ADDIS ABABA UNIVERSITY GRADUATE STUDIES SCHOOL OF PUBLIC HEALTH AND SCHOOL OF INFORMATION SCIENCE

HEALTH INFORMATICS PROGRAMME

ASSESSMENT OF CLIENT-HEALTH CARE PROVIDER COMMUNICATION AT ANTENATAL CARE CLINICS IN ADDIS ABABA, ETHIOPIA

By

WORKU TADESSE (Bsc)

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF SCIENCE IN HEALTH INFORMATICS.

June, 2012

ADDIS ABABA

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ADDIS ABABA UNIVERSITY GRADUATE STUDIES SCHOOL OF PUBLIC HEALTH AND INFORMATION SCIENCE DEPARTMENT HEALTH INFORMATICS JOINT PROGRAMME

Assessment of client-health care provider communication at antenatal care clinics in Addis Ababa, Ethiopia.

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ACRONYMS

AAU	Addis Ababa University
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
FANC	Focused Antenatal Care
HIV	Human Immunodeficiency Virus
MDG	Millennium Development Goal
PMTCT	Prevention of Maternal to Child transmission of HIV/AIDS
RH	Reproductive Health
UNICEF	United Nation International Children's Fund
WHO	World Health Organization

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ABSTRACT

Background Health care provider-client communication during Antenatal care is an effective strategy to improve maternal health care seeking behavior and satisfaction with health services. However, the presence of miscommunication, lack of communication, or unsatisfactory communication between health care providers and clients pose a significant challenge in the health care service utilization.

Objective The aim of this study was to assess the client-health care provider communication including client satisfaction in public hospitals at antenatal care clinics, in Addis Ababa, Ethiopia.

Method: A cross-sectional study design using both quantitative and qualitative methods was employed from October to June 2012. 425 consecutive clients of antenatal care took part in the study. Additionally, in-depth interview was conducted among 15 purposively selected antenatal clients, 17 conveniently selected health care providers using interview guides.

Results: The mean (SD) age of antenatal clients was 27.6±4.7 years; majority having secondary (33.4%) and tertiary education (34.4%); and Only 161(37.9%) antenatal clients were satisfied by health care providers' quality of communication. Getting care by one provider at different visits (AOR=0.55;95%CI:0.32,0.96), longer duration of time for discussion(AOR=0.29;95%CI:0.11,0.77), clients' feeling of privacy(AOR=0.47;95%CI:0.22,0.99),health care providers' empathy (AOR=0.41; 95%CI:0.22,0.77) and information provision (AOR=0.09; 95% CI: 0.05, 0.17) were significantly associated with better client satisfaction. Time constraint due to heavy clients' load (88.0%), multiple clinical task (71.0%), and lack of dedicated space for communication (58.8%) were the most common barriers of optimal communication reported by health care providers.

Conclusion and Recommendation: more than 3 out of 5 of antenatal clients were not satisfied by the providers' quality of communication. Insufficient discussion time, suboptimal health care providers' empathy and information provision, lack of feeling of privacy and lack of continuity of care by same health care providers were the main factors that contributed to the low antenatal client satisfaction on health care provider's quality of communication.

Better demonstration of empathy, information provision, longer discussion time, continuity of care with one provider and providing sufficient feeling of privacy should be encouraged to improve antenatal clients' satisfaction on health care providers' quality of communication. Attempt should be made to free health care providers at ANC from multiple clinical tasks with more attention given to ensuring dedicated space to improve optimal provider-client communication.

1. INTRODUCTION

1.1 Back ground

Antenatal care is a care that a woman receives during pregnancy which helps to ensure healthy outcomes for women and newborn. It includes planning for pregnancy and continues in to the early neonatal and postpartum period [1]. The antenatal care strategies is to empower women understanding the care they receive, as well as the antenatal care procedures used, enabling informed decision making of pregnant women particularly to prevent maternal to child transmission of HIV/AIDS.

The medical approach of the care in general is to identify and minimize risk factors that may influence maternal and fetal health [2]. To achieve these goals it is necessary for the professional to have good communication skills. From a medical perspective, good communication is associated with ability to elicit a history from a patient, in order to make diagnosis accurate and linked with patient satisfaction, adherence to medical recommendation and health outcome [3].

Health care provider- client communication is a dynamic two ways verbal and non verbal information exchange starting from diagnosis to treatment plan. The qualities of communication are necessary to ensure good-quality services are provided and service users are satisfied. It is through communication that trust and rapport are established between the provider and user of a service. Emotional support and the communication of concern and understanding by health staff are often as crucial in providing quality services as is clinical care. If there is a strong provider-user relationship established in this way, it becomes easier to move towards open dialogue on more sensitive aspects of reproductive health. [4, 5].

The health care provider client communication varying along the dimension of patient's autonomy and provider paternalism.

Physician-centered in this relationship provider will determine the best course of action for the patient to act in accordance with the providers' recommendations in which the autonomy of the client included under the physician's responsibility and the care provider underestimate client's desire of information with frequently interrupts immediately after they begin their opening statements.

Client centered; provider conveys technical expertise and assist clients to interpret and understand their own values more fully. Client and provider work together as partner to reach a mutually acceptable decision.

When clients are informed and involved in decision making, they are more adherences to medical recommendation and carry out more health related behavioral change [3, 6, 7].
Good communication between users and providers of any service is essential; but it is especially important when providing RH services, given the sensitive nature of some of the issues that are addressed (such as sexual violence, female genital mutilation, and providing contraceptives to adolescents, pregnancy diagnosis and follow up [5]. The "three phases of delay Model "also highlights the importance of quality of communication between clients and health care providers in the prevention of maternal death by describing the sequence of events from late recognition of danger signs to maternal death [8].

However, previous research on communication between health care providers and consumers of health care has shown that women do not receive adequate information about their pregnancy. For example, some of these researchers found that providers of health care impose barriers to communication by sort out different categories and they not pay attention to information requests of the client. Physicians and midwives also found to give advice that pregnant woman were expected to accept without question.[9,10,11]. Thus, it is not surprising that studies in Guinea Bissau and Pakistan reveal that pregnant woman prefer the services of traditional birth attendants to hospital staff because they enjoy free interaction and are shown respect[12].

The aim of this study is therefore, to assess the barriers for provider barrier of communication and the client satisfaction with health care provider quality of communication in the context of an antenatal care in Addis Ababa hospitals. Multiple tools are available to assess the competence of communication but for this research the researcher uses,'' the primary evaluation criteria'' that comes from the Kalamazoo consensus statement (KCS) which define seven essential element of health care provider-client communication (establish rapport, open discussion, gathers information, understand client perspective of illness, share information, reach agreement on problems and plan and provide closure) [13].

1.2 Statement of the problem

Antenatal care provides an important opportunity to improve maternal understanding of care during and after pregnancy [1] .Global experiences show that ANC utilization is higher than delivery by a professional in the larger majorities of countries in the developing world and similarly in our country Ethiopia [14].

Relatively high coverage of antenatal care enables health care personnel to reinforce communication across visits, which is an integral part of health care system and most frequently performed intervention during antenatal care starting from general prenatal care, danger sign counseling, birth preparedness, clean delivery to new born care, in addition in antenatal care, health service communication is a fundamental platform in order to reduce the health burdens that arise due to pregnancy related complication [1,2].

The various ability of health care provider in diagnosis as well as the unique challenge of maternal health care affects the health outcomes .Despite these challenge the way health care provider-client interact in decision-making, finding of opportunity treatment and sharing of ideas in other topic influenced by communication [15].

Even though provider-client communication reduces the challenge that arises due to pregnancy related complication and critically affects the delivery services, it is mostly ignored in medical research and practices.[16] and there is lack of communication, which creates situations where medical errors to occur. Medical errors, especially those caused by miscommunication, lack of communication, or unsatisfactory communication between health care provider and client pose a significant challenge in health care system particularly in developing country including Ethiopia [17].

1.3 Research questions

The present research, tries to assess what factors facilitate or hinder the communication between clients and health care providers on the provider perspectives.

What are the major determinants of client satisfaction with their health care provider quality of communication in public hospitals in Addis Ababa, Ethiopia.

1.4 Significance of the study

The quality of antenatal care communication is an important strategy to promote awareness of maternal health and evidence based new born care practice, which averts new born mortality and maternal to child transmission of HIV/AIDS[2,3]. Moreover, to strength national health system in order to achieve the millennium development goals 4 and 5 which calls for reducing under five and maternal mortality by half and three fourth respectively.

In developing country the magnitude of antenatal clinic coverage also indicated by, whether the pregnant women's in many contexts can be advised on care of the new born prior to birth along with maternal care during pregnancy and birth preparation [9, 17].

A number of studies have been conducted in Ethiopia to assess the quality of maternal and child birth services. In these studies client-health care provider communication constituted only a small aspect, to the knowledge of the researcher none have been found to examine the area in depth. In addition no local studies have investigated in-depth. The present research, tries to assess the barrier of effective communication in provider perspective and the client satisfaction with the health care providers quality of communication in five public hospitals. It is hoped that the findings will offer a better understanding of those aspects of childbirth services that are of unacceptable quality and also constitute key predictors of client satisfaction or dissatisfaction with the quality of health care provider communication. It is the desire of the researcher that the implementation of the findings should impact on reducing the high infant and maternal morbidity and mortality as well as increased ANC service utilization in order to achieve MDG by the year 2015.

2. LITRATURE REVIEW

2.1 Communication

Quality and timely communication between clients –health care provider is important to ensure patient safety, quality of care and evidence based clinical practice. It starts from clinical diagnosis to treatment plan. Which helps us to learn about others and ourselves and is concerned with what is transmitted, how it is to be conveyed and what hinders or aids the process [6].

Communication between health professionals and client for whom they provide the care is important to the patient to experience positive interaction with the health care provider to make an accurate diagnosis [3, 18].

Patient who understand the nature of their illness, its treatments and who believe the providers concern about their well being show greater satisfaction with the care received and are more likely to comply with treatment regimens in the same manner provider gain confidence in knowing and seeing positive result from displaying their technical competency and helping guide patient towards positive health behavior [6, 18, 19].

The interpersonal communication is also vitally important to all health caring professionals to avoid problems associated with patient non –compliance which is a constant facet of health facilities. Through use of good communication skills and process behaviors, a provider can make a patient more comfortable and can encourage good dialogue. The positive and appropriate health care outcome highly influenced by the effectiveness of communication between health care providers and clients [4, 6, 17].

Interpersonal skills are a prerequisite for effective communication. The principles of effective communication**,** as described by Neal in Hinchliff *et al* include: Being treated warmly

- Being listened to
- Being reassured
- Being able to express fear, concern and information
- Being respected
- Being given enough time [19].

