who was with me was good, and encouraging me throughout labour. Even if they didn't talk to me much, I didn't see any negative interaction between us" ***(Participant #05, IDI, 30 years)***

"As myself, I like it, and they tell me clearly for what I ask. They kept saying 'few minutes left you be strong'." (Participant #07, IDI, 23 years)

Subtheme 6: Abusive and disrespectful care

Some women related midwives manner of communication and practice as undignified and disrespectful care. They were bothered when care provided yelled, insulted (even their family) and made them not to scream during labour and delivery service.

"...one of them were nice and encouraging, but the one who was giving birth were upset and insulting, saying "jazbaa", while I was tried to do my best." ***(Participant #02, IDI, 24 years)***

"... While I ask him to make it easy for me, he said 'yours is different'. It will be comforting to keep your mind and serve you during the delivery... And to the women who was lying next to my bed, they held her mouth shut so she wouldn't scream." ***(Participant #11, IDI, 25 years)***

"I wish he had insulted me alone, rather than insulting them (her mother's), they are elderly people" ***(Participant #02, IDI, 24 years)***

Some women recalled as midwives made some harm on their body during second stage of childbirth by doing painful procedure and make the clients not to move during delivery by hitting on the thigh or using different other materials.

"...he stuck something like a scissors in my thigh, and I said to him please take it off the one you stuck in my leg, it hurts more than labor, but he refused to listen to me." ***(Participant #02, IDI, 24 years)***

"The main problem I had seen was, while they stich the tear. There is a tear during childbirth, which hurt a lot when I was about to be stitched, and they hit me if I moved a little" ***(Participant #04, IDI, 24 years)***

The other is issue of equity of service provided by midwives among clients. Participants perceived that knowing some staff, being from urban and being well-dressed make them specially treated.

"... Even if you had a guard you knew, they would treat you differently, not only this but also they do not treat someone from the rural and the city equally. I called my husband's friend

and came with him and he was an employee here, so they treated me well" ***(Participant #01, IDI, 22 years)***

"They look at the dress, especially people coming from the rural areas was not equally treated with that of well-dressed and urban residents" ***(Participant #07, IDI, 23 years)***

Patients feel discomforted by midwives poor practice of maintaining privacy. Especially during vaginal examination due to number of students, no screen is used, and sometimes even door was left open.

"You didn't let someone to look at your body parts, if you are not in a problem. She examined (vaginal examination) while other people were still with me and without any separating screen between beds, and she just opened the door and left." ***(Participant #03, IDI, 28 years)***

"In relation to maintaining privacy … no privacy screen, even the door will not be closed, and anyone who suddenly enter can look at your private parts" ***(Participant #04, IDI, 24 years)***

"…there are many students, I did feel discomfort while there is many people surrounds me and look at my private part." ***(Participant #08, IDI, 26 years)***

