ST. MARY'S UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTEMENT OF SOCIOLOGY

THE QUALITY OF PRENATAL HEALTH CARE SERVICE PROVIDED BY NGOs : THE CASE OF FAMILY GUIDANCE ASSOCIATION OF ETHIOPIA, KALITY AKAKI SUB-CITY

By

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ADDIS ABABA, ETHIOPIA

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Acronyms and Abbreviations

SRH: Sexual and Reproductive Health Service

ANC: Antenatal Care

IPPF: International planned Parenthood Federation

CBS: Community Based Service

CSO: Civil Society Organization

FGAE: Family Guidance Association of Ethiopia

NGO: Non-Governmental Organization

WHO: World Health Organization

HIV: Human Immunodeficiency Virus

CRDA: Christian relief development association

MOJ: Ministry of Justice

FMOH: Federal Ministry of Health

DPPB: Disaster Prevention and Preparedness Bureau

Abstract

The main objective of this study was to investigate the quality of NGOs in delivering primary health service of prenatal care in Family Guidance Association of Ethiopia, kalityakaki sub city .In consideration of this; both primary and secondary data were collected and used. The primary data was collected through questionnaire, focus group discussion and an interview whereas the secondary data was collected via document review. Simple random sampling and purposive or judgmental sampling designs were employed to select the sample respondents from the total population and staffs from the association. regarding analysis of this research the researcher used this method and collected both quantitative and qualitative data from FGAE using the same variables, analyzed them separately, and then compared the results to see if the findings confirm or disconfirm each other. The researcher made the comparison within a discussion presented first one set of findings and then the other, which is called a side by side comparison approach. It implies that, first quantitative data was analyzed and it was supported by secondary data. The collected data was analyzed qualitatively and quantitatively by statements, tables, figures and percentage. As per the researcher's observation and interviews made, usage of modern technologies and suitable medical tools are also very low in the association, Less flexibility of the service by employing and using different options for the delivery of antenatal care based on the beneficiaries' specific needs. The finding goes with the WHO's suggestion of an integrated and comprehensive package of all these services has to be delivered to improve the quality of ANC and to improve maternal, fetal and newborn outcomes, related to prenatal care. Based on the findings of this research, the researcher recommend different options for the FGAE to apply it in the future for a better and quality services in the prenatal care providence for its expecting mothers and for a great and better role that it should play in delivering primary health care service for the society.

***Key Words**: Prenatal care, Primary health care, Social Network Analysis, Quality service*

CHAPTER ONE

1. Introduction

This introduction section includes background of the study, statement of the problem, general and specific objectives of the study, research questions and significance of the study, scope of the study and organization of the paper

1.1 Background of the study

World health organization's recommendation on antenatal care for a positive pregnancy experience prioritize person-centered and accepted by the member countries of WHO as the key to achieving the goal of health for all (WHO2016|). There are eight elements of essential health service in primary health care. Education for health (E), locally endemic disease control (C), expanded program for immunization (E), material and child health including responsibility parenthood (M) essential drugs (E) nutrition (N), treatment of communicable and non-communicable disease (T), and finally safe water and sanitations (S). In most parts of the world, NGOs have played key roles in improving the health status of the population and access to health services 30% of health needs in developing countries are met by NGOs (Richard, 2007).

In sub- Saharan Africa NGOs hospitals provide 43% of medical services in Tanzania, 40% in Malawi, 34% in Ghana .Additionally, there is a global recognition that NGOs health institutions provide a large potential for improving health and health care delivery systems of developing countries.

The FGAE is a national organization that owns profound experience in the delivery of a wide range of reproductive health services. It was established in 1966 as a non government, voluntary organization. The association has gone through series of institutional development stages to assume its present status of wider national significance and recognition at the international level. Upon establishment, it pioneered family planning thinking and methods. Through time it able to provide many-options in contraceptive methods including surgical contraception. In addition, emphasizing other quality of care considerations, it ramified its service frontier to include sexual and reproductive health. FGAE has eight area offices in different geographical regions of the country.

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According to Ethiopia's Ministry of Justice (MOJ), which is responsible for the registration of NGOs, there are over 3,700 local and international NGOs operating in the country. NGOs make a significant contribution to Ethiopia's health sector. The NGOs healthcare system comprises over 300 health institutions in the country constituting 7%of the 8,236 health facilities, most of which are at the primary level. They provide financing and general (curative, preventive and rehabilitative) healthcare services,HIV/AIDS and reproductive health services in clinics and through health education.

A larger portion of fees paid for health services is spent in non-MOH facilities and cost-recovery in NGOs facilities is 70% Considering this number, we can say that the NGO sector in the country as compared with Sudan, Eritrea, Djibouti and Somalia is large. However, when compared to other countries in Africa this is small. The history of NGOs in Ethiopia began by providing relief services, which lasted for a long time. (FDRE,1998)

The World Health Organization (WHO) envisions a world where every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal period.(WHO, 2016)

Previous studies showed that pregnant women who received quality prenatal care were 4.6 to 47.1% globally and 24.3 to 69.5% in Ethiopia .NGOs are a key partner of the health sector by contribution to the national health sector development goals. Prenatal care refers to services a pregnancy to ensure a healthy outcome for herself and new born .however limited studies have so far been done to assess the quality of prenatal care service. The study examined the relevance of NGOs on delivering prenatal care service associated factors at Family Guidance Association of Ethiopia, kalityakaki sub-city.

1.2 Statement of the problem

The active participation of NGOs has its own significance in the overall development activity of Ethiopia mainly by improving the lives of the poor and disadvantaged groups in providing basic services. On the other hand, NGOs have their own role on the country's economy and development programs; on the process of democracy building, access to justice and good governance; on public awareness and empowerment.

Accordingly, an analysis of the current situation in regard to NGO participation and partnership in health development is considered to be timely and initiate strategies promote and enable NGOs to engage meaningfully in collective action for health development. NGOs have made significant contributions to reproductive and sexual health in many areas in the study area where their reproductive and child health services have decreased child and maternal mortality. The importance of NGOs in the delivery of services have gained recognition in terms of filling gaps in government program (Boboya J., 2014)

So far Ethiopia has not been able to extend health service to the entire population and service quality is suffering from the inadequate resource to meet the need. NGOs and the private sector are major partners in improving the health status of Ethiopians. NGOs participate in the delivery of primary health through health infrastructure development, human resource development, health facility capacity building, and communicable disease prevention and so on. However, there is lack of national strategy or plan that sets out clear and complementary roles of NGOs in the health sector and their comparative advantage are not identified and /or recognized (CRDA, 2004).

In this scenario, the mother might blame the nurses or the association for her own fault. This affects the reputation of the association and undermines its service quality and the performance of the health care practitioners as well. According to the finding, majority of mothers did not accomplish their secondary education so, the chances of not listening and act according to their nurse's advice is very low and this shows how being educated is important for the mothers and how an awareness raising programs should also be provided for them more frequently.

The researcher selected case study at FGAE because this NGO is a key partner of the health sector by the government of Ethiopia for its contribution to the national health sector development goals.

Moreover, The FGAE brought a fruitful result in terms of saving and changing the lives of underserved and vulnerable mothers and young lives in the country by availing integrated and quality services. (FGAE, 2020)

Additionally, the FGAE's main focus is on youth, underserved and vulnerable population and from some of the services that are delivered by FGAE is Maternal care, sexual and reproductive health care, Family planning and contraceptive uses, free HIV test and counseling, basic laboratory test and health care services are included. The International human rights law includes fundamental commitments of states to enable women and adolescent girls to survive pregnancy and childbirth as part of their enjoyment of sexual and reproductive health rights and living a life of dignity (Human Rights Council, 2021). The World Health Organization (WHO) also envisions a world where "every pregnant woman and newborn receives quality care throughout their pregnancy, childbirth and postnatal periods" (WHO2016)

The basic materialization of this vision is only through the efforts of a well utilized antenatal care service, as the world health organization have demonstrated a positive relationship between ANC service utilization and pregnancy outcomes (World Health Organization, 2016).Moreover, it was found in the same study that, at least one ANC visit is associated with 3.82%points reduced probability of giving birth to a low birth weight baby, 4.11% and 3.26% points reduced stunting and underweight probability respectively. A conclusion was therefore drawn from the same study that, currently, the existing and accessed ANC services in most low-income and middle-income countries are directly associated with improved birth outcomes and long term reduction of child mortality and malnourishment (Kuhnt& Vollmer 2021).

Ethiopian Demographic Health Survey (EDHS) showed that the maternal mortality rate was 673 deaths per 100,000 live births and infant mortality rate was 77 deaths per1000 live births (EDHS, 2005). This shows us that there are many premature deaths which can be easily preventable and manageable with simple doable measures and actions, starting from the community to higher health facility level intervention. Antenatal care service is one of the basic elements of Maternal

and Child Health (MCH) service which improves health of pregnant woman and the new born, and reduces maternal morbidity and mortality.

The researcher has identified some of the gaps of previous researches. Quality Service provision should be assessed to identify the strength and weakness of the ANC service and to find out the unmet needs of pregnant women who seek this service. Currently, access to health service is improved. However, availability of service alone cannot be warrant the effective provision of all necessary service elements which help to obtain the desired goals of pregnancy outcomes.

Even if there had been literatures and documents are available which focus on the role of the NGOs in Social development and availability of prenatal care services and other issues. However, researchers have not been done (or at least adequately) in the areas of providing quality prenatal care service regarding NGO's. Government programmers has a feasible strategy to improve the equity of maternal and neonatal health programs.

The service performance of the prenatal care might also be affected by the negligence act of the beneficiaries. This might lead them for the miscarriage of the baby and might leave the mother's health in a challenging situation too. Thus, this study examined the quality of prenatal care service provided by Family Guidance Association of Ethiopia, kality Akaki Post .

1.3 Objectives

1.3.1 General Objectives

The general objective of this study was to examined the quality of prenatal care service provided by Family Guidance Association of Ethiopia, kalityAkaki Post. Targeted the case study on Family Guidance Association of Ethiopia in Akakikality branch

1.3.2 Specific Objectives

Specifically, the study tried to:

- Identify the major prenatal care services which are highly utilized by the beneficiaries
- Assess the quality of the prenatal care service
- Measure the level of collaboration between health care provider and beneficiaries

1.4. Research Questions

The study was guided by the following questions:

- What are the major prenatal care services which are highly utilized by the community?
- How was the level of adoption of the health care providers in using digital technology?
- How was the quality of the health service provided by the Family Guidance Association of Ethiopia on prenatal care service?
- How was the level of collaboration between the health care providers and the beneficiaries?
- What were the major challenges that are faced by Family Guidance Association of Ethiopia in delivering prenatal health care services to expecting mothers?

1.5 Significance of the Study

This study contributed to the existing literature on FGAE in delivering primary health care service on prenatal care to improve in the issue of delivery quality service performance, which is needed to be examined by other stakeholders. This study also examined how quality services are delivering in primary health care service on prenatal care in order to improve in the issue of delivery quality service performance specially mother and child biased . Another significance of this assessment its helps other NGOs to analyze the gap and to involve process, outcome and practice of prenatal health care on community biased. The findings of this study have implications for policy and practice, as they provided insights and recommendations for the government and different stockholders. Moreover, the study also suggested directions for further research on this topic.

1.6 Scope of the study

The study has its own scope. The study adopted a specific definition and a specific geographical location and focuses on investigating the relevance of the NGOs in providing primary health care of among the many existing ones in the literature, which may limit the scope and depth of the analysis of NGOs on prenatal care service in the Family Guidance Association Akaki-kality sub-city post role in this process.

Regarding methodological scope, the researcher used cross sectional survey design, mixed-methods approach to explore the practice of quality prenatal health service. The time horizon of the data collection period was from April to May 2024

1.7Limitation of the Study

Moreover, cross sectional which has a potential drawback for temporality of cause and effects. Another limitation of the study was to access information and provision of update available data from Administration.

1.8 operational Definition of Term

- **Service Quality:** service quality(SQ) is a dimension of quality related to terms and conditions in which clients services, and almost indicates the methods' of providing care and the setting in which services are delivered

- **Endemic disease: a** disease or outbreak of disease that is typically present in a particular region or population.

- **Contraceptives:** This can be a device, a medication, a procedure or a behavior. Contraception allows a woman control of her reproductive health and affords the woman ability to participate in her family planning..

1.9organization of the study

This study is organized into five chapters. The first chapter contains the background, statement of the problem, research questions objectives of the study, significance of the study scope and limitation of the study, the next, chapter 2 deals with both theoretical and empirical literatures addressing Chapter 3 describes study area, research design, sampling method sample size. Additionally, chapter 4 deals with data analysis, interpretation and discussion of the result or findings of the study. Finally, chapter 5 includes summary of the research findings, conclusions and recommendations. Last but not least, following the above chapters, list of reference materials and annexes incorporated at the end of the paper

CHAPTER TWO

2. REVIEW OF THEORETICAL AND EMPIRICAL LITERATURES

This chapter discusses theoretical and empirical literature relevant to the study. Accordingly, it is divided into four broad sections: theoretical literature review, empirical literature review, summary and knowledge gape, and conceptual framework

2.1.1Review of theoretical literature

Pregnancy is a universal condition, effecting significant maternal adjustment and change, marked by fetal development and maturation. Maternal physiologic challenges present throughout the ante partum period, necessitating adaptation in order to nurture and support fetal growth. Prenatal maternal surveillance throughout pregnancy is integral to the promotion of positive maternal and newborn outcomes. Prenatal care presents as an opportunity for assessment, early identification of problematic issues, timely management of pathology, and intervention to direct improved maternal, fetal, and delivery outcomes (Haddrill, Jones, Mitchell, &Anumba, 2014; Madappa& Sharma, 2010; Ziyo, Matly, Mehemd, &Dofany, 2009)

Literature has demonstrated a link between maternal non-adherence to prenatal care and adverse fetal conditions including low birth weight, preterm delivery, and ante partum fetal death (Almeida et al., 2007; Jin& Wen, 2003; Ziyo et al., 2009). Complications associated with preterm delivery increase the likelihood of stress, financial strain, and health burdens, with the possibility of continued impact upon well-being throughout the lifespan. Despite the importance of prenatal care, maternal non-adherence to routine scheduled visits remains persistent, pervasive, and problematic globally (Fisher et al., 2010; Tough, Siever, & Johnston, 2007).