The client-health care provider quality of communication influences a variety of patient outcomes, short-term outcomes which are the direct result of provider and patients such as better understanding about breast feeding and hazards of smoking and alcohol drink during pregnancy, client satisfaction on service utilization, recall the treatment regimen. Intermediate outcomes: such as adherence, and long term outcome such as symptom resolution, self actualization and quality of life [17].

Communication difficulties of patient involvement in discussion or inadequate provision of information to the patient cause impaired outcome of the disease progress, the problem of communication mostly occurred during history taking or during discussion of the patient management. This may be related to lack of communication skills of the patient or providers, due to different barriers of communication and the attitude of clients and health care providers towards information provision.

A recent study surveyed 74 health care provider and a sample of their patient in order to compare the importance of information delivery as an indicator of the quality, provision of information was ranked the second in importance by patient and six by health care provider .[20].

Another cross-sectional survey of 133 general internists and 484 of their patients in the United States showed that among patients, a wide variety of barriers were reported including their own discomfort (19%), insufficient time (13%), a belief that their physician did not have a viable solution (11%), and concerns about the impact of discussions on quality of care (9%). Among physicians, the most common barriers reported were insufficient time (67%) and a belief that they did not have a solution to offer (19%) [21].

Time, multiple clinical responsibilities of physician, lack of communication training, privacy of the room, language, and lack of continuity of care also determine the scope and quality of communication.

A study conducted in Benin on antenatal counseling in maternal and newborn care, use of job aids to improve health worker performance and maternal understanding on antenatal communication shows that lack of dedicated space for counseling remained a challenge along with language barrier,

multiple clinical task .the same research also shows that lack of time was the most commonly reported barrier for providers, that good communication takes time [22].

2.2 Antenatal care

Antenatal care is the care that a woman receives during pregnancy, which helps to ensure healthy outcomes for women and newborn babies, and it is an important opportunity to improve maternal understanding about pregnancy, childbirth, and care of the newborn. Antenatal care also provides a chance for health care provider to interact with a pregnant woman so that the woman can make appropriate choices and decisions that will contribute to optimum pregnancy outcome and care of the newborn [1-3].

The general health status of pregnant women depends largely on the quality of antenatal services available to them. The provisions of good antenatal services ensure early detection and promote management of any complication or disease that may adversely affect pregnancy outcome. To achieve these goals it is necessary for the professional to have good communication skills. From a medical perspective, good communication is associated with ability to elicit a history from a patient, in order to make diagnosis accurate and linked with patient satisfaction, adherence to medical recommendation and health outcome [3].

The institutionalization of quality assurance measures that continuously elicit information on the quality of maternal health service is one being promoted globally to achieve the objective of reducing maternal and infant mortality [23].

The world health organization’s focused antenatal care model also recommend, information and counseling be provided to all pregnant women in areas related to the health needs of the pregnant women, birth and emergency preparedness, nutrition, preventive home practice, and support for care seeking through danger sign recognition in addition to routine examination, screening and treatment[1].

It also maintains that good quality antenatal services should involve the client in decision-making and see them as active participant in improving their own health [4.5]. One of the pre xiii world congresses of Ob/Gyn workshops in 1991 also stated that paternalism (materialism) approaches to

health care must be replaced by a partnership approach in the provision of quality of the care to the whole women including assistance dealing with personal sexual problem [24].

The provision of services with client centered enables women to express their opinion and it requires providers to respect a clients' point of view, encourage clients to discuss their needs, provide the appropriate medical information to the client and assist them in making decisions rather than telling them what to do [7].

Many client view health providers in the same light as a parent consequently, clients expect providers to behave and act in a manner deserving such respect and they want from the provider to spend more time listing to their problems (concern), to explain the examination/procedure, to explain the treatment to give clear instruction about medication, to give clients the opportunity to ask questions and to provide a referral if necessary [7, 25].

In order to achieve the client perspective point of views the health care provider needs to listen to the concerns of pregnant women and not dominate the relationship. Understanding the actions that pregnant women have reported as important to them can guide the practice of those who provide antenatal care.(19) However, apparently health care workers do not take the views and opinions of pregnant women regarding what constitutes effective antenatal care into consideration [9, 10].

2.3 Antenatal care communication

Communication provided during antenatal care has been shown to be an effective strategy to improve maternal understanding and health practice [3, 4, 5].

A national British survey of woman's views on maternity care revealed that women need and want good communication with their care givers, enough information about what is happening and the opportunity to find out more if there is a need. They also wanted health care providers to have excellent communication skills which include being able to supply information and seeing women as partners, sharing information and give enough time and information for them in order to understand their pregnancy progress. [26].

In India the use of family planning increased from 22.8% in 1980-81 to 44.1% in 1990-91 and further increased to 56.3% in 2005–06 because of the quality information provided by nurses during the ANC visit [27].

Similarly the United Kingdom, report that women who continued to breastfeed were more likely to have had sufficient time with a midwife who gave health education on the importance of breastfeeding, in which time spent during antenatal care improved the communication between client-health care provider communications [28].

WHO, FANC estimated that antenatal care takes 46 minute for 1st visit and 35 minute for revisit, counseling alone takes 15 minute both 1st and revisit.[1].
But recent studies shows that duration of antenatal consultation and adequacy of information is low in many developing countries with even less time spent on communication. .

Across sectional survey of 457 pregnant women conducted in the Gambia shows that most pregnant women (70.5%) said they spent 3 minutes or less with antenatal care provider .and only19.3% communicate with the health care provider on what to do if there was a complication [11].

And interventional research in Tanzania provider spent 40 minute for initial visit and 20 minute in second and higher visit respectively. The same research also conclude that the communication between client –health care provider is unidirectional with the provider giving information and the client listing what the provider says and only half of the clients given chance to ask question, 18% of clients who not informed for the prognosis of pregnancy and 42% of clients were not informed about danger sign [9].

In order to ensure high quality care, antenatal services need to be evaluating at regular intervals, both from provider and client perspective, to ensure their effectiveness in improving the health status of pregnant women. Supporting this view point the World Health Organization sates that the role of positive interactions between women and health care providers as critical in improving client compliance.

Providers and clients may perceive quality of care differently. Providers may be anxious to ensure technical correctness; whereas clients may be more concerned with issues like moral support and cultural beliefs [29].

The health care provider has the potential to play a major role in improving women's health status. However, for the health care provider to be effective in improving women's health status, antenatal services need to be effectively utilized by clients. [29].

Clients are the best source of information about a hospital system's communication, education, and health care management processes, and they are the only source of information about whether they were treated with dignity and respect. Their experiences often reveal how well a hospital system is operating and can stimulate important insights into the kinds of changes that are needed to close the gap between the cares provided and the care that should be provide [30] to achieve this clients should be allowed to define their own priorities and evaluate their care accordingly, rather than having those criteria selected by professionals [7].

There are a number of ways by which quality of communication could be assessed, but client centered outcome such as satisfaction, appears to have taken center stage as the primary means of measuring the effectiveness of health care provider- client communication.

Client satisfaction is the litmus test that enables health programs to assess the impacts of their services. Hence it is an integral part of the quality assurance process of health facility, health staff should be communicates effectively with the client during their antenatal visit. The positive behavior of the health staff and the warm reception mothers received in the antenatal care unit were the most satisfying part of the service [20, 31].

There is widespread agreement that client satisfaction with health care provider quality of communication is an important indicator that can effectively provide a good reflection of the quality of the care. [25].

It is also clear from the literature that although system aspects such as cost, access, availability, and waiting time are related to patient satisfaction they have always been identified as being less

important than the human aspect of medical care.[32] furthermore, established evidence depicted that even though technical aspect of care has its impact on satisfaction, it is through interpersonal communication that the technology of western world reaches the patient and curing occurs, in addition it is recognized More than ever the quality of health care for the 21st century is built on the premise that optimal health care can best be achieved in the context of long term relationship between providers and clients [33]

Donabediance regards with patient satisfaction/dissatisfaction states that patients can give judgment on the quality of care in all aspect, particularly concerning with the interpersonal process [34]. Satisfaction studies can function to give providers of care some idea of how they would have to modify their provision of services in order to make their patients more satisfied [35].

The extent to which consumer opinion can influence policy makers and health care personnel is not only dependent upon collecting the right kind of data, it also requires that policy makers and health personnel accept the value of the consumer's point of view. Unlike clinical process measures, which are strictly facility centered, patient satisfaction is a "patient centered" process measure. It reflects the patient's personal response to, and evaluation of care (as opposed to the hospitals view of what is appropriate) Patient satisfaction is the only available measure of the personal impact of the full spectrum of the care process. [36].

In general Patient satisfaction is one of the desired outcomes of care, an element in health status, a measure of quality of car, and as indispensible to assessment of quality of communication as to a design and management of health care system [20, 25, 31].

According to this viewpoint Harriott states that communication and provision of adequate information are determinants of satisfaction with child birth services. When clients satisfied with the health care provider quality of communication it is not only increased their likely hood of institutional deliver, but also it enhances the positive impact of the number of antenatal visit on the institutions [36].

It has been proposed that the effectiveness of health care is determined, to some degree, by satisfaction with the service provided, support for this point has been found in studies that have

reported. a satisfied patient is more likely to utilize health services, comply with medical treatment and continue with the health provider [35,37].Continuity of care when an expectant mother sees the same health care provider throughout the antenatal visit, labor, delivery, a closer trusting relationship between the provider and consumer of health service can develop. According these view point the Neal Hinchliff *states that* Women should be allocated to a specific midwife during pregnancy so that they can build a strong relationship of trust and understanding (19).

Privacy and confidentiality clients are more comfortable if provider respect their privacy during counseling session, examination, and procedure, Client report higher satisfaction with the provider who keeps their needs and personal information, lack of privacy can violate women's sense of modesty and make it more difficult for them to participate actively [38].

Another cross sectional study in west showa, central Ethiopia on determinant of outpatient satisfaction with health care provider interaction shows that ,Knowing the provider, frequency of visit, privacy of the room, feeling of privacy during consultation and telling one's own private issues had statistically significant association with patient satisfaction with health care provider communication/interaction. Patients who knew the health care provider very well had an average increase of 0.499 unit in their satisfaction with their interaction with the provider compared to those who did not know the provider at all. Clients who did not tell their private issues had an average of 0.598 decreases in satisfaction score as compared to those who told their private issues to the provider. Moreover, patients who felt that they did not have privacy during consultation had an average decline of 0.400 in their satisfaction score as compared to those who felt there was sufficient privacy [39].

A cross sectional quantitative study conducted on clinician-patient information exchange among HIV patients showed that long spend time, better health statues, old age and higher educational statues were associated with client satisfaction on health care provider quality of communication[40].

In the delivery of maternal health care services, eliciting the views and satisfaction of women is even more important because of the sensitivity and the cultural undertones that surround issues of

pregnancy and childbirth, in which poor quality services and women's dissatisfaction with childbirth services continues to be cited as being responsible for the gross under utilization of facility based childbirth service [41, 42, 43].

