ENHANCING UTILIZATION OF HEALTH FACILITY-BASED DELIVERY AMONG ATTENDEES OF FOCUSED ANTENATAL CARE IN ADDIS ABABA, ETHIOPIA

by

ENDALEW GEMECHU SENDO

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

SUPERVISOR: Dr M E Chauke

CO- SUPERVISOR: Prof M Ganga-Limando

FEBRUARY 2019

DEDICATION

This research thesis is dedicated to my wife Sr. Wegnesh Kelbessa and my children: Amanuel, Rahel and Segni.

Student number: 57657750

DECLARATION

I hereby declare that this research thesis on **ENHANCING UTILIZATION OF HEALTH FACILITY-BASED DELIVERY AMONG ATTENDEES OF FOCUSED ANTENATAL CARE IN ADDIS ABABA, ETHIOPIA** is my own work and all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree in any other Institutions.

Endalew Gemechu Sendo Date: February 2019

ACKNOWLEDGMENTS

First of all, I thank the almighty God for giving me strength, patience and guidance throughout this study period. I want to thank you my dear Father for reminding me that I should be still and know that you are supreme God who keep your promise for me.

I am indebted to Dr. M E Chauke for her tremendous support and unrelenting guidance from inception to the completion of the research project. Indeed, you have made an enormous impact on my academic journey and shared your expertise with me. I am truly thankful for your efforts and self-sacrificing inputs towards this research project.

I am also grateful to my co - supervisor, Prof M Ganga-Limando for his unique approach, encouragement and guidance. I appreciate your efforts and selfless involvement towards this project.

It is with great pleasure that I acknowledge Dr. Eshetu Girma from School of Public Health, Addis Ababa University, for he introduced me to techniques of data analysis and took time to go through all the steps involved in the qualitative data analysis and for his encouragement during such hard times. Thank you very much!

My family has been immensely concerned for me. My whole-hearted thanks go especially to my wife Sr. Wegnesh Kelbessa who held the fortress and accomplished the duties of both a father and mother during the whole periods of being on the study leave. My sincere thanks go also to my three Children (Amanuel, Rahel and Segni), who were all the time with me and devoted their time to always supporting and encouraging me and their enthusiasm to see my PhD studies completed timely.

Finally, I am indebted to Addis Ababa City Health Bureau for providing me permission to conduct the study in public health facilities. My appreciation also goes to the women who took part in the study and shared their experiences. My understanding was deepened through them.

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STUDENT NUMBER: 57657750

NAME OF STUDENT: ENDALEW GEMECHU SENDO DEGREE

DEGREE: DOCTOR OF LITERATURE AND PHILOSOPHY

DEPARTMENT: HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR ME CHAUKE

CO- SUPERVISOR: PROF M GANGA-LIMANDO

ABSTRACT

The purpose of this study was to propose women-centered guidelines to enhance the utilization of health facility-based delivery among attendees of FANC in Addis Ababa, Ethiopia. A qualitative exploratory and descriptive research design was used to achieve the aims and objectives of the study. The design was contextual in nature.The study was conducted in three phases, using purposively selected attendees of FANC who participated in individual and focus group interviews in phases I and II respectively. Data were analyzed by means of thematic analysis. In phase III of the study, the findings of the first two phases and literature were used as the basis for the development of guidelines to enhance the utilization of health facility-based delivery services among attendees of FANC in Addis Ababa, Ethiopia.

From the analysis of individual interview data, four (4) themes emerged, namely, perceived benefits of home delivery, knowledge deficit about health facility-based delivery, poor access to health care facilities and inadequate resources. These themes were identified as rich and detailed account of the perspectives of facility-based and home delivery among attendees of FANC in Addis Ababa, Ethiopia. Two (2) themes emerged from the analysis of focus group interviews data, namely provision of quality, respectful and dignified midwifery care and increased awareness of FANC. These themes were identified as the rich and detailed account of the views of, and recommendations made by attendees of FANC on measures needed to enhance the development of women-centred guidelines to enhance the utilization of health facility-based delivery services. The recommended

measures addressed the negative perceptions of health facility-based delivery among attendees of FANC, with the aim of decreasing home deliveries and increasing the number of institutional deliveries.

The study recommends that the Ministry of Health, Addis Ababa Health Bureau and the health facilities use the proposed guidelines to enhance the utilization of health facility-based delivery.

Key words: Women, Utilization, Health facility-based delivery, focused antenatal care.

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LIST OF ABBREVIATIONS

ANC Ante-natal Care

CSA Central Statistics Agency

DHS Demographic Health Survey

EDHS Ethiopian Demographic Health Survey

FDRE Federal Democratic Republic of Ethiopian

FANC Focused Ante-natal Care

FBD Facility Based Delivery

FGD Focus Group Discussion

FMoH Federal Ministry of Health

LMICs Low and Middle Income countries

MMR Maternal mortality rate

MoH Ministry of Health

PMTCT Prevention of Mother to Child transmission

SDG Sustainable Development Goal

SSA Sub-Saharan Africa

WHO World Health Organisation

UNICEF United Nations Children's Fund

UN United Nations

USAID United States Agency for International Development

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1. INTRODUCTION

In this chapter, the orientation to the study is presented, highlighting the problem statement, purpose of the study, research objectives and questions as well as the significance of the study. In addition, the theoretical foundations and a brief introduction of the study methodology as well as the scope of the study are included. The last section of the chapter includes the conclusion and the outline of the structure of the thesis.

1.2. BACKGROUND INFORMATION

Maternal mortality related to pregnancy and childbirth remains a global public health problem even though it has declined from by 44% from 385 deaths per 100 000 in 1990 to 216 per 100 000 live births in 2015 (WHO, UNICEF, UN Population fund & World bank 2015). Alkema, Chou, Hagan, Zhang, Moller, Gemmill, Ma Fat, Boerma, Temmerman, Mathers and Say (2016: 462) estimate that 3.9 million women will die from maternal causes in the next fifteen year if the current reduction rate of 2.9% in maternal mortality rates (MMR) continues. The implication is that, there is an urgent need to accelerate the drop in MMR in order to achieve the sustainable development goal (SDG) 3.1 of reducing the global maternal mortality ratio to less than 70 per 100 000 live births by the year 2030, with no country having a maternal mortality rate of more than twice the global average (WHO 2016).

Sub Saharan Africa (SSA) contributes two thirds of the world's annual maternal deaths despite the remarkable decline in the global maternal mortality. Regional MMR for 2015 ranged from 12 deaths per 100 000 livebirths for developed regions to 546 deaths per 100 000 for sub-Saharan Africa (Alkema et al 2016:462). The lifetime risk of maternal mortality is estimated at 1 in 4,900 in developed countries while the risk is 1 in 36 for a woman living in Sub Saharan Africa (Alkema et al 2016: 462; Tafere, Afework, & Yalew, 2018: 2); making the lifetime risk of maternal mortality in SSA over 47 times greater than that of a woman living in the United States of America (UNICEF 2013; USAID 2014). Like many developing

countries, the MMR remains high in Ethiopia even though, according to the Federal Ministry of Health (FMoH), the maternal mortality rate dropped significantly by over 30% in five years. The 2016 Ethiopian Demographic Health Survey (EDHS) report indicates that more than 1400 mothers per 100,000 live births died in 1990, and the mortality rate dropped to 412 per 100,000 live births in 2016. The decline was attributed to the government's interventions and commitment through expanding emergency obstetric care services during labour with skilled birth attendants helping mothers in thousands of health facilities across the country. In addition, enhanced knowledge of mothers in antenatal and postnatal care provided by tens of thousands of health extension workers and other community interventions mainly in rural parts of the country contributed to the reduction of maternal mortality in the country (EDHS 2016). However, as many as 10 000 mothers still die every year in Ethiopia due to childbirth-related complications, the major ones being hemorrhage, hypertension and infection (EDHS 2016). According to Ethiopia's FMoH (2010:10), a 75% reduction in the maternal mortality rate was planned for 2015, but the country managed to achieve 72%. The government of the Federal Democratic Republic of Ethiopia (FDRE) aims to reduce the maternal mortality to 199 per 100,000 live births in 2020 and 70 or less by 2030 in line with the target set by the World Health Organization (WHO). The target set by WHO is achievable because most of maternal deaths are preventable if access to ANC in pregnancy, skilled care during delivery and care and support in the weeks after childbirth were increased (EDHS 2016).

Maternal and newborn health are priorities for the government of Ethiopia (FDRE 2015). Among the established measures to decrease maternal mortality is antenatal care (ANC). In 2010, the management protocol on selected obstetric topics was developed, with the aim of guiding health care practitioners providing obstetric, medical and surgical services for pregnant women in the country. In this guideline, focused antenatal care (FANC) was identified as one of the pillars of safe motherhood. Focused ANC is a model of antenatal care provided over four visits at specified intervals, at least for healthy women with no underlying medical problems (Baffour-Awuah, Mwini-Nyaledzigbour & Richter 2015:60). In this model, pregnant women are classified into two categories, namely those who can follow basic care and those women with special health conditions and/or are at risk of

developing problems that require special care (FMoH 2010:10). Focused ANC emphasizes the quality of care rather than the quantity. The major goal FANC is to help women maintain normal pregnancies through health promotion and disease prevention, early detection and treatment of complications and existing diseases and birth preparedness and complication readiness planning (Finlayson 2013:2; FMoH 2010:10).

One of the key and proven interventions to reduce maternal mortality related to childbirth is to increase the number of women who deliver in a health facility (Annette, Wung, Ivo, Atanga, Fon & Atashili 2016; Baffour-Awuah et al 2015; Bellows, Kyobutungi, Mutua, Warren & Ezeh 2012; Miltenburg, van der Eem, Nyanza, van Pelt, Ndaki, Basinda & Sundby 2017). Facility-based delivery increases skilled attendance at birth by ensuring proper management of childbirth complications and or timely referral of delivering women to higher levels of care where childbirth complications can be better managed (Baffour-Awuah et al 2015). Annette et al (2016) state that maternal mortality reduces by 52% worldwide when women deliver in health facilities. According to Kebede, Hassen and Teklehaymanot (2016), in almost all countries where more than 80% of deliveries are attended by health care professionals, the maternal mortality rate is less than 200 per 100 000 live births.

According to the standard guidelines for ANC in Ethiopia, every pregnant woman should receive ANC from a skilled provider, including a comprehensive physical examination, blood tests for infection screening and anaemia, a urine test, tetanus toxoid injections, iron and folate supplements, as well as deworming medications (Central Statistics Agency [CSA] 2016:169; FMoH 2010:10). The 2016 Ethiopian Demographic Health Survey (2016) reports that 62% of women who had a live birth in the 5 years before the survey obtained ANC from a skilled provider at least once. Thirty two percent of women had at least four ANC visits during their last pregnancy as recommended by WHO and 37% of women in Ethiopia had no ANC visits. According to CSA (2016:168), rural women are more likely to have had no ANC visits than urban women are (41% and 10%, respectively). Only 20% of women had their first ANC during the first trimester, 26% during their fourth to fifth month of pregnancy, and 14% during their sixth to seventh month of pregnancy. Two (2%) of women did not receive any ANC until the eight month of pregnancy or later (CSA 2016: 168).

1.3. STATEMENT OF THE RESEARCH PROBLEM

Research shows that FANC is an important intervention to increase the utilisation of skilled delivery care during a health facility-based delivery. In addition, research shows that women who have had at least one registered ANC visit are five times more likely to utilise health facility-based delivery service than those who did not visit ANC during pregnancy. Globally 80% of live births occurred with the assistance of skilled health professionals for the period 2012-2017 while, the percentage of deliveries attended to by skilled health personnel in Sub Sahara was 77% for the same period (Bako, Ukpabi & Egwuda, 2017; UN, 2015; WHO 2017). According to CSA (2016:249), the proportion of Ethiopian women who received ANC from a skilled provider increased from 33% in 2011 to 62% in 2016, home deliveries declined from 90% in 2011 to 73% in 2016, whilst institutional deliveries increased from 10% in 2011 to 28% in 2016. However, the decline in unskilled or home deliveries and the increase in institutional deliveries were not substantial.

The low utilization of health facility-based delivery services seem to be reason for the slow rate at which MMR dropped during the five year period 2011-2016. There is therefore a need to accelerate the decrease in unskilled home deliveries and the increase in health care facility-based deliveries if the sustainable development goal 3.1 is to be achieved (WHO 2016:2).The gap between the attendance of FANC of more than 62% and the low health care facility based deliveries (1 in four women) among women in Ethiopia motivated the researcher to conduct a study on this topic with a specific focus on developing guidelines (from the women's perspective) for increasing use of facility-based delivery services among attendees of FANC.

1.4. STUDY PURPOSE

The purpose of this study was to propose women-centered practice guidelines to enhance the utilization of health facility-based delivery among attendees of FANC in Addis Ababa, Ethiopia.

1.4.1. Research Objectives

In order to achieve the purpose of this study, the following objectives were formulated, namely to

- Explore and describe the perspective of health facility-based delivery among attendees of FANC
- Explore and describe the perspective of home delivery among attendees of FANC
- Describe the views of attendees of FANC on measures needed to enhance the utilization of health facility-based delivery services
- Propose the practice guidelines to enhance the utilization of health facility-based delivery among attendees of FANC in Addis Ababa, Ethiopia.

1.5. SIGNIFICANCE OF THE STUDY

Study significance is an important factor in research and must contribute meaningfully to the body of knowledge, practice and research (Polit & Beck 2012:77). Population based surveys have adequately captured important information regarding the proportion of births occurring in health facilities but they were unable to capture explanations for women's health practices and preferences regarding the location of delivery. Qualitative research was conducted to complement population-based surveys to obtain understanding of how women perceive, interpret and consider a number of factors affecting their choice of the location of delivery (home delivery in this study).

The findings of this study added to the existing body of knowledge on the perspective of facility-based delivery services among attendees of focused antenatal care at selected public health facilities in Addis Ababa, Ethiopia. Understanding the women's perspectives on facility-based and home delivery is important and helpful in guiding health care practitioners design women-centered guidelines that address negative perceptions of health facility-based delivery, so that the number of home deliveries could decrease and the number of institutional deliveries among attendees of FANC could increase. The proposed guidelines for enhancing the utilization of health facility-based delivery have the

potential to increase the proportion of women who deliver in a health facility, as well as making repeated visits to public health facilities with future childbirths. Consequently, the majority of direct obstetric complications, which are the leading causes of maternal deaths, would be better managed, ensuring a substantial reduction of maternal mortality and morbidity in Ethiopia.

1.6. DEFINITIONS OF TERMS

Attendees: According to the American Heritage dictionary (2011), an attendee is one who is present at or attends a function or a specific event. For the purpose of this study, attendees of FANC refer to women who received FANC at selected public health facilities in Addis Ababa, Ethiopia.

Antenatal care: Antenatal care (ANC) is the care that a woman receives during pregnancy, aimed at ensuring a healthy pregnancy state that would result in the delivery of a healthy baby without impairing the mother's health. It provides a key entry point for a broad range of health promotion and preventive health services (USAID 2007:1).

Enhancing: According to the Oxford Advanced Learner's Dictionary (2010:112), to enhance is to increase the intensity of something, to strengthen, to improve or to escalate. For the purpose of the study enhancing means to increase and to intensify the utilization of health facility based delivery among women who attended FANC at the selected public health facilities in Addis Ababa, Ethiopia. It also means to increase the number of births delivered at health facilities in Addis Ababa, Ethiopia.

Focused antenatal care: a four-visit model of preventive health care targeted at primary, secondary and tertiary prevention of diseases and pathological conditions during pregnancy and delivery. It is evidence-based, and an intervention focusing on individual women's needs and concerns, and what is appropriate for the gestational period at that time of pregnancy (Baffour-Awuah, Mwini-Nyaledzigbour & Richter 2015:60).

Guideline: The Oxford Advanced Learner's Dictionary (2010:691) describes a guideline as rules or instructions that are set by an authorized organization specifying how to perform

something. In this study, a guideline refers to a set of recommended women- centered practice rules or directives that Ethiopian public health facilities can implement to enhance the utilization of health facility based delivery services at selected health facilities in Addis Ababa, Ethiopia.

Health facility-based delivery: a birth attended at a health facility of any public health institution (health center, hospital or private clinic) by a skilled birth attendant such as a midwife, doctor or nurse (Kebede, et al 2016:466).

Perspective: a particular attitude towards something, way of thinking about something or a point of view (Oxford Advanced Learner's dictionary 2010:1132). In the present study, perspective refers to women's viewpoint on health facility-based delivery, home delivery and the measures needed to enhance the utilization of health facility-based delivery services in public health facilities in Ethiopia.

Utilisation: refers to the use of health facility-based delivery services by women who attended FANC at the selected public health facilities in Addis Ababa, Ethiopia.

1.7. THEORETICAL FOUNDATIONS OF THE STUDY

Theories are fundamental part of research, and it is important that researchers understand the concept "theory" and its role in research. Schmidt and Brown (2015:134) define a theory as a set of concepts linked through proposition to provide a coherent explanation or interpretation of one or more phenomena. Theories provide guidance for the development of research questions and testable hypotheses, as well as inform study methods and designs (Neal 2016:4). In the social sciences, it usually implies a set of statements describing and explaining the relationship between human behavior and the factors that affect or explain it. A theory is thus an essential tool of research for stimulating the advancement of knowledge and for providing a framework for action and for understanding.

Researchers also need to demonstrate knowledge and comprehension of the related research philosophies that underpin the different principles of the research. The research philosophy that underpins the study is reflected in different principles, as outlined by the

relevant research paradigm, discussed in the paragraphs that follow.

1.7.1. Research Paradigm

A paradigm is a way of looking at natural phenomena; a worldview that encompasses a set of philosophical assumptions and that guides one's approach to inquiry (Creswell 2014; Kumar 2011:33; Polit & Beck 2012:736). According to Neil and Koekemoer (2016), research paradigm is a particular worldview that constitutes the researcher's values, beliefs and methodological assumptions. Paradigms are thus important for they provide beliefs and dictates, which, for scholars in a particular discipline, influence what should be studied, how it should be studied, and how the results of the study should be interpreted (Kivunja & Kuyini 2017:27). The paradigm defines a researcher's philosophical orientation and, has significant implications for every decision made in the research process, including choice of the research design and methods, which is how meaning will be constructed from the collected data, based on our individual experiences. Neil and Koekemoer (2016) and Kivunja and Kuyini (2017:27) advise that qualitative researchers should start out their inquiry by stating clearly the paradigm in which their studies will be located.

The constructivist paradigm guided and informed this study. The constructivist paradigm has its roots in philosophy and the human sciences, and it focuses on exploring the complexity of social phenomena with a view to gaining understanding. Its purpose is to understand and interpret events, experiences and social structures, as well as the values people attach to these phenomena (Rubin & Babbie 2010:37). Constructivists believe that reality is subjective as it happens in the mind of human beings hence the presence of multiple realities from different individuals (Polit & Beck 2012:12). In addition, constructivist paradigm is based on the belief that reality is constructed in the social and cultural context. Researchers working from this viewpoint seek to understand how people make sense of their world and thereby construct meaning (Botma, Greeff, Mulaudzi & Wright 2010; Willig 2013), and in order to gain that understanding, they need to establish close and empathetic relationships with their participants (Neil & Koekemoer 2016). Constructivists do not subscribe to the existence of a social and physical reality 'out there' separate from the

individual. They emphasise the relationship between socially engendered concept formation and language, they believe that understanding human experience is as important as focusing on explanation, prediction, and control (Halloway & Wheeler 2010:25). The use of constructivist paradigm in this study was to gain in depth understanding of women's perspective of health facility-based delivery and home delivery with the aim of developing guidelines to enhance the utilization of health facility-based delivery among attendees of FANC in Addis Ababa, Ethiopia. In addition, the constructivist paradigm was used to guide the selection of the research methodology required to reach an understanding or an explanation that would enable the social researcher to appreciate the subjective meaning of social actions (Neil & Koekemoer 2016).

1.7.2. Philosophical assumptions on which the research was founded

Assumptions refer to basic principles that are accepted as being true based on logic or reason without proof (Polit & Beck 2012:748). The same authors further explain that assumptions are self-evident truths, or the truth which is self-evident to those who hold them regardless of their objective status, meaning or truth-value. Because all research is inevitably based on assumptions, it was important for the researcher to clarify assumptions to enable the readers to understand the basis on which the research was being conducted. The philosophical assumptions on which the study was founded are described in the paragraphs that follow.

Ontology

Ontology is a philosophical study of the nature of existence or reality, or being or becoming, as well as the basic categories of things that exist and their relations (Kivunja & Kuyini 2017:27). It is concerned with assumptions we make in order to believe that something makes sense or is real, or the very nature of the social phenomenon under investigation (Cooper & White 2012:16; Polit & Beck 2012:13; Yilmaz 2013). Ontological assumptions concerning reality are fundamental to understanding how meaning of the data collected is made. In addition, they allow the researcher to state whether there is reality out there in the social world or it is a construction, created by one's own mind. Ontological assumptions, concepts or propositions help to orientate one's thinking about the research

problem, its significance and how one might approach it to find its solution (Kivunja & Kuyini 2017:27). The same authors further explain that ontological assumptions seek to determine the foundational concepts, which constitute themes that we analyse to make sense of the meaning embedded in research data. The notion of subjective and multiple reality, as seen by participants in the study is accepted. The ontological assumptions on which the study is based included:

- Life-world is constituted moment-to-moment and accordingly, the women's' views about utilization of health facility based delivery services in public health facilities change over time.
- Some of the aspects of FANC, in particular health facility-based delivery are perceived negatively, hence the preference to deliver at home in spite of having attended FANC.

In applying ontology in this study, the researcher used quotes and themes in words of the participants, with evidence of different perspectives of facility-based and home delivery services, as well as measures needed to enhance the utilisation of facility-based delivery among attendees of FANC.

Epistemology

Epistemology refers to how we come to know something; how we know the truth or reality or what counts as knowledge within the world (Cooper & White 2012:16; Kivunja & Kuyini 2017:27; Kumar 2011; Polit & Beck 2012:13). It is concerned with the bases of knowledge, namely its nature, forms and how it can be acquired and communicated to other human beings (Kivunja & Kuyini 2017:27). The same authors further explain that epistemology focuses on the nature of knowledge and comprehension that researchers or knowers can possibly acquire to be able to extend and deepen understanding in their field of research. Epistemological assumptions help to establish faith in the research data and affects how researchers go about uncovering knowledge in the social context that will be investigated (Kivunja & Kuyini 2017:27). Epistemological positions are influenced by the researcher's ontological viewpoint. For example, based on the belief in multiple or situated realities that are constructed in particular contexts, the idea that understandings are created through

interaction between the knower and the unknown subject should be accepted (Yilmaz 2013:315). According to this view, knowledge is created through the exploration of beliefs, perceptions, and experiences of the world, often captured and interpreted through observation, interviews and focus groups. It is therefore important that there is alignment between ontology (what can we know) and epistemology (how can we know it). The study was based on the following epistemological assumptions:

- The research participants were autonomous people who shared information willingly and gave honest responses to the questions during the interviews.
- Enhancing utilization of health facility based delivery service as constructed by women who had received FANC would shape the provision of women friendly delivery services in public health facilities in Addis Ababa, Ethiopia.
- Women who visited FANC are more likely to utilize health facility-based delivery services and decrease the MMR related to childbirth complications.
- Participants will collaborate and make suggestions on measures needed to enhance the utilization of health facility-based delivery services among attendees of FANC
- Qualitative research yields information, which, when abstracted sufficiently, meets the requirement of rigorous science and scientific knowledge.

The implication for practice is that the researcher needs to lessen the distance between himself and that, which is being studied by spending time with the participants.

Methodological assumptions

Methodological assumptions refer to the way researchers obtain knowledge, meaning the approach to be used, as well as data collection and analysis methods (specific tools to be used). According to Kivunja and Kuyini (2017:28), methodology articulates the logic and flow of the systemic processes followed in conducting research to gain knowledge about the research problem. In the present study, an explorative, descriptive and contextual study design was used. The study was based on the following methodological assumptions:

- The inclusion criteria of the sample are appropriate and therefore, assures that the participants have all experienced the same or similar phenomenon of the study.
- The participants will answer the interview questions in an honest and candid manner.

The researcher described in detail the context of the study and continually revised questions from experiences in the field

Axiology

Yilmaz (2013:316) defines axiology as the study of value or goodness, while Kavunja and Kuyini (2017:28) view it as the ethical issue that need to be considered when planning research. Axiology addresses the question "*what is the nature of ethics or ethical behaviour*, or *what are the moral issues that need to be considered when one is conducting research*" The research should be conducted in a socially just, respectful and safe (avoid or minimise physical, psychological, legal, social and economic risk or harm) manner.

Axiological assumptions are about the role of values in research and that each research paradigm has an embedded set of values. For example, positivism values the lack of bias and assumes that science is value free while constructivism assumes that research is value laden and that there will always be bias brought about by the various actors in the research process. The study was based on axiological assumptions that:

- The women who attended FANC experience some aspects of the facility-based delivery services negatively and their views on facility-based delivery should be respected.
- Women who attended FANC will utilise facility-based delivery service
- Women who have positive perceptions of facility-based delivery service will be willing to make suggestions on measures needed to enhance the utilisation of health facility based delivery services in public health facilities in Addis Ababa, Ethiopia.

The researcher discussed openly the values that shaped the narratives and included her own interpretation in conjunction with the participants' interpretation. The researcher demonstrated ethical conduct by showing what was right and wrong behaviour (ethical considerations) as the research was conducted.

Rhetoric

Rhetorical assumptions refer to the language of research (Yilmaz 2013:316). The positivist approach uses formal, impersonal, defined language and places much emphasis on quantification and statistical analysis while the constructivist paradigm focuses on rich description and the language of comparison and distinctiveness.

The study was based on the rhetorical assumption that existential philosophy and the qualitative research paradigms independently provide specific terminology that pertinently illuminates phenomena studied within the realm of these constructs. The researcher used an engaging style of narrative and used the language of qualitative research when writing the report of the study.

In summary, with regard to assumptions, it is important that researchers understand when to apply assumption in general and in their studies (Yilmaz 2013).

1.7.3. Theoretical Framework

A framework is the overall conceptual underpinnings of a study. A concept is an idea or complex mental image of a phenomenon (object, property, process, or event). A conceptual framework offers a foundation or structure that guides the development of the study and assists the researcher to link the findings of the study to the body of knowledge (Creswell 2014; Polit & Beck 2012: 13; Powers & Knapp 2006: 23).