A number of socio demographic characteristics of the individual affects the underlying tendency to seek care (Addai, 2000). In this regard, good examples are maternal age and parity, which have been examined as determinants of health care use repeatedly (Adekunle et al., 1990;

The greater confidence and experience of the older and higher parity women, together with greater responsibilities within the household and for child care, have been suggested as explanatory factors for their tendency to use services less frequently (Kwast and Liff, 1988).

Maternal education has also been shown repeatedly to be positively associated with the utilization of maternity care services (Addai, 2000;) In General, women in higher socioeconomic groups tend to exhibit patterns of more frequent use of maternal health services than women in the lower socioeconomic groups, factors such as education appear to be important mediators (Addai, 2000;Addai, 1998; Leslie and Gupta, 1989).

This chapter deals with different literatures related to relevance of NGOs in delivering primarily health care services . In the light of this, attempts were made to review both the theoretical and empirical works of various writers.

Prenatal Attachment

Rubin's recognition of binding-in is consistent with the concept of prenatal attachment (Cranley, 1981). The notion of attachment was introduced by John Bowlby, a psychoanalyst in the 1970s whose focus was on the child's attachment to the caregiver. In contrast, the focus here is on the bonds that are forming between the mother to her inner baby and the father's emotional ties to his fantasized future child.

Maternal–fetal attachment was primarily conceptualized by nurses such as Rubin (1961) and Cranley (1981). Later, conceptions of prenatal attachment have focused on the mother's and father's psychological bond to the unborn child that is visible in parental behaviors (Brandon, Pitts, Denton, Stringer, & Evans, 2009; Condon, 1985; Klaus &Kennell, 1976). Prenatal attachment generally increases across the pregnancy, facilitated by the realism of hearing the fetal heartbeat, seeing the baby on ultrasound, and feeling fetal movements. Mothers have higher levels of attachment than fathers until after birth when both parents see, hold, and care for their baby (Brandon et al.). Nurses can note signs of prenatal attachment through assessing the way expectant mothers speak about their baby, call the baby by name, or wrap their hand protectively over their protruding belly. An indicator that prenatal attachment has not occurred or is being disrupted may be observed in a woman showing a lack of interest in her unborn baby.

Motivation–Ease as a Middle-Range Theory

The Motivation-Ease Middle-Range Theory states that maternal motivation interfaces with the ease of clinic access to affect access and utilization of prenatal care. The concepts of this middle-range theory are derived from Lewin’s grand theory of human behavior. His “field theory of

human behavior" arose in the 1930s as an antireductionist approach yet compatible with empirical study. Lewin stated that all behavior is a function of the person and the environment as it exists for that person. In the M-E model of prenatal care, the middle range concept of motivation is the aspect of person, and ease represents an aspect of that person's clinical environment. Access is a function of that interface. Utilization of care is the behavior that emerges from a successful interface. The parsimony of this theory and the simplicity of the terms provides a transferable, comprehensible and useful model at the real-life, operational level: the interface of pregnant women and the clinic.the surface and consider seeking more information, if needed.

According to Anderson and Newman's model of health service utilization, access to and use of particular health service is a function of three main characteristics which includes predisposing factors, enabling factors and need factors (Anderson & Newman, 1973)

2.1.2Empirical Review

The number of NGO's in Ethiopia has increased in the last decades because of different reasons. Most of them were engaged in micro level projects and support the state development program working on education, health, HIV/Aids, street children community development legal reform and etc. the NGO's target population could be national, local or specific section of population. As an example, the Ethiopian Red Cross association managers blood bank service and Cheshire foundation of medical rehabilitation program aids children from all over the nation. (CRDA, 2004).

The target population of the organization varies. Some targets a specific program theme, concern or population which includes family planning service Malaria, trachoma water, sanitation and so on, while others implement integrated primary health care. as the data from CRDA suggests that:

"About 400 local and international NGOs implement health or health- related projects. In Addis Ababa 43 NGOs manage by health projects: and two health centers, two hospitals and eight health posts are managed by NGOs. In Oromia, 77 NGOs are implementing 132 health projects and they also manage four hospitals, two health centers, 85 clinics and four health posts. Their contribution to health service coverage of the regions is about 4% furthermore, two nursing schools are owned by NGOs (ORHB, 2004). In SNNPR, 48 health projects are managed by

NGOs. In this region, 31 clinics, 2 health centers, 4 hospitals and 1 nursing School are owned by NGOs" (CRDA, 2004).

The advantages of the participation of NGOs/CSOs in the health sector are both instrumental and value based. It is instrumental because NGOs potentially contribute flexibility, responsiveness,
adaptability, and efficient and effective performance to the health sector. Its value is related to the contribution of participation in health sector program to democratization and improved governance by creating opportunities for dialogue, accountability and transparency that advance societal transformation towards more democratic governance (Brinkerhoff, 2000). The argument is that creating and strengthening NGOs/CSOs increases opportunities for citizens to participate in decision making and action related to policy formulation and implementation. Thus, "NGOs/CSOs are criticalto developing new patterns and practices of governance."Ethiopia, like most developing countries, is struggling with limited resources to meet thebasic health needs of its rapidly increasing and predominantly young population, in the face of severepoverty, cycle of natural disasters, the AIDS epidemic, and chronic conflicts (CRDA, 2004).

Such levels of service coverage are considered low even by sub-Saharan standards. The results of Demographic and Health Surveys conducted in other sub-Saharan countries show coverage of antenatal care ranging from 35 percent in Niger to 90 percent in Kenya. Delivery care utilization ranges from a low of 15 percent in Niger to 69 percent in Zimbabwe (Stewart et al., 1997). The observed higher coverage for antenatal care compared with both delivery and postnatal care is consistent with other studies done elsewhere(Adekunle et al., 1990; Belay, 1997; Leslie and Gupta, 1989; Mekonnen, 1998; Stewart et al.,1997; UNICEF, 1989). The lower coverage for delivery and postnatal care has often been attributable to the unpredictability in the onset of labor and the difficulty of travel, particularly for long distances, during labor, during delivery, and even within a few days after delivery. Moreover, the relatively high cost of delivery care is often blamed for the low rate of utilization of delivery services

In sub-Saharan Africa, nearly three quarters (72%) of women initiate their first ANC check-up after the first trimester of pregnancy (WHO, 2016). Also according to Yamba (2018), about 98% of Sierra Leone women between 2009 and 2013 attended ANC during their last pregnancy where 89%had four (4) or more visits. To add on, a study by Abubakari and Abiiro (2018)

among nursing mothers attending postnatal and child welfare clinics in three districts in Northern Ghana, it was found that approximately 81% of their study respondents have visited ANC four time or more with a coverage of over 99%. Also, Adu et al. (2018) analyzed data from the 2014 Ghana Demographic and Health Survey and found that irrespective of respondents' marital status, majority of them had four or more antenatal visits (89.2%), while very few had less than four visits (10.8%)

In other literatures however, ANC underutilization is highly observed. In Nigeria for instance,

Table 2.1: Types of NGOs/CSOs involved in the health sector based on some selected criteria

International links	Indigenous	Indigenous with international links	International		
Ownership	Religious (churches, congregations)	Private individuals	International Private Organizations		
Orientation to client	Public service contract	Grassroots organization	Membership organization		
Major activities	Technical innovations	Service delivery	Resource mobilization	Human resource development	Public education and mobilization
Links with grassroots	Intermediary funding	Umbrella or organizational	Direct grassroots/		
Links with GoE	Capacity building	Capacity building with service delivery	Service delivery alone		
Sources of fund	Regional governments	Private pay, fees	Community financing	Religious charity	Donors, project based
Types of services	Single program (FP, malaria, trachoma,)	Comprehensive primary health care services	Strengthening public health institutions	Training of nurses	
Scope of coverage	Multinational	National	Regional	Wereda	Sub-Wereda
Beneficiaries profile	Urban	Peri-urban	Rural	Special population (women, children, adolescents, etc.)	

Source: CRDA, 2004

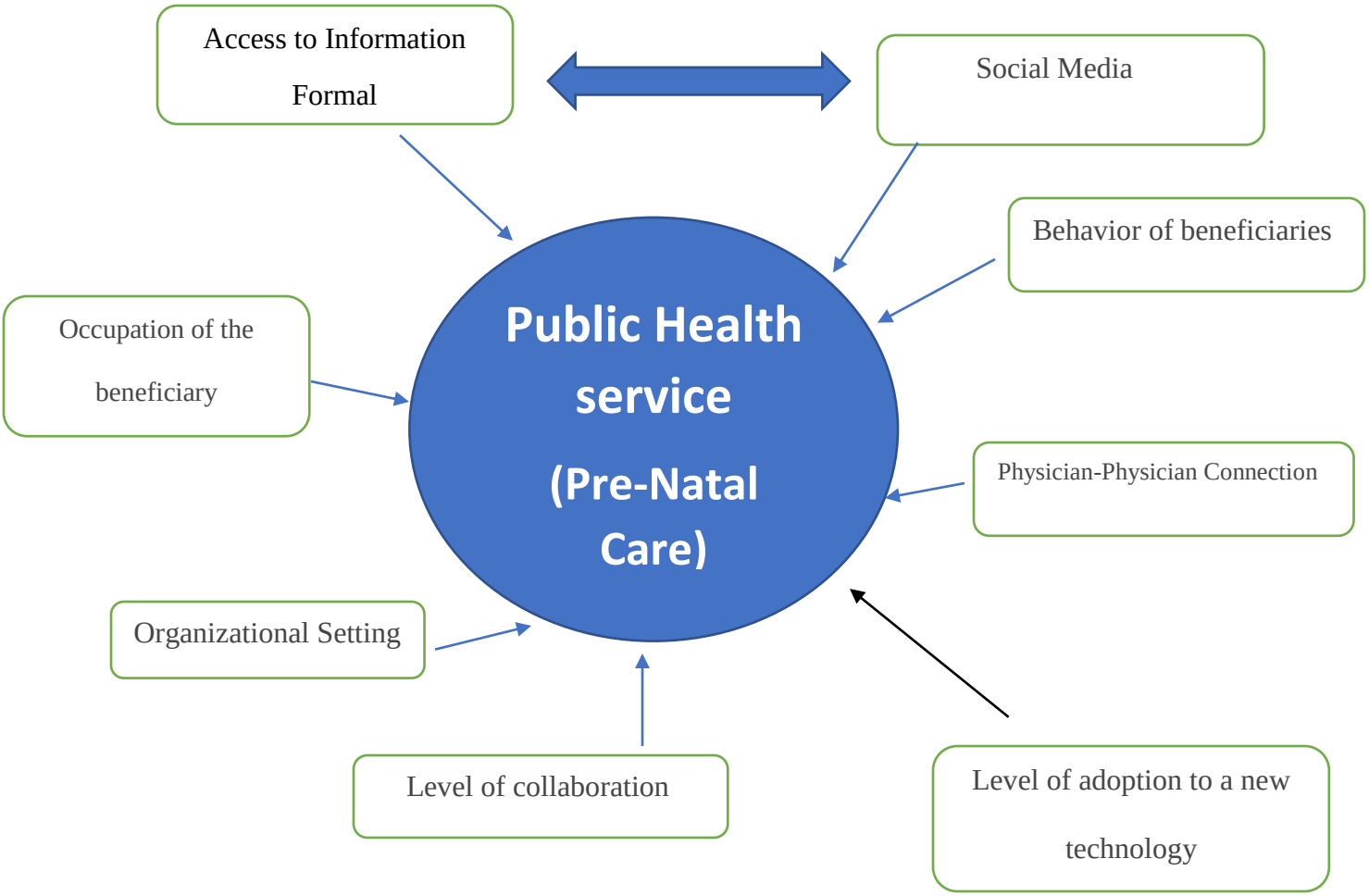
2.2Theoretical framework of the research

2.2.1 Social Network Analysis

An author Scott defined social network analysis as follows “Social Network analysis is the study of structure, and how it influences health, and it is based on theoretical constructs of sociology and mathematical foundations of graph theory. Structure refers to the regularities in the patterning of relationships among individuals, groups and/or organizations. When social network analysis is undertaken, the underlying assumption is that network structure, and the properties of that structure have significant implications on the outcome of interest. Due to its focus on network structure rather than individual characteristics and or behaviors of network members, the data required for appropriate analysis differs from what is typically collected in non-relational epidemiologic study designs.” (Scott J. 2000).

Another writer Caroline suggested that “It is an approach and set of techniques used to study the exchange of resources among actors (i.e., individuals, groups, or organizations). One such resource is information. Regular patterns of information exchange reveal themselves as social networks, with actors as nodes in the network and information exchange relationships as connectors between nodes. Just as roads structure the flow of resources among cities, information exchange relationships structure the flow of information among actors. Social network analysis assesses information opportunities for individuals or groups of individuals in terms of exposure to and control of information. By gaining awareness of existing information exchange routes, information providers can act on information opportunities and make changes to information routes to improve the delivery of information services.”(Haythornthwaite, 1996)**.**

Figure 2.1Conceptual Framework



2.3 Limitations and threat analysis of NGOs health projects

NGOs are frequently with limited scale of intervention when compared to the demand for health service in Ethiopia and the health projects reach defined target population, and hence, it is imperative for NGOs to work in partnership with the public sector to bring meaningful and sustained change in the health of Ethiopian people. NGOs health developments also have the potential to test new health strategies at community level. However, explicability of small projects, where resources are often concentrated, is not always easy. Service expansion might not also be within the goal and mission of a particular NGO (CRDA, 2004).

In order to mention some of the boundaries of NGOs in the health sector are; limited role to present represent the civil society limited scale of intervention, dependent on outside resource; challenge of enhanced sustainability limited creativity potential for explicability and

sustainability and so on. Whereas the threats are like benefits are not suited beyond the life of the project, killing community initiatives and creativity, and bring about dependency on outside interventions etc. (CRDA, 2004). NGOs have limited participation in policy formulation and national program evaluation/reviews, though gradually invited to participate in annual health sector reviews, and in formulating national strategic frameworks.

For the reason that the diversity of NGOs, it is hard to establish satisfactory mechanisms for their full participation in the formulation and implementation of health sector policies and program. The involvement of CSOs and local NGOs [often small] to the formulation and implementation of the Health sector development program is limited. Hence, the establishment of coalition and networking forum by groups mainly concerned with health issues and programs are essential for experience sharing, exchange of information, policy participation, and advocacy (CRD 2007).

