ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

WOMEN'S AND MIDWIVES' EXPERIENCE OF COMPASSIONATE RESPECTFUL MATERNITY CARE DURING FACILITY-BASED DELIVERY IN BISHOFTU TOWN, SELECTED PUBLIC HEALTHFACILITIES, OROMIA, ETHIOPIA, 2020

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I, the undersigned MSc student, declare that I have submitted my original work on a title **women's and midwives' experience of compassionate respectful maternity care during facility -based delivery in Bishoftu town, selected public health facilities,Oromia,Ethiopia ,2020**

Submitted by:

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Name of student **Signature** **Date**

This thesis has been submitted for examination with my approval as advisor

Approved by:

Dr. Endalew Gemechu (Ass. Prof)  18.9.20

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APPROVAL BY THE BOARD OF EXAMINATION

This thesis by Hirut Dinku is accepted in its present form by the board of examiners as satisfying thesis requirement for the master of Maternal and reproductive health nursing.

EXAMINAR

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STATEMENT OF DECLARATION

By my signature below, I declare and affirm that this thesis is my own work. I have followed all ethical principles of scholarship 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.

The thesis will be deposited in the Addis Ababa University Digital Library and will be 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.

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List of Acronyms and Abbreviations

CRC Compassionate and Respectful maternity care

D&A Disrespect and Abuse

EDHS Ethiopian Demographic and Health Survey

ETB Ethiopian Birr

FMoH Federal Ministry of Health

ICM International Confederation of Midwives

MCHIP Maternal and Child Health Integrated Program

MMR Maternal Mortality Ratio

SDG Sustainable Development Goals

SSA Sub-Saharan Africa

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ABSTRACT

Background: Every woman has the right to a positive birth experience and compassionate care from knowledgeable, skilled providers. Compassionate and respectful maternity care encompass the universal right of every childbearing woman to receive care that includes respect for the woman's autonomy, dignity, feelings, choices, and preferences including choice of companionship and cultural rituals at birth in institutional delivery, whenever possible. Compassionate and respectful maternity care is closely related to eliminating disrespect and abuse during pregnancy and childbirth.

Objective: The main objective of this study was to explore women's and midwives' experiences of compassionate and respectful maternity care during facility-based delivery in Bishoftu town in selected public health facilities, Oromia, Ethiopia, 2020.

Methods: A qualitative exploratory research design was carried out from May 1-June 30, 2020 in three health facilities of Bishoftu city, Oromia, Ethiopia. A total of 22 in-depth interviews were done. The data were collected using semi-structured questionnaires. Data analysis was initiated alongside data collection using a thematic approach described by Braun and Clarke.

Results: From the analysis of in-depth interview data, four major themes emerged, namely, meanings of compassionate and respectful care (CRC), midwives' Practice of CRC, mistreatments, and barriers' to CRC.

Conclusion: The findings show that the provision of CRC in labor and delivery care increases the quality of care and health-seeking behavior of women. Good interpersonal communication on delivery care results in a positive birth experience to women. On the other hand mistreatment negatively affects women's experience of facility-based delivery. Barriers such as inadequate supplies, motivational problems and, work overload were found to decrease the provision of CRC. Therefore, addressing barriers and reducing mistreatments is important to increase quality of care and facility-based delivery.

Key words: Women, Midwives, compassionate and respectful maternity care, Institutional delivery, Bishoftu.

CHAPTER ONE

INTRODUCTION

1.1. Background

Childbirth also is known as labor and delivery, is the ending of pregnancy by one or more babies leaving a woman uterus. It is a life-changing event in which a woman goes through a lot of biological, social and emotional transitions (1). At this time all women and their babies need midwifery care(2). Midwifery care is a "skilled, knowledgeable and compassionate care for childbearing women, newborn infants, and family. Midwives are key maternity care providers(3) and they are responsible for an active guide through pregnancy and birth and inform, encourage women to overcome the challenges of birth(4)

Every woman has the right to a positive birth experience and compassionate care from knowledgeable, skilled providers (5).World health organization defines compassionate and respectful maternal care as the right every woman to attain the highest standard of health. This includes the right to dignity, compassionate and respectful health care to all childbearing women around the world throughout pregnancy, childbirth, and the postnatal period (6).

In Quality of Care Framework for maternal and newborn health of the World Health Organization effective communication, respectful and dignified care and emotional support are identified as the domain of care to improve women's experiences of care(7). Improved care for birthing mothers implies working with women to obtain their perspective on what constitutes a positive experience during labor and delivery(8).

Women's experience of care varied from positive to negative. Participating in making decisions regarding childbirth care and being supported by healthcare providers gives a positive memory and increases the woman's confidence and love for the baby and better adjustment to motherhood and experiences and future directions(7). Negative experiences have been associated with poor support and care, fear, excessive pain, discomfort, and undesirable outcomes These Negative childbirth experiences may lead to undesirable effects including failure to breastfeed, reduced love for the baby, emotional upsets, post-traumatic disorders and depression among mothers(9).

Women's memories of their childbearing experiences stay with them for a long time and are often shared with other women and influences their decision to seek care (10). Positive childbirth experience is a significant endpoint for all women undergoing labor (6).

1.2. Statement of the problem

According to the World Health Organization report, an estimated 3.9 million women will die from maternal causes in the next fifteen years if the current reduction rate of 2.9% in maternal mortality ratio (MMR) continues globally (11). The implication is that there is an urgent need to accelerate the drop in MMR in order to achieve the sustainable development goal (SDG) 3.1 of reducing the global maternal mortality ratio to less than 70 per 100 000 live births by the year 2030, with no country having a maternal mortality ratio of more than twice the global average (12).

Sub Saharan Africa (SSA) contributes two-thirds of the world's annual maternal deaths despite the remarkable decline in global maternal mortality. Regional MMR for 2015 ranged from 12 deaths per 100 000 live births for developed regions to 546 deaths per 100 000 for sub-Saharan Africa(11). Like many developing countries, the MMR remains high in Ethiopia even though, according to the Federal Ministry of Health (FMoH), the maternal mortality rate dropped significantly by over 30% in five years. The 2016 Ethiopian Demographic Health Survey (EDHS) report indicates that more than 1400 mothers per 100,000 live births died in 1990, and the mortality rate dropped to 412 per 100,000 live births in 2016 (13).

Maternal mortality is high in countries where the proportion of birth attended by skilled provider is low(11).In Ethiopia,although progress has been made in making maternity services available closer to the community, the rate of deliveries attended by skilled birth attendants is still low (50%)(14).