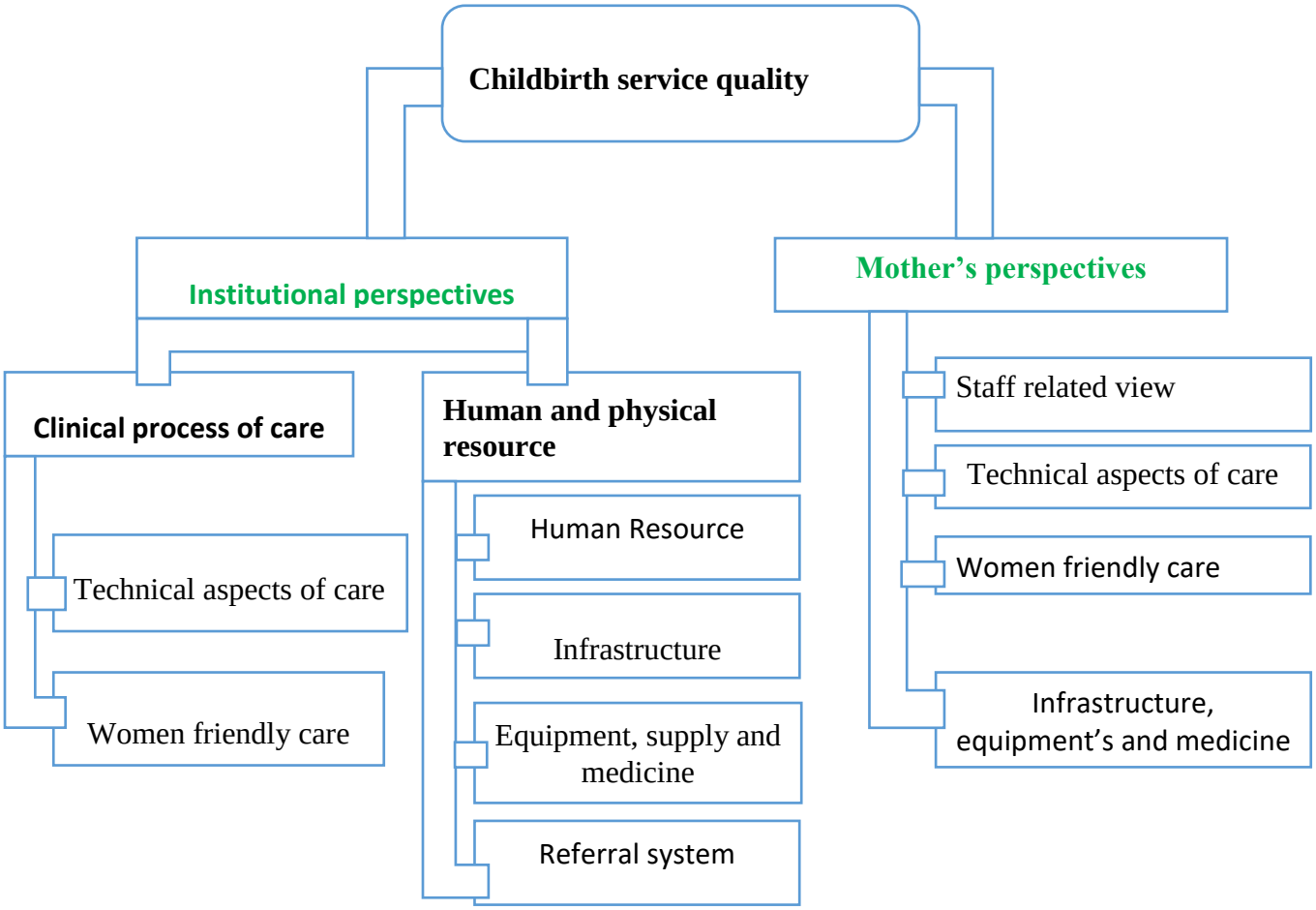

Figure 2: Diagrammatic presentation of the study finding on childbirth service quality at Shashemene town.

6. DISCUSSION

This qualitative study tried to assess quality of childbirth service provided at public hospitals of Shashemene town. It aimed to provide full picture of childbirth service quality from both service users and providers based on hulton and colleagues conceptual framework. In general, the finding of the data was summarized in to three broad themes: First one, 'quality of human and physical resource', which emphasizes on quality of enabling environment to provide quality care. Secondly, 'quality in process of clinical care', which emphasizes on quality of care provided by health personnel during childbirth as of national/international guideline. Thirdly, 'quality of care experienced by users', summarize childbirth service quality from mothers perspective.

The availability of sufficient and qualified human resources, as well as the required equipment, supplies, and infrastructure, is necessary for the provision of quality delivery services. The physical environment of a health facility must be suitable, with sufficient access to energy, water, sanitation, and medications for routine maternal and newborn care as well as for the management of problems, in accordance with WHO guidelines of quality care (72).

In this study many critical gap area to provide quality childbirth service were identified through observation and interview. According to the finding, there was inadequate number of staff per case flow especially during the nighttime that leads to increased workload and some participants complained on incompetent service provided by student. Moreover, there was poor satisfaction and motivation of staff related to case overload and unsatisfactory payments. The unproportioned ratio of a laboring mother with healthcare professionals contribute to provision of poor-quality delivery care service for the mother. In line with this finding, the study done in Ethiopia, Tanzania and Uganda shows the number of healthcare professionals is not proportional to caseload, increased workloads, inadequacy of capacity building mechanism and low salary bring lack of motivation and satisfaction to the healthcare professional on their job (38, 45, 46).

HSTP targeted 100% availability of essential drugs, supplies and equipment's, for health facilities (73). However, in this study finding almost all emergency and basic drug were available for free, a few supply and drugs like personal protective equipment, normal saline, syringes were rarely available. According to study done in different parts of Ethiopia shortages of essential drug, and equipment and supply were challenging to provide quality care. (40-42)

Concerning to infrastructure status, electric power is available with backup generator, but inadequate and uncleaned room and bed, interrupted availability of water, easily inaccessible toilet and shower, with bad unpleasant odor were the major finding suggested as a concern by both care providers and mother's. Similar finding were reported in study done at North West of Ethiopia and Ghana that inadequacy and uncleaned infrastructural environment, and bad odor in the labor wards were some of informants described as they experienced (27, 30).

The hospitals serves at referral and general level. Even if Ambulance and telephone were available for referral case with assigned liaison officer at each hospitals, poor communication made from low-level facility before referring the case were compromised the care given to mothers. Similar to this finding the study done in Addis Ababa reported lack of dedicated phone lines hampered pre-referral communication (35).

According to WHO recommendations, every mother and child should get regular, evidence-based care for problems during labor, delivery, and the early postnatal period (72). In this study, physical examination is limited to vaginal examination and vital sign measurement during admission. Vital sign measurement include BP, PR and FHB. RR and T^{oc} were not measured but recorded on the history sheet. This data supported the finding of different study that describe, providers were not performed fetal heart rate monitoring, blood pressure, temperature and pulse rate uniformly, and temperature and respiratory rate is rarely measured(16, 47).

In the study, most of mothers repeatedly reported as they were unsatisfied with follow up of labour progress, maternal and fetal condition made by attendants and it was the most repeatedly observed gap during clinical care assessment. Attendants were available around them if they call or complained of increased labour pain and contraction and the assessments were limited to conducting vaginal examination. Partograph aids in the early detection of fetal and maternal

complications and helps birth attendants diagnose and manage prolonged and obstructed labor (71). As finding of this study partograph sheet is available at both facility but incomplete and retrospectively filled, and not used for the management purpose. In line with this finding, different studies conducted in different regions of Ethiopia showed that partograph use is not yet practiced properly and some of them had utilized it incorrectly (16, 23, 57).