The author also mentioned that "Such a forum has a potential to facilitate an effective participation of NGOs/CSOs in policy and program formulation and relevant decision-making processes and forums. So far, CRDA is the largest membership NGO operating in Ethiopia. However, linkages between CRDA and its members focus on information provision, technical support and training, and facilitation of grants and funding. An effort to organize CRDA members for input to the health policy process or to develop advocacy positions and strategies on particular health issues is limited. The increased openness of the GOE to work with NGOs/CSOs presents opportunity to strengthen cooperation and partnership. Hence, establishing focus group or mechanisms that will assist NGOs/CSOs in developing position papers on the various issues related to accessing health services, health promotion, and disease prevention is essential." (Starfield, 1992)

2.4 Effective Community Health Care Systems

Community perceives health care institution as an essential public service, like the school system, fire department, and police protection. The effective health care organization of the future will embrace a mission of community service. Primary care and prevention will be the services around which production process will be organized. Collaboration among providers will be vital to successful performance. Achieving goal requires substantial change, but there are models to follow. Grounding the total health care system in community service has important implications (Peter M.1998).

These include the following;

1. The delivery system should seek the enhance community health.
2. The system should be frugal, because communities do not appreciate or wasted resources in their public services.
3. The critical health care delivery organization is not physical institution such as hospital, nursing home, or group practice but a local system of primary care (that is community health network. The traditional approach designing health care organization focuses on the structure of institution, by focusing on the system rather than on an instruction, this chapter of health care system is proceeding in a different direction.
4. The mission of the local health care system is not the matter of strategic choice. Instead, the mission must be optimization of community health. This requires an emphasis on primary care, health promotion, and prevention.
5. Alternative structures for community – based health system are more similar than they are different. Key consents are vertical integration, community – orientated primary care, community governance, population-based planning, and information systems that demonstrate account ability.

In keeping with this perspective, the first goal of every health service system is to optimize the health of the population by employing the most advanced knowledge about the causation of disease, illness management, and health maximization. This goal is not a matter of strategic choice. Health care organizations that choose to do otherwise declare them peripheral to the health care system and risk losing both legitimacy and community support. That some health care providers have ignored the reality in the pursuit of patients, prestige, or profit is irrelevant. Given that the purpose of health care organization is to optimize community, health, its mission statement can be expected to emphasize primary care, health promotion and disease presentation (Peter M.1998).

2.5Patient-Provider relationship in prenatal care delivery

The patient–doctor relationship can be seen as a specialized form of human relationship, and work in other disciplines has distinguished between the dynamic interactive aspects of relationships and the mental associations made by people ‘in’ relationships, which are

'historically derived representations of experience'. All of these elements are thought to be important, but in the absence of a conceptual framework that can be applied to patient–doctor relationships, we are unlikely to establish the significance of the different parts and how they affect patient care. Broadly speaking, the patient–doctor relationship can be viewed as either a process or an outcome, and opinion on which is most appropriate is divided.[1] Although the purpose or function of the relationship is likely to vary according to the perspective of the observer, clinical imperatives emphasize its value as a component of the care process that might improve health outcomes. A better understanding of those aspects of patient–doctor relationships that affect patient care is required, because it has implications for how doctors are trained and health care is organized. If continuity, for example, makes a unique contribution to patient–doctor relationships, then it may be unwise to pay excessive attention to doctors' communication skills in isolated consultations; instead greater emphasis on organizational systems that promote continuity may be appropriate.

The doctor-patient relationship remains the cornerstone of medical practice. At the same time it is one of the most complex interactions in health care, which goes beyond consultation and clinical practice and involves aspects that are developed outside the encounter. On the one side of this relationship stands the doctor, whose diagnosing skills, prescribing patterns and referral decisions determine not only health outcomes but also, and to a great extent, health care costs. On the other side stands the patient, who is increasingly empowered to make decisions that concern his health. In many cases he chooses among a number of physicians, he collects information from sources other than the doctor and finally decides whether to adhere to the medical recommendations. These are all decisions that impact on his health but also on health care utilization and expenditure. Health economists and policy makers realize the importance of this relationship on health systems and put great effort in exploring its underline mechanisms. A number of models have been proposed to understand the elements of the physician's utility function and different payment schemes have been designed in an effort to change physicians' behavior. The patient's side has received less attention. In health economics the agency relationship that is often used to describe the doctor-patient interaction implies that the doctor acts on the patient's behalf and therefore the majority of the decisions are taken mainly by the former and less by the latter. In medical sociology three main theoretical models have been

developed to describe the doctor-patient relationship with regard to decision making. These are paternalism, shared and informed decision-making model (Charles et al. 1999).

- **Paternalism**

This is the traditional model of the doctor-patient relationship, in which the doctor, as the expert, diagnoses the patient and decides on the appropriate treatment. In this model the patient has a passive role and no active involvement in the decision-making process. Coulter (2002) avoids the term 'paternalistic' and calls this model 'professional choice', arguing that it may be appropriate under some circumstances for the doctor to make decisions without the patient being actively involved. This passive role of the patient in paternalism makes the model similar to that of perfect-agency in health economics.

- **Shared decision model**

This model was developed by Charles et al. (1997), who argue that there should be four specific characteristics for shared decision making to be effective:

1. Both the physician and patient are, to some extent, involved in the treatment decision-making process.

2. Both parts share information.

3. Both take steps to participate in the decision-making process by expressing treatment preferences.

4. A treatment decision is made and both the physician and the patient agree on the treatment to be adopted. In this framework, both the patient and the doctor are active members in the decision-making process. Evidence on whether this works in practice, has not favored the model. A study by Stevenson et al. (2000) of 62 consultations in Britain along with interviews with patients and general practitioners revealed that there is little evidence that patients and doctors both participate in the consultation in the way described in the model. The study concluded that even the first two of the four components that are necessary for the shared decision making to be upheld, i.e. for both parts to be involved and exchange information, were not present in the consultations which were studied.

- **Informed decision-making model**

The informed decision-making model is often presented together with the shared decision-making model (Britten 2004) as both indicate a reaction to the model of paternalism. However, Charles et al. (1999) argue that the two models have essential differences which are mainly concerned with the information exchange. In the shared decision model, the flow of information is two-sided as both the patient and the doctor exchange information, the latter mainly on the medical level and the former more on the personal level, such as experience and preferences. In the informed decision-makingmodel, the information is mainly one-sided, with the doctor supplying the information to the patient, regarding medical aspects. Also, in the shared decision model the final decision is a common agreement between the two parties while in the informed model it is the patient who decides.

2.6. Adoption of Technologies in prenatal care services

Health technologies, in the widest meaning of the word, have changed continuously ever since the early stages of medicine. Increasing knowledge and diagnostic, preventive, treatment and rehabilitation possibilities have altered the content of health care systems. In turn, health systems have also evolved into complex entities with changing roles and responsibilities for patients, health professionals, payers and regulators. The 'digital transformation of health services' is seen as an important and influential process, that has already had a substantial impact on current health care and health systems and is expected to have a further fundamental impact on health care and health care delivery in the future. It is also immediately acknowledged that 'the digital transformation of health services' is a complex and multifaceted issue. Digitalization, ranging from the use of computers and electronic health dossiers to home monitoring of patients, electronic medical devices, and the application of computer aided visualization and decision support systems, has affected and is expected to affect many aspects of health care systems in terms of structure, culture, professions, treatments and outcomes. This 'digital transformation' indicates that health care services and systems are in a transition in which more health services and processes will be digitalized. The digital transformation encompasses the instrumented effort to meaningfully introduce new digital information and communication technologies and corresponding new processes into the health care sector. Some of this digitalization is health care specific, another part is a consequence of the broader digitalization trend in society. Both can

lead to changes and innovations in health technologies and health care delivery processes, and thus impact health, health care and health systems. The digital transformation in some of its aspects therefore represents a fundamental change in the mode and culture of care delivery of organizations (Walter et.al, 2019).

Digital technologies provide concrete opportunities to tackle health system challenges, and thereby offer the potential to enhance the coverage and quality of health practices and services. Digital health interventions may be used, for example, to facilitate targeted communications to individuals in order to generate demand and broaden contact coverage.

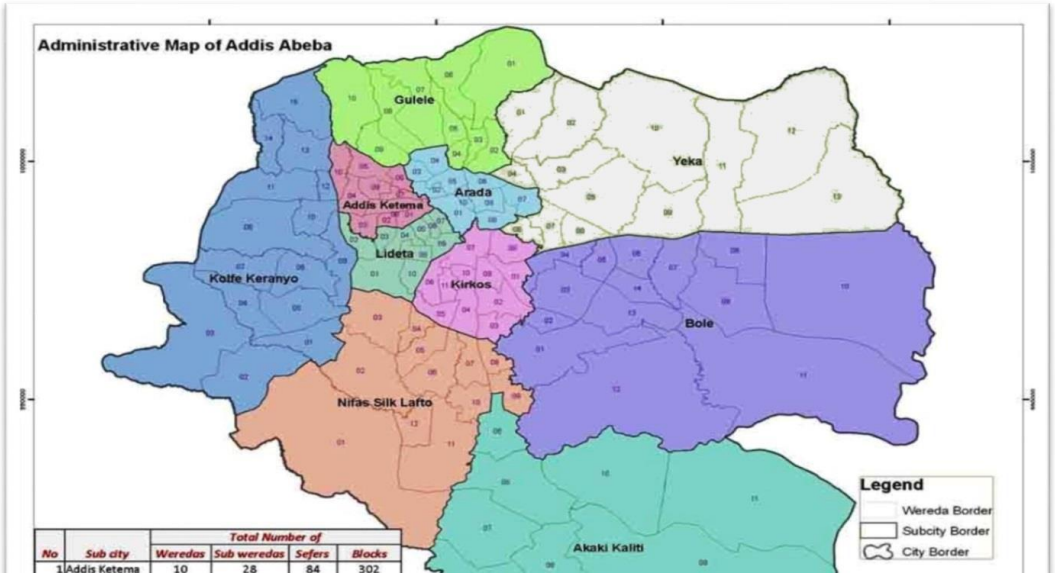
2.7. Quality of prenatal care

High quality prenatal or antenatal care (ANC) is an essential component of the reproductive, maternal, newborn and child health continuum of care. During the critical prenatal period, health care providers can educate women about healthy pregnancy behaviors, danger signs of complications, breastfeeding and family planning; identify and treat pregnancy-related conditions such as pre-eclampsia; refer mothers to specialized care when necessary; encourage the use of a skilled birth attendant; and minimize the risk of mother-to-child transmission of HIV. For many women around the world, an ANC visit is their first adult contact with the health care system, serving as a gateway to health services both during and beyond maternity care. In addition to diagnosing and managing pregnancy-related complications, ANC provides an opportunity to screen for and treat other chronic conditions and non-communicable diseases. The newest guidelines from the World Health Organization recommend that women attend 8 ANC visits. Antenatal care is the care that a woman receives during pregnancy, which helps to ensure healthy outcomes of women and newborns (1). It is also a key entry point for pregnant women to receive a broad range of health promotion and preventive health service (2). Evidences showed that over 70% of women worldwidehave at least one antenatal visit with a skilled provider during pregnancy (3).In the industrialized countries coverage is extremely high, with 98% of women having at least one visit (3). But in Sub-Saharan Africa, the coverage was lower than other regions with 68% of women reports at least one antenatal .

CHAPTER THREE

DESCRIPTION OF THE STUDY AREA AND RESEARCH METHODOLOGY

3.1 Description of the Study Area



SourceFig. 1.2.Administrative map of Addis Ababa city with its 11 sub cities and 116 werdas.

Addis Ababa city is over a hundred years old. It was established in the late 19th century by Emperor Menelik II as the permanent capital of the emerging modern Ethiopian state. The city covers a total area of 540 square kilometers. Prior to 1974, Addis Ababa was one of the few chartered cities of the Empire of Ethiopia administered by a lord mayor (kantiba) appointed by the Emperor.

In the past, most urban areas were governed by a parallel system of municipal government in which institutional structures, rights and responsibilities were assigned. Under the highly centralized Derg regime (1975 to 1991.G.C.), Ethiopia‘s municipalities were marginalized and did not function as independent local authorities.

When the current government came to power in 1991.G.C it proclaimed a decentralized form of government and developed a constitution that established a Federal Democratic Republic, consisting of: nine Regional States, the special administrative region of Dire Dawa and the federal capital Addis Ababa.

Addis Ababa is the largest as well as the dominant political, economic, cultural and historical host of the country. It has the status of both a city and a state. It is the capital of federal government and a chartered city. It is where the African Union and its predecessor, the OAU are based. It also hosts the headquarters of the United Nations Economic Commission for Africa (UNECA) and numerous other continental and international organizations. It is the largest city in Ethiopia.

Hosting 30 percent of the urban population of Ethiopia, Addis Ababa, is one of the fastest growing cities on the continent. Its population has nearly doubled every decade. KalityAkaky sub- city is one of 11 sub cities and 119werdas in Addis .

Most of the beneficiaries of the study area which is the Family Guidance Association of Ethiopia located in KalityAkski Sub-City,around 330 beneficiaries on the prenatal health care so the researcher used a sample respondent of 178 of prenatal care at FGAE to conduct the research.

3.2Research design and approach

To conduct this study, the researcher used a Cross-sectional survey design and convergent parallel mixed method.

Cross sectional Research design involves the collection of information from any given sample of population elements only once. The researcher used this method to collect information of 178 sample respondents from Family Guidance Association Ethiopia only once.

Convergent parallel mixed method: regarding analysis of this research the researcher used this method and collected both quantitative and qualitative data from FGAE using the same variables, analyzed them separately, and then compared the results to see if the findings confirm or disconfirm each other. The researcher made the comparison within a discussion presented first one set of findings and then the other, which is called a side by side comparison approach. It implies that, first quantitative data was analyzed and it was supported by secondary data and qualitative data analysis.

3.4Population Of the study

Populations of the study were the list of beneficiaries from FGAE who are getting a prenatal health care service. According to the data the researcher collected from the FGAE kalityakaki post, the total population was 330.

3.3 Sources of data

To conduct this study, the researcher used both primary and secondary data sources as the primary sources are relevant to provide first-hand information, the secondary source, provides a compressive understanding of the study topic.

The primary data sources are the first hand information that are collected directly from the respondents. The primary respondents of this research were the prenatal mothers who are getting a heath care service under the FGAE of kalityAkakipost and the number of the sample respondents was 178. The researcher used questionnaire that included both open ended and close ended questions to collect the first hand information. The researcher also used an interview to collect the primary data because the nature of the topic needs an interview which could help the researcher understand more the unfilled questions of the respondents. For those who are uneducated, the researcher selected data collectors based on their language and subject matter and trained them how to facilitate the data collection process. For this the researcher used Simple random sampling to have the sample that the researcher needed for the thesis.