A multi-level life course framework of facility-based delivery in low and middle-income countries (LMICs) which was developed by Bohren, Hunter, Munthe-Kaas, Souza and Vogel (2014:13) was adopted and found to be applicable to frame the current study and to link the findings of the study to the body of knowledge. A detailed discussion of the conceptual framework for the study is presented in Chapter 2.

1.8. RESEARCH DESIGN AND METHODS

A research design is the blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings as it gives the greater control (Creswell

2014: 41; Kumar 2011: 41; Polit & Beck 2012). Research design is the architecture of the study whereby its structure, namely the details of the study population, time frame, methods, and procedures are explicitly stated in the research protocol. The study design guides the methods and decisions that researchers must make during their studies and sets the logic by which they make interpretations at the end of their studies (Polit & Beck 2012:741).

A qualitative exploratory and descriptive research design was used to achieve the aims and objectives of the study. The design was contextual in nature. The study was conducted in three (3) phases as described in the paragraph that follow:

Phase I: Exploration and description of women' perspectives of facility-based and home delivery. Purposively selected participants participated in individual interviews. This was in line with objectives 1 & 2 of the study.

Phase II: Description of women's views on measures needed to enhance the development of women-centered practice guidelines to enhance the utilization of health facility-based delivery services. In this phase, purposively selected participants took part in focus group interviews.

Phase III: Development of women-centred guidelines to enhance utilisation of facility-based delivery among attendees of FANC. The researcher used the findings of the study and literature as the basis for the development of guidelines to enhance the utilization of health facility-based delivery services among attendees of FANC in Addis Ababa, Ethiopia. The researcher, in identifying necessary guidelines from the data findings and literature employed a strategy of deductive reasoning. A detailed description of the research design used in this study is presented in chapter 3.

1.8.1. Research setting

The present study was conducted in public health care facilities including health care facilities and one district hospital in Addis Ababa, Ethiopia. These were Yekatit 12 Medical College Hospital, Semein Health Center, Woreda six (6) Health Center and

Woreda four (4) Health Center. The details of the study setting are described in Chapter 3.

1.8.2. Research methods

Research methods refer to to the techniques used to structure a study and to gather and analyse relevant information to the research question in a systematic manner (Polit & Beck 2012:12). A detailed discussion of the research methods used in this study is presented in Chapter 3.

1.9. SCOPE OF THE STUDY

The focus of the study was the description of the women' perspectives of facility-based and home delivery as well as the measures to enhance the utilisation of the facility-based delivery among women who attended FANC in Addis Ababa, Ethiopia.

1.10. STRUCTURE OF THE THESIS

This thesis comprise seven chapters as shown in table 1.1.

Table 1.1 Chapters of the Thesis

Chapter 1	Orientation to the study highlighting the problem statement, research questions, and research objectives, significance of the study, methodology, and the scope of the study.
Chapter 2	Literature review
Chapter 3	Research design and methods
Chapter 4	Analysis, presentation and description of findings of individual interviews
Chapter 5	Analysis, presentation and description of findings of FGDs
Chapter 6	Guidelines on women-centered practice to enhance health facility based delivery at public health facilities in Addis Ababa
Chapter 7	Conclusions and recommendations

1.11. CONCLUSION

This chapter provided a broad overview of the study. The background information about the research problem and the aim and objectives of the study were presented. The researcher also introduced the research design and methods used in the study as well as the reflections on the significance of the study. Lastly, an outline of the structure of the chapters of the thesis was presented. In the next chapter, the literature review pertinent to the study is presented.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

The purpose of this chapter is to present the results of a literature review pertinent to FANC, health facility-based and home delivery. The researcher conducted the literature review to broaden his knowledge base on developments in FANC and facility-based delivery service. The literature review was also conducted to identify, summarise, synthesise what has been studied earlier, and help sharpen the focus of the research question (Schmidt & Brown 2015:95). In addition, the literature review was undertaken to identify appropriate methods for the study, point to an appropriate conceptual framework that would help the researcher interpret the findings of the study (Polit & Beck 2012:116). The chapter begins with a discussion of FANC, with specific focus on its characteristics, goals, and implementation including the challenges related to health facility-based delivery service. The second section deals with the theoretical framework selected to help the researcher interpret the findings of the study (Polit & Beck 2012:116).

2.2. SCOPE OF THE LITERATURE REVIEW

A computer-assisted search was conducted in the cumulative index of nursing and allied health literature (CINAHL), the national library of medicine (PubMed) service, and UNISA repository databases using the key words antenatal care, focused antenatal, maternal mortality rate and health facility-based delivery. The reviewed literature included research conducted globally and within Ethiopia from 2008 to 2019. The researcher conducted the literature review to evaluate the current practices, available and up-to-date knowledge about FANC and health facility-based delivery service from related journals, books, articles, research reports, dissertations and policy documents.

2.3. LITERATURE REVIEW

The results of the literature review are presented using the headings, focus antenatal care (FANC), aims and goals, principles, guidelines and implementation of FANC, including the challenges related to health facility-based delivery service.

2.3.1 Focused Antenatal Care (FANC)

Focused antenatal care service is a model of preventive health care aimed at primary, secondary and tertiary prevention of disease and pathological conditions during pregnancy and delivery (Baffour-Awuah et al 2015:60). It is a goal-oriented antenatal care approach (UN 2014: 32), which was recommended and adopted by the World Health Organization (WHO) in 2002. Focused ANC is provided over four visits at specified intervals, at least for healthy women with no underlying medical problems (Baffour-Awuah et al 2015:60; FMoH 2010:10). It comprises focused antenatal services, which provide specific evidence-based interventions for all women, carried out at certain critical times in the pregnancy (Baffour-Awuah et al 2015:60). In this model, pregnant women are classified into two categories, namely those who can follow basic care and those women with special health conditions and/or are at risk of developing problems who might need a special care (FMoH 2010:10). FANC addresses the most prevalent health issues affecting women and newborns, adjusted for specific populations/regions, appropriate to gestational period, and based on firm rationale.

2.3.1.1 Aims and goals of FANC

The aim of FANC is to promote the health of mothers and their babies through targeted assessments of pregnant women. Its goals include assisting women to maintain normal pregnancies through health promotion and prophylaxis, early detection of complications and other potential problems that can affect the outcomes of pregnancy, treatment of complications and existing diseases. In addition, FANC ensures that women are prepared for birth and complication readiness planning (Finlayson 2013:2; FMoH 2010:10). In the paragraphs that follow, a summary of the aims and goals of FANC is presented.

Health promotion is achieved through health education and counselling on birth preparedness, nutrition, immunization, personal hygiene and family planning. Women are also given information on danger symptoms that indicate the need for immediate help from a health professional (Ekabua, Ekabua & Njoku 2011; Miltenburg et al 2017).

Prophylaxis is an intervention aimed at preventing a disease or disorder from occurring. During FANC, conditions such as anaemia, malaria, and sexually transmitted infections including HIV, urinary tract infections and tetanus are prevented and treated because they can affect the outcomes of pregnancy negatively (Finlayson 2013:2).

FANC utilizes an individualized and client centred approach; it focuses on individual woman's specific needs and concerns, circumstances, and what is appropriate for the gestation period at that time of pregnancy. Individualised care is given to each woman at FANC to help maintain the normal progress of her pregnancy through timely guidance and advice. Unlike in the traditional frequent antenatal care visits as a routine activity for all, and categorising women based on routine risk indicators, the FANC service providers are guided by each woman's individual situation.

Comprehensive care ; FANC emphasizes disease detection rather than risk assessment, screening to detect and treat a problem rather than screening to predict a problem (Baffour-Awuah et al 2015; Ekabua, Ekabua & Njoku 2011; Miltenburg et al 2017; Mohammed 2011).

Quality versus quantity ANC visits; the number of visits reduced without affecting outcome for mother and baby to a minimum four visits. The care is provided by skilled health professional who has formal training and experience, knowledge, skills and qualifications, practices at home, hospital, health center, may be midwife, nurse or doctor.

Family responsibility; this approach also makes pregnancy care a family responsibility whereby the health service provider discusses with the woman and her husband the possible complications that she may encounter; they plan together in preparation for the birth, and they discuss postnatal care and future childbirth issues. Pregnant women receive fundamental care at home and in the health institution; complications are detected early by

the family and health service provider; and interventions are begun in good time, with better outcomes for the women and their babies.

2.3.1.2 Developments in FANC Guidelines

In 2016, the WHO designed new ANC guidelines for pregnant women and adolescents. These guidelines were intended to reinforce the existing ones on the management of specific pregnancy-related complications. The aim of the 2016 WHO guidelines was to provide women with respectful, individualised, person-centred care at every contact with the health facility (Oshinyemi, Aluko, & Oluwatosin, 2018:92). According to the new guidelines, visits were increased from four (4) to eight (8) visits. Oshinyemi et al (2018:92) explain that the increase in the number of visits was necessary because the evidence from review of literature indicated lesser satisfaction of women with the four-visit FANC model, and that the four-visit model did not offer women adequate contact with health care practitioners. The term “contact” was preferred to “visit” as it implies active connection between the pregnant woman and the health provider and it can take place at the health facility or at community level (WHO 2016). Another reason is that contact helps facilitate context –specific recommendations Table 2.1 shows a comparison of the timing of the visits and contacts of WHO FANC model and WHO 2016 new model respectively.

Table 2.1 The comparison of WHO 4-visit FANC and the 2016 WHO guidelines

Trimesters of pregnancy	WHO FANC model	2016 WHO FANC model
1st Trimester	Visit 1: 8-12 weeks	Contact 1: Up to 12 weeks
2nd Trimester	Visit 2: 24-26 weeks	Contact 2: 20 weeks Contact 3 : 24 weeks
3rd Trimester	Visit 3: 32 weeks Visit 4: 36-38 weeks	Contact 4: 30 weeks Contact 5: 34 weeks Contact 6: 36 weeks Contact 7: 38 weeks Contact 8 :40 weeks
Return for delivery at 41 weeks if not given birth		

WHO guideline on Antenatal care (2016)

2.3.1.3 Basic Principles of Focused Antenatal Care

The basic principles of FANC are thorough evaluation, intervention and health promotion and they are presented in the paragraphs that follow.

- **Thorough evaluation;** the aim of thorough evaluation is to identify and treat existing obstetric and medical problems. The service providers make a thorough evaluation of the pregnant woman to identify and treat existing obstetric and medical problems. The aim is achieved by history taking, physical examination and basic investigations. History taking involves questioning and examining the mother at the first antenatal visit to see if they had any risk factors during the previous pregnancy (stillbirth or neonatal loss, history of three or more consecutive spontaneous abortions, a low birth weight baby (<2500 g) or a large baby (>400 g), hospital admission for hypertension, pre-eclampsia or eclampsia and the current pregnancy (maternal age less than 16 years or more than 40 years, diagnosed or suspected twins, or a higher number of multiple pregnancies, mother has blood type Rhesus-negative, has vaginal bleeding, or a growth in her pelvis, mother's diastolic blood pressure of 90 mmHg or more, mother currently has diabetes, heart disease, kidney disease, cancer, hypertension or any severe communicable disease such as TB, malaria, HIV/AIDS or another sexually transmitted infection (STI). The mother's body and the foetus should be checked by performing basic physical examinations such as pulse rate, blood pressure, respiration rate, temperature and tests

such as urine testing. The data collected should be compared with the documented norm (interpreted), a diagnosis made and any risk factors should be evaluated. An individualised care plan is designed if no abnormalities are identified, and the care plan will focus on counselling, birth preparedness and complication readiness. The mother should be categorised under the specialised component of FANC which needs close follow-up and referral to a higher level health facility for additional monitoring if there is one or more risk factors in the history of the previous or current pregnancy.

- **Intervention** includes prevention/prophylaxis and treatment. Antenatal care service providers administer prophylaxis as indicated, for example preventive measures for malaria, anaemia, nutritional deficiencies, sexually transmitted infections, including prevention of mother to child transmission of HIV (PMTCT) and tetanus. The mother and the ANC care service provider decide on where to have the follow-up antenatal visits, how frequent the visits should be, where to give birth and whom to be involved in the pregnancy and postpartum care.

Health promotion is achieved through health education and counselling. The antenatal care service providers should give advice on the importance of good nutrition in pregnancy (including advice on exclusive breastfeeding), and routine iron and folate supplementation. In addition, advice on malaria prevention and if necessary provide insecticide-treated bed nets is given. HIV counselling and PMTCT services should be provided. Important discussions between the health provider and the family about preparation for delivery and saving money in case there will be need to refer if there is an emergency requiring transport to a health facility. The antenatal care provider should provide specific answers to the woman's questions or concerns, or those of her partner.

2.3.1.4 Advantages of FANC

FANC reduces the maternal and perinatal mortality and morbidity. It also provides an opportunity to promote the use of skilled attendance at birth. Skilled attendance at birth refers to the process by which a woman is provided with adequate care during labour, delivery and early postnatal period. The process requires the presence of a skilled birth

attendant and an enabling environment with adequate resources, efficient and effective communication and referral. According to the WHO, skilled birth attendant is an accredited health professional, (midwife, doctor or a nurse) who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of women to higher levels of care (Crowe, Utley, Costello, & Pagel 2012; UN 2015:4). One of the ways of ascertaining skilled attendance at birth is delivery at a health facility.

FANC is an appropriate approach for resource-limited countries where health professionals and health facilities are few and limited. In addition, the majority of pregnant women cannot afford the cost incurred by the frequent antenatal visits required by the traditional antenatal care approach. From the financial and logistical viewpoint, the traditional approach is a burden on the healthcare system. As a result, many developing countries, including Ethiopia, have adopted the FANC approach.

2.3.1.5 Challenges of FANC

Several studies show that women who attend FANC are more likely to seek skilled delivery care. However, only 56% of births to women who attended at least four ANC visits were delivered in a health facility as compared to 8% of births to mothers with no ANC visits (CSA 2016: 171). About 20% of all women who attended FANC four times or more in developing countries do not seek skilled delivery attendance (Magoma, Requejo, Campbell, Cousens, Filippi & Magmas 2010: 6). Efforts to understand the complex factors underlying this discrepant pattern between relatively high utilization of antenatal care and low use of skilled birth attendance (which is the focus of the current study) must be studied (Bako et al 2017; Bohren et al 2014; Magoma et al 2010: 7; Shiferaw et al 2013).

In many low-income settings with a high burden of maternal deaths, few women use facilities for birth, often choosing a higher-risk birth at home, often without professional medical assistance (Titaley, Hunter, Dibley, & Heywood 2010; WHOb 2012: 5; Yebyo et al 2015).

Other challenges include lack of political will on policy change and implementation factors, resistance to change from the present traditional model of ANC of frequent visits to the practice of FANC or reduced antenatal visit by health care workers and client (Ekott, Edet, Ovwigho, Udoh, Akinwunmi & Babatunde 2017). Inadequacy of human and material resources affect the implementation of FANC negatively. In addition, the prevailing cultural norms, illiteracy, and misconceptions about pregnancy and childbirth make some women to consult unskilled birth attendants (Oshinyemi et al 2018).

2.3.1.6 Health Facility-based Delivery Service

As indicated in 2.3.6, deliveries in health facilities can ensure skilled attendance at birth. A variety of studies have shown that using health facility-based delivery service is an important intervention that reduces maternal morbidity and mortality from delivery or child birth related issues (Annette et al 2016: 416; Baffour-Awuah et al 2015:61; Bellows et al 2013:135; Kebede et al 2016:466 ;Yaya, Bishwajit, Uthman, & Amouzou 2018:1). Yaya et al (2018) further explain that the role of health facility delivery plays in preventing and treating pregnancy related complications and reducing maternal and neonatal mortality rate is indisputable. According to Kebede et al (2016) delivering at a health facility is the single most important strategy in preventing maternal and neonatal deaths because it ensures proper management of childbirth complications and or timely referral of delivering women to higher levels where childbirth complications can be better managed.

Statistics show that maternal mortality reduces by 52 % worldwide when women deliver in health facilities (Annette et al 2016:416). According to Crowe at al (2012) and Moyer, Dako-Gyeke and Adanu (2013b:32), the presence of a skilled birth attendant at delivery could prevent around 16% to 33% of maternal deaths and neonatal mortality by 20-30 % worldwide. It therefore follows that, in order to reduce maternal mortality related to childbirth the number of women who deliver in a health facility should increase (Annette et al 2016:416 ; Baffour-Awuah et al 2015: 60; Bellows, Kyobutungi, Mutua, Warren & Ezeh 2013:134; Miltenburg et al 2017: 1).

Globally, 80% of live births occurred with the assistance of skilled health professionals for

the period 2012-2017, but the percentage of deliveries attended to by skilled health personnel in Sub Sahara was 77% for the same period (Bako, Ukpabi & Egwuda 2017:1104; UN 2015).

- *FANC and utilisation of health facility-based deliveries*

Several studies on the benefits of antenatal attendance and the pregnancy outcomes have reported positive associations when the pregnant woman attends more sessions of FANC (Nabwire 2017: 20; Pervin et al 2012:1; Tsegay et al 2013: 2). A multi-country study conducted in 28 African countries to explore the association between antenatal care attendance and skilled birth attendance found that 66% of women who attended antenatal care had a skilled birth attendance; and among women who received ANC components such as blood pressure check, blood tests and danger signs information the odds were higher (Chukwuma, Wosu, Mbachu, & Weze, 2017). Similar studies done using demographic health survey (DHS) data in Uganda and Pakistan demonstrated that the more components of ANC package a pregnant woman received the more likely she was to have a health facility delivery (Agha & Williams 2016: 84; Ekott, Edet, Ovwigho, Ameh, Udo, Akinwunmi & Babatunde 2017:4; Miltenburg et al 2017; Nabwire 2017: 20).

However, there is adequate evidence of women who attend FANC and did not seek skilled delivery attendance. Magoma et al (2010) report that at least 20% of all women who attend ANC four times or more in Sub Sahara Africa and in Asian countries do not seek skilled delivery attendance. Studies also show that in many low-income settings with a high burden of maternal deaths, few women use facilities for birth, often choosing a higher-risk birth at home, often without professional medical assistance (Kebede 2016: 467; Titaley, Hunter, Dibley & Heywood 2010: 2; Yebyo, Alemayehu & Kahsay 2015: 2).

FANC is the accepted policy in Ethiopia. The key components of the HSTP (2015) of the government of Ethiopia include delivery at a health facility, with skilled provider and sanitary environments to decrease the complications and infections during labour and delivery, timely postnatal care that treats complications from delivery and education of the mother on care for herself and her infant (CSA 2016:166; FDRE 2015). According to the

guideline for ANC in Ethiopia, every pregnant women should receive ANC from a skilled provider, including a comprehensive physical examination, blood tests for infection screening and anemia, a urine test, tetanus toxoid injections, iron and folate supplements, and deworming medications (CSA 2016: 169; Villadsen et al 2015: 2). However, Ethiopia is facing a challenge of low attendance of FANC and low utilisation of health facility based delivery among the few who attend FANC. The majority of Ethiopian women who attended FANC did not utilize health facility based delivery service. The percentage of women who received antenatal care from a skilled provider was 62% and only 26 % of births in Ethiopia were delivered at a health facility (EDHS 2016). Home delivery is still common despite efforts to promote health facility-based delivery. Many women continue to give birth without the supervision of skilled provider even though the statistics showed a decrease in home deliveries from 95% in 2000 to 90% in 2011, and 73% in 2016. Seventeen percent of women and 13% of newborns received a postnatal check within the first 2 days of birth in the country (Berhan & Berhan 2014: 39; CSA 2016: 167). This indicates that fewer women in Ethiopia receive the benefits of FANC.

There is clearly a gap between attendance of FANC and health facility delivery utilization (Berhan & Berhan 2014: 39; CSA 2014: 39). Efforts to understand the complex factors underlying the discrepant pattern between utilization of FANC and low use of skilled birth attendance in Ethiopia must be studied (Bako et al 1104; Bohren et al 2014; Magoma et al 2010: 1; Shiferaw, Spigt, Godefrooij, Melkamu & Tekie 2013: 2), hence the focus of the study.

2.3.1.7 Birth Preparedness, Complications Readiness and Emergency Plans

Development of a birth and emergency plan starts from the first visit of FANC, and the plan is discussed and modified throughout all FANC visits. The WHO recommends that all pregnant women develop a written plan for dealing with birth and any unexpected adverse events, such as complications or emergencies that may occur during pregnancy, childbirth, or the immediate postnatal period (Annette et al 2016:416). Birth preparedness is the process of planning for a normal birth while complications readiness refers to anticipating the actions needed in case of an emergency. Emergency planning is the process of identify and

agreeing all the actions that need to take place quickly in the event of an emergency, and that the details are understood by everyone involved, and the necessary arrangements are made. The plans should be discussed with the skilled attendant at every FANC assessment and one month before the expected date of birth (Annette et al 2016:416; Tarekegn, Lieberman & Giedraitis 2014:2; Yaya et al 2018).

The skilled attendant and the woman should plan for 1) the desired place of delivery and how to get there, 2) the location of the closest appropriate health care facility, 3) the preferred skilled attendant to be present at the birth, 4) items needed for delivery, source of funds for meeting the financial commitments/bills during childbirth including emergency transportation, 5) transport to a health facility for the birth and transport in the case of an obstetric emergency, identification of compatible blood donors in case of emergencies, 6) support during and after childbirth (birth companion), 7) support in looking after the home and children while the woman is away and 8) the appropriate response in case of life-threatening complications: this will include a person designated to make decision on her behalf, in case she is indisposed, a way to communicate with a source of help (Baffour-Awuah et al, 2015:61; Magoma et al 2010; Tarekegn et al 2014:2).

Among women who received FANC for their most recent live birth in the past 5 years, 56% were informed about a birth preparedness plan. Eighty seven percent (87%) of women were informed about place of birth, 39% about supplies needed for giving birth, 20% about emergency transportation, 19% about an emergency fund or money, 5% about support during and after birth, and 3% about potential blood donors (CSA 2016:135). Although little evidence exists to show the direct correlation between birth preparedness and reducing morbidity or mortality for mothers and babies, small-scale studies show that there is considerable benefit to be gained from this intervention. For example, the adoption of new practices associated with planning (such as setting aside money for the birth, transport arrangements, and the use of a birth plan) at family and community levels is encouraging. The presence of a person of the woman's choice to provide social support during childbirth has shown to have a positive effect (Baffour-Awuah et al 2015; Tarekegn et al 2014).

In preparing for normal birth, it is important that mothers and families be educated about the normal signs of labour, with specific emphasis on what to do when labour starts and ensuring that someone will call the facility or another skilled attendant for the birth *as soon as possible.* These instructions must be written in particularly the local language. The woman must be given all the necessary information about safe and clean delivery, but her choice of the preferred location, and who she wants to be during labour should be respected. The plan should include identification of sources of support for her and her family during the birth and the immediate postnatal period, planning for any additional costs associated with the birth preparing supplies for her care and the care of her baby.

Complications readiness is the process of anticipating the actions needed in case of an emergency and making an emergency plan. Pregnancy-related disorders such as high blood pressure and bleeding can begin any time between visits for antenatal check-ups, and any other illness may occur during the pregnancy. If such conditions are suspected at any stage, the woman should be referred immediately if danger symptoms are observed. For emergency plan, the family should be informed about where to get help.

2.3.2 Conceptual Framework

A conceptual framework offers a foundation or structure that guides the development of the study and assists the researcher to link the findings of the study to the body of knowledge (Creswell 2014; Polit & Beck 2012: 13). A multi-level life course framework of facility-based delivery in low- and middle-income countries (LMICs) developed by Bohren, et al (2014: 13) was applicable to frame the current study and link the findings of the study to the body of knowledge. Bohren et al (2014:13) developed this framework using the multi-level life course approach to explore how experiences earlier in an individual's life impact their subsequent decisions and actions, and how these experiences range across individual, family, community, health facility and national level influences. The key constructs of this model were considered applicable to the study, and aided the researcher to conceptualize them in practice through the development of women-friendly care guidelines to promote quality health facility-based delivery service provision in the public

health facilities in Addis Ababa, Ethiopia. The key constructs of this model are shown in figure 2.1.

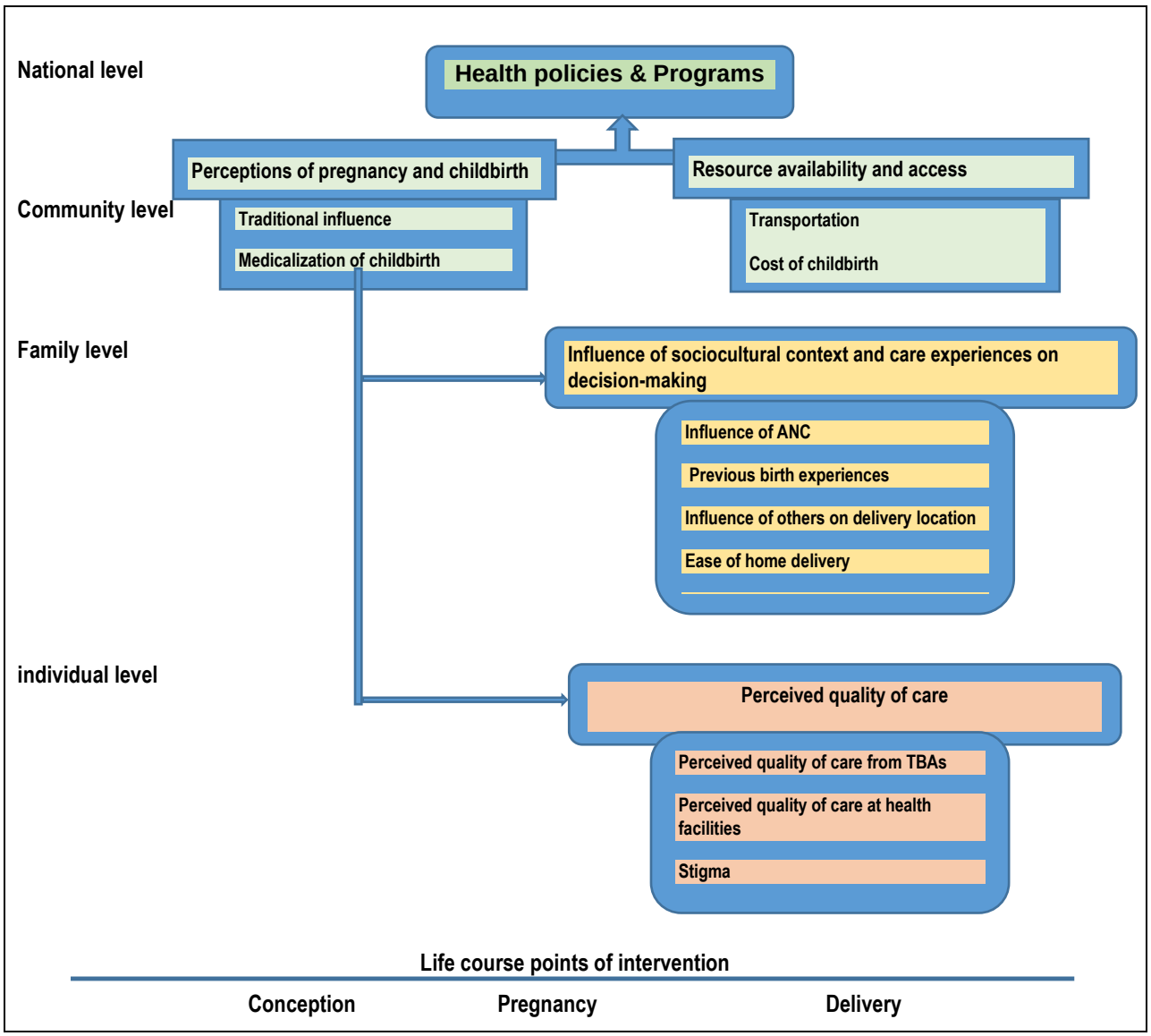

Figure 2.1 Multi-level life course framework of facility-based delivery in LMICs (adapted from Bohren et al 2014: 13).

