

**CLIENTS' PERSPECTIVES OF QUALITY EMERGENCY OBSTETRIC CARE IN
PUBLIC HEALTH FACILITIES IN ETHIOPIA**

by

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submitted in accordance with the requirements for
the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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November 2013

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DECLARATION

I declare that **CLIENTS' PERSPECTIVES OF QUALITY EMERGENCY OBSTETRIC CARE IN PUBLIC HEALTH FACILITIES IN ETHIOPIA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

A handwritten signature in blue ink, consisting of several overlapping loops and a horizontal line at the bottom.

SIGNATURE
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ABSTRACT

The contribution of Emergency Obstetric Care (EmOC) in reducing maternal mortality in Ethiopia is very minimal as evidenced by poor provision and low utilization of EmOC. Client centred EmOC provision improves the provision and utilization of EmOC; leading to the treatment of the majority of obstetric complications which are the main causes of maternal mortality. This study describes clients' views and perspectives concerning the quality of EmOC provision in Ethiopian public health facilities. An explorative and descriptive phenomenological qualitative study design was used in the study in order to explore and describe the lived experiences of clients with EmOC services. Key informant interviews with women who had direct obstetric complications and received EmOC at three public health facilities in Addis Ababa generated rich data on their lived experiences. Content analysis was used to analyze the data as it complies with the phenomenological data analysis and Atlas ti version 6.2 qualitative data analysis software was employed. The findings revealed that quality EmOC is a welcoming, life-saving timely care given in a clean environment with humility, respect, equal treatment and encouragement. It is care that is safe for the client, technically sound, responsive and meets clients' needs and expectations. Accessibility of life saving care at all time and collaborative and coordinated care created good experiences for the clients. The causes of clients' disappointment with the provision of EmOC were higher expectations from female providers, underestimation by providers, non responsive providers, and ethical misconduct by providers such as mocking, insulting, yelling, advantage taking providers, undelivered promises by providers, expectation with place of delivery, expectation with newborn care and a limited number of health workers attending delivery. Discrimination, high cost of care and asking client to buy drugs and supplies and referrals from centres, are some of the barriers on r the use of EmOC at public

health facilities. The provision of EmOC is constrained by overloaded staffs, shortage of space to accommodate clients and inadequate number of beds. In conclusion, clients have expectations and experiences of provision of EmOC that influence their future decision to seek care. Finally, a client centred guideline for the provision of client centred EmOC provision was developed.

KEY TERMS

Quality of care, emergency, emergency obstetric care, client, perspective, experience.

ACKNOWLEDGEMENTS

I would like to thank the following persons and institutions for their valuable contributions to the undertaking and completion of this thesis:

- Prof L Zungu: For your kind support, encouragement and relentless guidance from inception to the finalization of the study
- Dr R Cheglil: For his tireless support and guidance
- Wongel Nigussie: My wife for her unconditional love and encouragement
- Zewdie Helelo and Genet Legesse: My parents for their inspiration and support
- Tom Clarke: For his support and advice
- Addis Ababa City Bureau of Health for permission to conduct the study in the city administration
- All the management, physicians, midwives and nurses at Yekatit 12 hospital, Zewditu hospital and Ghandi hospital
- Most of all, clients with obstetric complication who volunteered to give me their invaluable time to share their experiences at public health facilities

Dedication

This work is dedicated to my late sister Milion Zewdie and all women needlessly suffering from diseases, disabilities and deaths associated to childbirth

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List of abbreviations

| | |
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| AMTSL | Active Management of the Third Stage of Labour |
| AMDD | Averting Maternal Death and Disability |
| APH | Antepartum Haemorrhage |
| CFR | Case Fatality Rate |
| COPE | Client Oriented Provider Efficient |
| CSA | Central Statistical Agency |
| DALY | Disability Adjusted Life Years |
| EmOC | Emergency Obstetric Care |
| FGD | Focus Group Discussion |
| FMOH | Federal Ministry of Health |
| GLAAS | Global Annual Assessment of Sanitation and drinking water |
| HIV | Human Immunodeficiency Virus |
| IOM | Institute of Medicine |
| KHI | Kissito Health Care International |
| MDG | Millennium Development Goal |
| PLWHA | People living with HIV/AIDS |
| PPH | Postpartum Haemorrhage |
| UN | United Nations |
| UNDP | United Nations Development Program |
| UNISA | University of South Africa |
| WHO | World Health Organization |

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Research that examines clients' perspectives of Emergency Obstetric Care (EmOC) is limited. Available research on the process aspect of quality of care, specifically the interpersonal aspect of EmOC, assessed the levels of client satisfaction (Dogba & Fournier 2009:7). However, attempts to measure client satisfaction side-lined the clients' views on quality of care (Brown 2007:125). Coulter and Cleary (2001:245) elucidate client satisfaction as subjective, whereas an exploration of client views and perspectives elicits factual data on what the clients consider as important and mandatory in quality improvements. Yet, the clients' views and perspectives on quality EmOC provision remain relatively unexplored.

This study examines clients' views and perspectives concerning the quality of EmOC provision in Ethiopian public health facilities. The chapter introduces the study by providing an overview of the entire thesis report. It provides the background information to the study, which highlights the core issues that stimulated the researcher's interest to investigate on this topic. The chapter also highlights the research problem, aim and significance of the study, the foundations, research design and methods of the study. The conclusion to the study consists of a brief discussion of the study' scope, limitations, and its overall structure. .

1.2 BACKGROUND TO THE RESEARCH PROBLEM

1.2.1 The need for improving maternal health service provision

Pregnancy, child birth and its consequences are the leading causes of death, disease and disability among women of reproductive age. Over 300 million women in developing countries suffer from short-term/long-term illnesses brought by pregnancy and child birth (World Health Organization (WHO) 2005:10). Furthermore, eight million of the

estimated 210 million women who become pregnant each year experience life-threatening complications (WHO 2009a:2). Ninety nine percent of the 287,000 global maternal deaths in the year 2010 occurred in developing countries and 162,000 maternal deaths occurred in sub-Saharan Africa (WHO 2012a:22).

There is a huge disparity on maternal deaths between developed and developing countries. The maternal deaths that are avoided in African countries are only one third compared to nearly all maternal deaths in developed countries (WHO 2005:62). The average annual decline of maternal mortality ratio in sub-Saharan Africa between 1990 and 2010 was 2.6%. This is very slow compared to the rate per year reduction of 5.5% required to achieve the millennium development goal five (MDG 5) target seeking to reduce the maternal mortality ratio by three quarters between 1990 and 2015 globally (WHO 2012a:26). Hence, avoidable maternal deaths continue to take the lives of women, which undermine most of the developing countries' efforts at meeting MDG 5. .

Although maternal mortality ratio has declined in Ethiopia by 64% in the years between 1990 and 2010 and the country is classified as making progress towards the MDG 5, the notable progress made in reducing maternal mortality did not result from improvements in maternal health service provision or utilisation (WHO 2012a:39; Koblinsky, Tain & Tesfaye 2010:12). Only 10% of all the country's child births between 2005 and 2010 were attended by a skilled provider and 90% of the child births occurred at home (Ethiopian Central Statistical Agency (CSA) & ICF International 2012:126). Koblinsky et al (2010:12) notes that the decline in maternal mortality in Ethiopia is attributed to a decline in the fertility rate and not improvements in maternal health service or its use. Therefore, improving maternal health service provision and utilisation will reduce maternal mortality and improve maternal health in Ethiopia.

1.2.2 Interventions to reduce maternal mortality

There are cheap and effective interventions that can prevent deaths and disabilities attributable to childbirth. These interventions include access to skilled attendance at childbirth, EmOC, post-partum care, prevention of unsafe abortion, and widening contraceptive choices (WHO 2009a:2). Maternal mortality remains high and static despite the existence of these interventions due to delays in seeking care, inability to act on medical advice and the health system's failure to provide quality care (WHO

2005:22). Besides, the fact that most childbirths take place outside health facilities means that, a less number of childbirths are attended to by skilled attendants, poor/ an absence of provision of EmOC and failure to translate the lifesaving knowledge into effective action keeps maternal mortality high (Glasier, Gülmezzoglu, Schmid, Mareno & VanLook 2006:1597).

Risk screening approaches include interventions that include antenatal care and training traditional birth attendants, while quality delivery care approaches include access to skilled attendants and the existence of a functional EmOC and referral system. The risk screening approach does not prevent the majority of maternal deaths from happening because the vast majority of obstetric complications occur in women with no known risk factors and obstetric complications occur suddenly and unpredictably. Hence, risk screening programmes have little impact on overall maternal mortality rates (Glasier et al 2006:1597; Freedman, Wirth, Waldman, Chowdhury & Rosenfield 2003:22). Nonetheless, the risk screening approach is mainly pursued to reduce maternal mortality and improve maternal health in resource poor settings.

The quality care approach, whose elements include skilled attendance at childbirth, EmOC and a functional referral system, enables the treatment of obstetric complications which occur suddenly, unpredictably and are the leading causes of maternal deaths. This approach is based on the principle that every pregnant woman is at risk of life threatening complications and need lifesaving interventions. It is therefore evident that countries that made a deliberate effort to provide professional childbirth care with midwives and other skilled attendants that were backed up by hospitals were able to improve maternal survival dramatically (Freedman et al 2003:23).

Freedman et al (2003:38) opines that countries must ensure that EmOC is available, accessible and appropriately utilised to reduce maternal mortality and meet the MDG target. Various studies have revealed that EmOC can significantly reduce maternal mortality by providing lifesaving interventions for potential life threatening complications, as an estimated 15% of childbirths get complicated and need EmOC (Fortney 2001:95; Paxton, Maine, Freedman, Fry & Lobis 2005:189; WHO 2009b:19). However, the strategy is not fully utilised as very few facilities have a functional EmOC; comprehensive EmOC is available to serve a minimum size of the population, basic EmOC is not available in sufficient numbers and all life saving interventions are not

performed in facilities offering maternity services (Paxton, Bailey, Lobis & Fry 2006b:303).

The potential of EmOC to prevent maternal deaths by treating obstetric complications is unrealised in countries with high burden of maternal mortality. This emanates from a poor functional status and a low utilisation of EmOC services. In Ethiopia for example, the availability of EmOC facilities to the population ratio is below the minimum standard. Only 10% of health facilities, 58 health facilities, were fully functioning EmOC facilities and the functioning EmOC facility to population ratio is 0.6 per 500,000 which is significantly below the recommended 5 EmOC facilities to 500,000 population ratio (Federal Ministry of Health [FMOH] 2008:33). In addition, the unmet need for EmOC is high, as very few, 3%, of all childbirths took place in fully functioning EmOC facilities and only 3% of women who had major direct obstetric complication were treated in EmOC facilities (FMOH 2008:40).

The quality of EmOC provision generally remains poor in most public health facilities in Ethiopia and other developing countries in general (FMOH 2008:46; Paxton et al 2006b:303; Leigh, Mwale, Lazaro & Lunguzi 2008:109; Ziraba, Mills, Madise, Saliku & Fotso 2009:7; Gao & Barclay 2010:184). Nearly half, 44%, of the hospitals in Ethiopia provide poor quality EmOC as measured by the direct obstetric case fatality rate and the fact that the quality of EmOC provision is low in the country (FMOH 2008:46). This indicates the need to improve the quality of EmOC provision and utilisation to prevent maternal deaths and reduce maternal mortality.

An exploration of clients' perspectives on the quality of EmOC is important to develop client centred EmOC guidelines that will improve the quality of EmOC provision and utilisation. This is because an exploration of the clients' views and perspectives will provide factual data on what clients consider as important and mandatory in quality improvements. However, there is sub-optimal knowledge of client perspective and experience of EmOC.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The Ethiopian Federal Ministry of Health has not utilised the potential of EmOC to reduce maternal mortality and improve maternal health. Although the country has made

notable progress and reduced maternal mortality from the level where it was 20 years back, maternal mortality remains unacceptably high and among the highest in the world. The notable progress the country has made is attributed mainly to fertility rate decline but not to improved maternal service provision or service use.

The contribution of EmOC in reducing maternal mortality in Ethiopia is very minimal as evidenced by the poor provision and low utilisation of EmOC. EmOC can significantly reduce maternal mortality but only 10% of the facilities in Ethiopia have functional EmOC and only 3% of all births with complications took place in fully functioning EmOC facilities. Hence, direct obstetric complications which account for the leading causes of maternal deaths remain untreated or poorly treated. The researcher thus holds the view that client centred EmOC provision improves the running and utilisation of EmOC, thus leading to the treatment of a majority of obstetric complications which are the main causes of maternal mortality.

Knowledge of clients' perspectives of quality EmOC is important to provide client focused EmOC. Globally, research into perspectives of clients regarding quality of EmOC provision is sub-optimal. This study therefore sought to qualitatively answer the broad question:

What are clients' perspectives regarding the quality of EmOC services in three public health facilities in Addis Ababa?

It is therefore envisaged that the results of this study will lead to the development of a client centred practical guideline that will promote quality EmOC service provision in Ethiopian public health facilities.

1.4 AIM OF THE STUDY

1.4.1 Research purpose

The purpose of this study was to develop client centred practical guidelines to promote the quality of EmOC service provision in Ethiopian public health facilities. Such guidelines would also address the needs and expectations of clients with obstetric complications; create favourable experience with EmOC that will increase client

satisfaction, increase facility birth and meet the need for EmOC and ultimately achieve improved maternal health through treatment of obstetric complications.

1.4.2 Research objectives

In order to achieve the purpose of this study, a number of objectives were set. The objectives are to:

- Explore and describe clients' perspectives regarding the quality of EmOC service provision in public health facilities in Ethiopia.
- Develop a guideline for the provision of client centred quality emergency obstetric care in Ethiopian public health facilities.
- Formulate recommendations for the implementation of the guidelines for EmOC provision at Ethiopian public health facilities.

1.5 SIGNIFICANCE OF THE STUDY

It is envisaged that the result of this study will contribute to the existing body of knowledge on improving the quality of EmOC service provision and further the understanding of the client perspective on EmOC in Ethiopian public health facilities. The results of the current study will lead to the development of guidelines that promote quality EmOC service provision in the health facilities. These guidelines will enable clients with obstetric complications to meet their needs and expectations in Ethiopia's public health facilities. This will contribute to improved maternal health and increase client satisfaction with EmOC, as well as repeated visits to public health facilities in future childbirths and recommendations for other women to give birth in the health facilities. Hence, the majority of direct obstetric complications which are the leading causes of maternal deaths would be treated in Ethiopia, thus, resulting in the dramatic reduction of maternal mortality.

The guidelines developed in this study will enable stakeholders to facilitate the provision of client centred EmOC and utilisation. This provision will ensure the treatment of a majority of direct obstetric complications. Policy makers should consider the guidelines in formulating proactive policies that will improve the provision and utilisation of EmOC. The Ethiopian Federal Ministry of Health and health workers should utilise the guideline

to improve the overall quality of EmOC provision in Ethiopian public health facilities. This will ultimately contribute to the prevention of maternal deaths and improve maternal health in Ethiopia.

1.6 FOUNDATIONS OF THE STUDY

1.6.1 Meta-theoretical grounding and assumptions

The ontological, epistemological and methodological assumptions used in current study to explore and describe clients' perspectives on quality EmOC in public health facilities in Ethiopia are listed below.

1.6.1.1 *Ontological assumptions*

Ladyman (2007:303) defines ontology as the theory of what exists and as the study of the fundamental questions of being and nature of reality. Ontology as a philosophical inquiry is about the nature of reality (Lincoln & Denzin 2005:22).

The ontological assumptions are:

- Multiple realities and socially constructed realities are central to exploring and describing the perspectives of clients regarding the quality of EmOC service provision in Ethiopian health facilities.
- Clients have expectations and preferences about the quality of EmOC service provision.
- The lived experiences of EmOC as perceived by clients who received EmOC could indicate lived experiences of clients in the real world.

1.6.1.2 *Epistemological assumptions*

The epistemological assumptions are:

- The quality of EmOC services as constructed by women who had obstetric complications and received EmOC will shape the provision of client centred EmOC.

- Client centred EmOC service provision will increase the utilisation of EmOC services and significantly reduce maternal mortality resulting from obstetric complication.

1.6.1.3 Methodological assumptions

Methodology is the theory of scientific methods focusing on the philosophical inquiry: “How do we know the world or gain knowledge of it” (Ladyman 2007:303; Lincoln & Denzin 2005:22). An explorative and descriptive phenomenological qualitative study design is used in this research. The qualitative method was selected because it enables the researcher to explore and describe the lived experiences of clients with EmOC services. Key informant interviews with women who had obstetric complications and received EmOC services will generate rich data on their lived experiences.

1.6.2 Conceptual framework

Conceptual framework provides a rationale or structure that guides the development of the study and enables the researcher to link the findings of the study to the body of knowledge (Moleki 2008:28). A conceptual framework with provision and experience of quality maternity care model is used to frame the study and link the findings of the study to the body of knowledge and conceptualise this in practice through the development of client centred practical guidelines to promote the quality of EmOC service provision. The conceptual framework of this study is based on a survey list which explores and describes the lived experiences of clients who received EmOC services.

Key concepts under the conceptual framework applicable to the phenomena of interest in this study have been adopted from a survey list used by Moleki (2008:162). Moleki (2008:29) described the survey list as follows:

The ‘**purpose**’ or ‘terminus; relates to the type of activities, their boundaries and goals that a person engages in (Moleki 2008:29). In this study the purpose is to explore and describe clients’ perspectives regarding the quality of EmOC service provision in public health facilities in Ethiopia in order to develop client centred practical guidelines to promote the quality of EmOC service provision.

An 'agent' according to the survey list is someone who has the knowledge and ability to perform identified activities or provides a solution to a problem (Moleki 2008:29). In this study the agent is the health care worker or professional qualified to provide quality EmOC services in Ethiopia. These health care workers include nurses, midwives, health officers, doctors, gynaecology/obstetricians and other paramedical staff.

A 'recipient' is a beneficiary of the activities designed by an agent (Moleki 2008:29). In this study the beneficiary of EmOC services were the clients with obstetric complications.

The '**framework**' is presented as the **context** or **environment** in which activities take place (Moleki 2008:29). This provides for living experiences at the public health facilities. In this study the perceptions of clients were explored in public health facilities where EmOC services were provided.

The '**dynamics**' provide the energy source or the motivating factors for the quality of EmOC service provision (Moleki 2008:30). The dynamics in this study include the experience of human and physical resource, cognition, respect, dignity and equity, emotional support, provision of human and physical resources, referral, maternity management information system, use of appropriate technologies, and internationally recognised good practices.

The '**procedures**' are the techniques or protocols that guide the activities (Moleki 2008:30). In this study the procedures were the client focused best practice guidelines for EmOC service provision.

The provision and experience care model

The provision and experience care model, is the quality of care model used, as the theoretical framework for this study. The model classifies quality of care in maternity services in to two dimensions, which are provision of care and experience of care (Hulton, Matthews & Stones 2007:2084). The model helps to explore and describe the client perspective of quality EmOC as client experience is one of the dimensions of the model. The nine elements of the model are: the experience of human and physical

resource, cognition, respect dignity and equity, emotional support, provision of human and physical resources, referral, maternity management information system, use of appropriate technologies, and internationally recognised good practices and frame both the provision and experience of quality maternity care (Hulton et al 2007:2093). Figure 1.1 outlines the nine elements of the model and how they link in an effort to create quality care.

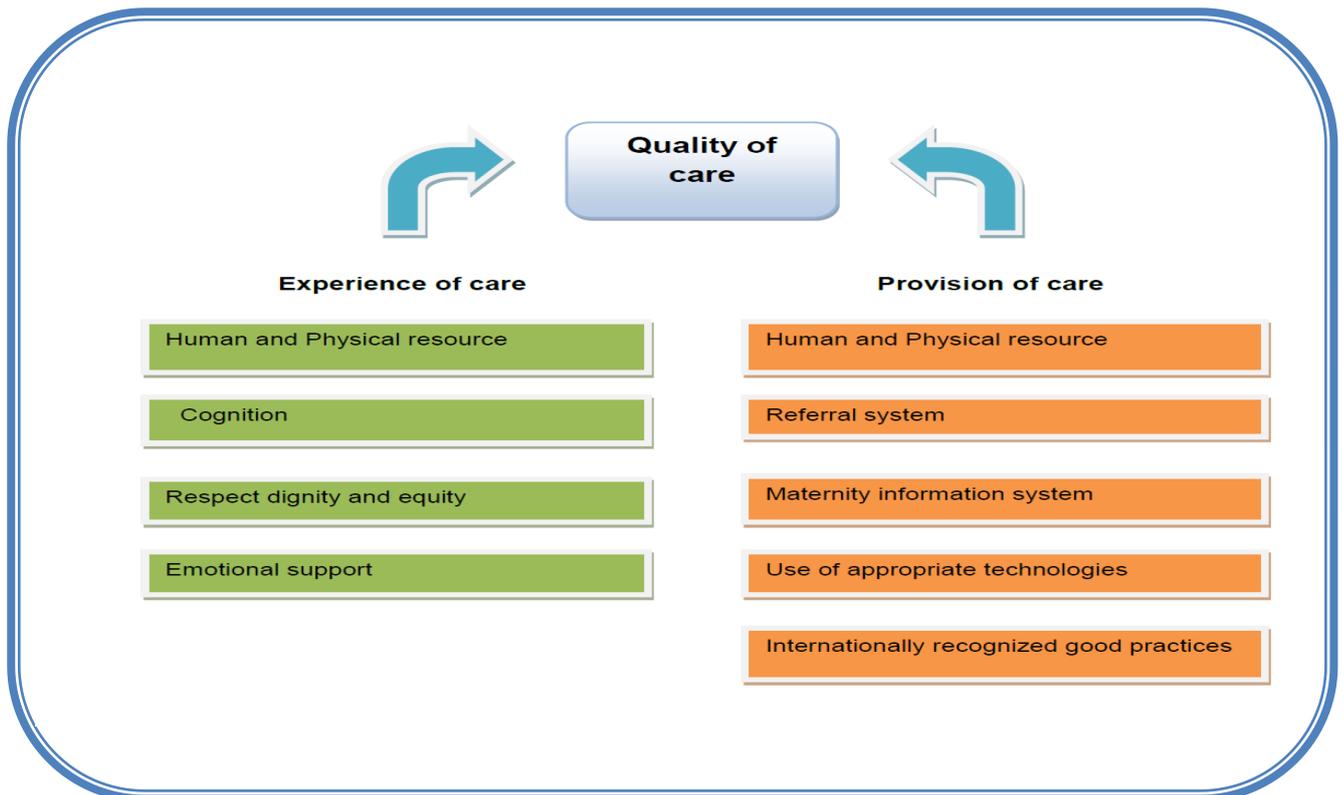


Figure 1.1 Conceptual framework for quality of care in maternity services
(Hulton et al 2007:2093)

The details of the model will be presented in chapter 2 of this thesis report.

1.7 DEFINITION OF KEY CONCEPTS

Quality

The Oxford Advanced Learner’s Dictionary (2010:1240) refers to quality as a feature of something, especially one that makes it different from something else. It is the totality of features and characteristics of a product or service that bears on its ability to satisfy

stated or implied needs (Trybus 2009:1333). In this study, quality refers to EmOC services that meet client needs and create satisfactory client experiences.

Quality of care

Carrol (2009:998) defines quality of care as the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes that are consistent with the current professional knowledge. In this study, quality of care refers to EmOC that treat obstetric complication and incorporate the client perspective of care to create satisfactory experiences.

Emergency

The Oxford Advanced Learner's Dictionary (2010:496) defines an emergency as a sudden serious and dangerous event or situation which needs immediate action to deal with it. In this study the term emergency denotes obstetric complications that need immediate care.

Direct obstetric complications

Direct obstetric complications are complications that occur during childbirth and include haemorrhage, obstructed labour, sepsis, eclampsia and pre-eclampsia (WHO 2009:19).

Emergency obstetric care

EmOC is a strategy for reducing maternal mortality through the treatment of obstetric emergencies in hospitals and health centres (Bailey, Paxton, Lobis & Fry 2006a:286).

Client

The Oxford Advanced Learner's Dictionary (2010:1112) defines a client as a person who is receiving medical treatment. In this study, client refers to women with obstetric complications receiving EmOC.

Perspectives

The Oxford Advanced Learner's Dictionary (2010:1132) defines a perspective as a particular attitude towards something or view point. In this study, perspective refers to client views on the quality of EmOC.

Experience

The Oxford Advanced Learner's Dictionary (2010:534) defines experience as things that have happened to people and influence the way they think and behave. In this study, experience refers to a client's encounter with EmOC.

Guideline

The Oxford Advanced Learner's Dictionary (2010:691) describes a guideline as rules or instructions that are given by an official organisation telling how to do something. In this study, a guideline refers to a set of suggested rules or instructions that Ethiopian public health facilities can use to promote the provision of client centred EmOC.

1.8 RESEARCH DESIGN AND METHOD

Babbie and Mouton (2001:74) define a research design as a blue print of how a researcher intends to conduct their research. Kalaian (2008:725) defines it as the structure of research that guides the process of research from the formulation of the research questions up to reporting the research findings. A research design and method describes strategies used to carry out an entire study in order to achieve the set objective/s.

1.8.1 Research design

The purpose of this research is to develop client centred practical guidelines to promote the quality of EmOC service provision in Ethiopian public health facilities. An exploratory and descriptive phenomenological qualitative research design was used to explore and describe clients' perspectives of quality EmOC provision. A detailed description of the research design and methods used in this study is presented in chapter 4.

1.8.2 Research setting

The study was conducted among women who had obstetric complications and received EmOC in three hospitals with a high number of deliveries per annum in the country. The hospitals are located in Addis Ababa and the annual number of child births attended by these hospitals is 10,977. The three hospitals selected were suitable for this study's attempt at exploring and describing the clients' perspectives on quality EmOC as they see complicated cases on daily basis. A detailed account of the study setting is provided in chapter 4.

1.8.3 Research population

The study population of this study comprises of all women who received EmOC in public health facilities in the year 2012 in Addis Ababa city government. The target population of the study includes women who had complications during child birth and received EmOC in three hospitals in Addis Ababa. Chapter 4 provides a detailed account of the target population and the study sample.

1.8.4 Data collection procedure

An interviewer administered semi-structured interview questionnaire was used to collect data on the clients' perspectives on quality EmOC. The instrument was structured with some open-ended questions to enhance the richness of data collected. Key informant interviews were held with women, who had complications during child birth and received EmOC. The interviews were conducted in the obstetric wards of the hospital. A detailed description of the data collection procedure is outlined in chapter 4.

1.8.5 Data analysis

Data analysis was done simultaneously with data collection. Content analysis was used to analyse the data as it complies with the phenomenological data analysis. The data was analysed using Atlas ti version 6.2 qualitative data analysis software. A detailed account of the data analysis is presented in chapter 4.

1.8.6 Ethical considerations

Ethical clearance was obtained from the Research and Ethics Committee, Department of Health Studies, University of South Africa (UNISA) (see annexure D). Approval to collect data was obtained from Addis Ababa City Government Health Bureau (see annexure B). The current study complies with moral principles of respect for persons, avoidance of harm, beneficence and justice. Details of these are presented in chapter 4.

1.9 SCOPE AND LIMITATIONS OF THE STUDY

The scope of the current study was to explore and describe clients' perspectives on quality EmOC provision in public health facilities in Ethiopia. The study was conducted in three hospitals that have functional EmOC in Addis Ababa. The results of this study are not generalisable beyond the three hospitals. However, it provides the depth of information required to explore and describe the clients' perspectives on quality EmOC. The providers' perception of the quality EmOC was not studied.

1.10 STRUCTURE OF THE THESIS

This thesis report is presented in eight chapters, and they are described as follows:

Chapter 1: Orientation of the study

The chapter gives an overview of the whole study. It discusses the background, research problem, statement of the research problem, aim, study objectives, significance of the study, the foundation of the study, the research design and method, ethical consideration and the scope and layout of the thesis.

Chapter 2: Literature review

This chapter reviews literature review on issues pertaining to quality of EmOC. The chapter highlights the paradigm for improving maternal health, strategies and approaches to maternal mortality reduction, potentials of EmOC, quality of care concepts and models.

Chapter 3: Theoretical orientation

This chapter discusses paradigms and theoretical orientations that underpinned the study.

Chapter 4: Research design and method

The chapter presents the study's research paradigm and research design, data collection approach and methods, data collection instruments and data analysis, trustworthiness and finally ethical considerations.

Chapter 5: Analysis, presentation and description of the research findings

The chapter discussed the analysis of data and description of the research findings.

Chapter 6: Conclusions and recommendations

The chapter discusses the findings of the research. It also provides a set of recommendations on how to improve the quality of EmOC.

Chapter 7: Guidelines for the provision of Client focused EmOC in Ethiopian Public health facilities

The chapter discusses guidelines for the provision of client focused EmOC in Ethiopian public health facilities.

1.11 CONCLUSION

This chapter outlines an orientation to the study on how to reduce maternal mortality in resource poor settings. The notable progress Ethiopia has made in reducing maternal mortality is mainly due to a reduced fertility rate but not due to improved maternal service provision and utilisation as evidenced by poor quality provision and low utilisation of EmOC. Exploring client views and perspectives on EmOC provides factual data that will assist on improving quality of EmOC provision and increasing EmOC

utilisation. Hence, client centred EmOC provision enables the treatment of direct obstetric complications which are the leading causes of maternal deaths. Yet, clients' perspectives of quality EmOC is relatively unexplored and hence the current study explores and describes clients' perspectives in order to develop a client centred EmOC guideline.

The chapter gave a general background, aim of the current study, methodology followed in the study and the conceptual framework around which the thesis revolved.

The next chapter reviews literature reviewed which relates to the focus of the current study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a review of literature review on the quality of EmOC and the clients' perspectives on EmOC in Ethiopia's public hospitals. It considers local and international studies related to the topic of the study, the quality of EmOC and clients' perspectives of EmOC in public hospitals in Ethiopia. The literature review describes the concept of emergency obstetric care, unrealised potential of EmOC, clients' perspectives of EmOC and outlines the model that provided grounding to the current study. Relevant studies were identified through a review of research articles found through electronic search and the UNISA library.

2.2 THE CONCEPT OF EMERGENCY OBSTETRIC CARE

Quality EmOC provision is fundamental in the reproductive health rights paradigm to improve maternal health. The reproductive health rights paradigm places women as people and citizens who have rights to conditions that would enable them to experience a safe pregnancy and a childbirth that has the best chance of having a healthy infant (Freedman et al 2003:12). The notion of improving maternal health, primarily for the benefit of women themselves, distinguishes it from past paradigms where maternal health was a secondary priority to other ambitions. For example, the demographic frameworks focused on reducing women fertility rate by availing contraceptives to reduce population growth and the political and economic paradigm sought to produce healthy children who would become productive workers and robust soldiers who would safeguard a nation's cultural and military aspirations (Freedman et al 2003:12; WHO 2005:2). Quality EmOC provision is central in the current paradigm of improving maternal health by focusing on saving the life of women and their newborn.

Improving maternal health in the current paradigm demands that direct obstetric complications, which are the leading causes of death in women of reproductive age

group, be treated. An estimated 15% of all childbirths get complicated and the probability that a normal delivery can face complications is unknown (Paxton, Bailey & Lobis 2006a:198). Risk screening approaches like antenatal care and trained traditional birth attendants attempt to predict and prevent obstetric complications on the basis that some women develop obstetric complications with certain probability and that complications can be predicted. Whereas, the quality childbirth care approach assumes that obstetric complications cannot be predicted and the probability that a normal childbirth can face complications is unknown (Freedman et al 2003:13, 23), and quality delivery care approaches effectively treat obstetric complications than risk screening approaches.

