

**ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL ALLIED OF HEALTH SCIENCES
DEPARTMENT OF NURSING AND MIDWIFERY**

**ASSESSMENT OF MATERNAL COPING MECHANISMS
FOLLOWING PERINATAL DEATH IN SELECT PUBLIC
HOSPITAL ADDIS ABAA, ETHIOPIA,2018**

BY – ESETE AYALEW (BSC)

**A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY,
SCHOOL OF ALLIED OF HEALTH SCIENCES, COLLEGE OF
HEALTH SCIENCE, DEPARTMENT OF NURSING AND
MIDWIFERY IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTERS OF
SCIENCE IN MATERNITY AND REPRODUCTIVE HEALTH.**

**JUNE, 2018
ADDIS ABABA,
ETHIOPIA**

**ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL ALLIED OF HEALTH SCIENCES
DEPARTMENT OF NURSING AND MIDWIFERY**

**ASSESSMENT OF MATERNAL COPING MECHANISMS
FOLLOWING PERINATAL DEATH IN SELECTED
PUBLIC HOSPITAL**

BY: ESETE AYALEW (BSC)

ADVISORS: 1. HAWENIE ADUGNA (BSC, MSC)

2. FEKERTEMARIAM ABEBE (BSC, MSC)

A RESEARCH THESIS TO BE SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF ALLIED HEALTH SCIENCES, DEPARTMENT OF NURSING AND MIDWIFERY IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF MASTER DEGREE IN MATERNITY AND REPRODUCTIVE HEALTH.

**JUNE, 2018
ADDIS ABABA, ETHIOPIA**

Approval by the Board of Examiners

This thesis by Esete Ayalew is accepted by the board of examiners as satisfying thesis requirement for the degree of Master of Science in Maternity and RH

Research Advisors:

Full Name	Rank	Signature	Date
S/r Hawenii Adugna (BSc, MSC)	_____	_____	_____
S/r Fekertemariam Abebe (BSc, MSc)	_____	_____	_____

Examiner:

Full name	Rank	Signature	Date
Birhanu wordofa	_____	_____	_____

Chair of Department

Full name	Rank	Signature	Date
Leul Deribe	_____	_____	_____

ACKNOWLEDGMENT

Foremost, I would like to express my sincere gratitude to my advisors S/r Hawenie A. (MSc.) and S/r Fikerte Mariam (MSc.) for the continuous support of my MSc. thesis proposal, for their motivation, enthusiasm, and immense knowledge. Their guidance helped me in all the time of writing of this thesis proposal.

My sincere thanks also goes to Tizeta Ayalew for the long discussion on the topic of my research and my husband to support me in every aspect.

LIST OF ABBREVIATIONS

ANC	Antenatal Care
PNC	Postnatal Care
IUFD	Intrauterine Fetal Demise
PMR	Perinatal Mortality Rate
WHO	World Health Organization
PNM	Perinatal Mortality
SNNPR	South Nation National People Republic
MDG	Millennium Development Goal
TBA	Traditional Birth Attendant
NMR	Neonatal Mortality Rate

TABLE OF CONTENTS

ACKNOWLEDGMENT	iii
LIST OF ABBREVIATIONS	v
LIST OF FIGURES	x
LIST OF TABLES	xi
Abstract	12
1 Introduction	13
1.1 Background	13
1.2 Problem Statement	15
1.3 Significance of the Research	17
2 LITERATURE REVIEW	18
2.1 Perinatal Death	18
2.2 Perinatal Death and Coping Mechanism	18
2.3 Factors Associated with Perinatal Death	Error! Bookmark not defined.
2.4 Culture and Perinatal Loss	21
2.5 Conceptual Framework	22
3 OBJECTIVES OF THE RESEARCH	23
3.1 General Objective	23
3.2 Specific Objectives	23
4 METHODS AND PROCEDURE	24
4.1 Study Area and Setting	24
4.2 Study Design and Period	24
4.2.1 Source Population	24