- **Health policies and programs**

Access to health facility delivery is affected at a community or national level, which is

beyond the individual women's control. Previous research addressed the effects of policies and programs in relation to the location of a woman's delivery, which consist of national health insurance systems, social welfare programs, population policies regulating the number of children permitted per couple, and national programs aimed to surge facility-based deliveries (Bohren et al 2014: 13).

- **Perceptions of pregnancy and childbirth**

Traditional influences

Traditional influences and pressure covering local understandings of disease causation and externally-focused loci of control play vital roles in understanding decision making on the place of delivery. Care-seeking might be postponed in conditions where some health problems are regarded as spiritual in nature rather than physical like eclamptic seizures (Bohren et al 2014:4; Magoma et al 2010:5; Mirgissa, Tesfaye, Zergu, & Ismael, 2016: 97).

Medicalization of childbirth

Existing literature report that several women try first home delivery and consider facility based delivery only if problems arose. These studies further report that both women and men termed the birthing process as a "normal" or "routine" episode and believed that childbearing was a woman's "natural rite of passage". Thus, there was no basis for delivering at a health facility (Bohren et al 2014:7; Gebrehiwot et al 2012:4; Magoma et al 2010:6).

- **Resource availability and access**

Transportation

Physical distance and substantial travel times to health facilities are factors that determine or influence women's place of delivery. Furthermore, the availability of traditional birth attendants in the community might confirm a woman's decision to give birth at home (Bohren et al 2014: 12-13; Magoma et al 2010; Moyer & Mustafa, 2013a:5). Similarly,

inadequate accessibility of transportation opportunities played a vital role in whether or not a woman in labor could reach a health facility in time. Dearth of access to transportation, good roads, sufficient funds, and communication systems also make arranging referrals for obstetric problems a lengthy process (Bohren et al, 2014: 12; Mirgissa, Tesfaye, Zergu & Ismael, 2016: 97).

Cost of childbirth

Direct costs linked with childbearing were too high for numerous women who regarded themselves as too poor to deliver in a health facility (Bohren et al 2014: 12). Economically constrained women might have concern obtaining funds to pay for facility-based delivery care at the time-of-service, predominantly those families who depend on intermittent labor. Some women regarded costs outside of the direct cost for childbirth as “unseen” and difficult to prepare for (Bohren et al 2014:12; Gebrehiwot et al 2014: 6; Magoma et al 2010: 4; Moyer et al 2013b:8).

- **Influence of sociocultural context and care experiences on decision-making**

Influence of antenatal care

Some women may consider that ANC attendance will reduce the likelihood of a difficult delivery, and ANC use might be viewed in a preventative method, guaranteeing a normal pregnancy and home delivery (Bohren et al 2014: 12). This may elucidate why in some circumstances ANC coverage is almost universal while health facility-based delivery rates stay low (Bohren et al 2014: 4; Magoma et al 2010:6). ANC workers might not be effectively instructing women of the significance of facility-based delivery service because perhaps heavy workload and constrained time to deliberate complex matters with their clients (Bohren et al 2014:4; Izugbara & Kabiru 2009: 7; Magoma et al 2010:6).

Previous birth experiences

A number of women decide their level of risk for difficult deliveries in part based on their previous delivery practices and birth results, which tells their prospect delivery place

(Bohren et al 2014: 4). A woman might possibly give birth at a health facility during her first birth or if she had a prior obstetric problem (Bohren et al 2014: 4; Shiferaw et al 2013). Nevertheless, if a woman delivered her first child without difficulties, using a health facility for ensuing births is frequently regarded as superfluous (Bohren et al 2014: 4; Shiferaw et al 2013: 5; Story, Burgard, Lori, Taleb, Ali, & Hoque 2012:28).

Influence of others on delivery location

Women may not be in control of the decision to seek facility-based delivery, rather relying on decisions made by elder women, husbands, other family members, and neighbors (Bohren et al 2014: 8; Titaley et al 2010: 3). Although the influence of some players may assist gain access to skilled care, the participation of too many actors frequently effects in the delay or deterrence of health facility-based births (Bohren et al 2014: 8; Gebrehiwot et al 2012: 5; Titaley et al 2010: 4).

Ease of home birth

Logistically home deliveries are easier than health facility deliveries and meet women's needs to be encircled by their possessions and the likelihood of keeping home duties (Bohren et al 2014: 12; Titaley et al 2010). Although women may receive support in their domestic responsibilities from their neighbors, co-wives, or husbands, women were concerned that domestic chores would be neglected if they attended a health facility for delivery (Bohren et al 2014:12; Gebrehiwot et al 2012:10; Moyer et al 2013b:2; Mirgissa et al 2016: 97).

2.4. CONCLUSION

The literature review provided some insights into FANC and facility-based delivery service in respect of goals, principles, the four-visit model, developments and the challenges of FANC globally and in the country of the study, Ethiopia. In addition, the review also identified previous studies conducted on FANC and facility deliveries worldwide and in Ethiopia. The literature review also pointed to the appropriate conceptual framework for the study. In the following chapter, a description of the research design and methods utilized in the study to achieve the objectives of the study is presented.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1. INTRODUCTION

In this chapter, the research design and methods used in this study are presented. The chapter begins with a discussion of the research design followed by a description of the research methods used, namely the population selected for the study, sampling procedures, the specific methods used for data collection and analysis, trustworthiness as well as related ethical considerations.

The research design and methods used in the study facilitated the attainment of the following research objectives stated in chapter 1, namely to:

- Explore and describe the perspective of health facility-based delivery among attendees of FANC
- Explore and describe the perspective of home delivery among attendees of FANC
- Describe the views of attendees of FANC on measures needed to enhance the utilization of health facility-based delivery services
- Propose the practice guidelines to enhance the utilization of health facility-based delivery among attendees of FANC in Addis Ababa, Ethiopia.

3.2. RESEARCH DESIGN

A research design is a procedural plan that researchers adopt to answer questions validly, objectively, accurately and economically (Kumar 2011:94). It is the arrangement of conditions for the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure (Kumar 2011:94). Through a research design, the researcher communicates decisions regarding how the study design will be used, how the study participants will be selected, how data will be collected and analysed and how the study findings will be communicated (Kumar 2011:94). The same author further explain that the researcher needs to describe in detail the rationale and justification for each decision shaping answers to the research question. The choice of an appropriate research

design is fundamental in allowing a researcher to reach at valid findings, comparisons and conclusions (Creswell 2014:41; Kumar 2011:41). The selection of the design largely depends on the beliefs and values of the researcher, the accessibility of research subjects, the availability of resource and whether the selected method is ethically sound (Parahoo 2014:165). A qualitative, exploratory, descriptive research design was used for addressing the objectives of this study. The design was contextual in nature.

Qualitative research

Qualitative research is a systematic, interactive and subjective approach used to describe life experiences and to give them meaning (Polit & Beck 2012:220). The same authors further explain that, qualitative research is broad and holistic and the researcher's views and perspectives have an impact on the outcome of the study. The goal of qualitative research is to describe and understand the phenomenon studied by capturing and communicating participants' experiences in their own words through interviews and observation (Yilmaz 2013:313). Qualitative studies are therefore concerned with process, context, interpretation, meaning or understanding through inductive reasoning. Polit and Beck (2012:220) add that the aim of qualitative research is to understand how people think of their behavior as individuals or as part of a group. Numerous authors (Creswell 2014:41; Kivunja & Kuyini 2017: 34; Kumar, 2011:41; Parahoo 2014; Polit & Beck 2012:220 & Yilmaz 2013:313) agree on the characteristics of qualitative research designs, and these are summarized in the following paragraphs.

Qualitative research design:

- Assumes that knowledge is not independent of the knower, but socially constructed and that reality is neither static nor fixed. Multiple realities that different cultural groups construct are based on their worldviews or value systems, resulting in multiple interpretations or perspectives on any event or situation. It therefore follows that understanding the phenomenon under investigation from the perspectives of the participants is critical.
- Assumes that events, processes, situations and behaviors change over time and are context-dependent.

- Approaches pay specific attention to particular individuals, groups, contexts, or cultures to provide a deep understanding of a phenomenon in local context.
- Postulates that events, cases, processes, situations, individuals and their behaviors are unique, context-dependent and largely non-generalisable. What is therefore required is thick description of purposively selected small samples and not reductionism.
- Requires the researcher to become the research instrument, meaning that the researcher must be able to observe behavior and interview people face-to-face. The researcher should establish close contact with the research participants when collecting detailed, rich, complex, and extensive qualitative data.
- Qualitative approaches often use inductive logic or both inductive and deductive logic, start with the data, and build up to a description, theory, or explanatory model.
- Demands time in analysis that is equal to the time in the field, thus calling for ongoing analyses of the data. The bottom-up approach to data analysis with open coding strategies should be practiced to allow themes and patterns to emerge from data.
- Involves informed consent decisions and is responsive to ethical concerns.
- Incorporates room for description of the role of the researcher as well as description of the researcher's own biases and ideological preference (Creswell 2014:41; Kivunja & Kuyini 2017: 34; Kumar 2011:41; Polit & Beck 2012:220 & Yilmaz 2013:313).

In this study, the researcher could only understand the participants' perceptive of facility-based and home delivery as well as their actions (non-utilization of health facility-based delivery) from the participants' own perspective, stated in their own words and in the context in which they lived. The primary purpose of the study was not to generalise the outcome to other settings, as it was specific to its context.

Exploratory research

Researchers use exploratory research when little is known about the phenomenon to be studied or when the subject of the study is relatively new (Botma et al 2010:185; Grove et al 2013:370). Rahi (2017) further state that the focus of exploratory studies is on obtaining

new insights into current situations and issues. Exploratory research is useful for clarifying concepts and for enabling researchers to compile a list of possible answers and solutions to predefined questions. It is usually conducted in the early stages where concepts have not been clear enough to develop an operational definition (Rahi 2017).

The purpose of exploration in this study was to gain a deeper understanding of the perspective of health facility-based and home delivery among the attendees of FANC in the context of Addis Ababa, Ethiopia. An extensive literature review pertaining to FANC and the utilisation of facility-based delivery among attendees of FANC was conducted to enhance exploration of the concepts related to the research topic.

Descriptive design

According to Rahi (2017), descriptive method of research refers to the type of research that is aimed at obtaining information on the current state of the phenomenon under study. It is mainly done to provide an accurate profile of situations, people or events. It does not draw conclusions from that data or determine cause and effect because it seeks to observe and document an occurring phenomenon that cannot be ascribed an objective value (Rahi, 2017). Chauke (2014:81) observed that when exploratory research is used in combination with descriptive research, it becomes a valuable tool for increasing the understanding of the questions, situation or events that the researcher is striving to comprehend. It therefore follows that exploratory research must happen first for descriptive research to be effective because the latter organizes the data found during the exploratory process.

Contextual design

Contextual research is described as one in which the phenomenon under investigation is studied in terms of its intrinsic and immediate environment or contextual significance. De Vos, Strydom, Fouche and Delport (2011) explain “context” as the study of people in their natural setting in order to understand the dynamics of human meanings as full as possible. The context of study is also referred to as the research setting, which is the physical location and conditions in which data collection takes place (Polit & Beck 2012:743). The research setting might be natural, partly or greatly controlled (Kumar 2011; Polit & Beck 2012:

743). Conducting a study in a natural setting means that the researcher does not influence or alter the study setting.

The context (research setting) of the study was public health care facilities (including health centers and district hospitals) in Addis Ababa, Ethiopia. The health care delivery system in Ethiopia comprise three levels, namely the first, second and third level.

- Level 1 is the primary health care unit or district health system comprising a primary (district) hospital (to cover 60,000-100,000 people), health centres (1/15,000-25,000 population), and their satellite health posts connected to each other by a referral system.
- Level 2 is a general hospital covering a population of 1-1.5 million people.
- Level 3 is a specialized hospital covering a population of 3.5-5 million people.

District level facilities are organized to provide obstetric first aid at health post levels with early referral to health centres that can provide basic emergency/essential obstetric care and further referral to district hospitals for comprehensive emergency/essential obstetric care (FDRE 2014:4). The health facilities of Addis Ababa include eleven (11) public hospitals (specialized, referral and general), 86 public health centers and about 720 private and non-governmental (NGO) health facilities at different levels (CSA 2007:19).

3.3. RESEARCH METHODS

Research methods comprise the forms of data collection, analysis, and interpretations that the researchers use in studies (Bayou 2014:65; Furry 2015:54; Polit & Beck 2012:733). The research methods used in this study are presented in the paragraphs that follow.

3.3.1. Population

A population is an aggregate of all the individuals or objects to be studied with some common defining characteristics (Kumar 2011: 65; Polit & Beck 2012: 738). According to Creswell (2014), a population is the totality from which cases are sampled based on definite

criteria. Polit and Beck (2012:274) distinguish between the target and accessible populations. White (2014) defines a target population as a collection of objects or peoples whose description is the major goal of the study while Polit and Beck (2012: 274) define it as the aggregate of cases about which the researcher would like to generalize. The same authors further explain that the aggregate cases in the target population have to meet the set inclusion criteria. The target population should therefore be clearly defined in terms of place, time and other factors relevant to the study.

The accessible population is the aggregate of cases that conform to designated criteria and are accessible for a study (Boswell & Cannon, 2018; Cooper & White 2012: 251; Polit & Beck, 2012: 274). According to Botma et al (2010:124) accessible population comprise persons who meet the sampling criteria and are available to participate in the study.

The study populations in the current study comprised site population (public health care facilities including health centers and district hospitals in Addis Ababa, Ethiopia) and the participant populations, namely women who attended FANC, delivered live babies in the past one year preceding data collection and reported to the clinic for registration of maternal and child health clinics in Addis Ababa district, Ethiopia. The target site population included district level public health facilities in the Addis Ababa. District level facilities provide essential obstetric care and further referral to district hospitals for comprehensive emergency/essential obstetric care (FDRE 2014:4). The health facilities that attended to the highest number of skilled deliveries in the past one year were included in the study. The target site population was accessible in terms of the geographical arrangement (within 10km radius) and the fact that they are under the same district health administration (Addis Ababa Health Bureau). This enhanced the process of requesting consent to conduct the study.

With regard to the target participant population, women who met the eligibility criteria were included in the study, while the accessible population comprised those women who met the eligibility criteria and were available for participation in the study.

- **Eligibility and exclusion criteria**

Eligibility criteria defines the characteristics that the study participants must have in common to be part of the target population (Boswell & Cannon 2018:149). In order to be included in the study, the participants had to have

- attended FANC in the selected public health facilities and had given birth to babies at home and health facilities in the past one year preceding data collection
- had reported to the clinic for registration of maternal and child health clinics in Addis Ababa district
- resided in Addis Ababa for at least for 6 months.

Exclusion criteria comprised women who attended FANC but had not experienced home delivery.

3.3.2. Sample, sampling methods and sample size

A sample is a selected subset of the accessible population that represents the entire population (Polit & Beck, 2012:742) while sampling refers to the process of identifying or selecting a subset of research participants from the general population to participate the study to make inferences about the population (Polit & Beck, 2012:275). Non-probability purposive sampling was used to select the study samples. Rahi (2017) defines non-probability sampling as the sampling approach in which the chance or probability of each unit to be selected is not known or confirmed. Purposive sampling is a method in which the researcher selects participants based on personal judgment about which participants will be most informative (Polit & Beck 2012:279; Kumar 2011:189).

The main aim of purposive sampling is to select and study a small number of participants whose involvement in the study produces a wealth of detailed information and an in-depth understanding of complex experiences and situations (Yilmaz 2013:313). However, purposive sampling limits the possibility of generalising research findings to other settings. The procedures used for site and participant sampling are described in the paragraphs that follow.

3.3.2.1. Site sampling: Public health care facilities

Three (3) health centers and one district hospital were purposively selected for the present study. These were Yekatit 12 Medical College Hospital, Semein Health Center, Woreda six (6) Health Center and Woreda four (4) Health Center. The public health facilities were selected for they attended to high number women who attended FANC and attended to less skilled deliveries in the past year preceding the study as compared to other public health facilities.

3.3.2.2. Sampling of Participants

Purposive sampling was used to select women who were able to provide rich information that adequately answered the research questions because of their experience of FANC, facility-based and home delivery. In order to be included in the study, women had to meet the eligibility criteria described in 3.3.1.

3.3.2.3. Sample Size

Grove et al (2015:274) define sample size as the number of subjects or elements participating in the study from whom data will be collected. Instead of relying on the number of participants, qualitative research focuses on the quality of information from the participants and different perspectives and opinions of participants. The number of participants in qualitative research is adequate when data saturation is achieved. According to Hancock, Amankwaa, Revell and Mueller (2016), the qualitative research "gold standard" for quality research is data saturation. The same authors explain that data saturation or adequacy is reached when there are no new emerging ideas of information in the data, the point in coding when no new codes occur in the data (Saunders, Sim, Kingstone, Baker, Waterfield, Bartlam, Burroughs & Jinks, 2018). The researcher initially intended to use a sample size of 30 women for individual interviews and 40 for focus group interviews (10 women at each of the four (4) selected health facilities). A sample of 30-40 was based on the recommendations for qualitative studies, in particular on the desired level of depth for the research questions (Niccolai, Hansen, Credle & Shapiro 2016). However, data

saturation was reached after 8 individual interviews and 32 participants for FGDs respectively.

3.3.3. Data Collection

Data is described as information that is gathered from counts, measurements responses or observations (Grove et al, 2013:507) while data collection is the precise and systemic gathering of information to address a research question (Polit & Beck, 2012:725). The data collection process involves the generation of large amounts of data from the use of a variety of data collection methods. Different methods and instruments used to yield data for the qualitative investigation include different types of interviews (standardized open-ended, semi-structured and structured), observations and document analysis (Polit & Beck 2012: 532; Yilmaz 2013:315).

In addition to the study methodologies available, there are different ways of recording what was said and done during the data collection process. Qualitative research reports must provide the reader with sufficient quotations from the participants and researchers are expected to keep the study findings in context and report any personal or professional information that may have had an impact on data collection, analysis and interpretations (Yilmaz 2013:315). The data collection methods and instruments used in this study are described in the paragraphs that follow.

3.3.3.1. Data Collection Methods

Individual face-to-face and focus groups interviews were used to collect data during phase 1 and phase 2 of the study respectively. Interviews were selected to ensure that the researcher obtains all the information required whilst giving the participants the freedom to provide as many illustrations and explanations as they wished (Polit & Beck 2012:537). Interviews are relevant as a data collection method when the data needed is based on personal and privileged information such as participants' views, perceptions, viewpoints, visions and insights this study sought to explore and describe (Chauke 2014:98).

Individual interviews

Individual face-to-face interviews, using an interview guide were used to collect data. Using face-to-face interviews enabled the researcher to explore issues for better understanding of the women's perspective of facility-based and home delivery, and to probe or clarify issues (Polit & Beck, 2012:537) regarding facility-based delivery.

The purpose of individual interviews in this study was to explore and describe the perspectives of facility-based and home delivery among attendees of FANC who delivered their babies at home (in line with objectives 1 and 2 of the study). One of the advantages of data collection using individual interviews is that the interview focuses directly on the study topic and it is insightful. However, if the questions are not well constructed, there could be bias, inaccuracies due to poor recall or the participants may give what they think the researcher wants to hear. As noted by Doody and Noonan (2013:3), individual interviews can be time-intensive and they require a certain level of expertise from the researcher

Focus Group Discussions (FGDs)

Focus group discussions (FGDs) were conducted to address the third objective of the study, namely to gain insight into the views and opinions of attendees of FANC on measures needed to enhance the utilization of health facility-based delivery services. A focus group is a carefully planned, facilitated group discussion in which a researcher raises issues or asks questions that arouse discussion among members of the group (Kumar 2011: 336; Maltby, Williams, & McGarry, 2010: 378; Polit & Beck 2012: 537). In a focus group, discussions are designed to obtain attitudes, opinions, viewpoints or perceptions on a defined area of interest in a permissive and non-threatening environment (Krueger and Casey 2009:2), facilitated by a skilled researcher.

According to Maltby et al (2010: 378), focus groups generate data on a designated topic through discussion and interaction provided the participants are selected based on their ability to offer the most important information on the topic. In a focus group interview, the interviewer (researcher) guides the discussion based on a written set of questions or topics to be covered. The focus group sessions are cautiously scheduled, taking advantage of

group dynamics for accessing rich information in an economical manner (Maltby et al 2010: 74; Polit & Beck 2012: 537).

The assumption with the FGDs is that individual's attitudes, beliefs and actions do not form in a vacuum and people often need to listen to others' opinions and understandings in order to form their own. According to George (2013:257), the interaction between focus group participants has the potential to create a dynamic synergy which is not present in individual interviews. In this study, focus group discussions were conducted with the objective of gaining insight the views and opinions of attendees of FANC on measures needed to enhance the utilization of health facility-based delivery services. Some participants who did not utilise health care facility for delivery might be reluctant or feel intimidated when interviewed individually so group dynamics and interaction produced by focus groups greatly minimised this feeling of isolation (Burns & Grove 2009: 513). In addition, in focus groups participants do not only talk about their own views and experiences, as in a one-to-one interview, but also on their responses to others' own views and experiences (Maltby et al 2010: 138). The focus group participants in this study comprised women only, and were therefore comfortable discussing the topic.

During the facilitation process of FGDs, certain considerations such as equal participation, appropriate wording of questions and maintaining neutral position were taken. As the researcher facilitated the discussion, he had to ensure that all members of the group participated. In addition, the researcher had to guide the participants to focus on the topic of concern. The advantage of FDGs is that they allow sharing different opinions that cannot be determined statistically (Brink et al 2014:158; Grove et al 2013:274). However, one of the disadvantages of FDGs is that it may be difficult to capture all views at the same time. It therefore requires a skilful facilitator to ensure that one person speaks at a given point and, with the permission of the participants; the focus groups may be audio-recorded. In addition, the researcher should bear in mind that using communication skill such as summarising key points is important to reflect opinions evenly and fairly.

3.3.3.2 Data Collection Instruments

For the purpose of the study, the researcher used interview guides to collect data

through individual interview and focus group discussions (FGDs). Interviews guides consist of a question or questions written to guide the interviewer and to enable the researcher to cover all areas required (Polit & Beck 2012:731). The researcher developed both the individual interview and focus group interview guides.

- **The development of data collection instruments**

The interview questions that were formulated were guided by the objectives of the study as well as the relevant literature reviewed. The researcher ensured that the interview questions were formulated to answer the research questions and that all the necessary questions measuring the concept were included (Castillo-Mantoya 2016:815; Dikko 2016). The interview guides comprised a broad or central question, as well as additional questions aimed at exploring and probing deeply into different aspect of the research phenomenon. The probing questions were based on the participants' responses to the question. For probing, the researcher used questions such as *"please tell me more…, what do you mean by…"*

Gill, Stewart, Treasure and Chadwick (2008) propose that the initial question should be the stage setting question, the question that is easy to understand and should not deal with sensitive issues. This helps put participants at ease, builds up confidence and rapport and often generates rich data that subsequently develops during the interview further. Open-ended questions were used to enable the participants to talk freely about their opinions and views regarding facility-based and home delivery service.

The two interview guides, namely individual interview (Annexes 8 & 9) and FGD's interview guide (Annexes 10 & 11) were prepared in English, and translated to Amharic by the language expert. Amharic is the common language spoken in Addis Ababa, Ethiopia and the Amharic version was used for data collection.

- **Pilot study**

Pilot studies are useful procedures as preparation of a full-scale study, regardless of paradigm (Majid, Othman, Mohamad, Lim & Yusof 2017:1073).The aim of piloting in this

study was to test the appropriateness of the questions, to gain experience and practice in conducting interviews, as well as to build rapport with the participants. Jacob and Furgerson (2012) suggest that building a good rapport with the participants could facilitate better responses.

There is adequate literature on the importance of piloting in qualitative research. According to Mikuska (2016), piloting means finding out if the study key informant interview guide or observation form will work in the real world by trying it out first on a few people. Castillo-Montoya (2016:817) add that interview protocols could be strengthened through piloting interviews and that piloting can help find flaws or limitations within the interview design and allow the necessary modification to the major study. The same author further explain that it is helpful to pilot the interview questions and adjust the interview guide accordingly before conducting the actual study.

The researcher piloted the interviews schedule on three (3) women who met the set eligibility criteria. These women were not included in the main study. The results were not included in the main study as the purpose was to test whether the research questions generated appropriate responses. The pilot study helped researcher to improve the interview guide. Some changes were made due to the issues that emerged during the pilot study. For example, some questions were rephrased and sequentially aligned.

The researcher also consulted content and qualitative research experts, and their feedback was used to improve the interview (Botma et al 2010).