Risk screening approaches have a limited impact in the reduction of maternal mortality and improvement of maternal health (Glasier et al 2006:1597; Freedman et al 2003:22). The approach has not yielded any reduction of maternal mortality as set by the safe motherhood initiative whose goal was to reduce maternal mortality by 50% by the year 2000 (Islam & Yoshida 2009:123). The main reason for the low impact of the risk screening approach's ability to reduce maternal mortality is that the majority of complications occurred in women with no known risk factors (Freedman et al 2003:13, 22). Fortney (2001:95) notes that maternal mortality reduction depends on effective treatment of obstetric complications than prevention. Some countries have been able to reduce maternal mortality ratio to less than 200 per 100,000 live births by ensuring the treatment of obstetric complications (Campbell & Graham 2006:1296). Therefore, quality childbirth care that detects and manages obstetric complications prevents maternal deaths and improves maternal health.

EmOC provision treats virtually all life threatening obstetric complications which are the leading causes of maternal deaths. Care during the intra-partum period impacts greatly on maternal mortality as most of the maternal deaths occur between third trimester and the first week after the end of pregnancy as well as the fact that deaths are extremely high on the first and second days after childbirth (Ronsmans & Graham 2006:1193; Campbell & Graham 2006:1291). EmOC is an intra-partum care that can treat obstetric complications effectively by providing lifesaving interventions for the life threatening obstetric complications (Paxton et al 2006a:198; Fortney 2001:95; Paxton et al 2005:189,198). Maternal mortality can hardly be reduced without access to EmOC services nor the ability to treat women with obstetric complications (Rosenfield, Maine &

Freedman 2006:1133; Ijadunola, Ijadunola, Esimai & Abiona 2010:5). Skilled attendance, EmOC and an effective referral system that treats obstetric complication, reduce maternal mortality (Starrs 2006:1131; Horton 2006:1129; Freedman et al 2003:23; Glasier et al 2006:1597). Hence, provision of quality EmOC averts maternal deaths and it is an effective strategy to reducing maternal mortality.

Although EmOC provision is the strategy recommended in high maternal mortality burden areas, the strategy is not implemented in these areas (Campbell & Graham 2006:1284-1285). Costello, Azad and Barnett (2006:1477) opine that the provision of intra-partum care, including EmOC services in these regions of the world, is not a sound strategy to reduce maternal mortality as the settings lack infrastructure and resources. There is less evidence on the effect and cost effectiveness of EmOC services in poorly resourced settings. Costello et al (2006:1478) recommend community based strategies in poorly resourced settings, although community based strategies were not able to contribute to the significant reduction of maternal mortality in poorly resourced settings (Campbell & Graham 2006:1292). Even in the case of skilled attendance at home, the skilled attendant works in extremely basic conditions that compromise the care provided and inefficiently uses time and ability to cope with emergencies (Campbell & Graham 2006:1292).

The other reason for not employing EmOC as a strategy to reduce maternal mortality in poorly resourced settings is that EmOC provision needs investment in the health system and yield medium term results (Richard, Hercot, Ouédraogo, Delvaux, Samaké, Olmen, Conombo, Hammonds & Vandermoortele 2011:49; Freedman et al 2003:24). Interventions that yield short term results are preferred by funders as they tend to be simple to implement over a short period of time and reach a high level of coverage quickly, whereas investment in the health system requires more time and effort to bring a tangible impact. However, investment in the health system creates long term sustainable model that contribute to a significant reduction of maternal mortality on a long term basis as opposed to the quick impact model (Richard et al 2011:49; Islam & Yoshida 2009:123). EmOC is a medium-term intervention which requires 24/7 service and a functioning health system (Richard et al 2011:49; Rosenfield et al 2006:1134). Quality EmOC provision impacts significantly on maternal mortality nonetheless the approach is less prioritised to be implemented in poorly resourced setting by funders.

2.3 UNREALISED POTENTIAL OF EMOC IN RESOURCE POOR SETTINGS

The potential of EmOC to reduce maternal mortality is not realised in poorly resourced settings. The global pattern on availability of EmOC indicates that fewer than the expected EmOC facilities are actually functioning. Comprehensive EmOC is available to serve a minimum size of population and basic EmOC is not available in sufficient numbers. Besides, all lifesaving interventions are not performed in most facilities where EmOC is available (Paxton et al 2006b:303-304). With regard to performing the signal functions in EmOC, medical lifesaving functions are performed more often than manual lifesaving functions. Mostly, parenteral administration of oxytocics, parenteral administration of antibiotics and parenteral anticonvulsants were the medical lifesaving interventions most frequently performed. The manual removal of placenta, retained products and assisted vaginal deliveries were used less frequently (Bailey et al 2006a:287-288). Thus, EmOC is hardly available to treat obstetric complications and reduce maternal mortality in resource poor settings.

The Ethiopian Federal Ministry of Health has not utilised the potential of EmOC to reduce maternal mortality and improve maternal health as measured by the UN process indicators. The availability of EmOC measures the capacity of health facility to provide lifesaving interventions as well as assess the presence or existence of enough functioning EmOC facility to serve the population (Bailey, Paxton, Lobis & Fry 2006b:294; WHO 2009b:10). The functioning EmOC facility to population ratio is 0.6 facilities per 500,000 populations in Ethiopia, whereas the minimum standard, according to the UN process indicator, is 4 basic EmOC facilities and 1 comprehensive EmOC facility (5 EmOC facilities) to a population of 500,000 (FMOH 2008:33; Admasu, Haile-Mariam & Bailey 2011:102; Bailey et al 2006b:294; Paxton et al 2006a:193; WHO 2009b:10). Only 10%, 58 health facilities, in Ethiopia had fully functioning EmOC facilities (FMOH 2008:30). The majority of the existing health facilities do not provide EmOC services and are not fully functioning EmOC facilities. The reason for not performing the signal functions were lack of drugs/supplies/equipment, and lack of human resource/ training issues (FMOH 2008:37-38).

The country's performance of EmOC with regard to other UN process indicators is also weighed below the globally recommended minimum level. The minimum recommended level for proportion of expected births delivering in EmOC facilities is 15% with the

assumption that 15% of the pregnancies will develop obstetric complications, however, only 7% of all the expected births occurred at health facility in Ethiopia (Paxton et al 2006a:198; WHO 2009b:16; FMOH 2008:39-40; Admasu et al 2011:103). Met need for EmOC assess whether women with obstetric complications are receiving EmOC and reflects women seen but not treated/benefited (Paxton et al 2006a:198-199; WHO 2009b:19). The minimum recommended level of met need for EmOC is 100 % but the met need for EmOC services was only 3% in Ethiopia (Paxton et al 2006a:198, WHO 2009b:21; FMOH 2008:40; Admasu et al 2011:103). Developing countries continue to experience the high maternal mortality as most births are occurring outside of health facilities without skilled attendants (Glasier et al 2006:1597).

The quality of EmOC is generally poor and the utilisation of EmOC is low in poorly resourced settings. The quality and utilisation of EmOC are measured by the case fatality rate from direct obstetric complications and the met need for EmOC. Overall, the case fatality rate from direct obstetric complications is high and the met need for EmOC is low in poorly resourced settings. Therefore, the following section describes the case fatality rate and met need for EmOC: the two UN process indicators that measure quality and utilisation of EmOC.

2.3.1 High case fatality rates from direct obstetric complications

The case fatality rate from direct obstetric complications is a relative crude indicator of quality and addresses the question whether treatment is successful or not (Nirupam & Yuster 1995:S80; WHO 2009b:31). It is the proportion of women admitted to EmOC facility with major direct complication or who develop such complication after admission and die before discharge (WHO 2009b:31). It indicates whether women who reach an EmOC facility and experience a serious complication are likely to survive (Paxton et al 2006a:202; WHO 2009b:31). The quality of EmOC provision can be generally measured by the case fatality rate.

Developing countries face a high case fatality rate from direct obstetric complications. The case fatality rate from direct obstetric complications in Ethiopia was 2% (Admasu et al 2011:103), while that of Benin and Chad is 3.5% and 3.9% respectively (AMDD Working Group on Indicators 2004:113). In addition, the case fatality rate in Guinea-Bissau is 7% and 5 % in Malawi's district hospitals (Fauveau 2007:238; Hussein,

Goodburn, Damisoni, Lema & Graham 2001:68). Although some developing countries have CFR less than the recommended 1%, researchers found that deaths are underreported in those facilities. The case fatality rate in Gabon, Bolivia and El Salvador is 0.8%, 0.66% and 0.11%, respectively (Fauveau 2007:236; Bailey 2005:225, 227), just as that of Honduras and Afghanistan is 0.23% and 0.8%, respectively (Bailey 2005:230; Kim, Zainullah, Mungia, Tappis, Bartlett & Zaka 2012:195). None of these lowest case fatality rates were below the case fatality rate in United States which is 0.06% where all deaths are reported (Lobis, Fry & Paxton 2005:204). Therefore, developing countries have high case fatality rates if all maternal deaths are reported.

2.3.2 Low met need for EmOC

The met need in most of the developing countries is below 30%. The met need for EmOC in Chad, Benin and Gabon is 12%, 23% and 30%, respectively (AMDD Working Group on Indicators 2004:113, 115; Fauveau 2007:235). The met need in Malawi, Afghanistan and Gambia is 19.8%, 20% and 21%, respectively (Hussein et al 2001:66; Kim et al 2012:195; Fauveau 2007:239). In addition, the met need in Guinea-Bissau and Bolivia is 27% and 24%, respectively (Fauveau 2007:237; Bailey 2005:224). The lowest met need for EmOC is in Ethiopia, which is at 3% (Admasu et al 2011:103). Honduras and El Salvador both have a high met need that is 77% and 92%, respectively (Bailey 2005:226, 229). However, the highest met need for EmOC in developing countries has not reached the met need in United States which is 98.9 % (Lobis et al 2005:204). Therefore, developing countries have a low met need for EmOC. As a result, few of the women in developing countries that are expected to have a life-threatening obstetric emergency receive the treatment. This high maternal mortality in developing countries is emanates from high case fatality rates and low met needs for EmOC indicating the need to improve quality of EmOC provision and utilisation through quality improvement approaches.

2.4 QUALITY OF EMERGENCY OBSTETRICS CARE SERVICES

Quality of care is defined by the WHO as timely care adherent to evidence base which takes into account the preferences and aspiration of individual clients and the cultures of their communities in a way that maximise resource use. It is geographically reasonable and provided in a setting where skills and resources are appropriate to

medical needs (WHO 2006:9). Accordingly, the dimensions of quality of care in health systems are effectiveness, efficiency, accessibility, acceptability, equity and safety which are congruent with dimensions of quality of care according to the Institute of Medicine (IOM). The six dimensions or characteristics of quality of care according to IOM are safety, timeliness, effectiveness, efficiency, equitable and client centeredness and these dimensions are complementary and synergistic (IOM 2001:53). The concept of quality has evolved from physician characteristic to systems of care determined as health care organisations' capacity to promote health and prevent error (Katz, Kessler, Connell & Levin 2007:137). Clients would experience care that was safer, more reliable, more responsive, more integrated, and more available if health care systems gain in the six dimensions (IOM 2001:5-6).

The effectiveness of care is in providing services that are based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit. It refers to care that is based on the use of systematically acquired evidence to determine whether an intervention produces outcome than alternatives (IOM 2001:46-47). It is care that is adherent to evidence base and results in improved health outcomes for individuals and communities based on need (WHO 2006:9). The effectiveness of EmOC in the treatment of obstetric complications is achieved through the provision of lifesaving interventions for the life threatening obstetric complications (Paxton et al 2006a:198; Fortney 2001:95; Paxton et al 2005:189). This is evidenced by the 62% DALYs saved by EmOC in Bangladesh, where it is clear that the delivery of EmOC is cost effective in poorly resource settings (McCord & Chowdhury 2003:89). Therefore, effective emergency obstetric care not only reduces maternal mortality but also improves the quality of life.

The deaths that could be averted by availing EmOC also show the effectiveness of EmOC in the reduction of maternal mortality. The deaths that could have been averted by administering magnesium sulphate in pre-eclampsia and eclampsia were 66.7% and 41.7%, respectively, which means that the administration of magnesium sulphate avoided only 33.3% and 58.3% of deaths from pre-eclampsia and eclampsia respectively (Karolinski, Mazzoni, Belizán, Althabe, Bergel & Buekens 2010:178). EmOC is thus effective in reducing maternal mortality and improving the quality of life as measured by DALYs.

The efficiency of care is in *avoiding* waste, including that waste of equipment, supplies, ideas, and energy. It avoids use of resources without benefit to the clients. Most quality improvements result in lower resource use (IOM 2001:52). It thus entails the delivery of health care in a manner which maximises resource use and avoids waste (WHO 2006:9).

Safety of care involves avoiding injuries to clients from the care that is intended to help them. The health care environment should be safe for all clients, in all of its processes, all the time (IOM 2001:44-45). It involves the delivery of health care in a way that minimises risks and harm to service clients (WHO 2006:10).

Equity of care involves the provision of care that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographic location, and socioeconomic status (IOM 2001:39-40; WHO 2006:10).

Accessibility of care refers to the provision of care that is timely, geographically reasonable and provided in a setting where skills and resources are appropriate to medical needs (WHO 2006:10).

The IOM describes timeliness as one dimension of quality of care. Timeliness of care reduces waiting times and sometimes harmful delays for both those who receive and those who give care (IOM 2001:50). The third delay according to Thaddeus and Maine (1994:1092) are related to quality of care and reception of adequate and appropriate treatment after reaching a health facility. These are caused by factors at facility level such as lack of basic medical supplies, lack of blood transfusion (Cham, Sundby & Vangen 2005:3).

Client-centeredness care involves the provision of care that is respectful of and responsive to individual client preferences, needs and values, and ensuring that client values guide all clinical decisions. It also encompasses qualities of compassion and empathy (IOM 2001:49). The WHO dimension of care that corresponds with this dimension of care is acceptability of care. Acceptability of care refers to delivering health care which takes into account the preferences and aspiration of individual service clients and the cultures of communities (WHO 2006:9).

Campbell, Roland and Buetow (2000:1612) note that access and effectiveness are important in dealing with individual users. They also point out that other dimensions, efficiency and equity are important in putting the care in context so that it can reach the population. The effectiveness of care is the extent to which care delivers its intended outcome or results in a desired process and in response to need. The intended health outcome for an individual client is a result of access to effective care. Therefore, EmOC provision that reduces maternal death requires a high met need and low case fatality rate and more importantly a low case fatality rate that is not from underreporting.

2.5 QUALITY IMPROVEMENT OF EmOC

2.5.1 Need for quality of care improvement

Quality of care improves health outcome and utilisation of services. It is quality of care provision and utilisation that brings intended health outcomes but not mere access to service and utilisation. Women suffer adverse outcomes because they do not access service at all, access them once its late and due to poor quality of care provision (Schneider 2006:259). Moreover, poor quality of care due to inadequate staffing and equipment and inhospitable formal providers are some of the barriers to service utilisation (Essendi, Mills & Fotso 2010:S360). Therefore, quality improvement in emergency obstetric care improves case fatality rate and met need for EmOC.

2.5.2 Quality improvement and case fatality rate

Quality improvement of emergency obstetric care enhances the performance of EmOC and contributes to the reduction of maternal mortality. Quasi-experimental studies conducted to assess the effectiveness of EmOC demonstrated that improved EmOC provision reduced case fatality rates. Improved emergency obstetric care provision, through training physicians and midwives in recognition and management of obstetric complication, enhanced availability of essential drug and supplies, and reduced the case fatality rate from 22% to 5% at Kebbi State Referral Hospital in Nigeria (Oyesola, Shehu, Ikeh & Maru 1997:S79). Similarly, the improvement of EmOC provision at Makeni, in Sierra Leone, reduced the case fatality rate from 32 to 5% (Leigh, Kandeh, Kanu, Kuteh, Plamer, Daoh & Moseray 1997:S59). Thus, the improvement of the quality

of EmOC enhances maternal health by treating obstetric complication and reducing case fatality rates.

Otchere and Binh (2007:171) attribute the dramatic decrease of the case fatality rate from 10.3% to 0% in Vietnam to the hospital's increased capacity and better competence of staff to manage obstetric complications. The introduction of a criteria based audit and client oriented provider efficient (COPE) identified more than 200 problems of which 31% were related to clinical care and 29% related to readiness and hospital management. Strikingly, 90 % of the problems were resolved by the obstetric departments themselves (Otchere & Binh 2007:168). A 22% overall reduction of case fatality rate at the Zaria teaching Hospital in Nigeria was attributed to blood banking (Ifenne, Essien, Golji, Sabitu, Alti-Mu'azu, Mussa, Adidu & Mukaddas 1997:S42).

Santos, Diante, Baptista, Matediane, Bique and Bailey (2006:199) do not explain the reasons behind the decline in case fatality rate from 2.9% to 1.6% in Mozambique but mention that improvements in the management of haemorrhage, obstructed labour and sepsis have taken place. These interventions focussed on infrastructure development, human resource development, transportation, communication system and management. The interventions related to management were supportive supervision, logistics for supplies, equipment and drugs, record keeping, monitoring and evaluation and quality improvement techniques (Santos et al 2006:193-195). In another case, a 51% reduction of case fatality rate was recorded due to the implementation of similar interventions in South Western Bangladesh (Islam, Hossain, Islam & Haque 2005:303). Furthermore, the case fatality rate from haemorrhage decreased from 14.8% to 1.9% and case fatality rate from pre-eclampsia from 3.1% to 1.1% at a regional hospital in Ghana. The contributing factors include timely referral, ultrasound for high-risk clients, protocol adherence for hypertension management and labour induction (Srofenyoh, Ivester, Engmann, Olufolabi, Bookman & Owen 2012:20). Therefore, case fatality rate can be reduced significantly by improving the quality of EmOC provision.

Maternal death reviews and criterion-based audit improves professional practice and reduces case fatality rates. The introduction of audit and feedback in hospitals and health centres in Malawi reduced the case fatality rate from 3.7% to 1.5% between 2005 and 2007 (Kongnyuy, Leigh & Van den Broek 2008:152). Hence, quality improvement approaches reduce maternal mortality.

2.5.3 Quality EmOC improvement and met need

The improvement of quality EmOC provision increases the utilisation of services. Quality improvement interventions in EmOC that reduced case fatality rate also improve the met need for EmOC (Santos et al 2006:198; Islam et al 2005:302; Otchere & Binh 2007:170). The met need for EmOC increased from 11.3% to 32.8% in Mozambique after quality improvement interventions (Santos et al 2006:198). Improved reporting of complication and increased referrals are some of the factors that contributed to the increased met need (Santos et al 2006:199). The met need also increased from 11.1% to 26.6% in Bangladesh (Islam et al 2005:302). That of EmOC increased from 30% to 84% with quality improvement of EmOC in Peru (Kayongo, Esquiche, Luna, Fraix, Vega-Centeno & Bailey 2006:305). In addition, the met need for EmOC increased from 16% to 87% as a result of quality improvement interventions in Vietnam. The increase in the met need for EmOC is attributed to the capacity of the hospital and competence of staff (Otchere & Binh 2007:170). The met need for EmOC increased from 15.2 % to 18.8% in Malawi after the introduction of maternal death reviews and criterion-based audit (Kongnyuy et al 2008:152). The slight increase of met needs for EmOC is explained by the absence of fully functioning basic EmOC facilities and low institutional delivery rates (Kongnyuy et al 2008:154). Hence, the met need is attributed to quality EmOC provision but improving the experience aspect of EmOC can also contribute to an improvement the met need.

2.6 CLIENTS' PERSPECTIVES ON QUALITY EMERGENCY OBSTETRIC CARE

Women's understanding and perception of quality and how quality of care is defined affects their decision to seek care. Access to health services does not guarantee the use of the service by the target group as there are many barriers associated with the utilisation of services. Even, the utilisation of service does not guarantee the intended health outcomes. The concept of quality highlights the reason why women do not access services at all, access them late or suffer an avoidable adverse outcomes despite timely presentation (Schneider 2006:259). Essendi et al (2010:S360) identified various barriers that limit the uptake of formal obstetric services in Nairobi. The barriers are inability to identify danger signs, poor health decision making, unaffordable health care seeking, poor physical access, inadequately equipped health facilities and inhospitable formal providers. Therefore, understanding the perceptions on and

experience of EmOC will increase the utilisation of EmOC, and guide health facilities to provide client centred EmOC.

Dogba and Fournier (2009:9) espoused that the technical aspects of quality of EmOC has not been adequately studied. The process aspect of care, one of which is the interpersonal was assessed from the clients' perspectives by satisfaction questionnaire. Dissatisfaction influences clients' use of health service and compliance with treatment. Client satisfaction is used as an outcome measure for the improvement of EmOC provision (Clapham, Basnet, Pathak & McCall 2004:88). However, client satisfaction can be affected by factors that are external to the health system, thereby making it difficult to measure the performance of health system. Bleich, Özaltın and Murray (2009:274) found the association between client satisfaction and client experience of care, client expectation, self-perceived health status and type of care. Rohrer, Lund and Goldfarb (2005:2) examined the different levels of satisfaction on the basis of racial differences, which obviously is external to the health system. Nevertheless, Lule, Tugumisirize and Ndekha (2000:254) assert that women's satisfaction is attributed to many factors, which include women's expectation of care, knowledge level about health care, previous experience from using other health facilities and their perception of the government health system.

Tayelgn, Zegeye and Kebede (2011:3) found health facility related factors and health providers' characteristics as important predictors of the overall maternal satisfaction. Women's satisfaction with delivery care is based on the wanted status of the pregnancy, favourable immediate maternal condition after delivery, short waiting time, perceived availability of waiting area, measures that assure privacy and the amount of cost paid. Satisfaction with health care depends more on factors that are external to the health system that cannot be measured through experience only. This means that client satisfaction can hardly measure the performance of service provision. In fact, ethnic difference, husband status and education affect experience of maternity care (Raleigh, Hussey, Seccombe & Hallt 2010:194). Therefore, client experience of care gives a better impression of quality of care than client satisfaction.

Brown (2007:125) elucidates that clients' views of quality have largely been side lined by the number of attempts seeking to determine client satisfaction. There is a worrying downgrading of clients' perspectives on what they feel comprises quality health care,

despite the attempts to measure client satisfaction with their health care experiences. Exploring client views and perspective on what they consider important to quality of care assists in achieving quality improvement. The advantage of the measurement of clients' experiences over client satisfaction is that the former elicit factual data that may be easier to interpret whereas the latter is subjective and determined by expectation (Coulter & Cleary 2001:245).

There are a number of aspects that are perceived by women as constituting quality care. Goberna-Tricas, Banús-Giménez, Placio-Tauste (2011:e233) identified three aspects of quality of care as perceived by women. These are safety aspect, relational aspect and structural aspect. The safety aspects of care include technology and technical /professional expertise. The relational aspect of care is interaction between provider and client. The structural aspect determines the context in which the health care is provided. These three aspects of care are constituent of the experience dimension of the provision and experience of care model.

2.7 THE PROVISION AND EXPERIENCE OF CARE MODEL

The provision and experience of care model is developed by Hulton Louise and her team as part of a research project on maternal health in India. The model is based on the notion that provision of quality care prevents maternal deaths and avoids missed opportunities, but women in some institutions in developing countries continue to receive and experience appalling care (Hulton et al 2007:2083). The assumption in the model is that an improved quality of care results in the improved utilisation of services by contributing to client satisfaction and better client outcome (Hulton et al 2007:2084).

The provision and experience of care model was chosen to ground the current study from other quality care models in maternal and neonatal health care. This choice acknowledges that the quality of care models are limited and there is no single agreement on comprehensive model/framework appropriate for EmOC. The existing models in maternal and newborn health care are: the structure-process-outcome model, COPE framework, perspective model and provision-experience of care model (Raven, Tolhurst, Tang & Broek 2011:681).

The provision and experience of care model is selected to frame the current study as it divides quality in to two parts. These are the quality of clients experience and quality of

provision of care which consider both the provider and consumer of care as opposed to the provision of care only approach (Hulton et al 2007:2083). Another element of the model's dimension of quality of care is the client experience of care that enables an objective assessment of client view and perspective as opposed to client satisfaction that side-line clients' views of quality of care (Brown 2007:125; Coulter & Cleary 2001:245).

Hence, models that boldly consider clients' experiences were chosen for this study to provide a solid framework, given that exploring clients' experiences elicit factual data on what clients consider important and mandatory in quality improvements.

Client experience of care is boldly considered only in the provision and experience of the care model but the other models address clients either in the interpersonal aspect of care, client satisfaction with care or client right (Donabedian 2005:693; Morestin, Bicaba, Sermé & Fournier 2010:6). Client satisfaction is the outcome dimension of quality of care on the basis of the Donabedian model or structure-process-outcome model (Donabedian 2005:695; Morestin et al 2010:6). According to the model, the setting in which care takes place and the proper practice of medicine result in client satisfaction among other outcomes, but the outcome is affected by other factors and the cause effect relationship between the dimension is tenuous (Donabedian 2005:692). Therefore, client satisfaction has less to do with quality improvement than client experience.

Clients are autonomous health care consumers with a right to quality health care in the COPE framework (EngenderHealth & AMDD 2003:6). The clients' rights under the COPE framework are access to EmOC services and continuity of care, competent EmOC, information and informed choice, privacy and confidentiality, dignity, comfort and expression of opinion (EngenderHealth & AMDD 2003:20). Enabling clients to express their feelings and opinions about services received will enhance quality improvement and service utilisation. The framework defines the process that helps health care providers to improve the quality and efficiency of services in a way that is responsive to the clients' needs (EngenderHealth & AMDD 2003:5). Most of the client rights mentioned under COPE are elements in the provision and experience of care model. Finally, the perspective model's underlying principle is that there are different perspectives on quality of care and the client perspective of quality of care is about

personal attention to their need, preference and values (Pilgrimiené & Bučiūniné 2008:105; Korst, Gregory, Lu, Reyes, Hobel & Chavez 2005:319). Therefore, the study employed the provision and experience of care model to guide the study.

2.7.1 Description of the model-its elements

The dimensions of quality of care in the model adapted and used in the current study are clients' experiences of care and provision of care (Hulton et al 2007:2084). Client experience of care is part and parcel of the model and has four elements, which are client experience of human and physical resources, cognition, respect dignity and equity and emotional support (Hulton et al 2007:2093). The provision of care dimension has six elements in the model and these are human and physical resources, referral system, use of appropriate technologies, use of internationally recognised good practices and management of emergencies (Hulton, Matthews & Stones 2001:10).

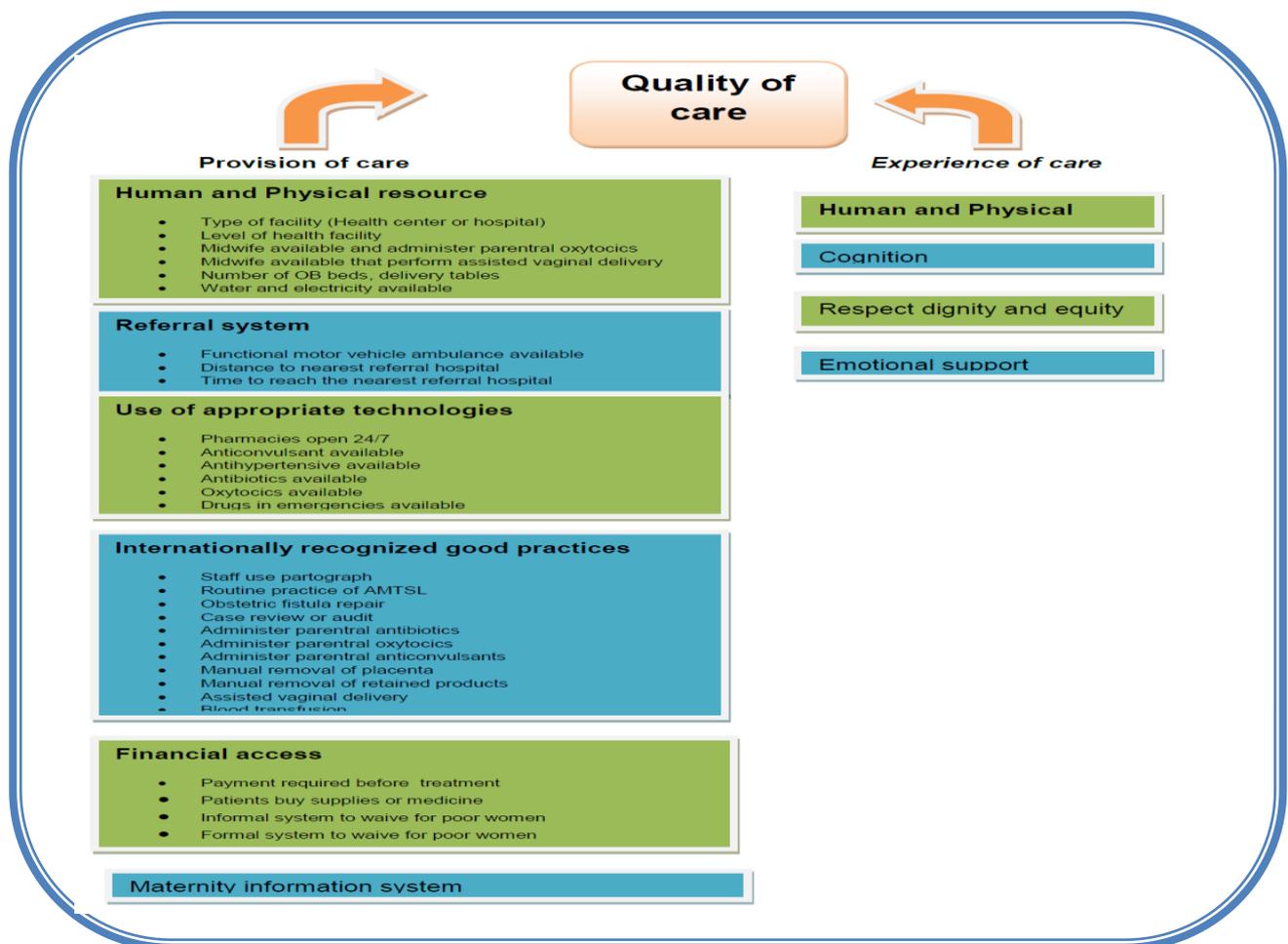


Figure 2.1 Provision and experience of EmOC model

(Adapted from Hulton et al 2007:2093; Hulton et al 2001:10)

2.7.1.1 Experience of human and physical resources

Experience of human and physical resources in the model refers to the client's impression of the state of infrastructure and actual contact time with providers (Hulton et al 2007:2087; Hulton et al 2001:39).

2.7.1.2 Cognition

Cognition refers to the extent to which a client feels she understands what is happening, on whether her question have been answered adequately and receives information in a form that she understands and has the right to know (Hulton et al 2007:2088; Hulton et al 2001:340).

2.7.1.3 Respect, dignity and equity

Respect, dignity and equity refer to client provider encounters characterised by supportive relationships and avoiding expression of inherent conflict and social disparities as clients vary by status, power and culture (Hulton et al 2007:2089; Hulton et al 2001:42).

2.7.1.4 Emotional support

Emotional support refers to support given by friends, family members and providers that can relieve stress, anxiety and pain during labour (Hulton et al 2007:2090; Hulton et al 2001:44).