Most gaps were identified during second and third stage of labour related to standards of care provided. Inappropriate procedure like adding oxytocin to the running NS fluid to shorten 2nd stage of labour, undue fundal pressure, lack of perineal support during delivery of head, suturing tear without analgesia and routine exploration of uterus. The data support finding of the study done in India and five Sub-Saharan countries including Ethiopia that describe some of observed harmful treatments like: use of fundal pressure, routine episiotomy, and the lack of anesthesia for episiotomies or suturing of tears, administered uterotonic drug prior to delivery (51, 52).

In most of cases, immediate postpartum and neonatal care is not provided as standard, which include, immediate skin-to-skin contact, examining of completeness of placenta and membrane. All postpartum women should receive a routine assessment for vaginal bleeding, uterine tone, and vital signs during the first 24 hours, according to the WHO postnatal guidelines. According to this study, postnatal visit relies on the mothers/ family call or during discharge of clients. Women's were allowed to stay at facility for 6 – 10 hours depending on the time of delivery, if no complication is identified. During mothers stay taking vital sign, antibiotics administration and assessing uterus status were not performed regularly. In line with this finding different study shows immediate postpartum care and neonatal care was not provided according to the standards (39, 52-54).

The likelihood of infection to healthcare providers, patients, and the public is quite high when basic infection prevention methods are not followed, which also results in poor service quality (71, 73). Partial use of personal protective equipment, poor handwashing practice before procedure, poor disposal of used gloves and other materials contaminated by blood and other fluids were the main finding of this study related to infection prevention practice of health care provider's. Which is similar to a research done in India that found that healthcare professionals

failed to wash their hands before putting sterile gloves, their equipment weren't sterilized, and they disposed of sharps improperly (52).

According to WHO guidelines every women has a right to access highest attainable health, which include the right to access dignified and respectful care. Some of the care provided by midwives at public health facility were in the manner of unfriendly service. According to different study, perceived quality of care by women's were the main reason to decide a place to give birth due to maltreatment (25, 74, 75).

Effective communication between the care providers and women's is important for the betterment of client satisfaction and feel confident by the service being provided. Some women in this study described their experience of communication; as language was a barrier to understanding each other, communication way of staff is rude, forwarding offensive words such as shouting. In line with this, as the study done in Nigeria and Malawi stated women's were challenged to communicate with provider due to language barriers, and nurses were rude in their communication they "shout," and "talk badly" (63, 64, 76).

Federal ministry of health tried to implement intervention on disrespectful care through CRC initiatives and improving quality of maternity care(73). In this study, some verbal and physical abuse were encountered during labour and delivery care in the form of insulting mothers and their family, harshly push or hit women on the thigh during delivery. It is the right of childbearing women to access care safely and free of threatening, which increase utilization of maternity care service at facility. The data support the finding that suggest over one-fifth of mothers were encountered physical and verbal abuse in the form of verbal insulting to even hitting or pinching during labor and delivery in health facilities (49, 50, 77)

The other finding that clients discomforted with during labour and delivery service were physical privacy. Women's were not comforted to expose their private areas to over crowded number of the student, In addition to, rare use of interpatient screen. In line with this finding lack of privacy is the main concern in study done in two districts of Hadiya zone (48).

Provision of continues support during labour was crucial women-centered care with better maternal and neonatal health outcome(78). However, in this study, staffs were rarely

encouraged and supported women's psychologically and in most cases, one person (women) was allowed during labour, but at second stage of labour mothers were separated from the companion. This finding was congruent with study conducted in Kenya among the most cause of mothers dissatisfaction with care provided was not allowing birth companions in the facilities (58).

Attention and priority based on social attachment, demographic area and economic difference were some of the discrimination made by care providers in providing care between population groups as finding of this study. It's in consistent with the findings from a study done previously in eastern Ethiopia and Guinea that indicates some healthcare providers discriminate against patients due to social status and place of residence(65, 66)

Implication

The finding from the assessment of human and physical resource quality indicates that mainly there is a need to review the number, motivation and satisfaction of health care professional engaged on childbirth service to decrease workload and create conducive environment for care providers. In addition, the facility needs to work on adequate availability of water, bed and cleanliness of each room especially including delivery couch to relive discomfort of women and care provider in labour and delivery environment. The other is poor communication made with low level facility challenged referral system and delayed women's access of care, and each facility needs to improve their way of communication with other facility.

There should a need be improve the skills of care provider to implement updated practical guideline in provision of technical aspects of care. The other was midwives need to update themselves with partograph use and appropriate management of 2nd and 3rd stage of labour including postnatal follow-up and counseling.

Despite ministry of health tried to integrate practical care with compassionate and respectful care in every service providing facility through policy and training. There is still a need for practical application of respectful maternity care by using different mechanism like training or supportive supervision on a noted verbal and physical abuse, communication and privacy related issue and discrimination among women during labour and delivery service.

7. STRENGTH AND LIMITATION

Strength

The study findings were meaningful to describe about quality of childbirth service provided in public hospitals. Since the qualitative approach was used, it was better to explore in-depth understanding of the quality of care provided.

The study used multiple methods of data collection, which helps in triangulation of data. In addition, broader areas of quality of care were used which helps to view the service provided from different perspectives.