In Gambia the researchers conclude in their findings that information, education, and communication during antenatal care seemed to be poor. The same study also concluded that pregnant women who do not get adequate and appropriate information about pregnancy and childbirth would be ill-equipped to make choices that would contribute to their well being [10].

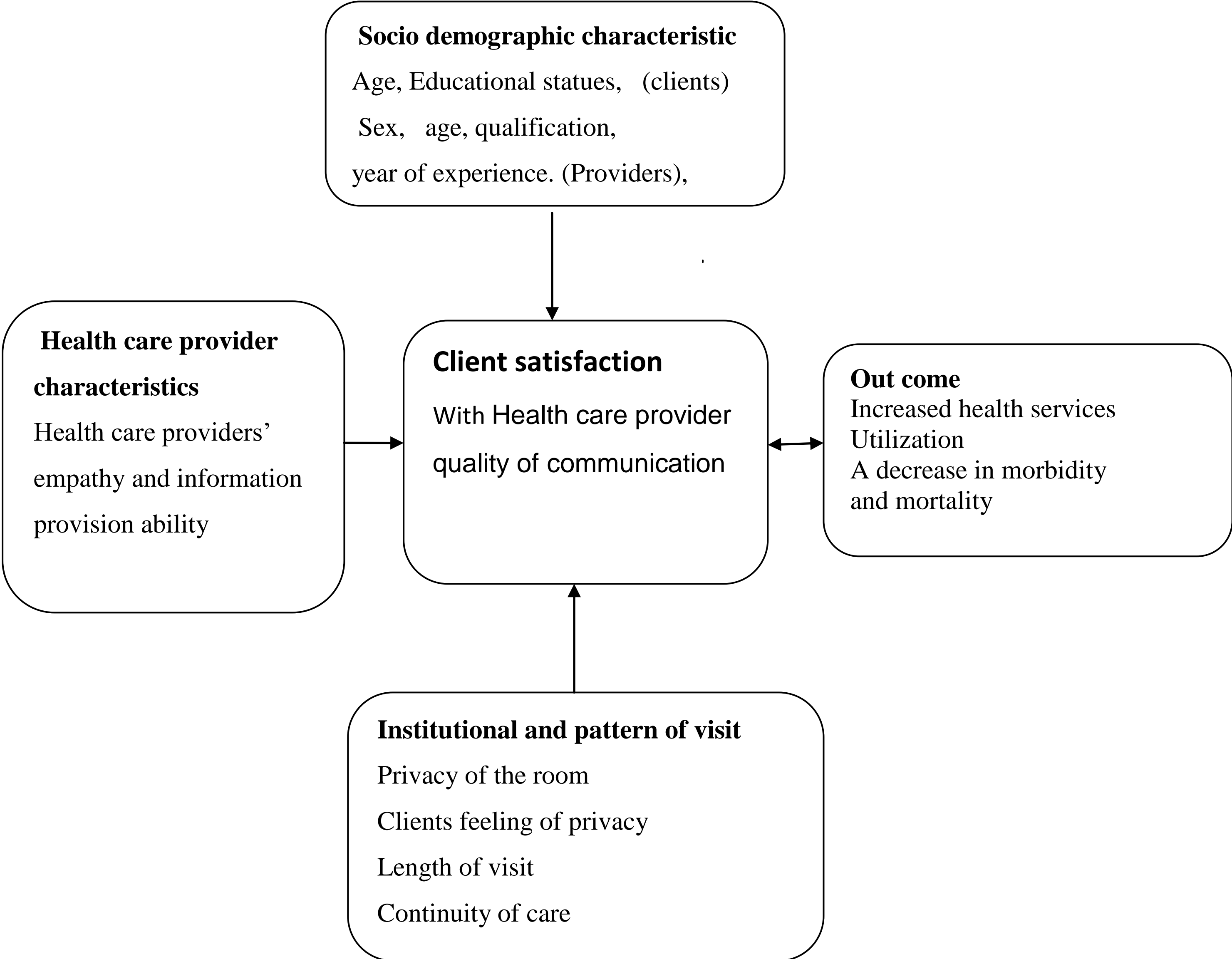

Fig 1: adapted conceptual models of clinical communication between clients and health care providers.

3 OBJECTIVE OF THE STUDY

General objective

The objective of this study is to assess quality of client-health care provider communication in Antenatal care.

Specific objectives

- Assess satisfaction of antenatal care clients on quality of communication with health care providers
- Assess barriers to optimal communication from the health care providers' perspectives.

4. METHOD AND MATERIALS

4.1 Study design and period

A cross-sectional quantitative survey was used. This was complemented by qualitative study in the form of in-depth interviews. From October to June 2012

4.2 Study area

The study was carried out in Addis Ababa, the capital city of Ethiopia, with an area of 530km and a total population approximately 4 million (44). It has 10 sub-cities. In Addis Ababa there are 8 hospitals. The hospitals are under the Federal Ministry of health; St. Paulos. Addis Ababa University; Tikur Anbessa, and Addis Ababa City Health administration Bureau; Zewditu, St petros, Minilik, Yekatit 12, Ras Desta and Ghandi hospitals. Out of these hospitals those hospitals which provide ANC services were included in the study (Tikur Anbessa, Zewditu, Yekatite 12, St. Paul and Ghandi hospitals).

4.3 Study population

4.3.1 Source population

- All pregnant women who were on antenatal care follow up, visiting public hospitals.
- Clinicians working in ANC clinics of selected public hospitals in Addis Ababa.

4.3.2 Study participant

- Pregnant women who came for antenatal care during the data collection period, and fulfill the inclusion criteria.

Inclusion criteria;

- Mothers who followed antenatal care in the selected hospitals.
- Pregnant women in all stages of pregnancy, regardless of parity or status (new registry or follow up), in the selected hospitals.
- Health care providers, providing ANC services for at least 6 months.

Exclusion criteria;

- Pregnant women who came for delivery.
- Health care providers, who are engaged in administrative service only.

4.3.3 Sample size

Sample size (n) was determined based on the following assumptions;

- A 50% proportion of clients who were satisfied with their communication to health care providers were taken, due to lack of previous studies.
- Expected margin of error (d) of 0.05
- $Z_{a/2}$= 95% confidence level(1.96) and
- 10% contingency for non-response during the actual survey.

$n= (Za/2)^2 *p (1-p)$, $n= (1.96)^2 *(0.5)^2/(0.05)^2$

n =384+38=422.

The sample size for each hospital was determined based on the number of clients served in each hospital during 2011. As a result, 425 clients were participated in the study.

4.3.4 Sampling procedure

As shown in figurer 2: all public hospitals in Addis Ababa which provide antenatal care services were included in the study.

- 425 clients and 17 health care providers enrolled in structured interview were selected by using convenience sampling method (consecutive clients of antenatal care took part in the study).
- 15 clients enrolled for the in-depth interview were selected purposively (3 clients from each study hospital).

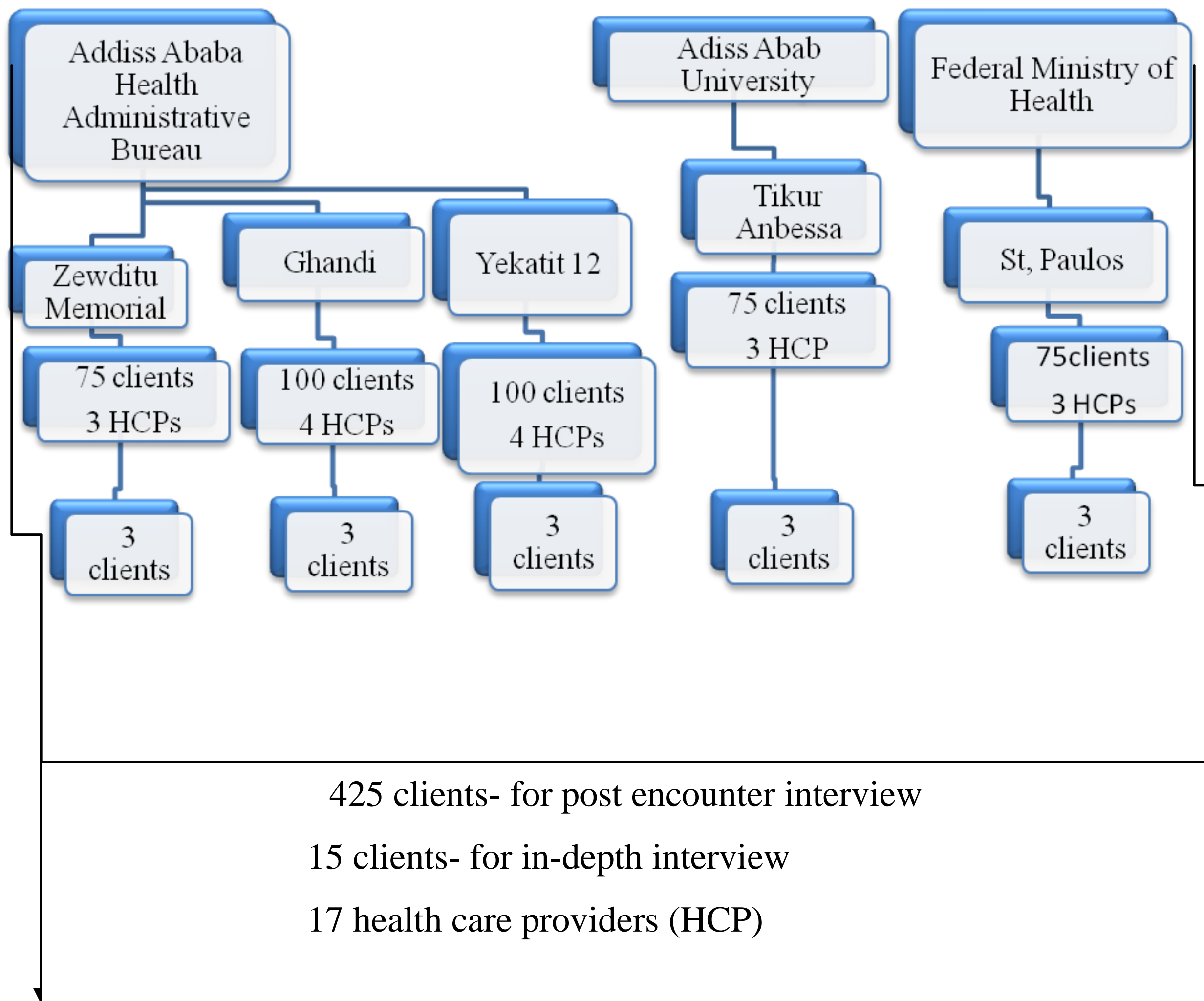

Figure 2: Schematic diagram of sampling procedure at Antenatal care clinics of five public hospitals in Addis Ababa, June 2012

4.4 Data collection

4.4.1 Data collection tools

- Quantitative data was collected using structured questionnaire adapted from Kalamazoo consent statement and safe mother hood tools (13, 43).The questionnaire was first written in English and then translated to Amharic version and it was pre-tested and revised accordingly before the main study was undertaken. Two grade 12 complete interviewers were recruited and trained on the process of data collection for two days by the principal investigator. Daily supervision of the data collection process was maintained by the principal investigator.
- To collect data on clients' perceptions of the health care providers' empathy during the clinical encounter, clients were asked six questions to rate different aspects of the empathy. Each question was scored with poor=1 to excellent=5. All six items taken together yield maximum scores of 30 and minimum of 6. Clients with scores of mean 19(63%) and above were considered as good empathy while those clients scores lower than the mean were categorized as poor empathy.
- Information provision about pregnancy was measured using thirteen items with poor=1 to excellent =5, All thirteen items taken together yield maximum scores of 65 and minimum of 13. mean scores of 39(60%) and above were considered good information provision about pregnancy and those who obtained lower than the mean scores were considered as poor information provision.
- The Clients' satisfaction on quality of health care providers' communication were assessed using one item on a five Likert scale ranging from strongly disagree =1 to strongly agree =5.
- To assess barriers of optimal communication on health care providers' perspectives structured self administered English version questionnaire was used.
- For in-depth interview semi structured Amharic version questionnaire was used.