2.7.1.5 Provision of human and physical resources

The provision of human and physical resources include the availability of health and non health workers, configuration of staff, levels of supervision, management styles, population based staffing ratios, nature and frequency of staff training, general infrastructure such as water and electricity, and equipment (Hulton et al 2001:19). The provision of human and physical resources in the current study refers to the availability of midwives 24/7 and midwife performance of signal functions. Midwives are selected because they can be found both in health centres and hospital labour and delivery

wards compared to other health cadres. The other reason is that the highest response in the 2008 baseline EmOC survey was from the midwives, which was 462 for midwives, 124 nurses, 71 for general practitioners, 60 health officers and 35 gynaecologists/obstetricians. Finally, the physical resources in the model include availability of obstetric beds and tables and whether the facilities have electricity and water.

2.7.1.6 Referral system

Referral system in the model asks whether there is reliable transport, communication systems, and accessibility of drugs during emergencies (Hulton et al 2001:22). It also refers to the availability of motor vehicle/ ambulance (and functional) and distance to nearest referral hospitals for obstetric surgery/caesarean section.

2.7.1.7 Use of appropriate technologies

The use of appropriate technology includes assessment of whether effective pain relief is provided, use of caesarean section within limits or that intramuscular oxytocin is not used to speed up labour (Hulton et al 2001:31). The use of appropriate technologies in the adapted model includes whether pharmacies are open 24/7 and the availability of antibiotics, anticonvulsants, antihypertensive and oxytocics.

2.7.1.8 Internationally recognised good practices

The international good practices include the use of magnesium sulphate, considering women for vaginal delivery and the routine use of prophylactic antibiotics (Hulton et al 2001:32-33). Internationally recognised practices in the adapted model refers to the active management of third stage of labour (AMTSL), use of partograph to manage labour in the last 3 months of labour, provision of focused antenatal care, provision of post natal care, and facility case review or audit. Others include facility administration of parenteral antibiotics, oxytocics, and anticonvulsants; the manual removal of placenta, manual removal of retained products in the last 3 months, assisted vaginal delivery and blood transfusion.

2.7.1.9 Financial access

Financial access in the adapted model considers whether formal payment is required before consultation/treatment. It considers whether clients pay fees or buy supplies for delivery, or whether payment is required before treatment in obstetric emergencies.

2.7.2 Rationale for choosing the model

The provision and experience of care model is adapted and used as the conceptual framework for this study. This model/framework was selected because it boldly considers experience of care as one dimension of quality of delivery care. Other models consider client satisfaction as part of the outcome aspect of care which is affected by external factors not related to quality care provision (Donabedian 2005:693; Morestin et al 2010:6). The other reason is that the model tries to consider both from the client and provider side of care. A comprehensive assessment of quality of EmOC needs to include protection of human rights, women satisfaction and informed consent (Moyo & Liljestrand 2007:177). Finally, the model enables the development of guidelines that enhance good client experience with EmOC.

2.7.3 Limitations of the model

The model does not allow the assessment of the quality of emergency care from both the provision and experience dimension as management of emergency belong to the provision aspect of the model (Hulton et al 2001:34). However, management of emergencies is a care that has the two dimensions of quality care and cannot be categorised into the provision aspect only. Therefore, the model is adapted and used to accommodate emergency obstetric care as care that has both the provision and experience dimension.

2.8 CONCLUSION

This chapter focussed on a review of literature on EmOC, quality EmOC, technical and clients' perspectives on quality EmOC and describes the provision and experience of care model that ground this study. Quality of EmOC provision was noted to be fundamental in the paradigm of improving maternal health demands provision of client

centred care and the creation of positive client experience. This requires assessing client experience of EmOC to elicit factual data for quality improvement as opposed to client satisfaction which is affected by factors external to the care provision. The provision and experience of care model was used as the model to ground the current study and guide the development of best practice guidelines as it strongly considers the client experience. The chapter also described the elements and limitations of the model.

The next chapter presents theoretical grounding of the research.

CHAPTER 3

THEORETICAL GROUNDING OF THE RESEARCH

3.1 INTRODUCTION

This chapter discusses the paradigms, philosophical inquiries theoretical orientations and the rationale for choosing the theoretical orientation that underpinned the study. Descriptive phenomenology and feminism guide the current study objective, which is to explore and describe the clients' perspectives on quality emergency obstetric care.

3.2 PARADIGM

A paradigm is a world view and belief that shape how researchers see the world and act in it (Lincoln & Denzin 2005:22; 183). It is defined as a frame of reference to organise observation and reasoning (Babbie 2010:33). Punch (2005:27) defines a paradigm as a set of assumptions about the social world, and what constitutes proper techniques and topics for inquiry. Patton (2002:69) defines a paradigm as a way of thinking about and making sense of the complexities of the real world. It helps to better understand the views and action of others. It provides the opportunity to find new ways of considering and explaining things by adopting different paradigms (Babbie 2010:33). It subsumes, defines, and interrelate the exemplars, theories, methods and instruments that exist within it (Ritzer 2005:543). Munhall (2007:78) notes that paradigms and traditions influence ways of knowing and shaping a body of knowledge. Munhall (2007:79) describes the influence of paradigm and tradition as specifying the domain of study, the legitimate modes and the method of inquiry open to a researcher within a discipline.

Philosophical inquiry in to truth and reality depends on the type of knowledge being sought and the nature of things being studied (Bunge 2001:14569). It involves examining the nature of knowledge itself, how it comes into being and is transmitted through language (Patton 2002:91-92). Patton (2002:134) lists six core questions that distinguish the variety of inquiry. The six core questions are:

- What do we believe about the nature of reality? – ontological debate
- How do we know what we know? – epistemological debates
- How should we study the world? – methodological debates
- What is worth knowing? – philosophical debates
- What question should we ask? – disciplinary and interdisciplinary debates
- How do we personally engage in an inquiry? – praxis debate

Bunge (2001:14569) describes the philosophy of science as having three main components, which are ontology, epistemology and methodology. Guba (1990:17) in Lincoln and Denzin (2005:22) defines a paradigm as the net that contains the researcher's epistemological, ontological and methodological premises.

3.3 ONTOLOGICAL, EPISTEMOLOGICAL AND METHODOLOGICAL ASSUMPTIONS OF THE STUDY

3.3.1 Definition of concepts

Ladyman (2007:303) defines ontology as the theory of what exists and as the study of the fundamental questions of being and nature of reality. Ontology as a philosophical inquiry is about "what is the nature of reality?" (Lincoln & Denzin 2005:22).

Epistemology is defined as the study of the nature of knowledge and justification. It is concerned with analysis of knowledge and its relationship to belief and truth, the theory of justification and how to respond to the challenges of local scepticism (Ladyman 2007:303). The philosophical inquiry is outlined by Lincoln and Denzin (2005:183) as encapsulated in the question: "How do I know the world?"

Methodology is the theory of scientific method (Ladyman 2007:303). The philosophical inquiry is entailed in the question: "How do we know the world or gain knowledge of it" (Lincoln & Denzin 2005: 22). The focus of methodology is on the best means of acquiring knowledge about the world (Lincoln & Denzin 2005:183).

3.3.2 Assumptions of the current study

The ontological, epistemological and methodological assumptions used in this exploration and description of client perspectives on quality emergency obstetric care at Ethiopian public hospitals with most deliveries are listed below.

The ontological assumptions are:

- Multiple realities and socially constructed realities are central to exploring and describing the perspectives of clients regarding quality EmOC provision in Ethiopian public health facilities.
- Clients with direct obstetric complications have expectations and preferences about quality EmOC.
- The lived experiences of EmOC as perceived by clients with direct obstetric complications indicate the lived experiences of women in real life.
- Client experience of care guide the improvement of quality of care.

The epistemological assumptions are:

- The quality of EmOC as constructed by clients with direct obstetric complications will shape the provision of client centred EmOC.
- Creating good client experiences with EmOC improves satisfaction with EmOC.
- Client centred EmOC provision will increase utilisation of EmOC and therefore reduce maternal mortality from direct obstetric complications.

Methodological assumption

This study considers the qualitative method as the appropriate methodology. As a result, descriptive and explorative qualitative research method is assumed to be the appropriate method for exploring and describing the clients' lived experiences with EmOC.

3.4 THEORETICAL ORIENTATIONS

Theory as a concept is best understood in the context of philosophical debates about knowledge, the nature of reality and how we know and represent reality (Shaw, Briar-Lawson, Orme & Ruckdeschel 2010:180). Markovsky (2005:831) defines theories as 'repositories' of general knowledge that provide explanation for wide ranges of phenomena in the complex world. They provide the framework to generalise findings into wider groups and other contexts and explanations of the topic under investigation.

Theories help organise and make sense of what has been seen and observed. They provide explanations about causation and the relationship among phenomena (Shaw et al 2010:180). They reveal the essence of the evidence, whereas evidence is used in the theory generation (Avis 2005:7-8). This relationship is described by Thomas Kuhn as observation determined by paradigm and theory. For example, the logical positivists describe the relationship between theory and observation as one way and that a theory has a logical deductive structure (Packer 2011:17-18). Meaningful statements are those that are capable of verification through observation or those that are demonstrable logically (Schwandt 2005:233). It asserts that direct observations can provide an indubitable foundation for knowledge. However, observation relies on assumptions which cannot be tested without other assumptions (Hammersley 2007:586). Therefore, theories are important in making sense of what is seen and observed.

There is a uniform set of criteria for defining, constructing and evaluating theories. Theories that do not have explicit set of criteria are called quasi-theories. They are also known as perspectives, frameworks, orientations, and meta-theories (Markovsky 2005:831). The later, Meta-theory, is a subtype of meta-study that focuses on the examination of theory and theorising (Zhao 2005:501). Meta-theory refers to critical reflections on the nature of a scientific inquiry. It describes the nature and structure of scientific theories, the meaning of truth, explanation and objectivity (Babbie & Mouton 2001:20).

There is no definitive way to categorise theoretical perspectives. Zhao (2005:502) identifies four major meta-theoretical orientations in sociology as positivist, hermeneutic, critical and postmodern perspectives. Creswell (2012:10) distinguishes five qualitative traditions of inquiry, which are biography, case study, phenomenology, grounded theory

and Ethnography. Lincoln and Guba (2000) in Patton (2002:79) identify five alternative inquiry paradigms and these are positivism, post-positivism, critical theory, constructivism and participatory. Finally, Schwandt (2000) in Patton (2002:79) identifies interpretivism (symbolic interaction, phenomenology and hermeneutics) and social constructivism epistemological stances. The following paragraphs will describe briefly some of the theoretical perspectives followed by the rationale for choosing the theoretical orientations that underpin the current study.

3.4.1 Positivism and post-positivism

Auguste Comte established three stages in the progression of knowledge. These are the theological, metaphysical and scientific stages. The scientific stage or positive stage cast abstraction in terms of invariable natural laws relating to observable phenomena and events (Ritzer 2005:573). Positivists assert that genuine knowledge is the only verifiable claim directly based on experience (Patton 2002:92). They assert that an objective account of the real world can be given (Lincoln & Denzin 2005:27).

Positivism seeks to establish universal laws, believing that all knowledge can be reduced to observable facts and the relationship between them. The overall methodological approach is 'it goes forth and quantifies'. It presumes that a real world with verifiable patterns can be observed and predicted. It poses the questions: 'what can we establish with some degree of certainty?' and 'What are plausible explanations for verifiable patterns?' (Patton 2002:91). The principles include objective measurement, hypothesis testing, [law like generalisation], reproducible designs (Avis 2005:3). It is a philosophical system grounded on the rational proof or disproof of scientific assertions and assumes a knowable objective reality (Babbie 2010:35). It strives to get the closest approximation of reality and helps to explain in quantitative terms how variables interact, shape events and cause outcomes (Ulin, Robinson & Tolley 2005:15).

Logical positivism coined by Vienna builds on unification of science and empiricism which are the two core themes of positivism (Ritzer 2005:574). Logical positivism emphasised the logical deductive structure to theory development and knowledge from direct experience or inferences from experience. Real knowledge in this philosophical perspective is knowledge that could be logically deduced from theory, and operationally measured and empirically replicated (Patton 2002:92).

Post-positivism asserts that natural and social scientific knowledge serves sectional interest rather than being value free (Ritzer 2005:576). It asserts that knowledge is relative rather than absolute and proves the problematic nature of causality in explaining social phenomena because knowledge is embedded in paradigms and that methods are imperfect (Patton 2002:92). It asserts that only partially objective accounts of the world can be given (Lincoln & Denzin 2005: 27).

3.4.2 Constructivism

Humans interpret and construct reality in addition to the physical reality. Social construction and constructivism asserts reality is constructed by humans. It studies the multiple realities constructed by people and the implications of those constructions for their lives and interactions with others (Patton 2002:96). It is built on ontological relativity which states that existence depends on one's world view and is relative to time and place (Patton 2002: 97).

The distinction between constructivism and constructionism is that constructivism is about how the individual mind creates meaning and constructionism is collective creation of meaning such as the influence of culture on constructing reality (Patton 2002:97). The basic contribution of social construction and constructivist perspective inquiry are capturing and honouring multiple perspectives, attending to the ways in which language as a social and cultural construction shapes, distorts and structure understandings, how method determines findings and the importance of thinking about the relationship between the investigator and the investigated, especially the effects of inequitable power dynamics and how that relationship affects what is found (Patton 2002:102-103).

With a constructivist view, the researcher holds that the lived experiences of clients with direct obstetric complications forms the basis of their perspectives regarding the quality of EmOC provided at public health facilities.

3.4.3 Symbolic interactionism

Symbolic interactionism is a paradigm that views human behaviour as a creation of meaning through social interaction with those meaning conditioning subsequent interaction (Babbie 2010:37). It emphasises on the importance of meaning and interpretation as fundamental for understanding human behaviour. The foundational question is 'what common set of symbols and understanding has emerged to give meaning to people's interaction?' (Patton 2002:112-113). The words used express the perspective and the situation of the people who use them. It involves adopting the existing languages and perspectives of people in the study setting to use towards the phenomena under study (Brown, Crawford & Hicks 2003:206).

Under symbolic interactionism, clients interact with health care workers and form perspectives which can be expressed in the form of views regarding quality of care. These perspectives can be expressed when given an opportunity to interact and recall during interviews or focus group discussions.

3.4.4 Phenomenology, heuristic inquiry and Ethnomethodology

Phenomenology is the theoretical orientation that focuses on exploring how human beings make sense of experience and transform experience into consciousness, both individually and as a shared meaning. The foundational question is 'what are the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?' (Patton 2002:104).

Heuristic inquiry is a form of phenomenological inquiry that necessitates a researcher's intense interest in the phenomenon under study and personal experience. It is the combination of personal experience and intensity that yield an understanding of the essence of the phenomenon. The foundational question is 'what is my experience of this phenomenon and the essential experience of others who also experience this phenomenon intensely?' (Patton 2002:107).

Ethnomethodology is the form of phenomenological study about norms, understanding, and assumptions of the ordinary and the routine of everyday life. The foundational

question is 'How do people make sense of their everyday activities so as to behave in socially acceptable ways?' (Patton 2002:110-111).

The researcher formed a heuristic phenomenological inquiry into the way clients receive care during delivery. He reviewed the perspectives shared by women in relation to the local norms and cultures, which he is quite immersed in and knowledgeable about.

3.4.5 Critical theory

Critical theory provides the descriptive and normative bases for social inquiry aimed at decreasing domination and increasing freedom in all their forms. It aims at explaining and liberating human beings from circumstances that enslave them (Bohman 2012:1). The major tenet of critical theory is that the understanding and addressing unequal relations of power could lead to emancipation and social justice (Lincoln & Denzin 2005:88). Thus, the aim of critical theory is to understand and transform society (Babbie & Mouton 2001:34).

The application of this theoretical orientation in this study is aimed at preserving the rights of women to reproductive health, while seeking their perspectives regarding the quality of EmOC provided in public health facilities. Information obtained from this study will be useful in promoting the rights of women towards quality delivery and post-partum care.

3.4.6 Feminism: a variant of critical theory

The central tenet of feminism is that women are made but not born. It examines the core values and standard practices that affect women in society. It gives the frame to understand women's experience and lives (Ritzer 2005:269). The epistemological assertion of feminism is that women and men perceive and understand society differently (Babbie 2010:40). Feminism is about valuing women, their ideas, ideals and experiences and facilitating women towards taking meaningful action in their lives (Kralik 2005:251). It is concerned with the gender and power dimensions of social phenomena that shape peoples' lives. It seeks insight into the influence of gender and power on human behaviour (Ulin et al 2005:21).

3.4.7 Ethnography

The foundational question of ethnography is ‘what is the culture of this group of people?’ The central and guiding assumption is that any human group of people interacting together for a period of time will evolve a culture (Patton 2002:81). Ethnography seeks to reveal the meaning that people give to their action and interaction, structures and interactions in the society (Holloway & Todres 2005:99). Organisational ethnography is the term used for the theoretical orientation for interpreting and applying findings in organisations from cultural perspectives (Patton 2002:83-84). Ethnography can offer an in depth description of larger organisations, such as hospitals and an understanding health care (Brown et al 2003:211). The fact that findings are interpreted from the cultural perspective makes ethnography a distinct approach (Patton 2002:84).

Ethnography first emerged as a method for understanding the outsider view. This implied that there is some degree of detachment between the observer and the observed. The effect of the value and cultural background of the observer on what is observed was questioned. This gave birth to auto-ethnography. The foundational question of auto-ethnography is: ‘How does my own experience of this culture connect with and offer insights about this culture, situation, event, and/or way of life?’ (Patton 2002:84).

As a researcher who resides in Ethiopia and have years of working experience in maternal health and the health care system in the country, the researcher assumed an auto-ethnographic theoretical orientation towards this study.

3.4.8 Hermeneutics

Hermeneutics is a theoretical approach that asserts that the meaning of things depends on cultural context in which it is originally created and that with which it is interpreted. The foundational question is; ‘what are the conditions under which a human act took place or a product was produced that make it possible to interpret its meaning?’ (Patton 2002:113). In this study, the researcher will describe clients’ perspectives of quality of EmOC under the conditions and context of the Ethiopian public health facilities.

3.4.9 Grounded theory

The grounded theory, as defined by Babbie (2010:33), is an inductive approach to the study of social life that attempts to generate a theory from the constant, while comparing unfolding observation. Simply put, it is a theory that emerges from systematic comparative analysis and is grounded in the field work, which seeks to explain what has been seen and observed (Patton 2002:125). The focus is on developing plausible and useful theories that are closely informed by actual events and interaction of people and their communication with each other (Holloway & Todres 2005:97). The objective or aim should not be narrowly stated for lest it will inhibit the process of discovery. In addition, the literature review should be minimised in order to avoid the constitution of preconceived ideas. Scholars argued the need for a literature review and that bracketing prior assumption provides knowledge to compare with categories as they emerge (Bluff 2005:150).

In this study, the researcher exhaustively reviewed related literature to provide the basis for comparison of data emerging from the qualitative method. The qualitative research design utilised in this study inductively generated ideas relevant for the development of theories related to clients' experiences of EmOC.

3.5 THEORETICAL ORIENTATION OF THE STUDY

3.5.1 Phenomenology as the theoretical orientation of the study

Interpretivism highlights how much of our knowledge of the world is confined to interpretation and the restrictions of language. Its basic assumption is that the social world is actively constructed by human beings and we are continuously involved in making sense or interpreting our social environment. Its methodological approach is that "goes forth and qualify". It helps to understand the meaning that people attach to objective facts (Ulin et al 2005:17-18). It assumes that multiple realities are constructed socially through interaction and assigning meaning to perceptions and experience (Bowling 2009:139).

Theories are used to guide and interpret empirical evidence. Evidence tells little if theory is not used to interpret the evidence (Avis 2005:7). This study is underpinned by the

theoretical orientation of phenomenology. Phenomenology is a philosophical school of thought that describes how our consciousness gains the reality of the world (Srubar 2007:558). Patton (2002:104) defines phenomenology as the theoretical orientation that focus on exploring how human beings make sense of experience and transform experience into consciousness both individually and as a shared meaning. The foundational question is: 'what are the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?' (Patton 2002:104). The central focus is the lived experience of the world of everyday life and the goal of phenomenology is to describe lived experiences (Speziale & Carpenter 2007:77).

The concept was developed by Edmund Husserl. His conception was able to bridge the opposing school of thoughts that assert knowledge from pure logic and authenticity of knowledge from lived experiences. He contended that philosophy must employ pure logic and clarify basis on intentional consciousness (Srubar 2007:559). Phenomenological reduction asserts that the meaning making process of consciousness can be revealed by investigating experience. This means that we understand not only the experience but how we derived the meaning of that experience. The reduction is therefore the phenomena and the meaning of that phenomenon. Experience is viewed as phenomena and at second level what the phenomena means to us is the meaning establishing acts of consciousness (Srubar 2007:559).

The world is experienced through unity of mind and body. Access to the world is gained by body and it is through consciousness that we are aware of being in the world. The unquestioned meaning about the world today and natural attitude, were once experienced, interpreted and passed on to generations. Individuals gain access to experience the world through perception (Munhall 2007:161; Srubar 2007:559). Phenomenology is concerned with the experience as individual perceives it. The central idea of phenomenology is that what is perceived as happening is important than what is happening (Srubar 2007:559; Lincoln & Denzin 2005:485).

Descriptive phenomenology asserts description as vital to account for a variety of phenomena (Rapport 2005:130). It defines how meanings are precisely presented to consciousness as they are presented (Rapport 2005:132). Whereas, interpretivist phenomenology asserts that interpretation is vital to account for variety of phenomena (Rapport 2005:130). It is concerned with clarification of meaning in terms of plausible

hypothesis or theoretical models (Rapport 2005:132). The current study will be guided by descriptive phenomenology; that is to describe the lived experiences and perceptions of clients regarding the quality of EmOC in public health facilities in Ethiopia.

3.5.2 Justification for selecting theoretical orientation

Descriptive phenomenology was chosen to guide the study. The rationale behind choosing descriptive phenomenology to underpin the current study is based on the research question and objective of the study, which is to explore and describe the clients' perspectives on quality EmOC provision.

Descriptive phenomenology was selected to guide the study as the objective of the study is related to client experience. Babbie and Benaquisto (2010:317) describe the aim of phenomenology as to discover subject's experiences and how subjects make sense of them. The emphasis is with the world view of people being observed or interviewed. Brown et al (2003:214) notes further that phenomenology seeks to provide a balanced account of the lived experiences of individuals. The experience of clients with direct obstetric complication with emergency obstetric care will be best explored and described under the theoretical orientation of descriptive phenomenology.

Feminist constructivism was also proposed as the theoretical orientation for the study. This is because women have their own understanding and constructing of the quality of EmOC which could differ from those of the men. However, the interest of the current study is to do more with the experience of emergency obstetric care. Feminism has been considered as the power relations due to gender issues and that the study is dealing with women: clients who had direct obstetric complications during delivery. Therefore, feminist descriptive phenomenology was considered a more plausible theoretical orientation.

3.6 CONCLUSION

This chapter presented the concept of paradigm and philosophical inquiry approaches. It presented a brief description of different theoretical orientations underpinning the study. It also explained the rationale for choosing feminist descriptive phenomenology as the theoretical orientation of the study. The feminist descriptive phenomenology is

the theoretical orientation that underpinned the exploration and description of clients' perceptions and experiences of EmOC provision in public health facilities in Ethiopia.

The next chapter, chapter 4, presents the research design and methods.

CHAPTER 4

RESEARCH DESIGN AND METHODS

4.1 INTRODUCTION

This chapter provides a detailed account of the research methods and processes that were followed to conduct the current study. This chapter also describes the study's setting, sampling procedure, data collection tool and methods of data analysis. Trustworthiness and ethical considerations relevant to the study are also presented.

4.2 RESEARCH DESIGN

4.2.1 Research paradigm

The qualitative paradigm was employed in this study to explore and describe the clients' perspectives on the quality of EmOC. This is because the qualitative paradigm enables the exploration of varying perspectives and experiences of people. This complies with Babbie and Mouton's (2001:53) assertion that the qualitative paradigm enables the studying of the insider view or perspective on social actions with the goal of describing and understanding human behaviours in natural settings. It helps in the acquisition of an understanding of social behaviour by exploring people's subjective accounts of social life (Avis 2005:4). It attempts to view the world through the perspective of the actors themselves and describes the participants' view points (Babbie & Mouton 2001:271; Speziale & Carpenter 2007:21). Hence, the qualitative paradigm is applied in the current study to explore and describe clients' perspectives on the quality EmOC.

The qualitative paradigm is also applied in this study, unlike the quantitative paradigm, because quantitative paradigm uses standardised measures to fit the varying perspectives and experiences of people to a limited number of predetermined response categories (Patton 2002:14). The quantitative paradigm uses highly structured methods and a rigid style of eliciting and categorising responses reducing extensive interaction (Mack, Woosong, MacQueen, Guest & Namey 2005:3). Therefore, the quantitative

paradigm is not the preferred method in the current study as it prohibits exploration and description. Whereas, the qualitative paradigm produces textual data that differs from the expectation/anticipation of the researcher based on extensive interaction and uses interpretive and open-ended methods to provide insights into the meanings of decisions and actions by asking how, why and under what circumstance things occur, thus fostering exploration and description (Patton 2002:14; Ulin et al 2005:6). Therefore, the qualitative paradigm is applied in the current study as it enables the exploration and description of clients' perspectives on the quality of EmOC provision in public health facilities in Ethiopia.

4.2.2 Research design

The current study employs a descriptive and explorative phenomenological research design to enhance exploration and description of the clients' perspectives on quality of EmOC provision in public health facilities in Ethiopia. A research design explicates how the researcher intends conducting the research and guides the process of research from the formulation of the research questions up to reporting the research findings (Babbie & Mouton 2001:74; Kalaian 2008:725; Brown 2006:64). An explorative and descriptive phenomenological research design was employed in the current study to address the research question. This research design was preferred as it helps to describe and explore the experiences of clients who had direct obstetric complications. This complies with Speziale and Carpenter's (2007:77) assertion that the goal of phenomenology is to describe the lived experiences and the foundations, for phenomenological inquiry are holistic perspectives and the study of experience as lived. Therefore, topics related to human life experiences are appropriate for phenomenological method (Speziale & Carpenter 2007:92). As a result, exploring and describing the perspectives of clients who experienced EmOC perfectly fits with the goal of phenomenology and phenomenological inquiry as applied to the current study.

A descriptive design in qualitative paradigm serves to describe situations and events and to examine patterns and their implications (Babbie & Mouton 2001:81). The current research attempts to describe clients' perspectives on EmOC. Thus, the descriptive and explorative phenomenological design was applied in the current study with the objective of exploring and describing client perspectives on the provision of EmOC in public health facilities in Ethiopia.

4.3 THE RESEARCH METHOD

4.3.1 Population and sampling

4.3.1.1 Population

Babbie and Mouton (2001:173) define population as the theoretically aggregation of study elements. It is the total collection of whatever is the researcher wishes to examine (Brown 2006:66). In addition, a population is an aggregation of elements from which the sample is actually selected (Babbie & Mouton 2001:174). The research population of the current study was clients who had direct obstetric complications and received EmOC in three hospitals in Addis Ababa. This population creates the whole reason for the existence of EmOC services in Ethiopia.

The inclusion criteria are a set of predefined characteristics used to identify subjects who will be included in a research study. Proper selection of inclusion criteria optimises the trustworthiness of the study and improves its feasibility (Velasco 2010:590). The researcher included clients that gave birth in public hospitals in Addis Ababa, who had direct obstetric complication, received EmOC and willing to provide verbal consent to participate in the study. The inclusion criteria for region or city administration in Ethiopia were better performance of EmOC as measured by the UN process indicators. These UN indicators for EmOC are availability of functional EmOC, met need for EmOC, and case fatality rate from direct obstetric complications. Hospitals that attended most deliveries in the year between 2007 and 2008 were also included in the study. Those who failed to meet the inclusion criteria were excluded from the study.

4.3.1.2 Sample and sampling technique

A multi-stage purposive sampling technique was used in this study. Purposive sampling is the deliberate seeking out of participants with particular characteristics, according to the needs of the developing analysis and emerging theory (Morse 2004a:885). Purposive sampling was the preferred technique because it enables the selection of clients who experienced EmOC in public health facilities in Ethiopia. This is in line with Plays' (2008:698) view that the tenet of purposive sampling is one well-placed and

articulate sample that often advances the research far better than any randomly chosen sample.

First, the Addis Ababa city administration was purposively selected for this study because the service provision in the city met most of the UN process indicators for EmOC, such as availability of EmOC, met need for EmOC and case fatality rate. Then, Gandhi Memorial Hospital, Yekatit 12 Hospital and Zewditu Hospital were purposively selected because the three are under the supervision of the city government of Addis Ababa Health Bureau and are among hospitals with most deliveries in the country. The annual number of childbirths attended by health care workers in the targeted hospitals between the years 2007 and 2008 was 10,977: Gandhi Memorial Hospital attended 5,842 childbirths; Yekatit 12 Hospital attended 2,581 childbirths and Zewditu Hospital attended 2,554 childbirths, thus increasing the probability of handling clients with direct obstetric complications (FMOH 2008:241). The condition of the provision of care in these hospitals is not different from others except for the high number of child births attended and that they are all run by government.

Finally, sampling units were also purposively selected. A sampling unit is an element or set of elements considered for selection at some stage of sampling (Babbie & Mouton 2001:174). The sampling units in this study were clients who had direct obstetric complications and received EmOC in the hospitals as identified by the midwife and verified from the client's card. The clients identified had recent experience with EmOC, which ranged from one day to a maximum of one week before the interview.

4.3.1.3 Sample size

A sample size is the number of data sources that are actually selected from the total population (Morgan 2008:799). A total of 12 key informant interviews were conducted in the 3 health facilities or hospitals used for this study. The total number of key informant interview participants was 12, with one participant in each interview session. Therefore, the total number of data sources that were actually selected from the total population was 12.

Data saturation could be achieved with a relatively small sample if participants are adequately informed about the research phenomenon and if they are able to reflect on

their experiences and communicate them effectively (Polit & Beck 2008:357). Ensuring richness and depth will be achieved by having a relatively small sample as the current study objective is to explore and describe the clients' perspectives of the quality of EmOC provision. This is in line with the assertion made by Brink, Van der Walt and Van Rensburg (2006:137) that exploratory designs call for small samples.

Table 4.1 Number of key informant interviews conducted in the three hospitals

| Hospitals | Key informant interview |
|-----------------|-------------------------|
| Gandhi Memorial | 4 |
| Zewditu | 4 |
| Yekatit 12 | 4 |
| Total | 12 |

4.3.2 Data collections

4.3.2.1 Data collection approaches, methods and processes

The primary method of data collection used in phenomenology is in-depth interviews with individuals who have experienced the phenomenon (Kalaian 2008:730). In-depth interviews are sensitive to the unique experiences and subjectivity of the interviewee (Packer 2011:2). The current study aimed to capture the experiences of clients on emergency obstetric care. Besides, clients who had direct obstetric complications were few in number averaging 2 in a given day to conduct focus group discussions. Hence, the in-depth interview the data collection method was used effectively in the current study.

4.3.2.2 Development, testing and characteristics of the interview questionnaire

The interviewer administered semi-structured interview questionnaire was used to collect data in this study. Ayres (2008:811) opine that an interview guide may be very specific, with carefully worded questions, or it may be a list of topics to be covered. The general topics were identified from the objective of the study, central research question and information obtained from the literature review to develop the interviewer administered semi-structured interview questionnaire and enhance the conversation

with participants during data collection. Open-ended questions also encouraged participants to interpret questions themselves which is in line with Ulin et al (2005:82) assertion that open-ended question enable participants to explain more on specific topic. In addition, the probing questions ensured in-depth information was sourced from the participants.