4.2.2	Study Population	24
4.2.3	Eligibility Criteria	24
4.3	Sample Size _____	25
4.3.1	Quantitative study	25
4.3.2	Qualitative study	29
4.4	Study Variable _____	29
4.5	Operational Definition of Working Concepts of the Research _____	29
4.6	Method of data collection and procedure _____	32
4.6.1	Quantitative data collection tool	32
4.6.2	Qualitative data collection tool	32
4.7	Data quality control management _____	32
4.7.1	Quantitative study	32
4.7.2	Qualitative study	33
4.8	Data Analysis _____	34
4.8.1	Quantitative Data Analysis.....	34
4.8.2	Qualitative Data Analysis.....	34
4.9	Ethical Consideration _____	35
4.10	Dissemination of Result _____	35
5	RESULT _____	36
5.1	Maternal socio-economic and demographic factor _____	36
5.2	Maternal cultural characteristics, factors related to pregnancy and desire of pregnancy _____	38

5.3	Bereavement support of the mother _____	40
5.4	Delivery in institution or home _____	41
5.5	Coping mechanism _____	43
5.6	Factors associated with maternal coping following perinatal loss _____	53
6	Qualitative Analysis Result _____	56
6.1	Basic Information and Demographic Data _____	56
6.2	THEMATIC ANALYSIS _____	57
6.3	THEME EMERGED _____	58
6.3.1	Theme 1: Deep Emotional Response	58
6.3.2	Theme 2: Obsessed and Loss Hope.....	59
6.3.3	Theme 3: No Single Coping Mechanism fits all	60
6.3.4	Theme 4: Spiritual Faith Matters.....	61
6.3.5	Theme 5: Another Chance Another Baby	62
6.3.6	Theme 6: Loved ones Share	62
6.3.7	Theme 7: Informed and Involved in Health Care	63
7	Discussion _____	64
8	Conclusion and recommendation _____	66
8.1	Conclusion _____	66
8.2	Recommendation _____	66
9	STRENGTH AND LIMITATION OF THE STUDY _____	67
9.1	Strength of the study _____	67
9.2	Limitation _____	67
10	REFERENCES _____	68

11 APPENDICES	71
a. For Qualitative	71
b. For Quantitative	72
<i>CONSENT FORM FOR POSTNATAL FOLLOW UP MATHER (ENGLISH VERSION</i>	75

LIST OF FIGURES

Figure 1 conceptual Frame work for factors associated with maternal coping mechanism following perinatal death	22
Figure 2 Schematic presentation of sampling procedure on assessment of maternal coping mechanism following perinatal death in selected public hospital.....	28
Figure 3 Bereavement support of mother in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital, Addis Ababa, Ethiopia, March 1 to March 30 2018/	41
Figure 4 Health seeking behavior of mother in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital, Addis Ababa, Ethiopia, March 1 to March 30 2018/	42

LIST OF TABLES

Table 1: Maternal socio-economic and demographic factor in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital , Addis Ababa, Ethiopia, March 1 to March 30 2018/	36
Table 2: Maternal cultural characteristics, factors related to pregnancy and desire of pregnancy in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital, Addis Ababa, Ethiopia, March 1 to March 30 2018/.....	39
Table 3: Behavioral characteristics of the mothers in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital , Addis Ababa, Ethiopia, March 1 to March 30 2018/.....	42
Table 4: Coping mechanism of the mother after perinatal loss in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital , Addis Ababa, Ethiopia, March 1 to March 30 2018/.....	44
Table 5: Bivariate and Multivariate logistic regression indicating factors associated with maternal coping in Black Lion specialized Hospital, St. Paulo’s Millennium College & Gandhi Memorial Hospital, Addis Ababa, Ethiopia, March 1 to March 30, 2018.....	54

Abstract

Introduction: For most women, pregnancy is an emotionally charged experience representing the realization of dreams, hopes, and aspirations. Unfortunately, not all pregnancies result in the birth of a child. In Ethiopia EDHS 2016 report showed 236 per 1000 live birth and perinatal mortality also 33 per 1000. Worldwide, neonatal mortality accounts for 38 percent of all under five mortalities where 75 percent of the deaths took place during the first week of the neonatal period. For women who come across to this condition, there are wide range of coping strategies that can be used in a variety of situations.