4.4 .2 Data collection procedure

- First the health care provider filled out self administered English version questioners.
- Clients in structured interview were approached in daily basis after the encounter at the waiting room and it takes 5-10 minutes.
- For the in-depth interview similar approach were used. Clients were interviewed after the encounter at the waiting room and it takes 20-30 minutes.

4.4.3 Data quality control

- The questionnaires were pre-tested in a similar setting (Yekatit 12 hospital) which is part of the study and the necessary adjustment was made after the pre test was completed.
- Two days of training was given for the data collectors, during which they practiced on how to complete the questionnaire.
- Close supervision was carried out by the principal investigator.
- About 5% of the collected data was being assessed daily for the completeness that helped to take corrective measures in the future.

4 .4.4 Study variables

Dependent variable

- Clients' satisfaction with the health care providers' quality of communication (Dissatisfied to Satisfied)

In dependent variables

Client characteristics

- Socio demography (age, educational status)

Institutional and Visit characteristics

- Time of interaction between clients and health care providers (Visit length)
- Frequency of visit (number of prenatal visits)
- The service given by the same health care providers (continuity of care giver)
- privacy of clients during the encounter

Health care provider characteristics

- Socio-demography (age, sex, qualification,)
- Provider empathy and information provision

4.4.5 Operational definitions

Client Somebody who is sick or well but having body changes like when pregnant and visit a health care facility.

Health care provider a nurse, health officer, midwife, doctors working in the facilities participating in the study.

Communication is the basic element of human interaction that allows people to establish, maintain and improve contact with others.

Antenatal care: the care that a woman receives during pregnancy.

Continuity of care a process of getting the antenatal care services by similar health care provide.

4.5 Data entry and analysis

The data collected using quantitative method was computerized using EPI info version 4.0 and analyze (transferred) to SPSS version16.0 window soft ware computer program.

To analyze and present data, frequency distribution, percentage, and bivariate analytical method was used to detect association between dependent and independent variables at 95% CI. And multiple logistic regression was also used to control confounders.

The qualitative data was transcribed manually from the notes taken and the results were analyzed manually written by summarizing the ideas forward by antenatal clients.

4.6 Ethical Considerations

All processes were started after the study was approved from Addis Ababa University, College of Health science ethical review committee, Addis Ababa administrative Health Bureau ethical committee and from hospitals Institutional Review Board (IRB).

Informed consent was obtained from individuals who were going to be involved in the study after explaining the purpose of the study. Confidentiality of the information given and the privacy of the interview had been kept throughout the data collection and the entire study period.

4.7 Dissemination of results

The result of this study are more beneficial for health providers, planers, health bureau and nongovernmental organization(NGO) who are more engaged in antenatal care activities.

5. RESULTS

5.1 Quantitative result

5.1 .1 Socio demographic characteristics

As shown in table 1 below, a total of 425 clients were participated in the study with a response rate of 100%. Of total respondents (n=425), the majority 175(41.2%) were within the age range of 25-29. The mean (SD) age of the respondents was 27.6± 4.7 years old (range of 18-40). Concerning educational status, the majority 146 (34.4%) had tertiary level of education and 85 (20.0%) of the respondents had attended no formal education.

Table 1: Socio demographic characteristics of antenatal clients at Antenatal care clinics of five public hospitals in Addis Ababa, June 2012

Characteristics	Frequency	Percent
Age		
15-19	15	3.5
20-24	101	23.8
25-29	175	41.2
30-34	85	20.0
≥35	49	11.5
Educational status		
No formal education	85	20.0
Primary	52	12.2
Secondary	142	33.4
Tertiary	146	34.4

As shown in table 2, seventeen health care providers were participated in the study, out of which the Majority 8 (47.1%) were within the age range of 37-42. The mean (SD) age of the health care providers was 32.4±5 (range 25-50), of these, 10 (58.8%) of them are male and 6(35.3) are general practitioner.

Table 2: Socio demographic characteristics of healthcare providers at Antenatal care clinics of five public hospitals in Addis Ababa, June 2012(n=17)

Characteristics	Frequency	Percent
Age		
25-30	2	11.8
31-36	4	23.5
37-42	8	47.1
≥43	3	17.6
Sex		
Male	10	58.8
Female	7	41.2
Professional cat		
General practitioner	6	35.3
Nurse	3	17.6
Health officer	5	29.4
Gyn/Obs	3	17.6

5.1.2 Institutional aspect and pattern of visit characteristics.

Among the total number of respondents, 358(85.2%) visited the antenatal clinic more than once and 134(31.9%) four or more times. Participants who made their visit for the first time constituted only 62(14.6%). On average, 3.0 prenatal care visits were made. Of the total respondents 167 (39.4%) of the respondents didn't previously know the health care provider who treated them.

89 (21.0%) of the respondents claimed that their privacy was not respected during consultation. more than half of antenatal clients 250 (58.8%) were seen by a male health care providers and 150(35.3%) of antenatal clients were seen by general practitioner(not tabulated) The median interaction time of client and health care provider was 10 minutes (range 1-60).

Table 3: Institutional aspect and pattern of visit characteristics at Antenatal care clinics of five public hospitals in Addis Ababa, June 2012 (n=425)

Characteristics	Frequency	Percent
ANC visit		
First	62	14.8
Second	89	21.2
Third	135	32.1
Fourth	49	11.7
More than 4	85	20.2
Continuity of care		
Yes	257	60.6
No	167	39.4
Feeling of the privacy		
Not at all	26	6.6
Slightly	63	14.8
Somewhat	72	16.9
Very much	262	61.6
Time spend in minute		
1-5	146	34.4
6-11	111	26.1
12-17	57	13.4
18-23	35	8.2
24-29	21	4.9
≥30	51	12

5.1.3 Antenatal clients' perception of health care providers' empathy

To investigate health care providers' empathy, six questions (Table 4) ranging from poor=1 to excellent=5 were provided for the antenatal clients.

As a result, 75.5% of the respondents have ranked care and concern, 72.5% respectful treatment of the health care provider's as good, very good and excellent. Moreover, 72.1 and 71.7%) of clients announced that attention giving and talking without interruption respectively as good, very good and excellent. On the other hand, 30.1% and 33.3% of respondents recognized greeting and permitting to express clients' idea by providers as poor or fair respectively.

Table 4: Antenatal clients' perceptions of health care providers' empathy at antenatal care clinics of five public hospitals in Addis Ababa, June 2012(n=425)

Communication items	Good (%)	Poor (%)
Greeted me in a way that made me comfort	69.9	30.1
Treated me with respect	72.5	27.5
Showed care and concern	75.5	24.5
Let me talk without interruption	71.7	28.3
Permit me to tell may idea	66.7	33.3
Paid attention to me	72.1	27.9

As shown in the fig, 1. Clients' perception of the health care providers' empathy during their encounter were demonstrated by using summery measure of all the 6 items on communication. Based on the score given to each communication item, the mean value of clients' score on health care providers' empathy was found to be 19 with standard deviation 6.6. About 173 (40.7%) clients have scores below the mean (poor) and 252 (59.3%) have scores above the mean (good).

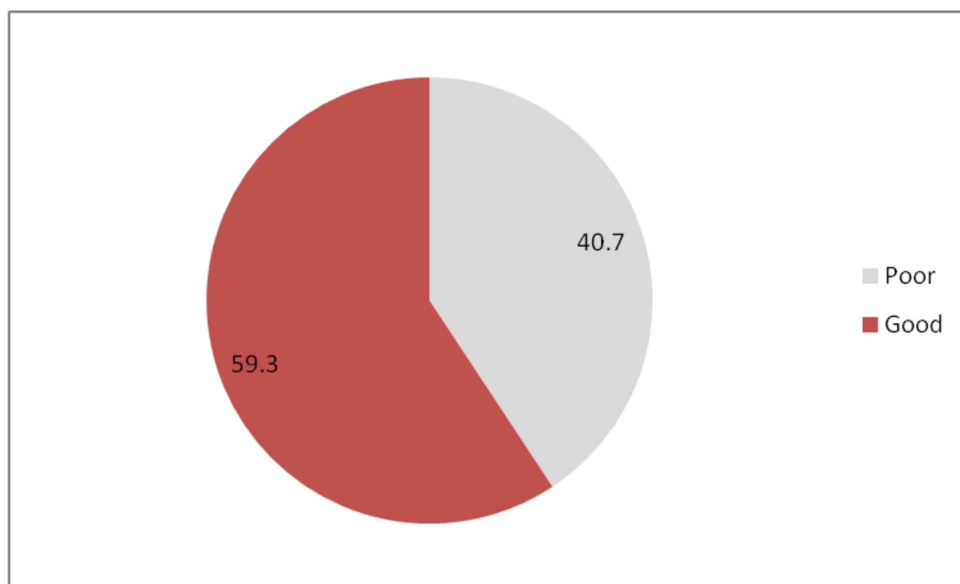

Fig 3: Antenatal clients' perception score of health care providers' empathy at Antenatal care clinics of five public hospitals in Addis Ababa, June 2012(n=425)

5.1.4 Antenatal clients' perception of health care providers' information provision

Thirteen items (Table 5) with range of poor =1 to excellent=5 were used to measure the extent in which relevant information was provided to the clients in relation to their pregnancy.

Accordingly, 78.1% of the clients were perceived as good, very good and excellent; the way the health care provider explains about PMTCT, 70.0% of the clients on the skill of the health care provider to communicate information in understandable manner, 79.5% of the clients on ability of health care provider to discus about follow ups .However, More clients were perceived as poor or fair on, discussing issues of substance use such as alcohol and others(55.0%), intention to rechecking whether clients understand what they have been told (44.7), encouraging clients to ask question (41.1%), and participating them in the process of decision(40.7%).