The absence of compassionate and respectful maternity care (CRC) is thought to have contributed to the low utilization of facility-based delivery services(15). Compassionate and respectful maternal care encompass the universal right of every childbearing woman to receive care that includes respect for the woman's autonomy, dignity, feelings, choices, and preferences including choice of companionship and cultural rituals at birth in institutional

delivery, whenever possible(16).Compassionate and respectful maternity care is closely related to eliminating disrespect and abuse during pregnancy and childbirth(17).

While several factors might affect CRC, to the best of the researcher's knowledge, Ethiopia has a limited number of studies on this topic, and the previous quantitative studies are rather focused on disrespectful and abuse during childbirth. This qualitative study is thus aimed to explore the experiences of women and midwives about compassionate and respectful maternity care during facility-based delivery in Bishoftu, selected public health facility, Oromia, Ethiopia.

1.3. Significance of the study

Population-based surveys have investigated vital information regarding disrespect and abuse occurring in health facilities during childbirth but they were unable to capture explanations of clients and providers about compassionate and respectful care during maternity care. Qualitative research will thus be conducted to complement population-based surveys to obtain an understanding of how women and midwives perceive, interpret and consider a number of factors affecting maternity care during delivery in this study.

The study also adds to the existing body of knowledge on women and midwives' perspectives of compassionate and respectful care during facility-based delivery services. Understanding of their perspectives is essential and helpful in guiding health care practitioners to design women-centered practice guidelines that address negative perceptions of health facility-based delivery. Ultimately, enhanced positive experiences with the delivery care could enhance the uptake of facility delivery in the future and assist with avoiding of direct obstetric complications and maternal death. Furthermore, the information that will be generated through this research will be useful to other researchers as reference material.

CHAPTER TWO

LITERATURE REVIEW

In this chapter different literature mainly published articles related to compassionate and respectful maternity care in line with the study, objectives are reviewed.

2.1. Midwives experience of provision of maternity care

2.1.1 .Who is Midwife?

The International Confederation of Midwives (ICM) define a midwife as: "a person who has completed a midwifery education program that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery"(18).

Midwives have a wide-ranging and uniquely skilled place in caring for women not only throughout pregnancy and childbirth but also in antenatal and postnatal care; neonatal care; sexual health and fertility services in partnership with women and their families(19).

2.1.2. Midwives care during child birth

Midwives are the primary professional group to provide care during childbirth (3).an exploratory study done in Sweden showed midwives experience creating a calm and safe environment by their caring attitude and sharing of responsibility(20). A similar study done in Norway identified midwife's first encounter with the woman as a key opportunity for establishing rapport during labor This study also identified being mentally present and actively developing mutual trust as two important factors for building a relationship for laboring mothers (21). Other studies done in Afghanistan reported that skilled birth attendants provided all necessary services to laboring mothers including checking vital signs, use of partograph during labor, administration of medication. And also they provided moral support and required information about the progress of labor (22).

"It is challenging to be expected to provide excellent maternity care whilst you do not have enough midwives in a day to cover a shift let alone those specialist midwives that we are dreaming of and we do not have. We are extremely short-staffed in the maternity ward"

The above quote is taken from the study done in South Africa and showed the effect of the shortage of midwives in providing quality maternity care. This study further describes the shortage of material, Indecisive manager, poor staff communication and lack of management support as some factor that leads to poor provision maternity care (23). A study done in Amhara regional state, Ethiopia on quality of intrapartum midwifery care reported competence of midwives, insufficient availability of essential equipment, lack of training as barriers to giving quality labor and delivery care(24)

2.2. Women experience of maternity care

2.2.1. Experience of care in health system

Experience of care is a process indicator and reflects an interpersonal aspect of the quality of care received. This indicator broadly composed of three domains: effective communication, respect and dignity and emotional support (25).facility-based delivery is one chance for women to get health care experience. Women need service to be provided respectfully but evidence showed that women face humiliating and undignified conditions in health facilities(26)

2.2.2. Abuse and Disrespect in facility based delivery

All childbearing women need and deserve respect and protection of their autonomy and right to self-determination during facility-based delivery (10)however many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth(5). Disrespect and abuse in childbirth defined as interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified(27). In a 2010 landscape analysis, Bowser and Hill described seven categories of disrespectful and abusive care during childbirth these are physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities(10).

A number of studies have identified the disrespectful and abusive treatment of women during facility-based delivery. An observational study done in Malawi reported that 94% of laboring mothers experienced disrespect and abuse(28). In a study done in South Africa, 51% of women reported to have non-respectful maternity care and teenage and young mothers, a mother with no schooling or primary education, Mother from other country and mother with less than 20-year residency in South Africa reported more negative experience(8).

Facility and community survey in rural Tanzania showed that the prevalence of disrespect and abuse was found to be 19.5% in an exit interview and 28.2 in the follow-up interview(29). The same study done in Kenya also revealed that 20% of the women reported any form of disrespect and abuse (D&A)(30). A cross-sectional study done in southern Mozambique showed that the prevalence of disrespect and abuse was found to be 24% in central hospital and 80% in the district hospital and lack of confidentiality/privacy reported as the main type of D&A(31).

In Ethiopia, the rate of D&A ranged from 67% in western Oromia(32), 78% in Addis Ababa(33), to 99% in southern Ethiopia(34).

2.2.3. Midwives perspective on disrespectful and abusive maternity care

A study done in Ghana identified abusive and disrespectful care to be practiced by both practitioner midwives and staff midwives and the reason for disrespectful care is explained as an alternative way not to lose the life of baby or mother(35). A Similar study in Nigeria reported midwives' belief of disrespectful care as an appropriate measure to ensure good outcomes to mother and baby(36). Similar study done in Tigray region reported the practice of disrespect and abuse by midwives and put resource scarcity of the health facility as reason behind the practice(37). Other similar study done in Ethiopia reported physical and verbal abuse as well as non-consented care to be practice by midwives during labor and delivery and most midwives explained these abusive care to be unintended and are the result of weakness in the health system or from medical necessity(38).

CHAPTER THREE

OBJECTIVE OF THE STUDY

3.1. General Objective

To explore women's and midwives' experiences of compassionate and respectful maternity care during facility-based delivery in Bishoftu town, selected public health facilities. Oromia, Ethiopia, 2020

3.2. Specific objectives

- To explore women's experiences of compassionate and respectful care from midwives during labor and delivery
- To explore midwives' experiences of compassionate and respectful maternity care to clients

CHAPTER FOUR

METHODS AND MATERIALS

4.1. Study area and period

The study was conducted in Bishoftu town. Bishoftu town is located 47 Km from Addis Ababa, in East Shewa Zone of the Oromia Regional State. Its astronomical location is 8º 43‟- 8º 45‟ North Latitude & 38º 56‟- 39º 01‟ East Longitude. According to the 2015 Central statistics Agency, it's estimated that the total populations of Bishoftu was 147,100. The city has one general hospital and five health centers. The study was done on three selected public health facilities namely Bishoftu General Hospital, Bishoftu health center and Keta health center. Based on the information found from Bishofu town health office, Bishoftu General Hospital was established in 194l G.C at that time, it was serving as a prison park of the Italian military, now the hospital has 171 inpatient beds and provides service for three towns and five districts, for the total of 1.2 million people, within its 255 staffs. The labor and delivery is one unit of the hospital and it has one gynecologist, two emergency surgeons, and 18 midwives. Bishoftu and keta health centers have equal three midwives who provide maternity care service. These health facilities were selected due to their high client flow.