Limitation

The view expressed are that of participants, not necessarily reflect the view of every women who accessed childbirth service at facility, and generalizability of the results is limited to similar situations and cultures. Interview data collection were limited to mothers with vaginal delivery and study failed to include complicated labour and delivery.

During observation, staff action may have been influenced by presence of observers, in order to minimize this bias, a day spent to familiarizing to the setting and interacting with staff before conducting the observation. The other one is observer bias during data collection and interpretation. In order to minimize this, unstructured guide from standardized checklist used to record data. However, acknowledged that this potential bias may remain.

8. CONCLUSION AND RECOMMENDATION

8.1 Conclusion

This study presented finding from different perspectives including mothers, healthcare managers and observation of facility care provision to explore childbirth service quality at public hospitals. The study assessed childbirth service quality from three components of care. The human and physical resource were inadequate to provide quality care. As explained by inadequate number of staff, poor motivation and satisfaction, shortage of room and beds, easily unavailability of water and toilet, and uncleaned room. In most of cases, the technical process of care provided was not up to standard of national and international guidelines. The identified gaps include poor follow up of labour progress by partograph, incomplete history and physical examination, preforming not recommended procedure, gaps during immediate postpartum and neonatal care provision, and failure to follow proper infection prevention practice. The third components were quality of nontechnical care that mainly focus on clients to care provider's relationship during care provision. The finding from most of participant includes rarely encouraged and supported, inadequate and rude way of communication, verbal and physical abuse, privacy and discrimination during care provision. Based on the finding the quality of hospital infrastructure and their human resource should be prioritized and followed by gaps in process of care in order to provide quality childbirth service. Since most of the finding from both perspectives (mothers and care provider) were based on quality of infrastructure and human resource.

8.2 Recommendations

Based on the identified gaps the following recommendation was forwarded to the concerned body.

For regional health bureau and hospital administrators

- Increased workload and unsuitable working environment were the main finding related to infrastructure issue. Hospital administration and other stakeholders should need to work on their financing system to retain and utilize their revenue on priority problems.

Like shortage of staffs, inadequate room and bed, easily inaccessibility of water and toilet, and cleanliness of the room.

- Focus on the way pre or in-service training for care provider on respectful and compassionate care to all childbirth service providers will be addressed with supporting non-governmental organization.
- Facilitate educational and training opportunity, appreciating and recognizing staff with 'best practice' to maintain quality of care within available resources.
- Supportive supervision should be undertaken to ensure adherence to clinical care protocols and quality standard.

For further research

- The study only reflected on quality of service during spontaneous vaginal delivery, so further large-scale research is necessary including emergency management of complicated delivery and CS.

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8. ANNEXES

Annex 1: Participant informed consent and interview guide (English version)

Information sheet

Read the statements to mothers

Introduction

Hello, my name is_____ I am studying master's degree in maternity and reproductive health nursing at Addis Ababa University College of health sciences. I am interested in exploring quality of institutional childbirth service in shashemane town. This interview is designed for academic purposes, which will be approved, by Addis Ababa University, College of health sciences, School of Nursing and Midwifery, in partial fulfillment of master's degree in maternity and reproductive health nursing.

Purpose of the Research Project: This study is one part of evaluating quality childbirth service in Shashemane town. The main aim of this particular tool is to explore mother's experience of quality childbirth service.

Procedure: The interview will take estimated time of 30-40 minutes. I will do the interview and take some notes; my research assistant will record this interview because, I do not want to miss any of your important responses. In order to collect our data, we invite you to take part in our project. If you are willing, you need to understand and sign the consent form.

Benefits, Risk, and /or Discomfort: By participating in this research project, you may feel some discomfort especially on sacrificing your time otherwise no risk in participating in this study. If you are participating in this research project, the output of the study will have both direct and indirect benefit to you, as you and your families will use the services in the future. You will not be provided any incentives or payment to take part in this study.

Confidentiality: The information collected from this research project will kept confidential and information about you that will be collected by this study will be stored in a file, without your

name, but a code number assigned to it. In addition, it will not be revealed to anyone except the principal investigator and will be kept locked with key.

Right to Refusal or Withdraw: You have the full right to refuse from participating in this research and you can interrupt at any time.

With due understanding of the aforementioned information, are you willing to participate in the study?

1. Yes --------continue 2. No -------End

Informed consent

I, the undersigned, have been informed that this study is going to be conducted to explore quality of childbirth service in shashemane town. I am informed that the information I give will be kept confidential, and only used for this study. I am also conscious that I have the right not to respond to any question without my interest. Hence, I agree to participate in the research voluntarily.

Signature_____ Date_____

Person to contact: If you want to know more information you can contact; **Roba Gemechu**
Mobile number: +251-09-27-33-37-73, E-mail robertgemechu@gmail.com

Part II: Interview guide questions

Demographic intake sheet

Facility Code-------- Participant Code ----------

Age_____ Education_____ Occupation-------

Gravida_____ Number of parity_____ No of Children_____

Marital status_____ Admission date_____ Mode of delivery_____

Total Hospital stay_____ (in Hrs.)

1- How you explain about the overall labour and delivery service in this facility? Probe: about (welcoming, triage system, material and drug supply, adequacy and skills of staff)

2- How did health workers/staffs treat the mothers/women?