Table 5:Antenatal clients' perception of health care providers' information provision at Ante care natal clinics of five public hospitals in Addis Ababa, June 2012 (n=425)

Information provision	Good (%)	Poor (%)
Explained about my pregnancy	62.7	37.3
Explained reason of diagnostic test and procedure done	64.2	35.8
Explained about birth preparedness and complication readiness	62.5	37.5
Explained and remained me about the need for ANC follow up	61.7	38.3
Told me about problems with alcohol and other substances	45.0	55.0
Explained about nutrition	59.6	40.4
Explained about PMTCT	78.1	21.9
Explained about breast feeding	63.4	36.6
Talked in term I could understand	70.0	30.0
Cheeked to be sure I understand everything	55.3	44.7
Encourage me to ask question	58.9	41.1
Involved me in decision as much as I wanted	59.3	40.7
Discussed next step including appointment	79.5	20.0

In order to determine association between Clients' perceptions of the health care providers' information provision with their satisfaction on health care providers' quality of communication during their encounter were demonstrated by using summery measure of all the 13 items on communication. Based on the scores given to each communication item, the mean value of clients' scores on health care providers' information provision was found to be 39 .About 207 (48.7%) of the clients have scores below the mean (poor) and 218 (51.3%) have scores above the mean (good).

5.1.5 Outcomes of client- health care provider communication

Among 425 clients, majority 264 (62.1%) were dissatisfied on health care providers' quality of communication.

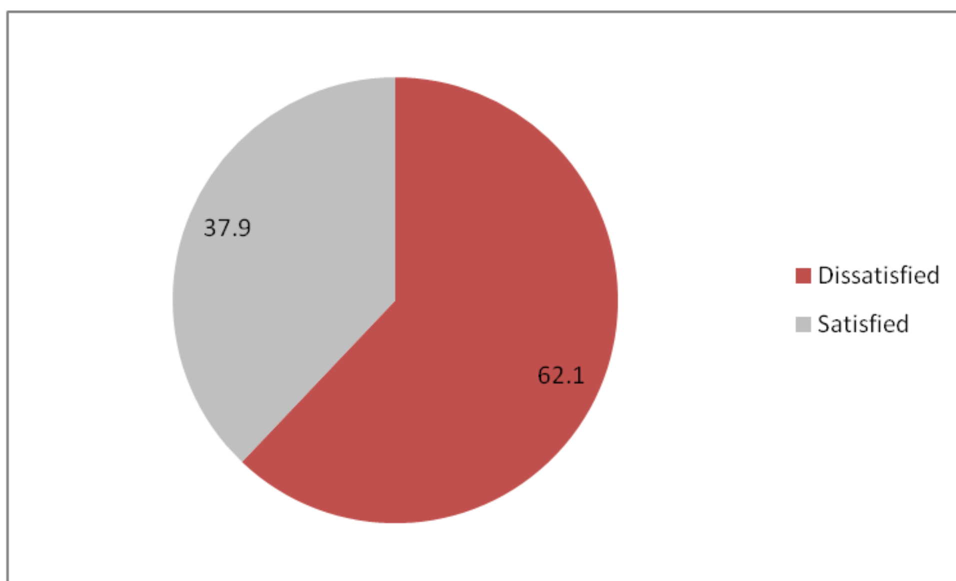

Figure 4: outcomes of clinical communication between antenatal clients and health care providers at Antenatal care clinics of five public hospitals in Addis Ababa, June 2012 (n=425)

5.1.5 Factors affecting antenatal Clients' satisfaction with the quality of communication with health care providers

Using the bivariate analysis sex and professional category of care providers are significantly associated with clients' level of satisfaction. Clients cared by male health care providers were 1.7 more likely to be satisfied than those clients cared by female health care providers (COR =1.68; 95% CI:1.12,2.52), while those clients cared by nurse health care providers were less satisfied than clients cared by obstetricians (COR=0.4; 95% CI: 0.20,0.78).

Clients cared by Health care providers within the age group of 25-30 (56%) were more satisfied compared with clients cared by Health care providers within the age group of 37-42 (33%). But this difference was not statistically significant.

Using the multivariate analysis, Perceived providers' empathy and information provision, Visit length in minute, suboptimal feeling of privacy and Continuity of care were found to be independent determinants of clients' satisfaction of communication by their care providers.

Clients who felt that they have suboptimal feeling of privacy during consultation had an average decline of 0.47 in their satisfaction score as compared to those who felt there was sufficient privacy(AOR=0.47; 95CI: 0.22,0.99).

The odds of satisfaction was lower for those clients who spent 12-17 minutes with their care provider compared to those who spent more than 30 minutes (AOR=0.3;95% CI: 0.11,0.77).

Clients who did not get care by the same provider at different visits were less satisfied than those who have cared by the same health care providers (AOR=0.55, 95% CI: 0.32, 0.96)

Those clients who perceived the health care providers' information provision good were more likely satisfied than clients perceived as poor (AOR=0.09, 95% CI:0.05-0.17).

More over clients who perceived the health care providers' empathy as good were more satisfied compared to those clients perceived as poor (AOR=0.41, 95%CI: 0.22,0.77).

Table6: bivariate and multivariate analysis of clients and health care providers characteristics and level of client satisfaction at antenatal care clinics of five public hospitals in Addis Ababa, June 2012(n=425)

Independent variables	Level of satisfaction		COR (95% CI)	AOR (95% CI)
	Dissatisfied	Satisfied		
Age of providers				
25-30	22 (44)	28 (56)	2.1(0.93, 4.62)	1.20(0.37, 3.88)
31-36	144 (64)	81(36)	0.92 (0.49, 1.73)	0.92(0.28, 2.97)
37-42	67 (67)	33 (33)	0.80 (0.40, 1.63)	0.54(0.20, 1.50)
≥43	31 (62)	19 (38)	1.00	1.00
Sex of providers				
Male	143(57.2)	107(42.8)	1.68(1.12, 2.52)*	1.96(0.78, 4.94)
Female	121(69.1)	54(30.9)	1.00	1.00
Professional category				
General practitioner	95(63.3)	55(36.7)	0.62 (0.35, 1.08)	1.27(0.42, 3.88)
Nurse	55(73.3)	20(26.7)	0.40 (0.20, 0.78)*	1.16(0.32, 4.25)
Health officer	75(60)	50(40)	0.72 (0.41, 1.29)	1.83(0.56, 6.03)
Gyn/obs	39(52.2)	36(48)	1.00	1.00
Age of client				
15- 19	9 (60)	6 (40)	0.89 (0.27, 2.89)	1.88(0.36, 9.89)
20-24	64 (63.40)	37 (36.6)	0.77 (0.38, 1.55)	0.92(0.36, 2.35)
25-29	112 (64)	63 (36)	0.75 (0.39, 1.43)	1.051(0.44, 2.52)
30-34	51(60)	34 (40)	0.89 (0.44, 1.81)	0.74(0.28, 1.92)
35 and above	28 (57.1)	21 (42.9)	1.00	1.00
Educational status				
Non formal	53(62.4)	32(37.6)	1.2 (0.70, 2.12)	0.85(0.40, 1.81)
Primary	30 (57.7)	22(42.3)	1.3 (0.72, 2.66)	0.91(0.37, 2.22)
Secondary	81(57)	61(43)	1.5 (0.93, 2.41)	1.40(0.73, 2.68)
Tertiary	98 (67.1)	48(32.9)	1.00	1.00
Number of ANC visit				
First	40(64.5)	22(35.5)	1.06(0.53, 2.11)	1.014(0.40, 2.56)
Second	61(68.5)	28(31.5)	0.89(0.47, 1.67)	0.85(0.37, 1.97)
Third	76(56.3)	59(43.7)	1.5(0.85, 2.63)	1.83(0.85, 3.92)
Fourth	28(57.1)	21(42.9)	1.45(0.70, 2.98)	1.34(0.52, 3.47)
>fourth	56 (65.9)	29(34.1)	1.00	1.00

Continuity of care				
Yes	174 (67.7)	83(32)	0.54 (0.36, 0.81)*	0.55(0.32, 0.96)*
No	89 (53.3)	78(46.7)	1.00	1.00
Feeling of the privacy				
Not at all	20 (76.9)	6 (23.1)	0.49(0.19, 1.18)	0.67(0.19, 2.34)
Slightly	44 (69.8)	19 (30.2)	0.60 (0.34, 1.08)*	0.85(0.39, 1.85)
Some what	53 (73.6)	19 (26.4)	0. 47(0.26, 0.83)*	0.47(0.22, 0.99)*
Very much	146 (55.7)	116(44.3)	1.00	1.00
Visit length in minute				
1-5	105(71.9)	41(28.1)	0.21(0.11, 420)*	0.56(0.23, 1.33)
6-11	71(64)	40 (36)	0.31(0.15, 0.61)*	0.64(0.26, 1.55)
12-17	39(68.4)	18 (31.6)	0.25 (0.11, 0.56)*	0.29(0.11, 0.77)*
18-23	19 (54.3)	16 (45.7)	0.46(0.19, 1.11)	0.73(0.24, 2.22)
24-29	10(47.6)	11 (52.4)	0.60(0.21, 1.68)	0.72(0.20, 2.69)
≥30	18(35.3)	33(64.7)	1.00	1.00
Providers' empathy				
Poor	147(85.0)	26(15.0)	0.15(0.09, 0.25)*	0.41(0.22, 0.77)*
Good	117 (46.4)	135(53.6)	1.00	1.00
Providers' information provision				
Poor	186(89.9)	21(10.1)	0.06(0.040, 0.11)*	0.09(0.05, 0.17)*
Good	78(35.8)	140(64.2)	1.00	1.00

**-Significant at 95% CI*

5.2 Barriers of effective communication on health care provider perspectives

In order to assess whether barriers of effective communication between health care providers and clients stem from the parts of health care providers, the health care providers were asked if they use communication aid to improve understanding, and summarize the information provided.

Accordingly, the findings revealed that all of 17 health care providers did not use communication aid. However, it was found out that almost all 16(94.1%) of the respondents agreed on the fact that communication aid was necessary. According to them, using communication aid facilitates better understanding and reduces time. Whereas only one respondent has argued that communication aids was not necessary because according to him there were no communication barriers encountered in antenatal care.

Likewise, barriers of optimal communication were assessed through eight rank ordered questions (those ranks ranging 1-4 were taken as major while those assigned ranks from 5-8 were taken as minor barriers.