- **Data collection process**

The women who met the eligibility criteria were contacted through the midwives/nurses in-charge of the maternal and child health units of the selected hospitals and health centers to discuss the purpose of the study, the study activities and the request for participation in the study. The researcher ensured that all women who agreed to take part in the interviews were given the necessary information regarding the interviews. The purpose of the interview was explained to them before they signed consent forms. The participants

were informed of their rights to refuse to participate or to revoke their participation without explanation or consequence (Polit & Beck 2012:157).

During the interviews, a favourable, relaxed and non-threatening environment was created. The researcher introduced himself to the participants and explained the individual interview and FGDs process. Both individual and FGDs took place in the private rooms of selected health facilities. With the permission of the participants, the individual interviews and FGDs were audio-recorded and notes were written during the interview in order to capture the original accounts of the participants' responses and to verify their interpretations by referring back to the original responses. The researcher conducted the interviews in Amharic in a quiet and private room, free from disturbances, and where the participants felt safe (Maltby et al 2010: 139; Polit & Beck 2012:765). Individual interview sessions lasted for about 30-50 minutes while the duration of FGDs sessions was 45-60 minutes. In the paragraphs that follow, the data collection process as it applied to individual interviews and FGD's is presented.

Individual interviews

The researcher conducted individual interviews with women who attended FANC, and had delivered live babies at home in the past one (1) year preceding the data collection for the study. The central question for the interview was *"What were your reasons for attending FANC (which promotes the use of skilled attendance at birth) but decided to deliver your baby at home and not at the health facility?* Additional questions based on objective 1 and 2 of the study were included;

Objective 1: Explore and describe the perspective of health facility-based delivery among attendees of FANC

- What prompted you to attend antenatal care?
- How many times did you receive ANC during this pregnancy?
- What were the benefits of attending antenatal care for you?
- What information did you receive from the health care providers about health facility based delivery?
- What is your opinion regarding delivering a baby in the health facility? What are the

benefits of going for institutional delivery?

- Would you recommend health facility delivery to your friends?

Objective 2: Explore and describe the perspective of home delivery among attendees of FANC

- Why did you chose to deliver your baby at home?
- What are your views regarding the advantages of home delivery?
- Would you recommend home delivery to your friends? Why?

Individual interviews were conducted until saturation, which was reached after eight (8) interviews, when additional data did not lead to any new emergent codes and themes. During the interview, the researcher became aware of the details that made up the interview context including confidence in answering questions, hesitations, the tone of participants as well as the shared experiences of researcher and participants. These observations and experiences were recorded in the researcher's reflexive journal and they formed part of the data.

The researcher utilized various communication skills such as paraphrasing, listening and probing to enhance understanding and to guide the participants to elaborate on their responses. Prompts such as attentive lean, silence and reflective summary were used to get additional information where it was required. These skills enabled the participants to respond freely to open-ended questions using their own words; giving in-depth information regarding their perspective of facility-based and home delivery services.

Conducting Focus Group Discussions (FGDs).

Focus group discussions (FGDs) were conducted to address the third objective of the study, namely to describe the women's opinions and views on measures needed to enhance the utilization of health facility-based delivery services among attendees of FANC. The researcher conducted FGDs with women who attended FANC, and had delivered live babies at home and at health facilities in the past year preceding data collection for the study. The goal was to ask questions that elicited responses and generated maximum discussions and opinions among the study participants within a given period of time.

Four (4) focus group interviews involving 32 participants from the three (3) selected health centres and one district hospital were conducted.

Table 3.1 shows the breakdown of focus groups participants.

Table 3.1 Breakdown of focus group participants			
Focus groups	**Number of participants**	**Location of delivery**	
		Health Facility	**Home**
Group 1	10	4	6
Group 2	8	5	3
Group 3	8	4	4
Group 4	6	2	4
Total	**32**	**15**	**17**

In order to allow effective communication in the FGDs, the discussants were seated in a circle so that each participant had a full and equal view of others (Maltby et al 2010: 139). The main question for focus group discussion was; '*What do you think should be done to enhance utilization of health facility-based delivery service among attendees of FANC?*

Additional questions included;

- Why do women prefer home delivery to facility-based delivery service?
- What are your views regarding the advantages of facility-based delivery?
- What measures should be implemented to enhance the utilization of health facility-based delivery service among attendees of FANC?

Focus group discussions were continued until data saturation was reached. Determining focus group data saturation was a challenge. However, the researcher used data saturation by group as suggested by Hancock et al (2016:2126), which was the point in coding when no new codes occurred in the data.

3.3.4. Data Analysis

De Vos, Strydom, Fouche and Delport (2011:410) explain that data analysis involves reducing the volume of raw data, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what data reveals. Data analysis brings order, structure and meaning to the mass of collected data. Qualitative data analysis is the non-numerical examination and interpretation of observations for discovering underlying meanings and patterns of relationships (Polit & Beck 2012:556). It involves integrating and synthesising narrative, non-numerical information that has been reduced to categories and themes by means of a coding process (Botma et al 2010:220; Burns & Grove 2009: 45). In qualitative studies, data collection and data analysis take place concurrently (Polit & Beck 2012:556; Botma et al 2010:220).

In the current study, data analysis began at the initial stage of data collection, and the process of data analysis went through the eight steps of Tesch's open coding approach (Creswell 2014: 248) to categorize, analyse and interpret the data. The process comprised description, data reduction, analysis and interpretation. It included the integration and synthesis of non-numeric data that was reduced to themes and sub-themes by means of coding (Botma et al 2010:224). Audio-recorded interviews and field notes were data sources in the current study. In the paragraphs that follow, the analyses of both individual and focus group interviews are discussed.

3.3.4.1. Data Analysis Process

The audio recordings of individual interviews and FGDs were transcribed and translated verbatim from Amharic to English by language expert. They were entered into, and saved as Microsoft Word files by the researcher. Verbatim transcription of the tapes is a critical step in preparing for data analysis, and researchers need to make sure that transcriptions are precise and that they reliably reflect the interview experience (Polit & Beck 2012:557). The transcript format made it easy to understand, manage and retrieve the data. Tesch's eight steps of data analysis were applied to the study as follows;

- **Preparation of data**

The researcher listened to the voice recordings in order to verify and to ensure the accuracy of the transcription. In addition, the researcher read the notes made during the interviews to get the sense of the whole.

- **Data coding**

Coding is the process of reading attentively through the transcribed data, line by line, and allocating it into meaningful analytical units. Codes are tags or labels that are assigned to segments of the transcripts such as paragraphs, sentences or words to help catalogue key concepts while preserving the meaning of the descriptive or inferential information obtained during the interviews. The researcher read the transcripts several times to be better acquainted with the content as well as taking note of how participants responded to questions. Accordingly, meaningful data units were coded and ideas that came to mind were written down in the margin (Botma et al 2010: 224). The data coding process was done following the steps suggested by Tesch in Creswell (2014:248), which included:

  - Getting a sense of the whole by reading all the transcripts carefully.
  - Select one interesting document to examine for the underlying meaning.
  - Annotate the selected document in the margin formulating topics into columns.
  - Check for any emergence of new codes and categories.
  - Combine categories that are associated to each other.
  - Shorten each category and put codes in alphabetical order.
  - Bring together the data material fitting in each category in one place and perform an initial analysis.
  - If necessary, recode the existing data.

- **Establishing themes or categories**

The next phase of the data analysis process was to organize or combine related codes into themes or categories. Each category were assigned a label or identifying name. Data fitting to the same category were assembled, and redundant information was identified and eliminated (Botma et al 2010:224).

- **Structuring the analysed data**

The researcher examined the categories and identified how each category was linked or related to other categories. This was accomplished by means of diagramming, which is a process of making a sketch, drawing or outline to show how something works or to classify the relationships between the parts of a whole.

- **Interpreting the data**

After identifying codes, the data analysis process continued with generating patterns and themes to describe the data in a form, which summarises it, yet retaining the richness, depth and context of the original data. The researcher critically reviewed the codes, taking notes of similarities and differences as well as linkages to generate themes. This process required him returning to the data several times to check the evidence supporting each theme. The independent reviewer then reviewed the transcripts once again the list of codes, the matrix and the themes. A meeting was held with the independent reviewer to discuss areas of disagreements, and the agreement was reached with the independent coder regarding the themes and sub-themes that were identified during data analysis. The study supervisors further reviewed the codes, matrix and themes. In table 3.2, a summary of the research methods used in the study is presented.

Table 3.2 Summary of the research methods used in the study

Phases	Phase 1	Phase 2	Phase 3
Objectives	Explore and describe the perspective of health facility-based and home delivery among attendees of FANC.	Describe the views of attendees of FANC on measures needed to enhance the utilisation of health facility based delivery services.	Propose women centred practice guidelines to enhance the utilisation of health facility-based delivery among attendees of FANC in Addis Ababa, Ethiopia
Accessible population	Purposively selected sample of attendees of FANC with a history of at least one birth at home in the last 1 year preceding the date of data collection	Purposively selected sample of attendees of FANC with a history of at least one birth at home or at the health care facility in the last 1 year preceding the date of data collection	The researcher was the main data collection instrument.
Data collection method	Face-to-face individual interviews	Focus group interviews	
Data collection instruments	Individual interview schedule. Researcher's notes	FGDs interview schedule Researcher's notes	Findings of phase 1 and 2 Relevant literature review
Data analysis	Thematic analysis	Thematic analysis	
Findings	Description of the perspective of health facility-based and home delivery among attendees of FANC.	Description of the views of attendees of FANC on measures needed to enhance the utilisation of health facility based delivery services	Proposed women centered practice guidelines to enhance health facility based delivery in Addis Ababa

3.4. TRUSTWORTHINESS

Grove et al (2015:392) define trustworthiness as a determination that a qualitative study is rigorous enough and it is of high quality. The same authors further explain that the trustworthiness of a qualitative study is determined by the extent to which it is dependable, confirmable, credible and transferable. It is worth noting that these criteria are inter-related and the more confirmable and dependable a study is, the more credible it is (Creswell 2014:39; Grove et al 2015:392). The four criteria for developing trustworthiness as recommended by Lincoln and Guba (1985 in Polit & Beck 2012:584) were used as described in the paragraphs that follow.

3.4.1 Credibility

Credibility refers to the extent to which data and data analysis are believable, trustworthy or authentic (Kivunja 2017:34). According to Yilmaz (2013:321), credibility means that the study participants find the results of the study true or credible (Yilmaz 2013:321). The same authors further explain that, for a qualitative study to be credible, it must be sufficiently descriptive, including a great deal of descriptions of people, activities, interactions and

settings so that the reader can understand what happened and how it happened during the research process. The researcher used the following strategies to ensure credibility of the study

- **Prolonged engagement**

Yilmaz (2013:321) note that, since the nature of qualitative research is fundamentally people-oriented, researchers are required to get close enough to the people and situation under study to capture what actually takes and what people actually say. To this end, they should spend prolonged time in the setting. Prolonged engagement refers to the lasting presence during the observation of long interviews or long lasting engagement in the field with participants. The researcher spent considerable time(four weeks) interacting with the participants during individual and focus group interviews in order to develop a rich understanding of their perceptions of facility-based and home delivery service until data saturation. The time spent during data collection was sufficient to establish rapport with the participants.

- **Member checking**

Member checking, also known as informant feedback, is the process through which the participants check and evaluate the research findings to determine if its descriptions, themes and interpretations accurately reflect their viewpoints (Yilmaz 2013; 321). It involves the process of asking participants to review and react to study data, emerging themes and conceptualizations (Polit & Beck 2012:599). Member checking can be done during data collection through deliberate use of probing and clarification questions to ensure correct understanding of responses and meanings attached to responses.

The process of member checking also involves returning to persons from whom data were collected and asking them if they can recognise the data interpretation reported as themes and categories as accurate representations of their experiences (Creswell & Clark 2011:91; Polit & Beck 2012:599).

In this study, on the spot member checking was performed during the interviews by repeating what the participant said and what was documented in the field notes to the participants and confirming that is what they wanted to say. Through member checking, feedback was given to the participants. The researcher also obtained feedback regarding the participants' response to the interpretation of the data from them as individuals (Holloway & Wheeler 2010:305).

- **Thick description**

Thick description involves a detailed description of the process, context and people in the research including the meaning and intentions of the participants' and researcher's conceptual developments (Holloway & Wheeler 2010:310). Thick description necessitates prolonged engagement in the setting (Holloway & Wheeler 2010:311). Prolonged engagement in the setting and immersion in the data were discussed in the previous paragraphs. In addition, the individual interviews were audio-recorded to document the findings and to serve as a backup method for the enormous amount of data that emerged during the discussions. Data from information-rich participants were collected until data saturation was reached. The researcher provided a factual, accurate and detailed report of the rich description of the research phenomenon in order to provide sufficient information to permit judgments about contextual similarity.

3.4.2 Dependability

It refers to a criterion for evaluating integrity in qualitative studies namely the stability of data over time and over conditions; analogous to reliability in quantitative research (Polit & Beck 2012:725; Kumar 2011:172; Botma et al 2010:233; Burns & Grove 2009: 431). According to Kivunja (2017:320), the study is dependable of the process of selecting, justifying and applying research strategies, procedures and methods is clearly explained, and its effectiveness evaluated by the researcher and confirmed by an audit trail. Polit and Beck (2012: 585) suggest that dependability could be attained by tracking the research procedures and changes in detail. To ensure dependability in the study the researcher

liaised with the supervisors regularly by email, personal contact and phone calls to track any changes carried out in the protocol and procedures

3.4.3 Confirmability

This criterion refers to the extent to which the research findings could be confirmed or corroborated by other researchers in the field (Kivunja 2017:33). It is concerned with establishing that data and interpretations are not figments of the inquirer's imagination, but clearly derived from the data. According to Holloway, Wheeler and Holloway (2010:303), the findings of research are confirmable if the readers of the study are able to trace data to their original sources and the findings are grounded in the data and inferences based on the data are logical and clear (Yilmaz 2013:320). Confirmability was enhanced by means of an audit trail and reflexive journal.

- **Audit trail**

Polit and Beck (2012:591) view an audit trail as the process of critically and systematically collecting documents and materials during the study to allow an independent person to review and make informed conclusions about the study. The same authors emphasise that raw data, data reduction and analysis products, audio tapes, process notes, information on researcher's intentions, pilot forms and subsequent draft reports should be saved for audit trail. For the purpose of this study, transcriptions, methodological procedures including analysis, and possible changes were kept in order. All decisions and approaches or changes taken were recorded to account for such actions. The data was thus traceable through raw data from transcripts, field notes and the study report.

- **Reflexive journal**

According to Krefting (1991:77) in Anney (2014:279), reflexivity is an assessment of the researcher's own background, perceptions and interests on the qualitative research process. It involves a critical self-reflection about oneself as researcher in terms of own biases, preferences, preconceptions and the research relationship to the participants and how it affects the participants' answers to the research questions (Kotstjens & Moser

2018:121). The researcher is required to keep a reflexive journal, which should include all events that happened in the field, personal reflections in relation to the study. The researcher's personal reflections are reported in 3.3.4.

3.4.4 Transferability

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other similar contexts or settings or groups (Polit & Beck 2012:585; Kumar 2011:172). In qualitative research, the intention is not to generalize the findings but qualitative researchers have a responsibility to produce sufficient data that is conceptually representative of the people studied within a specific context and they need to account for contextual factors when data is transferred from one situation to another. In this study, background information was provided to establish context of the study and a detailed description of people, actions and events studied to ensure transferability.

3.5. ETHICAL CONSIDERATIONS

Biomedical and human research requires observation of the broad ethical principles of respect for persons, beneficence, non-maleficence and justice to ensure that research procedures adhere to professional, legal, and social obligations to the study participants (Burns & Grove 2011:107; LoBiondo-Wood & Haber 2010: 250; Polit & Beck 2012:727).

In the paragraphs that follow, ethics pertinent to the current study are presented under the headings respondents, institutions and the integrity of the researcher:

3.5.1. The Respondents: Respect for Persons

Horner (2003:268) cited in Beckmann (2017:7) states that the principle of respect for persons fosters and enhances the self-determination (self-governance) of others and refrains from interfering with free choice and strives to protect vulnerable persons as much as possible. The principle of respect for persons means that a person must choose voluntarily whether to participate in research based on the accurate (truth) flow of information given to participants regarding the risk and benefit of research. The process of providing the necessary information and of engaging with the person before a decision is

reached is known as the informed consent (Human-Vogel & Coetzee 2011:178 cited in Beckmann 2017:16).

The basic rights of participants in research are included in the discussion about the principle of respect for persons and these rights include right to full disclosure about the research, anonymity and confidentiality, the right to privacy and the right not to be harmed in any way.

Informed consent is an ethical principle that requires researchers to obtain the voluntary participation of subjects, after informing them of possible risks and benefits (Kumar 2011: 220; Maltby et al 2010:141; Polit & Beck, 2012: 158). Polit and Beck (2013:231) describe an informed consent as an agreement or explicit permission given by the participants, indicating their willingness to take part in the study under certain conditions. The same authors state research participants can only make informed decisions regarding their participation in the study if there was full disclosure about the research and that the participants have sufficient knowledge and comprehension of the research activities. Research participants should therefore be informed about the nature of the study and all of the aspects of the research that are likely to affect their willingness to become participants should be disclosed (Polit & Beck 2012:158; Kumar 2011:220).

To ensure that the participants were afforded the opportunity to make an informed choice, they were given information about the purpose of the study, objectives, the nature and activities of the research as well as the expected duration of participation in the study. The voluntary nature of participation, the option to refuse to participate in the study and the option to withdraw from the study at any time without any disadvantage were part of the written information given to participants (Annexes 4 & 5; English & Amharic version respectively).

Before participants signed the consent form, which was written in Amharic and English (Annexes 4 & 5), the researcher ensured that participants understood the information given by using the language of the choice, and at the level of their understanding. The study participants who were 18 years and above, were given consent forms to sign indicating their voluntary participation in the study and permission for audio recording of the interviews.

Anonymity and confidentiality: Anonymity means that the researcher should ensure that no participant in the study could be identified from any of the responses that they have given. Confidentiality means that the information that the researcher obtains about and from the research participants should not be divulged to other people without their permission (Creswell 2014; Kumar 2011: 221; Maltby et al 2010: 125; Polit & Beck, 2012: 342). To ensure that the participants' rights to anonymity and confidentiality were protected, the researcher took the following measures:

- The participants were assured that all of the information given by them would be treated in strict confidence and would only be used for the purpose of the study
- The researcher made sure that the collected raw data were kept safe and confidential, locked up in a secure place and the files were password protected.
- Names of the participants were not written in study records and data were reported in a manner that did not identify or link the participants with the information.
- For focus group interviews, the participants signed a confidentiality binding agreement (Annexes 6 & 7 English & Amharic version respectively), which stated that they agreed that no information or discussion outside the group would take place to ensure confidentiality.

Beneficence and Non-maleficence: This principle refers to the ethical obligation to maximise benefit and to minimise harm to the research participants, and it requires that the risks of harm posed by the research must be reasonable in the light of anticipated benefits (Creswell 2014; Kumar 2011: 221; Maltby et al 2010: 336). Non-maleficence is closely associated with beneficence and assumes that no harm will come to the individual as a result of taking part in the research study (Kumar 2011:221). Harm can be physical, emotional, psychological, social, economic and legal (Polit & Beck 2012:171; Yilmaz 2013:316).

The participants were at no foreseeable physical harm given the fact that participation in the study involved interviews. However, the researcher maintained confidentiality because breach of confidentiality can cause social and/or psychological harm. The participants did not experience any financial loss because the researcher covered transport costs.

Justice: Justice is a principle, which states that all participants should be treated alike, and equitably (Grove, Burns & Gray 2013:172). Fair treatment denotes that research participants are selected fairly without social, cultural or sexual biases and risks or benefits fairly distributed based on the parameters of the study. In this study, the selection of study participants was based on the pre-determined eligibility criteria.

Privacy: privacy describes the person's interest in controlling access to her personal information**.** According to Beckmann (2017:17), the right to privacy in the field of research is expressed more concretely in the following 'rules': the right to:

- Refuse to be interviewed,
- Refuse to answer any question, and the right not to be interviewed at meal times or at night, or for long periods.

In this study, the measures taken by the researcher described in 3.5.1 (respect for persons; informed consent) also addressed the right to privacy. In addition, interview sessions were conducted in private rooms, with only the researcher and the potential participant or the participants.The expected duration of the interviews was stated in *3.5.5.3.*

3.5.2. The Institutions

Ethical clearance: Before the commencement of the study, ethical clearance was obtained from the Research Ethics Committee of the Department of Health Studies, University of South Africa (Annexe 1).

Access to the setting: A written request to conduct the study was made to the Addis Ababa City Government Health Bureau (Annexe 2) and the permission to conduct the study was granted by the Addis Ababa City Government Health Bureau (Annexe 3).

3.5.3. The Scientific Integrity of the Researcher

The scientific integrity of the researcher refers to the competence of the researcher in conducting the research. The Research Ethics committee of the Department of Health Studies at UNISA acknowledged the researcher's competence to conduct the current study

by approving the research proposal, and by issuing the ethical clearance certificate. To this effect, the researcher was assigned supervisors to guide the researcher in ensuring that the sound research design and methods result in reliable and valid data and outcomes that address the research objectives. The research process was followed and documented. Research methods were not manipulated in any way to support the researcher's viewpoints and all the sources used were acknowledged accordingly.

Upon accomplishment of the study, the researcher would communicate the findings to the FMoH research coordinator to distribute the information to all pertinent stakeholders. Consultation with the language editor ensured that the researcher's report complies with the scientific writing standards. Finally, research outcomes will be disseminated in the form of peer reviewed journal articles and in the form of a doctoral thesis in UNISA repository.

3.6. CONCLUSION

In this chapter, the research design and methods used in the study were presented. A specific, related research design used for the achievement of the study objectives was described. The research setting, the population selected for the study, the sample and sampling procedures, data collection, and measures taken to ensure trustworthiness as well as data analysis were described. The ethical considerations related to the study were presented in the last section of the chapter. In the next chapter, the findings of the current study are presented.

CHAPTER 4

DATA ANALYSIS, PRESENTATION AND DESCRIPTION OF RESEARCH FINDINGS OF PHASE 1 OF THE STUDY

4.1. INTRODUCTION

This chapter provides a description of data analysis, presentation and the description of research findings of the first phase of the study. The data collection and analyses presented in this chapter occurred according to the research methods described in chapter 3. This chapter begins with data management and analysis, followed by the presentation and the description of the findings.

4.2. DATA MANAGEMENT AND ANALYSIS

In the first phase of the study, data was collected by means of face-to-face, individual interviews, with the purpose of exploring and describing the perspective of health facility-based and home delivery among attendees of FANC in Addis Ababa, Ethiopia. Raw data comprised the verbatim transcriptions of interview data from the audio-recordings and notes made during the interviews. The data collected were stored electronically as audio recordings to use as a form of backup and the transcriptions and notes were stored as MS word files. The MS word files were password protected to ensure confidentiality. The researcher used Techs' eight steps of qualitative data analysis method for analyzing data from individual interviews (Creswell 2014:248; Polit & Beck 2012:745).

4.3. RESEARCH FINDINGS

The findings of the study are presented under the headings sample descriptions and themes that emerged from the analysis of data

4.3.1 Sample Description

The sample comprised 8 (eight) women who attended FANC with a history of at least one birth at home in the last 1 year preceding the date of data collection. All the participants

resided in Addis Ababa for at least for 6 months. The study participants met the set eligibility criteria.

4.3.2. Themes

From the analysis of individual interview data, 4 (four) themes emerged. These themes were identified as the rich and detailed account of the perspectives of facility-based and home delivery among attendees of FANC in Addis Ababa, Ethiopia.

4.3.2.1. Theme I: Perceived benefits of home delivery

The first theme that emerged from data analysis was *perceived benefits of home delivery*. Within the theme, 3 (three) categories *support, familiarity and warmth of the home setting and affordability of home delivery* emerged. The sub-categories were as shown in table 4.1.

Theme	Categories	Sub-categories
Perceived benefits of home delivery	Support available during home delivery	(i) Partner, family and neighbors' supportive presence at birth
	Familiarity and warmth of the home setting	(ii) Familiar, comfortable and convenient home setting
	Affordability of home delivery	(iii) The cost of health facility-based delivery services too high

Table 4.1 Theme I: Perceived benefits of home delivery

(i) Partner, family and neighbours' supportive presence at birth

The findings revealed that benefits of home delivery (as perceived by the participants) was one of the reasons women decided to deliver their babies at home and not at the health facilities. Some of the participants indicated that the presence of partners, family members, friends and neighbours offer the required support and assistance during delivery at home. Other participants perceived home delivery safe because of the confidence they have in experienced members of the community such mothers, grandmothers and neighbours who assist during delivery. Sample responses included;

"I am scared of delivering at a health facility alone because family members (especially my husband) aren't

permitted to attend a woman in the labour room. I won't have such problems when I deliver at home." (Participant 05).

"Men are not allowed to accompany their wives to labour ward for the reasons I don't know. What is wrong if he is allowed to stay with wife during childbirth?" (Participant 03)

"Yet, men aren't permitted to attend a woman in the labour room and only one female relative is sometimes allowed to be with a woman in labour ward" (Participant 02).

"I delivered at home without any problems and was assisted by my mother" " (Participant 08).

"My grandmother asked me to wait a little longer at home. She told me to wait and I gave birth spontaneously. We have confidence in her (TBAs)" (Participant 04).

"When labour started me at night I was alone because my husband was on field work. So, there was nobody else close to me. I then shouted to call my neighbors but I already delivered before they came" (Participant 01).

(ii) Familiar, comfortable and convenient home setting

The findings revealed that some of the participants identified familiarity with home setting and warmth of the home setting as another benefit of home delivery, in that at home one can rest comfortably in own bed. This finding was apparent in the following sample responses;

"At home, you can rest in *your* bed after delivery, and your family and friends feed you porridge "(Participant 05).

"I would have lost the comfortable house where my close families, relatives and neighbours nearby me, had I gone hospital for delivery" (Participant 07).