Probe (in terms of privacy, respect, equity, emotional support)

3-How was the attitude of staff/care providers for the mothers/women and their companion? (Respect, kindness, communication / support)

4- Have you observed any problems, while you gave a birth in this facility? If yes would you explain_____ (Attentively follow them, without interruption)

5-What are your recommendations for improving quality of delivery care?

Probe (preference; service provider skills and attitude, culture and trends in the community during labour and delivery, infrastructure and equipment's, referral system etc.)

6- Finally if there is something to add?

Thank you for your time and idea

Annex 2: Participant informed consent and interview guide (Afaan Oromo version)

Ibsa waayee qorannoo kanaa

Akkam jirtu, maqaan koo_____ jedhama ani barataata digrii lammaffaa Yuunivarsiitii finfinnee Kolleejjii saayinsii fayyaatii. qulqullina tajaajila da'umsaa dhaabbilee fayyaa magaalaa shashemanee qorachuuf fedhii waan qabuufin as dhufe. Af-gaaffiin kun kaayyoo barnootaaf kan qophaa'e yoo ta'u, kunis, Yuunivarsiitii finfinnee, Kolleejjii saayinsii fayyaa, kutaa baruumsaa narsii fi miidwaayifariitin, ni mirkanaawa.

Kaayyoo qorannichaa: Qorannoon kun tajaajila da'umsaa qulqullina magaalaan Shaashamannee qabu madaaluuf qaama qorannoo keessaa isa tokko. Kaayyoon kutaa qorannoo kanaa inni guddaan muuxannoo haadholii tajaajila da'umsaa qulqullina qabu irratti qaban qorachuudha. odeeffannoo kana akka nuuf kennitaniif qorannoo kana irratti akka hirmaattan kabajaan isin afeerra. Yoo fedhii qabaattan unka hayyamaa hubattanii akka mallatteessitan isin gaafanna. qorannoo kana irratti hirmaachuu keessaniin yeroo keessan aarsaa gochuu irratti alatti miidhaan biro isinnirratti dhaqqabu hin jiru. Yoo pirojektii qorannoo kana irratti hirmaachaa jirtan ta'e, bu'aan qorannichaa kallattiinis ta'e al-kallattiin faayidaa isiniif qabaata, sababiin isaas isinis ta'e maatiin keessan gara fuulduraatti tajaajila kana ni fayyadamtu. Qo'annoo kana irratti hirmaachuuf kaffaltiin kamiyyuu isiniif laatamu hin jiru. Odeeffannoon pirojektii qorannoo kana irraa walitti qabame iccitii ta'ee kan eegamu ta'a, odeeffannoon waa'ee keessan qorannoo kanaan walitti qabamu faayila keessatti kan kuufamu, maqaa kee malee, lakkoofsa koodii itti ramadameti. Kana malees qorataa muummee malee nama biraatiif kan hin mul'anne yoo, furtuudhaan cufamee kan turu ta'a. Qorannoo kana irratti hirmaachuu diduu mirga guutuu waan qabduuf yeroo barbaaddetti addaan kutuu dandeessa.

Nama qunnamuu dandeessan: maqaa ; Roobaa Gammachuu

Lakkoofsa bilbila: +251-09-27-33-37-73,

Imeelii: robertgemechu@gmail.com

Odeeffannoo armaan olitti ibsame kana hubannoo sirrii ta'een, fedhii qorannicha irratti hirmaachuu qabduu?

1. Eeyyee --------itti fufa 2. Lakki -------Dhaabi

Qorataa: Maqaa _____ Mallattoo _____guyyaa_____

Suppervaayizara: Maqaa _____ Mallattoo _____guyyaa _____ .

Ani kan armaan gaditti mallatteesse qorannoon kun qulqullina tajaajila da'umsaa magaalaa shashemanee qorachuuf akka ta'e beeksifameera. Odeeffannoon ani kennu iccitii akka ta'u, fi qorannoo kanaaf qofa akka oolu naaf himameera. Gaaffii kamiifuu fedhii koo malee deebii akkan hin kennine mirga akkan qabus beeka. Kanarraa ka'uun qorannoo kana irratti fedhii kootiin akkan hirmaadhuuf walii gala.

Mallattoo_____ Guyyaa_____ .

In-depth interview guides (Afaan Oromo version)

Koodii hospitaalaa--------- Koodii hirmaataa---------- .

Umurii_____ Sadarkaa barnoota_____ Hojii------- .

Hamma ulfaa_____ Hamma da'uumsaa_____ baayyina Ijoollee_____ .

Haala gaa'elaa_____ Guyyaa seensaa_____ haala da'umsaa_____

Turtii Hospitaala Waliigalaan_____ (Sa'aatiidhaan).

1- Waa’ee tajaajila da’umsaa dhaabbata kana keessatti kennamu ibsuu dandeessu? waa’ee (simannaa, sirna adda baasuu, dhiyeessii meeshaa fi qoricha, gahaa ta’uu fi dandeettii hojjettootaa) .

2-Hojjetoonni fayyaa dhukkubsataa/Maamila akkamiin keesummessan? (eegumsa iccitii dhuunfaa, kabaja, walqixxummaa, deeggarsa miiraatiin) .