In this study the researcher also used the secondary data source to support the finding of the study which includes FGAE brochures, documents, internet sources and journals, previous researches on the issue and other related materials or sources that are related to the topic.

3.4 Methods and Instrument of data collection

Questionnaire

A Survey is important quantitative data collection method which is described as the collection of data from the sample respondents who are selected from the population by using questionnaire. The total sample respondents of this research were 178 mothers who are getting a prenatal care at the FGAE. This method was used to inference the data from the sample to the entire population. The researcher used this method because it was suitable to conduct, organize and analyze the collected information. A Questionnaire is a survey instrument with uniform information is

extracted from the sample respondents. It is used as instrument of data collection and it facilitates the study to collect data with in short period of time as well as easy to conduct by a single researcher. A questionnaire is contained both open ended and close ended questions. This questionnaire was translated in to Amhariclanguage to minimize the time that the respondents spent to answer the questions and to collect the data without confusing the respondents. .

Key informant interview

An Interview is one of the qualitative methods of data collection which was used to gather the information by the researcher. Interviews offer indirect access to the range of experiences, situations and knowledge that the researcher would not be able to study otherwise. Moreover, interview allows the meaning and definition that individuals give to events and activities to be explored and understood. Therefore, the researcher used this method of data collection in order to have the advantage of using key informant interview. The researcher had interviewed two health care practitioners, (Nurses) the clinical service director of the NGO, and one person from Regional Health Bureaus officials.

Focus Group Discussion (FGD)

A focus group discussion (FGD) is a good way to gather together people from similar backgrounds or experiences to discuss a specific topic of interest. The researcher arranged two focus group discussions where the group of participants was guided by a moderator (or group facilitator) who introduces topics for discussion and helps the group to participate in a lively and natural discussion amongst themselves. Therefore, the researcher used this method by gathering a group of 9mothers from FGAE with similar background or experience to discuss about the prenatal and related issues. This enabled the researcher to gather more information.

Check list Guide

In this study the researcher used a check list as an instrument for a data collection because it was expected to fulfill those which might not be gathered by questionnaires and also to provide a rich and more intensive information and question that a key informant thinks is more flexible.

3.6Sampling design and techniques

Selecting a sample is fundamental for conducting a research. The researcher used both probability and non-probability sampling techniques. From the Probability sampling the

researcher used Simple random sampling where every item in the population has an even chance and, likelihood of being selected in the sample. This is because not only it is meant to be an unbiased representation of a group but also with an assumption that it brings us out in most cases, a balanced subset that carries the greatest potential for representing the larger group as a whole, free from any bias. So, the researcher had selected a sample size of the respondents from the 330 list of beneficiaries of the association. To get the representative sample size the researcher used a formula from Ratio soft sample size calculator. It has 95% confidence level and 5% precision. The total sample size will be 178. From the non-probability sampling the researcher used Purposive or Judgmental sampling where, the researcher selected units to be sampled based on their knowledge and professional judgment so, the researcher selected the respondents who are supposed to have a better knowledge of the organization and the service that it gives. The researcher had interviewed two health care practitioners, (Nurses) the clinical service director of the NGO, and one person from Regional Health Bureaus officials.

3.7Methods of data analysis

The data was analyzed by both qualitative and quantitative methods. The quantitative data that are gathered through questionnaires were analyzed quantitatively using table, frequency percentage and other statistical tools whereas for those qualitative data that are gathered through key informant interview and questionnaires were analyzed qualitatively employing narration and description of the data qualitatively.

3.8 Reliability and Validity

“In qualitative research, the validity of the findings was related to the careful recording and continual verification of the data that the researcher undertook during the investigative practice. If the validity or trustworthiness could be maximized or tested, then more credible and defensible results could lead to generalizability as the structure for both doing and documenting high-quality qualitative research (Cypress, 2017).

The researcher employed four ways of gathering data which were: in-depth interviews with the NGOs, in-depth interviews with the individual beneficiaries, focus group discussions. Using one way of gathering data posed a risk of not being able to unearth all factors relating to the purpose of the study.

To aid reliability of the study, the researcher used the following techniques:

a) The researcher personally conducted the interviews in order to ensure consistency in data collection.

b) The interviews were conducted in local languages

c) All the interviews were audio-recorded to ensure proper capturing of the discussions and then transcribed to verbatim by the researcher.

d) After individual interviews, the researcher conducted focus group interviews with same participants so as to further explore the topic under discussion and to consolidate findings.

3.9 Ethical Consideration

Ethical considerations refer to the morality, uprightness and justification of the researcher's conduct in carrying out research. It is compulsory to follow ethical measures for the research as guidelines. The researcher was guided by the following main considerations**.** The researcher tried to establish good relationships with all the respondents because the selection of potential and appropriate people plays important role for the reliability and validity of the data that was generated. The informants that contributed for this research first gave their informed consent to participate in the study. In addition, the questions were made simple and clear to avoid any misunderstanding and avoid ambiguity, as well as sensitivity to the pieces of information the informants would provide to the researcher.

Moreover, an informed oral consent was obtained from each study subject. Confidentiality and privacy were maintained during data collection. Besides this, no personal identifier was taken and each questionnaire was coded. Beside The researcher acknowledged all published sources of literature used in the study

CHAPTER FOUR

4. DATA REPRESENTATION AND DISCUSSION

Introduction

This part of the paper presented and analyzed the data collected to seek appropriate answer for the basic questions raised in this study. Data have been collected from beneficiaries of FGAE, nurses of the association, the Clinical Service Director Thus; this section presents the results of the primary data collected via questionnaire interview, focus group discussions and checklists. The findings of this study presented in this chapter have been organized according to the specific objectives of the study, literatures review & logically constructed questionnaire. The results are presented in tables to show frequency counts,& statistical descriptive such as mean percentages for different questions and followed by narrative explanations by supporting the explanation with interview results as well as necessary secondary data triangulation has been made to support the explanation.

4.1 Socio-economic Characteristics of the Respondents

The beneficiaries of prenatal care in the FGAE Kalityakaki post were characterized by various composition in terms of age, address, education, marital status, occupation, household type, and other socio demographic and economic features. It is mentioned as follows.

Table 4.1: Socio-demographic Characteristic of Respondents

Variable	Item	Frequency	Percentage	Cumulative Frequency
Age group	19-22	22	12.40%	12.40%
	23-26	41	23.00%	35.40%
	27-30	64	36.00%	71.30%
	31-34	27	15.20%	86.50%
	35-38	24	13.50%	100.00%
	Total	178	100.00%	
Address of Respondent	KalityAkaki	166	93.30%	
	Outside kalityAkaki	12	6.70%	
	Total	178	100.00%	
Educational Background of the Respondent	Can’t read and Write	14	7.90%	7.90%
	Elementary	24	13.50%	21.30%
	Secondary Education	46	25.80%	47.20%
	Preparatory Education	12	6.70%	53.90%

	Vocational Training	18	10.10%	64.00%
	Diploma	32	18.00%	82.00%
	Degree and above	32	18.00%	100.00%
	Total	178	100.00%	
Marital Status	Married	160	89.90%	
	Single mother	18	10.10%	
	Total	178	100.00%	
Occupation of the Spouse	Public Organization	75	42.10%	
	Private Organization	25	14.00%	
	Self employed	38	21.30%	
	Unemployed	4	2.20%	
	Other	18	10.10%	
	Total	160	89.90%	
	Missing**	18	10.10%	
	TOTAL	178	100.00%	
Type of Household	Male Headed	156	87.60%	
	Female Headed	22	12.40%	
	Total	178	100.00%	
Number of Children	0	15	8.40%	8.40%
	1	51	28.70%	37.10%
	2	73	41.00%	78.10%
	3	33	18.50%	96.60%
	5	6	3.40%	100.00%
	Total	178	100.00%	
Occupation of the respondent	Public Organization	41	23%	
	Private Organization	38	21.30%	
	Self Employed	12	6.70%	
	Housewife	40	22.50%	
	unemployed	47	26.40%	
	Total	178	100.00%	

Source: Own survey, 2024G.C

As a result, 64 (36%) of the respondents are between the age of 27-30, additionally, the majority of the respondents i.e. 127 (71.3%) of the respondents are below the age of 30. It is also clear that the mean age of the beneficiaries was 28.4 (which is approximately 28). This implies that the majority of the expecting mothers are young women.

In addition to this, the study has also founded that except the few respondents that is 12(6.7%) of them the majority of the respondents (166 of them or 93.3%) came from Kality-Akaki subcity. Besides, a small number of prenatal care participants 46 (25.8 %) attended/accomplished Secondary school (9-10) and only 64 (36%) respondents were lucky to pursue their Diplomas and Degree education. On the other hand, the majority of respondents (160 or 89.9%) were married and the rest 18 (10.1%) respondents were Single mothers who had been raising their child by their own. According to the above Findings, we can also see that 75 (42.1%) of the respondents' spouse were employed in the public sector while the other 14% (25) of them are employed in the Private sector. The study has also founded that the majority 156 (87.6%) of the beneficiaries' family are male led where the husband is the chief bread-winner as well as the administrator of the house where he is the major decision maker of the family.

In addition to this, 73 (41%) of the respondents had only 2 Children where 15 (8.4) of the respondents expect their first child. On the other hand, according to the central statistical agency of Ethiopia, the mean child birth rate of children is four. So, it contradicts with the child birth rate at national and regional level. (CSA,2020)

The other significant finding regarding to the socio-demographic characteristics of the respondents is, regarding to their occupation. The study has founded that 47 (26.4%) of beneficiaries are unemployed and 40 (22.55%) of them are housewives. The finding goes withthe central statistical agency of women's employment status that implies in twelve months preceding the survey 46% of women are not employed. (CSA, 2020)

The occupational status of the respondents is more interesting when we compare it with their counterpart sex of their spouses. While 38(21.8%) of the spouses of the beneficiaries have the chance to employ themselves only 12(6.7%) of the beneficiaries were able to make it. The unemployment status is also varying from 2.2% to the spouses of the beneficiaries to 26.4% of the beneficiaries. The research findings that are stated above is in accordance to the cases in developing nations, where majority of mothers did not accomplish their secondary education and

are unemployed and house wife in their occupation which lay them back to the very standard line of capacity to be equal bread-winner of the family and have an equal chance in decision-making process of matters of their family and leading their house.

Table 4.1.1 Occupation of the Respondents Vs. Frequency of Visit as per the recommendation of the Health practitioners

		I frequently visit as per the recommendation of my health practitioner					Total
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
Occupation of the respondent	Public Organization	10	0	0	0	31	41
	Private Organization	8	0	4	0	26	38
	Self Employed	0	0	0	0	12	12
	Housewife	6	0	12	0	22	40
	unemployed	19	0	2	0	26	47
Total		43	0	18	0	117	178

Source: Own survey, 2024G.C

According to the above table, the researcher has founded that out of 91 respondents who are currently working (including those in the private and public organization and self-employed) the majority of the respondents which is 75.8% (69 of them) strongly agreed to the frequent visit they make as per the recommendation of their health practitioner. And 58% of the respondents strongly disagreed to the frequent visit as per the recommendation of their health practitioner and this respondent are housewives and unemployed.

This majority of the populations, who are currently working, are those who frequently visit as per the recommendation of their nurses. The housewives and the unemployed mothers visit less frequently. This implies that expecting mothers who are working tends to have a better access to education and information it could be through a social media or mass Medias. This creates a health seek behavior so that they will be more curious to know about their health status. Therefore, they visit frequently as per the recommendation of the health care practitioners. The employed expecting mothers are those who are literate. When people are literate, they would have an exposure of different opportunities and tends to create different network. This network gives them all the information they need to know about their health condition. According to the

findings of the this study the less educated mothers and the unemployed ones are those who aren't visiting as per the recommendation of their health care practitioners. This shows that the less educated people won't be in touch with important information and useful knowledge and strong social network with the outside the world. So, they couldn't care less about their health condition.

Table 4.1.2 Educational Background of the Respondents Vs. The adequacy of the service given by FGAE

		The service you receive from FGAE is adequate					Total
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
Educational Background of the Respondent	Can't read and Write	8	0	6	0	0	14
	Elementary	7	0	0	0	17	24
	Secondary Education	6	7	0	0	33	46
	Preparatory Education	0	6	0	0	6	12
	Vocational Training	13	5	0	0	0	18
	Diploma	21	5	0	0	6	32
	Degree and above	11	16	0	0	5	32
Total		66	39	6	0	67	178

Source: Own survey, 2024G.C

The researcher also cross tabulate the Educational Background of the Respondents and the adequacy of the service given by FGAE and as it is shown in the above table, from the total 66 respondents who strongly agreed that the service given by the association is not adequate 45 (68.1%) of them are respondents who have an educational background of vocational training certificate and above. In contrary, among the 67 respondents who strongly agreed that the service given by the FGAE is adequate, 56 (83.5%) of them are respondents with an educational background below a vocational training.

The majority of the highly educated expecting mothers strongly disagreed to the adequacy of the service while those who are below preparatory and uneducated ones strongly agreed to the adequacy of the service delivery. This might show that people who are more educated tends to have a better knowledge about different service deliveries and has an exposure of discovering

and exploring useful information. This could lower their level of satisfaction on the adequacy of the service.

This implies that the educated expecting mothers would have a strong social network with different sources of information and access to useful service deliveries. The more educated they are the more they want to know about different ways of taking care of their unborn child. Networking with social Medias and using search engines, they might expand their knowledge concerning the prenatal issues. Through this and other means they would know about various ways or technologies of prenatal service deliveries. So, according to this study finding, the majority of expecting mothers believed that the service given by the association is inadequate.

Table 4.1.3**Address of Respondent Vs. Provision of a better service by FGEA than respondent's local service delivery providers**

		FGAE provides a better quality of service than your local service delivery providers					Total
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
Address of the Respondent	Kality-akaki	82	0	12	0	72	166
	Outside Kality Akaki	5	0	0	0	7	12
Total		87	0	12	0	79	178

Source: Own survey, 2024G.C

Here, the researcher tries to relate the address of the respondents and their level of agreement on the provision of a better service which is given by the FGAE versus their local service providers. Accordingly, the researcher has founded that from the total number of 12 respondents who are residing outside kalityAkaki, 7 (58.3%) of them strongly agreed that the associations service delivery is a better one while the rest 5 (41.7%) strongly disagreed. In contrast, when we come to the respondents who are residing in Kality-akaki, out of the total number of 166 respondents, only 72 (43.3%) of them strongly agreed that the associations' service delivery is a better one from their local service providers while almost an equal size of the respondents (with a bit higher percentage of 49.3%) opposes that.