The study was conducted from May1-June30, 2020.

4.2. Research Design

A qualitative exploratory research design was used to achieve the objectives of the study. The purpose of exploration in this study was to gain a deeper understanding of women's and midwives 'perspectives of CRC associated with facility-based delivery in the study setting.

4.3. Population, Sample and sampling

The study population was women who had given birth in the past 2 weeks in health facilities and midwifery experts who provided maternity care in labor and delivery wards of the health facilities. The participants for the study were selected with the purposive sampling method on account of their ability to provide information. A total of 10 Midwives and 12 women were interviewed in the study. Twenty two sample sized was finalized based on data saturation.

4.4. Eligibility criteria

4.4.1. Inclusion criteria for women:

Women who fulfill the following criteria were included in the study:

- who had given birth attended by a midwife within the past two week in selected health facility , in Bishoftu town
- Had reported to the selected health facility for registration of maternal and child health clinics
- provide written consent to participate in the study

4.4.2. Inclusion criteria for midwives:

Midwives who fulfilled the following criteria were included in the study

- Graduated with Diploma or BSc in Midwifery
- Has worked as a midwife in the labor and delivery ward for at least one year.
- provide written consent to participate in the study

4.5. Data collection tool

In-depth interview using semi structured interview guide question was used to collect the data. The interview guide was prepared in English translated into Amharic by language expert and translated back to English by third person to check for consistency. Matching was made on the exact fitness of the two versions. Throughout the interviews a probe was used to offer clarification and encouraging elaboration from the participants on specific issue or topic that are domains of interest to the researcher. Using in-depth interview had enabled the researcher to explore issues for a better understanding of women's and midwives' perspectives on CRC related to health facility-based delivery care in the context of the study site. A total of 22 in-depth interviews were held in each of the three selected public health facilities. Instead of relying on the number of participants, qualitative research focuses on the quality of information from the participants and different perspectives and opinions of participants. Twenty two sample sized was finalized based on data saturation.

Data saturation or adequacy is reached when there are no new emerging ideas of information in the data, the point in coding when no new codes occur in the data(39).

4.6. Data collection process

The women and midwives who meet the eligibility criteria were contacted through the in-charge person of the maternal and child health units of the selected hospitals and health centers to discuss the purpose of the study, and requested for participation in the study. The researcher ensured that all study participants who agree to take part in the interviews were reminded of the purpose of the study, expected benefit, their right to withdraw from the study and protection of confidentiality before they sign consent forms. The principal investigator and one research assistant having qualitative data collection experience conducted the interviews. All interviews were conducted in Amharic by using tape audio recorder. The individual interview was taken place in the private rooms of selected health facilities. During the interviews; a favourable, non-threatening and relaxed environment was created. With participant approval, the interviews were audio-recorded to ensure a complete transcript and notes were written during all interviews in order to capture the original accounts of the participants' responses. The audio-recorded interviews ranged from 20-45 minutes. Since the data collection was employed during a coronavirus outbreak to prevent the possible transmission of the disease; the interviews were conducted in a well-ventilated room, keeping distance between participants and the interviewers, both participants and interviewers wore a mask, and alcohol-based hand rub used to clean hands before and after the interviews.

4.7. Data analysis process

The analysis of data was done simultaneously with data collection. The audio recordings of individual interviews were transcribed and translated verbatim from Amharic to English. The researcher made sure that transcriptions were precise and that they reliably reflect the interview experiences. Furthermore, field notes were taken concerning the participant's gesture, tone, and language in doing so. To understand participant experience of compassionate and respectful maternity care a thematic analysis was conducted using the six steps described by Braun and Clarke(40). The transcripts were examined by breaking down

the text into small units. These meaning units were sorted into first order themes by collating similar unit together. Finally four major themes were identified. The researcher used ATLAS.ti version 7.5.16 software for the analysis.

4.8. Trustworthiness

The trustworthiness of a qualitative study is determined by the extent to which it is dependable, confirmable, credible and transferable(41).

Credibility

Credibility refers to the extent to which data and data analysis are believable, trustworthy or authentic. According to Yilmaz, credibility means that the study participants find the results of the study true or credible(42).To ensure credibility the researcher discussed data coding, data analysis and interpretation continuously throughout the research process with peers who are also conducting qualitative researches and with a researcher who is experienced in doing qualitative researches. Member checking with participants was also carried out throughout data collection by probing questions, within this, member checking occurred by reiterating statements made participants' during interview.

Dependability

It refers to a criterion for evaluating integrity in qualitative studies namely the stability of data over time and conditions; analogous to reliability in quantitative research(41).to establish dependability, the findings of this study was audited and verified by advisors and others who have experience in qualitative research so that an outside individual can examine the data. Each process was documented and audio records are available for cross-checking.

Conformability

This criterion refers to the extent to which the research findings could be confirmed or corroborated by other researchers in the field. It is concerned with establishing that data and interpretations are not figments of the inquirer's imagination, but clearly derived from the data(41).To establish conformability, when the interview is conducted, Field notes were taken furthermore the interviews were tape-recorded hence the raw data is available. By refining the

data collection instrument in the course, by using codes and categorization and by developing themes from the coded data, the data's were analyzed without personal biases

Transferability

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other similar contexts or settings or groups(41).To this end, we provided description that could be rich enough for other researcher to be able to make judgment about the transferability of our research findings to other similar context.

Triangulate

Triangulation technique was utilized to cross verify data source. If themes are established based on converging several sources of data or perspectives from participants, then this process can be claimed as adding to the validity of the study (42) .