One participant mentioned the immediate celebration of the birth of child by women singing traditional songs as one of the benefits of home delivery. In addition, she mentioned caring and feeding of the mother by the neighbours. This is what she said *'Following childbirth, neighboring women will make some porridge and will serve the woman. They (women) will celebrate this special occasion with singing traditional songs and eating porridge. If childbirth takes place in the facility, you miss this wonderful event and the warmness of your home. I think this ceremony is unique to Ethiopian women (Participant 01).*

(iii) Cost of facility-based delivery too high

The high cost of delivering at a health facility was mentioned as one of the reasons women decide to deliver their babies at home. The sample response

> "You know you need someone who arranges taxi and pays money for it.to go to health facility''

Theme I: Overview of the findings and literature control

According to the findings, the women who took part in this study chose home based delivery because of the supportive presence of partners (husbands), family members and neighbours during childbirth as well as the comfort and convenience of the home environment. These findings were consistent with findings of previous studies. Adinew and Assefa (2017) reported similar findings that Ethiopian women who took part in their study chose home-based and traditional birth attendants to facility-based delivery and health professionals respectively. The same authors explain that the choice was based on the familiarity, comfort and convenience of the home environment. In addition the home environment does not limit the involvement of traditional birth attendants who are trusted by the community because of their status and the perceived quality of care (skill and warmth) they render during childbirth (Adinew & Assefa 2017; Gebrehiwot et al 2012; Magoma et al 2010). According to the study findings, women indicated that the presence of family and traditional birth attendants provide physical, social and emotional support during childbirth. According to Bohren et al (2014: 13) and Magoma et al (2010), the availability of traditional birth attendants in the community might confirm a woman's decision to give birth at home.

The findings also revealed that it is easier for women to deliver at home where they are able to use their own belongings and receive support from their neighbours. One participant said, "*At home, you can rest in your bed after delivery, and your family and friends feed you porridge".* Gebrehiwot et al (2012), Magoma et al (2010) and Titaley et al (2010) reported similar findings.

This finding is consistent with the Bohren et al (2014) Multiple-level life course framework of facility-based delivery in low- and middle-income countries (LMICs) according to which

the ease of home delivery facilitates the utilisation of home, and not facility-based delivery. This is the framework that was used for the purpose of the current study.

Another important finding was that traditional practices influenced some of the women's decision to deliver at home and not at a health facility, evidenced in the sample response "*Following childbirth, neighboring women will make some porridge and will serve the woman. They (women) will celebrate this special occasion with singing traditional songs and eating porridge. If childbirth takes place in the facility, you miss this wonderful event and the warmness of your home. I think this ceremony is unique to Ethiopian women"* This finding is consistent with the results of previous studies (Moyer et al 2013; Gebrehiwot et al 2012; Magoma et al 2010; Oyerinde, Harding, Phillip, Garbrah-Aidoo et al 2012; Spangler & Bloom 2010).

According to the Multiple-level life course framework of facility-based delivery in low- and middle-income countries (LMICs), traditional influences and pressure on the perception of childbirth play vital roles in understanding decision making on the place of delivery. Care-seeking might be postponed in conditions where some health problems are perceived as spiritual in nature rather than physical (Bohren et al 2014:4; Magoma et al 2010:5; Mirgissa, Tesfaye, Zergu, & Ismael 2016: 97). The unique, cultural celebration of the birth by the community facilitated home delivery in this study.

Affordability of home delivery was mentioned as one of the reasons some of the women who participated in the study preferred home-based care delivery. Yaya et al (2018) conducted a survey in Ethiopia and Nigeria to examine country level variations of the self-reported causes of not choosing to deliver at a health facility. The results of the same study identified cost as one of the barriers reported for not attending health facility delivery in both countries. Oyerinde et al (2012), Spangler and Bloom (2010) and (Tabatabaie, Moudi, & Vedadhir, 2012) reported similar findings in Sierra Leone, Tanzania and Iran respectively. There is no need to arrange and pay for transport during a home birth.

This finding is consistent with the Bohren et al (2014) Multiple-level life course framework of facility-based delivery in low- and middle-income countries (LMICs) according to which the cost of childbirth may become a barrier to facility-based delivery. According to Bohren

et al (2014:12), economically constrained women might have concern obtaining funds to pay for facility-based delivery care. The same authors indicate that some women regarded costs outside of the direct cost for childbirth as "unseen" and difficult to prepare for (Bohren et al 2014:12; Gebrehiwot et al, 2014: 6; Magoma et al 2010: 4; Moyer et al., 2013b:8).

4.3.2.2. Theme II: Knowledge Deficit

The second theme that emerged from data analysis was *knowledge deficit*. Within the theme, two categories *inadequate information received from the health professionals* and *beliefs about home and facility-based delivery* emerged. The sub-categories were as shown in table 4.2.

Table 4.2 Theme II: Knowledge deficit

Theme	Categories	Sub-categories
Knowledge deficit	Inadequate information received from health professionals	(iv) Lack of knowledge about facility-based delivery
	Perceptions of home and facility-based delivery	(v) Home delivery is for normal delivery (vi) Unnecessary procedures carried out at health facilities

(iv) Lack of knowledge about facility-based delivery

According to the study findings, lack of knowledge about facility-based delivery influenced the women's decision to give birth at home. Some of the participants stated that they did not know about the facility-based delivery service at public health facilities. Sample responses in that regard included:

> "We must been told the significance of health facility delivery by the service providers at the ANC clinic. Nobody raised the issue to us. So, we decided to give birth at home. There is a TBA in our community and she was called and assisted me" (Participant 02).

> "The nurse I was attended to by was busy and she only checked my abdomen and gave me an appointment to return. Otherwise, I don't recall anything I was told about facility delivery" (Participant 05).

> "I didn't receive any information about delivering in a facility. She (the midwife) only checked me and told me

to come on the next appointment…. I guess it is because they are at times busy or they might not well prepared to do so (Participant 01).

(v) Perception that home delivery is for normal delivery

The study findings revealed some participants' perceptions of home delivery that made them decide to give birth at home, even though they attended FANC. The finding was evident in the following sample responses;

> "I delivered my last child at home because it was normal delivery, however, I would have gone to hospital had any complication occurred '' (Participant 08).

> ''If I encounter difficulty to deliver in my home I can go there at last while labour is prolonged and painful. Otherwise, why should I visit a health facility while I am healthy? '' (Participant 05).

> ''I delivered 5 children at home being assisted by TBA, my families and relatives. You will continue to deliver at home if you deliver the first child at home" (Participant 02)

(vi) Perception that unnecessary procedures are carried out at health facilities

According to the study findings, some of the women had a perception that unnecessary procedures are carried out at health facilities during delivery. Sample responses in that regard included:

> "Lots of women are cut and stitched for the reasons I don't know. For example, if one goes to private hospital, almost every one of them deliver by operation." (Participant 01)

> "Fear of Caesarean section delivery discourage us [women] to come for health facility-based delivery" (Participant 08)

Theme II: Overview of the findings and literature control

The findings of the study revealed that women's lack of knowledge about facility-based delivery influenced their decision to give birth at home. The findings of the study are consistent with some of the previous studies that found that knowledge deficit regarding the benefits of health facility-based childbirth made women choose home delivery. Various researchers are of the opinion that ANC workers might not be effectively instructing women on the significance of facility-based delivery service possibly because of heavy workload

and constrained time due to deliberate complex matters with their clients (Bohren et al 2014:4; Izugbara & Kabiru 2009: 7; Magoma et al 2010; Moyer et al 2013).

The findings of the study also revealed a perception among some participants of the study that home delivery is for women who had a history of normal delivery. The study findings are consistent with the research done by Øxnevad (2011) on perceptions and practices related to home-based delivery and a qualitative study by Bedford, Ghandi, Admassu and Girth (2012) on the location of childbirth in rural Ethiopia. According to the findings of the same studies, the birthing process was considered a normal event, and women considered home delivery first and considered facility-based delivery only if complications arose.

The results of the survey that was conducted by Yaya et al (2018), showed that one in four women in Ethiopia reported that it was not necessary to attend health facility-based delivery considering that delivery is a natural phenomenon and not an ailment requiring health facility services. Kebede et al (2016) conducted a quantitative study on factors associated with institutional delivery service Ethiopia and found that women who faced problems during pregnancy were 2.8 times more likely to utilize health care facility-based delivery than those who did not face problems during pregnancy.

This finding is consistent with the Bohren et al (2014) Multiple-level life course framework of facility-based delivery in low- and middle-income countries (LMICs) according to which the previous birth experiences may affect the women's choice of the location of delivery of the baby. For a woman who delivered her first child at home without difficulties, using a health facility-based delivery for subsequent deliveries may be regarded as unnecessary (Bohren et al 2014: 4; Shiferaw et al 2013: 5; Story, Burgard, Lori, Taleb, Ali, & Hoque, 2012:28).

Bohren et al (2014: 12) point out that some women may consider that ANC attendance will reduce the likelihood of a difficult delivery, and that ANC may be viewed as a preventative method, guaranteeing a normal pregnancy and home delivery. This may explain why in some circumstances ANC coverage is almost universal while health facility-based delivery rates stay low (Bohren et al, 2014: 4; Magoma et al, 2010).

According to the study findings, the perception of some of the women who took part in the study was that unnecessary procedures are carried out at health facilities. The findings are consistent with some of the studies that identified fear of cutting (caesarean section, episiotomy) during delivery as one of the factors that facilitated home-based delivery (Bedford et al 2012; Ghazi et al 2012; Magoma et al 2010).

The multiple-level life course framework of facility-based delivery in low- and middle-income countries (LMICs) suggests that medicalization of childbirth may be one of the reasons women prefer home to facility-based delivery. According to the model, women in low- and middle-income countries may fear various undesirable interventions and procedures such as episiotomies and caesarean sections and may prefer to deliver at home. This fear is usually based on the perception that birthing is a "normal" process which is a woman's "natural rite of passage" with no basis for delivering at a health facility (Bohren et al 2014:7; Gebrehiwot et al 2012:4; Magoma et al 2010:6).

4.3.2.3 Theme III: Poor Access to Health Facilities

The third theme that emerged from data analysis was *poor access to health facilities*. Within the theme, two categories *lack of transport* and *financial constraints* emerged. The sub-categories were as shown in table 4.3.

Table 4.3 Theme III: Poor access to health facilities

Theme	Categories	Sub-categories
Poor access to health facilities	Lack of transport	**(vii)** Inaccessible and inadequate ambulance service **(viii)** Lack of prior arrangement for transport **(ix)** Distance and poor roads
	Financial constraints	**(x)** Lack of emergency and complications readiness planning

(vii) Inaccessible and inadequate ambulance service

According to the study findings, the participants ended up giving birth at home because of poor access to health facilities. The difficulty of getting transport, in particular ambulance

services to the health facility, especially at night resulted in women delivering their babies at home. Sample responses included;

> "In the night, it is difficult to get the ambulance as fast as you need it." (Participant 01)
>
> "There is limited access to ambulance service mainly in the night."(Participant 06)
>
> ''Sometimes, driver doesn't respond to the telephone call and, the woman will deliver at home'' (Participant 03)

(viii) Lack of prior arrangement for transport

Planning for childbirth include decisions about the location of delivery, transportation planning and money to pay for the childbirth. The findings of the study revealed that study participants did not arrange for transportation to a health facility. This was evident in the sample responses;

> "We didn't arrange transportation before".
>
> "I delivered this baby at home because labor started in the night while it was heavily raining, and there was no time to arrange transport" (Participant 02*).*

(ix) Distance and poor roads

According to the study findings, the long distance to the health care facilities, as well as the bad state of the roads diminished access to health care facilities. One participant explained *"My home is a bit far from the main road and a taxi can't come in because of the bad road (cobblestone was under construction); (Participant 04).*

(x) Lack of emergency and complications readiness planning

The study findings identified lack of funds in an emergency as a barrier to utilization of facility-based delivery

> "You know you need someone who arranges taxi and pays money for it.to go to health facility (Participant 03).

Two mothers reported that they delivered at home because labour was unpredictably too fast, and did not give their families a chance to reach the health facility for delivery. Childbirth after an unusually rapid labour, culminating in the rapid and spontaneous

expulsion of the infant is called precipitate delivery. In precipitate delivery, the first and the second stage of labour are combined, and the duration of labour is under two to three hours (Silver & Sabatino 2012; Suzuki 2015:151). The sample responses included;

> *"Suddenly*, I went into labor pain after midnight (at 1pm) and delivered normally my last child at about 2 pm. There is a well-known TBA in our community and she came and assisted me" (Participant 08).

> "I delivered this baby at home because labor started in the night while it was heavily raining, and the baby was born *soon"* (Participant 06).

These findings are similar to the findings, which were reported in previous studies by Alabbi, O'Mahony, Wright and Ntsaba (2015) and Yakubu, Benyas, Emil, Amekah, Adanu, and Moyer (2014).

Theme III: Overview of the findings and literature control.

According to the findings of the study, poor access to health facilities played an important role in influencing women's location of delivery (home-based delivery in this study). The findings indicate that the women who took part in the study failed to reach the health care facilities because of the difficulty of getting transport to the health facility at night, long distance to travel to the health facilities, poor conditions of the roads to health facilities and financial constraints. Similar findings were reported in a variety of previous studies (Doctor, Findley, Ager, Cometto et al 2012; Gebrehiwot et al 2012; Spangler & Bloom 2010; Yaya et al 2018). A noteworthy finding is that women who attended FANC did not make plans for emergency and complications readiness plan, as it is expected in line with WHO (2016). The WHO recommends that all pregnant women develop a written plan for dealing with birth and any unexpected adverse events such as complications or emergencies that may occur during pregnancy, childbirth, or the immediate postnatal period (Annette et al 2016:416). Birth preparedness is the process of planning for a normal birth while complications readiness refers to anticipating the actions needed in case of an emergency. Emergency planning is the process of identify and agreeing all the actions that need to take place quickly in the event of an emergency, and that the details are understood by everyone involved, and the necessary arrangements are made. The plans should be discussed with the skilled

attendant at every FANC assessment and one month before the expected date of birth (Annette et al 2016:416; Tarekegn, Lieberman & Giedraitis 2014:2; Yaya et al 2018).

4.3.2.4. Theme IV: Inadequate Resources

The fourth theme that emerged from data analysis was *inadequate resources*. Within the theme, two categories *inadequate skilled health professionals* and *inadequate equipment* emerged. The sub-categories were as shown in table 4.4.

Table 4.4 Theme IV: Inadequate resources

Theme	Categories	Sub-categories
Inadequate resources	Inadequate skilled health care professionals	(xi) Perceived incompetence among health care professionals (xii) Negative attitudes of health care professionals and poor service at health facilities
	Inadequate equipment	(xiii) Inadequate beds/ supplies

(xi) Perceived incompetence among health care professionals

From the participants' perspective, inadequacy of both skilled health care professionals and equipment are some of the reasons some women do not use health care facility-based delivery services. The findings revealed perceived incompetence of health care professionals, lack of knowledge, skill and appropriate attitudes to care for pregnant women during pregnancy and childbirth as reasons women do not go for health facility-based delivery. The participants expressed confidence in traditional birth attendants. Sample responses include

> "I was really upset with how they took care of me when I delivered my first child in the health center. She [the nurse] who attended to me didn't even know how to manage removal of the placenta, and the baby. It seemed that she didn't get proper training or she lacked some experience" (Participant 01).

> "We have confidence in traditional birth attendants" (Participant 04).

(xii) Negative attitudes of health professionals and poor service at health facilities

The findings of the study revealed that women did not choose facility-based delivery because of negative attitudes of health care professionals and poor service at health facilities. Many participants mentioned physical and verbal abuse, lack of respect and lack of sympathy at the hands of midwives and nurses. These findings were evident in the following sample responses;

> "That some of the midwives, they even beat you, and scream on you, they don't have tolerance for you. They are verbally abusive, impolite, and lack sympathy" (Participant 01).

> "There are some negligent staff. We go there to get their help, but they talk and chat about their private issues. So, it is not advisable to go there" (Participant 03)

> "While I delivered my second baby at a health center I was in pain and shouting for help to the midwife who was chatting with her friends. She didn't show any concern to me and one physician also came and yelled at me. I suggest that these people have to in the first place respect their clients and also know their professional duties and responsibilities" (Participant 06).

(xiii) Inadequate equipment (beds, BP apparatus, bed sheets and thermometers)

The participants stated that the equipment required for providing quality care at health care facilities was inadequate. According to the findings, there was shortage of beds, bedsheets, blood pressure monitoring equipment, as well as thermometers, resulting in women in early labour sent home. Some of the women indicated that the health professionals sent them back home because there were no beds, hence the home delivery even though they had planned to have facility-based delivery. Sample responses included; "For me, I don't think delivering at home is safe. I wanted to give birth at health facility but they returned me home because the contractions weren't strong and there weren't sufficient admission beds in the health center" (Participant 04).

> "I went to deliver my first born child and they sent me home and I delivered that evening at home. So, if there were enough delivery beds I wouldn't deliver at home" (Participant 05).

> "Due to shortage of beds, some women are referred from one facility to another. At times, the health facilities even don't have gloves, bed sheets, drugs, equipment like thermometer and BP apparatus" (Participant 08).

> "Let me tell you my own story. I was referred to hospital due to heavy vaginal bleeding when delivered my second baby. There was no BP apparatus in the hospital except one at the emergency room. There are staff, hospital and patients but no BP apparatus even in that big hospital" (Participant 02).

Theme IV: Overview of the findings and literature control.

The findings of the study revealed that women did not choose facility-based delivery because of the perceived incompetence and negative attitudes of health professionals, as well as poor service at health facilities. Similar findings were reported in previous studies. According to Adinew and Assefa (2017), women who took part in their study chose home-based and traditional birth attendants to facility-based delivery and health professional respectively because of the skill and warmth demonstrated by the traditional birth attendants. A number of studies found that women were mistreated during childbirth in health facilities, hence the decision to give birth at home (Adinew & Assefa 2017; Bohren, et al 2015; Ishola, Owolabi & Filippi 2017: 3; Reed, Sharman & Inglis 2017:21; Yaya et al 2018). The same authors reported similar findings of disrespectful treatment, unskilled care, poor health provider client interaction as reasons women preferred to give birth at home. Bohren et al (2014) conducted a systemic review with the aim of synthesizing qualitative evidence related to the facilitators and barriers to delivering at health facilities in low-and middle-income countries. Thirty four studies from 17 countries were included in the review, and in the majority of studies reports of disrespectful and abusive obstetric care were found.

The multiple-level life course framework of facility-based delivery in low- and middle-income countries (LMICs) suggests that previous birth experiences may be one of the reasons women prefer home to facility-based delivery. Bohren et al (2014: 4) state that a number of women decide their level of risk for difficult deliveries based on their previous experience of delivery practices and birth results. For example a woman might choose to give birth at a health facility if she had a previous positive experience of facility-based delivery (Bohren et al 2014: 4; Shiferaw et al 2013).

The findings of the study are inconsistent with WHO (2016) which supports health system approach and strengthening regarding availability of supplies and positive pregnancy and delivery experience.

4.4 Summary of the Findings according to the Study Objectives

In phase 1 of the study, individual face-to face interviews were used to collect data that ensured attainment of the following study objectives;

- Explore and describe the perspective of health facility-based delivery among attendees of FANC
- Explore and describe the perspective of home delivery among attendees of FANC

The participants had to answer the following central question; *"What were your reasons for attending FANC (which promotes the use of skilled attendance at birth) but decided to deliver your baby at home and not at the health facility?*

Thematic analysis of the interview data was done, and four (4) themes emerged, namely, perceived benefits of home delivery, poor access to health care facilities, inadequate resources and knowledge deficit about FANC. These themes were identified as the rich and detailed account of the perspectives of facility-based and home delivery among attendees of FANC in Addis Ababa, Ethiopia.

A review of literature pertaining to the facility and home delivery for the purposes of literature control was done after the data analysis process had been completed. The aim of literature control was to present a critical analysis of the relevant literature and to verify the results. In the paragraphs that follow, a summary of the findings is presented according the study objectives.

- **Perspectives of home delivery among attendees of FANC**

According to the findings, the women who took part in this study chose home based delivery because of the perceived benefits of home delivery. The benefits, from the perspective of study participants included the presence of partners, family members and the neighbours during childbirth. The women indicated that the presence of family and traditional birth attendants provide physical, social and emotional support during childbirth. Many participants perceived home delivery as safe because of the confidence they have in

experienced members of the community such mothers, grandmothers and neighbours who assist during delivery.

Another benefit of home delivery that was mentioned by study participants was that women found it easier to deliver at home where they were able to use their personal space and belongings. In addition, the study participants stated that home delivery provided them with an opportunity to exercise their traditional, celebratory and baby-welcoming practices. One participant said, "*They (women) will celebrate this special occasion with singing traditional songs and eating porridge. If childbirth takes place in the facility, you miss this wonderful event and the warmness of your home. I think this ceremony is unique to Ethiopian women".* The women who took part in the study cited the comfort and convenience of the home environment and affordability of home delivery as reasons they prefer not to use facility-based delivery. With home delivery, there is no need to arrange and pay for transport during child birth.

- **Perspectives of facility-based delivery among attendees of FANC**

The findings of the study revealed that women's lack of knowledge about facility-based delivery influenced their decision to give birth at home. The participants indicated that health professional did not inform them about the availability and the importance of health facility-based delivery service. Various researchers are of the opinion that ANC workers might not be effectively instructing women on the significance of facility-based delivery service possibly because of heavy workload and constrained time due to deliberate complex matters with their clients (Bohren et al 2014:4; Izugbara & Kabiru, 2009: 7; Magoma et al, 2010; Moyer et al 2013).

The findings of the study also revealed some misconceptions and beliefs among some of the participants of the study. One of the misconceptions was that women with a history of normal deliveries are the one for home delivery whilst health care facility-based deliveries were to be used by women with a history of abnormal deliveries. The same findings were reported by Øxnevad (2011), who conducted a study on perceptions and practices related to home-based delivery and a qualitative study by Bedford, Ghandi, Admassu and Girth (2012) on the location of childbirth in rural Ethiopia. According to the findings of the same

studies, the birthing process was considered a normal event, women considered home delivery first and considered facility-based delivery only if complications arose. The results of the survey that was conducted by Yaya et al (2018), showed that one in four women in Ethiopia reported that it was not necessary to attend health facility-based delivery considering that delivery is a natural phenomenon and not an ailment requiring health facility services. Kebede et al (2016) conducted a quantitative study on factors associated with institutional delivery service Ethiopia and found that women who faced problems during pregnancy were 2.8 times more likely to utilize health care facility-based delivery than those who did not face problems during pregnancy.

Bohren et al (2014: 12) reported a misconception and beliefs that some women view the attendance of ANC attendance as a preventative method, guaranteeing a normal pregnancy and home delivery. The reported belief was that FANC will reduce the likelihood of a difficult delivery, hence the choice to deliver at home despite the attendance of FANC. This may explain why in some circumstances ANC coverage is almost universal while health facility-based delivery rates stay low (Bohren et al 2014: 4; Magoma et al 2010).

According to the study findings, the perception of some of the women who took part in the study was that unnecessary procedures are carried out at health facilities for child birth. The cited procedures were episiotomy and Caesarean section. The findings are consistent with some of the studies that identified fear of cutting (caesarean section, episiotomy) during delivery as one of the factors that facilitated home-based delivery (Bedford et al 2012; Ghazi et al 2012; Magoma et al, 2010).

Poor access to health facilities played an important role in influencing women's location of delivery (home-based delivery in this study). Women reported that they failed to reach the health care facilities because of the difficulty of getting transport to the health facility, especially at night, and poor conditions of the roads to health facilities and lack of money.

The findings of the study also revealed that women did not choose facility-based delivery because of the perceived incompetence, negative attitudes of health professionals, and poor service at health facilities. The major resources needed for quality ANC, in particular

childbirth were inadequate. The participants stated that there was unavailability of sufficient skilled health professionals and material resources (beds), which resulted in women in early labour sent home. Some of the women blamed the health professionals for sending them back home because there were no beds.

Literature control

Various studies conducted in different developing countries and in different part of Ethiopia revealed different determinants of place of birth. Some of these factors are similar to those found in the current study while others were different. Most of the studies used the quantitative approach, while others used qualitative and mixed method research. The common factors in literature that were the same as those found in the study include the perceived benefits of home delivery, lack of access to health facility, absence of previous pregnancy related complications, women's lack of knowledge of the importance of FANC, misconceptions regarding FANC and home delivery.

In Ethiopia, researchers have documented a variety of the reasons women are not accessing facility-based delivery services. The findings of this qualitative study adds the existing body of knowledge on perspectives of attendees of FANC on home and facility-based delivery.

Personal reflections

During the proposal stage of the study, the researcher intended to use the quantitative approach because he is trained in technical, scientific writing, statistics and computer statistical programs. However, after being encouraged by the primary supervisor, the researcher used the qualitative approach. The decision to use qualitative approach was based on the study purpose, objectives and the research questions. In addition, the literature review revealed many studies that were conducted in different developing countries and in different parts of Ethiopia on the study phenomenon using mostly population-based surveys. The researcher realised that surveys did not capture explanations of "how" and "why" behind the decision-making process regarding the location of delivery of the baby (Bohren et al 2014). The qualitative approach and methods were used to complement the available population-based surveys. This was a challenge for me

but a learning opportunity as I had to attend workshops and training in qualitative research methods, in particular conducting of interviews. At present, the researcher is comfortable with the highly remarkable procedures of qualitative research he has learnt in the process of undertaking the current study.

I spent time interacting with participants through interviews, observations and writing notes, which were taken during and after each interview session. The notes taken were about contextual factors that were helpful during data analysis. Taking notes did not disturb the researcher from listening and observing participants (Polit & Beck 2012:731). The researcher listened attentively to research participants as they responded to the interview questions. During the individual interviews, one participant expressed reservation about the use of the audio tapes, even after the researcher had assured confidentiality of the collected data for the study. The researcher respected her wish by switching off the audio tape for her interview.

The non-verbal communication included facial expressions of satisfaction with the presence of partners and family members during childbirth. Some showed surprise looks when talking about the fact that in facility-based delivery, partners were not allowed. *"Men are not allowed to accompany their wives to labour ward for the reasons I don't know. What is wrong if he is allowed to stay with wife during childbirth?" (Participant 03)* and *'Yet, men aren't permitted to attend a woman in the labour room and only one female relative is sometimes allowed to be with a woman in labour ward" (Participant 02*). Other participants displayed anger at health professionals who mistreated them, abused them and did not emphasise the importance of health care facility-based delivery. Fear of cutting, stitches and Caesarean section was expressed, but not displayed.

The researcher ensured that his beliefs, opinions and experiences about the phenomenon under study did not affect data collection and data analysis through use of bracketing. The researcher's gender (male midwife) and background did not in any way affect the data collection process and data analysis for the present study (Creswell 2014: 186).