The majority of the respondents who are living outside KalityAkakibelieved in the better quality of the FGAE's service provision while the majority of those mothers who are living in Kality

Akakipreferred their local service providers. This shows that people who are living in Kality Akakimight have different options to go to and even compare their qualities and types to make them their preference while the rest who are living outside Kality Akakidoesn't have more choices.

The finding also implies that city dwellers tend to have a better information because they have a better network, knowledge and accessibility compared to rural dwellers. However, the woredalevel service is limited to the health post level service with less qualified health care providers.

Table 4.1.4**Number of Children Vs. Fairness of the cost of the service**

		The service fare of FGAE for the health service delivery is fair					Total	% (strongly agree)
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree		
Number of Children	0	0	0	6	0	9	15	60%
	1	0	7	0	11	33	51	64.7%
	2	0	0	0	27	46	73	63. %
	3	0	0	0	6	27	33	81..8
	5	0	0	0	0	6	6	100%
Total			7	6	44	121	178	

Source: Own survey, 2024G.C

Here, respondent's number of children and their level of agreement on the fairness of the cost of the service are cross tabulated. The last column of the table is designed by the researcher to show the percentage of respondents who strongly agreed in the cheap and fair service provision of the association from the total respondents associated with respective number of children.

Consequently, the researcher has founded that the total percentage of each group of respondents based on the number of children has shown an increment in the level of agreement of the cheap service given by the association as their number of children increases. It finally reaches to the level of 100% respondents who have 5 children, strongly agreed to the low-cost service of the association. The more children they have the more the respondents comply with a strong agreement level of the cost of the service.

The majority of the expecting mothers strongly agreed to the low-cost service of the association. Especially those who have more children, strongly agreed that the cost is totally fair. The more children they have the more they start to compare how less they are paying for their health and spending more in other aspects of their life.

4.2 Major Prenatal care services

This section of the study discussed about the major prenatal care services which are needed and highly utilized by the prenatal mother of the community this includes, Maternal and Fetal Assessment, Nutritional Intervention and Supportive Counseling, Preventive measures, Family planning and Contraceptive measures counseling. The FGAE provides all of the aforementioned services in the center.

Table 4.2: Major Prenatal care services

	N	Mean	Std. Deviation	Coefficient of Variation	Coefficient of Variation (%)
parents come here for Maternal and Fetal Assessment	178	1.02	.129	0.1269	12.69%
parents come here for Nutritional Intervention and Supportive Counseling	178	1.71	.453	0.2646	26.46%
parents come here for Family planning and Contraceptive measures counseling	178	1.76	.429	0.2441	24.41%
parents come here for Preventive measures	178	1.81	.390	0.2147	21.47%
Valid N (listwise)	178				

Source: Own survey, 2024G.C

(N.B this is a dichotomy group and a multiple response analysis table).

Accordingly, we can see that the majority (98.3%) of respondents confirm that they came to the association for Maternal and fetal assessment. Pregnant mothers of the research targets who

came to receive Nutritional intervention and supportive counseling made the second major group of service which accounts for 28.7% of them.

The researcher has analyzed that the beneficiaries usually came for Maternal and fetal assessment service and received other services on their way. This is because the respondents who try to come to the association in need of the other services (beyond maternal and fetal assessment) are rounded up to a total of 60% out of 169%.

The finding goes with the WHO's suggestion of an integrated and comprehensive package of all these services has to be delivered to improve the quality of ANC and to improve maternal, fetal and newborn outcomes, related to prenatal care. Effective communication should be facilitated at all service contacts, to cover: presence of any symptoms; promotion of healthy pregnancies and newborns through lifestyle choices; individualized advice and support; timely information on tests, supplements and treatments; birth-preparedness and complication-readiness planning; postnatal family planning options; and the timing and purpose of ANC contacts(WHO, Recommendation son antenatal care for a positive pregnancy experience, WHO Press, 2016)

Most of the expecting mothers are not missing the main prenatal care service that's included in the WHOs recommendation for expecting mothers which is maternal and fetal assessments that promotes a healthy pregnancy.

4.3 The Service Quality of Prenatal care

The impact of the quality of prenatal care on the health of both the mother and the child is very significant. The quality of the service is also very significant on the experience of beneficiaries and their actual health status. The quality of the prenatal care of the association has been examined on a Likert scale questions provided to the beneficiaries. Here are the results and their interpretations.

Table 4.3: Quality of the service

No.	Questions	N	Mean	Std. Deviation	Coefficient of Variation	Coefficient of Variation (%)
1	FGAE provides a better quality of service than your local service delivery providers	178	2.91	1.935	0.6649	66.49%
2	The service you receive from FGAE is adequate	178	2.79	1.784	0.6394	63.94%
3	The service delivered by the FGAE is fair	178	4.30	.654	0.152	15.2%
4	The service you received from FGAE has changed your health condition	178	3.09	1.875	0.606	60.6%
5	The service fare of FGAE for the health service delivery is fair	178	4.57	.743	0.1625	16.25%
6	The health practitioners of FGAE is performing good	178	3.80	.959	0.2523	25.23%
7	I frequently visit as per the recommendation of my health practitioner	178	3.83	1.709	0.4462	44.62%
Valid N (list wise)		178				

Source: Own survey, 2024G.C

Grand Mean=3.612857

According to the above table, it is very clear that in the questions of agreement regarding a better quality of service of FGAE than respondents' local service delivery providers and the question on adequacy of the service have greatest coefficient of variation (66.49% and 63.94%respectively), which shows that there is a great variation of agreement regarding these two questions among the beneficiaries. The other finding that the researcher has observed is that there is a low level of agreement variation regarding the cost of the service and the fairness of it (a coefficient variation of 15.2% and 16.25% respectively). This shows that the majority of the respondents corporately agree (close to strong agreement which is a 4.3 and 4.57 mean score respectively) that the service given by the association is fair enough and not expensive.

Cost and life changing ability of the service Vs. Quality of the service

According to the findings almost all of the beneficiaries agreed on the fairness of the service cost of the FGAE. This is the other major high score of agreement on the quality of the service with an average result of 4.57. This shows that the association giveslow-priced services.

The findings also go hand in hand when the researcher run across tabulation (pinned in the Annex)

for occupation of the respondent and their level of agreement on the fairness of the cost. It is founded that among 121 beneficiaries who are strongly agreed that the service is inexpensive, 51(42.1%) of them are unemployed and housewives. These indicates that for those of beneficiaries whose income is limited, the service is low-cost as well as economical. Economic capacity and cost of the service are very essential elements in developing countries like Ethiopia and lowering the expenses of health care service especially, regarding to maternal health care without compromising on the quality of the service is crucial in reaching people in need of such basic services. It is a means to realize the ability to expand one's service accessibility and coverage.

The finding of this research is in line with that ofMin Kyoung Kim and etal. thatsocioeconomic status (SES) is one of the most important factors associated with medical outcomes. When SES is low, medical care is inadequate and this has been attributed to adverse outcomes. In pregnant women, low SES can increase the risk of adverse pregnancy outcomes. They have also stated that revealed that low SES is associated with pregnancy complications such as abortion, preterm delivery, preeclampsia, eclampsia, and gestational diabetes. Inadequate prenatal care is associated with poor obstetric outcomes, including preterm delivery, preeclampsia, and stillbirth (*Min et al, 2018)*

Nevertheless, things have to be improved related to the ability of the service in regard to changing their life. The result of the research has shown that the average level of agreement of the beneficiaries regarding the service in changing their life is 3.09. This average actually falls in neutral score, but its interpretation gives us that the beneficiaries do not have a strong believe that the service actually changed their life condition. They reported that the service they get from the association is sometimes very far to be realized in their real-life situation.

A respondent said the following:

"…. I usually get counseling on my way when I came here for my appointment visit. I get advises from them on what to eat and avoid, what to do and what not to do……the problem is I don't have the capacity to choose among the categories of the foods they bring. To tell you frankly, I don't have even the categories of the food they advise me to avoid" (FGD1)

While they affirm that the most common services regarding to the fetal assessment had been really good, they still have some complains on the counseling services. Another respondent also stated that:

"….They don't know me. They only know that I am a mother of the fetus inside me…they don't know my family and who I live with and how much sacrifice I'm paying to came here. I know they are telling us the fact and the science but I always wonder how these facts could be linked to our real lives which is very challenging and difficult." (FGD2)

Another respondent added:

"…. I thank God that my health has been good since I came here. I often get different services and can ask questions regarding my health but, about the services in relation to changing my health condition, I have always asked them why they are not focusing on promoting our health rather than focusing only on preventive measures we had to take. We should get more information which could be beyond protecting ourselves from the most common complications of pregnancy. I think health should be beyond protecting myself from bad situations." (FGD1)

The totality medical services of prenatal care have to incorporate the comprehensive nature of its core element, the Mother. This has to go beyond a patient-practitioner relationship to see and observe the real-life situation of their status. In addition to clinical guidance, practitioners also have to involve themselves in prenatal care interventions to improve the utilization and quality of antenatal care in accordance with the flexibility of the service to employ and use different options for the delivery of antenatal care based on the beneficiaries' specific needs.

Table 4.4: Satisfaction rate in accordance to the Quality of the service

		Prenatal health care delivery service at FGAE	Speed of health care service at FGAE	Availability of health care practitioners in FGAE
N	Valid	178	178	178
	Missing	0	0	0
Mean		3.43	3.08	3.57

Source: Own survey, 2024G.C*Grand Mean*=3.36

As it is shown above, the researcher opted to make use of two different categories of questions. The first group is directly associated with the quality of the service given by FGAE and the second group of questions are measures of quality of the service through beneficiaries' satisfaction.

Prenatal Health care Delivery

According to the beneficiary's satisfaction rate, the average result on satisfaction rate of the prenatal care delivery service in general is 3.43. This shows that, the beneficiaries are neutral with the prenatal health care delivery of the association. Though, they are not fully satisfied by the service delivery they are getting from the health sector of FGAE. This shows that there should be some improvements for the betterment of the prenatal service in order to satisfy the expecting mother's needs. This affects the service quality of the association.

Speediness

The other factor the researcher used to determine the satisfaction rate of the beneficiaries is speed of the service delivery. According to the finding, the average result on the satisfaction rate of the speed of the service delivery is 3.08. The beneficiaries are neutral on this. This shows that, the speed of the service delivery is low. Almost all of the beneficiaries aren't satisfied with the speed of the service they are getting from the center. The researcher has also observed the long wait the expecting mothers encounter during the prenatal service delivery process. Speed is a crucial element on providing quality service for patients or the expecting mothers. If the mothers are sitting for more than an hour in a waiting room, it would be so tedious and exhausting for them. They will not even consider coming for the next visit or recommend others to use the service there. The health care practitioners will also be tightened and this leads them not to concentrate on their job rather focus on finishing early so that they could get rid of their patients

fast. The recklessness of the health care practitioners will affect the service quality of the prenatal care.

Availability

The other feature of the beneficiary's satisfaction rate that the researcher used to find out about the service quality is the availability of the health care practitioners at the FGAE. The average result on the satisfaction rate on the availability of the health care practitioners at their work place is 3.57. This shows that they are almost (In the middle) satisfied with their availability. This doesn't mean that they are very satisfied. So, there are times where the health practitioners aren't available at their work place on time. This will create an inconvenience for the mothers and it will be challenging for them to come another time. So, a quality service couldn't be reached out for the mothers at the right time when they are needing it the most. This affects the service quality of the association.

Besides, the average result on agreement of the adequacy of the service delivered by FGAE is 2.79.As a result, the beneficiaries are not in full agreement of the prenatal care services delivered by FGAE here in Kality-Akaki post is adequate enough. In fact, the result shows that there has to be other service that has to be incorporated to the association. This finding of the researcher is even further supported by the result that the researchershave found during the focus group discussion and case studies. In one of the respondent's case study she said that:

Focus Group Discussion 1
".... they have lack of ambulance which they used it for multiple purposes. If they are transporting a referred patient an emergency call for the ambulance will be busy. And the same will be true vice versa. I strongly believe that they should consider having another ambulance. Think about the nature of the service they are giving..."

The problem of adequacy is not only limited to physical resources. Another respondent added during an interview saying:

".... adequacy? Think of a pregnant woman who prefer to give birth by operation? They don't have such a service here. In my previous child birth, I have been taken care of well for eight consecutive months. And you know what happened? They sent me to Gundi Hospital for a delivery because the only way for me to deliver the child was through operation. Going there

in pain and coming here again for the whole documents, even seeing new faces of the doctors and nurses at the final time…. It was all uncomfortable."

But improving the beneficiaries' health outcomes has to involve the provision and uptake of prenatal services that has to be timely, sufficient and adequate.

The other element of the question is regarding the fairness of the service. As it is reported in the table one of the questions with a higher agreement rate is that of the fairness of the service given by the association which resulted an average of 4.3. The respondents strongly believe that the service is free from partiality, favoritism and prejudice. On the Focus group discussion two of the beneficiaries gave the following statement. The respondent stated that:

"…we always appreciate them in this regard. We have seen such favoritism in other hospitals before but here, there is no such a thing. The place you are coming from doesn't matter to them they just welcome you with good vibes. There is no such partiality." (FGD1)

The other respondent continued;

"…I had my first delivery in the governmental hospital here in kalityAkakie and you need to know someone who works at the hospital to get more additional service and to get additional benefits or schedule appointments but I didn't see such impartiality at FGAE. You don't have to know someone to get a better treatment." (FGD2)

Performance of the practitioners & Plan for frequent visit Vs. Quality of the service

Other elements to measure the service quality provided by the association are the performance of the practitioners and their plan for frequent visits. The finding shows that each element has an average score of 3.8 and 3.83, respectively. The score on the performance of health practitioners reveals that the beneficiaries are near to a basic agreement that the medical staffs are good at their job and this which has also affected the general mean score of the beneficiaries on an agreement level on the quality of the service. The trust that the beneficiaries have on the professional performance of the practitioners creates some sort of confidence that theyare getting a good quality of service form the association.