4.9. Ethical consideration

The study was conducted after full approval and ethical clearance was obtained from Addis Ababa University, College of Health Sciences, School of Nursing and Midwifery. Written permission was obtained from Bishofu Town Health Office and each of the participating health facilities provided permission to conduct the study in their premises. Before participants signed the consent form, which was written in Amharic and English**,** the researcher ensured that participants understood the information given by using the language of the choice and at the level of their understanding. All study participants were above 18 so consent forms were given to sign indicating their voluntary participation in the study and permission for the audio recording of the interviews. Participation in this study was voluntary; the right of the participants to refuse answer for few or to withdraw at any time from the study was respected. To protect the participants' rights to anonymity and confidentiality: The participants' information was treated in strict confidence and only used for the purpose of the study; the collected raw data was kept safe and confidential, locked up in a secure place and the files were password-protected, and names of the participants were not written in study records and data was reported in a manner that doesn't identify or link the participants with the information.

4.10. Dissemination of the study

The result of this study will be disseminated to Addis Ababa University College of Health Sciences, School of Nursing and Midwifery and Bishoftu Town Health office. Attempts to publish parts of the research findings in reputable local and/or international journals will finally be made. The results will also be disseminated through workshops and seminar

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RESULTS

5.1 Participant's Socio-Demographic Characteristics

Ten midwives and twelve women participated in the study. Of the midwives, 6 were males and 4 were females, their age ranged from 23-30 years. Eight of the midwives were BSc. graduates while 2 had Diploma in midwifery. Their work experience in the discipline ranged from 2-12years. All of the women who had delivered in health facilities and participated in the study were married, their aged spanned from 19-28 years, and educated from 5th grade to Bachelor Degree.

Table 1: Socio demographic profiles of study participants [midwives]

Midwife	Study area	Sex	Age	Religion	Marital status	Year of experience
Mid1	Bishoftu general hospital	M	30	Protestant	Married	9
Mid2	Bishoftu general hospital	M	27	Protestant	Unmarried	5
Mid3	Bishoftu general hospital	M	23	Protestant	Unmarried	3
Mid4	Bishoftu general hospital	M	25	Protestant	Unmarried	5
Mid5	Bishoftu general hospital	M	29	Orthodox	Unmarried	5
Mid6	Bishoftu general hospital	F	29	Protestant	Married	6
Mid7	Keta health center	F	25	Protestant	Married	2
Mid8	Keta health center	F	30	Protestant	Married	7
Mid9	Bishoftu health center	F	28	Orthodox	Unmarried	3
Mid10	Bishofu health center	F	30	Orthodox	Married	12

Table 2: Socio demographic profiles of study participating women

Woman	Age	Marital status	Religion	Educational status	Number of children
Wom1	28	Married	Orthodox	11	2
Wom2	24	Married	Orthodox	10+3	1
Wom3	23	Married	Orthodox	Degree	1
Wom4	20	Married	Orthodox	12	1
Wom5	28	Married	Orthodox	8	3
Wom6	28	Married	Orthodox	8	3
Wom7	26	Married	Orthodox	12	2
Wom8	23	Married	Orthodox	8	1
Wom9	21	Married	Orthodox	8	2
Wom10	25	Married	Orthodox	12	1
Wom11	19	Married	Orthodox	10	1
Wom12	24	Married	Muslim	5	4

5.2 WOMEN'S AND MIDWIVES' EXPERIENCES OF COMPASSIONATE AND RESPECTFUL MATERNITY CARE

From the analysis of in-depth interview data, four themes emerged, namely, meanings of compassionate and respectful care (CRC), midwives' Practice of CRC, mistreatments, and barriers' to CRC.

5.2.1 Meanings of compassionate and respectful care: Midwives' views

This theme reflected participants' description of behavior and practice that they considered as compassionate and respectful care. The findings of the study revealed that most participating midwives described compassionate and respectful maternity care as provision of care in a way that the client expects care from us. Clients usually want to be treated kindly, equally and ethically. Sample quotes are the following:

"…… A woman who seeks care should be treated regardless of her backgrounds: ethnicity, economic and educational status……. So for me, this is what I mean compassionate and respectful care (CRC) (P1).

A midwife is expected to provide his/her clients ethically and should have a sound ethical principle. So, CRC is behaving ethically sound while providing care to clients (P5)

''…… Respecting clients' needs is to be compassionate for her….. (P7)

The findings of the study also revealed that some midwives mentioned that avoiding physical and verbal abuse; showing respect, patient and sympathy are at the hands of midwives. These findings were evident in the following sample responses:

'' …… CRC means just treating them [Clients] politely …'' (P8)

''While they are in labor, women might be aggressive and uncooperative. So, we [Midwives] should understand their behavior; we should avoid physical and verbal abuse; showing respect, patient and sympathy to the clients…'' (P9)

5.2.2 Midwives' Practice of Compassionate and respectful maternity care

According to the study findings, almost all participating midwives described providing compassionate and respectful maternity care during child birth as a good quality of care. Participants described compassionate care as personal; referring to the women they are caring for in labor as "my women". Compassion in caring for laboring woman made it seem as if the midwife was caring for her own family. Participants often made the point that each laboring woman is unique and should be seen as an individual, with their own individual needs and wishes.

Most participating midwives stated actions and practices such as greeting clients warmly, showing good face, understanding client's needs, and providing information to the clients. Compassionate and compassionate care happens when a midwife and team comes around a woman and empower her to have the best birthing experience she can ever have. These findings were evident in the following sample responses:

''……I am compassionate and I always approach them [Women] like I know them before. I would refer the women I care in labor as "my women". I would greet them by their names and ask if they have pains or any discomforts and would treat her kindly (P6).

.....I warmly greet her and take time to explain what is going to happen next, and give her a chance to ask questions and address to her needs (P7)

……The midwives care the laboring woman as their own family .....(P8)

The findings of the individual interviews revealed that Provision of compassionate and respectful maternity care was perceived by some providers to result good health-seeking behavior because it builds a sense of trust among the women and midwives. These findings were evident in the following sample responses:

''…… Treating our clients with respect and dignity increases acceptance and builds a trusting relationship with them (P5)

Most Women also linked compassionate and respectful care practices to midwives' manner of communication and described midwives' care as dignified and respectful.

"……they [Midwives] treated me like a friend …I would say that the midwife cared for me was respectful and dignified" (M3)

"…… It was my first time to deliver in the health facility. The midwife there encouraged me, and helped me positively and delivered normally [M2].

"…she [midwife] supported me a lot and with her [midwife] help I gave birth…just support and encouragement is big thing for us [women]''(M8).