Objectives: The main aim of the study was to assess the coping mechanism of women following perinatal death in selected three public hospitals in Addis Ababa.

Methods: Institution based Cross-sectional study for quantitative and thematic analysis for qualitative study was conducted from March 1– March30, 2018. The total sample size of 371 study participant were selected using random sampling technique.

Result: In this study a total of 371 participants give complete response. 168 (45.3%) had positive status on mother ability to cope following perinatal loss , the respondent who had friend support 3.86 times more likely cope the grief positively (AOR= 3.86,95% CI (2.087,7.135) compared with those who had no support, Among the factors secondary and more than secondary education was significantly associated with positively coping effect following perinatal loss with p-value <0.05. Applying thematic analysis on the interview seven themes were emerged as a result. The first two themes are related to emotional experience and the other five are related to coping mechanisms.

Conclusion: In all, the result of the study provides assessment of coping mechanisms that specifically focus on perinatal loss. Considering the severity of the perinatal death in the context Ethiopia, it has paramount importance to exploit and further extend this research results to guide mothers who will enter such situation.

1 Introduction

1.1 Background

According to WHO definition perinatal mortality as the “number of still birth and deaths in the first week of life per 1000 total births, the perinatal period commences at 22 completed weeks (154days) of gestation ends seven completed days after birth”. Other definition according to the International Classification of Diseases, a stillbirth or late fetal death is that which occurs after 22 weeks of gestation, or when the crown-heel length is 25 centimeters or more, and the weight is at least 500 grams (1). For the purpose of international comparison, stillbirth better described as fetal death at a gestational age of 28 completed weeks or a crown-heel length of 35 centimeters or more and birth weight is at least 1000 grams(2). In Ethiopia EDHS 2016 report showed 236 per 1000 live birth and perinatal mortality also 33 per 1000(2). Worldwide, neonatal mortality accounts for 38% of all under five mortalities where 75% of the deaths took place during the first week of the neonatal period. From the 6.3 million perinatal deaths (i.e. 3.3 million stillbirths and 3million early neonatal deaths) that were estimated to occur annually, 98% took place in developing countries(1).

Perinatal mortality study in Ethiopia the PMRs reported from ten hospital based studies were in the range of 66 to 124 per 1000 births. The reports of the large-scale community based PMRs were in the range of 37 to 52 per 1000 births. The proportion of stillbirths and early neonatal deaths reported from the hospital based and community-based studies was very high (60-110 and 20-34/1000 births (3).

For most women, pregnancy is an emotionally charged experience representing the realization of dreams, hopes, and aspirations. Unfortunately, not all pregnancies result in the birth of a child. For women who come across to this condition, there are wide range of coping strategies that can be used in a variety of situations. Regardless of the experience, coping is an integral part of day-to-day living and a necessary

component in navigating successfully through life's difficulties and hardships. There are both positive and negative coping strategies(5). In this thesis, 'coping strategies' refers to any method that women have used to successfully navigate through the difficult experience of perinatal death.

Perinatal death has been shadowing the joy of bearing children for many parents in the history of humankind. Though there is a decline in child mortality, still perinatal mortality is considerably high in the developing world (5).

Stages of Grief, The most widely known and frequently cited stages of grief are adapted from Psychiatrist Elisabeth Kubler-Ross's 1969 work *On Death and Dying*. These stages of grief based on her studies of the feelings of patients facing terminal illness, but, over the decades, many people have generalized them to apply to other types of negative life changes and losses, including the death of a loved one or the breakup of a relationship (6).

After a pregnancy loss, a woman might experience a range of emotions, like: Mother might find herself in shock or disbelief, also feel angry at the unfairness of her loss, loss of interest or pleasure in normal activities, intensely envy expectant parents also imagine what you would be doing with her baby now.

Other loved ones, including the baby's grandparents, might experience similar emotions including anxiety, bitterness and helplessness (17).

A positive experience of pregnancy WHO guideline provides global, evidence-informed recommendations on routine antenatal care, aims to capture the complex nature of the issues surrounding ANC health care practices and delivery, and to prioritize person-centered health and well-being, not only the prevention of death and morbidity (1).