The score on their plan to frequent visit (3.83) also shows that, the beneficiaries are willing to continue their medical care in the association regardless of some deficiency in the quality of the service. Through the focus group discussion, the researcher has founded that the minimal cost they spent on their frequent visit, their noble trust on their medical practitioners and the service

they have already taken from the association are some of the factors that push them behind to continue their frequent visit to the association. This was elaborated in their own terms as following:

"…I am planning to continue my visit here because the nurses are so helpful. They treat me well and they are really good at their profession. They might not be perfect but I prefer continuing my treatment here" (FGD2)

Another beneficiary added on this:

> "I want to get a medical care in here until I gave birth to my child. I preferred this association because of its low cost for a needy mother like me. These days, it is very hard to get proper medical care in other governmental hospitals due to a large number of clients, long queues and the doctors and nurses are too busy treating patients. Here, I am comfortable. I believe there are some things that should be improved yet, I feel safe here." (FGD2)

Another respondent added the following:

"…I'm going to have my next visits here in the association not just because the professionals are really good but, after all these months even if they have some minor problems, I don't need to adopt new doctors and nurses. I don't think it will be good for me and my child. I am good here and I will continue…."(FGD1)

Both the scores helped for a moderate mean of the agreement on the quality of the service.

Finally, we can see that the general question on the quality of the service has (3.61), the satisfaction rate we get from asking questions related to quality of the services (3.36) and finally a question of agreement on the quality of the service is (2.91) All indicators shows that the association has to go forward to integrate physical, financial and human resources to further strength the quality of its service. An interview with the Clinical service Director of the association also affirms the above statement. She Said that:

> *"……of course, we have some challenges within us. You can easily identify that we have only four nurses and two doctor so We face a lot of challenges that are handling our service quality but we are now considering to revise our service care provisions and planning on making some adjustments."*

One of the FGAE nurse Added:

"Most of our beneficiaries are so happy to be at FGAE but, we always see them complaining about the delayed service we give for the reason that the high number of prenatal mothers FGAE is serving once at a time through our three nurses and two doctors in a day. Our health practitioners are not sufficient to address the need of all of our beneficiaries without making them wait for long."

If the satisfaction of the prenatal care service is poor and women's experienceof it is negative, it may have a consequence that the quality of the service could also be undermined irrespective of the different services given by the association in number and kind.

Another nurse from FGAE said that:

"In the prenatal care, we need them to take medicines frequently such as iron, folic acid and prenatal pills but we see some of them failing to do so because of many medically unaccepted excuses like they are suffering from a gastric problem or referring to the side effects of the medicine that is bringing to their health. Though, what they are missing is how important the medicine is for the child. Thus, they fail to understand the consequences of their actions. This comes from lack of awareness about the issue so, we consult them during their visit, to be more cautious and alert to their actions."

According to the findings, the service performance of the prenatal care might also be affected by the negligence act of the beneficiaries. Most of the expecting mothers were uneducated or less aware of the importance of doctor's advices and medical intakes. This leaves them to be more dependent on applying socially accepted metaphors, sayings or religious rituals. This might lead them for the miscarriage of the baby and might leave the mother's health in a challenging situation too. In this scenario, the mother might blame the nurses or the association for her own fault. This affects the reputation of the association and undermines its service quality and the performance of the health care practitioners as well. According to the finding, majority of mothers did not accomplish their secondary education so, the chances of not listening and act according to their nurse's advice is very low and this shows how being educated is important for the mothers and how an awareness raising programs should also be provided for themmore frequently.

4.4The Social Network Analysis setting found in the Association

This research recognizes the complexity of healthcare, and the interacting and interdependent nature of components of a health system. To better understand such systems, advanced methods are required to show and analyze their structures. This paper describes social network analysis as a methodology to depict, diagnose, and evaluate health systems and networks therein. Social network analysis is a set of techniques to map, measure, and analyze social relationships between people, teams, and organizations. Through use of questionnaires exploring information flows and relationships among beneficiaries, the health care practitioners and the organization itself, this paper illustrates some of the commonly used network- and node-level metrics in social network analysis, and demonstrates the value of these maps and metrics to understand systems.

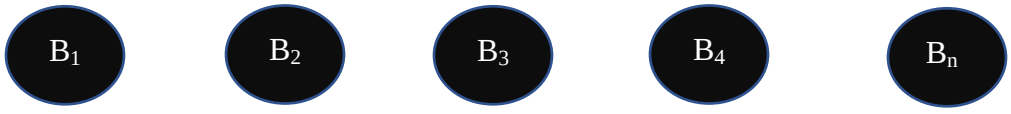
4.4.1 An Inner Network among the Beneficiaries

The researcher has found that, there are no network ties among the beneficiaries. During the focus group discussion, the respondent has confirmed that, thereare no network ties that are lined for them to share information and have a relationship between them. On the previous findings and analysis, the researcher has already mentioned that the respondents never heard about the association on the social media. A respondent in the focus group discussion reflectedthe following:

> *"No, we don't have any network relationship among us. We come to get our medical service and go back to where we came from without getting further contacts. I don't know any of the beneficiaries here. Almost all of them arenew faces for me."*

The following could be a representation of the diagram which portray a zero node-level interaction among the agents (beneficiaries).

Diagram 4.1: A simple diagram of the No- Social Network ties among Beneficiaries



*Where B_1 is Beneficiary one, B_2 is Beneficiary two and continues till n

Currently, the respondents were asked about the network ties and apparently, the nodes have to be linked in lines which would indicate the flow of information and an existence of a relationship

among the beneficiaries but there are no ties among the beneficiaries. Such result shows that the association has to form a physical or digital space where beneficiaries freely send, receive and share their ideas and useful information among themselves. Additionally, such networks will open spaces for the beneficiaries to share their experience andlearn from others. The use of network ties can bring returns to the association in charge of healthcare as well as, the patients and the practitioners. The association might use them as publicity, customer service, and patient education; on the other hand, the expecting mothers can use the network ties to obtain information, evaluate their progress and receive supports.

4.4.2 A Professional Network among the Practitioners

In reverse to the network ties among the beneficiaries, the practitioners have a strong tie among themselves. They exchange information easily between them. Not only the flow of information is kept well, but also the responses. Hierarchical flows of data are also set aside, so that there should not be a leak of data's and misusing. In an interview with one of the nurses, she stated the following:

> *"we have a weekly meeting every Tuesday between the health care practitioners to discuss about medical issues and give each other feedbacks about delivering a better health care service for the beneficiaries. A monthly, quarterly and annually meetings will also be held between us to evaluate how we are performing throughout the month and the year. We also have a review day where we look up to the comments given by our beneficiaries. It is helping us to perform better, learn from our past mistakes and strive to deliver a quality service for the mothers."*

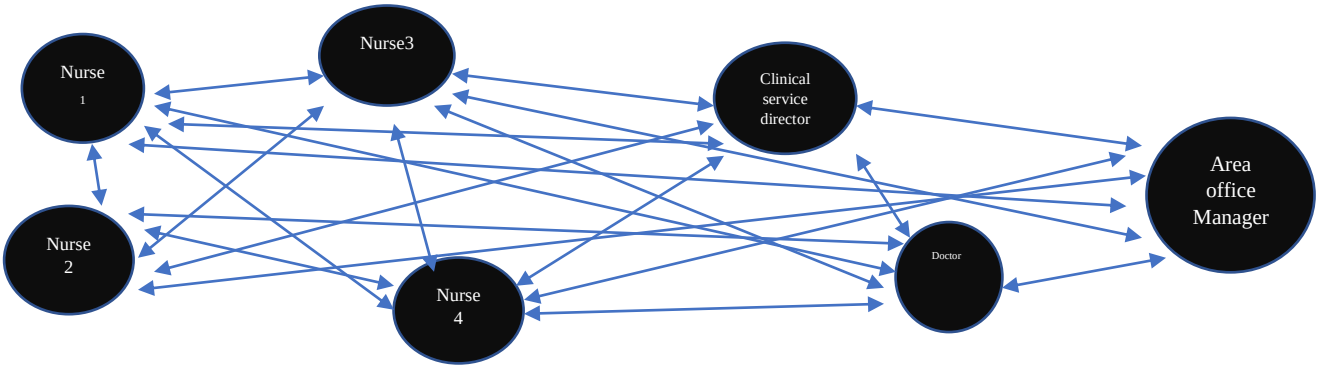
By using Social Network ties, the association can look for this existing connection, and tap them to make more effective team that enjoy working together. The network ties focus on the *relationships* between agents (here in the case of the association's medical practitioners)rather than an agent's attributes or features. The medical practitioner's attributes aren't comprised on their skills or knowledge in the network ties rather, the concern here is whether they knew each other well and are working in the line of the relationship. The above nurse also added the following:

> *"We have a web of interconnection between us. The ties are not only among ourselves, but also to the Clinical service director, the Doctor and upward. Our relationship helps us to support*

each other especially, in time of stressful settings. Since we are dealing with expecting mothers where there isa frequent alteration of moods and needs,return has a big impact on us. Dealing with patients including mothers in labor has some psychological influence on us."

The following could be a representation of the diagram which can show the relationship and flow of information among the nurses, the Clinical Service director, the Doctor and the Area Office Manager. The N stands for the nurses while the CSD is for the Clinical service director, the D is for the doctor and AOMstands for the Area Office Manager. The lines are the flow of information and directions of relationships.

Diagram 4.2: A simple diagram of the network ties among the practitioners



The above diagram shows that the network ties which represents the relationship and the flow of information between the medical practitioners in the FGAE is, an instance of a Social Network Analysis that could be seen in the health care system. The four nurses have a platform of discussion and a formal relationship where they exchange information and knowledge more easily. They easily discuss about diagnoses and treatments of patients. As the nurses also statedthat this is the space where they analyze and make use of feedbacks. There is also a straight line of information flow from the nurses to the Doctor and clinical service Director stretched back all to the Area Office Manager. Especially, when there are managerial decisions that demand the participation of all of the workers, the line between the nurses and the Area Office Manager becomes bold. This platform is a way of building up professional confidence and self-esteem to the medical practitioners. As one of the other nurses stated in her own words as:

"Yes, we do have a network. In our weekly formal discussions and meetings, we discuss issues which are professional and sometimes personal. This is a platform for us to share our experiences, knowledge and understandings. As you know, medicine is a vibrant field of study where there will be new findings, discoveries and updates. So, every week, we share

these professional knowledge's thatwe had already collected from different sources as much as we could. See, this boosts up our level of knowledge and confidence while we are doing our job."

Since individuals' attitudes and other personal characteristics will be influenced by the people who are around, the network ties and the flow of professional knowledge between the health practitioners will also be influenced by each other andthese builds and strengthen the way they do their job. Generally, during the course of providing healthcare services to the beneficiary's physician collaboration including professional relationship among physicians, is vital to be more effective. Therefore, providing a help for each other on sharing information and experiences could be a way of scaling up their professional knowledge and ethic.

4.4.3 An Organizational Network of the Association

In this research, health care systems are recognized as they encompass the density of medical services and healthcare, and the interacting and interdependent nature of components of a health system. To better understand such systems, this paper describes social network analysis as a methodology to depict, diagnose, and evaluate health systems and networks therein. The network ties of flow of information and relationship is not only limited to beneficiaries or between the professionals but, it is extended to the organizational network ties the association has with other similar organizations and to the larger network of health care system. A health care system contains a complexity of webs that are connected to each other.

In this manner, there are an existing linkbetween different NGO s with other NGOs. The relationship that exists among the NGOs is a relationship tie to exchange different strategies, techniques and methods of delivering quality service. The Clinical service Director of the association affirms that there is an exchange of basic and vibrant information among themselves. This was her words:

"We have a good relationship with other NGOs that are located are around Kality-Aakaki sub city. Especially, in regard to providing training and seminars. When one has an exposure to a new resources and methods of work, then there is a way of sharing to others. We have a deliberate meeting for such manners. Since we all have an exposure to different donors and sources, our information and method of work is also different. So, in such manner, we

exchange useful information among us. This seminars and trainings helped us a lot in not only sharing different techniques, but also, in bridging the gap among us."

Both NGOs and the local government are aware and isbecoming firmly committed to collaboration because of a convincement of its value. The central government as the head of the relationship has a role to play on identifying the national vision of the country's future as a motivation to the NGOs to participate in the investment, partnership, and trust of them which helps in the success of the national plans and projects. The following simple diagram shows us the relationship that exists among the different NGOs (including FGAE) and the relationship tie between these NGOs and the regional health bureau (RHBT).

Diagram 4.3: A simple diagram of the network ties among the different NGOs and the different health bureau

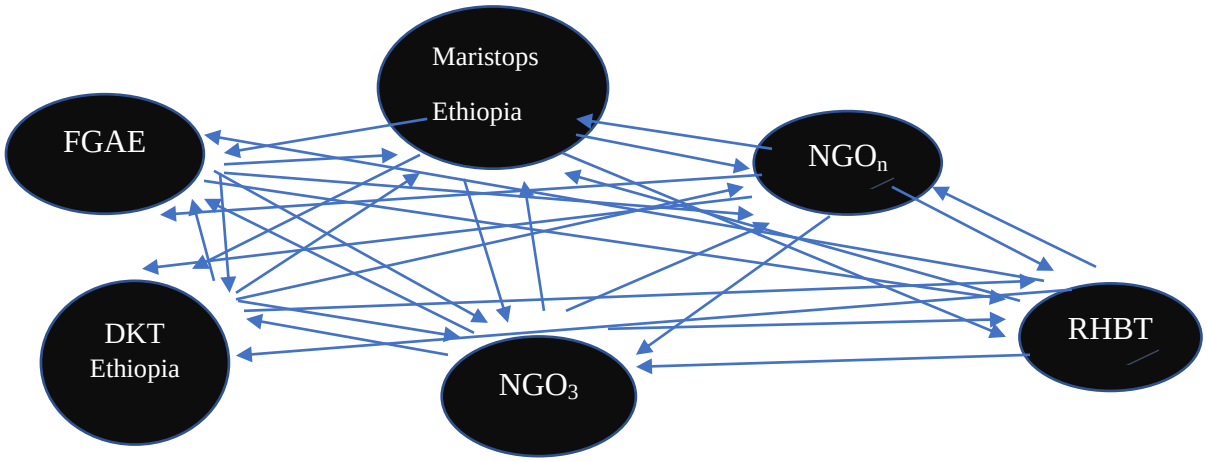


Table 4.4.4 Source of Information

	N	Mean	Std. Deviation	Coefficient of Variation	Coefficient of Variation (%)	N (who Sayed yes)	% of those who said yes
Did you get the information about the pre-natal care service from previous beneficiaries?	178	1.17	.375	0.32	32%	148	83.14%
Did you get the information about the pre-natal care service from friends?	178	1.40	.491	0.3507	35.07%	107	60.11%
Did you get the information about the pre-natal care service from Relatives?	178	1.66	.476	0.2867	28.67%	61	34.26%
Did you get the information about the pre-natal care service from Radio?	178	1.90	.295	0.1552	15.52%	17	9.55%
Did you get the information about the pre-natal care service from Health extension programs/trainings?	178	1.99	.075	0.0376	3.76%	1	0.56%
Did you get the information about the pre-natal care service from social Media?	178	2.00	.000	0	0%	0	0
Did you get the information about the pre-natal care service from Television?	178	2.00	.000	0	0%	0	0
Did you get the information about the pre-natal care service from Print Advertisement?	178	2.00	.000	0	0%	0	0
Did you get the information about the pre-natal care service from other Sources?	177	2.00	.000	0	0%	0	0
Valid N (list wise)	177						

In the table below the researcher wants to show the flow of information within the beneficiaries and the association itself by asking the beneficiaries where they heard about the association before coming to the association for a prenatal health care service.