The interviewer administered semi-structured questionnaire was prepared in English and translated to Amharic which is the national language in Ethiopia and spoken well in Addis Ababa. The main question posed to the participants was: How do you define quality Emergency obstetric care? This is an open-ended question that initiated the discussion. Then probing questions helped to explore the client perspectives on quality EmOC.

Audiotape recorders were used to capture the interviews and to ensure the researcher captured most of the data during data collection. An explanation on why audiotape recorders were being used was given to the participants and verbal consent was obtained prior to commencement of the interview. The two data collectors carried two audiotape recorders, one as a back up in the event that the other audiotape recorder failed.

Pretesting was done in the current study to streamline the questionnaire and to ensure that the research questions and the method used in asking would bring forth the required information. The pretesting was done a week before the actual data collection in Yekatit 12 Hospital. Two key informant interviews were conducted with clients with direct obstetric complications and had received EmOC to pre-test the interviewer administered semi-structured interview questionnaire. This helped to streamline the questionnaire by rephrasing and rewording some of the questions, re-ordering the sequence of questions and introduction probes to the semi-structured interview questionnaire.

The interviewer administered semi-structured interview questionnaire consisted of two sections which are described below:

Section 1 built the rapport between the researcher and the participants. It included information on the objective of the study and information to obtain informed consent. It

also had the demographic intake data sheet to gather information on the participants' characteristics, such as age, average income, parity, gravidity and history of complication among others.

Section 2 had all the research questions and sub questions. The research questions and sub-questions were open-ended, provoked discussion and engaged the participants. The main question posed to the participants was: How do you define quality Emergency obstetric care? This was followed by sub questions such as: What constitutes quality emergency obstetric care? [Probe and see if it includes the following: effectiveness, efficiency, accessibility, acceptability, equity and safety]; How is the quality of obstetric care (emergency) in the facility? [Probe to define using their own definition]. The semi-structured interview questionnaire annexed to the current study.

4.3.3 Data collection process

The three phases followed to collect data in this study were the preparatory phase, gaining access to the field and leaving the field (Patton 2002:213). The preparatory phase included preparing the semi-structured interview questionnaire, finding data collectors with previous experience of qualitative data collection, arranging refresher training on qualitative data collection, obtaining a letter of support from UNISA and availing the necessary supplies for data collection such as audiotape recorders.

The data collection team comprised of the researcher and two female research assistants. The female research assistants were hired as data collectors in order to ensure the clients' openness to discussions and to comply with the study's feminist theoretical stances. The data collectors were graduates in the fields of health and social sciences, with previous experiences in qualitative data collection. They were trained on interview skills, data transcription, and data management prior to the actual data collection. Data collection took between 45 minutes to 1 hour.

During the second phase, which is about gaining access to the field, the researcher purposively selected hospitals with most deliveries from the national baseline survey in Addis Ababa. The medical directors and heads of gynaecology and obstetrics departments in the hospital granted the researcher access to the hospitals after being informed fully about the study.

Data collectors were introduced to the hospital matron and midwife in the post delivery wards. The clients eligible for the study were identified by the midwife and the researcher confirmed whether the clients had direct obstetric complications and received EmOC by referring to the clients' cards. Data collectors introduced themselves and obtained informed consent from the clients before commencement of actual data collection. Semi-structured key informant interviews were conducted in Amharic and Oromiffa languages. Interviews were conducted in the client recovery room. Amharic is the national language in Ethiopia and Oromiffa is well spoken on the out skirts of Addis Ababa. A semi-structured key informant interview questionnaire was used to collect data. Clients were encouraged to speak openly and extensively about their experiences with EmOC at the hospitals. Data collectors expanded notes immediately after the interview sessions and shared with the researcher. The researcher realised that no new ideas came after the 10 semi-structured key informant interviews which depicted data saturation. An additional two semi-structured key informant interviews were conducted to ensure that the theoretical saturation point was reached. These additional two semi-structured key informant interviews were conducted in an attempt to stop more data collection as the level of data saturation was achieved.

During the third phase, data collectors and the researcher thanked the midwives, head of department of obstetrics/gynaecology and the medical director who facilitated the successful hosting of the key informant interview.

4.4 DATA ANALYSIS

The goal of qualitative data analysis was to reveal patterns or themes, and build explanation or theoretical understanding from data. It was concerned with how to determine what was important to observe and how to formulate analytical conclusions on the basis of the observations (Babbie & Benaquisto 2010:387). It improves understanding, expand theory and advance knowledge (Neuman 2011:507). Hence, it reflects the ways in which the researcher gets conclusions from data (Punch 2005:195). In the current study, data analysis describes how the researcher identified relevant themes, derived understanding and created meaning out of data.

Qualitative data, according to Patton (2002:466), includes data extracted from reviews, transcripts and tape records. Analysis of data started on the field before data collection was completed. The researcher read through the expanded notes and transcripts once the interview sessions had ended and transcripts were ready. This helped the researcher to shape and modify subsequent interviews to capture more information and give feedback to data collectors. The qualitative data generated and used for the analysis in the current study were the audiotape records and transcripts. All audiotape records of the semi-structured key informant interviews were transcribed and field notes were expanded by data collectors to prepare the interview transcript. Hence, the interview transcripts were produced both from the transcription of the audiotape record and expanded filed notes. The Amharic transcription was directly translated into English by the researcher. The Oromiffaa transcription was translated first to Amharic by data collectors who speak Oromiffaa and Amharic before it was translated into English by the researcher. Another Oromiffaa translator was hired to translate the transcript in Oromiffaa to Amharic for the second time as the researcher does not speak Oromiffaa and to ensure the validity of the translation. Therefore, the two Amharic transcripts were compared and differences were sorted out before the researcher translated it into English. The researcher's colleague who speaks both Amharic and English languages checked the transcripts. The researcher's engagement in translation familiarised and acquainted him with all the concepts as the researcher read through both the Amharic and English transcripts repeatedly in the process.

This study adopted content analysis and inductive data analysis, where the in-depth analysis discovered new insights. Content analysis refers to data reduction and a sense making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings (Patton 2002:453). Content analysis was used to comply with the phenomenological data analysis. The researcher analysed available data and collected more, where necessary, to get new insights from the study. It involved discovering patterns, themes and categories throughout the researcher's interaction with data. This complies with the notion by Babbie and Benaquisto (2010:390-391) that the key to phenomenological analysis is a combination of grounding concepts in data and researcher's creativity.

Qualitative data analysis was conducted using Atlas ti version 6.2 qualitative data analysis software. The rationale for choosing Atlas ti, as opposed to other qualitative

data analysis software like Open code, was the fact that Atlas ti is a powerful workbench for the qualitative analysis of large bodies of textual, graphical, audio, and video data and the software was provided free by UNISA. The software was accessed from UNISA Akaki Regional Learning Centre. .

Steps in qualitative data analysis

The steps in qualitative data analysis were reading, coding, displaying, reducing and interpreting (Ulin et al 2005:144). The current study followed these steps during the qualitative data management and analysis.

- **Reading/immersion**

Qualitative data analysis began with immersion reading and re-reading texts and reviewing notes (Ulin et al 2005:144). The researcher familiarised himself with the field notes during data collection although the researcher was not able to interview the participants due to the feminist theoretical orientation. Each interview was transcribed by data collectors immediately after each interview session and /or before conducting the next interview. The researcher checked the transcription against the audio records every day of the data collection process. For interviews where the participants were not willing to be audiotape recorded, the researcher relied on the expanded notes of data collectors and read through the field notes. The researcher read all the Amharic transcripts and translated them into English transcriptions. This familiarised the researcher with the collected qualitative data. The researcher became very familiar with the transcripts by reviewing the qualitative data generated in the field, checking the transcripts against the audiotape records, verifying the proper translation of the transcripts from Oromiffaa to Amharic and translating Amharic transcripts to English.

- **Coding**

Themes emerged through reading and re-reading the transcripts. The researcher attached labels or codes to chunks of texts that represented themes (Ulin et al 2005:144). Main themes and sub themes were identified once the researcher was immersed in and familiarised with data through reading and re-reading; in addition to

ensuring the validity of the transcribing and translation process. This eased the coding process.

Coding is the development of concepts and categories in the recognition and ordering of themes. It refers to applying labels to strips of data that illustrate ideas and concepts and to the continuing process of identifying, modifying and refining concepts and categories that sustain emerging themes and patterns (Babbie & Benaquisto 2010:394). The first step in the current data analysis was open coding which involved close examination of data, identifying implicit/explicit conceptual categories and theoretical possibilities. Constant comparisons and the coding procedure play key roles on how theory develops. The constant comparison evaluated what could be learned from further data collection and analysis and what was learned (Babbie & Benaquisto 2010:390-391).

Transcripts of the key informant interviews were prepared in the MS Word document format. The transcripts were imported to the Atlas ti qualitative data analysis software as primary document using the assign command in the main menu of the Atlas ti. The researcher labelled the texts/coded with the words that sense the text description. The techniques employed for coding were open coding, quick coding and coding by list. The researcher used the open coding command for coding in first time. Coding by list was used to assign existing code to a selection. Quick coding was used to assign currently selected code to consecutive text segments.

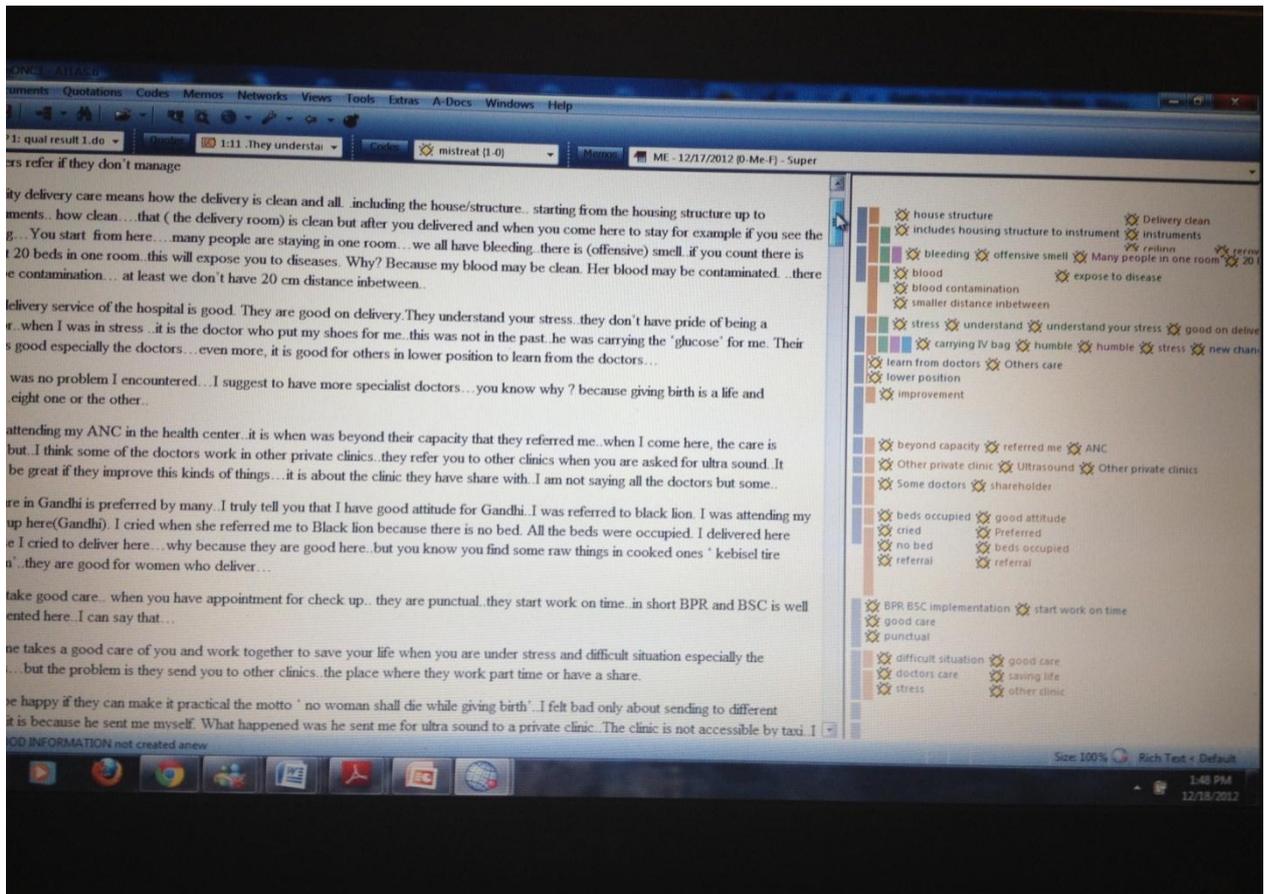


Figure 4.1 Screen shot showing the primary document and codes used in coding the primary document

- **Displaying/exploring thematic area**

The second step that followed built on items of information already known (extension), making connection between different items (bridging), proposing new information that ought to fit, and verifying its existence (surfacing) (Patton 2002:466). The researcher displayed data for further analysis. Displaying data means laying out or taking an inventory of what one knows is related to a theme; capturing the variation or richness of each theme; separating qualitative and quantitative aspects and noting differences between individuals or among subgroups. The first step taken in data displaying was to identify the principal sub themes that emerged from the data. The second step involved returning to the data and examining the evidence that supported each theme (Ulin et al 2005:157). Once the researcher identified the themes and sub themes, the researcher focused on one theme at a time. The researcher sought evidence from data that supported each theme. For example, delayed treatment was one of the themes that

emerged from the study. Therefore, the researcher focused on and sought evidence from the data, that supported delayed treatment.

High-order concepts such as quality of care developed from summarising and integrating concrete levels of data. The levels of abstraction in the qualitative paradigm include indicators, first-order concepts, second-order concepts, and finally the high-order concepts (Punch 2005:203). Abstraction or conceptual development progresses with systematic and constant making of comparisons. Comparisons are essential in identifying abstract concepts and in coding. For example, comparing first order concepts leads to the second order concept. Comparing second order concepts leads to high order concept (Punch 2005:204). Concepts emerged as a result and the provisional relationships between the concepts were identified and constantly checked. The goal of this constant comparative method was to make sure the indicators of the concepts were true to data and that the enlarging datasets were true to the range of possibilities (Babbie & Benaquisto 2010:390). A constant comparison of data, identification of relationship of different concept and summarising using the Atlas ti software in this study resulted in emergence of concepts from data.

- **Reducing**

Data reduction is the process of distilling the information to make visible the most essential concepts and relationships. The goal is to get an overall sense of data and distinguish central and secondary themes (Ulin et al 2005:160). Atlas ti has network editor view that helped to link concepts and relationships. It helped to organise codes and build conceptual relationships between codes.

4.5 TRUSTWORTHINESS

The rigor of qualitative research is described by trustworthiness which ensures the extent to which the results can be trusted (Given & Saumure 2008:896; Mathison 2005:425). The study ensured trustworthiness through ensuring credibility, transferability, dependability and confirmability which, according to Mathison (2005:425), are the criteria for trustworthiness.

4.5.1 Credibility

The credibility of a research ensures an accurate and rich description of the phenomena in question by representing data accurately (Given & Saumure 2008:896). Patton (2002:552) asserts that the credibility of qualitative research depends mainly on rigorous methods, credibility of the researcher and a philosophical belief in the value of qualitative inquiry. Thus, the credibility of the research in this study was ensured by triangulation.

Triangulation provides more perspectives to addressing the inadequacy of a single method, source or analysis to reveal the different aspects of empirical reality (Patton 2002:555). The researcher triangulated data obtained from clients with different backgrounds and social status, to ensure credibility. Also, thematic and content analysis, using Atlas ti, were used to examine and validate conclusions about meaning. The researcher also interacted with experienced research colleagues who provided guidance for research design and conducted independent data analysis for comparison with the researcher's. Hence, analyst triangulation assessed the consistency of the finding using different analyst and theory/perspectives to interpret the data (Patton 2002:556). Transcripts prepared by data collectors were checked by the researcher. The audio records were checked against the transcript.

Reflexivity also enhanced the credibility of this study as the researcher was open to deeper meanings that unfolded during the research process. The researcher maintained this by recording detailed field notes throughout the research process. The principle is to report any personal and professional information that might have affected data collection, analysis and interpretation positively or negatively in the minds of users of

the findings (Patton 2002:566). The researcher was aware of bias and no information was manipulated in anyway.

4.5.2 Transferability

Transferability is the extent to which study findings can be generalised to other situations (Polit & Beck 2008:539). In this study, the researcher ensured transferability by clearly describing the nature of participants, research method, data analysis and interpretation of the findings because an in depth description of methods ensures transferability.

4.5.3 Dependability

Dependability assess whether a similar explanation for the phenomena is found when similar conditions, such as procedure and research instruments, are applied (Given & Saumure 2008:896). It refers to the stability of data over time and over conditions (Polit & Beck 2008:539). In this study, keeping notes on any of the decisions made during data analysis, keeping raw data for interested researchers to crosscheck or verifying and making effective interpretations ensured dependability. Independent checks by colleagues helped to ensure dependability of data.

4.5.4 Confirmability

Confirmability tells whether the researcher's claims are from data and ensures that interpretations match data (Given & Saumure 2008:896). In this study, data collection approaches, decisions on what data to collect, raw data, analysis notes and interpretation of data were documented to ensure confirmability.

4.7 ETHICAL CONSIDERATION

In the present research, the ethical principles were adhered to and protected during the research process. The rights of both the participants and the institutions were protected.

4.7.1 Permission to conduct the study

Ethical clearance was obtained from the Research and Ethics Committee, Department of Health Studies, UNISA (see annexure D) to conduct the current study. The UNISA Akaki Regional Learning Centre wrote a letter of support to the Addis Ababa city bureau of health to conduct the study. The health bureau granted access to the hospitals and wrote a letter to the three hospitals selected for this study. Finally, the medical directors and the departments of gynaecology and obstetrics of the respective hospitals allowed the study to be conducted.

4.7.2 Informed consent

Full information was provided for the research participants to make an informed decision (see annexure E). This is in line with Polit and Beck's (2008:172) assertion that researchers are obliged to provide true and adequate information to participants. Accurate and complete information about the research was provided to enable clients to make voluntary and thoroughly reasoned decisions about their participation in the principle of voluntary participation and autonomy. The research participants were fully informed about any potential impact of the investigations and informed consent was obtained. In the present study, clients were informed about the purpose of the study, estimated duration of the interview, and their rights to participate or withdraw from the study. Informed verbal consents were also obtained from the clients to use audiotape recorders after fully explaining the purpose. Where clients consented to participate in the study but felt uncomfortable in voice recording, notes were taken by data collectors. Clients were also informed that they could withdraw at any point of the interview or not answer any question they felt uncomfortable answering. Only research participants who gave their verbal consent were allowed to participate in the study as noted by Strydom (2011:117) that involving participants without their consent impairs their self-determination. Verbal consent was taken instead of written consent as most clients were not able read and write. Hence, this study protected the self-determination or autonomy of clients.

4.7.3 Privacy and confidentiality

The study's research participants were not identified by name or disclosed by their personal characteristics, thus they cannot be identified. Data collectors and transcribers

signed confidentiality agreements. The information that the participants provided was kept confidentially and used only for the research purpose. Filled questionnaires were stored and data was secured by proper backup systems and no information was disclosed indicating individual client, respondent and health institution. Interviews were conducted in the recovery room in a way that did not affect the clients' privacy. Clients' privacy was ensured while conducting the interviews by arranging time and place. For example, interviews were conducted after morning physician rounds, in isolated spaces or furthest place from the other clients in the recovery room.

4.7.4 Protection from harm

All potential harm or distractions to the participants were considered. The researchers assured participants that their refusal to participate in the study would not affect their use of care in the health facility in any way. The discussions with the participants also considered their health status. Clients were not interviewed while experiencing pain or conditions that needed any treatment. Where harm was potentially indicative due to the clients' condition during the interview, such clients were excluded or asked to discontinue from the study. Furthermore, clients were interviewed after physician rounds and after getting their care from the ward midwife nurses to ensure the normal working environment or routine proceedings in the wards were not interfered with.

4.8 CONCLUSION

This chapter described the research design, method of data collection, data analysis, trustworthiness, and ethical considerations of the study. The explorative and descriptive phenomenological qualitative research design was used to explore and describe clients' perspectives on quality of EmOC provision. The study was conducted among clients who had direct obstetric complications and received EmOC. In-depth interviews were used as the data collection method employed, complying with phenomenological theoretical orientation. Interviewer administered semi-structured interview questionnaire was used to collect data. The inductive analysis approach was used to analyse data using the qualitative data analysis software, Atlas ti. The chapter also described the ethical requirements of the study and steps taken to ensure trustworthiness of the study.

The next chapter will present the findings of the study.

CHAPTER 5

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

5.1 INTRODUCTION

The previous chapter described the research design and methodology to conduct the study. This chapter focuses on data analysis and the presentation and description of research findings on the clients' perspectives on quality EmOC.

5.2 DATA MANAGEMENT AND ANALYSIS

This study adopted an inductive data analysis where an in-depth analysis led to the discovery of new insights. Phenomenological data analysis was applied to explore and describe the clients' perspectives on quality EmOC in Ethiopia's public health facilities. A thematic framework approach of data analysis was used for initial data coding and this was followed by content analysis. Content analysis was used as it complies with the phenomenological data analysis.

The steps followed in data analysis were reading, coding, displaying, reducing and interpreting. The researcher familiarised himself with the data as he read expanded notes, transcribed the notes and translated the Amharic transcripts into English transcripts. The network view of Atlas ti eased the explanation on how the networks of concepts responded to the original study questions and showed how thematic areas related to each other.

5.3 BIOGRAPHICAL PROFILE OF THE PARTICIPANTS

The participants of the study were twelve clients who had direct obstetric complications and received EmOC in the chosen three public health facilities. The participants' profile, including age, average income, educational level, gravidity, parity, history of

complications, history of still births, history of spontaneous abortions and outcomes of last pregnancy were described.

Table 5.1 Age distribution of the participants (n=12)

| AGE RANGE | FREQUENCY | PERCENTAGE |
|------------------|------------------|-------------------|
| 20-24 | 1 | 8.3 |
| 25-29 | 8 | 66.7 |
| 30-34 | 1 | 8.3 |
| 35-39 | 2 | 16.7 |
| Total | 12 | 100.0 |

Up to 66.7% of the participants were in the age range of between 25 and 29 years.

Table 5.2 Income levels of the participants (n=12)

| INCOME LEVELS | FREQUENCY | PERCENTAGE |
|----------------------|------------------|-------------------|
| 194-419 | 4 | 33.3 |
| 420-614 | 2 | 16.7 |
| 615-809 | 2 | 16.7 |
| 810-1004 | 2 | 16.7 |
| Don't know | 2 | 16.7 |
| Total | 12 | 100.0 |

Up to 33.3% of the participants had an average income range of between 194 and 419 Ethiopian Birr per month.

Table 5.3 Educational level of the participants (n=12)

| EDUCATIONAL LEVEL | FREQUENCY | PERCENTAGE |
|--------------------------|------------------|-------------------|
| No education | 4 | 33.3 |
| Elementary (1-6) | 2 | 16.7 |
| Secondary (7-8) | 1 | 8.3 |
| High school (9-12) | 4 | 33.3 |
| Higher education | 1 | 8.3 |
| Total | 12 | 100.0 |

Up to 33.3% of the participants had no education while another 33.3% were in high school.

Table 5.4 Gravidity of the participants (n=12)

| GRAVIDITY | FREQUENCY | PERCENTAGE |
|------------------|------------------|-------------------|
| 1 | 5 | 41.7 |
| 2 | 3 | 25.0 |
| 3 | 1 | 8.3 |
| 4 | 2 | 16.7 |
| 5 | 1 | 8.3 |
| Total | 12 | 100.0 |

Up to 41.7% of the participants were pregnant for the first time while 25% were pregnant twice.

Table 5.5 Parity of the participants (n=12)

| PARITY | FREQUENCY | PERCENTAGE |
|---------------|------------------|-------------------|
| 1 | 7 | 58.3 |
| 2 | 2 | 16.7 |
| 3 | 2 | 16.7 |
| 4 | 1 | 8.3 |
| Total | 12 | 100.0 |

Up to 58.3% of the participants had given birth for the first time while 16.7% had given birth twice and thrice.

Table 5.6 History of obstetric complications (n=7)

| HISTORY OF OBSTETRIC COMPLICATIONS | FREQUENCY | PERCENTAGE |
|---|------------------|-------------------|
| Yes | 3 | 42.9 |
| No | 4 | 57.1 |
| Total | 7 | 100.0 |

Up to 42.9% of the participants who were pregnant in the past had a history of obstetric complications.

Table 5.7 Participants' history of still births (n=7)

| HISTORY OF STILL BIRTHS | FREQUENCY | PERCENTAGE |
|--------------------------------|------------------|-------------------|
| Yes | 1 | 14.3 |
| No | 6 | 85.7 |
| Total | 7 | 100.0 |

Up to 14.3% of the participants had a previous history of still births.

Table 5.8 Participants' history of spontaneous abortion (n=12)

| HISTORY OF SPONTANEOUS ABORTIONS | FREQUENCY | PERCENTAGE |
|---|------------------|-------------------|
| No | 9 | 75.0 |
| Yes | 3 | 25.0 |
| Total | 12 | 100.0 |

Twenty five percent of the participants had history of spontaneous abortion.

Table 5.9 Participants' outcomes of last pregnancy (n=12)

| OUTCOME OF LAST PREGNANCY | FREQUENCY | PERCENTAGE |
|----------------------------------|------------------|-------------------|
| Healthy baby | 8 | 66.7 |
| Still births | 4 | 33.3 |
| Total | 12 | 100.0 |

Up to 66.7% of participants' last pregnancy outcomes were healthy babies, while 33.3% had still births.

5.4 ANALYSIS OF DATA OBTAINED FROM THE INTERVIEWS

Five major themes emerged from the analysis of data obtained from the key informant interviews. They include; EmOC quality as perceived by clients, EmOC that created good experience for the clients, causes of clients' disappointment with EmOC, barriers for the use of EmOC at health facilities, and barriers for the provision of EmOC. Each theme is presented below with categories, sub categories and meaning of units.

Table 5.10 Schematic presentation of themes and categories of clients' perspectives

| THEME | CATEGORY |
|---|---|
| EmOC quality as perceived by clients | <ul style="list-style-type: none"> • Safe and accessible care • Interpersonal care • Technology supported care • Physical structure aspect • Organised/coordinated care |
| EmOC that created good experience for the clients | <ul style="list-style-type: none"> • Interpersonal care • Availability of life saving care |
| Causes of clients' disappointment with EmOC | <ul style="list-style-type: none"> • High expectations from female providers • Undermining attitudes of providers • Not answering clients' calls • Ethical misconduct • Misunderstanding of the care processes |
| Barriers for use of EmOC at health facilities | <ul style="list-style-type: none"> • Discrimination • Cost of care • Drugs and supplies • Referral weaknesses |
| Barriers for provision of EmOC | <ul style="list-style-type: none"> • Staff related • Facility infrastructure related |

5.4.1 Theme 1: EmOC quality as perceived by clients

Quality of care is care that treats clients equally with respect and humility. It refers to the care of clients from the point of receiving and welcoming to the public health facility up to the time the client leaves the public health facility after getting proper services. It includes responding to the requests of and needs that encourage clients.

“The quality can be maintained only when they have humility and respect for people, when they treat all equally, when they avail medicine and other things and ask the money, if they encourage the women, if they follow up the clients, if they reply when they are called. Therefore, when we say quality care it means serving the clients in proper ways and when the clients leave after getting the service...”

Quality emergency obstetric care is a welcoming, life-saving timely care given in a clean environment with humility, respect, equal treatment and encouragement. It is care that

is safe for the client, technically sound care, responsive and meets the clients' needs and expectations. It also involves the provision of advice and information.

EmOC quality as perceived by clients has been categorised into safe and accessible care, interpersonal care, technology supported care, structure aspect and organised/ coordinated care. Each of these categories has sub categories.

5.4.1.1 Category 1: Safe and accessible care

Safe and accessible care includes client safety, availability of care, which includes on call service, timely and emergency care. Safe and accessible care impacts on maternal mortality reduction as the intervention is available to serve those who need care the most.

Table 5.11 Safe and accessible care

| Category | Sub-category | Meaning units |
|--------------------------|---|--|
| Safe and accessible care | <ul style="list-style-type: none"> Client safety of EmOC as perceived by clients Availability of care including on call service as perceived by clients | <p>"...when you come here for treatment, you don't have to get another illness. Here, those who are not sick do not come..."</p> <p>"...separate care for those PLWHA...I am not saying they should be stigmatised."</p> <p>"From what I observed, they don't have toilets...They have only one...It is not clean and exposes client to diseases..."</p> <p>"...You will get treated as a client without any appointment...You will finish timely...you will get what you need."</p> <p>"...They (providers who performed operations) were not there (in the public health facility)...they were called and brought by car to save my life...This is very pleasing..."</p> <p>"...when it was beyond their capacity, they called the doctor around 4 am...He (the doctor) came and operated because my blood pressure was high...that is how I am here today..."</p> |

| Category | Sub-category | Meaning units |
|----------|---|---|
| | <ul style="list-style-type: none"> Timely care/ emergency care in EmOC | <p>“I met good people at the delivery room...especially the doctor who saved my life...to tell you the truth, I would have been dead...my blood pressure was high...but finally to save my life he performed an ‘operation’(caesarean)...”</p> <p>“They take good care...when you have an appointment for a checkups...they are punctual...They start work on time.”</p> <p>“Antenatal care is better than delivery care...they [antenatal care providers] send you for ultrasound...They give you drugs...You will get treated as a client without any appointment...You will finish timely...you will get what you need...”</p> |

- Safety of EmOC as perceived by clients**

Quality EmOC is care that does not bring other health problems in the course of receiving care.

“...when you come here for treatment, you don’t have to get another illness. Here, those who are not sick do not come...”

Clients fear that compromising their safety of care exposes them to diseases as others who also are receiving care are not healthy. They fear contamination and contracting disease from other clients. They are concerned about getting other diseases while seeking delivery care. Hence, clients would like providers to take care and not expose them to other diseases. They feel they are at risk of HIV infection during delivery. Some suggest separate delivery care for people living with HIV (PLWHA). They explained that they did not intend for the PLWHA should be stigmatised against, but advocated for separate care for PLWHA in order to avoid risks of HIV infection.

“...separate care for those PLWHA...I am not saying they should be stigmatised.”

A compromised cleanliness of facilities also exposes clients to diseases. Clients want cleanliness of health facilities to be ensured as they experience perceived risks of contamination.

- **Availability of care as perceived by clients**

The availability of life saving care is mandatory to save the lives of women. Clients perceived that the availability of EmOC ensures that treatment can be obtained without appointment. In other words, care is always available.

“...You will get treated as a client without any appointment...You will finish timely...you will get what you need.”

Accessibility of service is made possible through having physicians on call beyond the normal working hours, to complement the skills of midwives who run shift duties.

“...They (providers who performed operation) were not there (in the public health facility)...they were called and brought by car to save my life...This is very pleasing...”

- **Timely care/emergency care in EmOC**

Clients know that access to EmOC is a lifesaving intervention applied timely in a coordinated manner. It is made possible by a team of committed health workers, including a doctor trained to perform caesarean sections. Clients perceived EmOC as a lifesaving intervention that averts maternal death.