5.2.3 Mistreatments: Women's and Midwives' perspectives

According to the study findings, both the midwives and women described the presence of mistreatments in the labor and delivery service. The most commonly reported categories of mistreatments were lack of privacy, abandonment of care and non-dignified care. According to most participating midwives, the utmost mistreatments were non -intentional and committed while the provider thought the safety of the mother and unborn child were at risk

due to the lack of cooperation' from the woman. These findings were evident in the following sample responses:

"……the Women don't know why we are sometimes shouting. We just shout at them to save their lives and unborn child… but they don't understand us. I would be angry with her if I tell her sometime and doesn't listen to me'' (P8)

''At the second stage of labor, we ask her to push as the vulva is wide open and head is bulging. It makes me angry when she doesn't do so and I might shout at her but this not personal. I can do it unintentionally'' (P7)

"……during the 2nd stage, if the baby gets distressed, I might powerfully say" open your leg" and this is for her sake not to my advantage"(P3)

Some women inferred being yelled at as a sign that they were not liked. In this case, a woman felt hated due to her low financial status. Physical abuse was scarcely mentioned and entailed a fear of abuse rather than enacted violence. One woman described fearing that she would get hit or beaten during labor if she yelled too much or "talked back" to a provider. She reported witnessing this behavior among others, but did not experience it herself. These findings were evident in the following sample responses:

''They [Midwives] just shout at us … they don't like us especially if we are poor. She [Midwife] left me alone and unattended to me……. '' [M5]

"*A friend of mine told me that 'she was beaten by her midwife because she talked back to the midwife' '' [M7]*

A midwife attending to me ignored me the whole night. My husband asked her to be with me but she checked my abdomen once and went to sleep…… [M1]

5.2.4 Barriers in the provision of CRC: Women's and Midwives' perspectives

The midwifery participants stated that the resources required for providing quality care at health care facilities was scarce. According to the findings, there was shortage of midwifery staff. A small number of midwives attend to a large number of clients in various public health facilities; and these causes fatigue and overburden to the midwives and comprises the quality

of care. Besides to shortage of staff, most midwives also reported low payment, lack of different benefit package, limited career development, skills to exercise their midwifery profession to the standard. Lack of health insurance was mentioned as one of the challenges by the participants. Sample quotes are the following:

"…… there is limited midwife at our department. When you attend follow up and delivery room at same time, it compromises the quality of your work …" (P8)

"…Workload due to limited staff is one of the main challenges and comprises the individualized care, including CRC (P10)

"…… You can't provide CRC while caring for 2 or 3 clients at the same time (P3)

"…… Our monthly salary and the workload is not proportional; this can upset you sometimes because life is very expensive and you may reflect your anger on your clients (P5)

"… There is no educational opportunity to advance our knowledge and skills. The workload and the payment never fit……" (P6)

"…… The authorities should recognize our works and provide us health insurance. Health insurance is a fundamental issue for all health providers….. (P10)

According to the findings, the midwives reported that there was shortage of beds/couch; screen, ultrasound and some drugs were reported as additional challenge. Sample responses included:

"…..... There is no curtain or screen in the health facility and clients will be exposed when the midwife performs vaginal examination… (P3)

"…….Screens should have been available at the side of every bed… These factors hinder you from working fully."(P4)

"……It's better if we have ultrasound machine because there are mothers who have no enough money for ultrasound image (P8)

Participant women also reported the need for some supplies or resources for health institutions to make labor and delivery care more compassionate and respectful. Sample responses are the following:

"…I went to hospital but there was no bed and they [Hospital] sent me here[health center]… sending the laboring mother to another health facility due to shortage of bed is not safe, a lot of things may happen…so it would be good they [Hospital] improve this thing". (M9)

"…The rooms are not separated, people see each other these prevent privacy and freedom, it would be good if they have any means that helps to protect our[women] privacy".(M10)

"…I have seen curtain rod in front of every bed but, there is no curtain.it would have been good for our[women] privacy if there were curtain…".(M3)

CHAPTER SIX

DISCUSSION

This study explored women's and midwives' experience of compassionate and respectful maternity care during facility based delivery in Bishoftu, Oromia, Ethiopia. In the previous studies, good interpersonal relationship between women and midwives in the form of greeting, encouraging women, creating comfortable environment where the women relax and explaining labor process and treatment were reported as common aspects of respectful child birth care(10,36). The findings of the present study revealed that most participating midwives described that compassionate and respectful maternity care as provision of care in a way that the client expects care from the provider. It was reported that clients usually want to be treated kindly, equally and ethically while receiving maternal health care. Provision of this compassionate and respectful care increases health seeking behavior of women. It seems that women's experience of compassionate and respectful maternity care during facility based child birth determines women's and family choice about where to give birth(26) .

The WHO Intrapartum care guideline recommends effective communication among maternity care providers and women in labor(6). Effective communication from maternity care providers can help women in labor and birth, to feel in control and feel respected(16). Similarly, in this study, women reported that good communication of midwives made them feel respected and dignified. This shows women's high value for effective communication when giving birth in the health facility.

Women have the right to give birth in environment which is free from mistreatments (33).However mistreatment of women during facility based delivery is prevalent globally(6). Bowser and Hill identified seven categories of mistreatments which are physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities (10).In this study both midwives and women described the presence of mistreatments and the most commonly reported categories of mistreatments were non-dignified care, lack of privacy and abandonment of care.

Previous studies have identified different forms non-dignified care including scolding, threatening and blaming (20,24,25,27). Similarly this study found that providers in the study area practiced non dignified care particularly shouting on clients and leaving a women alone or unintended for a long time. These findings were consistent with study done in west Oromia. (32).

Both women and midwives in this study reported lack privacy as another type of mistreatment. The most common reasons mentioned were, shortage of materials and space in the health facilities. This finding is similar with other study which state scarcity of resource as contributor of mistreatments(37).

Mistreatment of women include both the deliberate and unintentional practice which affects women's right to respectful and dignified care(38).In the current study, most of mistreatments were reported as non-intentional and done by participant midwives when they thought the safety of the mother and unborn child is at risk. This finding were consistent with study done in Nigeria (36). This shows most mistreatments were unlike to be deliberate but were resulted from concern about women's and baby's wellbeing. Whether it is intentional or non-intentional, mistreatment during childbirth can amount to a violation of the human right and could be a powerful disincentive from seeking facility-based maternity care (23).

In this study midwives reported staff shortage, inadequate supplies, weak support structure and limited infrastructure as barriers in the provision of compassionate and respectful maternity care. These findings were similar with previous studies that showed the difficulty of providing respectful and dignified care with limited staff, heavy workload and inadequate space(33,34).This shows that significant role of work environment in shaping providers abilities to promote CRC.

6.1. Strengths and limitations of the study

6.1.1. Strength of the study

This qualitative study is one of the first studies in the study setting. It should also be clear that the emerged themes were substantiated by the local and global works. Hence, the findings are valuable to health organizations that need to improve CRC during health facility-based delivery services.