Source: Own survey, 2024G.C

N.B "1" refers to a yes and "2" refers to a "No"

As the above table shows, the researcher wants to identify where the respondents heard the information from, about the association with an assumption that the data provides the mechanisms of the informational diffusion to the public about what services are comprised of and delivered by the association. As it is shown in the above table, the mean score for the last

four variables which is whether they received the information about the pre-natal care service from social Media, Television, Print Advertisements or other Sources is 2.

This indicates that no one has received the information from the above listed sources and there is no variation among the respondents (Since the coefficient variation is 0). Additionally, no respondent (0%) has obtained an information about the association from these sources.

On the other side, the majority of the respondents heard about the organization from previous beneficiaries and friends, 148 (83.14%) and 107 (60.11%) of them respectively. The current customer to customer ties discussed on the topic of the network ties among the beneficiaries previously. So, according to the finding, the customers have network ties with previous beneficiaries not with the current ones. This might be due to lack of organizational platforms among the customers.

Now from these, the researcher observed that there are both an opportunity and threat to the network ties the association has with its beneficiaries. The opportunities are, since the majority of the respondents obtained the information about the organization from one-to-one ground level or from their friends and beneficiaries, the organization has to expand its ways of reaching the society in such manners using societal grassroots level communions such as “Edir” and “Ekub” where the member of the community shares different topics of life together. The threat could be, the association has to expand its digital technologies to reach out massive number of people as it is an era of social Medias and digital technologies. These means of communications doesn’t only allow the association to reach as many people as it possibly could but also it modernizes the way it delivers the service and manage its beneficiaries.

4.5 Level of Collaboration

An understanding on the importance of collaboration between medical care practitioners such as obstetricians, family physicians and nurses may promote cooperation among professionals who are providing maternity care in the institutions. The following section includes the level of collaboration among physicians. The qualitative data that the researcher gathered through an interview from the medical practitioners will be cross-examined with the quantitative data gathered through the questioners given to the respondents.

Table 4.5 level of Agreement of the respondents towards Practitioners' collaborations

Table 4.6Satisfaction rate in accordance to collaboration of the health practitioners

The healthcare providers are collaborative enough in delivering prenatal health care service		
N	Valid	178
	Missing	0
Mean		4.34

Level of collaboration		
N	Valid	178
	Missing	0
Mean		4.2809

Source: Own survey, 2024G.CSource: Own survey, 2024G.C

As it is shown in the above table, the average mean of the expectant mother's agreement towards the cooperativeness of the health practitioners is 4.34 which falls in the score of adequate agreement. The respondents approved that the health practitioners are helpful and supportive in their service delivery.

This is further stated by one of the beneficiaries who said the following:

> *"They are very helpful. When we came here, they sometimes welcome us with such a warm smile and treat us well. Anything we noticed that worries us, we can tell them freely. They even remember our cases at first glance. They are very collaborative. We are not afraid to tell whatever we felt and ask them whatever questions we have".*

This level of cooperation plays its own role in the service delivery by making it easy for practitioners to do their job and to take a good care of the pregnant mothers. Additionally, the fact that the health and wellbeing of a patient depends on the collaboration between the health care provider and the patient should not be undermined. Another respondent also states the following:

> *"Three years ago, I gave birth to a child from other place, but the way they treated us was notgood. When a labor painhas started, they shouted at us and tell us to shut up* and because *of that mistreatment, I have decided to deliver here. They are very nice here and are helpful. They treat us like their friend and we are not ashamed of anything to ask and tell. When we even yell sometimes, they treat us in a good manner and tell us calmly that it's some hormonal problem of ours that forced us to behave in that manner."*

Their confirmation of the cooperativeness of the health professionals are also seen on the average score of the satisfaction rate which is around 4.3. The other thing the researcher has observed is that, there is a moderate or intermediate (yet close to strong) correlation (around 0.66) between the level of agreement and their level of satisfaction on the cooperativeness of the health professionals (which the table is attached to the Annex). This indicate us that the level of their collaboration has a moderate (close to strong) relationship with their satisfaction towards the helpfulness and friendliness of the health practitioners. For sure, the need for multidisciplinary maternity care and inter-professional collaboration has also to get in line, as it helps to solve the shortage of care providers in the maternity care system, and guarantees improvement in maternity care services. The researcher has also examined the relationship among the health care practitioners for the assurance of a good care of their patients. Though, while interviewing the nurse, she confirmed that they have a good interpersonal relationship which she relates it to the service delivered to the beneficiaries.

This was her words:

> *"…. we have a good relationship among us. We believe that the quality and essence of our relationship is a core value to the service we give. If I get in to a trouble with my colleagues, I will also get in to a trouble with my patients. Furthermore, you have to create an atmosphere of a descent and cheerful space where you, your colleagues and my patients enjoy. In that way, we keep in check that we have a good relationship with our beneficiaries."*

This shows that they have a good inter personal relationship with their beneficiaries. Both the beneficiaries and the nurses agreed on this and it indicates that the level of collaboration of the health practitioners is very good and they provide a quality service in this regard.

The other nurse also added that:

> "We keep the quality of our relationships to be noble and strong as much as we can because; it is one of the core values of our association. Not only this but, since we believe that the way we interact with each other and act in accordance has an impact on our service delivery, we value and take a good care of the relationship we have with them."

The ultimate aim of collaboration is to integrate services for the progression of an improved maternal care. This is to say that the individual factors such as, skills, competence, and work experience can serve to support various inter-professional networks and teamwork has a direct impact on the quality of service delivery of the association. Its impact will be seen for instance, if the health practitioners are collaborative enough, there is a high chance that the mothers would make FGAE as their next follow up preference and might even suggest it for other mothers to make their follow up process there.

The following case study of one of the beneficiaries in the FGAE shows the level of collaboration of the nurses.

> "…. I was feeling so hopeless while I was four and a half months pregnant because my husband left me and married another one and I have decided to abort the child immediately. That's how I came to the FGAE first but the nurse's advice saved the life of my child. They convinced me to keep the child. They changed my mind and here I am now I'm about to give birth after a month. I'm so thankful about the nurses."

The health care practitioner's collaboration shouldn't be underestimated as it has a potential to save lives of the children. Themore collaborative the health practitioners are the more they will be able to save the life of the children.

4.6 Level of Adoption to a Digital Technology

The following section provide an analysis to the level of adoption to a new technology by the association. The question was provided to the beneficiaries regarding to the above topic and also interview was made with the Clinical service Director to cross check the result. Here, below is what the researcher has found.

Table 4.7 Level of Agreement of the respondents towards FGAE in using Digital Technologies

The FGAE is good in using digital technology		
N	Valid	178
	Missing	0
Mean		2.39

Source: Own survey, 2024G.C

The above table show us that the level of agreement of respondents on the association to use digital technology is very low (2.39) which is a score close to disagreement.

This shows that the employees of the FGAE including the health care practitioners are not using digital technologies such as computer registration methods, filing and storing personal data of the patients in a computer, using social medias as a means to communicate, raise awareness and inform their services, displaying useful prenatal care awareness raising videos on the reception area or at the waiting rooms and etc. none of this methods are applied in the association. Even if the expecting mothers wanted to use them, they are not available. Besides, the health care practitioners don't have the knowledge on how to operate the digital technology let alone adopting a new one. So, reaching out the mothers easily is impossible. They should adopt new technologies to easily do their jobs.

There are different problems aroused by the beneficiaries regarding to the poor use of digital technologies by the association. These problems vary from the weak management of beneficiary's medical portfolio, to the poor use of different media technologies to portray useful pregnancy related information. A beneficiary states the following during a focus group discussion:

> *"Among other things, they are very poor in using digital technologies. When you first enter to the card desk, they will register you on a computer but every time you came by, a recorded*

book has to be opened and they will start searching your history there. The medical reports are also controlled traditionally which you can clearly see when you get to their archive. We know other hospitals have a computerized recording system. I recommend they follow that."(FGD1)

The problem of using a digital technology is not only limited to the patient card section. Another respondent added the following:

"…my oldest boy downloads videos of prenatal care and pregnancy related videos from the internet and he lets me watch it every time. He always searches different useful information regarding to pregnancy. Now, I even have a mobile application which tells me what to expect at any month of pregnancy period but here, they don't even tell us about such things clearly. I sometimes want to give it to them so that others could see."

The researcher also observed that no respondents (zero rate) has come through the help of social media for search of a service from the association. This indicates that the association has to work on it. This is because one important nature of the contemporary use of digital media that requires emphasis is, users are not passive consumers of information that they find in this media. Rather, they play an active part in creating original content, as well as engaging in practices of curating, tagging, liking, recommending, sharing and sometimes reformulating the information that they come across in these media. They can use other digital medias to generate details about their situation and their fetus. Some applications and websites facilitate pregnancy-tracking so, that women can enter details about her expected date of delivery and her medical details such as body weight, level of physical activity, diet and can find out what to expect during the early trimester of her pregnancy period or changes that could occur on her body every months.

4.7 The Role of FGAE in delivering Primary health care service

NGOs are expected to play a greater role in delivering primary health care service to the community since they are considered as an ally to the government in promoting health and tackling challenges. Government as a standby organization, sees them as a gap filling institutions in which they fill in breaches of health care service accessibility. To identify the status of NGOs in this regard, the study has proposed and provided questions for beneficiaries and interviewed the Clinical service Director of the association and the Regional health bureau official. The

researcher also has searched some available literatures on the topic. Here, below there is an analysis on the contribution of NGOs in delivering prenatal care service by using the outputs of data gathered through the above methods.

The NGOshealthcare system comprises over 300 health institutions in the country constituting 7%of the 8,236 health facilities, most of them are at the primary level. They provide financing and general (curative, preventive and rehabilitative) healthcare services, HIV/AIDS and reproductive health services in clinics and through health education. The second National Health Account reported that in 2000 the Ethiopian health NGO community contributed 10% of the national health expenditure. A larger portion of fees paid for health services is spent in non-MOH facilities and, as one study found, cost-recovery in NGOs facilities is 70% (FMOH, 2013).

The following tables show the general contribution of NGOs in the health sector in Ethiopia.

Table 4.8: Contribution of NGOs to Ethiopia's health sector (2014)

Outputs	Unit	Local	International	Total
Health facilities				
• Health Posts	#	221	445	666
• Clinics	#	11	72	83
• Hospitals built/rehabilitated	#	1	20	21
Health personnel*				
• Doctors				578
• Nurses				914
Health Care/Services				
• Health education given Persons	Persons	5,668	8,260	13,928
• Health service (outpatient)	Persons	48,710	106,947	155,657
Financing (%) **				10

Source: Development Studies Association (2014).
Notes: *Field data acquired from the MOH; ** FMOH (2013)

According to the above table, one can see that, even if some changes and improvements are needed, NGOs has a crucial role in providing health facilities, health care professionals as well as their share in financing the health care system.

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CHAPTER FIVE

5. Conclusion and Recommendation

5.1 Conclusion

Ethiopia, as one of the developing countries lacking a potential of spreading health service delivery across the nation. Since the government is supported by the internal revenue and from the aids of developed nations, it still can't fulfill the national health service demands. Therefore, with such a case, the role of NGOs in the delivery of primary health care service has a paramount importance. The potential role it has in addressing the poorest segment of the population, the grass root level operation and the relatively low-cost service delivery gives it the chance to play a key contribution to the availability and accessibility of the health care services. The fact that NGOs can actively and efficiently work would create a ground for them to be helpful for local resource mobilization, cost recovery, and program sustainability.

Thus, by performing these activities NGOs, could show some indications of their potential to be annually for the general benefit of the society regarding their health and also gives a chance for the government to deploy NGOs in works where the hands of the government couldn't reach. Beyond being a significant actor in the health care service provision, the importance of the Non-governmental Organizations also provides people choices of different prenatal care services and helps to create an effective ground in respect to service needs and expectations. Moreover, these NGOs are imperative in identifying people's needs, arranging services and share their expertise of human and capital resources as well as technical, material and equipment capabilities. And, if this is the case then, there is a need to strengthen the relationship between government and NGOs and promote an inter-linkage platform among the NGOs themselves as it produces an effective and efficient ways of dealing with prenatal health care and other streams of health care service delivery. This study also indicates that NGOs can have a role to play in providing and supporting the existing health care service by both government and private sector. NGOs can have both complementary and supplementary advantages.

5.2. Recommendation

Based on the findings of this research, the researcher recommended the following options for the FGAE to apply it in the future for a better and quality services in the prenatal care providence for its expecting mothers and for a great and better role that it should play in delivering primary health care service for the society in general.

- The findings of this study show that the application of health care providers in delivering nutritional and maternal counseling is low so it has to be customized in accordance to the real-life situation of the expecting mother's status by providing trainings and applying digital data management in order to improve the beneficiaries' health outcomes.
- Strengthening NGOs familiarity on the usage of digital technologies and medias to create an awareness about the service provision and different useful maternal information.
- Creating an awareness for the practitioners on the usage of different digital technologies which deals with maternal and fetus indicators including, the use of some mobile applications and websites which facilitate self-tracking.
- Employing additional staffs and enriching the human resource capacity of FGAE, KalityAkakipost.
- Forming customer self-help groups in FGAE, Kalityakaki post.
- Where beneficiaries freely send and receive their ideas and useful information among themselves which might enable the beneficiaries share their experiences and learn from each other.
- In addition to clinical guidance, practitioners should also involve themselves in prenatal care interventions to improve the utilization and quality of antenatal care in accordance with the flexibility of the service by employing and using different options for the delivery of antenatal care based on the beneficiaries' specific needs.
- Strengthening the already existing collaboration among the physicians and making use of individual skills, competence, and work experience in teamwork for the successful service delivery of the association.
- Digitalized counseling methods for the growing customer needs should be introduced.