4.5. CONCLUSION

In this chapter, the description of the analysis and findings of individual interviews data were presented. The findings provided perspectives of attendees of home and facility-based delivery among women who attended FANC in Addis Ababa. The next chapter presents the findings of the second phase of the study.

CHAPTER 5

ANALYSIS, PRESENTATION AND INTERPRETATION OF FINDINGS OF PHASE 2 OF THE STUDY

5.1. INTRODUCTION

In this chapter, data analysis, presentation and interpretation of the findings of the second phase of the study are described. Focus group discussions (FGDs) were conducted to collect data for the second phase of the study, the objective of which was to explore and describe the views of attendees of FANC on measures needed to enhance the utilization of health facility-based delivery services. The aim was to use the findings and literature as the basis for the development of guidelines to enhance the utilization of health facility-based delivery services among attendees of FANC in Addis Ababa, Ethiopia. The data collection and analyses presented in this chapter occurred according to the research methods described in chapter 3. This chapter begins with data management and analysis, followed by the presentation and the description of the findings.

5.2. DATA MANAGEMENT AND ANALYSIS

Focus group discussions were continued until data saturation was reached. Raw data comprised the verbatim transcriptions of focus group interviews data from the audio-recordings and notes made during the focus group discussions. The data collected were stored electronically as audio recordings and the transcriptions and notes were stored as MS word files, which were password protected to ensure confidentiality. The researcher used Techs' eight steps of qualitative data analysis method for analyzing data from focus group discussions (Creswell 2014:248; Polit & Beck 2012:745).

5.3 RESEACH FINDINGS

The research findings are presented under the headings sample description and themes that were identified as rich and detailed account of the measures needed (from the

participants' perspectives) to enhance the utilisation of facility-based delivery among attendees of FANC.

5.3.1. Sample Description

The sample consisted of thirty two (32) attendees of FANC at selected public health facilities, but delivered live babies at home and in the health care facilities in the past year before data collection for this study. The researcher conducted the four FGDs with 32 women who met the eligibility criteria described in 3.3.1. The first FGD comprised ten participants, the 2nd and the 3rd FGDs involved eight participants while the 4th FGD comprised of six participants as shown in table 3.1

5.3.2. Themes

From the analysis of FGD interviews data, 2 (two) themes emerged. These themes were identified as the rich and detailed account of the measures needed to enhance the utilisation of facility-based delivery among attendees of FANC from the participants' perspectives.

5.3.2.1 Theme I: Provision of Quality, Respectful and Dignified Midwifery Care

The first theme that emerged from data analysis was *provision of quality, respectful and dignified midwifery care*. Within the theme, 4 (four) sub-themes, namely provision of competent staff, skills development programmes, effective referral systems and provision of adequate resources emerged. Sources of data from FGDs were as shown in table 5.1.

Table 5.1 Theme I: Provision of quality, respectful and dignified midwifery care

Theme	Sub-themes	Data Source: FGDs
Provision of quality, respectful and dignified midwifery care	I. Provision of competent staff	FGDs 1, 2,4
	II. Skills development programs	FGDs 1,2, 3
	III. Effective referral systems	FGDs 1, 2,3,4
	IV. Provision of adequate resources	FGDs 1, 2,3

From the findings of individual interviews, the participants identified mistreatment and verbal abuse by nurses as reasons for choosing home delivery. In the focus groups discussions, the participants made suggestions for enhancing the utilisation of facility-based delivery among attendees of FANC.

i. Provision of competent staff

The findings of the individual interviews revealed that women did not choose facility-based delivery because of the perceived incompetence and negative attitudes of health professionals, as well as poor service at health facilities. According to the participants, competent staff will not subject patients to mistreatment, such as verbal abuse, neglect or denial of services. To this effect, the participants suggested that competent staff (capable of providing quality care, characterized by respect and preservation of patients' dignity) should be made available at the health facilities. Sample responses included;

> "They (providers) have to respect their clients because human beings naturally need respect and dignity in childbirth" (FGD 1).
>
> "Indeed, staff should behave positively towards their clients and that they have to be trained ethically (FGD 4)".
>
> "Further education and in-service training opportunities will help the staff to update their skills and knowledge to manage childbirth and provide respectful care to the women (FGD 2)".
>
> "The providers will beat you, and they will shout on you without any mistakes. So, they should first stop such abusive behaviors if they want us go to there for childbirth. I mean they need to have a sound professional ethics and behavioral change" (FGD 2).
>
> "Exploring how best midwives/nurses can be educated, developed and supported to *provide high quality midwifery care in the facilities is needed and ensuring that in-service training for staff on obstetric care is also helpful* (FGD 2).
>
> "Some of the providers indeed lack midwifery experience and skills. It seems that they weren't trained well in school and not exposed to the clinical setting….so, the authorities should do something to improve their skills" (FGD 3).
>
> "In addition, deploying adequate number of supportive staff in non-clinical roles suggested to free nurses/midwives to provide more midwifery care in order to minimise their work burden" (FGD3).

ii. Skills development programmes

The focus group participants suggested skills development programmes which may include training, retraining, in-service education and refresher courses to enable nurses to manage not only childbirth, but to also to provide respectful care to patients. Sample

responses include

> "In-service training opportunities will help the staff to update their skills and knowledge to manage childbirth and provide respectful care to the women" (FGD 2).
>
> "In our community, most women nowadays deliver at health facilities and yet some women prefer delivering at home because of provider's attitudes. … That some of the midwives, are verbally abusive, impolite, and lack sympathy….. "(FGD 2).

iii. Effective referral systems

Referring a patient is a medical decision determined by many factors, including the skills of the referring staff, the tools for diagnosis, the availability of a health institution with specialist facilities, the quality of care at the referral institution, the cost of care, distance, transportation, communication, someone to travel with the patient, and feasibility of travel by the client (Finlayson & Downe, 2013; Singh, Doyle, Campbell, Mathew, & Murthy 2016) Delays in gaining access to referral services was viewed as a major factor contributing to feto- maternal deaths in the current study (Murray 2006: 7). The same author recommends supervision and increasing accountability of care providers. The findings of the study are consistent with previous studies. Strand et.al and Konganyuy et.al in Singh et al (2016: 17) suggest audits of referrals for obstetric emergencies to improve referral systems for obstetric care to prevent delays. Sample responses include;

> "Some women are referred from one facility to another because of shortage of supplies or diagnostic facilities" (FGD3). Referral should be based on the condition of the woman" FGD 1
>
> "Providing ambulance services with effective referral system to district hospitals is indispensable to increase facility based delivery services because poor women can't pay for tertiary-level hospitals" (FGD 3).
>
> "When you go there (HF), you are referred here and there and finally end up with dead baby". (FGD 2).

iv. Provision of adequate resources

The Ethiopian government encourages all women to delivery at the health facility. It therefore follows that drugs, and diagnostic facilities such as ultrasound examination should be made accessible because some poor women cannot afford to pay for them when they are referred for examination to other places. Sample responses include;

"At present, the government encourages all women to delivery at the health facility. So, drugs, and diagnostic facilities such as ultrasound examination should be made accessible because some poor women can't afford to pay for it when they are referred for examination to other places (FGD 1).

"If you visit public health facilities there is no or limited basic medical supplies, delivery beds and diagnostic facilities such as ultrasound examination, drugs etc." (FGD1).

"There is no bedsheets, soaps, and other items and the government should work on it" (FGD 3).

"Some women are referred from one facility to another because of shortage of supplies or diagnostic facilities" (FGD3).

5.3.2.2 Theme II: Increase Awareness

The second theme to emerge from data analysis was *increase awareness.* Within the theme, three subthemes *communication and family support emerged*. Sources of data from FGDs were as shown in table 5.3.

Table 5.2 Theme II: Increase awareness

Theme	Sub-themes	Data Source: FGDs
Increase awareness	v. Communication	FGDs 1, 2,3, 4
	vi. Family support	FGDs 1, 2,3,4

v. Communication

The findings of the individual interviews revealed a lack of awareness about the importance of facility-based births among some of the women who took part in the study, hence the suggestion to increase awareness through effective communication and health education. According to the WHO standards for improving maternal and new-born care in health facilities (2016), all women and their families should receive information about their care and have interactions with staff. There should be clear and accurate information exchange.

According to the study findings, some of the women held a belief that unnecessary procedures are carried out at health facilities, procedures such as caesarean section and episiotomy. This finding was based on lack of information to women and their families, hence the misconception. Sample responses

'I didn't receive any information about delivering in a facility. She (the midwife) only checked me and told me to come on the next appointment; I think I have the right to that information"

"They (providers) frequently did not communicate with the client or her family about the progress of the labour and childbirth" (FGD 1)..

"I was then very much upset and cried a lot but to whom do you report such case. I believe there should be a strong system where to report any annoying incidents and physical abuse otherwise close supervision is required by their boss" (FGD 2).

"Caesarean section delivery is quite common particularly in private facilities….I think they just do it without sufficient medical reasons" (FGD1).

"You know doctors rush to decide for Caesarean section and most of the time I believe they perform it without enough medical indications mostly in private hospitals" (FGD3).

vi Family support

Most women in FGDs were concerned about the health facility policies, which inhibit family members (including their husbands) from providing them the required physical and emotional support during labour and delivery. Many of them suggested that family members and husbands be allowed to support them in labour wards. This finding was evident in the sample responses;

"My sister lives in Europe and she told me that husband plays major roles in assisting his wife during labour and delivery. But our husbands don't come into labour ward to see their wives …… this has to be changed because they should be permitted to be with us… "(FGD1).

[….] I would be happy if my husband is allowed to accompany me to labor room because he has to also share my pain and suffering. So, I believe one day the facility will consider this issue and permit our husbands into labour wards (FGD2).

This finding is supported by the WHO standards for improving maternal and new-born care in health facilities (2016), which state that women can choose to have a companion of their choice present for labor and delivery and they must receive support to strengthen capability during delivery.

5.3.3 Summary of Findings of Phase II of the Study

The central question that was asked was "*What do you think should be done to enhance the utilisation of health facility-based delivery among attendees of FANC?*

Additional specific group interview questions fell into the categories, *discussion of participants' experience of facility-based delivery services, views and impressions of health facility-based delivery, barriers to health facility-based delivery and measures to enhance facility- based delivery services as suggested by attendees of FANC (*Annexe 10).

Even though determining focus group data saturation was a challenge, the researcher used data saturation by group, and the criteria for data saturation was set at five responses per theme and sub-theme based on data analysis as suggested by Hancock et al (2016).

Measures to enhance facility-based delivery as suggested by women

The measures suggested by women to enhance the utilisation of facility-based delivery were based on the findings of individual interviews, specifically on factors, which affected the utilisation negatively. For example verbal abuse by nurses, lack of skills and neglect as reported in chapter 4. The following suggestions were made to enhance facility-based delivery among attendees of FANC in Addis Ababa;

1. Provision of quality, respectful and dignified midwifery care

Increase the available competent staff

- Women in this study thus suggested measures such as exploring how best midwives/nurses can be educated developed and supported to provide high quality midwifery care in the facilities and ensuring that in-service training for staff on obstetric care is conducted with regular updates. In addition, deploying adequate number of supportive staff in non-clinical roles suggested to free nurses/midwives to provide more midwifery care in order to minimise their work burden.

Skills development

- The skills of service providers who work in public health facilities have to be improved through in- service training, refresher courses and continuing education.
- The identified skills included communication, interpersonal skills, in particular empathy.

Effective referral system

- Make appropriate and timely referrals to a higher level health facility for emergency care, arranging for ambulance service and care during transport.
- Reduce referring of women to health facilities of similar status in the district (prevent delay in seeking care).

Adequate resources

The findings show that study participants perceived that some of the buildings of health facilities were mostly small with limited delivery beds (couches) and waiting rooms for labouring women. Hence, the women recommend that more delivery beds (couches), drugs, and diagnostic facilities such as ultrasound examination should be made available.

2. Increase awareness

Improve communication

- All women and their families should receive information about their care and interact with staff.
- There should be clear and accurate information exchange.
- Enhance health providers' awareness about the rights of pregnant women to information and proper health care.

Family support

- Present opportunities for women to choose to have a companion of their choice present for labor and delivery and they must receive support to strengthen capability during delivery, particularly the presence of husbands or partners during delivery.

Personal reflections regarding focus group discussions

The researcher had to deal with a challenge of dominant participants during the second focus group interviews by posing questions directly to the silent members.

One research participant arrived late, after the interview had started. The researcher delayed the session until the participant had settled down and resumed the session.

Otherwise, the research participants were supportive and conformed to the ground rules throughout the interview session.

5.4 CONCLUSION

This chapter presented the findings of FGDs, whose purpose was to describe the women's views on measures needed to enhance the utilization of health facility-based delivery services.

CHAPTER 6

WOMEN-CENTRED GUIDELINES TO ENHANCE HEALTH FACILITY-BASED DELIVERY AMONG ATTENDEES OF FANC AT PUBLIC HEALTH FACILITIES IN ADDIS ABABA

6.1. INTRODUCTION

This chapter presents the guidelines on women-centred practice to enhance health facility based delivery at public health facilities in Addis Ababa. According to WHO Guidelines are defined as documents that are developed grounded on the recommendations for clinical practice and/or public health policy. Guidelines are proposed to help providers and beneficiaries of health care and other stakeholders to make informed decisions.

Worldwide client-centred care has grown as an essential health care provision approach that supports to advance the safety and quality of care. Consequently, establishing measures to delivery services based on the needs and preferences of clients is imperative (Kitson 2012: 4). The manner a woman practices pregnancy and delivery is absolutely essential as the outcome of delivery might be for women and their families.

Ethiopia has steadily been considering methods to increase the quality of delivery services like many developing nations. As underlined in the 2015-16 Health Sector Transformation Plan (HSTP), maternal and new-born health are priorities for the Government of Ethiopia (FDRE 2015). The client-centred method to health care delivery has its hallmark in individualising care. It involves qualities of care, and receptiveness to the needs, values and voiced preferences of clients. Health providers need guidelines that are explicitly delineated in documents including policies, operational procedures and protocols to successfully put women – friendly care principles into practice and as well as to lead the change process.

According to Birken, Lee and Weiner (2012:1), the gap between evidence and practice can be closed only if health care industries initiate to adopt evidence-based practices.

The guidelines are thus proposed to provide front liners(end users) clear guide of what might and ought to be performed in definite conditions to realise the best work life for providers and improved health outcomes for individuals or groups as regards preference, choice and resources utilization(WHO 2014). This guideline document is tailored for the provision of women - friendly delivery services in health facilities. It is intended to be used besides to other policies and working procedure documents that are existing in the country.

Although the standard guidelines for ANC exist in Ethiopia, they do not adequately address the client-centred method to health care delivery, which has its hallmark in individualising care. Antenatal care and delivery services in Ethiopia are characterised by unclear guidelines and a lack of training of providers in ANC and the health system registration practice (Villadsen, Negussie, GebreMariam, Tilahun, Friis, & Rasch; 2015:360). The guidelines should involve quality of care, receptiveness to the needs, values and voiced preferences of clients. Health providers need guidelines that include policies, operational procedures and protocols to successfully put women-friendly care principles into practice to lead the change process.

6.2. PURPOSE OF THE GUIDELINES

The purpose of the document is to offer evidence-based guidelines on women-centered services to assist health facilities and programme planners for devising measures to increase quality of maternal health care services in Addis Ababa, Ethiopia.

6.3. PROCESS OF GUIDELINES DEVELOPMENT

The development of the guidelines was based on the research findings (chapters 5 & 6), pertinent literature review and the researcher's insights. The findings of this study provided evidence on which to base the development of guidelines (Robertson, 2007: 3). Primarily, the researcher conscripted the guidelines based on the major themes that were emerged from the present study findings, review of other relevant literature and researcher's insights. Then midwifery experts who have clinical and research experiences in maternal health care were approached face-to-face, by email and phone for their

inputs. Six experts including three midwifery lecturers from 3 universities in Ethiopia and 3 midwives working in labour and maternity wards from university teaching hospitals reviewed the guidelines document. The researcher explained to the experts the objective of the study separately and then the draft guidelines document was sent by their emails for review. The researcher incorporated the experts' opinions in the document and sent them the revised guideline to reach a consensus and it was finalised. Figure 7.2 reveals the processes undertaken in guidelines development for Health Facility based delivery care.

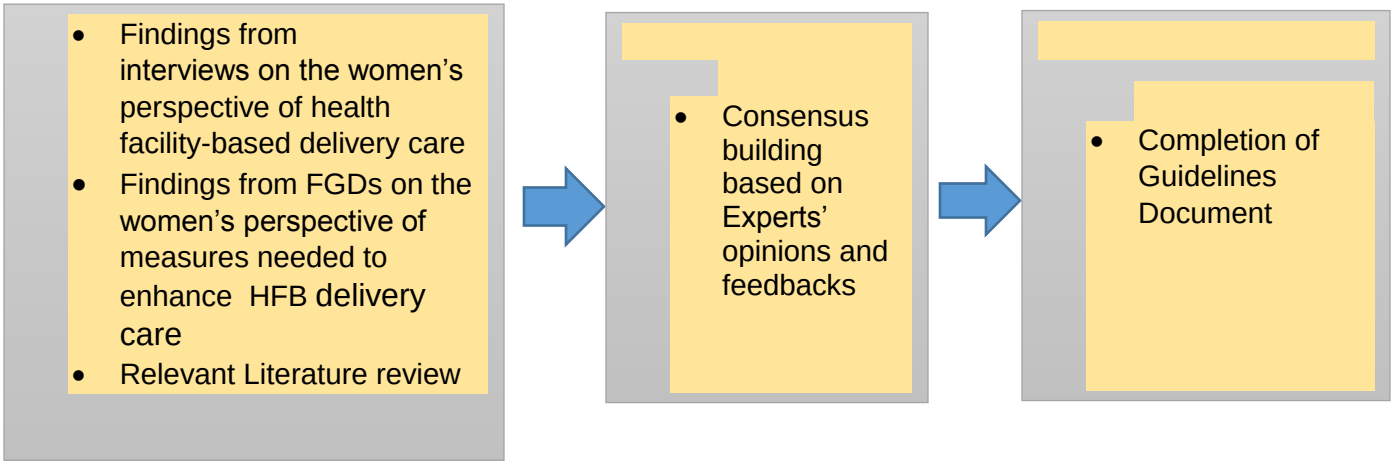

Figure 6.1 Shows the processes undertaken in guidelines development for Health Facility based delivery care in Addis Ababa.

6.4. THE SCOPE OF GUIDELINES

The guidelines are primarily meant for health care providers at district or health facility based level who are responsible for providing delivery services in Addis Ababa. Nevertheless, the Federal Ministry of Health and Regional Health Bureaus, and Implementing partners working in the fields of safe motherhood may also find the guidelines useful. Though the guidelines were proposed based on existing evidence and expertise opinion in the country testing in the field is compulsory. It is the researcher's belief that policy makers, programme planners, and service providers will better serve the women residing in Addis Ababa equally, impartially and women- friendly.

6.5. DEFINITION AND MEANING OF WOMEN-CENTRED CARE

Women-centred care and women-friendly care are used interchangeably in the guidelines. Women-centred means that the women comes first in the service delivery relationship. According to Anjum client-centred care is defined as 'focusing on patient and individual's particular health care needs, including client's view points and perspectives into management of her illness (Anjum 2014: 611). McCormack and colleagues (McCormack 2011:1) define the concept of women-friendly care as 'an approach to practice that is recognised through the formation and cultivating of therapeutic relationships amongst all care providers, clients, and others important to them.

The term has also been used as a method of care that consist of 'informing and involving clients, encouraging and valuing their preferences; reacting rapidly, effectively and safely to client's needs and rights; guaranteeing that clients are treated in a dignified and supportive manner; providing well-coordinated; and integrated care(McCormack 2011: 3). Evidence show that women-friendly care is life-saving in that women may refuse to seek care from a provider who "abuses" them or does not treat them well, even if the provider is skilled in preventing and managing complications (WHO/UNICEF/UNFPA 999). The women-friendly approach focuses on the rights of women to have access to quality care for themselves as individuals and as mothers, and for their infants. It is part of a broader strategy to reduce maternal and neonatal morbidity and mortality and requires strong partnerships among governments, health systems and communities (WHO/UNICEF/UNFPA 1999: 6). Health services can be considered women-friendly when they:

- Are available, accessible and affordable --they are located as close as possible to where the women live and are reasonably priced for both the women and the health care system;
- Provide safe and effective health and maternal care that complies with the highest possible technical standards, and makes use of the necessary supplies and equipment; even at the lowest level facility;

- Motivate providers, encourage their participation in decision-making, and make them more responsive to user needs; and
- Empower users and satisfy their needs by respecting their rights to information, choice, safety, privacy and dignity and by being respectful of cultural and social norms.

6.6. STRATEGIC OBJECTIVES AND ACTIVITIES

The researcher suggested the following strategic objectives and specific actions shown in table 6.1 to enhance health facility based delivery services based on the study findings.

Table 6.1 Strategic objectives and activities

Study findings	Strategic objectives	Specific actions
Policy and program interventions	Promote policies, rules and regulations to support women centred care in the facilities	• Deliberate the rights of the women: right to information about her health, right to be informed about what to expect during labour and delivery and obtain permission/consent during examination/procedures • Individualise care to woman's needs • Put a functional regulatory mechanism to: minimise delivery with C/S without medical indications mostly in private facilities, institute accountability for staff violating women's dignity or abuse them, help women report any annoying incidents and physical abuse during delivery, and reinforce health insurance scheme universally across the country to enhance facility based deliveries (i.e. will cover hidden expenses like drugs, supplies and ultrasound etc.) • Target the maternal health care services to the needy women: poor women residing in slum areas of Addis Ababa are the most disadvantaged segment population with regards to utilising ANC and facility based

		deliveries. • Revise health facility policies restricting family members (including husbands) from entering into maternity wards

Study findings	**Strategic objectives**	**Specific actions**
Inadequate skilled staff/ high workload/unexperienced young staff	Ensure accessibility of adequate skilled providers in the district health facilities	• Ensure workforce planning tool is set up on a regular basis to ensure staffing levels are safe and sufficient both by type and number • Ensure that workforce planners take account of future changes to the workforce arising from the staff retirement/transfer or death. • Deploy adequate number of supportive staff in non-clinical roles to free nurses/midwives to provide more midwifery care (minimise work burden) • Ensure that in the facility a woman receives skilled attendance at birth and emergency obstetric care whenever required. • Make certain that in-service training of staff on obstetric care is conducted with regular updates. • Empower health providers to be part of teams accountable for

		supporting women- centred care. • Program managers have to scrutinise organisational policies and rules to inspire the implementation of the principles of women-centred care practice. • Identify and recompense staff that show women- friendly care • Explore how best midwives/nurses can be educated, developed and supported to provide high quality midwifery care in the facilities: every higher education institution should maintain acceptable staff: student ratios to ensure quality of midwifery education, midwifery teachers should spend 20% of their time supporting students in clinical practice to help them the required competency, Midwife teachers should have a good basis in clinical practice and continue to be actively engaged in practice as a midwife teacher, and conduct more research on midwifery education outcomes to assess the value of different routes to becoming a midwife/nurse. • Make sure that midwifery/nursing students value and learn to provide women – friendly care: use of women – friendly approach in simulated setting(i.e. with anatomic models), put emphasis on women – friendly care during teaching of all procedures and type of care, and include the principles of women - centred care in all health training programmes, comprising pre-service training programmes. • Recognise the richness and spiritual significance of community and

		culture: aware of traditional beliefs and culture about pregnancy and childbirth in the community, and provide culturally sensitive care • Ensure that the skilled attendant at delivery will have the minimum set of skills to demonstrate cultural sensitivity and use good interpersonal skills, provide ANC throughout pregnancy; provide continuity of care throughout the perinatal period, educate woman and family about danger signs during pregnancy, when and how to seek emergency care, recognise delay in labour, prioritise care, take appropriate action, and evaluate the results of the intervention, relate all available information; record all relevant findings on maternal and new-born records; advise when to return for care, and use appropriate interpersonal communication skills and counselling skills
Negative staff attitude(disrespect/ stigmatisation /negligence)	Ensure that all women visiting maternity ward have the right to be treated with respect and dignity	• Authority should take action to ensure that: • All staff are trained in patient rights, health care provider rights and responsibilities and interpersonal communication skills. • Health provider respects all women and treat them with dignity specifically female providers in health facilities • Health provider calls women or refer to them by their names and not by other names (e.g. bed number or diagnosis)

		• Health provider speaks the language that is easy for women to understand • Women are treated equally and fairly regardless of their economic, religion or ethnic backgrounds • Health provider introduces him/herself to women when they arrive the health facility • Women's concerns are addressed in a respectful manner and timely. • Providers are trained on ethical conduct, and interpersonal skills • Include addressing women's concern in performance appraisal as one element. • Create an enabling environment for women to feel free to approach and discuss their fears and worries with their providers • Put a disciplinary mechanism in place to prevent clients from mistreatment and abuse. • Staffing levels are safe and adequate both by type and number to prevent burnout of providers. • Staff's salaries and other fringe benefits are improved to motivate them and overcome high inflations • cultural and religious barriers are addressed in the community that hinder women from using health facility based delivery • Inform and allow all pregnant women to have a companion of their choice during labour and delivery.

Study findings	Strategic objectives	Specific actions
Poor referral system/limited ambulance services	Reinforce functional referral system and link with the primary health care units and the community	Authority should take action to : • Minimise referring of women to health facilities of similar capacity in the district • Launch accurate communication systems among referral facilities of similar level prior to referring delivery cases • Put Protocols in place for referral of mothers amongst facilities particularly between public and private health care facilities • Conduct periodic joint review to monitor reasons of referrals and feedback mechanisms. • Provide accessible and reliable ambulance service with fair price or free of charge to enhance facility delivery • Increase the number of bed in public health facilities to admit more women particularly poor women in slum areas • Allocate funds for ambulance operative and maintenance costs to provide regular services. • Appoint a responsible body at health facilities to monitor the interaction between the community and the ambulance driver • Empower and involve health extension workers (HEWs) in the community to refer labouring women early to facilities. • Facilitate linkages between the community health facility, referral

		settings, and the HEWs in the community. • Make appropriate and timely referrals to higher level health facilities for emergency care, arranging for transportation and care during transport. • Put suggestion box in place to gather feedback from referred women about the quality of services and challenges faced. • Evaluate and document the quality improvements and challenges
Study findings	**Strategic objectives**	**Specific actions**
Limited or no facilities (few beds, medical supplies, equipment, drugs, diagnostic materials etc.)	Make sure that caring environment meets the requirement and expectations of women in the district	• Increase the number of bed to admit more labouring women to maternity units • Provide public health facilities with proper diagnostic services (e.g. U/S, X-rays etc.) • Make the required drugs and logistic supplies available in the public health facilities. • Review procedures for getting emergency medicines, blood and other supplies • Fortify the execution of health care financing schemes to warrant the accessibility of drugs and supplies. • Institute replacement mechanisms for drugs and supplies whenever scarcities arise (i.e. use of available supplies and drugs and replace them later) • Re-design Infrastructure to get enough space for the workload and help women's privacy, comfort and dignity.