6.1.2. Limitations of the study

Several limitations were encountered in this study. First the research was conducted at the time of COVID-19 pandemic, which caused obstacles to access clients easily to obtain the data timely. Besides, there limited literature on the topic giving a narrow point of reference when discussing the results.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

7.1 CONCLUSION

The findings show that the provision of CRC in labor and delivery care increases the quality of care and health-seeking behavior of women. Good interpersonal communication on delivery care results in a positive birth experience to women. On the other hand mistreatment negatively affects women's experience of facility-based delivery. Barriers such as inadequate supplies, motivational problems and, work overload were found to decrease the provision of CRC. Therefore, addressing barriers and reducing mistreatments is important to increase quality of care and facility-based delivery.

7.2. RECOMMENDATIONS

To improve compassionate and respectful maternity care and to promote birth at the health facilities, the results of this study suggested that:

For Ethiopian ministry of health

- It is better to employ adequate numbers of midwives for the health facilities
- It is recommended to address resource availability
- It is important to make midwives benefited from various benefit packages, including paying reasonable salaries. It was also marked that more attention is required to improve attitudes of maternity care providers to clients

For Health institutions

- Health institutions need to adapt to provide reasonable adjustments to accommodate CRC, individualized care.

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Annex I: Information and consent form (English Version)

RESEARCH TITLE: WOMEN'S AND MIDWIVES' EXPERIENCES OF COMPASSIONATE AND RESPECTFUL MATERNITY CARE DURING FACILITY BASED DELIVERY IN BISHOFTU TOWN, PUBLIC HEALTH FACILITIES, OROMIA, ETHIOPIA

Dear Respondent:

My name is **Ms. HIRUT DINKU** and I am currently studying my Master's degree at Addis Ababa University, School of Nursing and Midwifery.

I kindly request you to participate in a study that is aimed at exploring the **EXPERIENCE OF WOMEN AND MIDWIVES ABOUT COMPASSIONATE AND RESPECTFUL MATERNITY CARE IN BISHOFTU, OROMIYA, ETHIOPIA.** The research proposal has been approved by the Ethical and Review Committee of Addis Ababa University, School of Nursing and Midwifery. I would appreciate it very much if you could consider participating in this research. Your participation is important because it will provide valuable information and deep understanding of the experience of CRC during facility based delivery. Your involvements in the study include participation in face-to face interview, which will take approximately 30 minutes.

The participation in this study is voluntary; you can also withdraw at any time from the study if you feel uncomfortable. Refusal to participate will not affect your work or care you shall seek at any of the health facilities in any way. Confidentiality will be ensured by not using your name or address on the questionnaire and final thesis report. There are no foreseeable physical, psychological or social risks or discomforts involved in participating in this study.

The study has no immediate benefits to the respondents, but will have benefits later in improving compassionate and respectful maternity care and quality of Facility based delivery service.

If you have any questions about the research or any related matters, please contact the researcher at **+251-931-297477.**

Email- hirutbd@gmail.com

Consent form

I, the under signed, understand the nature of the study, benefits, my right to voluntary participation, confidentiality and withdrawal from the study without any victimization. I have had the opportunity to ask questions and answered to my satisfaction.

I hereby freely consent to take part in this study.

Name of participant _____

Signature of the participant_____

Date_____

Your participation will be greatly appreciated.

Yours Faithfully,

Annex II. Questionnaire (English version)

1. MIDWIVES IN-DEPTH INTERVIEW GUIDE FORM

Interview date: _____

Start time: _____

End time: _____

Interviewer: _____

[Guidance for interviewer: PLEASE START RECORDING IMMEDIATELY AFTER you have received the consent of the respondent and she/he has given consent.]

Section 1: Socio Demographic data

1. Sex Female ☐ Male ☐

2. How old are you _____

3. What is your marital status? _____

4. What is your religion? _____

5. How many children have you had?

6. How many years of midwifery training have you had? _____ Years

7. How long have you been working as a midwife? _____

Section 2: person centered care

8. In your opinion, how do women want to be treated?

a.To what extent do you give care that you have described? Please explain.

Section 3: **Defining compassionate and respectful care, and exploring whether it's being provided**

9. What does 'Compassionate and respectful care' during childbirth mean to you as a midwife?

a.To what extent do you provided kind of 'compassionate and respectful care' that you have described? Please explain.

Section 4: Mistreatment of women during child birth

10. Sometimes women are mistreated or poorly treated during childbirth. Have you ever seen, heard or done of this type of mistreatment

a. Can you explain the situation?

i. Did this incident occur in this facility**?**

ii. How was the woman mistreated?

b. Why do you think this happened?

c. How common is the situation that you described? [Probe: do situations like this happen often? [If they describe another scenario, follow-up with question 4a again]

Section 5: Perceived factors that influence how women are treated during childbirth

11. In your opinion, what factors might influence how respectfully (or disrespectfully) women are treated? Please explain. Probe for factors related to:

A. Related to supplies (availability of medication, equipment)

B. Related to health workers (number of staff, attracting and retaining staff, attitude towards patients)

C. Related to patient load (number of patients, overcrowding)

D. Related to your health facility: policies, management, infrastructure, services level (such as equal or unequal opportunities for female or male staff)

E. Other factors at a health facility level

F. Other factors at a health system level

G. Factors related to the client's behavior

H. Factors related to the client's personal attributes

12. To what extent are some women treated better or worse than other women in the health facility? Please describe. (Probe for issues related to age of woman, ethnicity, income, whether they had a birth companion with them, educational background, number of children, etc.).

13. In your opinion, what can be done to address these factors so that women are treated with respect during labor and childbirth?

Section 6: Wrap-up

14. Is there anything else that you would like to tell me?

Thank the participant for their time. Remind them that the information they shared will be kept confidential.

2. WOMEN IN-DEPTH INTERVIEW GUIDE FORM

Interview date:_____

Start time: _____

End time: _____

Interviewer: _____

[Guidance for interviewer: PLEASE START RECORDING IMMEDIATELY AFTER you have received the consent of the respondent and she/he has given consent.]

Section 1: Socio Demographic information

1. How old are you? _____
2. What is your marital status? _____
3. What is your religion? _____
4. Where do you live? _____
5. How many years of schooling have you had? _____
6. How many children have you had? _____

Section 2: Experiences of facility based deliver

7. Why do you choose to give birth in health facilities? Please explain how you chose ?
8. What kinds of services did you get from the midwife?

• Probes: health education, care during labor and delivery, post-partum care, breastfeeding support

9. How do you generally feel about the services that you got from the midwife?

Probes: Would you please explain how and why? What do you like, what do you not like (like less)?

Section 3: experience of respectful or disrespectful care

10. Do you feel like you were treated respectfully by midwives when you gave birth?

a.If yes, tell me more about why you felt respected. What did the provider do to make you feel respected?