3-Ilaalchi hojjettoonni maamiltootaa fi maatii keessaniif qaban akkam ture? (Kabaja, gaarummaa, qunnamtii / deeggarsa)

4-Qulqullinaan wal qabatee yeroo dhaabbata kana keessatti tajaaijlli da'umsa isiniif laatamu rakkoowwan dhaabbaticha keessatti argitan maali? (Xiyyeeffannoodhaan isaan hordofaa, osoo addaan hin kutin)

5-Qulqullina tajaajila da'umsaa fooyyessuuf yaadonni keessan maali? (filannoo; dandeettii fi ilaalcha tajaajila kennitoota, aadaa fi bartee hawaasa keessatti yeroo da’umsaa, bu’uuraalee misoomaa fi meeshaalee, sirna rifaralaa fi kkf)

6- xumura irratti wanti dabaltan yoo jiraate?

Yeroof yaada nuuf lattaniif galatoomaa

Annex 3: Participant informed consent and interview guide (Amharic version)

በጥናቱ ለሚሳተፉ የስምምነት ዉል እና አጠቃላይ መረጃ

መግቢያ

ሰላምታ, ስሜ ----------እባላለሁ ይህ ከአዲስ አበባ ዩኒቨርስቲ ሚድዋይፈሪ ትምህርት ክፍል ጋር በመተባበር በሻሸመነ ከተማ የመንግስት ሆስፒታሎች ላይ የወሊድ አገልግሎት ጥራት ዳሰሳ ላይ ለሚደረገው ጥናት መረጃ ለመስጠት ነው፡፡

የዚህ ጥናት አላማ፡ የወሊድ አገልግሎት ተጠቃሚዎች መረጃ ላይ ተንተርሶ የወሊድ አገልግሎት የጥራት ጉዳዮች ላይ ዳሰሳ ለማድረግ ነው፡፡ ይህ ጥናት የሚመለከተው አካል የአገልግሎት ጥራት ለማሻሻል ለሚያደርጉት ጥረት እንዲሁም ለውሳኔ ሰጪዎች ጥቅም ይኖረዋል፡፡ለዚህም በመጠይቅ ይሰበሰባል፡፡

የጥናቱ ሂደት: በዚህ ጥናት ውስጥ በሚሳተፉበት ወቅት ውድ ሰዓትዎን ከ 30- 40 ደቂቃ ሊያጠፉ ይችላሉ፤ ለዚህ ጥናት መሳካት ካለው ጥቅም አንጻር በትዕግስት ይሳተፉሉ ብለን እናምናለን፡፡

ጥቅማጥቅም፤ጉዳት እና/ወይም የማይመች ነገር: በዚህ ጥናት በመሳተፍዎ ሊደርስብዎት የሚችል ምንም አይነት ጉዳት የለም፡፡ በዚህ ጥናት የሚሳተፉ ሰዎች በቀጥታ የሚያገኙት ጥቅም አይኖርም፡፡ የጥናቱ ግኝት በተዘዋዋሪ የጨቅላ ሕጻናት እንክብካቤ ክፍልን የሚሰጠውን አገልግሎት ጥራት ያሻሽላል፡፡በጥናቱ ላይ መሳተፍ ምንም ጉዳት ወይም ስጋት አያስከትልም፡፡ ስለዚህ በዚህ ጥናት ላይ እንዲሳተፉ በትህትና እጠይቃለሁ፡፡ጥናቱን ጊዜ ወስደው መረዳት እና ለመሳተፍ ወይም ላለመሳተፍ መወሰን የራስዎ መብት ነው፡፡

ሚስጥራዊነት: የመረጃው ሚስጥራዊነት የሚጠበቅ ይሆናል፡፡ለዚህም የተጠያቂ ስም መጻፍ አያስፈልግም፡ ነገር ግን ለእሱ የተመደበው ኮድ ቁጥር ይኖረዋል። በተጨማሪም፣ ከዋናው መርማሪ በስተቀር ለማንም አይገለጽም እና በቁልፍ ተቆልፎ ይቆያል

የመቃወም ወይም የመተዉ መብት፡ አንዳንድ ጥያቄ መመለስ ካልፈለጉ የማይገደዱ ሲሆን መጠይቁን በፈለጉ ጊዜ ማቆም ይችላሉ ሆኖም የእርሶ ትብብርና ትክክለኛ መልስ ቢሰጡን ለጥናቱ ጠቃሚ ይሆናል፡፡ በታማኝነት እንድትመልሱ እጠይቃለሁ ምክንያቱም የእርሶዎ መልስ ለዚህ ጥናት አላማ መሠረት ነው፡፡ ይህንን መረጃ ለማዳመጥንላሳዩኝ ፍቃደኝነት ከልብ አመሰግናለሁ፡፡