1.2 Problem Statement

Ethiopia, as one of the developing countries is also suffering from high perinatal mortality. In Ethiopia, the perinatal mortality rate perinatal deaths that comprise stillbirths (loss that occurs after 7 months of gestation) and early neonatal (deaths of live births within the first week of life) have very high (2).

Mothers who have lost a pregnancy may encounter major emotional problems in adjustment during bereavement period. Perinatal loss is the most difficult situation for mothers. Since parents are not prepared for such situation, they are going to face this painful reality of the loss, then denial, and feeling that their world no longer makes sense. This are the most common way that parents reveal during this period(4).

The research findings indicate that women's perceptions of interpersonal and professional support impacted their grieving experience in both negative and positive ways. Women felt respected and supported when others acknowledged their grief and conveyed empathy and sensitivity towards them. Relationships with significant others were strengthened when women felt able to openly express their grief with others who shared a common understanding. In contrast, support was perceived as inadequate when women's grief was minimized or ignored, or when others responded insensitively to their loss. This often led to feelings of anger and hurt, and experiences of isolation and abandonment (16).

Perinatal mortality increases with mother's age at birth, from 28 deaths per 1,000 pregnancies for women age 20-29 to 63 deaths per 1,000 pregnancies for women age 40-49. This shows that perinatal mortality among children born to women age 40-49 is more than twice as high as for women age 20-29. The perinatal mortality rate is relatively high for first pregnancies (33 deaths per 1,000 pregnancies) and among women with a pregnancy interval of less than 15 months (45 deaths per 1,000 pregnancies). The perinatal mortality rate is higher in urban than in rural areas (42 versus 32 deaths per 1,000 pregnancies, respectively).

Study analysis has shown that demographic factors such as age at first birth, parity, birth order and birth interval are the main predictors of perinatal deaths(7)

In Ethiopia, coping mechanism following perinatal loss is different for individuals, women use different strategies to cope with repeated still birth and neonatal death and minimize the social consequences. They used traditional remedies such as taking herbal medicine or holy water and/or wearing necklaces made of parchment which is religious writing on it (16).

Several studies have been conducted on coping mechanism of different situations of life (such as physical, psychology).As coping mechanism depends on different situation and different contexts. Thus, in this research we will focus on the context of Ethiopia particularly to maternal coping following perinatal death.

This research aims to understand and explore women who have experienced pregnancy loss and provide enlightenment on how women cope, deal with, and manage following perinatal death, and how they move forward from the difficult experience. We will examine the positive and negative aspects of the participants' experiences, what impacted and influenced their coping, and how they were able to manage with and overcome their loss.

Generally, the aim of this study is to comprehensively explore and assess maternal coping mechanism and factors affecting perinatal death, which is essential to help Ethiopian mothers that utilize ANC, PNC and facility delivery.

This research is about assessing maternal coping mechanism following perinatal death (demonstrating by considering the context of Ethiopia in public hospital).

The scope of the research is limited in exploring maternal coping mechanism for perinatal death in Ethiopia. The research work focus on public hospital in Addis Ababa Ethiopia.

1.3 Significance of the Research

The result of the study proved assessment of coping mechanisms that specifically focus on maternity. Considering the severity of the perinatal death in the context of developing country particularly Ethiopia, it has paramount importance to exploit and further extend this research results to guide mothers who entered such situation. In general, the following research outcomes are anticipated from this work:

- An initial assessment of maternal coping mechanism for perinatal death specific to Ethiopian context.
- The magnitude of coping mechanisms following perinatal death and associated factors are useful for intervention for professionals and awareness creation
- Provide another opportunity to the community about the benefit of antenatal and postnatal follow up by supplementing good experience of coping mechanisms
- Provides researchers, practitioners and policy makers to further extend and provide a more enhanced way of approaching the situation.
- Contribute to Maternity Health discipline by providing the idea – list of mechanisms that existed within the community and help to extend further by collaborating with other disciplines such as psychology.