“I met good people at the delivery room...especially the doctor who saved my life...to tell you the truth, I would have been dead...my blood pressure was high...but finally to save my life he performed an ‘operation’ (caesarean).”

5.4.1.2 Category 2: Interpersonal care

Interpersonal care is the care between the provider and the client. It encompasses compassionate care, emotional support, dignity and respect, and information. Interpersonal care has a high potential of impacting clients' preferences on seeking EmOC. Compassionate care created good experience for the clients. Listening to them and understanding their situation relieves the clients' conditions.

"...even though those working in the card rooms were winning, the specialist doctor listened to me. That made me surprised."

Table 5.12 Interpersonal care

| Category | Sub-category | Meaning units |
|--------------------|-----------------------|--|
| Interpersonal care | • Compassionate care | <p>"The delivery service of the hospital is good...They understand your stress...They don't have pride of being a doctor...When I was in stress...it is the doctor who put my shoes for me...This was not in the past...he was carrying the IV bag for me. Their care is good especially the doctors...even more, it is good for others in lower position to learn from the doctors..."</p> <p>"The quality can be maintained only when they have humility and respect for people, when they treat all equally..."</p> <p>"...When I say quality EmOC it is treating the other person, showing good face, giving hope and this is more than anything..."</p> |
| | • Emotional support | <p>"...They say don't worry...What shall we do for you? What shall we bring? And this is very good..."</p> <p>"...They warmly welcome you and show you good face...but when you come for delivery care, they treat you badly like a dog."</p> <p>"...and they encourage you to labour..."</p> |
| | • Dignity and respect | <p>"The baby died in my womb...What would it be if they encouraged me? I would have been encouraged...How many things can I bear?"</p> |
| | | |

| Category | Sub-category | Meaning units |
|----------|--|---|
| | <ul style="list-style-type: none"> Information and advice | <p>“They were encouraging me. They say “you will be okay”...encouraging is a very good thing for human beings ...They say don’t worry...”</p> <p>“...Quality delivery care is...the physician should not annoy clients... it should be with humility and respect...”</p> <p>"...They treat you with respect, they take good care.”</p> <p>"...They treat you with respect, they take good care, they check you regularly, they check the heartbeat of the baby, and they encourage you to labour...”</p> <p>“...They tell you to do what is necessary and that which you need...”</p> <p>“...They also are good in information. They write. They have checked us a moment ago...”</p> <p>“...they advise you and tell you on what to take care of...”</p> |

- Compassionate care**

Provision of compassionate care involves warmly welcoming and treating clients, with humility and respect. Compassionate care maintains quality of EmOC provision. It is service oriented to clients by committed providers or health workers.

“The quality can be maintained only when they have humility and respect for people, when they treat all equally...”

“...When I say quality EmOC, it is treating the other person, showing good face, giving hope and this is more than anything...”

“...They say don’t worry...What shall we do for you? What shall we bring? And this is very good...”

“...They warmly welcome you and show you good face...but when you come for delivery care, they treat you badly like a dog.”

Poor compassionate care for clients is inhumane care. Clients compared the treatment received without compassion as being treated like a dog, which in the local context refers to treatment without courtesy.

Compassionate care created good client experience of EmOC. Clients feel good about their care when they find providers who understand their pain and stress. Listening to clients' concerns was by itself a good experience for clients. Besides, care that is provided with respect, humility and in a very supportive relationship creates good client experience with EmOC.

- **Emotional support**

Clients expect encouragement from healthcare workers, and encouraging them is identified to help them relief their stress. It gives strength to bear the challenges. Hence, they value care as good when providers encourage clients.

“...and they encourage you to labour...”

“The baby died in my womb...What would it be if they encouraged me? I would have been encouraged...How many things can I bear?”

“They were encouraging me. They say “you will be okay”... encouraging is a very good thing for human beings ...They say don't worry...”

- **Dignity and respect**

Respect is core in the clients' perspectives of quality EmOC provision. Respect comforts clients whereas disrespect annoys them.

“...Quality delivery care is...the physician should not annoy clients... it should be with humility and respect...”

“...They treat you with respect, they take good care, they check you regularly, they check the heartbeat of the baby, and they encourage you to labour...”

- **Information and advice**

Giving information is essential for clients’ quality EmOC. Clients also consider proper recording of data as quality because their condition is monitored through recording.

“...They tell you to do what is necessary and that you need...”

“...They also are good in information. They write. They have checked us a moment ago...”

“...they advise you and tell you what to take care of...”

5.4.1.3 Category 3: Technology supported care

Technology supported care is care provision that uses drugs, supplies and diagnostic services.

Table 5.13 Technology supported care

| Category | Sub-category | Meaning units |
|---------------------------|---|---|
| Technology supported care | <ul style="list-style-type: none"> • Use of drug, supplies and diagnostic services | “Antenatal care is better than delivery care ...they [antenatal care providers] send you for ultrasound...They give you drugs...” |

- **Use of drug, supplies and diagnostic services**

Clients perceive quality EmOC as timely care that meets their needs, using necessary examinations, diagnostic services and drugs. This can be inferred from a client’s reply when asked about the quality of delivery care compared to antenatal care.

“Antenatal care is better than delivery care...they [antenatal care providers] send you for ultrasound...They give you drugs...”

5.4.1.4 Category 4: Physical structure aspect

The physical structure aspect includes cleanliness and infrastructure.

Table 5.14 Physical structure aspect

| Category | Sub-category | Meaning units |
|---------------------------|--|--|
| Physical structure aspect | <ul style="list-style-type: none"> Cleanliness | <p>“I was attending my antenatal care in [X] health centre. The health centre is very clean. When you enter a delivery room there is no offensive smell. The toilet is also clean. I wish I delivered there.”</p> <p>“Antenatal care is better because they care and it is clean when you deliver there. There is no such thing here. It is different here and there why? Therefore, they have to take good care while attending delivery, they have to keep clean.”</p> <p>“Quality delivery care means how the delivery is clean and all including the house/structure...Starting from the housing structure up to instruments...”</p> |
| | <ul style="list-style-type: none"> Infrastructure | <p>“Many people are staying in one room...we all have bleeding...there is (offensive) smell...if you count there is about 20 beds in one room...this will expose you to diseases.”</p> <p>“From what I observed, they don’t have toilets...They have only one...It is not clean and exposes one to diseases...”</p> |

- Cleanliness**

Quality EmOC for some clients is how clean the delivery is. It extends to the cleanliness of the public health facility’s housing structure, equipment and supplies. Good delivery care is when all units are clean. A health facility is not of good quality when cleanliness is limited to a particular room. Instead, cleanliness should be maintained in all areas where clients get their care. For example, most health facilities keep delivery rooms clean but not the recovery rooms.

Cleanliness affects a client's decision and preferences on places of delivery. Women prefer to deliver in health centres than hospitals. Their reason is that health centres are reported to be kept clean than hospitals. Clean health facilities are free from offensive smell. This can be inferred from the following quote:

“I was attending my antenatal care in [X] health centre. The health centre is very clean. When you enter a delivery room there is no offensive smell. The toilet is also clean. I wish I delivered there.”

Cleanliness of health facilities conveys the message that providers care for the clients. Therefore, health facilities have to be kept clean not only for the sake of safety but also as an indicator that providers care about the clients.

Cleanliness has to do with client safety. Cleanliness, as described above, is important for clients and determines their preferred place of delivery. The need for cleanliness of health facilities is stressed because failure to maintain cleanliness increases the risk of infection and exposes clients to diseases.

“From what I observed, they don't have toilets...They have only one...It is not clean and exposes one to diseases...”

- **Infrastructure**

Health infrastructure is considered by clients as safety issues rather than a luxury. Larger rooms are preferred to avoid congestion. Cleanliness of instruments is also key for clients. In one of the public health facilities, there was only one toilet facility; yet, it was not clean, thereby raising concerns for exposure to diseases.

Quality delivery care means how the delivery is clean and all including the house/structure...Starting from the housing structure up to instruments...”

“Many people are staying in one room...we all have bleeding...there is (offensive) smell...if you count there is about 20 beds in one room...this will expose you to diseases.”

5.4.1.5 Category 5: Organised/coordinated care

Organised care includes integrated care, refers to the care for the mother and the baby, and care coordination on how the team works together to save lives.

Table 5.15 Organised/coordinated care

| Category | Sub-category | Meaning units |
|--------------------------------|---------------------|--|
| Organised/ coordinated care | • Integrated care | “They check you regularly; they check the heartbeat of the baby.” |
| | • Care coordination | “...They did their best to save my life...when it was beyond their capacity; they called the doctor around 4 am...” “Everyone takes a good care of you and work together to save your life when you are under stress and difficult a situation especially the doctors...” |

- **Integrated care**

Clients not only consider the care accorded to them but also to the baby. Care for the mother and the baby should not be seen as separate. Clients perceive quality EmOC and explain both from the care accorded to them and their babies.

- **Care coordination**

Team work and coordination among service providers was recognised as good practice to save live. Clients appreciate the team effort of providers in saving their lives. Good care therefore is care that saves life. It needs team work and immediate action to save life.

5.4.2 Theme 2: EmOC that created good experiences for the clients

Good interpersonal care and availability of life saving care created good experiences for the clients.

5.4.2.1 Category 1: Interpersonal care

Compassionate care, listening to clients and emotional support created good experiences for the clients. Clients were pleased, felt good and surprised by good interpersonal care.

Table 5.16 Interpersonal care

| Category | Sub-category | Meaning units |
|--------------------|------------------------|--|
| Interpersonal care | • Compassionate care | "...They understand your stress...They don't have pride of being a doctor...When I was in stress...it is the doctor who put my shoes for me...This was not in the past...he was carrying the IV bag for me." |
| | • Listening to clients | "...the specialist doctor listened to me. That made me surprised. Therefore I would be happy if the others (working in the card room) have ethics." |
| | • Emotional support | "They were encouraging me. They say "you will be okay"... encouraging is a very good thing for human beings ...They say don't worry..." |

- **Compassionate care**

Clients need the attention and help of providers, especially when they are in stressful situations. These needs were met when providers were able to serve the clients humbly and understand the clients' situations and concerns. Compassionate care created good clients' experiences of EmOC.

"...They understand your stress...They don't have pride of being a doctor...When I was in stress...it is the doctor who put my shoes for me...This was not the case in the past...he was carrying the IV bag for me."

- **Listening client**

Clients were surprised when providers listened to them and showed that they had ethics.

“...the specialist doctor listened to me. That made me surprised. Therefore I would be happy if the others (working in the card room) have ethics.”

- **Emotional support**

Clients who received emotional support had good experiences of EmOC. Clients were encouraged to bear the challenges they were facing. This created a good experience of EmOC.

“They were encouraging me. They say “you will be okay” ... encouraging for human being is very good thing...They say “don’t worry”...”

5.4.2.2 Category 2: Availability of life saving care

Collaborative care for saving life and accessing the available life-saving care create good experiences for clients. Clients are thankful for accessing their life saving care and pleasant about care as they recognised that they could have been dead were it not for EmOC. Therefore, the perceived level of risk and accessing of life-saving care contribute to good experience and satisfaction with care.

Table 5.17 Availability of life saving care

| Category | Sub-category | Meaning units |
|----------------------------------|---|---|
| Availability of life saving care | <ul style="list-style-type: none"> • Collaborative care for saving lives | <p>“The nurses also treated me well...in fact, when you get them mad...there are things they say but they took care of me...I could have died if they didn’t collaborate...they tried their best...when it was beyond what they could do, they called the doctor around 4 am...He came and operated... because my blood pressure was high...I was on oxygen...that is how I am here today...it is very good for me...I am pleased...”</p> |

| | | |
|--|---|--|
| | <ul style="list-style-type: none"> • Availability of call services and lifesaving care | <p>“...Imagine what would happen to your life if they treat you the same in the delivery rooms... but now...if they insult you there (card room) and say whatever, you ignore and say it is their character. You don’t take it seriously...”</p> <p>“...It was the care that I received that saved my life. It is not whether she gave me my card or not...in fact you will suffer but what matters is not whether she gives you the card or not but what you get there (at delivery room)...”</p> |
|--|---|--|

- **Collaborative care for saving lives**

Clients recognised that the collaborative effort of various units of health services in delivering care were determinant factors for their level of satisfaction. Therefore, their goals were to leave the healthcare system healthy. Each unit or department had to function properly for maximum impact and client satisfaction. Clients had different values and expectations from each functional unit or department of the public health facility. For example, getting client’s card and attending delivery were performed by different functional units of the public health facility.

Clients admired the care accorded to save their lives through collaboration. Each team member attempted to save lives and worked together for the common goal of creating good client experience. Hence, team approach and collaborative approaches created good experiences and resulted in better health outcomes.

- **Availability of call services and lifesaving care**

Although physicians were not around to treat clients at all the times, the collaborative system of having them on call when there was an emergency enabled the saving of lives. The presence of life saving care and call services for doctors were considered as a good experience by the clients. Therefore, clients attributed their continued existence to the availability of life saving care which they accessed.

“...when it was beyond what they can do, they called the doctor around 4 am...He came and operated...that is how I am here today...it is very good for me...I am pleased...”

5.4.3 Theme 3: Causes of clients’ disappointment with EmOC

There are various causes of clients’ disappointment with the provision of EmOC. They include higher expectations from female providers, underestimation by providers, non-responsive providers, ethical misconduct by providers, undelivered promises, expectation with place of delivery and expectation with newborn care.

5.4.3.1 Category 1: High expectation from female providers

High expectations from female providers caused disappointment with EmOC. Clients expect female providers to provide courteous care and be sympathetic.

Table 5.18 High expectation from female providers

| Category | Sub-category | Meaning units |
|---|--|--|
| High expectations from female providers | <ul style="list-style-type: none"> <li data-bbox="453 1021 746 1128">Lack of courteous care by female providers | <p data-bbox="778 1021 1374 1055">“They mistreat you as if they are not women.”</p> <p data-bbox="778 1099 1449 1171">“...if a lady is harsh and does not sympathise with you, for the lady that is very hard...”</p> <p data-bbox="778 1216 1449 1323">“...I don’t think they are human. I am surprised especially by the women. They don’t seem as if they will face the same tomorrow.”</p> |

- Lack of courteous care by female providers**

Clients expected more courteous care from female providers. They expected female providers to be more sympathetic than their male counterparts. They expected shared risk, fear and concerns from female providers, who are also women who could give birth. However, the female providers acted against the expectations of clients thus, creating the clients’ disappointment with EmOC provision.

“They mistreat you as if they are not women.”

“...if lady is harsh and does not sympathise for the lady that is very hard...”

“...I don’t think they are human. I am surprised especially by the women. They don’t seem that they will face the same tomorrow.”

5.4.3.2 Category 2: Undermining attitudes of providers

Clients were disappointed when they felt that they were being undermined by providers. Some clients gave comments, suggestions and expressed their complaints to providers about care provision, but none were attended to.

Table 5.19 Undermining attitude of providers

| Category | Sub-category | Meaning units |
|---------------------------------------|--|---|
| Undermining attitude of the providers | <ul style="list-style-type: none"> Considering clients as less educated | “...even if you want to give a suggestion, they say ‘do you know more than us’...this hurts...It is not just because they wore the white gown, the other person (client) might also be educated. It may also be knowledgeable...this is the situation...” |

- **Considering clients as less educated**

Clients were considered as less educated and ignorant about the care process. As a result, they were discouraged from giving comments and suggestions. Rejection of their comments and suggestions by providers and their undermining were a source of their disappointment.

“...even if you want to give a suggestion, they say ‘do you know more than us’...this hurts...It is not just because they wore the white gown, the other person (client) might also be educated. It may also be knowledgeable...this is the situation...”

“...I have given my comments in the suggestion box...I haven’t kept silent...I have written my complaints...I think I have to talk what I have to...”

5.4.3.3 Category 3: Not answering client calls

Leaving clients unattended and not answering client calls caused disappointments in clients who received EmOC.

Table 5.20 Not answering client calls

| Category | Sub-category | Meaning units |
|----------------------------|---|---|
| Not answering client calls | <ul style="list-style-type: none"> Reluctance to attend and respond to clients | <p>“I was crying and shouting the whole night. The others were also crying and shouting ...they don’t come when you call them...they ‘annoy and scold’ especially the women (Female providers)...The men (men providers) were better...when I was shouting for that long, there was no one to ask you what happened. They don’t come when you call them...”</p> <p>“...they don’t come when they are called...they treat us like dogs...”</p> |

- Reluctance to attend and respond to clients**

Clients were left unattended in the delivery room. Clients were disappointed when providers were reluctant to respond to their calls. They expected providers to ask what was happening when they screamed, shouted and cried during delivery. They also expected providers to come when they called out for help. But, some providers instead insulted and yelled at clients. This created disappointments in clients.

“I was crying and shouting the whole night. The others were also crying and shouting...they don’t come when you call them...they ‘annoy and scold’ especially the women (Female providers)...The men (men providers) were better...when I was shouting for that long, there was no one to ask you what happened. They don’t come when you call them...”

“...they don’t come when they are called...they treat us like dogs...”

5.4.3.4 Category 4: Ethical misconduct

Ethical misconduct of providers caused disappointment among clients who received EmOC.

Table 5.21 Ethical misconduct

| Category | Sub-category | Meaning units |
|--------------------|--|---|
| Ethical misconduct | <ul style="list-style-type: none"> Verbal abuse | <p>“Their care (the public health facility care) is good especially the doctors...even more, it is good for others in lower positions to learn from the doctors...the nurses also treated me well...In fact, when you get them mad...There are things they say but they took care of me...”</p> <p>“You will be disappointed every time especially when your blood pressure is high ‘over’. When you see the other, it makes you feel bad...even though those working in the card rooms were winning, the specialist doctor listened to me. That made me surprised. Therefore, I would be happy if the others (working in the card room) have ethics. Why because you are going to see them first...”</p> |

- Verbal abuse**

The ethical misconducts include mocking, insulting and yelling at clients. Clients mentioned that ethical misconducts were observed more among lower-level staff members. They also suggested that the conduct of lower level staff members needed improvement as clients were going to see them first, as well as more often.

“Their care (the public health facility care) is good especially the doctors...even more, it is good for others in lower positions to learn from the doctors...the nurses also treated me well...In fact, when you get them mad...There are things they say but they took care of me...”

“You will be disappointed every time especially when your blood pressure is high ‘over’. When you see the other, it makes you feel bad...even

though those working in the card rooms were wining, the specialist doctor listened to me. That made me surprised. Therefore I would be happy if the others (working in the card room) have ethics. Why because you are going to see them first...”

5.4.3.5 Category 5: Misunderstanding of the care process

Misunderstanding of the care process is also a cause of client disappointment with EmOC.

Table 5.22 Misunderstanding of the care process

| Category | Sub-category | Meaning units |
|--------------------------------------|--|---|
| Misunderstanding of the care process | <ul style="list-style-type: none"> Misunderstanding in newborn care | “...The other thing is they have to take good care when they deliver. They just deliver and give...why they give without washing the baby...” |

- **Misunderstanding in newborn care**

Clients’ satisfaction with obstetric care was determined not only by the care they received for themselves but the care they received as well as that of their newborn babies. Misconceptions and misunderstandings of newborn care by clients affect their perceptions on satisfaction. For example, clients expect their newborn baby to be washed instead of being dried with a towel.

“...The other thing is that they have to take good care when they deliver. They just deliver and give...why they give without washing the baby...”

5.4.4 Theme 4 : Barriers for use of EmOC at facilities

5.4.4.1 Category 1: Discrimination

Discrimination against clients was a barrier to receiving quality care. Discrimination affected care outcomes as those in lower social status received care later and not when they needed it. Some providers discriminated against clients on the basis of their places

of residence, wealth status and social ties. Clients perceived that those coming from rural areas were more discriminated against than those from urban areas. Similarly, the poor were more discriminated against than the rich. Those who did not know providers in the health facility were more discriminated against than those who knew the provider.

Table 5.23 Discrimination

| Category | Sub-category | Meaning units |
|----------------|---|---|
| Discrimination | <ul style="list-style-type: none"> • Discrimination related to wealth | <p>“The government treats all of us equal...why do they then discriminate against people? Those from urban or rural, those who know people and who don’t know...those who have money and who don’t have...what should the poor do then? You buy medicine, needles, supplies from outside...what can a person who has nothing can do?”</p> |
| | <ul style="list-style-type: none"> • Discrimination related to place of residence | <p>“Especially if you came from rural parts, if you don’t have someone you know...they nag you and scream at you and the insult will be much more...”</p> |
| | <ul style="list-style-type: none"> • Discrimination related to knowing providers or being relatives of providers | <p>“But here, there are lots of gaps...the other clients were also not talking good about this. Everyone is crying because of them...if you have someone who have close relationship with them, then they will come when you call them...they show you good face...”</p> |

Thus, the verbal abuse by providers was more pronounced when clients were poor, resided in rural areas or knew no provider in the health facility.

• **Discrimination related to wealth**

Discrimination related to wealth is a barrier in the use of EmOC at public health facilities. Poor clients were discriminated against by providers and were left with no other option.

“The government treats all of us equal...why do they then discriminate people? Those from urban or rural, those who know people and who don’t know...those who have money and who don’t have...what should the poor

do then? You buy medicine, needles, supplies from outside...what can a person who has nothing can do?"

- **Discrimination related to places of residence**

Discrimination related to places of residence is another barrier in the use of EmOC at public health facilities. People residing in rural communities are discriminated.

"Especially if you came from rural parts, if you don't have someone you know...nag you and scream at you and the insult will be much more..."

- **Discrimination related to knowing providers or being relatives of providers**

Clients who knew providers or were relatives of providers received treatment while others did not. Clients were discriminated on the basis of whether they were relatives of providers or knew providers at public health facility.

"But here, there are lots of gaps...the other clients were also not talking good about this. Everyone is crying because of them...if you have someone who have close relationship with them, then they will come when you call them...they show you good face..."

5.4.4.2 Category 2: Cost of care

Service charges and cost of supplies were major financial barriers to accessing EmOC. Clients incurred more costs than they anticipated when public health facilities asked them to buy supplies from private pharmacies. This created a financial burden and economic vulnerability for their families and themselves.

Table 5.24 Cost of care

| Category | Sub-category | Meaning units |
|--------------|---|--|
| Cost of care | <ul style="list-style-type: none"> • Fee for service • Effects of unaffordable prices | <p>“I would say the quality is good but the price has to be reduced...You know they charged me 200 birr...They also have to make consideration for those coming from far places...”</p> <p>“...I was attending at health centre for free but I paid here all that I should have spent for 9 months in the health centre...It would be good if the government can make subsidy...considerations has to be made for the poor and those coming from far places...health centres do not charge...even this doesn't harm...but should I be dead if I don't have money?”</p> <p>"...those who are coming from far they would like to borrow money but they know no one...they sell what they have at hand...Their mobiles ...Necklace...Otherwise she is going to die. They don't estimate that they will spend this amount of money..."</p> |

- **Fee for service**

Service charges for delivery in public health facilities were a barrier to accessing EmOC. The cost of care at the public health facility exceeded the amount of money spent while receiving antenatal care. In addition, clients spent more money as they were asked to buy supplies and medicines from private pharmacies outside the public health facility.

“...It would be good if the government can make subsidies ...considerations have to be made for the poor and those coming from far places...health centres do not charge...even this doesn't harm...but should I be dead if I don't have money?”

- **Effects of unaffordable prices**

Clients incurred costs more than they planned to spend for their care. As childbirth for clients is a life and death issue, they engaged themselves in any way possible to pay for the service. For example, they sold their valuables such as necklaces at prices lower

than the market rates, as coping mechanism. The coping mechanisms affected the clients and their families, thus forcing them to go through processes that increased their financial vulnerability.

“...I was attending at health centre for free but I paid here all...I should have spent for 9 months in the health centre...”

“...those who are coming from far they would like to borrow money but they know no one...they sell what they have at hand...Their mobiles...Necklaces...Otherwise they were going to die. They didn’t estimate that they will spend this amount of money...”

5.4.4.3 Category 3: Drugs and supplies

Asking clients to buy drugs and supplies was a barrier in the use of EmOC. It delayed treatment although the client was present at the health facility. It also exposed clients to the financial barrier to use EmOC. They ended up delaying the delivery of EmOC and exposing the families to financial vulnerabilities.

Table 5.25 Drugs and supplies

| Category | Sub-category | Meaning units |
|--------------------|---|--|
| Drugs and supplies | <ul style="list-style-type: none"> <li data-bbox="437 1294 805 1420">• Effects of asking clients to buy medicine and supplies on security of care takers <li data-bbox="437 1563 805 1727">• Financial effect of not availing drugs and supplies at public health facility pharmacies | <p data-bbox="823 1294 1445 1518">"When I was shouting, she brought me prescriptions to buy medicine at 4:00 A.M from outside...I was begging...it is allowed only for one person to stay in the hospital at night. The one who stayed for me was a woman. Besides, we came from a rural part. What could have we done?"</p> <p data-bbox="823 1563 1445 1921">“When you are referred you buy everything ...you buy needles, gloves...the problem here is that they ask you to buy something at night. Either at 1 AM or 2 AM...where can you buy at that time?...when you tell them, they yell at you...you are asked to buy from a pharmacy outside of the hospital suddenly without your expectation...where can you go at 2:00 or 3:00 am to buy what they ask you?...it is in the morning the family can buy and bring with them...it is difficult to ask at that time...”</p> <p data-bbox="823 1966 1445 2022">“It is said to be for free...when you are referred you buy everything...you buy needles, gloves”</p> |

- **Effects of asking clients to buy medicine and supplies on security of care takers**

Providers asked clients to buy supplies late at night, thereby exposing their caretakers to attacks or robbers on the streets. They were concerned about the safety of their care takers who had to go out at odd hours; such as after mid night. Therefore, asking clients to buy drugs and supplies at odd hours was a barrier to EmOC and posed threats to the safety of care takers.

- **Financial effects of not availing drugs and supplies at public health facility pharmacies**

Clients spent more money than envisaged to buy drugs and supplies when health facilities could not avail these drugs and supplies. Due to the urgency to save lives of their beloved ones, care takers bought from nearby private pharmacies at expensive rates compared to what was obtainable in the public health facility pharmacies. This led clients to fall into financial difficulties which competed with their ability to pay for services. As their ability to pay fees for services got compromised, clients' care takers sold their valuable items such as necklaces and mobile phones. They also entered into credit and borrowed money at higher interest rates from local lenders, in order to keep their relatives and loved ones alive.

5.4.4.4 Category 4: Referral weaknesses

Referral weaknesses were a barrier to accessing timely care. Some clients were referred to public health facilities without prior checking for space. As a result, such referrals created delays as clients had to visit multiple places in search of bed spaces. Hence, clients spent money and time while visiting multiple public health facilities in search of care.

Table 5.26 Referral weaknesses

| Category | Sub-category | Meaning units |
|---------------------|---|---|
| Referral weaknesses | <ul style="list-style-type: none"> <li data-bbox="456 253 743 398">• Effects of referral weaknesses on receiving timely care <li data-bbox="456 757 743 869">• Effect of referral weaknesses on cost of care <li data-bbox="456 1496 743 1574">• Referrals for diagnostic services | <p data-bbox="775 253 1433 712">“The doctor told me that I should deliver at the hospital (X). He said that you have to deliver in (Y or Z) hospital. I was in the midst of life and death at that time. I said I would not go there. My referral slip is for you I would rather die here. I asked what he was telling me before. I said you were telling me that I should deliver here. So what happened now? And I cried. They changed their reason and told me another reason that they don’t have beds...I insisted. Another person came and allowed me to enter (the delivery room) finally.”</p> <p data-bbox="775 757 1433 1014">“...I was referred from (X) health centre to here. They didn’t admit me here. They referred me to (Y) hospital. When I arrive at (Y) hospital they refused to admit me. We took a taxi and went back...We came here yesterday around 1pm...They referred me to (Z) but we managed to be here after begging for such long...”</p> <p data-bbox="775 1104 1433 1440">“I spent 300 birr for taxi to come here from Kotebe. Only for taxi...When I arrived here they said there is no bed...then I went to (X) and then to (Y)...then to another hospital, I forgot its name...I forgot the name of one hospital but I went to four hospitals. This is because they said they didn’t have a bed. They shouldn’t have said there is no bed...they could have at least said stay here on the chair...why do they refer?”</p> <p data-bbox="775 1485 1433 2056">“...I felt bad only about sending us different places for services that are available in the hospital. I feel bad because he had sent me, myself. What happened was he sent me for ultra sound to a private clinic...The clinic is not accessible by taxi...I was at term...After I reached there, they told me that they would do ultrasound on the day...I returned back and told him that they don’t have ultrasound on the date...what he said was you can try again tomorrow...I asked instead to go a faraway clinic the following day, why don’t they take ultrasound here. He replied there is one here but the ultrasound is not of good quality here...the ultrasound image is very clear in the private clinics...”</p> |

- **Effects of referral weaknesses on receiving timely care**

Weak referral systems caused delayed care, thereby reducing access to quality EmOC. Clients referred from health centres to the hospitals were referred to another hospital of similar capacity. The hospitals that received the referred clients again referred them to another hospital of similar capacity. Therefore, clients visited many hospitals before they got their care; thereby compromising their health outcomes.

"I spent 300 birr for taxi to come here from Kotebe. Only for taxi...When I arrived here they said there is no bed...then I went to (X) and then to (Y).then to another hospital I forgot its name...I forgot the name of one hospital but I went to four hospitals. This is because they said they didn't have beds. They shouldn't have said there is no bed...they could have at least said stay here on the chair...why do they refer?"

- **Effects of referral weaknesses on the cost of care**

Referral weaknesses also predisposed clients to financial burden and barrier to EmOC, as they travelled to multiple health facilities in search of bed space for EmOC.

- **Referrals for diagnostic services**

Referral for services outside the public health facility took away clients' energy, time and money. For example, a woman that was referred to a private clinic for ultrasound reported that the reason the provider sent her to the private clinic was to access good imaging; yet, ultrasound was functional in the public health facility. She was forced to travel long distances and incurred transport costs. She was disappointed because the provider sent her to a private clinic that was not accessible when there were other accessible private clinics around. This compelled the client to think that the provider was a shareholder in the private clinic.

5.4.5 Theme 5: Barriers for provision of quality EmOC as perceived by clients

5.4.5.1 Category 1: Staff related barriers for provision of quality EmOC

Clients perceive staff burnout due to overwhelming client load and shortages of staff as barrier for the provision of quality EmOC.

Table 5.27 Staff related barriers for the provision of quality EmOC

| Category | Sub-category | Meaning units |
|--|---|--|
| Staff related barriers for the provision of quality EmOC | <ul style="list-style-type: none"> <li data-bbox="434 687 663 721">• Staff burnout | <p data-bbox="801 687 1452 875">“There are many clients but the service provider is a person. And this person also gets tired...They may also have other work, attending school...Therefore, the quality can be poor.”</p> <p data-bbox="801 920 1452 1066">“There is delivery in the facilities day and night. All beds in recovery room stay occupied every day. They sacrifice their sleep and stay with the clients all night long.”</p> <p data-bbox="801 1111 1452 1299">“...Here there are many people...there are many referrals...It must be courageous....when there are lots of things to do, it causes poor quality. Here there are many referred cases I don't know why.”</p> <p data-bbox="801 1344 1452 1688">“The number of health workers attending delivery should be more than one. When they attend delivery, they shouldn't be one. How can she deliver alone? They should be two or three...When one delivers the other should take care of the baby...One attends to delivery and also takes care of the baby...How can she do both? Therefore, there needs to be two or three people attending delivery, not one...”</p> |

- **Staff burnout**

Poor quality care provision resulted from few providers who were serving too many clients. This led to burn out of service providers. Therefore, understaffing was one of the barriers to provision of quality EmOC.