11. Do you feel like you were treated disrespectfully by midwives when you gave birth?

a. If yes, tell me more about what happened. What happened that made you feel that you were not treated respectfully?

12. Do you think that some women are treated better or worse than other women at health facilities?

a. If yes, please describe. (Probe for issues related to age of woman, language or ethnicity, income, whether they had a birth companion with them, etc.).

13. In your opinion, what could be done so that women are treated better during labor and childbirth at facilities?

Section 4: Wrap up

14. Is there anything else that you would like to tell me about childbirth in your community or about your own personal childbirth experiences?

Thank the participant for their time. Remind them that the information they shared will be kept confidential.

Annex III: Information and consent form (Amharic version)

የ መረጃ እና የፈቃደኝነት ማረጋገጫ ቅፅ

የ ጥናቱ ርዕስ፡ሩህሩህነት እና አክብሮትን ማእከል ባደረገ የወሊድ የጤና አገልግሎት ላይ እናቶች እና ሚዳይፎች ያላቸው ልምድ፡ቢሾፍቱ፡ኦሮሚያ፡ኢትዮጵያ

ስሜ ሂሩት ዲንቁ ይባላል፡በአሁን ሠአት በ አዲስ አበባ ዩንቨርስቲ በ ነርሲንግ እና ሚድዋይፈሪ ት/ት ክፍል የማስተርስ ዲግሪ ተማሪ ነኝ

ትኩረቱን ሩህሩህነት እና አክብሮትን ማእከል ባደረገ የወሊድ የጤና አገልግሎት ላይ እናቶች እና ሚድዋይፎች ያላቸው ልምድ ላይ ጥናት እያረኩኝ እገኛለው በዚህ ጥናት ላይ እንዲሳተፍ በአክብሮት እጠይቃለው፡፡ይህ ጥናት በ አዲስ አበባ ዩንቨርስቲ በ ነርሲንግ እና ሚድዋይፈሪ ት/ት ክፍል ስነ ምግባር ኮሚቴ ተቀባይነት ያገኘ ነው፡፡

የእርሶ በእዚህ ጥናት ላይ መሳተፍ ጤና ተቃሙ ስለሚሰጠው ሩህሩህነት እና አክብሮታዊ የወሊድ ጤና አገልግሎት ጠቃሚ መረጃ እንዳገኝ ይረዳኛል፡፡ እንዲሁም በዚህ ጥናት ላይ በመሳተፎው ምንም አይነት ጉዳት አይደርስቦትም፡፡

በዚህ ጥናት ላይ በመሳተፎው ቀጥተኛ የሆነ ጥቅም ላያገኙ ይችላሉ ቢሆንም ግን የጥናቱ ውጤት ሩህሩህነት እና አክብሮታዊ የወሊድ የጤና አገልግሎት እንዲሻሻል እና የወሊድ አገልግሎት በጤና ተቃም እንዲጨምር ያደርጋል፡፡

ለዚህ ጥናት የሚሰጡት መረጃ በሙሉ ሚስጥራዊነቱ ተጠብቆ ይቀመጣል፡፡በጥናቱ ላይ ያለመሳተፍ ሙሉ መብት አልዎት፤እንዲሁም በማንኛውም ጊዜ ጥያቄ አቃርጦ የመውጣት መብት አሎት፡፡

ተጨማሪ ጥያቄ ካሎት በሚከተለው አድራሻ ያገኙኛል

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የፈቃደኝነት ማረጋገጫ ቅፅ

ጥናቱ የሚሰጠውን ጥቅም በመረዳት እንዲሁም በጥናቱ ላይ የመሳተፍ ሆነ አቃርጦ የመውጣት መብቴን በማወቅ ጥናቱ ላይ ለመሳተፍ መወሰኔን እገልፃለው፡፡

የተሳታፊው ስም----------

ፊርማ----------

ቀን----------

ስለተሳተፉ እናመሰግናለን፡፡

Annex IV. Questionnaire (Amharic version)

1.ለ ሚዳዋይፎች የተዘጋጀ ጥልቅ ቃለ መጠይቅ

ቀን_____

የተጀመረበት ሠዐት_____

የተጠናቀቀበት ሠዐት_____

[**ለጠያቂው መመሪያ፡** እባኮን የድምጽ ቅጅውን የፈቃድ ማረጋገጫውን እንዳስፈረሙ ይጀምሩ]

ክፍል አንድ ፡ ማህበራዊ እና ዲሞግራፋዊ ሁኔታዎች

1.ፆታ ሴት ☐ ወንድ ☐

2. እድምሜዋ ስንት ነው? _____

3. የጋብቻ ሁኔታዋ ምን ይመስላል? _____

4. የምን ሀይማኖቶ ተከታይ ኖት? _____

5. ምን ያህል ልጆች አልዎት? _____

6. የ ሚድዋይፈር ስልጠና ለምን ያህል አመት ወስደዋል? _____

7. ሚድዋይፍ ሆነው መስራት ከጀመሩ ምን ያህል አመትዎ ነው? _____

ክፍል ሁለት፡ግለሰብ ተኮር የጤና አገልገሎት በተመለከተ

8.እናቶች ምን አይነት የወሊድ አገልግሎት ይፈልጋሉ ብለህ ታስባለህ/ሽ?

ሀ. አሁን የገለፅከውን/ሽውን አገልግሎት በምን ያህል መልኩ እየሰጠው ነው ብለህ/ሽ ታስባለህ/ሽ፡እስቲ በደንብ ብታብራራው/ሪው

ክፍል ሶስት፡ሩህሩህዊነት እና አክብሮታዊ የወሊድ አገልግሎትን በተመለከተ

9.እንደ ሚድዋይፍ ሩህሩህዊነት እና አክብሮታዊ የወሊድ የጤና አገልግሎት ምን ማለት ነው ብለህ ታስባለህ/ለሽ?

ሀ.አሁን የገለከፅከውን/ሽውን ሩህራዊ እና አክብሮታዊ የወሊድ የጤና አገልግሎት በምን ያህል መልኩ እየሰጠው ነው ብለህ/ሽ ታስባለህ/ሽ? እስቲ በደንብ ብታብራራው/ሪው?

ክፍል አራት፡ በወሊድ ጊዜ እናቶችን የሚያጋጥም ተገቢ ያልሆነ አያያዝ

10.አንዳንዴ እናቶች በወሊድ ጊዜ ባልተገባ ሁኔታ ይስተናገዳሉ፡፡እንዲ አይነት ድርጊቶች ሰምተህ/ሽ፤አይተህ/ሽ፤ፈጽመህ/ሽ ታውቃለህለ/ሽ?