2 LITERATURE REVIEW

2.1 Perinatal Death

Perinatal deaths comprise stillbirths and early neonatal deaths (deaths of live births within the first 7 days of life). The causes of stillbirths and early neonatal deaths are somehow related. It is also difficult to differentiate the causes especially if there is no/less records of obstetrics management. The perinatal mortality rate comprises both stillbirths and early neonatal deaths, and offers a better measure of the level of mortality and quality of service at delivery (3).

According to the World Health Organization (WHO), the amount of neonatal death is about one third of the total mortality of age under five. Most of the neonatal mortality, which about three fourth of it happened during the first week the neonatal period. Due to various constraints of the region, developing countries neonatal mortality is much higher than (about 98 percent of the annually estimated neonatal death) in developed countries (1).

The highest risk to life for the mother and baby is consider during pregnancy and especially childbirth. If you see in terms of figure, the intra-partum related death accounts for over two fifth of the world's annual maternal deaths (2).

2.2 Perinatal Death and Coping Mechanism

In this section, presented those studies that are related to the context of my research work. My presentation included their major finding perinatal death and coping mechanism.

The first research is conducted in Kenya to assess the major factors that are associated with perinatal deaths. One of the major results of this study show that a perinatal death are significantly higher for women who have their first birth before reaching 20 years of age. The other result, socio-demographic factors were not significant. This

analysis underscores the need to examine predisposing factors for perinatal deaths and their contribution to the upsurge in infant mortality in Kenya (2).

Another recent study, suggest that mothers who have experienced perinatal loss can use two types of coping mechanisms to protect themselves and others from emotional distress in subsequent pregnancy, to reassure themselves, and to maintain hope that the pregnancy will result in a live birth. There is some evidence to suggest that mothers are aware that some of these coping strategies may affect their relationship with their unborn infant. What is unclear from these studies is whether this process is simply delayed and perhaps develops sometime later in pregnancy or postnatal (5).

Another study also documents the personal stories of women who undergone such situation, pregnancy loss and provide deep understanding of their experiences coping with perinatal loss. They used interviews with the mothers. This study uses a narrative approach to analyze seven in-depth interviews and the findings show that women benefit from having support during and after their perinatal loss, particularly from their spouse, family, friends, and health care providers. The research participants noted that they experienced silence and stigma surrounding perinatal loss, and that a considerable aspect of their coping involved talking openly about their experiences. (5).

Another literatures for maternal coping mechanism following perinatal death presented several area of effort and research into maternal coping mechanism following perinatal death has been evaluate how to cope mother after perinatal death and examine the factor to contribute perinatal death, the research results is described below. Related to factors associated with perinatal deaths in Kenya. There were 232 perinatal deaths and 6181 pregnancies in the five years preceding the survey. The results of the bivariate analysis indicate that among the socio-demographic factors, older woman and those whose first birth was after 30 years of age, women of birth order 7 and above and whose pregnancy interval was less than 15 months also had higher proportion of perinatal deaths. The results show that the odds of having a

perinatal death are significantly higher for women who have their first birth before reaching 20 years of age, for women with higher birth order (4+) and pregnancy intervals of less and more than 24 months. Socio-demographic factors were not significant. This analysis underscores the need to examine predisposing factors for perinatal deaths and their contribution to the upsurge in infant mortality in Kenya in line with the targets set for MDG(2).

Research examining complexities that women face following a pregnancy loss, childbearing literature suggests that women express a strong desire to conceive again. Deciding to try to conceive again often triggers conflicting emotions, self-doubt, insecurity, and fear of a further loss. In addition, women often report contradictory advice in relation to how long they should wait before trying to conceive again following pregnancy loss. A range of factors appear to influence the decision to try again, including maternal age, fears of infertility, the presence of other living children, the intensity of the grief following the loss and the perceived 'emotional readiness' to conceive again. The experience of subsequent pregnancy following pregnancy loss highlights the presence of ongoing and specific anxiety throughout the pregnancy. Many women worry about the outcome of their subsequent pregnancy and describe feelings of having lost their innocence and the ability to enjoy of being pregnant. To cope, women describe a tendency to 'hide' their subsequent pregnancy and keep their emotions guarded. Anxiety appears to be heightened around the anniversary of their baby's death (15).