“The number of health workers attending delivery should be more than one. When they attend delivery, they shouldn’t be one. How can she deliver alone? They should be two or three...When one delivers, the other should take care of the baby...One attends to delivery and also takes care of the baby...How can she do both? Therefore, there is need for two or three people to attend to delivery and not one...”

5.4.5.2 Category 2: Facility infrastructure related barriers

Shortages of space and inadequate numbers of beds emerged as barriers for provision of EmOC. Delivery beds were easily occupied and the delivery rooms were not able to take more clients. This resulted in the referring of clients to other public health facilities. The shortage of bed spaces affected clients to the extent that some delivered while waiting for bed space.

Table 5.28 Facility infrastructure related barriers

| Category | Sub-category | Meaning units |
|--|---|---|
| Facility infrastructure related barriers | <ul style="list-style-type: none"> Shortages of space to accommodate clients | <p>“Many people are staying in one room...we all have bleeding...there is (offensive) smell...if you count there is about 20 beds in one room...this will expose you to diseases. Why? Because my blood may be clean. Her blood may be contaminated. ...there can be contamination...at least we don’t have 20 cm distance in between...”</p> |
| | <ul style="list-style-type: none"> Inadequate number of beds | <p>“Yesterday even the delivery room was full...then labour started and they took her in. She gave birth immediately...the other delivered on the chair while they told her that there is no bed...”</p> |

- Shortage of space to accommodate clients**

Shortage of bed space was one of the barriers to the provision of EmOC. Research participants highlighted that the public health facility beds are usually fully occupied and clients had to wait prior to their deliveries. Some of the clients ended up being referred

to nearby public health facilities, adding to the delays in accessing EmOC. Clients who were lucky to be admitted stayed in congested rooms, thereby, threatening their safety.

Safety was compromised when many clients got admitted in one room, with cleanliness not maintained. There was perceived risk of blood contamination between clients. There was also offensive smells in the rooms, adding to their discomfort.

“Many people are staying in one room...we all have bleeding...there is (offensive) smell...if you count there is about 20 beds in one room...this will expose you to diseases. Why? Because my blood may be clean. Her blood may be contaminated. ...there can be contamination...at least we don't have 20 cm distance in between...”

- **Inadequate number of beds**

The shortage of beds was a barrier for the provision of EmOC. Clients were referred to other public health facilities due to a shortage of beds and others delivered on the chair while waiting their turn.

“Yesterday even the delivery room was full...then labour started and they took her in. She gave birth immediately...the other delivered on the chair while they told her that there is no bed...”

5.5 CONCLUSION

This chapter presented and described the study's findings. The themes that emerged from the data analysis were EmOC quality as perceived by clients, EmOC that created good experience for the clients, causes of clients' disappointment with EmOC, barriers for the use of EmOC at facilities, and barriers for the provision of EmOC.

The next chapter will present the conclusions and recommendations of the study.

CHAPTER 6

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY

6.1 INTRODUCTION

The previous chapter outlined the data analysis and research findings. This chapter discusses of the research findings, in relation to the study objectives, elements of provision and experience of care model and themes that emerged from the data analysis. The conclusions of the study as well as recommendations to improve the quality of EmOC are also presented.

6.1.1 Overview of the research discussion, conclusion and recommendation

This study adopted an inductive data analysis strategy to explore and describe clients' perspectives on quality EmOC in public health facilities in Ethiopia.

Five themes emerged from the study; including:

THEME 1: EmOC quality as perceived by clients

THEME 2: EmOC that created good experience for the clients

THEME 3: Causes of clients' disappointment with EmOC

THEME 4: Barriers on the use of EmOC at health facilities

THEME 5: Barriers on the provision of EmOC

The themes and sub-themes that emerged from the study were interpreted and discussed using literature sources, and in line with the provision and care model and objectives of the study.

6.2 BIOGRAPHICAL PROFILE OF THE PARTICIPANTS

Of all female participants studied, 41.7% were pregnant for the first time while 58.3% had given birth at least once. Sixty seven percent of the participants were aged 25-29 years old. Grøndhal, Karlsson, Hall-Lord, Appelgren and Wilde-Larson (2011:2544) found that sex and age had statistically significant impact on clients' perceptions on quality of care. In their study, women rated quality of care higher than men while older clients rated quality of care higher than younger clients. Stubbe, Brouwer and Delnoij (2007:8) found that older clients tended to be more satisfied with evaluation of quality of care. This was also corroborated by Larson (1999:697) who asserts that clients' perceptions on quality of care have positive correlation with increasing age. Young and, well educated women staying for shorter period of time reported less satisfactory care than other client groups (Larson 1999:698). Besides, Wieggers (2009:4) opines that women, regardless of parity, were very positive about the quality of maternity care received. Therefore, parity does not affect perceptions on quality of maternity care received. The current study was exploratory and descriptive; therefore, it does not determine any particular rating of clients' satisfaction with EmOC. Rather, descriptions of clients' experiences regarding EmOC were obtained from women who were mainly in their late twenties; less educated and had given birth at least once in their life time.

6.3 EMOC QUALITY AS PERCEIVED BY CLIENTS

Clients perceive the quality of EmOC as a care that is welcoming, safe and life-saving; given in a clean environment, with humility, respect, equity and passion. It is a timely care that responds to the client's need, from the time she arrives at the health facility until the client departs. The findings suggest that clients perceive the quality of EmOC from the quality of interaction with providers, care environment, timeliness of care, outcome of care and technical soundness; including the use of technologies. It emerged from the current study that the clients' important aspects of care relates to the five categories of care reported by Regula, Miller, Mauger and Marks (2007:1593), which are treatment, access to care, professional interactions, follow up care and environment of care. The clients' perceptions of quality of EmOC also comply with the four dimensions of quality as defined by IOM and WHO. The WHO (2006:9) dimensions of quality of care include accessibility, acceptability, equity and safety. The six dimensions or characteristics of quality of care according to IOM are safety, timeliness, equity and

client centeredness. These dimensions are complementary and synergistic (IOM 2001:53). Efficiency of care is not assessed, but the effectiveness of care is assessed in general terms by clients.

Clients assessed the effectiveness of care in general terms by acknowledging that they could have died if they had not received the care. Therefore, the outcome of care was survival. Client perception on effectiveness vary from the WHO and IOM effectiveness dimension of quality of care, which refers to delivering health care that is adherent to an evidence base and result in improved health outcome (WHO 2006:9; IOM 2001:3)

The sub-themes include safe and accessible care, interpersonal care, technology supported care, structure aspect and organised/coordinated care. Each of these themes and sub-themes are discussed below.

6.3.1 Quality of EmOC perceived as safe, accessible and life saving care

Safe and accessible care includes client safety, availability of care including on call service, timely and emergency care.

6.3.1.1 Safety of EmOC as perceived by clients

Safety of EmOC is care that does not bring other health problems in the course of receiving care. Compromised safety of care exposes clients to diseases or fear of contracting diseases from other clients while accessing EmOC. Hence, clients are concerned about sustaining injuries or acquiring other diseases while seeking EmOC. They also perceived themselves at risk of infection and contamination. They suggested that cleanliness of health facilities should be ensured to prevent risks of contamination.

“...when you come here for treatment, you don't have to get another illness. Here, those who are not sick do not come...”

The findings suggest that the cleanliness of health facilities is a safety issue for women in resource poor settings. An unclean care environment is generally a threat to clients. This affects their future decision to seek care at the health facility. The underlying perception is that public health facilities are for clients and need to be clean to avoid

cross-infection or contamination. Hence, maintaining cleanliness of the health care environment is crucial to ensuring quality EmOC services and enhancing utilisation. Generally, the perceived level of risk of infection affects the perception of EmOC provisions as well as the client experience of EmOC.

This conforms to the human and physical resource aspect of the experience of care model that the physical infrastructure and the overall maternity wards are acceptable to all women. About 1.4 million people suffer from hospital acquired infections at any given time (WHO 2011:2). Inadequate environmental conditions, poor infrastructure, insufficient equipment, understaffing, overcrowding, little knowledge and application of basic infection control measures and low hygiene compliance issues are some of the determinants of the burden posed by health care associated infections in developing countries (Rosenthal 2011:188; Pittet & Donaldson 2005:891). Environmental factors play crucial role in causing health care associated infections (Pittet, Allegranzi, Storr, & Donaldson 2006:420). Clients fall ill because of lack of access to safe water and adequate sanitation in health facilities (WHO 2012b:66). Clients are at risk of faeco-oral transmitted infections and therefore cleanliness of health care facilities is mandatory (Pittet & Donaldson 2005:893).

There are studies that showed how providers are at risk of health care associated infection, including HIV infection (Gerberding 2003:827). The current study found that clients were aware of the risks of getting other diseases while seeking EmOC from public health facilities that do not maintain cleanliness.

Conclusion

Cleanliness for clients is a safety issue rather than luxury. Clients' preferences of place of delivery include consideration of the level of the cleanliness of the health care environment. Therefore, clients' perceptions on the quality of EmOC and utilisation can be improved by enhancing cleanliness of health facilities.

6.3.1.2 Availability of care including on call service as perceived by clients

Clients access care at any time as health facilities have midwives who run shift duties and physicians on call beyond the normal working hours who complement the midwives'

skills. Care that is available whenever clients need them creates a good image of quality of EmOC.

“...when it was beyond their capacity, they called the doctor around 4 am...He (the doctor) came and operated because my blood pressure was high....that is how I am here today...”

“...They (providers who performed the operation) were not there (in the hospital)...they were called and brought by car to save my life...This is very pleasing...”

“...You will get treated as a client without any appointment...You will finish timely...you will get what you need.”

The finding suggests that availability and access to EmOC at all times creates good client experience. Goberna-Tricas et al (2011:e235) note that clients perceive the presence of a qualified professional as indispensable. Therefore, providers' availability should be ensured and managed properly. Cham et al (2005:5) opine that poor management of staff availability, particularly physicians, has been mentioned as a factor contributing to poor EmOC. Hence, providers should be available to ensure quality of EmOC and thereby create good experiences for the clients. Failure to manage the availability of providers during odd hours, in addition to the normal working hours, affects the clients' experience and utilisation of EmOC. This was corroborated by Shiferaw, Spigt, Godefrooij, Melkamu and Tekie (2013:4) and Gebrehiwot, Goicolea, Edin and Sebastian (2012:7) as one of the reasons for home delivery in Ethiopia, as health centres could not open during the night and weekend hours, which meant that skilled health care workers were not available to deliver EmOC. Fotso and Mukiira (2011:510) point out that opening hours and availability of doctors and midwives were among the accessibility factors that created good perceptions on access to care and quality care in their study.

There are challenges to avail providers during odd hours in addition to the normal working hours. Chodzaza and Bultemeier (2010:107) found that lack of transport for staff on call during odd hours was contributing to delays in provision of critical care.

Hence, transport for staff on call, especially, physicians should be in place to complement the skills of midwives when there is inadequate staffing of physicians.

The availability of providers during odd hours to provide EmOC fits with the experience of human and physical resource aspect of the model (Hulton et al 2001:39).

Conclusion

Care that is available and accessible at all times creates good experiences of care in the clients, enhances service utilisation and improves EmOC outcomes.

6.3.1.3 *EmOC perceived as a lifesaving intervention*

Clients perceived EmOC as a lifesaving intervention that averts maternal death. The finding suggests that clients know that there are interventions to curb maternal mortality and treat obstetric complications.

“I met good people at the delivery room...especially the doctor who saved my life...to tell you the truth, I would have been dead...my blood pressure was high...but finally to save my life he performed the ‘operation’(caesarean).”

Clients perceive that childbirth has risk associated with it and there are interventions to avert the risk. This was corroborated by Gebrehiwot et al (2012:4) who note that women recognise clearly the risk associated with childbirth and that a number of complications can occur during childbirth. They considered health facilities to be better prepared to deal with complications than traditional birth attendants at home. Clients acknowledge their opinion about the role of health facilities in dealing with delivery related complications, from rejection to acknowledging as life-saving interventions (Gebrehiwot et al 2012:7). EmOC averts maternal mortality by providing lifesaving interventions for the life threatening direct obstetric complications (Paxton et al 2005:189). Clients expressed their gratitude to providers as they felt they were near-miss cases and would have died were it not for the help of the providers (Kabali, Gourbin & Brouwere 2011:4). Thus, EmOC ensures the treatment of life threatening obstetric complications.

Conclusion

Clients perceive that they can encounter obstetric complications during childbirth and that public health facilities are better prepared to deal with such complications using EmOC.

6.3.2 Clients' perceptions on interpersonal care

Compassionate care, emotional support, dignity and respect, and information constitute the clients perception of interpersonal care. Clients value the more supportive and comfortable care.

Clients' past negative experiences with health facility care and perceived poor quality of care were identified as reasons for low institutional delivery attendance in Ethiopia (Shiferaw et al 2013:4). Interpersonal care plays a key role in creating a good experience for clients.

6.3.2.1 *Compassionate care*

A supportive relationship between the client and provider creates a good experience for clients. Clients assess quality of EmOC through the way providers welcome them (warmly or not), treat them with respect and humility, and listen and understand their concerns. Technically sound EmOC provision without courtesy could be unsatisfactory for the client.

“The delivery service of the hospital is good...They understand your stress...They don't have pride of being a doctor...When I was in stress...it is the doctor who put my shoes for me...This was not in the past...he was carrying the IV bag for me. Their care is good especially the doctors...even more, it is good for others in lower positions to learn from the doctors...”

“...When I say quality EmOC it is treating the other person, showing good face, giving hope and this is more than anything...”

This finding was corroborated by Goberna-Tricas et al (2011:e234) that clients distinguish between professional/technical skills and the human aspects of relationship management. They reported lack of warmth when treating mothers and newborn babies (Gebrehiwot et al 2012:7). The women demanded health professionals to be both technically skilled and capable of respecting their autonomy and values as women. They craved for health professionals to show a caring attitude and empathy (Goberna-Tricas et al 2011:e234).

Lack of empathy and commitment by providers was perceived as poor quality of care by clients (Muntlin, Gunninberg & Carlsson 2006:1053). Long waiting times and poor communication between clients and providers were also considered as lack of respect (Foster, Burgos, Tejada, Cáceres, Altamonte, Perez, Noboa, Urbaez, Heath, Hilliard, Chiang, & Hall 2010:509). This coupled with lack of confidence on the providers' ability to manage labour and delivery made clients to shun hospitals and deliver at home (Shiferwa et al 2013:4).

Conclusion

Compassionate care is an indispensable part of overall care that affects clients' experience with care.

6.3.2.2 Emotional support

Clients experiencing childbirth develop fear, anxiety and stress due to the technical procedures, care environment, perceived risk of infection, non-welcoming providers, and non-properly communicating providers, providers that they do not know before and the perceived level of risk associated with childbirth. Emotional support relieves clients stress and anxiety. Clients are relieved from fear, anxiety and stress when they are encouraged by providers. It gives them the strength to bear the challenges they face. Hospital maternity procedures induce fear, specifically vaginal examination and urinary catheterisation (Foster et al 2010:508). This is corroborated by Kabakian-Khasholian, Campbell, Shediak-Rizkallah and Ghorayeb's (2000:108) assertion that technical care is intimidating for women and makes them to experience discomfort. Clients reported that providers disregard their wishes for relatives to accompany them during delivery

(Gebrehiwot et al 2012:7). These wishes can relieve stress, anxiety and pain during labour (Hulton et al 2007:2090; Hulton et al 2001:44-45).

However, clients reported that providers were not sensitive to their privacy and care little about giving them psychological and emotional support (Shiferaw et al 2013:4). Wieggers (2009:4) found that women's score of quality of care during labour and childbirth was higher when they knew their provider or midwife. This was explained by Goberna-Tricas et al (2011:e235) as establishing trust with their provider. The sense of trust extends from knowing the provider to preferring to have the provider all alone for themselves and not shared by other clients (Goberna-Tricas et al 2011:e235).

Conclusion

Emotional support for clients gives them the strength to bear the challenges they are facing while receiving EmOC. The fear, anxiety and stress that clients develop while visiting public health facilities to give birth can be relieved by the provision of good interpersonal care. Emotional support plays a key role in relieving fear, stress and anxiety by encouraging clients to bear the challenges.

6.3.2.3 Dignity and respect

Dignity and respect emerged as core in the clients' perspectives of quality EmOC provision. It comforts and creates good experience for clients with EmOC. In addition, lack of respect for clients has created bad experiences in clients.

“...Quality delivery care is...the physician should not annoy clients...it should be with humility and respect...”

“...They treat you with respect, they take good care.”

Respect, dignity and equity refer to client-provider encounters characterised by supportive relationships and avoiding expression of inherent conflict and social disparities as clients vary by status, power and culture (Hulton et al 2007:2089; Hulton et al 2001:42-43). Groenewegen, Kerssens, Sixma and Eijk (2005:5) found that respectfulness of care is a very important aspect of care for clients. However, clients

feel disrespected by providers and were even insulted during delivery (Gebrehiwot et al 2012:7).

Conclusion

Respect for clients impacts on the utilisation of EmOC services. Clients' decision to seek care considers respect accorded to them by providers. Clients make rational decisions when seeking care from health facilities.

6.3.2.4 Information and advice

Clients have needs for information and advice that should be met by providers. Clients assess the quality of EmOC provision by finding out whether providers are good in information giving and offer advice.

“...They also are good in information. They write. They have checked us a moment ago...”

“...they advise you and tell you what to take care...”

The finding suggests that clients perceive proper information exchange and proper recording of data as a good experience.

Jansen and Wieggers (2006:56) state that clients' experiences of care are affected by the amount of information they receive and understand. Clients expect a clear, sufficient and good provision of information from providers and are less interested when providers give more information without clients enquiring. Therefore, clear information should be communicated in a participatory way to the clients. Clients should be fully aware of what is going on and consent before receiving care. Also, informing clients about the care they are to receive ensures the safety and appropriateness of care to the client. Clients that had experienced newborn deaths after a provider performed a caesarean section against their will attribute the deaths to lack of informed consent (Foster et al 2010:508).

Clients have a good experience when they are listened to by a provider and find providers that try to understand them. Women value good interaction with their provider

more than any other aspect (Kabakian-Khasholian et al 2000:109). This was corroborated by Jansen and Wiegers (2006:56) assertion that clients prefer a personal approach of providers, such as showing interest in them and listening to their concerns.

Cognition is an aspect of experience of care in the model. It refers to the extent to which a client feels she understands what is happening, feels that her questions have been answered adequately and receives information in a form that she understands and has the right to know (Hulton et al 2007:2088; Hulton et al 2001:340).

Conclusion

Clients' need for information and getting advice during childbirth affects their childbirth experience. Information exchange, trust building, empathy and proper recording of client data assures clients that the provision of EmOC is of good quality.

6.3.3 Clients' perceptions on technology supported care such as use of drugs, supplies and diagnostic services

Availability and use of drugs, supplies and diagnostic services in public health facilities constitutes clients' perceptions on technology supported care. Clients perceive quality EmOC as timely care that met their needs using necessary examination, diagnostic services and drugs.

“Antenatal care is better than delivery care...they [antenatal care providers] send you for ultrasound...They give you drugs...”

The finding suggests that availability of drugs, supplies and diagnostic services creates a good experience for clients with EmOC. Goberna-Tricas et al (2011:e233) point out that clients feel safe and reassured with the availability of technology. Few clients believe technology was not necessary as they believed that pregnancy was a physiological process. Clients consider the experience of pain to be unnecessary and felt that it was sensible to use modern technology. The use of ultrasound gave clients an assurance that the child was well (Goberna-Tricas et al 2011:e234). Clients appreciated availability of drugs at health facilities (Gebrehiwot et al 2012:7).

Conclusion

Availability of drugs, supplies and diagnostic services in public health facilities creates a good experience for clients with EmOC.

6.3.4 Clients' perceptions on physical structure of health facilities

Client perceptions on the physical structure affect their perception of quality of EmOC. The physical structure includes cleanliness and infrastructure of the care environment. The perception of the physical structure affects clients' preference for place of delivery.

6.3.4.1 Cleanliness

Quality EmOC for clients refers to how clean the delivery environment was and extends to the cleanliness of the health facility, the housing structure, supplies and equipment.

“I was attending my antenatal care in [X] health centre. The health centre is very clean. When you enter the delivery room there is no offensive smell. The toilet is also clean. I wish I had delivered there.”

“Quality delivery care means how the delivery is clean and all including the house/structure...Starting from the housing structure up to instruments...”

Cleanliness of health facilities conveys the message to clients that providers care about clients' safety. The perceived risk of getting other diseases is increased when health facilities are not kept clean. Cleanliness affects clients' decision and preference for places of delivery. Women prefer to deliver in health centres than hospitals. Clients are at risk of faeco-oral transmitted infections and therefore cleanliness of health care facilities is mandatory (Pittet & Donaldson 2005:893).

Conclusion

Maintaining cleanliness of the health facility not only makes clients feel good about the care environment but also assure clients that they are at lesser risk of infections. Cleanliness of health facilities affects clients' decision or preference of place of

childbirth. Cleanliness indicates to the client that providers care about their safety. Therefore, creating a good experience with EmOC requires that the health facility be maintained clean.

6.3.4.2 Infrastructure

The health infrastructure is considered by clients as a safety issue rather than a luxury. Larger rooms are preferred to avoid congestion and risk of infection. Poor infrastructure is among the determinants of the burden posed by health care associated infections in developing countries (Rosenthal 2011:188; Pittet & Donaldson 2005:891). This was supported by Muntlin et al (2006:1053) who note that the environment of care is important for clients even though the environment is not directly related to medical problems.

“Many people are staying in one room...we all have bleeding...there is (offensive) smell...if you count there is about 20 beds in one room...this will expose you to diseases.”

Conclusion

The infrastructure of public health facilities relates to the safety of clients. Ensuring adequate bed space can prevent cross infection at public health facilities.

6.3.5 Clients’ perceptions on organised or coordinated care

6.3.5.1 Integrated care

Integrated care refers to the care for the mother and the baby. Clients not only consider the care accorded to them but also that offered to the baby. Care for the mother and the baby should not be seen as separate. Clients perceive quality EmOC and explain both from the care accorded to them and their babies. Goberna-Tricas et al (2011:e235) found that the bond between a mother and an infant is a key feature of a woman’s entry to motherhood which can affect their experience of care. Hence, clients look for greater possible contact with their infant following childbirth. Kabali et al (2011:4) found that delays in getting care to the mother affected the baby’s chances of survival. Thirty three

percent of newborns were stillborn or died before discharge if their mothers survived and 55% of newborn died if their mothers died (Kabali et al 2011:4).

6.3.5.2 Care coordination

Care coordination refers to how the team works together to save lives. Team work and coordination among service providers was recognised as good practice to save live. Gynecologists/Obstetricians, midwives and nurses were perceived as highly skilled professionals (Goberna-Tricas et al 2011:e234). Clients' experiences with care have been affected by lack of team work. Some clients felt neglected or ignored by a provider during the daily ward round because caesarean sections were performed by another provider (Kabali et al 2011:4). Collaborative care for saving life and accessing the availed life saving care created good experiences for clients. The collaborative system of having a physician on call when there was an emergency saved lives.

Conclusion

Care that meets the needs of clients and their newborns creates good experiences. Clients recognised that the collaborative effort of various units of health services in delivering care to mother-infant pair were determinant factors for their level of satisfaction.

6.4 EmOC THAT CREATED GOOD EXPERIENCES FOR THE CLIENT

6.4.1 Interpersonal care

6.4.1.1 Compassionate care

Compassionate care created good experiences with EmOC for clients. Clients were pleased by providers who served them humbly and with understanding and concern.

“...They understand your stress...They don't have pride of being a doctor...When I was in stress...it was the doctor who put on my shoes for me...This was not in the past...he was carrying the IV bag for me.”

Clients demand a caring attitude and empathy from providers. This was corroborated by Goberna-Tricas et al (2011:e234) in their conclusion that clients craved for health professionals to show a caring attitude and empathy (Goberna-Tricas et al 2011:e234).

Conclusion

Compassionate care creates good experiences for clients. Clients consider compassionate care as an important aspect of care.

6.4.1.2 *Listening to the client*

Clients are surprised when they are given attention and listened to by the providers. Listening to clients and understanding their concerns creates good experiences for clients.

“...the specialist doctor listened to me. That made me surprised...”

Jansen and Wiegers (2006:56) corroborate that clients prefer a personal approach of providers such as showing an interest in them and listening to their concerns. Clients felt good when they are listened to by providers.

Conclusion

Listening to clients' concerns creates good experiences for clients.

6.4.1.3 *Emotional support*

Clients received encouragement and emotional support that made them happy. Emotional support is known to relieve stress, anxiety and pain during labour (Hulton et al 2007:2090).

“They were encouraging me. They say “you will be okay”...encouraging for human being is very good ...”

Conclusion

Encouraging clients creates good experiences with EmOC.

6.4.2 Availability of life saving care

6.4.2.1 Collaborative care for saving life

Clients admired the care accorded to save their lives through collaboration. Each team member attempted to save life and worked together with other members for the common goal of creating good client experiences. Hence, team approach and collaborative approaches created good experience and resulted in better health outcomes.

6.4.2.2 Availability of call service and life saving care

Clients are thankful for accessing their life saving care and pleasant about care as they recognised that they could have been dead were it not for EmOC. Therefore, the perceived level of risk and accessing life-saving care contribute to good experience and satisfaction with care.

“...when it was beyond what they can do, they called the doctor around 4 am...He came and operated...that is how I am here today...it is very good for me...I am pleased...”

This is corroborated by Fotso and Mukiira (2011:510) as shown in their statement that opening hours and availability of doctors and midwives were among the accessibility factors that created good perception of access to care and quality care in their study.

Conclusion

Availability of on-call service and lifesaving care creates good experience of care in the clients, enhances service utilisation and improves EmOC outcomes.

6.5 CAUSES OF CLIENTS' DISAPPOINTMENT WITH EMOC

The causes of clients' disappointment with the provision of EmOC were higher expectations from female providers, underestimation by providers and non-responsive providers. Clients were also disappointed by the providers' ethical misconduct such as mocking, insulting, yelling, advantage taking and undelivered promises. Other client disappointments included expectations on the place of delivery, expectations for newborn care and the limited number of health workers attending delivery.

Dissatisfaction influences clients' use of health services and compliance with treatment (Dogba & Fournier 2009:9). Previous experience from using other health facilities and their EmOC (Lule et al 2000:254), favourable immediate maternal condition after delivery, short waiting time, perceived availability of waiting area, measures to assure privacy and reduced cost for services were associated with women's satisfaction with delivery care (Tayelgn et al 2011:3).

6.5.1 High expectations on female service providers

Clients expect more courteous care from female providers, given that either they are already experienced or are hopeful that someday, they will also experience childbirth. However, their trust and expectations for female health care workers was limited by the unfriendly attitude of the female workers towards clients.

“...I don't think they are human. I am surprised especially by the women. They don't seem that they will face the same tomorrow.”

There are variations in findings regarding clients' preferences on the gender of their care provider. Clients prefer male obstetricians or midwives than their female counterparts in cases of obstetric complications. They were of the view that male obstetricians or midwives are more skilled than their female counterparts (Kabakian-Khasholian et al 2000:106). Prince, Pipas and Brown (2006:362) found that female emergency physicians were less likely than male emergency physicians to be recognised by clients as physicians. Although clients prefer male providers in general, they opt for female providers in normal deliveries because of ease in communicating

personal issues (Kabakian-Khasholian et al 2000:106). Therefore, female providers are preferred by clients, more for the interpersonal aspect of care than technical care.

Conclusion

Clients' high expectations for quality care from female providers were limited by the providers' unfriendly attitudes towards clients.

6.5.2 Service providers undermining clients

Clients were disappointed when they felt that they were being undermined by providers. Some providers considered clients as though they knew nothing and had nothing to contribute to their care process.

“...even if you want to give a suggestion, they say ‘do you know more than us’...this hurts...It is not just because they wore the white gown, the other person (client) might also be educated. It may also be knowledgeable...this is the situation.”

Conclusion

Respect for clients is crucial to create good experiences with EmOC. An attitude that undermines clients disappoints and creates bad experiences with EmOC.

6.5.3 Providers not answering to clients' calls

Clients were disappointed that providers were reluctant to respond to their calls. They expected providers to ask what was happening when they screamed, shouted and cried during delivery. They also expected providers to respond when they called. Some providers instead insulted and yelled at clients. This disappointed clients.

“...they don't come when they are called...they treat us like dogs...”

Conclusion

Providers left clients unattended to, even when they called for assistance.

6.5.4 Ethical misconduct of providers

Ethical misconduct includes mocking, insulting, and yelling at clients. Clients were disappointed when providers were not willing to listen to them. Clients mentioned that ethical misconducts were observed more among lower level staff members. Clients were insulted and embarrassed by providers during delivery (Gebrehiwot et al 2012:7).

Conclusion

Ethical misconduct of providers abuses the clients' rights to be respected and get humane treatment. Disrespect and embarrassing clients creates bad experiences with EmOC.

6.5.5 Misunderstanding on newborn care

Misconceptions and misunderstanding of newborn care by clients affects their perception and satisfaction. Therefore, clients should be informed about newborn care to clarify any misunderstanding. This will set the expectation of clients and can easily be met by providers as the procedure is clear for them.

“...The other thing is they have to take good care when they deliver. They just deliver and give...why they give without washing the baby...”

Conclusion

Clients' misunderstanding of the care process creates disappointment.

6.6 BARRIERS ON THE USE OF EMOC AT HEALTH FACILITIES

6.6.1 Discrimination as a barrier on the use of EmOC at health facilities

Discrimination affected care outcomes as those in lower social status received care late, or did not receive care when needed. Clients coming from rural areas were discriminated against than those from urban areas. The poor were discriminated against than the rich. Those who did not know providers in the health facility were also discriminated against.

“Especially if you came from rural parts, if you don’t have someone you know...they nag you and scream at you and the insult will be much more...”

“The government treats all of us equal...why do they then discriminate people? Those from urban or rural, those who know people and who don’t know...those who have money and who don’t have...what should the poor do then? You buy medicine, needles, supplies from outside....what can a person who has nothing can do?”

Foster et al (2010:508) corroborate that clients that did not have social connection with people or who were not known to people in the health care system were ignored while those who had a connection with providers were given special treatment.

Conclusion

Poor women who did not know providers or came from rural areas were discriminated against, and not given equal care as others.

6.6.2 Cost of care as a barrier on the use of EmOC at public health facilities

The cost of service and charges for buying supplies were common financial barriers to EmOC. Clients incurred costs more than they anticipated when hospitals asked them to

buy supplies from private pharmacies. This created financial burdens and rendered the clients and their families economically vulnerable.

6.6.2.1 Fee structure

Service fees were reported as high by clients. The clients' ability to pay for service was also affected as they were asked to buy supplies and medicines from private pharmacies outside the health facilities. This finding suggests that service charges in health facilities serve as barriers to accessing EmOC.

“...It would be good if the government can make subsidies ...consideration has to be made for the poor and those coming from far places...health centres do not charge...even this don't harm...but should I be dead if I don't have money?”

One of the most important reasons for not seeking institutional delivery in Ethiopia was the high cost of care (Shiferaw et al 2013:4). Pregnant women died while family members went to source for the required cash to pay for the service, since treatment was not provided before the full amount of money was paid (Kabali et al 2011:4). Therefore, inability to pay fees for service affected the outcomes of treatment. The clients' satisfaction with delivery care was associated with the amount of cost paid for service (Tayelgn et al 2011:3).