As a result, the majority 15(88.0%) ranked time constraint due to clients overload as major barrier. 12(71.0%) multiple clinical task, 10(58.8%) lack of dedicated space for communication, 9(52.3%) lack of privacy during the encounter),5(29.0%) language barrier between health care providers and clients, 5(29.0%) ,lack of training in communication from the health care providers, and one of the respondents ranked all of the five elements as appeared to be major barrier for optimal communication like lack of training in communication, lack of staff, , time constraint due to clients overload, lack of dedicated space for communication and multiple clinical task. And 14(82%) lack of staff and 16(94%) and lack of integration into routine interaction reported as minor barriers of optimal communication.

5.3 In-depth Interviews

5.3.1 Socio demographic characteristics

Generally, fifteen clients have completed the interview, 6 (40 %) were Primiparous, 7(46.7%) had secondary education. Their mean age was 26.8 ± 4.9, 73.3 % of those interviewed 60% had attended the antenatal clinic more than once and 40 % four or more times. On average, 3.3 prenatal care visits were made.

Table 7: Socio demographic characteristics of qualitative interview Antenatal clients at Antenatal care clinic of five public hospitals in Addis Ababa, June 2012

Characteristics	Frequency	Percent
Age		
20-24	4	26.7
25-29	7	46.7
30-34	3	20.0
35 and above	1	6.7
Educational statues		
Non formal	3	20.0
Primary	1	6.7
Secondary	7	46.7
Tertiary	4	26.7
Frequency of visit		
Second	4	26.7
Third	5	33.3
Fourth	3	20.0
Above fourth	3	20.0
Parity		
Primiparous	6	40.0
Multiparous	9	60.0

Health care provider’s empathy

The health care provider’s empathy, which is a core component of consultation, is often as crucial to the effective achievement of the patient satisfaction in that it encapsulates sensitive to both the informational and emotional aspects of communication. Clients are more likely to seek out and continue using the antenatal services if they receive respectful and friendly treatment.

In this study, majority of participants recognized that health care providers as not empathetic. However, there were some who have reported that there were many health care providers who showed empathy. For example one of the respondent age 26 years has reported that

> ‘*It is the health care provider’s empathy that helped me survive till today, when I was referred from the health center due to heavy bleeding the health care provider at the hospital treat me like a brother.’’*

Participants have also reported that there exist variations in empathy among health care providers in hospitals and health centers.

> *A 30 year Multiparous client reported that: ‘I prefer health centers providers than hospitals because in health center the provider give respect and is easy to communicate with them.’’*

Health care provider’s empathy may reduce due to patient over load and time constraint due to multiple clinical tasks. In hospital the health care provider see many client per day so they may be tiered to show good interaction a 34 years pregnant mother suggested that

‘*’In hospitals lack of empathy from health care providers may be attribute to the fact that they are accustomed to seeing many clients per day that they became exhausted’’*

Information provision to clients

The existing method or the way of health care providers provide information to clients about their pregnancy and the related complication was reported as poor by nearly half of the clients.

A 35 years HIV positive client, said 'information about our health status and the way we can give safe birth was very important but our doctors not willing to give sufficient information even after we asked any questions''.

With regarded to the health care providers' information provision, it was observed that clients' Satisfaction was affected by the way health care providers use their time.

For instance, a 26 years old Primiparous college student described as follow, "*many health care providers start work after 10:00 AM and usually they prefer to give another appointment without even telling me about the condition of my pregnancy status''.*

Clients' perception of privacy during the encounter

A condition that would foster good two way communication between the health care provider and clients at the antenatal clinic would be an opportunity to express their own thoughts and fears. Clients feel more comfortable if their providers respect their privacy during counseling session, examination, and procedures done.

In this regarded most participants have reported as they feel privacy when examined by Health care providers. But there were still some who have expressed their compliance concerning the privacy of the ANC room. For example, A 25 years old secondary school student said that

"There was no privacy in the examination rooms because the health care provider frequently open the door & rush in to the rooms while examinations were being carried out besides, discussions with the health care providers would often get disturbed due to presence of many health care providers around the examination beds.''.

There were also some participants who had expressed their compliance on the Uncomfortablelity the health care provision setups. Among these A 23 year client has said that ''*the rooms were not suitably organized for antenatal care provision. For example, there were no tables and enough chairs around the waiting area that most of the clients were urge to waite their turn standing for a prolonged period of time around the rooms which makes them dissatisfied''*

A 29 years old client also strongly supported this idea, she said that:

‘‘ The rooms were not only lack of privacy, but also were built in such a way that was not comfortable for antenatal care provision ‘’

Continuity of care

When a pregnant mother sees the same health care provider throughout the antenatal visit, labor and delivery a closer trusting relationship between the provider and client of health service can develop. With this respect, a 26 years old participant noted that:

‘’I prefer hospital cares than health center. In the former, there are tendency for a pregnant to be examined by the same health care providers every time she appeared’’

A 30 years old college student participant also shared this by more justified ‘’ the care given by the same health care providers in the hospital not only reduce the time spent for exchange with other health care providers but also strength the sound and comfortable relationship with the provider who already has been in charge of your case.’’

On the contrary, some of the respondent believed that having with only one health care provider may reduce the quality of communication because of the prevalence of competency among different health care providers.

For instance, a 26 years old client describe this as ‘’even though having care by the same health care provider have its Owen importance ,visiting other health care provider is better because ,there are difference among the health care provider concerning their communication skill’’

6. DISCUSSION

This study set out to assess the clients' satisfaction on health care providers' quality of communication and barriers of optimal communication on health care providers' perspectives**.**

Clients' have rated the elements of health care providers' empathy including showing concern and care during their encounters, treatment with respect, giving attention and talking without interruption as good attributes. In contrast, greeting and permitting clients to express their ideas were characterized as poor.

The health care provider information provision was associated with clients' satisfaction on health care providers' quality of communication. The aspects that clients scored highest for their perception of the provider information provision were, explaining about PMTCT (77.9%), communicating in understandable manner (67.5%), and discussion about follow up (79.5%).

However, communicating about problems with alcohol and other substance use (44.7%), checking that the client understands everything (54.4%), encouraging clients to ask questions (58.4%) and, involving them in decision making (58.6%) were relatively low. Furthermore, the in depth interview indicated that there is a problem in getting relevant and adequate information about their problems.

In this study it was found that the overall satisfaction level of clients with the health care provider quality of communication was 37.9%. This figure is considerably low when compared to what was reported in a study among HIV patients, which showed 84.8%. (40). The suggested reasons of this difference could be, due to short duration of clients and health care providers in antenatal care follow up clients than HIV patients. The qualitative findings also revealed low level of satisfaction.

This study also provides information on the barriers of optimal communication from the health care providers' perspective. Time constraint (88.0%), multiple clinical tasks (71.0%),lack of dedicated space for communication(58.8) , lack of privacy during the encounter (52.0%), and client's language, lack of training in communication (29.0%) were major barriers of optimal communication. These barriers might lead the health care providers to give the client only the information they think their client needs limiting the amount of time they should ideally spend with a given client

eventually affecting the quality of health care providers' communication and clients' satisfaction. This finding is in line with what was reported elsewhere [21, 22].

Other factors affecting clients' satisfaction on health care providers' quality of communication in multivariate analysis were;

Health care providers' empathy and information provision, duration of time spent in each encounter, knowing the health care providers and feeling of privacy were found to be significantly associated with clients' satisfaction on health care providers' quality of communication.

Clients who perceived the health care providers information provision as poor were less likely to be satisfied than those clients' perceived as good.

Moreover, clients who perceived the health care providers' empathy as poor were found to be less likely satisfied with health care providers' quality of communication than those clients who perceived as good. This finding is in line with a study result [39]

It was also found that clients who knew the health care providers very well had an average increase of 0.54 units in their satisfaction with the health care providers' quality of communication compared to those who did not know the providers at all. This finding is similar with study among HIV patients [40]. Clients' who spend with the health care providers 12-17 minutes were less likely satisfied than those clients spend more than 30 minutes but more likely satisfied than clients spend 1-5 minutes.

On the other hand age, sex and professional category of the health care providers, age of the client, educational status, and frequency of visit were found to be not statistically significant with client satisfaction on health care provider quality of communication. But clients cared by male health care providers were more satisfied than clients cared by female health care providers. This finding is contrary with a result find in [38]. And clients cared by obstetric health care providers were more satisfied than those clients cared by nurse health care providers.

Moreover clients who had three and fourth frequency of visit were more satisfied than those clients visit the clinics once and more than four.

7. STRENGTHS AND LIMITATIONS OF THE STUDY

Strengths

- The study used a valid and standardized survey instruments.
- The study focused on the clients' satisfaction which is one of the important strategies to improve service utilization and consequently to reduce child and maternal mortality rate which is the government millennium goals.
- The research involved both health care providers and antenatal clients which helped to get the perspectives.

Limitations

- The study focused on high risk mothers in public hospitals only. As a result, the situations with regard to low risk mothers in the health centers could not be assessed in the study which results in limited area of generalization.
- Is difficult to compare the results due to lack of prior research in the area.
- Non random Sampling method was used to select the client.

8. CONCLUSION

- About three out of five of clients were not satisfied by the providers' quality of communication.

- Insufficient discussion time, suboptimal health care providers' empathy and information provision, suboptimal feeling of privacy and lack of continuity of care by same health care providers were the main factors that contributed to the low client's satisfaction on health care provider's quality of communication.

- Health care providers' characteristics such as age within 25-29 years , male gynecology professional category were observed to be positively associated with client satisfaction on health care providers quality of communication

- .Clients' characteristics, those with age group 35 and above, primary and secondary education were observed to be positively associated with satisfaction on health care providers' quality of communication.

- Less privacy during communication was reported to be the reason of dissatisfaction of clients on health care providers' quality of communication.

- Time constraint due to heavy clients load followed by multiple clinical task and lack dedicated space for communication were major barriers of optimal communication in health care provider perspectives.

9. RECOMMENDATIONS

- There is communication gap between health care providers and clients that leads clients' to dissatisfaction on antenatal care services, so providers should improve the way of conveying information provision to the client through training.

- Better demonstration of empathy, information provision, longer discussion time and continuity of care with one provider should be encouraged to improve clients' satisfaction on health care provider quality of communication.

- Attempt should be made to free health care providers at ANC from multiple clinical tasks with more attention given to ensuring dedicated space to improve optimal provider-client communication.

- Hospitals which were under study should use the findings of this study to improve clients' satisfaction on health care providers' quality of communication.

- Observational studies are needed on client –health care provider communication to enhance the evidence in local context in both verbal and non verbal communication.