Other literatures for maternal coping mechanism in cultural context the terms grief, mourning, and bereavement are often referred to synonymously when discussing loss, and are used interchangeably. However, there are slight differences in interpretation and it is important to understand these terms when exploring bereavement experiences. Grief is defined as the process of psychological, social and somatic reactions to the perception of loss. Mourning is defined as the public expression of grief. It is usually described as the process through which the bereaved individual works to undo the psychological bonds that bind them to the deceased. Bereavement

is defined as the state or condition of having experienced a loss, to which the individual must learn to adjust (11).

2.3 Culture and Perinatal Loss

Culture is defined as “the ideas, customs, and social behavior of a particular people or society”. Thus, culture can influence/shape an individual and vice-versa. Considering the definition of culture, it is then the major determinant of the response for actions, thoughts and behavior of an individual. It is also considered as ever-changing set of recommendations that ultimately influence the behavior and actions.

In light of this, the way how a person express his/her grief is largely determined by culture. It is also important to note culture is not the only factor rather the personal character has also its own share. Thus, investigating the concept of how grief and culture interact will also determine by that person experiences grief behaves. In all, grief is a common experience that every human share, however the way how people respond to loss depends on their own cultural practice (11).

2.4 Conceptual Framework

Conceptual framework adapted from different literature (2,9,10).