		• Monitor the inventory of drugs and supplies regularly to recognise possible stock out. • Ensure the accessibility of diagnostic facilities (e.g. Ultrasound) free of charge or with low price for poor women.

Study findings	**Strategic objectives**	**Specific actions**
Limited knowledge/ unawareness of facility- based deliveries among slum residents in the community	Promote Health Facility based deliveries through existing health care system and community participation in the district	• Intensify the role of communities to promote the benefits of facility deliveries in their social networks • Strengthen to improve the skill of HEWs with appropriate provision of health information • Work in Integration with community leaders (including TBAs, imams, priests etc.) in recognising and addressing cultural barriers deterring facility childbirth in the communities. • Encourage community champions (role models) to educate and persuade pregnant women for childbirth in health facilities. • Collaborate with potential non- government organizations and private sectors working in safe motherhood initiatives to conduct community-based survey to evaluate gaps • Enhance health providers' awareness about the rights of pregnant women to information and proper health care • Use ANC visits to advise women about Birth preparedness and

		complication readiness, the utilization of facility deliveries and risks of home delivery to the mother and the new-born. • Establish good relationship with the pregnant women under the ANC care • Involve the woman in all discussions about her care and place of delivery plan, and respect her choices and decisions. • Involve family members particularly her husband/partner to recognise their significant role in the care of the woman.

6.7. CONCLUSION

In this chapter the developed guideline has been discussed in detail. The guidelines document was developed based on the study findings and relevant literature review. It was also reviewed by senior health expects in the field. They appraised it for clarity, simplicity, generality, and effectiveness. The guidelines should be used in line with the standing national policies, strategies and other guidelines. Although the guidelines are specific to women-centred childbirth care, it could also be adopted to suit other aspects of service delivery in the study setting.

CHAPTER 7

DISCUSSION OF THE FINDINGS, LIMITATIONS OF THE STUDY, IMPLICATIONS FOR FUTURE RESEARCH, RECOMMENDATIONS AND CONCLUSION OF THE STUDY

7.1. INTRODUCTION

In this chapter, conclusion drawn from study findings are presented, followed by recommendations, implication for practice, implications and suggestion for research, contribution of the study, limitations of the study and concluding remarks.

7.2. RESEARCH DESIGN AND METHODS

This research followed a qualitative, exploratory, descriptive research design for addressing the study objectives. The design was contextual in nature. The study was conducted in three phases as described in the following paragraphs;

Phase I: Exploration and description of women' perspectives of facility-based and home delivery. Purposively selected participants participated in individual interviews. This was in line with objectives 1 & 2 of the study.

Phase II: Description of women's views on measures needed to enhance the development of women-centered practice guidelines to enhance the utilization of health facility-based delivery services. In this phase, purposively selected participants took part in focus group interviews.

Phase III: Development of women-centred guidelines to enhance utilisation of facility-based delivery among attendees of FANC. The researcher used the findings of the study and literature as the basis for the development of guidelines to enhance the utilization of health facility-based delivery services among attendees of FANC in Addis Ababa, Ethiopia. The researcher, in identifying necessary guidelines from the data findings and literature employed a strategy of deductive reasoning. A detailed description of the research design used in the study was presented in chapter 3.

7.3. SUMMARY AND INTERPRETATION OF RESEARCH FINDINGS

In the paragraphs that follow, a brief summary and the interpretation of the research findings is presented.

7.3.1 Phase I

Individual face-to-face semi-structured interviews were used to collect data. Using face-to-face interviews enabled the researcher to explore issues for better understanding of the women's perspective of facility-based and home delivery, and to probe or clarify issues (Polit & Beck, 2012:537) regarding facility-based delivery.

The purpose of individual interviews in this study was to explore and describe the perspectives of facility-based and home delivery among women who attended FANC and delivered their babies at home (in line with objectives 1 and 2 of the study).

The researcher conducted individual interviews with women who attended FANC, and had delivered live babies at home in the past one (1) year preceding the data collection for the study. The central question that was asked was *"Would you tell me why you attended FANC (which promotes the use of skilled attendance at birth) but decided to deliver your baby at home and not at the health facility.*

Individual interviews were conducted until saturation, which was reached after eight (8) interviews, when additional data did not lead to any new emergent codes and themes. Individual interviews were conducted in Amharic and lasted for 30-50 minutes.

The findings of individual interviews are summarized and presented according to the first and second objectives of the study.

- **Description of the women's perspective of health facility-based delivery**

Three (3) of the four themes that emerged from the data analysis addressed the women's perspectives of the health facility-based delivery, and they are summarized in table 7.1.

Table 7.1 Women's perspectives of facility-based delivery

Theme II : Knowledge deficit	The findings of the study revealed that women's lack of knowledge about facility-based delivery influenced their decision to give birth at home. The participants indicated that health professional did not inform them about the availability of health facility delivery service. The findings revealed a belief among some participants of the study that home delivery is for normal delivery. According to the findings of the same studies, the birthing process was considered a normal event, women considered home delivery first and considered facility-based delivery only if complications arose. Some of the women believed that unnecessary procedures are carried out at health facilities. They specifically mentioned fear of caesarean section and episiotomy as one of the factors that made them choose home delivery and not facility-based delivery.
Theme III : Poor access to health facilities	Poor access to health facilities played an important role in influencing women's location of delivery (home-based delivery in this study). Women reported that they failed to reach the health care facilities because of the difficulty of getting transport to the health facility at night, long distance to travel to the health facilities, poor conditions of the roads to health facilities and lack of money. The two mothers reported that they delivered at home because labour was too fast, and before they could arrange for transport, the babies were born.
Theme IV : Inadequate resources	The participants stated that there was poor quality service, unavailability of sufficient skilled health professionals and material resources (beds), which resulted in women in early labour sent home. Some of the women blamed the health professionals for sending them back home because there were no beds.

- **Description of the women's perspective of home-based delivery**

One of the four themes that emerged from the data analysis addressed the women's perspectives of the home-based delivery as summarized in table 7.2.

Table 7.1 Women's perspectives of home-based delivery

Theme I : Perceived benefits of home-based delivery	According to the findings, the women who took part in this study chose home based delivery because of the supportive presence of family and neighbours during childbirth as well as the comfort and convenience of the home environment. The women indicated that the presence of family and traditional birth attendants provide physical, social and emotional support during childbirth. The findings also revealed that it is easier to deliver at home where women are able to use their own belongings and receive support from their neighbours.

A review of literature pertaining to the facility and home delivery for the purposes of literature control, which was done after the data analysis process, had been completed. The aim of literature control was to present a critical analysis of the relevant literature and to verify the results.

7.3.2. Phase II

The researcher conducted FGDs with women who attended FANC, and had delivered live babies at home and at health facilities in the past year preceding data collection for the study. There were four (4) FGDs involving 32 participants from the three (3) selected health centres and one district hospital. The number of participants in FGDs were between 6 to 10 women.

The purpose of FGDs in this study was to explore and describe the women's views on measures needed to enhance the development of women-centered practice guidelines to enhance the utilization of health facility-based delivery services. This was in line with objective 3 of the study. The central question for the FGDs was "*What do you think should be done to encourage women to utilise the health facility-based delivery service?*

Focus group discussions were continued until data saturation was reached. The researcher used data saturation by group as suggested by Hancock et al (2016:2126), which was the

point in coding when no new codes occurred in the data. The criteria for data saturation was set at five responses per theme and subtheme based on data analysis.

Field notes were made with the permission of the participants. The FGDs were conducted in Amharic and lasted for 45 – 60 minutes. The findings of FGDs are summarized and presented in the paragraphs that follow.

7.3.2.1 Measures to enhance facility-based delivery as suggested by attendees of FANC

The measures suggested by women to enhance the utilisation of facility-based delivery were based on the findings of individual interviews, specifically on factors, which affected the utilisation negatively. For example verbal abuse by nurses, lack of skills and neglect as reported in chapter 4. The following suggestions were made to enhance facility-based delivery among attendees of FANC in Addis Ababa;

Provision of quality, respectful and dignified midwifery care

Increase the available competent staff

- Women in this study thus suggested measures such as exploring how best midwives/nurses can be educated developed and supported to provide high quality midwifery care in the facilities and ensuring that in-service training for staff on obstetric care is conducted with regular updates. In addition, deploying adequate number of supportive staff in non-clinical roles suggested to free nurses/midwives to provide more midwifery care in order to minimise their work burden.

Skills development

- The skills of service providers who work in public health facilities have to be improved through in- service training, refresher courses and continuing education.
- The identified skills included communication, interpersonal skills, in particular empathy.

Effective referral system

- Make appropriate and timely referrals to a higher level health facility for emergency care, arranging for ambulance service and care during transport.
- Reduce referring of women to health facilities of similar status in the district (prevent delay in seeking care).

Adequate resources

The findings show that study participants perceived that some of the buildings of health facilities were mostly small with limited delivery beds (couches) and waiting rooms for labouring women. Hence, the women recommend that more delivery beds (couches), drugs, and diagnostic facilities such as ultrasound examination should be made available.

Increase awareness

Improve communication

- All women and their families should receive information about their care and interact with staff.
- There should be clear and accurate information exchange.
- Enhance health providers' awareness about the rights of pregnant women to information and proper health care.

Family support

- Present opportunities for women to choose to have a companion of their choice present for labor and delivery and they must receive support to strengthen capability during delivery.

7.3.3 Women-centered guidelines to enhance the utilization of health facility-based delivery services among the attendees of FANC in Addis Ababa.

The researcher used the findings of the study and literature as the basis for the development of guidelines to enhance the utilization of health facility-based delivery services among attendees of FANC in Addis Ababa, Ethiopia. The researcher, in identifying necessary guidelines from the data findings and literature employed a strategy of deductive reasoning. This was in line with objective 3 of the study.

In this study women recommended the following measures to enhance the development of women-centered practice guidelines to enhance the utilization of health facility-based delivery services among the attendees of FANC in Addis Ababa.

- Provide accessible and reliable ambulance service with fair price or free of charge to enhance facility delivery.
- Increase the number of bed to admit more women particularly poor women from slum areas.
- Make appropriate and timely referrals to a higher level health facility for emergency care, arranging for ambulance service and care during transport.
- Allocate funds for ambulance operative and maintenance costs to provide regular services.
- Reduce referring of women to health facilities of similar status in the district (prevent delay in seeking care).
- Ensure the accessibility of diagnostic facilities (including ultrasound and X-rays) in the facilities free of charge or with low price for poor women.
- Reinforce the health insurance scheme universally across the country to enhance facility based deliveries (i.e. will cover hidden expenses like drugs, supplies and ultrasound etc.).
- Enhance health providers' awareness about the rights of pregnant women to information and proper health care.
- Strengthen to improve the skill of HEWs with appropriate provision of health

information on facility based delivery specifically to the slum communities they serve in the district.

- Involve women in all discussions about their care and place of delivery plan during ANC visits, and respect her choices and decisions.
- Involve husband/partner in birth preparedness and complication readiness plan as it would enhance facility delivery service (i.e. the decision makers in many of the Ethiopian society are males).

7.4. APPLICATION OF MULTI-LEVEL LIFE COURSE FRAMEWORK OF FACILITY-BASED DELIVERY IN LMICS TO THE STUDY FINDINGS

National level: the access to health facility delivery is affected by health policies and programs in relation to the location of the delivery of the baby, at either community or national level, which is beyond the individual women's control. Previous research addressed the effects of policies and programs in relation to the location of a woman's delivery, which consist of FANC aimed at increasing facility-based deliveries (Bohren et al 2014: 13). FANC has been adopted in Ethiopia as a policy and program for antenatal care. The findings of the study identified problems related to the referral system, that arranging referrals for obstetric problems is a lengthy process (Bohren et al 2014: 12; Mirgissa et al 2016: 97).

Community level: the perceptions of pregnancy and childbirth affect the choice of the location of delivery of the baby. The perceptions comprise traditional influences and pressure around local understandings of the disease causation. The following perceptions of pregnancy and childbirth were identified as factors that promoted the choice of home over facility-based delivery;

- **Traditional influences and pressures around local understandings of disease causation:** The women who took part in individual interviews perceived *the process of birthing as a normal event,* and that health care facility-based deliveries are to be used by women with a history of abnormal deliveries whilst home delivery should be

used for normal deliveries. This perception was found in a variety of previous studies. For example, according to the findings of the study by Bedford et al (2012), women considered home delivery first and considered facility-based delivery only if complications arose. The results of the survey that was conducted by Yaya et al (2018), showed that one in four women in Ethiopia reported that it was not necessary to attend health facility-based delivery considering that delivery is a natural phenomenon and not an ailment requiring health facility services. Kebede et al (2016) conducted a quantitative study on factors associated with institutional delivery service Ethiopia and found that women who faced problems during pregnancy were 2.8 times more likely to utilize health care facility-based delivery than those who did not face problems during pregnancy. The attendance of ANC was also perceived as a preventative method, guaranteeing a normal pregnancy and home delivery. Bohren et al (2014: 12) reported similar findings. The same authors reported a perception that FANC reduces the likelihood of a difficult delivery, hence the choice to deliver at home despite the attendance of FANC.

- **Medicalization of childbirth:** According to the study findings, the perception of some of the women who took part in the study was that unnecessary procedures are carried out at health facilities for child birth. They cited procedures such as episiotomy and the Caesarean section. The findings are consistent with some of the studies that identified fear of cutting (caesarean section, episiotomy) during delivery as one of the factors that facilitated home-based delivery (Bedford et al 2012; Ghazi et al 2012; Magoma et al, 2010).

- **Resource availability and access** refer to transportation and cost of childbirth: Poor access to health facilities played an important role in influencing women's location of delivery (home-based delivery in this study). Women reported that they failed to reach the health care facilities because of the difficulty of getting transport to the health facility, especially at night, and poor conditions of the roads to health facilities and lack of money. Dearth of access to transportation, good roads,

sufficient funds, and communication systems also make arranging referrals for obstetric problems a lengthy process (Bohren et al 2014:12; Mirgissa, et al 2016: 97).

- **Cost of childbirth:** Affordability of home delivery was mentioned as one of the reasons some of the women who participated in the study preferred home-based care delivery. Direct costs linked with childbearing were too high for numerous women who regarded themselves as too poor to deliver in a health facility (Bohren et al 2014: 12). Economically constrained women might have concern obtaining funds to pay for facility-based delivery care at the time-of-service, predominantly those families who depend on intermittent labor. Some women regarded costs outside of the direct cost for childbirth as "unseen" and difficult to prepare for (Bohren et al 2014:12; Gebrehiwot et al 2014: 6; Magoma et al 2010: 4; Moyer et al 2013b:8). A noteworthy finding is that women who attend FANC are educated about birth preparedness, complications readiness and emergency plans. Birth preparedness involves planning for any additional costs associated with child birth. The women who attended FANC had no plans for additional costs and emergency plans.

At family level, the influence of sociocultural context and care experiences play an important role in decision-making about the location of delivery. The influence of sociocultural context and care experiences on decision-making, include the influence of antenatal care and previous birth experiences.

- **The influence of sociocultural context and care experiences on decision-making**

With regard to previous birth experiences, a number of women decide their level of risk for difficult deliveries in part based on their previous delivery practices and birth results, which tells their prospect delivery place (Bohren et al 2014: 4). In this study, women reported experiences of abuse, and disrespectful care at the hands of midwives. A woman might possibly give birth at a health facility during her first birth or if she had a prior obstetric

problem (Bohren et al 2014: 4; Shiferaw et al 2013). However, if a woman delivered her first child without difficulties, using a health facility for ensuing births is frequently regarded as superfluous (Bohren et al 2014: 4; Shiferaw et al 2013: 5; Story et al 2012:28).

- **The influence of antenatal care**

Some of the women who took part in the study indicated that they did not receive adequate information from the health care workers about the benefits of FANC while others were told to go back home because of the shortage of beds. According to Bohren et al (2014:4) and Magoma et al (2010:6), the ANC workers might not be effectively instructing women of the significance of facility-based delivery service because perhaps heavy workload and constrained time to deliberate complex matters with their clients.

The findings identified misconception that health facility-based delivery is for women with a history of difficult or complicated deliveries. Some women considered ANC attendance a preventative method, guaranteeing a normal pregnancy and home delivery (Bohren et al 2014: 12). This explains somewhat why in some circumstances ANC coverage is almost universal while health facility-based delivery rates stay low (Bohren et al 2014: 4; Magoma et al 2010:6).

- **Influence of others on delivery location**

The findings of the study showed that family members and the presence of traditional birth attendants encouraged them to deliver at home. Other participants perceived home delivery safe because of the confidence they have in experienced members of the community such mothers, grandmothers and neighbours who assist during delivery. According to Bohren et al (2014: 13) and Magoma et al (2010) availability of traditional birth attendants in the community might confirm a woman's decision to give birth at home.

- **Ease of home birth**

Logistically home deliveries are easier than health facility deliveries and meet women's needs to be encircled by their possessions and the likelihood of keeping home duties (Bohren et al 2014: 12; Titaley et al 2010). Women who took part in this study mentioned benefits of home delivery that included supportive presence of husbands, family members and neighbours. They also stated that home delivery allowed them to use personal belongings such as own bed, own linen and own space. Although women may receive support in their domestic responsibilities from their neighbors, co-wives, or husbands, women were concerned that they would miss out on immediate traditional celebrations of the birth if they attended a health facility for delivery (Bohren et al 2014:12; Gebrehiwot et al 2012:10; Moyer et al 2013b:2; Mirgissa et al 2016: 97).

Individual level: perceived quality of care of traditional birth attendants and at health care facilities

The findings revealed perceived incompetence of health care professionals, lack of knowledge, skill and appropriate attitudes to care for pregnant women during pregnancy and childbirth as reasons women do not go for health facility-based delivery. Physical and verbal abuse, lack of respect and lack of sympathy at the hands of midwives and nurses were mentioned as the reasons women chose home delivery. The major resources needed for quality ANC, in particular childbirth were inadequate. The participants stated that there was unavailability of sufficient skilled health professionals and material resources (beds), which resulted in women in early labour sent home. Some of the women blamed the health professionals for sending them back home because there were no beds.

The findings of the study revealed that women's lack of knowledge about facility-based delivery influenced their decision to give birth at home.

7.5. CONCLUSIONS DRAWN FROM THE FINDINGS

In summary, facility-based delivery service is a multifaceted subject which is determined by numerous factors, comprising characteristics of the pregnant woman herself, her close family circle, the community where she lives, the health facility that is nearby to her, and the context of her country. This qualitative study has generated evidence of why attendees of FANC give birth at home in Addis Ababa, Ethiopia, and the findings somewhat explain why in some circumstances ANC coverage is almost universal while facility-based deliveries remain low.

The findings raise a concern regarding the effectiveness of FANC in promoting facility-based deliveries as the attendees of FANC had not made plans for birth preparedness, complications readiness and emergency plans.

According to the focus groups findings, women who took in this study described their views on measures needed to enhance the development of women-centered guidelines to enhance the utilization of health facility-based delivery services among the attendees of FANC in Addis Ababa. The researcher used the findings of the study and literature as the basis for the development of guidelines to enhance the utilization of health facility-based delivery services among attendees of FANC in Addis Ababa, Ethiopia.

The guidelines are primarily meant for health care providers at district or health facility based level who are responsible for providing delivery services in Addis Ababa. This guidelines should be used in line with the standing national policies, strategies and other guidelines. Although the guidelines is specific to women-centred childbirth care, it could also be adopted to suit other aspects of service delivery in the study setting.

7.6. RECOMMENDATIONS

Recommendations for policy makers, programme planners and implementers

- Based on the study's findings the researcher has proposed the women–centred

guidelines which included strategic objectives and specific actions to enhance health facility based delivery services in the study area. The researcher recommends that Ministry of Health, Addis Ababa Health Bureau and the health facilities take into account this guidelines in planning and implementation of health programs to enhance health facility based delivery services among the attendees of FANC.

- In addition, the government should have a working referral system in place and the free maternal health care policy should also be supported to warrant the continuum of care in the health care delivery system.

Recommendations for health care facilities and staff

- Most women in Addis Ababa go public health facilities for ANC check-ups where the quality of care is perceived to be poor. As public facilities are the suppliers for the general population, particularly for deprived groups, humanising the quality of ANC services at those facilities is an imperative. Using ANC visits to advise women about birth preparedness and complication readiness, the emergency plans. The use of facility-based delivery services and the risks of home delivery to the mother and the new-born should be emphasised.
- Improve the skills of staff through in-service trainings on regular bases and these trainings should include staff qualities that will improve their attitudes through Behaviour change communication (BCC).
- Increase the role of communities including family, friends, neighbours, and other significant others to promote the benefits of facility deliveries in their social networks.
- Ensuring the accessibility of logistic supplies, drugs and diagnostic facilities (including ultrasound & X –rays) in the facilities free of charge or with low price for poor women is essential.
- Provide accessible and reliable ambulance service with fair price or free of charge to enhance facility delivery.
- Good staff-client interaction and client participation in care are central. Hence, staff should respect all women and treat them with dignity specifically female providers in health facilities and involve them in the care plan.

7.6.1. Implications for Practice

The researcher used the findings of the study and literature as the basis for the development of guidelines to enhance the utilization of health facility-based delivery services among attendees of FANC in Addis Ababa, Ethiopia. The Federal Ministry of Health in collaboration with Addis Ababa Health Bureau may adopt or adapt the guidelines through comprehensive discussions and facilitate its implementation along with other policies and working procedure documents that are prevailing in the country.

7.6.2. Implications and Suggestions for Research

The findings from this study provide a number of opportunities for future research.

- Research to investigate the effectiveness of FANC in promoting facility-based delivery among attendees of FANC.
- Studies to exploring the health care providers' needs for in-service education and skills development with regards to improved service delivery
- Applied research to investigate the proper use of national protocols and guidelines on service provision to minimise the unsupported C/S delivery rate in Addis Ababa.
- Further studies are needed to evaluate the referral practices and challenges faced by staff at lower level health facilities to decide when, where and how to refer the pregnant women to higher level facilities.

7.7. CONTRIBUTIONS OF THE STUDY

Research that examines enhancing utilization of health facility-based delivery (FBD) among attendees of focused antenatal care (FANC) in Addis Ababa, Ethiopia is limited. The findings of this study added to the existing body of knowledge on perspective of facility-based delivery services among attendees of focused antenatal care at selected public health facilities in Addis Ababa, Ethiopia. Understanding women's perspectives on facility-based and home delivery is important and helpful in guiding health care practitioners design women-centered guidelines that address negative perceptions of health facility-based

delivery, so that the number of home deliveries could decrease and the number of institutional deliveries among attendees of FANC could increase.

The proposed guidelines for enhancing the utilization of health facility-based delivery have the potential to increase the proportion of women who deliver in a health facility, as well as making repeated visits to public health facilities with future childbirths. Consequently, the majority of direct obstetric complications, which are the leading causes of maternal deaths, would be better managed, ensuring a substantial reduction of maternal mortality and morbidity in Ethiopia.

7.8. LIMITATIONS OF THE STUDY

The results of this study must be interpreted in the light of the following limitations:

- The study was conducted in public health facilities of Addis Ababa, Ethiopia. The perspectives of women attending FANC in private facilities and delivered at home were not explored in the study. The findings of this study applied to similar population in the study setting.
- Criticism related to qualitative research often refers to concerns of small sample, data interpretation and bias. In this study, however, the researcher was self-aware and cognisant of his immersion in the research process to allow the process to be as objective as possible. The researcher is of the view that the rich description of the sample, methods of data collection and the data analysis process reveal the translucent nature of the study.
- It is also vital to keep in mind that the analyzed data were based on information obtained from only women who delivered their last child at home in the last 12 months. However, the providers' views and practice as regards health facility- based delivery services was not studied.
- It should also be clear that the emerged themes were substantiated by the local and global works. Hence, the findings are valuable to health organizations that need to improve the health facility- based delivery services.

7.9. CONCLUDING REMARKS

In this chapter, conclusion drawn from study findings were presented, followed by recommendations, implication for practice, implications and suggestion for research, contribution of the study, limitations of the study, and concluding remarks.

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ANNEX 1

Ethical clearance certificate

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/495/2015

Date: 9 December 2015 Student No: 5765-775-0

Project Title: Enhancing utilization of health facility-based delivery among attendees of focused antenatal care in Addis Ababa, Ethiopia.

Researcher: Endalew Gemechu Sendo

Degree: D Litt et Phil Code: DPCHS04

Supervisor: Dr ME Chauke
Qualification: D Litt et Phil
Joint Supervisor: Prof M Ganga-Limando

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXES 2 & 3

Letter requesting permission to conduct the study

Letter granting permission to conduct the study

ANNEXE 2: Letter of request conduct the study

Date: 15/02/2016

TO: ADDIS ABABA HEALTH BUREAU

ADDIS ABABA

Subject: Permission Letter

I am a doctoral student (ID number: 57657750) at the University of South Africa in the Department of Health Studies. I will conduct a study on ‘’**ENHANCING UTILIZATION OF HEALTH FACILITY-BASED DELIVERY AMONG ATTENDEES OF FOCUSED ANTENATAL CARE IN ADDIS ABABA, ETHIOPIA’’** to pursue my PhD degree in health Studies. The research proposal was submitted to the higher degrees committee of the Department of Health Studies at UNISA for ethical clearance and was approved.

I kindly request permission to collect data in the selected health facilities of Addis Ababa District. Data will be collected from women who attended Focused antenatal Care (FANC) who had delivered alive babies at home in the past 12 months and report to the clinic for registration of maternal and child health clinics in Addis Ababa city government using Individual interview and focus group discussions(FGDs).