Conclusion

The effects of service fees were twofold. Firstly, it caused delays in receiving care, thereby affecting quality of EmOC. Secondly, the high costs paid for service affected clients' livelihood and resulted in economic vulnerabilities.

6.6.2.2 Coping mechanisms for high cost of care

Clients incurred more costs than they had planned to spend for their care. They coped with the challenge by selling their valuable items such as necklaces at lower prices than the market rates or sourced quick soft loans at high interest rates; thereby, exposing them to financial vulnerability.

“...those who are coming from far they would like to borrow money but they know no one...they sell what they have at hand...Their mobiles...Necklaces...Otherwise she is going to die..They don't estimate that they will spend this amount of money...”

Conclusion

Clients sold their valuables at cheaper rates and collected loans at high interest rates in order to pay their health services bills; thereby, causing financial vulnerabilities to the family.

6.6.3 Drugs and supplies as a barrier on the use of EmOC

Asking clients to buy their drugs and supplies caused delays in treatment, although clients were already in the health facility. This also exposed clients to financial barriers on the use of EmOC, if they were unable to pay for health commodities and other critical services. Such clients were forced into financial vulnerabilities which competed with their ability to afford further payment for services. Clients' family members sold their valuable items such as necklaces and mobile phones in order to fund health care. They also entered into credit and borrowed money with higher interest rates from local money lenders. Additionally, providers asked clients to buy drugs or supplies late at night; thereby exposing their caretakers to attacks by robbers on the roads.

“When you are referred you buy everything...you buy needles, gloves....the problem here is they ask you to buy something at night. Either at 1 AM or 2 AM...where can you bring at that time ...when you tell them, they yell at you... you are asked to buy from pharmacy outside of the hospital suddenly without your expectation...where can you go at 2:00 or 3:00 am to buy what they ask you?...it is in the morning the family can buy and bring with them...it is difficult to ask at that time...”

“It is said to be for free...when you are referred you buy everything...you buy needles, gloves.”

Conclusion

Searching around town to buy drugs and supplies contributes to delays in accessing quality EmOC, thereby causing poor outcomes and a perception of quality care as unsatisfactory.

6.6.4 Referral weakness as barriers to accessing timely EmOC

Some clients were referred to hospitals without prior checking for availability of bed space. This created delays as clients visited multiple places in search of bed space.

6.6.4.1 *Effects of referral weaknesses on receiving timely care*

A weak referral system caused delays in accessing care, thereby reducing access to quality EmOC. Poor referral communication between public health facilities exposed clients and their family members to losses of productive time and resources through travels between multiple health facilities in search of care.

“...I was referred from (X) health centre to here. They didn’t admit me here. They referred me to (Y) hospital. When I arrived at (Y) hospital they refused to admit me. We took a taxi and went back...We came here yesterday around 1 pm...They referred me to (Z) but we managed to be here after begging for such long...”

“I spent 300 birr for taxi to come here from Kotebe. Only for taxi...When I arrived here they said there is no bed...then I went to (X) and then to (Y).then to another hospital I forgot its name...I forgot the name of one hospital but I went to four hospitals. This is because they said they don’t have beds. They shouldn’t have said there is no bed...they could have at least said stay here on the chair...why do they refer?”

Women felt irritated when not referred promptly, yet, health workers failed to take immediate actions to address their concerns (Gebrehiwot et al 2012:7).

Conclusion

Weak referral systems cause delays in accessing quality EmOC and clients incur excessive costs on transportation and productive man hours on family members.

6.7 BARRIERS ON THE PROVISION OF QUALITY EmOC AS PERCEIVED BY CLIENTS

6.7.1 Staff related barriers for provision of quality EmOC

Clients reported that inadequate human resources in health facilities caused overwork and burnout of the few members of staff available.

“There are many clients but the service provider is a person. And this person also gets tired...May also have another work, attending school...Therefore, the quality can be poor.”

“There is delivery in the facilities day and night. All beds in recovery room stay occupied every day. They sacrifice their sleep and stay with the client all night long.”

The finding suggests that inadequate staffing of health facilities was a barrier for the provision of quality EmOC. Muntlin et al (2006:1053) state that the low nurse-client ratio contributed to nurses treating their clients without empathy.

Conclusion

Inadequate staffing contributes to provider burn-out and treatment of clients without empathy, commitment or respect for clients' dignity, thereby reducing their experience of quality EmOC.

6.7.2 Facility infrastructure related barriers to the provision of quality EmOC

Inadequate bed spaces forces clients in labour to be referred to other health facilities or to wait until there was a bed space. This results in poor, unprepared deliveries and ultimately poor EmOC.

“Yesterday even the delivery room was full...then labour started and they took her in. She gave birth immediately...the other delivered on the chair while they told her that there is no bed...”

One of the infrastructure related causes of delay and main factor for death is the unavailability of operating theatre (Kabali et al 2011:4).

Conclusion

Client treatment outcome and safety is affected by infrastructure related barriers to the provision of quality EmOC. Inadequate bed space compels providers to refer clients to other health facilities, thereby increasing delays for quality care and vulnerability to poor health outcomes.

6.8 CONCLUSIONS

The research question was answered by the research findings.

6.8.1 What are the clients’ perspectives regarding the quality of EmOC provision in public health facilities in Addis Ababa?

The clients’ perspectives regarding the quality of EmOC service provision in public health facilities in Ethiopia were views on the quality of EmOC, client disappointment with provision of EmOC, barrier on the use of EmOC and barrier on the provision of EmOC. The result of this study therefore identified five themes regarding client perspectives on the quality of EmOC provision in public health facilities. The conclusion of the study is presented under each of the themes identified and described below.

The clients' perceptions on the quality of EmOC as reported in this study include:

- Cleanliness for clients is a safety issue rather than luxury. Clients' preferences of place of delivery include consideration of the level of cleanliness of the health care environment. Therefore, clients' perceptions of the quality of EmOC and utilisation can be improved by enhancing the cleanliness of health facilities.
- Care that is available and accessible at all times creates good experience of care in the clients, enhances service utilisation, as well as improves EmOC outcomes.
- Clients perceive that they can encounter obstetric complications during childbirth and that public health facilities are better prepared to deal with such complication using EmOC.
- Compassionate care is an indispensable part of overall care that affects clients' experiences with care.
- Emotional support for clients gives them the strength to bear the challenges they are facing while receiving EmOC. The fears, anxiety and stress clients develop while visiting public health facilities for giving birth can be relieved by the provision of good interpersonal care. Emotional support plays a key role in relieving fear, stress and anxiety by encouraging clients to bear the challenges.
- Respect for clients impacts the utilisation of EmOC services. Clients' decisions to seek care consider respect accorded to them by providers. Clients make rational decisions when seeking care from health facilities.
- Availability of drugs, supplies and diagnostic services in public health facilities creates good experiences for clients with EmOC.
- Maintaining cleanliness of the health facility not only makes clients feel good about the care environment but also assures clients that they are at lesser risk of infections. Cleanliness of health facilities affects clients' decisions or preferences of place of childbirth. Cleanliness indicates to the client that providers care about their safety. Therefore, creating good experiences with EmOC requires that the health facility be always maintained clean.
- Clients look at the care provided to themselves and their newborns. Care that meets the needs of clients and their newborns creates a good experience. Clients recognised that the collaborative effort of various units of health services in delivering care to mother-infant pair were determinant factors for their level of satisfaction.

- Clients' high expectations for quality care from female providers were limited by the providers' unfriendly attitudes towards clients.
- Respect for clients is crucial to create good experiences with EmOC. An attitude that undermines clients is disappointing and creates bad experiences with EmOC.
- Providers left clients unattended to, even when they called for assistance.
- Ethical misconduct by providers abuses the clients' rights to be respected and get humane treatment. Disrespect and embarrassing clients creates bad experiences with EmOC.
- Clients' misunderstanding of the care process creates disappointment.

Participants were disappointed with EmOC in the following areas:

- Poor women who did not know providers or came from rural areas were discriminated against, and not given equal care as others.
- The effect of fee for service was two-fold. First, it caused delays in receiving care, thereby affecting quality of EmOC. Secondly, the high costs paid for service affected clients' livelihood and resulted in economic vulnerabilities.
- Clients sold their valuables at cheaper rates and collected loans at high interest rates in order to pay their health services bills; thereby, causing financial vulnerabilities to the family.
- Searching around town to buy drugs and supplies contributes to delays in accessing quality EmOC, thereby causing poor outcomes and perception of quality care as unsatisfactory.
- Weak referral systems cause delays in accessing quality EmOC and compel family members to incur excessive costs on transportation and productive man hours.

6.9 LIMITATIONS OF THE STUDY

The study was conducted in three public health facilities that had functional EmOC in Addis Ababa. A purposive sample of 12 participants was selected from three health facilities and interviewed in-depth, to elicit their perspectives regarding quality of EmOC. The study sample was not representative of all clients accessing EmOC in Ethiopia, and

a qualitative study paradigm was utilised in the study. Therefore, the result of this study is not generalisable.

Only in-depth interviews were conducted to collect data. Other approaches such as observation using checklists, structured interview questionnaire could have revealed different results on the experience of EmOC at public health facilities.

The clients' experiences of EmOC were only explored and described. Therefore, a quantitative client satisfaction rating could not be determined.

6.10 RECOMMENDATIONS

6.10.1 Recommendations for improving the quality of EmOC

- Maintain cleanliness of public health facilities.
- Ensure the availability of physicians to complement the skills of midwives during odd hours and beyond the normal working hours (at night and weekends) in order to guarantee accessibility of EmOC to clients.
- Educate communities about danger signs of pregnancy as well as the availability of life saving interventions at public health facilities.
- Provide emotional support for clients in order to relieve stress, anxiety and fear developed by visiting public health facilities.
- Build the interpersonal skills of providers through training and coaching to provide equitable, ethical, and respectful and client friendly care.
- Improve the infrastructure of public health facilities including sanitary facilities to accommodate more clients and avoid congestion.
- Improve the availability of drugs, supplies and diagnostic services for timely provision of EmOC.
- Coach providers on team work and build team spirit among them to improve care coordination.

6.10.2 Recommendations for further studies

- A quantitative study of the experience of clients with EmOC on a large scale to determine factors strongly associated with good experience of EmOC.
- Study to determine the association between quality of EmOC as measured by case fatality rate and good experiences with EmOC.
- A comparative study between facilities that implemented client focused quality EmOC and those that do not to rate the experience and satisfaction with EmOC.

6.11 CONCLUDING REMARKS

The client perspective regarding the quality of EmOC service provision in public health facilities in Ethiopia include EmOC quality as perceived by clients, EmOC that created good experience for clients, causes of client disappointment with EmOC, barriers on the use of EmOC and barriers on the provision of EmOC. EmOC quality as perceived by clients include safe and accessible care, interpersonal care, technology supported care, infrastructure aspect and organised and coordinated care. Causes of client disappointment with EmOC include: high expectation from female providers, undermining attitude of providers, not answering clients' calls, ethical misconduct of providers and misunderstanding in the care process. Cost of care and week referral systems are also barriers on the use of EmOC. The barriers on the provision of EmOC are staff related and infrastructure related.

The next chapter will present guidelines on the provision of client focused quality EmOC in Ethiopian public health facilities.

CHAPTER 7

GUIDELINES FOR THE PROVISION OF CLIENT FOCUSED QUALITY EMERGENCY OBSTETRIC CARE IN ETHIOPIAN PUBLIC HEALTH FACILITIES

7.1 INTRODUCTION

This chapter presents the guidelines for the provision of client focused quality emergency obstetric care in Ethiopian public health facilities. The guidelines were informed by the findings of the current study, relevant aspects of reviewed literatures, theoretical frameworks of the study and the researcher's insights. The themes from the study were categorised under the adapted model of the provision and experience of care model. Strategies and activities were then proposed for each theme, arising from relevant literatures and insights from the researcher. Finally, the chapter describes the validation process of the guidelines and the dissemination plan.

7.2 BACKGROUND AND MOTIVATION FOR GUIDELINE DEVELOPMENT

The clients' experiences and perceptions on care have been sidelined in the provision of care, especially during medical emergencies. Besides, clients continue to be passive recipients of care. Application of client experience in quality improvement work is limited (Wiig, Storm, Aase, Gjesten, Solheim, Harthug, Robert, Fulop & QUASER team 2013:11). Therefore, the development of guidelines for client focused EmOC will ensure the provision of care that centres on the requirements and expectations of the client; while complying with the requirement for technical practice. This is expected to improve the acceptability of EmOC and influence the decision to seek care for timely presentation at public health facilities. The timely arrival and provision of care will therefore improve the outcomes of care and enhance the utilisation of EmOC.

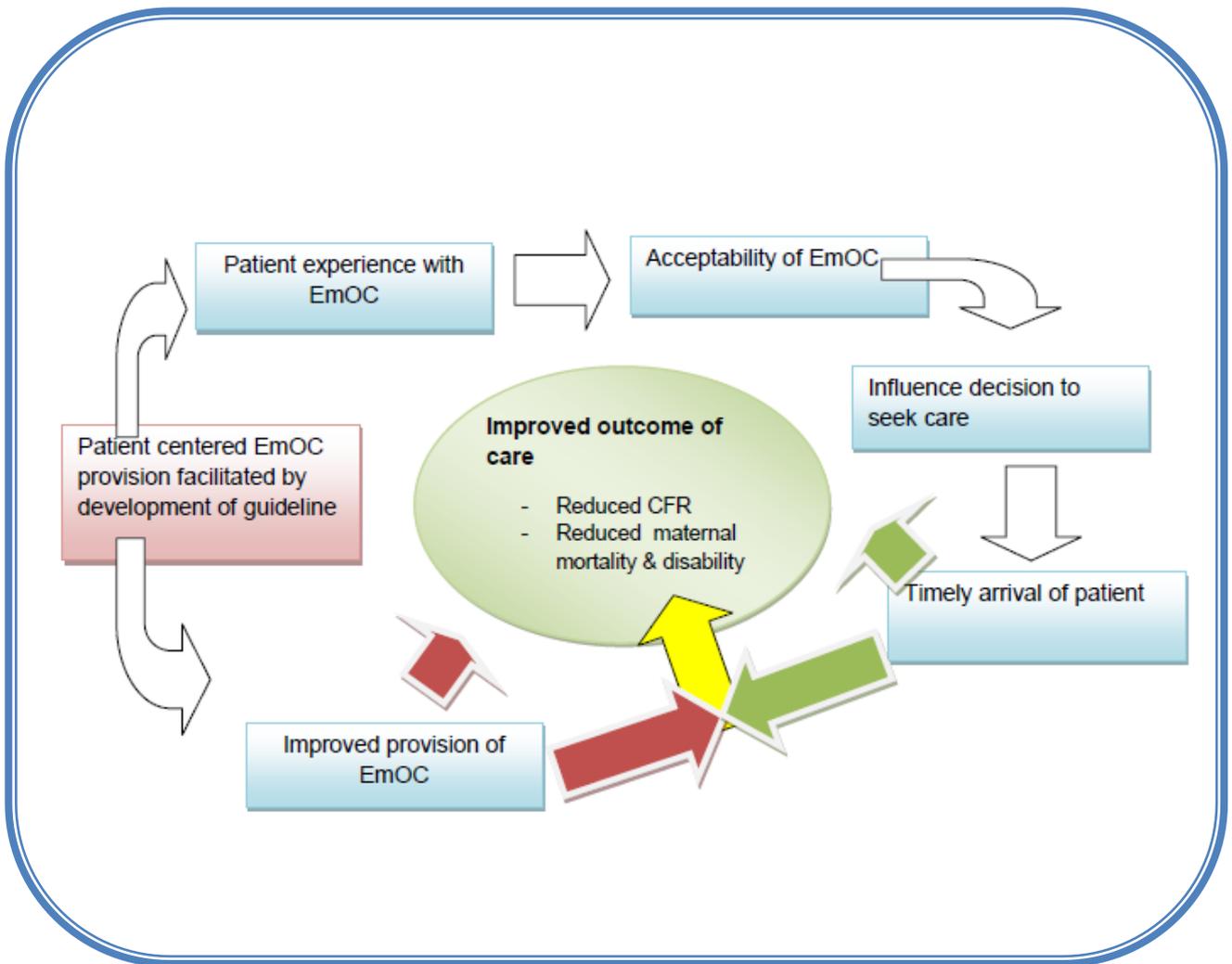


Figure 7.1 Motivation for the development of guidelines for client focused EmOC

7.3 THE PROCESS OF DEVELOPING THE GUIDELINES

The development of client focused quality emergency obstetric care guidelines was based on the major themes that emerged from the current study. Concepts and frameworks were applied to provide a structure to the guidelines. The guidelines have the purpose, the agent, the recipient, context, dynamics and procedures. The elements of the provision and experience of care model were applied to each theme to guide the description of procedures/activities based on their relevance to each theme. Included in each theme were guidelines categorised against the nine elements of the adapted model and include the experience of human and physical resource; cognition; respect, dignity and equity; emotional support; provision of human and physical resources;

referral; maternity management information system; use of appropriate technologies; and internationally recognised good practices.

7.4 APPLICATION OF THE CONCEPTUAL FRAMEWORK TO THE DEVELOPMENT OF THE GUIDELINES

A survey list consisting of the purpose or terminus, the agent, recipient, framework (context), dynamics and the procedures was used as the building blocks for guidelines development (Moleki 2008:162).

7.4.1 Purpose or terminus

The purpose of the guideline is to promote the quality of EmOC provision that creates good experiences for the client. The guidelines will assist facility managers and providers to provide care that is consistent with current professional practices, as well as provide care that is acceptable to the client.

7.4.2 Agent

The **'agent'** according to the survey list is someone who has the knowledge and ability to perform identified activities or provides a solution to a problem (Moleki 2008:29). In this study the agent is the health care worker or professional qualified to provide quality EmOC services in Ethiopia. These health care workers include nurses, midwives, health officers, doctors, gynaecologist/obstetricians and other paramedical staff.

7.4.3 Recipient

The **'recipient'** is the beneficiary of the activities designed by the agent (Moleki 2008:29). In this study the beneficiary of quality of EmOC service are the clients with obstetric complications.

7.4.4 Framework (context)

The **'framework'** is presented as the **context** or **environment** in which activities take place (Moleki 2008:29). This provides for living experiences at the public health

facilities. This study explored the perceptions of clients on public health facilities where EmOC was provided.

7.4.5 Dynamics

The **'dynamics'** provide the energy source or the motivating factors for quality of EmOC service provision (Moleki 2008:30). The dynamics in this study include the experience of human and physical resource, cognition, respect, dignity and equity, emotional support, provision of human and physical resources, referral, maternity management information system, use of appropriate technologies, and internationally recognised good practices.

7.4.6 Procedures

The **'procedures'** are the techniques or protocols that guide the activities (Moleki 2008:30). This study's procedures were the activities presented according to the nine elements of the provision and experience of care model seeking to achieve client focused best practice guidelines for EmOC service provision.

7.5 APPLICATION OF THE THEORETICAL FRAMEWORK TO THE DEVELOPMENT OF THE GUIDELINE

The provision and experience of care model is the quality of care model used as the theoretical framework for this study. The model classifies quality of care in maternity services into two dimensions, that is, provision of care and experience of care (Hulton et al 2007:2084). The nine elements of the model are the experience of human and physical resource, cognition, respect dignity and equity, emotional support, provision of human and physical resources, referral, maternity management information system, use of appropriate technologies, and internationally recognised good practices and frame both the provision and experience of quality maternity care (Hulton et al 2007:2093). The elements of the model, based on research evidence, are presented and linked to the research findings with recommended procedures/activities for the client focused guidelines for the provision of EmOC in Ethiopia's public health facilities.

7.5.1 Description of the adapted model

The provision and experience of the care model is adapted from the current study’s findings. The client experience of care has eight elements in the adapted model. The elements of the model include client experience of human and physical resources, cognition, respect for dignity and equity, emotional support, cost of care, care coordination and integration, safety of EmOC, and availability of life saving care. Cost of care, care coordination and integration, safety of EmOC, and availability of life saving care are the additional constructs. The provision of care dimension has six elements as the initial model, which are human and physical resources, referral system, maternity information system, use of appropriate technologies, and use of internationally recognised good practices.

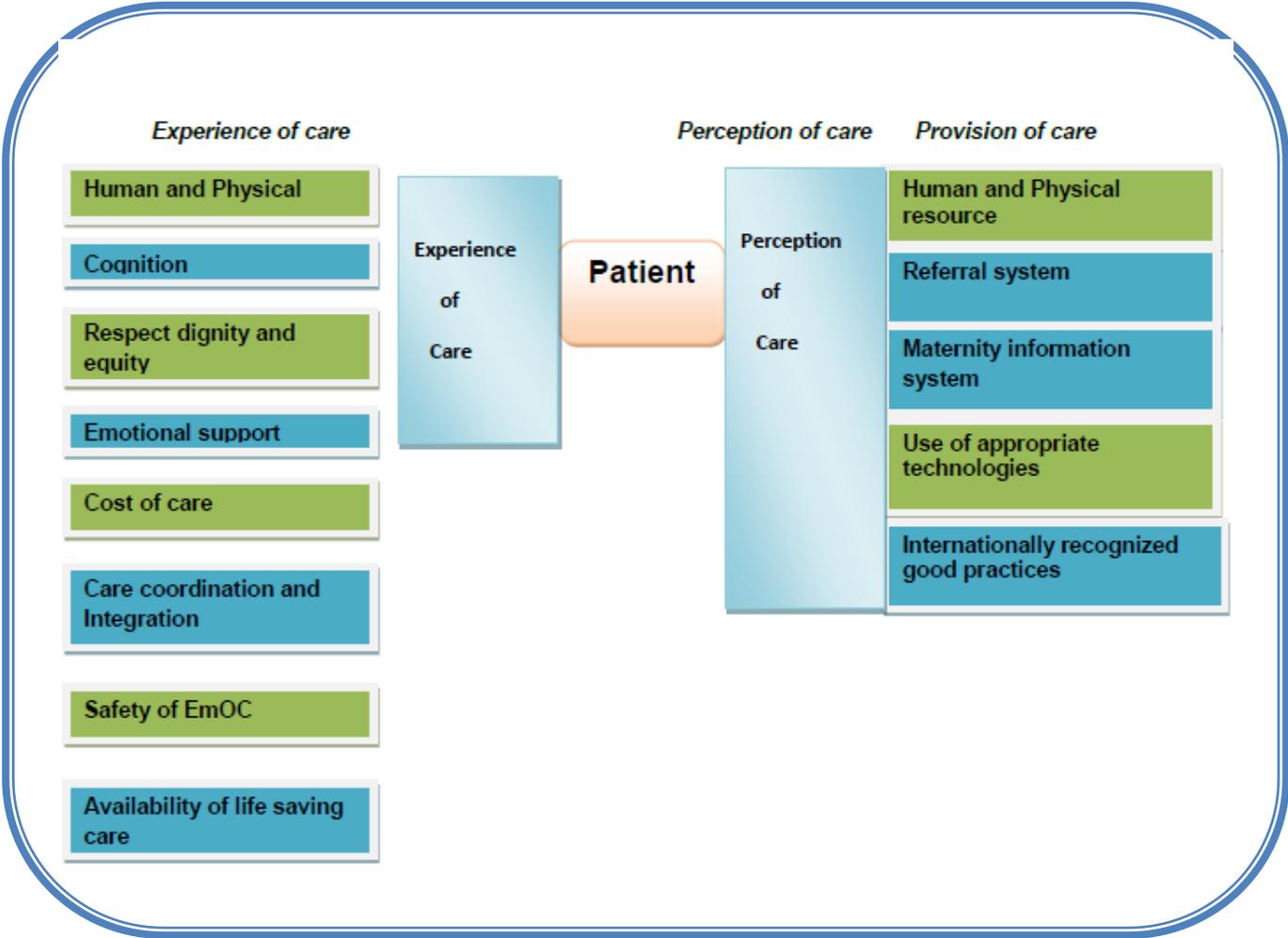


Figure 7.2 Adapted model of provision and experience of EmOC

7.5.1.1 Experience of human and physical resources

Experience of human and physical resources in the model refers to the client's impression of the state of infrastructure and actual contact time with providers (Hulton et al 2007:2087; Hulton et al 2001:39). Infrastructure also includes the availability of bed space and that of adequate number of beds to accommodate clients.

7.5.1.2 Cognition

Cognition refers to the extent to which a client feels she understands what is happening, feels that her questions have been answered adequately and receives information in a form that she understands and has the right to know (Hulton et al 2007:2088; Hulton et al 2001:340).

7.5.1.3 Respect, dignity and equity

Respect, dignity and equity refer to client provider encounters characterised by supportive relationships and avoid expressions of inherent conflict and social disparities as clients vary by status, power and culture (Hulton et al 2007:2089; Hulton et al 2001:42). Clients should receive equitable care regardless of their wealth status, relationship with the provider or place of residence.

7.5.1.4 Emotional support

Emotional support refers to support given by friends, family members and providers that can relieve stress, anxiety and pain during labour (Hulton et al 2007:2090; Hulton et al 2001:44).

7.5.1.5 Cost of care

Cost of care refers to direct and indirect costs clients incurred while seeking care. It includes transportation cost, cost of buying drugs and supplies, service charges at public health facilities and other miscellaneous costs associated with seeking care. It also includes the coping mechanisms for high cost of care.

7.5.1.6 Care coordination and integration

Care coordination refers to client perception of how providers work as a team and communicate among themselves to save the clients' lives. Integration refers to the clients' impression of care accorded to their newborns.

7.5.1.7 Safety of EmOC

Safety of EmOC refers to the client perception on how much they are prone to contracting disease from other clients while seeking childbirth care. This is related to the cleanliness of the facility and infrastructure. It therefore refers to how much all the wards and rooms the client visits are clean, availability of adequate space to accommodate clients, and availability of adequate sanitary facilities.

7.5.1.8 Availability of life saving care

Availability of life saving care refers to timely care aimed at saving the lives of clients. It refers to care that is given to the client without which the client could die.

7.5.1.9 Provision of human and physical resources

The provision of human and physical resources include availability of health and non-health workers, configuration of staff, level of supervision, management styles, population based staffing ratios, nature and frequency of staff training, general infrastructure including water, electricity, and equipment (Hulton et al 2001:19). In this study, it refers to availability of a midwife 24/7 and midwives' performance of signal functions. Midwives are selected because they can be found both in health centres and hospitals labour and delivery wards compared to other health cadres. The other reason is that the highest response in the 2008 baseline EmOC survey was from the midwives, which was 462 for midwives, 124 nurses, 71 for general practitioners, 60 health officers and 35 gynaecologists/obstetricians. The physical resources in the model include availability of obstetric beds and tables and whether the facilities have electricity and water.

7.5.1.10 Referral system

The referral system in the model asks whether there is reliable transport, communication systems, and accessibility of drugs during emergency (Hulton et al 2001:22). It also refers to availability of motor vehicle/ ambulance (and functional) and distance to nearest referral hospital for obstetric surgery/caesarean section.

7.5.1.11 Use of appropriate technologies

The use of appropriate technology includes assessment of whether effective pain relief is provided, use of caesarean section within limits or intramuscular oxytocin is not used to speed up labour (Hulton et al 2001:31). The use of appropriate technologies in the adapted model includes whether pharmacies are open 24/7, availability of antibiotics, anticonvulsants, antihypertensive and oxytocics.

7.5.1.12 Internationally recognised good practices

The use of magnesium sulphate, considering women for vaginal delivery and prophylactic antibiotics used routinely constitute internationally recognised good practices (Hulton et al 2001:32-33). Internationally recognised practices in the adapted model refers to the active management of third stage of labour (AMTSL), use of partograph to manage labour in the last 3 months of labour, provision of focused antenatal care, provision of post natal care, and facility case review or audit. Others include facility administration of parenteral antibiotics, oxytocics, and anticonvulsants; manual removal of placenta, manual removal of retained products in the last 3 months, assisted vaginal delivery and blood transfusion.

7.5.1.13 Financial access

The financial access in the adapted model considers whether formal payment is required before consultation/treatment. It considers whether clients pay fees or buy supplies for delivery, or whether payment is required before treatment in obstetric emergencies.