Using digitalized methods of card service, patient record arrangement and other services which are need to be computerized. While prenatal care has value in improving prenatal outcomes, it must be more accessible and acceptable to all pregnant women to affect changes in outcomes, especially for the most vulnerable women. Current theories of access to prenatal care are barrier-focused and offer little to clinicians and health planners that would shape a clear framework for action. The Motivation-Ease middle-range theory of access to prenatal care presents a theoretical orientation to the process of access emphasizing the role of the healthcare clinic and provider in facilitating the access process. The theory can be applied in practice and clinical research to frame interventions. There is no disciplinary specific jargon, and the concepts can be understood by all members of a team: providers, staff, and clients. Future research need to test this model for use in variety of populations of pregnant women.

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Appendix A

ST. MARY'S UNIVERSITY

School of Graduate Studies

Institute of Agricultural and Development Studies Master's Program in sociology

A Questioner for respondents

Dear respondent

First and foremost, I want to thank you in advance for your willingness to fill the questioners below. The questioners are prepared in order to gather information on The Relevance of NGOs in delivering Primary Health Care Service of Prenatal care in kality-Akaky Post : A case study at Family Guidance Association of Ethiopia, kality-Akaky Post. The aim of the questioner is for the partial fulfilment of my Masters of Arts in Sociology. The information that I am going to collect from you is very important and has a great impact on my thesis So, I kindly request you to answer the questions carefully and in a precise manner and as it is confidential, feel free to fill the form honestly for the good management and presentation of the thesis.

Please answer the following questions by ticking one box in each row and writing your answer for the open-ended questions on the space provided.

Section I Personal information

1. Age_____

2. Address_____

○ Kalityakakai

○ Outside kalityAkaki

3. Educational background

○ Can't write & Read Vocational Training

○ Can only Read and Write Certificate

○ Elementary education Diploma

○ Secondary education University Degree & above

Preparatory

4. Marital Status

○ Married

○ Single Mother

○ Widowed

○ Divorced

5. If Married, Occupation of Spouse

○ Public organization

○ Private organization

○ Self employed

○ Unemployed

○ Other

If your answer is other please mention it_____

6. Type of household

○ Male headed

○ Female headed

7. Family size (Number of children) _____

8. Employment status

○ Public organization

○ Private organization

○ Self employed

○ House wife

○ Unemployed

○ Other

If your answer is other please mention it_____

Section II Main questions

1. What type of service do you receive from the association? (Multiple Response is possible)

○ Maternal and Fatal Assessment

○ Nutritional Intervention and Supportive Counselling

○ Preventive measures

○ Family planning and Contraceptive measures counselling

2. For how many times did you utilize the service?

○ First Time

○ Two times

○ Three times

○ More than three

3. How did you get the information about the prenatal care service? (Multiple response is possible.)

○ Social Media Relatives Other

○ Health extension Programs/ Trainings Friends

○ Television and Print Advertisement

○ Radio Previous beneficiary

Please circle one of the numbers in each row to assess your level of agreement with the following aspects of your stay in FGAE

Questions	I strongly Disagree	I Disagree	I'm Neutral	I Agree	I strongly Agree
FGAE provides a better quality of service than your local service delivery providers	1	2	3	4	5
The service you receive from FGAE is adequate	1	2	3	4	5
The service delivered by the FGAE is fair	1	2	3	4	5
The health care providers are collaborative enough in delivering prenatal health care service	1	2	3	4	5
The service you received from FGAE has changed your life or health condition	1	2	3	4	5
The FGAE is good in using digital technology	1	2	3	4	5

The service fare of FGAE for the health service delivery is fair	1	2	3	4	5
The health practitioners of FGAE is performing good	1	2	3	4	5
I do have a plan for frequent visits here	1	2	3	4	5

Please circle one of the numbers in each row box to assess your level of satisfaction with the following aspects of your stay in FGAE

Questions	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
With the Prenatal health care delivery of FGAE	1	2	3	4	5
With the helpfulness of the Health Practitioners in FGAE	1	2	3	4	5
With the friendliness of the Health practitioners of FGAE	1	2	3	4	5
With the Speed of the health service in	1	2	3	4	5
Regarding to the availability of the health practitioners in FGAE	1	2	3	4	5
With the general service delivery of the FGAE	1	2	3	4	5

4. What will you recommend generally for a better participation of NGOs in the health sector of Ethiopia?

_____

_____

_____

_____

Appendix B

ST. MARY'S UNIVERSITY

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Check list of interviews (for the Nurses)

I am eyasuGetachew, a Masters of Sociology student at st.marys University. Currently, I am undertaking a research entitled; "The Relevance of NGOs in delivering Primary Health Care Service of Prenatal care : A case study at Family Guidance Association of Ethiopia, kalityakaki Post" to fulfil the partial requirements to earn my MA Degree. Your response is important and valuable to complete the research, so I kindly request you to participate in this study. The research is conducting with respect of research ethics and your response will be managed confidentially.

1. What are the major relevance of primary health care services on prenatal care which are needed and highly utilized by the community? -

_____

2. Is the quality of the health service provided by the FGAE on prenatal care service worth enough?_____

3. What are the major challenges that are faced by Family Guidance Association of Ethiopia in delivering prenatal health care services to expecting mothers?_____

_____

4. How is the level of collaboration between you and the beneficiaries?

_____

5. Do you think the service you deliver for prenatal mothers is fair?

_____

6. How do you describe the effect of your service delivery on the beneficiaries?

_____

7. How do you evaluate the effectiveness of the service you deliver?

_____

8. What do you think is the role of NGOs like FGAE?

_____

9. Is there any network relationship between the medical staffs of the Association?

_____

10. If there any network relationship how is it and what is its advantage?

_____

Appendix C

ST. MARY'S UNIVERSITY

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Check list for Focus Group Discussion

1. Do you think the service given here in FGAE is adequate?
2. What service do you think the present FGAE does not include but are important in the health service?
3. What do you think about the fairness of the service?
4. What do you think in regard to the cost of the service?
5. How do you explain the service given here in relation to its capacity to change your current life?
6. Do you have future plan to have a frequent visit here? Why?
7. Is there any platform for you beneficiaries to exchange different information regarding to your health?
8. How do you explain the relationship that you have with your medical practitioners?
9. Do the medical staffs here are helpful?
10. Do the medical staffs here are collaborative?
11. How do evaluate the capacity of the association in using different Digital technologies regarding to the service delivery?

Appendix D

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Check list for interview (office administrator)

1. How do you describe the relationship that your office has with NGOs that specifically work with maternal health and related services?
2. Are there any follow up mechanisms for you to check the quality of the service given by these NGOs?
3. What are the roles of these NGOs in delivering Primary health care especially in prenatal care?
4. Do you consider NGOs as your partner? If no,why? If yes what is the return of having them as a partner to the health service delivery system in general?

Thank you for your cooperation!

Appendix E

ST. MARY'S UNIVERSITY

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Institute of Agricultural and Development Studies Masters Program in sociology

Check list for interview

(For the Clinical Service Director of FGAE, kalityakaki Post)

1. What are the major challenges that are faced by Family Guidance Association of Ethiopia in delivering prenatal health care services for expecting mothers?
2. How do you explain the organizational relationship and flow of information with other NGOs?
3. How do you explain the organizational relationship and the flow of information between your organizations?
4. How is your organization at using different Digital technologies regarding to the service delivery?
5. What do you think is the role of NGOs like you are in, in delivering primary health care of prenatal service?

Thank you for your cooperation!

AppendixF

Some Statistical tables

Table A1: A cross tabulation on occupation of the respondent vs. their level of agreement on the fairness of the cost

Occupation of the respondent * The service fare of FGAE for the health service delivery is fair Cross tabulation

Count

		The service fare of FGAE for the health service delivery is fair				Total
		Disagree	Neutral	Agree	Strongly Agree	
Occupation of the respondent	Public Organization	0	0	12	29	14
	Private Organization	0	0	9	29	38
	Self Employed	0	0	0	12	12
	Housewife	7	6	6	21	40
	unemployed	0	0	17	30	47
Total		7	6	44	121	178

Source: Own Survey: 2024

Table A2: A correlation table *between the beneficiary's level of agreement and their level of satisfaction on the cooperativeness of the health professionals*

		The healthcare providers are collaborative enough in delivering prenatal health care service	Level of Collaboration
The healthcare providers are collaborative enough in delivering prenatal health care service	Pearson Correlation	1	656
	Sig. (2-tailed)		0
	N	178	178
Level of Collaboration	Pearson Correlation	656	1
	Sig. (2-tailed)	0	
	N	178	178

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Own Survey: 20224

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የሶሽዮሎጂድህረ-ምረቃተማሪዎች

ውድ ፡- ተጠያቂ

ከዚህበታችየተመለከቱትንጥያቄዎችለመመለስፈቃደኛስለሆኑከልብለማመስገንእወዳለሁ፡፡ እዚህጥያቄዎችየተዘጋጁትበቀድመወሊድጋርየተያያዙየጤናአገልግሎተችንየተመለከቱናቸው የዚህጥያቄየመመረቂያጽሁፌንበሶሺኦሎጂትምህርትላይየድህረምረቃለማድረግጠቃሚሆኖስ ለተገኘነው፡፡ ስለሆነምጥያቄዎችንበሚገባመልኩእንዲመልሱልኝበአክብሮትእጠይቃለሁ፡፡ የምትሰጡትምምላሽሚስጢራዊነቱየተጠበቀነው፡፡

እባክዎትንየተጠየቁትንጥያቄዎችመልሱንበምልክትበመግለጽእንዲመልሱልኝበትህትናእጠይ ቃለሁ፡፡

1. **እድሜ_____**
2. **አድራሻ_____**

   ○ **ቃሊቲአቃቂ**

   ○ **ከቃሊቲአቃቂውጪ**

3. **የትምህርትደረጃ**

   ○ **ማንበብመፃፍአልችልም**

   ○ **ማንበብናመፃፍብቻእችላለሁ**

   ○ **የመጀመሪያደረጃትምህርት**

   ○ **ዲፕሎማ**

   ○ **ዲግሪ**

4. **የጋብቻሁኔታ**

   ○ **ያገባ**

○ ያላገባችእናት

○ ባሏየሞተባት

○ የፈታች

5. ያገባች/ባ ከሆነየባለቤት/ሽ የስራሁኔታ

○ የመንግስትየስራተቀጣሪ

○ የግልድርጅትተቀጣሪ

○ የግልስራ

○ ስራአጥ

○ ሌላ

ከዚህውጪከሆነ_____

6. የቤቱአስተዳደርሁኔታ

○ በወንድ

○ በሴት

7. የቤተሰብብዛት_____

8. የሥራሁኔታ

○ የህዝብድርጅት

○ የግልድርጅት

○ የራስ

○ የቤትእመቤት

○ ስራአጥ

○ ሌላ

ከዚህውጪከሆነ

ጥያቄ 2

1. **በዚህምግባረሰናይድርጅትውስጥምንአይነትአገልግሎትወስደዋል**

    ○ **የቅድመወሊድክትትል**

    ○ **የስነምግብናየምክርአገልግሎትድጋፍ**

    ○ **የቅድመጥንቃቄድጋፍ**

    ○ **የቤተሰብእቅድናየወሊድቁጥጥርምክክርአገልግሎት**

2. **ምንያህልጊዜየአገልግሎትተጠቃሚሆነዋል**

    ○ **ለመጀመሪያጊዜ**

    ○ **ለሁለተኛጊዜ**

    ○ **ለሶስተኛጊዜ**

    ○ **ከዚያበላይ**

3. **ይህንየቅድመወሊድክትትልአገልግሎትእንዴትሊሰሙቻለሁ**
   (ከአንድበላይመመለስይችላለሁ)

    ○ **በህዝብመገናኛአገልግሎት**

    ○ **በጤናባለሙያስልጠናዎች**

    ○ **በቤተሰብ**

    ○ **በቴሌቪዥን**

    ○ **በሬድዮ**

እባክዎትንየተስማሙበትንቁጥርያክብቡ

በድርጅቱእየተሰጣባለውአገልግሎትእኔእጠቀምበትከነበረውቦታየተሻለነው	እጅግበጣምአልስማማም	አልስማማም	መወሰን ይከብዳል	እስማማለሁ	እጅግበጣምእስማማለሁ
በድርጅትውስጥየሚሰጡትድጋፍችበቂናቸው	1	2	3	4	5
በዚህድርጅትውስጥየሚሰጡትድጋፍሁሉንያማከሉናቸው	1	2	3	4	5
የጤናባለሙያዎቹበበቂሁኔታተባባሪናቸው	1	2	3	4	5
የዚህአገልግሎትተጠቃሚበመሆንዎትየጤናዎሁኔታተሻሽለዋል	1	2	3	4	5
የድርጅቱዘመናዊየሆነአገልግሎትመሳሪያዎችንይጠቀማሉ	1	2	3	4	5
አጠቃላይበዚህድርጅትያለውአገልግሎትለሁሉምእልአገልግሎትይሰጣሉ	1	2	3	4	5
የጤናባለሙያዎችጥሩናቸው	1	2	3	4	5
እኔእዚህድርጅትበተደጋጋሚክትትልለማድረግፈቃደኛነኝ	1	2	3	4	5

እባክዎትንስለአገልግሎቱያለዎትንሁኔታበማክበብይግለጹ

ጥያቄ

በድርጅቱየቅድመወሊድአገልግሎትላይ	በጣም ረክቻለሁ	አልረካሁም	መ/የለም	ረክቻለሁ	በጣምረክቻለሁ
በጤናባለሙያዎችድጋፍ	1	2	3	4	5
በጤናባለሙያዎቹቤተሰባዊፍቅር	1	2	3	4	5
የጤናባለሙያዎቹፍጥነት	1	2	3	4	5
የጤናባለሙያዎቹስራቦታላይመገኘት	1	2	3	4	5
አጠቃላይበአገልግሎቱሁኔታ	1	2	3	4	5

አጠቃላይበዚህየቤተሰብመምሪያአገልግሎትያለዎትንአስተያየትግለጹ