The purpose of the study is to develop an understanding of women’s perspectives of health facility-based delivery with the aim of proposing women-centred practice guidelines to enhance the utilization of health facility based delivery among attendees of FANC in Addis Ababa.

All respondents will be given full information about the study and written consent will be sought from the participants. Issues of confidentiality, anonymity and about their right to withdraw from the study if they feel uncomfortable will also be explained to the participants.

Therefore, I kindly request your esteemed organization to write me a letter of support to the selected health facilities to conduct the study accordingly.

With regards,

Endalew Gemechu Sendo(Ass. Prof)
Addis Ababa University
School of Nursing and Midwifery

ANNEXE 3: Permission Letter from Addis Ababa Health Bureau

Reference ፅ/ኮ/ሀ/6013/227
Date 23/02/2016

To Yekatit 12 hospital
Ghandi Hospital
Gulele sub city Semen health center
Gulele sub cityWoreda 6 Health center
Addis ketema sub city Woreda 4 Health center

Addis Ababa

Subject: Request to access Health Facilities to conduct approved research

This letter is to support **Endalew Gemechu Sendo** to conduct research, which is entitled as **"Enhancing utilization of health facilities based delivery among attendees of focused antenatal care in Addis Ababa, Ethiopia."** The study proposal was duly reviewed and approved by Addis Ababa Health Bureau IRB, and the principal investigator is informed with a copy of this letter to report any changes in the study procedures and submit an activity progress report to the Ethical Committee as required.

Therefore we request the Health facility and staffs to provide support to the Principal investigator.

With Regards

Mesfin Wossen
Ethical Clearance committee

Cc **Endalew Gemechu Sendo**
Addis Ababa
To Ethical Clearance Committee
Addis Ababa

ANNEXES 4 & 5

Participant Information and Informed Consent Form (English and Amharic Version)

ANNEXE 4: Participant Information and Informed Consent Form (English Version)

Dear participant,

My name is Endalew Gemechu Sendo, a registered doctoral student (student number: **57657750)** at the University of South Africa. I am conducting a research study entitled *Enhancing utilization of health facility-based delivery among attendees of focused antenatal care in Addis Ababa, Ethiopia***.** The purpose of my study is to explore and describe the perception of health facility and home delivery among attendees of FANC. The proposal for the study was approved by the higher degrees committee of the Department of Health Studies at UNISA and the ethical clearance certificate was issued.

I would appreciate it very much if you could consider taking part in my research. Your participation in this study is important because it will provide valuable information about perspectives of health facility-based and home delivery among attendees of FANC in Addis Ababa, Ethiopia. In addition, participating in this study will also give you the opportunity to make recommendations regarding the measures that should be taken to enhance the utilization of health facility based delivery

Your involvement in the study will include participation in face-to face individual, and group interviews (focus group interviews) at a later stage on the dates suitable for you. Participation in this study is voluntary; you can also withdraw at any time from the study if you feel uncomfortable. Refusal to participate will not affect the care you shall get at any of the health facilities in any way. Confidentiality will be ensured by not using your name or address on the research records and final thesis report. There are no foreseeable physical, psychological or social risks or discomforts involved in participating in this study. The study has no immediate benefits to the respondents, but will have benefits later by improving the utilization of health facility based delivery service among the attendees of FANC, thereby to reducing the maternal morbidity and mortality associated with complications of home delivery

Should you have any questions about the research or any related matters, please contact the researcher at **+251-911-196298.**

INFORMED CONSENT

I, the under signed, acknowledge that *Endalew Gemechu Sendo*, the researcher has explained the research study purpose and activities. I understand the nature of the study and the means by which my identity will be protected and that the information I give will be kept confidential. I have had the opportunity to ask questions and they were answered to my satisfaction. My signature on this form also indicates that I am 18 years old or older and that I give permission to voluntarily participate in this study. My signature here also grants permission for the interview to be recorded.

Name of participant _____

Signature of the participant_____

Date_____

Your participation is appreciated.

Yours Faithfully,

ANNEXE 5: Participant Information and Informed Consent Form (Amharic Version)

የተሳታፊው ስምምነት መግለጫ

የጥናቱ ርእስ፡ በአዲስ አበባ በሚገኙ የቅድመ ወሊድ እንክብካቤ ተከታታዮች ዘንድ የጤና ማእከል አገልግሎትን መሰረት ያደረገ የጤና አገልግሎት አሰጣጥን ማሻሻል፡፡

ጥናት አድራጊ **እንዳለው ገመቹ ሰንዶ በደቡብ አፍሪካ ዩኒቨርስቲ የጤና ትምህርት ጥናት ክፍል የዶክትሬት ተማሪ (መታወቂያ ቁ. 57657750) ነኝ፡፡**

ሴቶች በአዲስ አበባ በሚገኙ የቅድመ ወሊድ እንክብካቤ ተከታታዮች ዘንድ የጤና ማእከል አገልግሎትን መሰረት ያደረገ የጤና አገልግሎት አሰጣጥን ማሻሻል በተመለከተ ያላቸውን አስተያየት ለመዳሰስ ትኩረት ባደረገው በዚህ ጥናት ላይ እንዲሳተፉ በአክብሮት እጠይቃለሁ፡፡ የምርምር ምክረ ሀሳቡ (The research proposal) በዩኒሳ (UNISA) ላለው የጤና ትምህርት ጥናት ክፍል ከፍተኛ ዲግሪ ኮሚቴ ለስነምግባር ክሊራንስ ቀርቦ ተቀባይነትን አግኝቷል፡፡ የእርስዎ ተሳትፎ ሴቶች በአዲስ አበባ ኢትዮጵያ ቅድመ ወሊድ እንክብካቤ በሚከታተሉት ዘንድ የጤና ማእከልን መሰረት ያደረገ አገልግሎት አሰጣጥ ላይ ያላቸውን አስተያየት በተመለከተ ዋጋ ያለው መረጃ የሚሰጡ ይሆናል፡፡ በተጨማሪም የዚህ ጥናት ግኝቶች ቅድመ ወሊድ የጤና እንክብካቤ በአዲስ አበባ ኢትዮጵያ ለሚከታተሉ ሴቶች በሚጠቀመው መሰረት የጤና ማእከልን መሰረት ያደረገ የጤና አገልግሎት አሰጣጥ ለማሻሻል በሚወሰደው እርምጃ ላይ ለሚዘጋጁ ፅሁፎች ወቅታዊ አስተዋፅ ያደርጋል፡፡ በጥናቱ ላይ የሚኖርዎት ተሳትፎ ለእርስዎ አመቺ በሆነ ጊዜ የቡድን ቃለ መጠይቅ (FGD) መሳተፍ ነው፡፡

በዚህ ጥናት ላይ የሚኖሮትን ተሳትፎ በማንኛውም ጊዜ ለእርስዎ ምቾት የማይሰጥ ሆኖ ሲያገኙት ማቋረጥ ይችላሉ፡፡ በጥናቱ ላይ ለመሳተፍ ፈቃደኛ አለመሆን በስራዎት ላይም ሆነ በማንኛውም የጤና ማእከል የሚፈልጉት የጤና እንክብካቤ ላይ በማንኛውም መንገድ ተፅእኖ አያሳድርም፡፡ በመጠይቁ እና የመጨረሻው የጥናት ፅፍ ሪፖርት ላይ ስምዎ ወይም አድራሻ የማይሰፍር በመሆኑ የሚሰጡት መረጃ ሚስጢራዊነት የተረጋገጠ ይሆናል፡፡ በዚህ ጥናት የሚደርስ ቀድሞ ሊታይ ያልቻለ የስነ ልቦናም ሆነ የማህበራዊ አሉታዊ ውጤት ወይም መጉላላት አይኖርም፡፡

ጥናቱ ለተሳታፊዎቹ ምንም አይነት ቀጥተኛ ጥቅም ባይኖረውም በኋላ ላይ ግን ለነበሰጡር ሴቶች በሚሰጠው የጤና ማእከልን መሰረት ባደረገ አገልግሎት አሰጣጥ ላይ ማሻሻያዎች እንዲኖሩ በማድረግ በዚህም የእናቶችን ሞት እና ከወሊድ ጋር የተያያዙ ችግሮችን በመቀነስ ጠቀሜታ ይኖረዋል፡፡

ስለ ጥናቱ ወይም ስለተሳትፎ ማናቸውም ጥያቄን ለመቀበል ዝግጁ ነኝ፡፡ ስለጥናቱም ሆነ ተያያዥ ጉዳዮች ማናቸውም ጥያቄ የሚኖርዎ ከሆነ እባክዎ በስልክ ቁጥር **251-9111196298** ሊደውሉልኝ ይችላሉ፡፡

እኔ ከታች ፊርማዬ የሰፈረው የጥናቱ አይነት፣ ጥቅም፣ መብቶቼን መረዳቴን እና በፈቃደኝነት ለመሳተፍ እንዲሁም ሚስጢራዊነቱን በመገንዘብ እና ያለምንም አሉታዊ ውጤት ከጥናቱ መውጣት እንደምችል መረዳቴን እገልፃለሁ፡፡ ጥያቄዎችን ለመጠየቅ እድል ተሰጥቶኝ የነበረ ከመሆኑም ባሻገር በበቂ ሁኔታ ምላሽ ተሰጥቶኛል፡፡

በዚህ ጥናት ላይ ለመሳተፍ ስምምነቴን እገልፃለሁ፡፡

የተሳታፊ ስም፡ .....

የተሳታፊ ፊርማ፡ .....

ቀን፡ .....

ለተሳትፎዎ እጅግ አመሰግናለሁ

ANNEXES 6 & 7

Confidentiality binding form

(English & Amharic versions)

ANNEXE 6: Confidentiality Binding Form (English Version)

Research project: **ENHANCING UTILIZATION OF HEALTH FACILITY-BASED DELIVERY AMONG ATTENDEES OF FOCUSED ANTENATAL CARE IN ADDIS ABABA, ETHIOPIA.**

I …….. (participant) to the Focus Group Discussion for the study entitled *Enhancing utilization of health facility-based delivery among attendees of focused antenatal care in Addis Ababa, Ethiopia",* conducted by *Endalew Gemechu Sendo*, Doctoral student at University of South agree freely to participate to the Focus Group Discussion and to abide to the following:

- ✓ I will keep confidential all the information shared during the FGD
- ✓ I will respect the opinion expressed by my group members
- ✓ I will not disclose any information outside the group
- ✓ I will not link any information to any group member
- ✓ The researcher/facilitator agrees to take all reasonable steps to protect personal identity of the participants
- ✓ The researcher/facilitator agrees to take all reasonable steps to protect the privacy of the participants.

I fully understand the content of this entire agreement and undertake to freely participate to the group discussion.

The researcher The participant

Name: ……Name:……..

Sign…… Sign: …….

Date…… Date:…….

ANNEXE 7: የሚስጥራዊነት ማረጋገጫ ቅጽ (Confidentiality Binding Form)- Amharic Version

የጥናቱ ርእስ፡ በአዲስ አበባ በሚገኙ የቅድመ ወሊድ እንክብካቤ ተከታታዮች ዘንድ የጤና ማእከል አገልግሎትን መሰረት ያደረገ የጤና አገልግሎት አሰጣጥን ማሻሻል፡፡

እኔ_____(ተሳታፊ) እንዳለው ገመቹ ሰንዶ በአዲስ አበባ በሚገኙ የቅድመ ወሊድ እንክብካቤ ተከታታዮች ዘንድ የጤና ማእከል አገልግሎትን መሰረት ያደረገ የጤና አገልግሎት አሰጣጥን ማሻሻል ላይ በሚያደርገው ጥናታዊ ጽሁፍ ውስጥ በፍቃደኝነት በቡድን ውይይቱ (FGD) ላይ ለመሳተፍ እንዲሁም በሚከተሉትን ሃሳቦች ላይ ተስማምቻለው፡፡

- በውይይቱ ወቅት የሚነሱትን መረጃዎች በሚስጢር እጠብቃለሁ፡፡
- የተሳታፊዎችን ሃሳብ አከብራለሁ፡፡
- ከቡድኑ ውጪ መረጃውን ለማንም አላካፍልም፡፡
- ተመራማሪው ከውይይቱ ተሳታፊዎች ውጪ ለማናቸውም አካላት መረጃውን አሳልፈው እንደማይሰጡ ተስማምተዋል፡;
- ተመራማሪው የተሳታፊዎቹን የግል ሚስጢር ለመጠበቅ ተስማምተዋል፡፡

የዚህን ስምምነት ሙሉ ሃሳብ በሚገባ ተረድቼ በቡድን ውይይቱ(FGD) ላይ ለመሳተፍ ስምምነቴን እገልፃለሁ፡፡

ተመራማሪው

ስም_____

ፊርማ_____

ቀን_____

ተሳታፊው

ስም_____

ፊርማ_____

ቀን_____

ANNEXE 7: የሚስጥራዊነት ማረጋገጫ ቅጽ (Confidentiality Binding Form): Amharic Version

የጥናቱ ርእስ፡ በአዲስ አበባ በሚገኙ የቅድመ ወሊድ እንክብካቤ ተከታታዮች ዘንድ የጤና ማእከል አገልግሎትን መሰረት ያደረገ የጤና አገልግሎት አሰጣጥን ማሻሻል፡፡

እኔ [illegible] (ተሳታፊ) እንዳለው ገመቹ ሰንዶ በአዲስ አበባ በሚገኙ የቅድመ ወሊድ እንክብካቤ ተከታታዮች ዘንድ የጤና ማእከል አገልግሎትን መሰረት ያደረገ የጤና አገልግሎት አሰጣጥን ማሻሻል ላይ በሚያደርገው ጥናታዊ ጽሁፍ ውስጥ በፍቃደኝነት በቡድን ውይይቱ (FGD) ላይ ለመሳተፍ እንዲሁም በሚከተሉትን ሃሳቦች ላይ ተስማምቻለው፡፡

- በውይይቱ ወቅት የሚነሱትን መረጃዎች በሚስጢር እጠብቃለሁ፡፡
- የተሳታፊዎችን ሃሳብ አከብራለሁ፡፡
- ከቡድኑ ውጪ መረጃውን ለማንም አላካፍልም፡፡
- ተመራማሪው ከውይይቱ ተሳታፊዎች ውጪ ለማናቸውም አካላት መረጃውን አሳልፈው እንደማይሰጡ ተስማምተዋል፡፡
- ተመራማሪው የተሳታፊዎቹን የግል ሚስጢር ለመጠበቅ ተስማምተዋል፡፡

የዚህን ስምምነት ሙሉ ሃሳብ በሚገባ ተረድቼ በቡድን ውይይቱ(FGD) ላይ ለመሳተፍ ስምምነቴን እገልፃለሁ፡፡

ተመራማሪው

ስም [illegible]
ፊርማ [illegible]
ቀን Feb 17, 2017

ተሳታፊው

ስም [illegible]
ፊርማ [illegible]
ቀን Feb 17, 2017

ANNEXES 8 & 9

Individual interview schedule

(English & Amharic versions)

ANNEXE 8: Individual Interview Schedule (English Version)

Thank you for making time to take part in this interview. My name is *Endalew Gemechu Sendo* and I would like to talk to you about your reasons for attending FANC, which promotes skilled attendance at birth, but decided to deliver your baby at home and not at the health care facility.

Please remember that you are under no obligation to participate in this interview. You can withdraw from the study at this point or end the interview at any point during the interview without explanation or consequences. You do not have to answer any question that makes you uncomfortable. Should we come to any question that you do not want to answer, just let me know and we will go to the next question.

I promise to treat all information collected from this interview as highly confidential and it shall not be reported in a manner that identifies or links you with the results of the study. The interview should take about thirty (30) minutes. Even though I will be taking some notes, I cannot write fast enough that is why I will be recording this interview because I do not want to miss any of your comments. Because we are on tape, please make sure that you speak up so that we do not miss your important responses.

Do you have any questions regarding what I have just explained to you?

INTERVIEW QUESTIONS

Personal information

Please tell me about yourself (age, marital status, your children, highest level of education, your religion and your current employment)

Questions about focused antenatal care (FANC): facility-based and home deliveries.

1. Would you please tell me your reasons for attending FANC (which promotes the use of skilled attendance at birth) but decided to deliver your baby at home and not at the health facility?

Additional questions included

1. What prompted you to attend antenatal care?
2. How many times did you receive ANC during this pregnancy?
3. What were the benefits of attending antenatal care?
4. What information did you receive from the health care providers about preparing for giving birth at health facilities?
5. Why did you chose to deliver your baby at home?
6. What are your views regarding the advantages of home delivery?
7. What is your opinion regarding delivering a baby in the health facility?
   - Would you recommend health facility delivery to your friends? Why not? What are the barriers? What are the benefits of going for institutional delivery?
8. What is your opinion about delivering a baby at home?
   - Would you recommend home delivery to your friends? Why? What are the benefits of delivering a baby at home?

Thank you very much for taking part in this study.

ANNEXE 9: መጠይቅ (Individual Interview Schedule) – Amharic Version

በውይይቱ ላይ ለመሳተፍ ፍቃደኛ ስለሆኑ አመሰግናለሁ::በዛሬው እለት ውይይታችንን የምመራው እኔ **እንዳለው ገመቹ ሰንዶ** በደቡብ አፍሪካ ዩኒቨርስቲ የጤና ትምህርት ክፍል የዶክትሬት ተማሪ ነኝ:: ውይይታችን የሚያተኩረው የጤና አገልግሎት በጤና ማእከል ወይንም በቤቱ ውስጥ ስለሚሰጥበት ሁኔታ ያላችሁን የግል አስተያየት ነው:: በዚህ ጥናት ላይ የሚኖሮትን ተሳትፎ በማንኛውም ጊዜ ለእርስዎ ምቾት የማይሰጥ ሆኖ ሲያገኙት ማቋረጥ ይችላሉ:: እኔም የግል ሚስጢርዎን ለመጠበቅ ቃል እገባለሁ:: ውይይቱ በግምት 30 ደቂቃ ይወስዳል:: ምንም እንኳን ማስታወሻ ብይዝም ድምጽዎን ግን በመቅረጫ እቀርጻለሁ:: ምክንያቱም የሚሰጡኝን የትኛውንም መረጃ ማጣት ስለማልፈልግ ነው::

ከላይ በተደረገው ገለጻ ላይ ጥያቄ አለዎት?

የመጠይቅ ጥያቄዎች (INTERVIEW QUESTIONS)

የግል መረጃ

እባክዎ ስለ ራስዎ ያብራሩ(ዕድሜ፣ የጋብቻ ሁኔታ፣ ልጆች፣ የትምህርት ደረጃ፣ ሃይማኖት እና የቅጥር ሁኔታ)

የቅድመ ወሊድ እንክብካቤ ጥያቄዎች(FANC): በጤና ማእከል ወይንም በቤት ውስጥ መውለድ

1. የቅድመ ወሊድ ክትትል በጤና ማእከል ካደረጉ በኋላ ልጅዎን በቤት መውለድ ለምን ወሰኑ?

ተጨማሪ ጥያቄዎች:

- የቅድመ ወሊድ ክትትል ለማረግ ያነሳሳዎ ምንድነው?
- በመጨረሻው እርግዝናዎ ወቅት ሥንት ጊዜ የቅድመ ወሊድ የጤና ክትትል አደረጉ?
- የቅድመ ወሊድ የጤና ክትትል ጠቀሜታዎች ምንድን ናቸው?
- በቅድመ ወሊድ የጤና ክትትል ወቅት በጤና ማእከል እንዲወልዱ ከጤና ባለሙያዎች ያገኙት መረጃ ምን ነበር?
- ልጅዎን በቤት መውለድ ለምን መረጡ? ጥቅሙስ?
- በቤት መውለድ ጋር ተያይዞ ያለዎት አስተያየት ምንድነው?
- በጤና ማእከል ውስጥ ከመውለድ ጋር ተያይዞ ያለዎት አስተያየት ምንድነው?
    - ሴቶች በጤና ማእከላት ልጅ እንዲወልዱ ያረታታሉ? ለምን?
    - ሴቶች በጤና ማእከል ልጆቻቸውን እንዲገላገሉ የሚከለከል ባህል ነክ ልማድ አለ? ካለ ያብራሩት::

ለተሳትፎዎ እጅግ አመሰግናለሁ

ANNEXES 10 & 11

Focus group interview schedule

(English & Amharic versions)

ANNEXE 10: Interview Schedule for FGDS (English Version)

Thank you for making time to take part in this interview. My name is *Endalew Gemechu Sendo* and I would like to talk to you about the measures needed to enhance utilisation of facility-based delivery among attendees of FANC in Addis Ababa, Ethiopia.

Please remember that you are under no obligation to participate in this interview. You can withdraw from the study at this point or end the interview at any point during the interview without explanation or consequences. I promise to treat all information collected from this interview as highly confidential and it shall not be reported in a manner that identifies or links you with the results of the study. The interview should take about thirty (45) minutes. Even though I will be taking some notes, I cannot write fast enough that is why I will be recording this interview so I do not miss any of your comments. Because we are on tape, please make sure that you speak up so that we do not miss your important responses.

Do you have any questions regarding what I have just explained to you? I hope you have all signed the confidentiality binding form.

Interview schedule

The central question that was asked was "*What do you think should be done to enhance the utilisation of health facility-based delivery among attendees of FANC?*

Specific group interview questions fell into the categories:

1. Discussion of participants experience of facility-based delivery services
    - *Did you deliver any/ all of your babies at a health care facility?*
    - *How did you experience health care facility based delivery?*
    - *Were you satisfied with the services rendered?*
2. Impressions and views of facility based delivery services
    - *What are your impressions or views of facility based delivery?*

- *What do you think of delivering babies at the health facility?*

3. Barriers to utilization of facility based delivery services

   What do you think is the reason people choose deliver their babies at home?

   What change do you want to see in the facility based delivery services?

4. Measures to enhance facility based delivery services

- *What is your recommendation for improving facility based delivery services in your health facility?*
- *Please share with us your views on measures needed to enhance the utilization of health facility based delivery services.*

Thank you very much for taking part in this study.

ANNEXE : 11 የቡድን ውይይት ጥያቄዎች(Interview Schedule for FGDS) - Amharic Version

በውይይቱ ላይ ለመሳተፍ ፍቃደኛ ስለሆኑ አመሰግናለሁ::በዛሬው እለት ውይይታችንን የምመራው እኔ **እንዳለው ገመቹ ሰንዶ** በደቡብ አፍሪካ ዩኒቨርስቲ የጤና ትምህርት ክፍል የዶክትሬት ተማሪ ነኝ:: ውይይታችን የሚያተኩረው የጤና አገልግሎት በጤና ማእከል ውስጥ እንዴት መሻሻል እንዳለበት ለመወያየት ነው። በዚህ የቡድን ውይይት ላይ የሚኖሮትን ተሳትፎ በማንኛውም ጊዜ ለእርስዎ ምቾት የማይሰጥ ሆኖ ሲያገኙት ማቋረጥ ይችላሉ:: እኔም የግል ሚስጢራችሁን ለመጠበቅ ቃል እገባለሁ:: ውይይቱ በአማካይ 45 ደቂቃ ይወስዳል:: ምንም እንኳን ማስታወሻ ብይዝም ድምጻችሁን ግን በመቅረጫ እቀርጻለሁ: : ምክንያቱም የሚትሰጡኝን የትኛውንም መረጃ ማጣት ስለማልፈልግ ነው::

ከላይ በተደረገው ገለጻ ላይ ጥያቄ አላችሁ?

የተወሰኑ የቡድን ውይይት ጥያቄዎች እንደሚከተሉት ናቸው:-

1. **ተሳታፊዎቹ በጤና ተቋም መውለድ ላይ ያላቸው ገጠመኝ**

- በጤና ተቋም ውስጥ ወልደው ያውቃሉ?
- በጤና ተቋም መውለድ ጋር ተያይዞ ያለዎትን ገጠመኝ ያጋሩን::
- በአገልግሎቱ ረክተዋል?

በጤና ተቋም መውለድ ጋር ተያይዞ ያለዎትን ሃሳብና አመለካከት

- በጤና ተቋም መውለድ ጋር ተያይዞ ያለዎትን ሃሳብና አመለካከት ምን ይመስላል?
- በጤና ተቋም ውስጥ መውለድን እንዴት ያዩታል?

በጤና ተቋም ውስጥ መውለድ ጋር ተያይዞ ያሉት ተግዳሮቶች

- እናቶች በቤት መውለድን የሚመርጡት ለምን ይመስሎታል?
- በጤና ተቋም ውስጥ እንዲሻሻል የሚፈልጉት ነገሮች ምንድን ናቸው?

እናቶች በጤና ተቋም ውስጥ እንዲወልዱ መወሰድ ያለባቸው እርምጃዎች

- በጤና ተቋም ውስጥ ያሉት ክፍተቶች እንዲሻሻሉ ምን ምክረ ሃሳብ ይሰጣሉ?
- በጤና ተቋም ውስጥ ያሉት ችግሮች እንዲቀረፉ ምን እርምጃ መወሰድ አለበት ይላሉ?

ለተሳትፎዎ እጅግ አመሰግናለሁ

ANNEXES 12

Letter from the editor

Annexe 12: Letter from Language editor

ADDIS ABABA UNIVERSITY
አዲስ አበባ ዩኒቨርሲቲ

የአዲስ አበባ ቴክኖሎጂ ኢንስቲትዩት
ዘደ የህትመት ክፍል

Addis Ababa Institute of Technology
Zede Editorial Board

ቀን: Date 24 Dec. 2018

ቁጥር: Ref. No. Zede/045/2018

To: University of South Africa
Graduate Studies Program

Subject: Language Edition and Proofreading

I hereby certify that I have edited and proofread Mr. Endalew Gemechu Sendo's PhD Dissertation entitled: **Enhancing Utilization of Health Facility-Based Delivery among attendees of Focused Antenatal Care in Addis Ababa, Ethiopia for language and content.**

I found his thesis too easy and pleasant to read. Much of my editing primarily dealt with technical aspects of language which could have otherwise compromised smooth reading of the thesis. I believe that his work will be found to be an acceptable PhD standard.

Best Regards,

Berhanu Bekeko
Lecturer, School of Multi-Disciplinary Engineering ,AAU/AAiT
Managing Editor, Zede Journal of Ethiopian Engineers and Architects
Cell phone: +251911746944
Email: bekekoo@gmail.com

Tel. 011 1232436 P.O.Box 385 Fax: 00251(011)-1239480 Cable: AAUNIV