REFERENCES

1. WHO/UNICEF: *Focused antenatal care: providing integrated individual care during pregnancy,2003*
2. Alene GD, Wheeler JG, Grosskurth H: *Adolescent reproductive health and awareness of HIV among rural high school students, North Western Ethiopia. AIDS care, 2004,* 16(1):57-68

3. Arnold E, Underman-Boggs K: *Interpersonal Relationships: Professional communication Skills* for Nurses, 5th edn. Saunders,St Louis,MO, 2007
4. Rider A, Keefer CH: *communication skills competencies: definitions and teaching to olbox.* Medical Education,2006 ,40:624-629

5. Gustauo N,Muneer A;Womens' *opinions on antenatal care in developing country* BMC Public Health 2003,3-17
6. Roberts L ,Bucksey SJ: *communicating with patients :What happens in practice physical therapy* 87(5):585-594 providers and clients participant manual, center for human service 2007, 20814-4811

7. Epstein R.M, Franks P, Fiscella K : *Measuring patient –centered communication, patient – physician consultation: Theoretical and Practical Issues social science and medicine* 2005,61(7):1516-28
8. Maine D:*Too far to walk :maternal mortality* in context soc sci Med 1994,38:1091-1110

9. Anddrea B pembe, AndressCarlstedt, David purasa Gunilla Lindmark, Lennarth Nystrom, ElisabethDarj: *Quality of antenatal care in rural Tanzania, counseling on pregnancy danger sign.* 2010 [web site http;//www.biomedcentral.com/1471-2393/10/35 accessed date Nev 2011
10. Nyarko, P, Birungi, H, Armar-Klemesu, M, Arhinful, D, Deganus, S, Odoi-Agyarko, H & Brew G: *Acceptability and feasibility of Introducing the WHO focused antenatal care package in Ghana.* Ghana: *Reproductive and Child Health Unit Health Service*.2006
11. Anya, SE, Hydara, A & Jaiteh, L: Ante natal care in the Gambia: *missed opportunity information, education and communication. BMC Pregnancy and Childbirth.2008,* 8(9):1-7.

12. Pino A: Maternity Service: *The need to communicate*. Consumer Research.1992

13. Elizabeth A. Rider, MSWMD, Margaret, Hinrichs and Beth A. Lown (2006). *A model of communication skill assessment a cross the under graduat curriculum 2006, 28.*No.5 [Website,http;//informahealthcare.com/doi/abs/10.1080/01421590600726540 accessed 24 Dec 2011

14. Federal Democratic Republic of Ethiopia Ministry of Health: *HSDP III Woreda based annual core plan.*2010, version 2

15. John E,Ekabua,Kufre J,Patience O,Thomas U,Agan,Christopher U,Aniekan J,Etokid M: *Awareness of birth preparedness and complication readiness* in southern Nigeria ,International scholar research network.2011

16. Chopra M ,Doherty T, Jackson D, Ashworth A: *preventing HIV transmission to children:* quality of counseling mothers in south Africa.2005, 94(3):357-363

17. Ammentorp J, Sabroe S, Kofoed PE, Mainz J: The effects of training in communication skills on medical doctors and nurse self-efficacy: a randomized controlled trial. Patient Education and Counseling.2007 66(3):270-277

18. Sofaer S.D, Flack K.D, McCoy T.E. Vaughn: *Does patient –centered care improve provision service?* Journal of General Internal Medicine.2005

19. Hinchliff S,Norman S,Schober J**:** Nursing practice and Health care. New York: Oxford University Press,2003

20. Surjit S, Wadhwa : *Customer satisfaction and health care delivery system*, the internet Journal of NucearM 2002, volume1 number 1

21. Caleb alexander G, Lawrence P Casalino, Chien-Wen Tseng, Diane McFadden, David O Meltzer: *Barriers to patient-physician communication about out –of-pocket costs.* What is patient physician communication, in PubMedcentral will retrieve 8 records.2004, 19(8): 856–860

22. Larissa J, Ander S, Yebadokopo, Jean A: *Antenatal counseling in maternal and newborn care: use of job aids to improve health worker performance and maternal understanding, BMC Pregnancy and Childbirth.2010*

23. Ransom E, Yinger N,V: *Making motherhood safer overcoming obstacles of the pathway to care population* reference bureau.2002
24. WHO/FIGO: *women's perspectives and participation in reproductive health* report of a pre –congress workshop organized by the joint Task Force, Singapore, 1991, 11-12.

25. Margaret Brawley: The client perspective: *What is quality health care service*? A literature review USAID Cooperative Agreement.2000, 617-00-00-00001-00
26. . WHO: *Changing medical education*: An agenda for action Geneva WHO division of human resource Midwifery journal.1991, 14(2):94-100
27. WHO: country health profile .Geneva: WHO, 2007

28. Whelan A and Lupton P: *promoting successful breastfeeding among women with a low income .1999*
29. WHO: *Improve the quality of maternal health services. Division of Reproductive Health* Geneva: WHO.1998

30. Michael Oerlemans, Terry Mills and Jenni Ham: *Measuring Patient Satisfaction*, Last Updated by Bill Fawcett, 5 June 2004,
31. Mohammed G, Rajiv R :*Satisfaction among expectant mothers with antenatal care services* in Musandam region of oman,2008,Sultan Qaboos Univ Med J 8(3) :325-332
32. Myriam D: *doctor –patient communication in general practice* :An observational study in six European countries.2006
33. John M, Robert R, Gilbert E : *patient-physician communication :Why and How*.2005
34. .Donabedian A The quality of care: how can it be assessed? Jam Med Assoc 1988,260:1743-1748
35. Irwin Press, *The measure of Quality* , Q Manage Health Care , Vol. 13 , No. 4 , pp 202 -209 16.

36. Harriott E.M, Williams, T.V ,Peterson M.R.: Childbearing in US military hospitals: *dimensions of care affecting womens perception of quality and satisfaction birth* 2005, vol,32

37. Gertrude S, Andy B, Gordon A.N :*predication of satisfaction with childbirth services* in public hospitals in Ghana 2009
38. Neter M, Kim L, Gunilla L, Kylike C: *Communication patterns between health care providers and their clients at antenatal clinic in Zimbabwe*. Health Care for women International,2003,24:2,83-92

39. Zewdie B,Tsion A,Mirkuzie W,Sudhakar M:Determinants of satisfaction with health care provider interaction at health centers in Ethiopia , BMC Health Services Research,2010,10:78
40. Mekedess assefa An assessment of health information exchange between clinicians and PLWHA on ART at Public hospitals in Addis Ababa may 2009
41. Girma S,human resource development for health in Ethiopia :Challenges of Achieving the Millennium development Goals. Ethiop J health dev 2007,21(3)

42. Claire Batchelor, David J. Owens, Martin Read and Michael Bloor, Patient Satisfaction Studies, Methodologies, Management and Consumer evaluation. An international Journal of Health Care Quality Assurance, Volume7.No7, 1994, 22 – 30.
43. Lissner C: Safe mother hood needs assessment. IN WHO/RHT?MSM/96.18.World Health Organization , Geneva ,2001
44. Census conducted by Central Statistical Agency of Ethiopia (CSA) , 2011 [Website,http;//www.evi.com/q/how many, accessed 22 June 2012

ANNEXS

II Questionnaire English version

Consent form

A study on assessment of client-health care provider communication in Addis Ababa Town, Ethiopia. Addis Ababa University School of graduate studies Department of health informatics

Post visit client Questionnaire

Name of the hospitals -------

Checked by---------------------

Investigators signature------------------ **Date-------------------------**

INTRODUCTION

Hello /Good Moring/Afternoon

My name is------------------------------

This study is conducted by AAU to assess client health care provider communication in ANC clinic of public health institutions in Addis Ababa the information collected help the client and the health care provider how they effectively communicate to enhance the quality of the health service provided and to know what factors hinder the communication effectively. With the long run it improves the maternal health statues by incorporate communication is one of the health service strategy.

Confidentiality and informed consent statement

I am going to ask you question about communication. You are one of the participants purposively selected during the ANC time. Your name will not appear on this questionnaire and all the information you provide to me will be strictly confidential .You are not obliged to answer any questions that you do not wish to answer ,and you can put an end to this interview at any time .your participation in this study does not involve any direct risk or benefit for you but is very use full since your answers ,as well as those of other participant will help to improve the quality of the health services provided in the area .Would you like to participate in the study? 1. Yes------------------------- ---------- 2. No----------------------------

Interview Guide

Patient Id---------------- **clinician Id---------------**

Date of interview--------

Section I: Socio demographic characteristics

Question	Coding categories	Cod
Age (in complete year)	-------------------------------------	
Educational status	1 illiterate 3 read and write 2 primary 4 secondary 5 college/university	
Frequency of visits	1.First 3.Third 2. Second 4.Fourth 5. Above fourth	
Number of parity	1. One 3 Three 2. Two 4 four 5.above four	

In-depth-interview

1. How do you describe your communication with health care providers in the ANC clinic in terms of the relationship you build with them, the way they try to understand your problem and provide information?
2. Describe your understanding of the health information provided by the health care providers working in the ANC clinic?
3. Describe the effect of continuity of care givers in communication?
4. Describe the institution (hospitals) environment in terms of privacy for communication.

Patient Id----------------- **clinician Id----------------**

Date of interview--------

Section I: Socio demographic characteristics

Question	Coding categories	Cod
Age (in complete year)	--------------------------------------	
Educational status	1 illiterate 3. primary 2 read and write 4. secondary 5 college/university	
Frequency of visits	1. First 3.Third 2. Second 4. Fourth 5. > fourth	
Number of parity	--	

Section II: Elements of communication

No	Elements	Poor(1)	Fair(2)	Good (3)	V.good(4)	Excellent(5)
	Providers empathy					
1	Greeted me in a way that made me comfort					
2	Treated me with respect					
3	Showed care and concern					
4	Let me talk without interruption					
5	Paid attention to me (looked at me ,listen carefully)					
6	Permit me to tell my idea (perception about my pregnancy)					
	Giving information					
7	Has explained about my pregnancy					
8	Has explained about the reason for the diagnostic test order and any procedure done					
9	Has explained about birth preparedness and complication readiness.					
10	Has explained and remained me about the need for ANC follow up					
11	Told me about problems with alcohol and other substance use					
12	Has explained about nutrition					
13	Has explained about PMTCT					
14	Has explained about breast feeding					
15	Talked in term I could understand					
16	Checked to be sure I understand everything					
17	Encourage me to ask question					
18	Involved me in decision as much as I wanted					
19	Discussed next step including my appointment or follow up					

Section III .Institutional aspect and pattern of visit characteristics

1. How do you rate your health status during the recent three months period?
   1. Poor
   2. Fair
   3. Good
   4. Very good
   5. Excellent

Continuity of care

2. Was today the first time you have been treated by this doctor?
   1. Yes
   2. No

3. How important is it to have **privacy** while you are with your doctor
   1. Very much
   2. Somewhat
   3. Slightly
   4. Not at all

Visit length

4. How many minutes spent with your health care providers---------------------------?

Section IV

5. **I am totally satisfied with the health care providers' communication?**

   1. Uncertain
   2. Strongly disagree
   3. Disagree
   4. Agree
   5. Strongly agree

Questionnaire for the health care provider
Name of the hospital----------------- Date-------------------- Clinician Id---------------------