የበለጠ መረጃ ከፈለጉ የጥናቱ ዋና ተጠሪ ሮባ ገመቹ

በዚህ አድራሻ ማግኘት ይችላሉ፡፡ ስልክ : +251-927-333773፣ ኢሜይል፣ robertgemechu@gmail.com

ከላይ የተገለጸውን መረጃ በመረዳት በጥናቱ ላይ ለመሳተፍ ፍቃደኛ ነዎት? አዎ ☐ ከሆነ ይቀጥሉ አይደለም☐ ከሆነ ያቁሙ

የጥናቱ ተሳታፊዎች ፍቃደኝነት ቅፅ

እኔ የጥናቱ ተሳታፊ የሆንኩኝ ይህ ጥናት በሻሸመ ከተማ በሚገኙ ሆስፒታሎች ዉሰጠጥ የወሊድ አገልግሎት ጥራት ለመዳሰስ የቀረበ ጥናት መሆኑን አውቂያለሁ፡፡ የምሰጠውም ግላዊ መረጃዬ በሚስጥራዊነት እንደሚጠበቅ እና ለዚህ ጥናት አላማ ብቻ እንደሚውል ተነግሮኛል፡፡ ጥናቱ ውስጥ ያለፍላጎት ተሳታፊ ሆኜ መቀጠል እንደለለብኝ እና መቀጠል ባልፈለግሁ ጊዜ ማቆም እንደምችል ተረድቻለሁ፡፡ በአጠቃላይ ከላይ የተዘረዘሩትን ሙብቶቼን በማወቅና የእኔ በዚህ ጥናት ላይ መሳተፍ ጥቅም አለው ብዬ በማመን በሙሉ ፍቃደኝነት ለመሳተፍ ተስማምቻለሁ፡፡

ፊርማ _____ ቀን_____

In-depth interview guides (Amharic version)

የሆስፒታሉ ኮድ ----- የተሳታፊ ኮድ ----------

ዕድሜ _____ ትምህርት_____ ሙያ ---

የ ኢርግዝና ብዛት _____ የወሊድ ቁጥር _____ የልጆች ብዛት_____

የጋብቻ ሁኔታ _____ የመግቢያ ቀን _____

ጠቅላላ የሆስፒታል ቆይታ _____ (በሰዓት)

1- በዚህ ጤና ተቐም ውስጥ ስላለው ኣጠቃላይ የወሊድ አገልግሎት ማብራራት ይችላሉ? ስለ (አቀባበል፣ የመለያ ሥርዓት፣ የቁሳቁስ እና የመድኃኒት አቅርቦት፣ የሰራተኞች ብቃት እና ችሎታ ወዘተ)

2-የጤናሰራተኞች ለታካሚ/ደንበኛውን ምሰጡት አገልግሎት ኢንደት ይገልጹታል? (ከግላዊነት፣ አክብሮት፣ ፍትሃዊነት፣ ከተለያዩ ድጋፍ አንፃር)

3-ሰራተኞች ለታካሚዎች እና በተሰቦቻቸው ያላቸው አመለካከት እንዴት ይገልጹታል? (አክብሮት, ደግነት, ግንኙነት / ድጋፍ)

4-በተቋሙ ውስጥ በመውለድዎ ወቅት ከጥራት ጋር በተያያዘ በተቋሙ ውስጥ የተመለከቷቸው ችግሮች ኣሉ? ካለ ልያብራሩልኝ ይችላሉ? (በትኩረት ተከታተላቸው፣ ያለማቋረጥ)

5- የወሊድ አገልግሎቱን ለማሻሻል ምን ምክሮች አሉዎት? (ፍላጎትዎ፣ የአገልግሎት አቅራቢዎች ችሎታ እና አመለካከት፣ ባህል እና በህብረተሰቡ ዉስጥ የወሊድ ጊዜ ያሉ ልምዶች ፣ መሠረተ ልማት እና መሳሪያዎች ፣ ሪፈራል ስርዓት ወዘተ.)

6- በመጨረሻም ምትጨምሩት ነገር ካለ? ለካፈሉን ግዜና ሐሳብ በጣም አመሰግናለዉ።

Annex 4: Participant informed consent and interview guide for KII (English version)

Information sheet

Hello, my name is_____ I am studying master's degree in maternity and reproductive health nursing at Addis Ababa University College of health sciences. I am interested in exploring quality of institutional childbirth service in shashemane town. This interview is designed for academic purposes, which will be approved, by Addis Ababa University, College of health sciences, School of nursing and midwifery, in partial fulfillment of master's degree in maternity and reproductive health nursing.

Purpose of the research project: This study is one part of evaluating quality childbirth service in Shashemane town. The main aim of this particular tool is to assess availability and quality of human and physical resource in your facility. In order to collect our data, we invite you to take part in our project. If you are willing, you need to understand and sign the consent form. By participating in this research project you may feel some discomfort especially on sacrifice of your time otherwise there is no risk or direct benefit in participating. You will not provided any incentives or payment to take part in this study. The information collected from this research project will kept confidential and information about you that will be collected by this study will be stored in a file, without your name, but a code number assigned to it. In addition, it will not be revealed to anyone except the principal investigator. You have the full right to refuse from participating in this research and you can interrupt at any time.

Person to contact: If you want to know more information you can contact; **Roba Gemechu Mobile number: +251-09-27-33-37-73, E-mail: robertgemechu@gmail.com**

With due understanding of the aforementioned information, are you willing to participate in the study?

1. Yes --------continue 2. No -------End

Interviewer: Name _____ Signature _____date_____

Informed consent

I, the undersigned, have been informed that this study is going to be conducted to explore quality of childbirth service in shashemane town. I am informed that the information I give will be kept confidential, and only used for this study. I am also conscious that I have the right not to respond to any question without my interest. Hence, I agree to participate in the research voluntarily.