ሀ.የነበረውን ሁኔታ በደንብ ብታብራራልኝ/ሊኝ

ለ.እንዴት ነበር እናትየዋ ባልተገባ ሁኔታ የተስተናገደችው

ሐ.ለምን እንዲ ሆነ ብለህ/ሽ ታስቢያለህ/ሽ

መ.ይሄ ድርጊት ምን ያህል የተለመደ ነው (ማውጣጫ፡እንዲ አይነት ድርጊቶች በተደጋጋሚ ይፈጠራሉ፡አዲስ ተጨማሪ ታሪክ ካለ ከሀ አማራጭ መጀመር)

ክፍል አምስት፡እናቶች በወሊድ ጊዜ እሚያገኙትን የጤና አገልግሎት ይወስናሉ ተብሎ የሚገመቱ ምክንያቶች

11.እንዳንተ/ቺ ለእናቶች አክብሮትን ያማከለ (የላማከለ) አገልግሎት እንዲገኙ ያደርጋሉ ተብሎ የሚታሰቡ ሁኔታዎች ምንድናቸው ብለህ ታስባለህ/ሽ?በደንብ ብታብራሪው ማውጣጫ ሁኔታዎች፡

ሀ.አቅርቦት(የመዳኒት አቅርቦት፡ይእቃ አቅርቦት)

ለ.ከጤና ባለሙያው(ቁጥር፤ ፤አቅርቦት)

ሐ.የደንበኛ ቁጥር

መ.ከጤና ተቃም ህግ፤አመራር

ሠ.ከጤና ተቃሙ ጋር የተያያዘ ሌላ ሁኔታ

ረ.ከ ጤና ሲስተም ጋር የተያያዘ ሌላ ሁኔታ

ሰ.ከደንበኛ ባህሪ ጋር የተያያዘ ሌላ ሁኔታ

ሸ.ከደንበኛ ጋር የተያያዘ ሌላ ሁኔታ

12. በምን አይነት ሁኔታ አንዳንድ እናቶች ከሌሎች በተሻለ (ባነሰ) መልኩ በጤና ተቃሙ ውስጥ ይስተናገዳሉ? እስቲበደንብቢገልፁት፡

ማውጣጫ ሁኔታዎች፡እድሜ፤ቃንቃ፤ብሄር፤አጋዥ ሰው፤የት/ት ደረጃ፤የገቢ መጠን፤የልጆች ቁጥር

13.እንዳንተ/ቺ አመለካከት እኚህ ችግሮች ተፈተው እናቶች በምጥ እና በወሊድ ጊዜ አክብሮትን ያማከለ የጤና አገልግሎት እንዲያገኙ ምን መደረግ አለበት ብለህ/ሽ ታስባለህ/ሽ?

ክፍል ስድስት፡ የማጠቃለያ ጥያቄ

14.ከዚህ በተጨማሪ ማንሳት የሚፈልጉት ሀሳብ ካለዎት መጨመር ይችላሉ

ስለተሳተፉ እናመሰግናለን የሰጡን መረጃ በመሉ ሚስጥራዊነቱ ተጠብቆ ይቀመጣል::

ለ እናቶች የተዘጋጀ ጥልቅ ቃለ መጠይቅ

ቀን_____

የተጀመረበት ሠዐት_____

የተጠናቀቀበት ሠዐት_____

[**ለጠያቂው መመሪያ፡** እባኮን የድምጽ ቅጅውን የፈቃድ ማረጋገጫውን እንዳስፈረሙ ይጀምሩ]

ክፍል አንድ ፡ ማህበራዊ እና ዲሞግራፋዊ ሁኔታዎች፡፡

1. እድምሜዋ ስንት ነው? _____
2. የጋብቻ ሁኔታዋ ምን ይመስላል? _____
3. የምን ሀይማኖቶ ተከታይ ኖት?_____
4. የ ት/ት ደረጃዎን ቢገልፁልኝ?_____
5. የት አካባቢ ነው ሚኖሩት ?_____
6. ምን ያህል ልጆች አልዎት ?_____

ክፍል ሁለት፡በጤና ተቃሙ ወሊድ አገልግሎት ልምድ በተመለከተ

7. በጤና ተቃም ለመውለድ ለምን ፈለጉ? እንዴት እንደመረጡት ቢያብራሩል:
8. ከሚዳዋይፎች ምን አይነት አገልግሎት አገኙ?

ማውጣጫ፡የጤና ምክር፤በምጥ እና በወሊድ ጊዜ እገዛ፤ከወሊድ በሃላ እገዛ፤ጡት የማጥባት ድጋፍ

9. .በአጠቃላይ ከሚዳይፋ/ፉ ያገኙት አገልግሎት እንዴት አገኙት?

ማውጣጫ፡እስቲ በደንብ ቢያብራሩት፤ የትኛው አገልግሎት ደስ አሎት ፡ቅር ያሎት ምን ነበር

ክፍል ሶስት፡ አክብሮት ያለው ወይም አክብሮት የጎደለው የወሊድ አገልግሎት ልምድ በተመለከተ

10. ሲወልዱ ሚዳዋይፋ/ፉ በአክብሮት አገልግለውኛልው ብለው ያስባሉ

ሀ.አዎ ከሆነ ለምን እንዲ እንደተሳማዎት ቢያብራሩልኝ፡ሚዳይፋ/ፉ በአክብሮት በምን መልኩ ነበር ያገለገልዎት/ችው

11. 11.ሲወለዱ ሚድዋይፋ/ፉ ክብር የጎደለው አገልግሎት ነው የሰጠኝ ብለው ያስባሉ?ሀ.አዋ ከሆነ ፡እስቲ ምን እንደተፈጠረ ቢያብሩልኝ፡ክብር የጎደለው አገልግሎት ነው አንዲሉ ያረገዎት ምን ነበር?
12. እዚህ ጤና ተቃም ውስጥ አንዳንድ እናቶች ከሌሎች በበለጠ ይስተናገዳሉ ብለው ያስባሉ?

ሀ. አዎ ከሆነ እስቲ በደንብቢገልፁት፡ማውጣጫሁኔታዎች፡እድሜ፤ቃንቃ፤ብዜር፤አጋዥር ሰውመኖር

13. እናቶች ሲወልዱ ጥሩ አገልግሎት እንዲያገኙ ምን መደረግ አለበት ብለው ያስባሉ?

ክፍል አራት ፡የማጠቃልያ ጥያቄ

14. ተጨማሪ ስለ ወሊድ የጤና አገልግሎት ከህብሀተሰቡ የሰሙት ወይም ከራሶ ልምድ ካለ መጨመር ይችላሉ፡፡

ስለተሳፉ እናመሰግናለን የሰጡን መረጃ በመሉ ሚስጥራዊነቱ ተጠብቆ ይቀመጣል፡፡