Checked by **Supervisors signature------------------**	**Date-----------------------**
Investigators signature------------------	**Date-------------------------**

INTRODUCTION

Hello /Good morning/Afternoon

My name is-------------------------------

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1. Yes----------------------------------- 2. No----------------------------

Questionnaire for the health care provider

Name of the hospital---------------- Date------------------- Clinician Id--------------------

Checked by	
Supervisors signature-----------------	**Date----------------------**
Investigators signature-----------------	**Date-------------------------**

INTRODUCTION

Hello /Good morning/Afternoon

My name is------------------------------

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1. Yes----------------------------------- 2. No----------------------------

Section I Clinician practice characteristics

No	Question		Code
1	Age of the respondent(in complete Year)	--	
2	Sex	1. Male 2. Female	
3	Professional category	1. General practitioner 3. Nurse 2. Midwife 4. Health officer 5 .Gyn/obs	

1. How do the health care providers communicate with the client? Is there communication aids to clarify, to improve understanding, summarizing the information provide for the client?
   1. Yes 2. No
2. If No, why not, what do you think could be the reason? ---------------------------------------
3. Do you think health care provider optimally communicate with the client without any communication barriers
   1. Yes 2. No
4. If No, What are the major barriers, Put in rank order (from 1up to 8) that prevents health care providers to communicate with the client optimally?
   i. ----------------Lack of Training in Communication
   ii. --------------lack of staff
   iii. ---------------Lack of Integration into Routine Interactions
   iv. ---------------Clients language barrier
   v. --------------- Lack of dedicated space for communication
   vi. ----------------multiple clinical task
   vii. ---------------- Lack of privacy during the encounter
   viii. --------------- Time constraints due to heavy patient loads
5. If there is other barriers mention them---

አዲስ አበባ ዩኒቨርሲቲ

ድህረ ምረቃትምህረት ቤት
ሄልዝ እነፎረሜሽተክስ ዲፓርትመንት
ከህክማና በኋላ ለነፍሰጡር እናቶች የሚቀርብ ቃለመጠይቅ

የሆስፒታሉ ስም-----**----------------------------------**

ያረጋገጠው የቅረብ ተቆጣጣሪ ሰው ስም----------------ፊርማ---------------ቀን--------------

የጥናቱ ባለቤት ፊርማ----------------------------ቀን-------------------------

መጋቢያ

ጤና ይስጥልኝ እኔ ስሜ------------------ይባላል

ይህ ጥናት በአዲስ አበባ ዩኒቨርሲቲ የሚደረግ ነው የጥናቱ ዓላማ በአዲስ አበባ ከተማ የነብሰ ጡር እናቶች ህክማና አገላገሎት የሚሰጡ የመንግስት ሆስፒታሎች ውስጥ በህክምና ባለሞያወችና ታካሚወች መካከል የሚደረግ የጤና የመረጃ ልውውጥ ሂደትን ለመገምገም ነው፤ይህም ሁሉ ባለ ድርሻ አካላት ያለውን የመረጃ ልውውጥ ሂደትና ሂደቱን ሊያበለጽጉ ወይም ሊገድቡ የሚችሉ ሁኔታወችን በበለጠ እንዲረዱ ያግዛል፤በተጨማሪም የጥናቱ ግኝት ነፍሰጡር እናቶች የጤና ሁኔታ መረጃ አረዳድ የወሊድ ሁኔታ እና አጠቃላይ የእርግዝና እንክብካቤ ንና በሞያው ግንኙነት ላይ ያለውን እርካታ ለማሻሻል በመንግስት ተቋማት ውስጥ የተሸሉና ውጤታማ የመረጃ ልውውጥ ስልቶች ለመዘርጋት አስተዋጽኦ ይኖረዋል፤

በዘህ መሰርት በዚህ ሆስፒታል ውስጥ ያለውን የጤና መረጃ ልውውጥ ሂደት ለማወቅ ያስችል ዘንድ እርስወን ከሚከታተልወ ባለሞያ ጋር ክትትል ማድረግ ከጀመሩ ጊዜ ያሁኗን ቅን ጨማሮ ያደርጉት የነበረውን ውይይት ይዘት እጠይቅወታለሁ፤

በቅድማያ ግን ማንኝውም የሚሰጡኝ መረጃ ሚስጥራዊነት የተጠበቀ መሆኑን ልገልፅልወት እወዳለሁ፤በዘሁ የጤና ተቋም ውስጥም ሆነ በጥናቱ ላይ የሚሳተፉ ሌላ ሰው እርስወም የሰጡት መረጃ አያውቅም ፣ለዚህም ሲባል በመጠይቁ ላይ ስምወት ወይም የእርስወ ማንነት ሊገልጽ የሚችል ማንኛውም መረጃ አይሞላም፤

የሚሰጡኝ ማንኛውም መረጃ ጠቃሚ ነው ሰፋ ያለ አስተያየት ማግኘታችን በጉዳዩ ላይ ያለን ግናዛቤ በእጅጉ እንዲጨምር ይረዳናል.ለመመለስ ፍቃደኛ የማይሆኑበትን ጥያቄእንዲያልፍወትማድረግ ይችላሉ፤ቃለ መጠይቁንም ቢሆን በማንኛውም ጊዜ ማቆም ይችላሉ በቃለ-መጠይቁ ላይ ለመሰሳተፍ ፍቃደኛ ነወት

1 አወ ---------- 2 አይደለሁም------

አመሰግናለሁ

ክፍል 1

የጥልቅ ቃለመጠይቅ ጥያቄወች

እድሜ(በሙሉ ዓመት)		
የትማህርት ደረጃ	1 ያልተማረ 2. ማንበብና መጻፍ 2 የመጀመሪደረጃ 3. ሁለተኛ ድረጃ 5 ኮሌጅ/ዩኒቨርሲቲ	
የእርግዝና ጉብኝት ብዛት	------------------------------	

1. በ እናቶች ቁጥጥር እና ክትትል ክሊኒክ ውስጥ ህክምና ከሰጦት ባልሞያ ጋ ያሉትን የመረጃ ልውውጥ ሂደት ሞያዊ ግንኙኝነትን ከመፍጠር ፡ችግርን ለመረዳት ከሚደረገው ጥረት እና አስፈላጊውን መረጃ ከመሰጠት አንጻር እንዴት ይመለከቱታላ
2. በ እናቶች ቁጥጥር እና ክትትል ክሊኒክ ውስጥ ህክምና ከሰጦት ባልሞያ ጤናወን የተመለከተ መረጃ የአረዳድ ሁኔታ እንዴት ይገልጹታል
3. በተማሳሳይ ባለሞያ በተከታታይ ማየት ያለወን ጥቅምና ጉዳት ያብራሩ
4. የምርመራ ክፍሉ (አካባቢ) ከባለሞያው ጋር ሀሳብን ለመግለጽ ያለውን አመችነት ያብራሩ

ክፍል2 የመረጃ ልውውጥ ክፍሎች

ተ.ቁ	በህክማና ባለሞያወችና ታካሚወች መካከል የሚፈጠር መያዊ ግኑኝነት	በጣም አልስማማም (1)	አልስማማም (2)	አስተያየት የለኝም (3)	በጣም እስማማለሁ (4)	እስማማለሁ (5)
1	ወደ መመርመሪያው ክፍል ስገባ በጥሩ ሁኔታ ተቀብሎኛል/ላኛለች					
2	በአክብሮት አስተናግዶኛል/ኛለች					
3	ሊረዳኝ/ልትረጃ ፍላጎት አሳይቷ ል/ታለች					
4	ያለማቋረጥ ሀሳቤን እንዲገልጽ አድርጎኛል/ኛለች					
5	ሙሉትኩረትንሰጥቶአዳማጦኛል/ጣኛለች					
6	ሰለ እርግዝናየ ያለኝን እውቀት እንድናገር እድል ሰጥቶኛል/ታኝ ነበር					
	መረጃ አሰጣጥ እና መረጃ አሰባሰብ					
7	ስለእርግዝናየማብራርያ ሰጥቶኛል/ታኝ					
8	የታዘዘልኝየላባላቶሪምርመራወችምንነትናምክኒያትአስረለድቶኛ ል/ታለች					
9	የትመውለድእንዳለብኝእናአደገኛ ሁኔታ ሲያጋጥመኝ ምን ማድረግእንዳለብኝ አስረለድቶኛል/ታለች					
10	የእርግዝናክትትልጥቅምንአስረለድቶኛል/ታለች					
11	መጠጥ እና ሌሎች ሱሰ ሊያሲዙ የሚችሉ የመጠቀም ጉዳትን አስረለድቶኛል/ታለች					
12	የአመጋገብሁኔታየምንመሆንእንዳለበትአስረለድቶል/ታለች					
13	ኤቸአይቪከእናት ወደ ልጅ እንሚተላለፍአስረድቶኝ እንድመረመር ምክር ሰጥቶኛል					
14	ከወሊድቡኃላሰለጡትማጥባትጥቅምአስረድቶኛለች					
15	በቀላሉልረዳውየምችለውንቃላት/ቋንቋበመጠቀምስረድቶኛል/ታለች					
16	የተነገረኝንሁሉመረዳቴንአረጋግጣል/ጣለች					
17	ጥያቄወችንእንድጠያቅአበረታቶኛል/ታኛለች					
18	ጤናየንበተመለከተበሚደረጉውሳኔወችላይእንድሳትፍ አበረታቶኛል/ታኛለች					
19	በሚቀጥለው የህክምና ሂደት ቆይታ ተነጋግረናል					

ክፍል 3 የሆስፒታሉ እና የህክምና ቆይታ ሁኔታ

1. በዚህ ባለሞያ ህክምና ስታደርጊ ለመጀመሪያ ግዜሽ ነው

1 አወ 2 አይደለም

2. ከባለሞያው ጋር በነበረው ውይይት ነፃነተሽ

1 በጣም የተጠበቀ ነው 3 በጣም በትንሹ የተጠበቀ ነው

2 በትንሹ የተጠበቀነው 4 ምንም የተጠበቀ አይደለም

3. የእርግዝና መከታተያው ከፍል ከህክምና ባለሞያው ጋር ለመወያየት ያለው ነጻነት

1 በጣም የተጠበቀ ነው 3 በጣም በትንሹ የተጠበቀ ነው

2 በትንሹ የተጠበቀነው 4 ምንም የተጠበቀ አይደለም

4. ከህክምናባለሞያው ጋር ለምን ያህል ግዜ ቆይተሻል/የምርመራው ቆይታ/ በደቂቃ ቢገልጹል-------------------------

5. ባጠቃላይ ከህክምና ባለሞያው ጋር በነበኝ ውይይት ትደሰቻለሁ

1. እርግጠኛ አይደለሁም 3 አልስማማም

2. በጣም አልስማማም 4 እስማማለሁ 5. በጣም እስማማለሁ