Signature_____ Date_____

Interview guide for key informants

Heath Facility code: ____ Code: _____ Position: _____Work experience: _____

1- How you will explain skill mix in relation to patient flow at your facility? Area of probing (Number of qualified staffs, supervision, moral and satisfaction of staffs, staff training)

2- Can you explain about how Labour and delivery ward is equipped to adequately perform their functions according to internationally recognized good practice? Area of probing (status of beds, toilet, hand basins etc. per delivery, quantity of essential drugs, state of essential equipment, nature of sterilization procedures, diagnostic and therapeutic capabilities)

3- How was the state of general infrastructure of the facility to cope with demand and essential support service? (Electricity, water and transport. State of furniture, storage conditions)

4- Would you explain how staff is protected from risks associated with their works? (Practice on minimizing Exposure to body fluids, practice on sharp and waste disposal, hepatitis B vaccine, HIV testing and post exposure prophylaxis)

5- How the quality of human resource is maintained? Area of probe (reward and promotion, training opportunities, provision of study leave)

6- How was the structure of Facility management and their accountability? (Job description, salary payment, and staff and managers knowledge of responsibilities?

7- How was your facilities referral system? (Availability of transport, communication, staff and equipment)

8- Finally, any ideas you would like to add.

Thank you for your time and information

Annex 5: Interview guide for key informants (Afaan Oromo version)

Koodii hoospitaalaa_____ koodii hirmaataa_____

Gahee hojii_____ muxannoo hojii_____

1-Dhaabbata keessan keessatti baayyina yaalamaa fi keenniinsa tajaajila keessan akkamitti ibsitu? (Baay'ina hojjettoota gahumsa qaban, to'annoo, naamusaa fi itti quufinsa hojjettootaa, leenjii hojjettootaa).

2- Tajaajila da'umsaa akkaataa muuxannoo gaarii sadarkaa idil-addunyaatti beekamtii qabuun hojii keessan haala gahaa ta'een raawwachuuf, akkaataa meeshaalee keessani ibsuu dandeessu? (haala siree, mana fincaanii, bishaan harkaa, baay'ina qoricha barbaachisoo, haala meeshaalee barbaachisoo, maalummaa adeemsa sterilization, dandeettii qorannoo fi wal'aansaa).

3- Haalli bu'uuraalee misoomaa waliigalaa dhaabbatichaa fedhii fi tajaajila deeggarsa barbaachisaa ta'e akkamitti kenna jettani yaaddu? (Elektirikii, bishaanii fi geejjibaa. Haala meeshaalee manaa, haala kuusaa)

4- Hojjettoonni balaa hojii isaanii waliin walqabatee dhufu irraa akkamitti akka eegaman naaf ibsuu dandeessuu? (Dhangala'aa qaamaaf Saaxiluu xiqqeessuu irratti, meeshaalee qara qabanii fi balfa gatuu, talaallii hepatitis B, qorannoo HIV fi ittisa saaxilamummaa boodaa irratti)

5- Qulqullinni hojii hojjataa keessanii akkamitti eegama? (badhaasa fi guddina sadarkaa, carraa leenjii, kenniinsa boqonnaa, carraa barnootaa).

6- Caasaan bulchiinsa fi itti gaafatamummaa isaanii akkam ture? (Ibsa hojii, kaffaltii mindaa, fi hojjettoonni fi hoggantoonni itti gaafatamummaa beekuu?

7-Sirni rifaralaa dhaabbilee keessanii akkam ture? (Argamuu geejjibaa, qunnamtii, hojjettootaa fi meeshaalee)

8-dhuma irratti yaadni dabaluu barbaaddan yoo jiraate?

Yaadaaf yeroo nuuf laattaniif galatooma

Annex 6: Observation guide for assessment of provision of care

Date_____

Time_____

Name of observer_____

Part I: First stage of labour

1. How well routine assessment and evidence based care is given during admission and throughout first stage of labour.

   Preparation of mothers and necessary instrument

   _____

   History taking

   _____

   Physical examination

   _____

   Partograph follow up

   _____

Part II: Second stage of labour

Preparation of the mother and necessary equipment's

_____

Personal protective use

_____

How well labour is assisted.

Delivery of head and perineal support

_____

Delivery of shoulders and rest of the body

Part III: Observing AMTS of labour (how well intervene)

Oxytocin use

_____

delivery and examination of placenta

_____

Perineal and vaginal tear examination

_____

Post procedure tasks

_____

Part IV: Fourth stage of labour and documentation

Observing basic and immediate postpartum care for mother (how well intervene)

_____

Observing basic and immediate newborn care done

_____

General care

1. How was the interpersonal relationship between care provider and client?

   Communication with mothers and their family

   _____

   Respect and preservation of dignity

   _____

   Continual emotional support

   _____

   Privacy and free of discrimination

   _____

2. How the following not routinely performed procedure is done throughout provision of care, related to recommended practice.

   Episiotomy, Positioning, Manual revision of uterus, Oxytocin use, Vaginal examination, Pain relief method. If done?

   _____

   _____

   _____

   _____

   _____

   _____

   _____

3. How well Infection prevention practice is applied during service?

   Personal protective use

   _____

   _____

   Waste disposal and management

   _____

   _____

Part V: Infrastructure and equipment's

Explain how 1st stage, 2nd stage room is well suitable for labour and delivery and post-partum service? Physical environment, adequate water, sanitation and energy supplies

_____

_____

How was the availability of adequate and functional medical equipment's and drugs are?

_____

_____