Table 7.1 Matrix showing best practice guidelines for provision of client focused quality EmOC in public health facilities

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|---|--|--|--|
| Guideline to address clients' requirements and expectations for the provision of EmOC | Client safety | Experience of human and physical resource | <p>Keep public health facilities clean at all times.</p> <p>Keep all areas in the client care pathways (like wards and departments) at public health facilities clean to avoid cross infection and contamination.</p> <p>Ensure the equipment is cleaned properly to prevent nosocomial infections. Equip public health facilities sufficiently.</p> <p>Apply infection control measures at all times.</p> <p>Ensure clients and providers comply with good hygienic practices.</p> <p>Ensure the availability of water at public health facilities.</p> |
| | Availability of provider to offer care including on call service | Experience of human and physical resource | <p>Staff public health facilities adequately; both by type and quantity of providers to meet the clients' needs.</p> <p>Assign physicians on call or rotational duties during odd hours like evenings and weekends to complement the skills of midwives who run shift duties.</p> <p>Avail transport mechanism for providers to arrive timely when called during odd hours.</p> |
| | Emotional support to create good | Emotional support | Encourage clients going through childbirth experience. |

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|------------------|---|--|--|
| | experience | | Allow clients to be accompanied by their care takers/close family member they would like to be with during the child delivery process. |
| | Dignity and respect that create good experience | Respect, dignity and equity | <p>Create enabling environments for providers in order to avoid stress and anxiety, which quite often is the cause of provider misconduct, by</p> <ul style="list-style-type: none"> • Ensuring proper and adequate staffing both in quantity and quality (avoid staff overload) • Ensuring a functional supply chain management system • Ensuring facilities are properly equipped. <p>Train providers on interpersonal care provision skill and stress management during critical periods.</p> <p>Ensure the availability of a code of conduct for treating clients with the necessary disciplinary measures included.</p> <p>Ensure the provision of regular supportive supervision to address staff and HR issues.</p> <p>Create accountability mechanisms for providers violating clients' dignity.</p> <p>Integrate treating clients with respect and dignity as a performance measure for providers.</p> |
| | Information and advice creating | Cognition | Record clients' data properly as clients recognise that it is a tool to monitor their health condition. |

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|------------------|---|--|---|
| | good experience | | <p>Ensure proper information exchange between providers and clients to create good experiences.</p> <p>Provide adequate information and advise clients about the care they receive.</p> <p>Allocate sufficient time for clients to discuss on their concern, convey information and get feedback.</p> <p>Ask clients questions to understand their complaints and ensure providers have understood clients' concerns.</p> <p>Encourage clients to ask about the care they are going to receive.</p> <p>Limit the length of the information and advice session and convey pertinent information once the client is stabilised.</p> |
| | Technology supported care/ use of drugs, supplies and diagnostic services | Experience of human and physical resource | <p>Avail drugs and supplies at public health facilities.</p> <p>Strengthen the supply chain management system of public health facilities.</p> <p>Use an inventory list of drugs and supplies to identify stock that is out timely.</p> <p>Introduce replacement mechanism for supplies and drugs in case of shortages. Replacement mechanism means use supplies and drugs available at the public health facility and replace when client or their care takers buy one.</p> <p>Equip public health facilities to provide diagnostic services.</p> |

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|------------------|---------------------------|--|---|
| | | | <p>Maintain equipments at public health facilities regularly.</p> <p>Strengthen the implementation of health care financing strategies in order to ensure the availability of drugs and supplies.</p> <p>Encourage private pharmacies around public health facilities to provide their service with minimum margin of profit.</p> <p>Prioritise private pharmacies near public health facilities in an effort to strengthen the private public partnerships that will avail drugs and supplies at lower prices.</p> <p>Consider the establishment of private pharmacies in the public health facility premises that can avail their services at minimum margin profit to prevent clients from over spending in cases of stock outs.</p> |
| | Physical structure aspect | Experience of human and physical resource | <p>Ensure public health facilities have the right proportion of beds in relation to room size to avoid congestion of clients.</p> <p>Expand the bed size of public health facilities to accommodate more clients and avoid congestion.</p> <p>Monitor public health facilities to ensure that they operate and function at their level.</p> <p>Equip public health facilities adequately to provide care for example, have more delivery beds.</p> |

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|---|---|--|---|
| | | | <p>Ensure regular supply of water at public health facilities in order to maintain cleanliness and ensure the practice of hygiene.</p> <p>Construct and avail sanitary facilities that commensurate with the client load. For example, construct latrines at public health facilities and ensure they are functional and kept clean.</p> |
| | Organised or coordinated care creating good experience for the client | Care coordination and Integration | <p>Provide care with attention given to both the client and their newborn.</p> <p>Create and allow greater contact between the client and their newborn.</p> <p>Ensure providers work as a team for the goal of saving clients and newborn life.</p> <p>Establish collaborative systems that have physicians on call during obstetric emergencies.</p> <p>Train providers on team approach towards solving problems during critical period.</p> |
| Guideline to prevent clients' disappointment with provision of EmOC | Female service providers to meet the expectation of clients | Experience of human and physical resource | <p>Train female providers to improve interpersonal care with their clients and in the provision of courteous care.</p> <p>Ensure female providers recognise interpersonal care as equally important as technical care.</p> <p>Raise the awareness of female providers that clients have higher expectation in the care they provide.</p> <p>Explain to female providers the need for sympathy in their care provision as</p> |

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|------------------|--------------------|--|--|
| | | | <p>clients anticipate that they share the same risk as going through childbirth experience.</p> <p>Prioritise female providers in interpersonal skill development and compassionate care provision than male providers in resource constrained settings.</p> |
| | Respect for client | Respect, dignity and equity | <p>Appreciate clients for their comments and suggestion.</p> <p>Listen to clients' feedback and comments.</p> <p>Explain to clients politely and address their concerns, suggestions and questions.</p> <p>Clarify misunderstandings if any after listening to the clients' comments and feedback.</p> <p>Respond to clients' calls in a timely manner.</p> <p>Ask clients the help they need especially when they are shouting, screaming and crying during delivery.</p> <p>Create accountability mechanism for providers that undermine clients, yell at, mock, scold or insult clients.</p> <p>Incorporate properly addressing client concern as an important part of provider performance evaluation.</p> <p>Properly staff and manage the personnel at public health facilities to prevent burnout of providers.</p> |

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|---|--|--|---|
| | | | <p>Train providers on ethical conduct, interpersonal skills and the management of stress.</p> <p>Ensure that a disciplinary mechanism is in place to avoid and prevent clients from abuse.</p> |
| | Addressing misconception in newborn care | Cognition | <p>Educate clients on newborn care while they come for antenatal care.</p> <p>Integrate newborn care in health education programs targeting pregnant women.</p> <p>Attend childbirth with the assistance of other providers to ensure clients feel that their newborns are getting appropriate care.</p> |
| Guideline to overcome barriers on the use of EmOC at public health facilities | Discrimination or stigmatisation of client at public health facilities | Respect, dignity and equity | <p>Treat clients on a first come first served principle and the level of severity of their health condition.</p> <p>Notify clients that they are served on a first come first served principle and the level of severity of their health condition by using sign boards and posters to convey the message.</p> <p>Ensure that clients from rural communities are treated as equally as those from the cities.</p> <p>Ensure that clients who are poor get equal attention and treatment as clients who are rich.</p> <p>Ensure that clients get treatment regardless of whether they have ties with the</p> |

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|------------------|---|--|---|
| | | | <p>provider or not.</p> <p>Evaluate the promptness of care by segregating the time it takes to treat poor clients from rural communities and with no tie with providers.</p> <p>Segregate and measure treatment outcome of clients, such as the case fatality rate and maternal mortality rate, by place of residence, reported ties with provider and wealth status.</p> <p>Ensure/create accountability mechanisms for providers discriminating and stigmatising clients.</p> <p>Support the establishment of a mothers' support group to ensure that clients receive timely care regardless of their status.</p> <p>Ensure interventions to improve maternal health.</p> |
| | Mitigating cost of care to improve use of EmOC | [Financial access] | <p>Consider the clients' health situations; particularly during emergency care and avoid fee for service until the client is stabilised.</p> <p>Establish formal mechanisms to treat clients with obstetric complications swiftly, without asking for fee for service.</p> <p>Establish mechanisms to waive for clients unable to pay for services at public health facilities.</p> |
| | Mitigating indirect cost- drug and supplies to improve use of | [Financial access] | <p>Train, mentor and supervise public health facility staff and those from the Ministry of Health's supply chain management.</p> <p>Improve the supply chain management system of public health facilities.</p> |

| Identified theme | Study findings | Elements of provision and experience model | Activities/strategies |
|------------------|--|--|---|
| | EmOC | | <p>Establish replacement mechanisms for supplies and drugs used by clients after emergency care.</p> <p>Ensure the availability of essential drugs and supplies in public health facilities.</p> <p>Encourage the establishment of private pharmacies on the premises of public health facilities and bargain for best prices with a minimum margin of profit.</p> <p>Avail emergency referral and transportation mechanisms for clients to prevent them from spending additional money.</p> |
| | Avoiding referral between facilities of similar capacities | Perceptions on the referral system | <p>Avoid referral of clients between facilities of similar capacity.</p> <p>Audit the causes of referral regularly to avoid unnecessary referrals.</p> <p>Establish proper communication systems between referral facilities of similar level.</p> <p>Improve the bed capacity of public health facilities to accommodate more clients.</p> <p>Accountability mechanisms for maternal death should include clients who arrived at the facility and were successfully referred to other facilities.</p> <p>Avail vehicle ambulances at reasonable cost and make them accessible for emergency referrals.</p> |

7.6 FORMULATION OF BEST PRACTICE GUIDELINES FOR THE PROVISION OF CLIENT FOCUSED QUALITY EmOC IN PUBLIC HEALTH FACILITIES

The guidelines are presented under each of themes that emerge from this study.

7.6.1 Theme 1: Guideline to address clients' requirements and expectations on the provision of EmOC

7.6.1.1 *Experience of human and physical infrastructure*

(a) To ensure clients' safety in the provision of EmOC.

- Keep public health facilities clean at all times.
- Keep all areas in the client care pathways clean to avoid cross infection and contamination.
- Ensure that the equipment is cleaned properly to prevent nosocomial infections.
- Equip public health facilities sufficiently.
- Apply infection control measures at all times.
- Ensure clients and providers comply with good hygienic practices.
- Ensure the availability of water at public health facilities.

(b) To improve the availability of providers at all times including on call service.

- Staff public health facilities adequately both by type and quantity of provider to meet the client need.
- Assign physicians on call or rotational duties during odd hours, such as evenings and weekends, to complement the skills of midwives who run shift duties.
- Avail transport mechanisms for providers to arrive timely when called during odd hours.

(c) To ensure that clients receive care supported by technology such as drugs, supplies and diagnostic services.

- Avail drugs, and supplies at public health facilities.
- Strengthen the supply chain management systems of public health facilities.
- Monitor the inventory of drugs and supplies to identify potential stock out timely.
- Introduce replacement mechanisms for supplies and drugs in case of shortages. Replacement mechanisms mean the use of available supplies and drugs in public health facilities pending replacement when clients or their care takers buy one.
- Equip public health facilities to provide appropriate diagnostic services.
- Maintain equipments at public health facilities regularly.
- Strengthen the implementation of health care financing strategies in order to ensure the availability of drugs and supplies.
- Encourage private pharmacies around public health facilities to sale drugs and supplies at minimum margins of profit.
- Consider the establishment of private pharmacies in the public health facility premises that can avail their service at minimum margin profit to prevent clients from over spending in cases of stock outs.

(d) To ensure that the care environment meets the requirement and expectations of clients.

- Ensure public health facilities have the right proportion of beds in relation to room size to avoid client congestion.
- Expand the bed capacity of public health facilities to accommodate more clients and avoid congestion.
- Monitor public health facilities to ensure they operate and function at their level.
- Equip public health facilities adequately to provide quality care.
- Ensure regular supply of water at public health facilities in order to maintain cleanliness and ensure the practice of good hygiene.
- Construct and avail sanitary facilities that are commensurate with the client load. For example, construct latrines at public health facilities and ensure they are functional and kept clean.

7.6.1.2 Emotional support

- (a) To ensure that clients get emotional support in order to create good experience of care and improve outcome of care.
- Encourage clients going through childbirth experience.
 - Allow clients to be accompanied by their care takers/close family members who they would like to be with when giving birth.

7.6.1.3 Respect, dignity and equity

- (a) To ensure that clients are respected and get care without discrimination.
- Create enabling environments for providers in order to avoid stress and anxiety.
 - Ensure proper and adequate staffing both in quantity and quality (avoid staff overload).
 - Ensure a functional supply chain management system.
 - Ensure facilities are properly equipped.
 - Train providers on interpersonal care and stress management during critical periods.
 - Ensure the availability of code of conduct for treating clients with the necessary disciplinary measures included.
 - Ensure the provision of regular supportive supervision to address staff and HR issues.
 - Create accountability mechanisms for providers violating clients' dignity.
 - Integrate treating clients with respect and dignity as a performance measure for providers.

7.6.1.4 Cognition

- (a) To ensure that clients understand what providers are saying as well as their care process.

- Record clients' data properly as clients recognise that it is a tool to monitor their health condition.
- Ensure proper information exchange between provider and clients to create good experiences.
- Provide adequate information and advise clients about the care they receive.
- Allocate sufficient time for clients to discuss their concerns, convey information and get feedback.
- Ask questions to understand clients' complaints, and ensure providers have understood clients' concerns.
- Encourage clients to ask about the care they are going to receive.
- Limit the length of the information and advice sessions and convey pertinent information once the client is stabilised.

7.6.1.5 Care coordination and integration

(a) To integrate the provision of newborn and maternal care, and create synergy of human resources.

- Provide care with attention given to both the client and their newborn.
- Create and allow greater contact between the client and their newborn.
- Ensure providers work as a team for a goal of saving of clients' and newborns' lives.
- Establish a collaborative system that has physicians on call during obstetric emergencies.
- Train providers on team approach towards solving problems during critical periods.

7.6.2 Theme 2: Guideline to prevent clients' disappointment with provision of EmOC

7.6.2.1 Experience of human and physical resources

(a) Improving care provision by female providers to meet clients' expectations.

- Train female providers to improve interpersonal care with their clients and in the provision of courteous care.
- Ensure female providers recognise interpersonal care as equally important as technical care.
- Raise the awareness of female providers that clients have higher expectations in the care they provide.
- Explain to female providers the need for sympathy in their care provision to meet clients' expectations. Train female providers in interpersonal skill development and compassionate care provision.

7.6.2.2 *Respect, dignity and equity*

(a) To ensure the rights of clients are respected.

- Appreciate clients for their comments and suggestion.
- Listen to clients' feedback and comments.
- Explain to clients politely and address their concerns, suggestions and questions.
- Clarify misunderstandings, if any, after listening to their comments and feedback.
- Respond to clients' calls in a timely manner.
- Ask clients about the help they need, especially, when they are shouting, screaming and crying during delivery.
- Create accountability mechanisms for providers that undermine clients, yell at, mock, scold or insult clients.
- Incorporate proper addressing of clients' concerns as an important part of providers' performance evaluation.
- Properly staff and manage staff at public health facilities to prevent burnout of providers.
- Train providers on ethical conduct, interpersonal skills and managing stress.
- Ensure disciplinary mechanisms are in place to address client abuses.

7.6.2.3 Cognition

- (a) To educate clients and prevent misconceptions about newborn care.
- Educate clients on newborn care during antenatal care.
 - Integrate newborn care in health education programs targeting pregnant women.
 - Attend childbirth with assistance of other providers to ensure clients feel that their newborn is getting appropriate care.

7.6.3 Theme 3: Guideline to overcome barriers on the use of EmOC at public health facilities

7.6.3.1 Respect, dignity and equity

- (a) To mitigate discrimination or stigmatisation of clients at public health facilities.
- Treat clients on a first come first served basis and/or based on the level of severity of their health condition.
 - Notify clients that they are served on a first come first served basis and/or based on the level of severity of their health condition. Ensure that clients from rural communities are treated as equally as those from the cities.
 - Ensure that clients who are poor get equal attention and treatment as clients who are rich.
 - Ensure that clients get treatment regardless of any ties they may have with the providers.
 - Evaluate the timeliness of care and disaggregate results by socio-economic status of clients. Measure treatment outcomes of clients, for example, case fatality rate and maternal mortality rate, disaggregated by place of residence, reported ties with providers and socio-economic status.
 - Guidelines should be developed to ensure equal treatment for all clients.
 - Ensure accountability mechanisms for providers discriminating against and stigmatising clients.

- Support the establishment of mothers support groups to ensure that clients receive timely care regardless of their status.
- Ensure interventions to improve maternal health, especially for women from the rural, poor and underprivileged communities.

7.6.3.2 Financial access to care

(a) To improve clients' access to care by overcoming fee for service.

- Consider the clients' health situation particularly during emergency care and avoid fees for service until the client is stabilised.
- Establish formal mechanisms to treat clients with obstetric complications swiftly without fees for service.
- Establish mechanisms to waive fees for clients who are unable to pay for service at public health facilities.

(b) To improve clients' access to care by overcoming indirect costs such as buying drugs and supplies, transportation costs, etc.

- Train, mentor and supervise public health facility staff and those from the Ministry of Health's supply chain management.
- Improve the supply chain management systems of public health facilities.
- Establish replacement mechanism for supplies and drugs used by clients after emergency care.
- Ensure the availability of essential drugs and supplies in public health facilities.
- Encourage the establishment of private pharmacies in the premises of public health facilities and bargain for best prices with minimum margin of profit.
- Avail emergency referral and transportation mechanisms for clients to prevent them from spending additional money.

7.6.3.3 Referral system

- (a) To prevent referrals between facilities of similar capacity in order to prevent delays in receiving care.
- Avoid referral of clients between facilities of similar capacity.
 - Audit causes of referrals regularly to avoid unnecessary ones.
 - Establish proper communication systems between referral facilities of similar level.
 - Improve the bed capacity of public health facilities to accommodate more clients.
 - Accountability mechanisms for maternal deaths should include clients who arrive at the facility and were successfully referred to other facilities.
 - Avail vehicle ambulances at reasonable cost and accessible for emergency referral.

7.7 EVALUTAION OF THE GUIDELINES

The guidelines for client focused EmOC provision was evaluated for clarity, simplicity, generality, rational structure and operational adequacy. This was done in accordance with Chinn and Kramer (2008:237) evaluative criteria that are described below.

7.7.1 Clarity of the guidelines

The guidelines were validated for clarity and ensured that the theoretical meaning of concepts, connection between the conceptual framework and provision and experience of care model were clear, precise and concise.

7.7.2 Simplicity and operational adequacy of the guidelines

The guidelines were simple and operationally adequate in the provision of client focused EmOC as it appears in the summary matrix or table, followed by descriptions in simple and clear language.

7.7.3 Generality of the guidelines

Generality is the scope and purpose of the guideline (Moleki 2008:177; Chinn & Kramer 2008:237). The purpose of the guidelines was to promote quality EmOC provision that meets the needs and expectations of clients; facilitate the provision of EmOC to create good experiences for the clients and encourage clients to seek timely care. The guidelines will assist facility managers and providers to offer care that is consistent with the current professional practice and time as well as acceptable to the client.

7.8 IMPLEMENTATION OF THE GUIDELINES

This serves as the third objective of the study, which is to formulate recommendations for the implementation of the guidelines for EmOC provision at Ethiopian public health facilities.

7.8.1 Preambles/Qualifying statements

Clients with obstetric complications are not a homogenous group and have a wide range of needs, expectations and preferences. The researcher presumed that there will be valid exceptions to the approaches and recommendations provided within the guidelines.

7.8.2 Guidelines implementation

The researcher envisages that the family health department of the federal ministry of health of Ethiopia in partnership with Kissito Healthcare International (KHI) will promote the adoption of the guidelines. A review meeting will be conducted with relevant stakeholders to adopt and adapt the implementation of the guidelines in public health facilities. Once the guideline is reviewed, adapted and adopted by the Federal Ministry of Health, it will be integrated with training packages on Emergency Obstetric Care.

In a separate project, the researcher will work with the organisation, Averting Maternal Death and Disability (AMDD), to develop questionnaires and integrate them into the guide for health facility assessment of emergency obstetric and newborn care provision.

7.8.3 Guideline dissemination plan

The guidelines will be made accessible to all stakeholders in health, especially those in maternal health. This will include women of reproductive age group, policy makers, obstetric departments of public health facilities and health facility managers/directors. It will be accessible from UNISA libraries and publications in accredited journals. Research papers on the guidelines will be published in peer reviewed scientific journals and will be presented at national and international conferences.

7.9 CONCLUSION

This chapter described the development of guidelines for the provision of client focused quality emergency obstetric care in public health facilities. The guidelines were developed to promote quality EmOC provision that meets the needs and expectations of clients; facilitate the provision of EmOC to create good experiences for the clients and influence clients to seek timely care. The guidelines will help facility managers and providers to provide care consistent with the current professional practice and provide care that is acceptable to the client.

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ANNEXURE A

Letter granting permission to conduct the study



በአዲስ አበባ ከተማ አስተዳደር
የጤና ቢሮ
CITY GOVERNMENT OF ADDIS ABABA
HEALTH BUREAU

ቁጥር 2/2/ጠ/1324/227
Ref. No.
ቀን 10/1/05
Date.

ለየካቲት 12 ጤና ሣይንስ ኮሌጅ
ለዘውዲቱ ሆስፒታል
ለጋንዲ መታሰቢያ ሆስፒታል
አዲስ አበባ

በUniversity of South Africa (UNISA) የ PhD ተማሪ የሆኑት አቶ አንተነህ ዘውዴ Quality of Emergency Obstetric Care in Ethiopia በሚል ርዕስ በክልላችን በሚገኙ ጋንዲ መታሰቢያ ሆስፒታል ዘውዲቱ እና የካቲት 12 ጤና ሣይንስ ኮሌጅ ላይ ጥናታቸውን ለመስራት እንዲችሉ የትብብር ደብዳቤ እንዲጻፉላቸው ጠይቀውናል።

በመሆኑም ይህንኑ ጥናታቸውን ለመስራት እንዲችሉ ትብብር እንዲደረግላቸው እንጠይቃለን።

ከሰላም ጋር



የጤና ሥራ ስራ/የጤና ሥራ ስራ (ዶ/ር)
የሕክምና አገልግሎት አሰጣጥ
/የቢሮ ኃላፊ

ግልባጭ
ለሣይንስና ቴክኖሎጂ ሚኒስቴር
አዲስ አበባ
ለአቶ አንተነህ ዘውዴ
ባሉበት

ANNEXURE B

**Translation of letter granting permission to
conduct the study**

CITY GOVERNMENT OF ADDIS ABABA HEALTH BUREAU

To: Yekatit 12 Hospital

Zewditu Hospital

Gandhi memorial Hospital

Addis Ababa

Anteneh Zewdie, a PhD student at university of South Africa (UNISA), has requested permission to conduct study on quality of emergency obstetric care in Ethiopia in the hospitals located in the city government. To this end, he has asked to write a letter of support to Ghandi memorial hospital, Zewditu Hospital and Yekatit 12 hospital to conduct their study. I hereby request your support for him to conduct the study.

With regards,

Dr Mengistu Bekele

Vice Health Bureau Head & Head of Health Service Delivery

ANNEXURE C

**Letter of support from UNISA regional learning
center to conduct the study**

September 17, 2012

UNISA-ET/KA/ST/29/17-09-2012

Ministry of Health
Addis Ababa

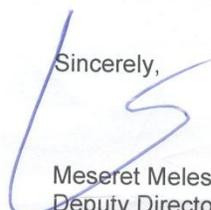
Dear Sir/Madam:

Mr. Anteneh Zewdie Helelo is a student in Doctor of Literature and Philosophy in Health Studies program at University of South Africa (UNISA). He is currently conducting research to write his doctoral thesis. His research topic is:

"Quality of Emergency Obstetric Care in Ethiopia"

The student needs to start collecting data for his research. I kindly request your cooperation in assisting him in facilitating his research and giving him access to data sources. I would like to thank you in advance for your assistance.

Sincerely,


Meseret Melese Tefera
Deputy Director

| | |
|-----------------------------------|-----------------|
| UNISA REGIONAL LEARNING CENTRE | |
| PO BOX 13836 ADDIS ABABA ETHIOPIA | |
| TEL | +251-114-350141 |
| | +251-114-350078 |
| FAX | +251-114-331243 |
| MOBILE | +251-912-191483 |



ANNEXURE D

**Ethical clearance certificate from the Department
of Health Studies, UNISA**

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences

CLEARANCE CERTIFICATE

Date of meeting: **17 May 2010** Project No: **47347805**

Project Title: Quality of health services in Gambela and Benishangul-Gumuz regions of Ethiopia

Researcher: **AZ Helelo**

Supervisor/Promoter: **Prof LI Zungu**

Joint Supervisor/Joint Promoter: **Prof M Ganga-Limando**

Department: **Health Studies**

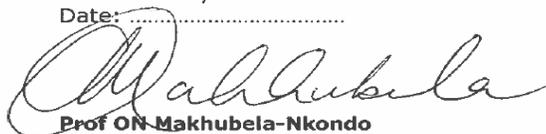
Degree: **D Litt et Phil**

DECISION OF COMMITTEE

Approved

Conditionally Approved

Date: **17 May 2010**



Prof ON Makhubela-Nkondo
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES



Prof MC Bezuidenhout
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES



ANNEXURE E

Consent letter for participants

Written Informed Consent Form

Good morning/Good afternoon,

We are conducting study on quality of emergency obstetric care in the hospital. The purpose of the study is to contribute to improvement in quality of emergency obstetric care provision in the country by understanding your perspective in the provision of EmONC.

I would like to request that you participate in a Key informant interview which will take 30 minute to 1 hour. I will be asking you questions about your experiences and views regarding quality of EmONC received in this health facility. The information you provide will be used only for the research purpose and handled confidentially. I would like also to ask for your consent to audio record this interview/FGD. The purpose of the audio record is to ensure I have complete documentation of the interview/discussion and to assist me in my analysis and write up. Your participation is completely voluntary. If you do not wish to participate, you may individually or collectively stop the FGD at any time. Your refusal to participate, to answer some questions or to withdraw during the course of the FGD will not involve any penalty, affect your ability to receiving treatment in the health facility or affect you in any other way. You are expected to speak freely to the issues I'll be bringing forward, except you do not wish to speak to any particular issue. Your responses are completely anonymous, I will not record your name in any of my transcripts or notes and your name will not appear anywhere in the final write up. The original responses that I gather from the interview will only be available to me.

Your participation in this research will not cost you anything. The benefit of the research is to enhance the knowledge base in improving the quality EmONC provision that take in to consideration your perspective. All information collected in this study will be analysed and no name will be recorded. No part of the final report can be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study. Your participation in this research is entirely voluntary. If you choose not to participate, this will not affect your treatment in this hospital in any way.

If you have any question about your participation in this research, you can contact the researcher (Anteneh Zewdie Helelo 0911198211).

Statement of person obtaining informed consent:

I _____ have fully explained this research to the participant and have given sufficient information, including about risks and benefits, to enable the participants make an informed decision.

DATE: _____ SIGNATURE: _____

NAME: _____

ANNEXURE F

**Picture of consent letter for participants in
Amharic signed by the data collector**

9

የፈቃደኝነት ማገልጫ ደርጎ

ጤና ያሰጥልኝ

በሆስፒታል ስለግሪፎው ደንብኛ የወላይ እንክብካቤ እየጠናኘ ነው። የጥናቱ ዓላማ በህይወት እየተሰከ ያለውን ደንብኛ የወላይ እንክብካቤ ጥራት ለማሻሻል የለው ትኩረት ከሰጥቶት ለመውጣት በስም የተገለጠን ለመሰብከት በጥራት ግንባራ ሂደት ለማስተካከል እንዲያስችል የታለመ ነው።

እርሶም በዚህ ዘመን ስንት በላይ በማግኘት ታላ ማጠቃለያ ወይም ወይም ወይም እንዲሁ ባለቤቱን አጠቃቀም። በሆስፒታል ስለግሪፎው ደንብኛ የወላይ እንክብካቤ ያልጠናኘ ልምድ እንዲያሻሽልን ያልቻልን ለመሰብከት እንዲገልጹ የተለያዩ ጥያቄዎችን አጠቃቀምታለሁ። እርሶም የግሪፎውን መረጃ ለጥናቱ እንዲያስተካክሉ ብቻ የግሪፎው ደህና። ግሪፎውንም ይጠቃልሉ። በተጨማሪም ታላ ማጠቃለያ ወይም ወይም በመታረግ ደምጽ መቀነስ እንዲረታደስኝ አጠቃቀም። ይህም የሰፈረክበት የጠቃሚ የሆነው ዓይነት ለጥናቱ የግሪፎ መረጃ እንዲያመልጠኝ ለጥናቱ ትንተና እንዲያገለግልኝ ነው።

የርሶም ተሳትፎ መሰሉ ለመሰሉ በፈቃደኝነት ላይ የተመሰረተ ነው። በጥናቱ መሳተፍ ባይፈልጉ በማንኛውም ሰዓት ግንባራ ይችላሉ። ጥናቱን ግንባራ ከመወሰንም በፊት የሰውነት መረጃ በጥናቱ ውስጥ ይካተታል። ለመሳተፍ ፈቃደኛ ለመሆን በማንኛውም መልኩ ከሆስፒታሉ የግሪፎውን እንዲያስተካክሉ ሊቀንስ ለሚችሉ ወይም ደገም መሳተፍ ባለመፈለግም ሆነም ዓይነት ትኩረት እያሰከትልብዎትኝ።

በማንኛውም ግንኛውም ሰዓት ላይ በገደብ መኖር ይኖርብዎታል። የግሪፎውን ሰዓት የርሶም መሳተፍ ላይ ሰው እያውቅም። የርሶም ስም በማንኛውም ማስታወሻ በጥናቱ ውስጥ ላይ አይገለጽም። የግሪፎውን መረጃዎች በጥናቱ የመረጃ ትንተና ውስጥ ያልተሰጡ።

ለሌላ ተጨማሪ መረጃ ከፈለጉ የጥናቱን መሪ በስልክ ቁጥር 091198211 ደውለው ማገልግሎት ይችላሉ።

የርሶምን የጥላው ስው ስም

እኔ ጠቃሚ ስለጥናቱ መሰሉ መረጃ የሰጠሁ መሆኔን ለውሳኔም እንዲረዳኝ ወይም በቀ መረጃ ጥቅም ሆኖ ጥናቱን ያስረዳሁ መሆኔን እንዲያሳዩኝ

ስም ጠቃሚ ቁጥር 12/02/2005
በቀ ጠቃሚ ስም ጠቃሚ

ANNEXURE G

Key informant interview questionnaire in Amharic

የወሊድ ክብካቤ

1. ጥራቱን የጠበቀ የወሊድ ክብካቤ ምንድነው?
2. ጥራቱን የጠበቀ የወሊድ ክትትል ምን ምን ያካትታል?

-ውጤታማ /ሊገኝ የሚችል (ጊዜ /ቦታ) ተቀባይነት ያለው አድሎአዊ ያልሆነ አደጋ የማያስከትል

3. የሆስፒታሉን የወሊድ አገልግሎት ጥራት እንዴት ይመለከቱታል?

-በራሳቸው ትርጉም እንዲያብራሩ እርዳታ አቸው

4. የሆስፒታሉን የወሊድ አገልግሎት ጥራት እንዴት መሻሻል አለበት ይላሉ?
5. ሆስፒታሉ ውስጥ የሚሰሩ የጤና ባለሙያዎች/ሰራተኞች/ እንዴት ነው የሚያስተናግዱላቸው?
6. የሆስፒታሉ ጤና ባለሙያዎች አመለካከት እንዴት ነው?

-የመረጃ ልውውጡ ምን ይመስላል?

መረጃው በቂ ነው በሚገባችሁና ሊረዱት በሚችሉበት መንገድ ነው ጥያቄዎቻችሁን በአግባቡ ይመልሱሉ ሀሳባችሁን ለመግለጽ እድል ይሰጣችሁል አክብሮት ባለው መንገድ

7. በሆስፒታሉ ያጋጠምዎት ችግር ምንድነው?
8. በዚህ ሆስፒታል ውስጥ አገልግሎቱን ለማሻሻል ምን አይነት ለውጥ ቢደርግ ብለው ይመክራሉ
9. በዚህ ሆስፒታል ለመውለድ ለምን መረጡ?
10. ሌሎች ታካሚዎች/ደንበኞች በሆስፒታሉ የሚሰጠውን የወሊድ አገልግሎት እንዴት ይመለከቱታል?

(ያዩታል)?

11. የቅድመ-ወሊድ ክትትልና የወሊድ ክትትል አገልግሎት ጥራት እንዴት ያንጸጽሩታል?

-የትኛውን አገልግሎት ይመርጡታል ?ለምን ?

12. በሆስፒታሉ ስለገጠሞት አዎንታዊ ወይም አሉታዊ ልምድ ቢያካፍሉ?

ANNEXURE H

Key informant interview questionnaire in English

Key Informant Interview Questionnaire

1. How do you define quality Emergency obstetric care?
2. What constitute quality emergency obstetric care? [Probe and see if it includes the following]
 - effectiveness, efficiency, accessible, acceptable, equity and safety
3. How is the quality of obstetric care (emergency) in the facility?
 - Probe to help them define using their own definition
4. What are the quality gaps you have observed in the hospital? [between your expectations and available services in the hospital]?
5. How can the quality of EmOC provision in the hospital be improved?
6. How did health workers/staffs treat you?
 - a. How was the attitude of staff?
 - b. How was the information exchange?[probe and see if it
 - Was Sufficient? Understandable? Addressed their question? Were able to express their views/opinions? With respect?
7. What are the challenges you faced in the hospital?
8. What are your recommendations for improving quality of care?
9. Why did you prefer to deliver in the facility?
10. How do other clients perceive the quality of obstetric care?
11. How do you compare the quality of antenatal care and delivery care?
12. Can you share with us your experience in the facility?

ANNEXURE I

Demographic intake sheet

Demographic intake sheet: *This form should be filled before the key informant interview*

Code of participant:

1. Age_____
2. Income_____
3. Education level_____
4. Parity____
5. Gravidity _____
6. History of complication? (Yes, No)
(eclampsia, preeclampsia, APH,PPH, obstructed labour,)
7. History of stillbirth? (Yes, No)
8. Outcome of the last delivery? (live birth, still birth, neonate died after delivery) Place of delivery_____
9. History of spontaneous abortion? (Yes, No)
10. Attended antenatal care? (Yes, No) if yes, number of visit____
11. Antenatal care attended in the facility that referred? (Yes, No)
12. Referred from other hospital? (Yes, No)

Name of interviewer:_____ Date and place of interview:_____

ANNEXURE J

**Picture of filled demographic intake sheet in
Amharic**