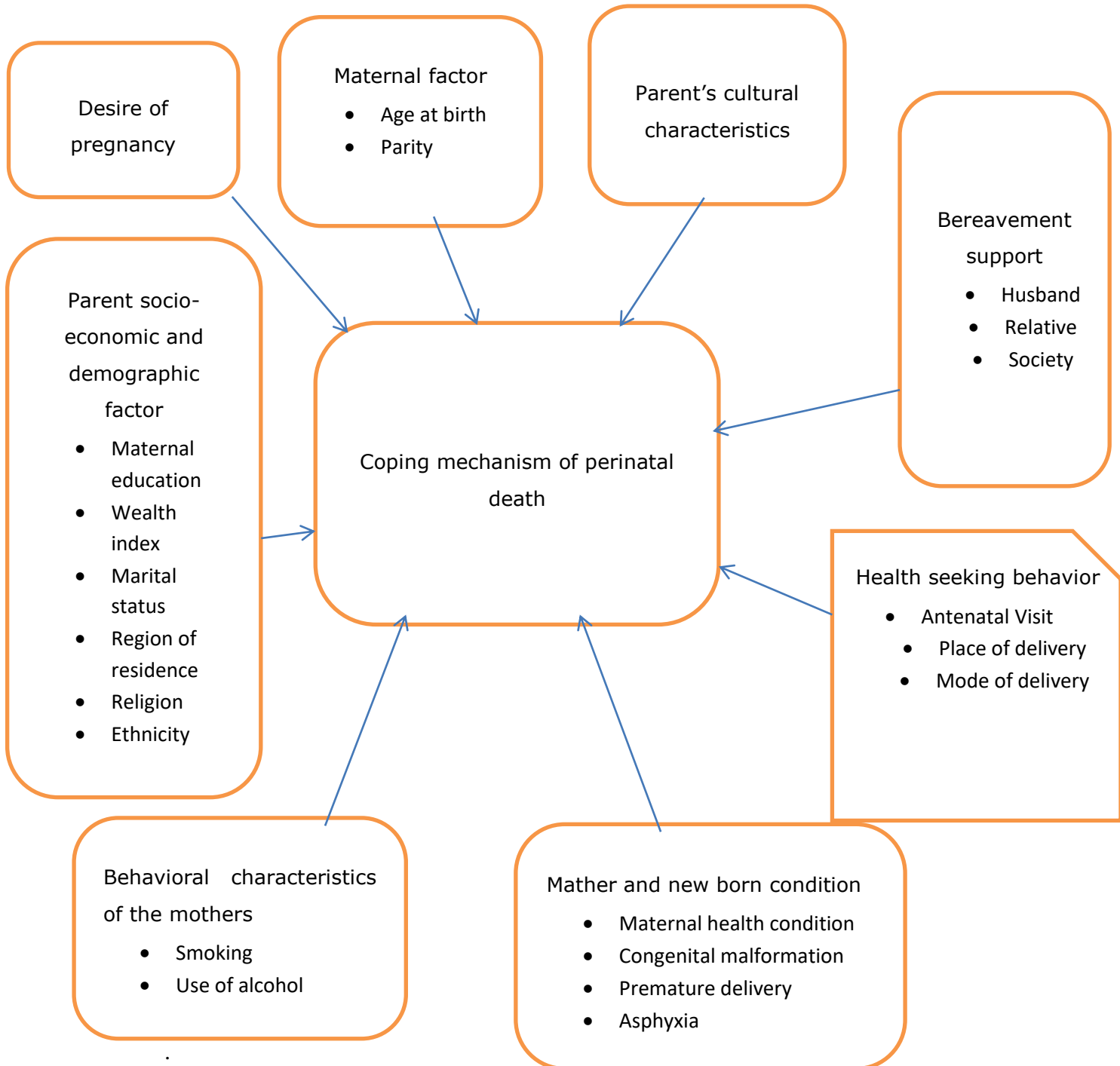


Figure 1 Conceptual Frame work for factors associated with maternal coping mechanism following perinatal death

3 OBJECTIVES OF THE RESEARCH

3.1 General Objective

To assess the coping mechanism of women following perinatal death in selected three public hospitals in Addis Ababa, Ethiopia, 2017-2018.

3.2 Specific Objectives

- Determine the coping mechanism that being used by Ethiopian mothers after the encountered perinatal death.
- Explore the major factors that affect maternal coping mechanism following perinatal death.
- Explore women experience level of grief pathway and coping status.

4 METHODS AND PROCEDURE

4.1 Study Area and Setting

Addis Ababa is a capital city of Ethiopia with area of 530 km² and total population of 3,384,569 according to the 2007 population census, with annual growth rate of 3.8%. Addis Ababa has highest concentration of health care facilities and health professionals. The study was conducted in three public hospitals (Tikur Anbessa specialized hospital, Gandhi Memorial hospital St Paulo's hospital millennium medical collage) of Addis Ababa. These three hospitals are the catchment area and maternal service coverage are similar.

4.2 Study Design and Period

Institution based Cross-sectional study for quantitative and thematic analysis for qualitative study was conducted from march1-march30, 2018.

4.2.1 Source Population

All women who were attend postnatal and ANC care service in three public hospitals.

4.2.2 Study Population

All women who were attend second visit in postnatal care service and ANC in selected public hospital during study period.

4.2.3 Eligibility Criteria

Inclusion Criteria

Those who come for postnatal and ANC care service and face perinatal death within the study period.

Exclusive Criteria

A woman's who came for postnatal and ANC care service and not face perinatal death within the study period and woman's who were involuntary.

4.3 Sample Size

4.3.1 Quantitative study

The actual sample size of the study was determined using the formula of single population proportion formula.

$$n = \frac{(Z\alpha/2)^2 p (1-p)}{d^2}$$

Where n = estimated sample size

$Z\alpha/2$ = Critical value at 95% confidence level of certainty (1.96)

P = prevalence

d = marginal error

To determine the sample size the following assumption was be used.

- Since there were no previous studies which estimate the assessment of maternal coping mechanism following perinatal death, a prevalence level that estimate maximum sample size (50%) was considered.
- A 95% confidence level, d (0.05).

$$n = \frac{(1.96)^2 \times 0.5(1-0.5)}{(0.05)^2} = 384$$

A 10% non-respondent rate were added to: $384 \times 0.1 = 38.4 = 38$

Therefore, the total sample size (n) was 422.

- Since the total population is less than 10,000, correction formula was used as follows:

$$n = \frac{no}{N}$$

$$1 + \frac{no}{N}$$

$$N$$

$$n = \frac{422}{1652}$$

$$(1 + \frac{422}{1652})$$

$$1652$$

$$n = 337$$

Then, considering 10% for non-responsive rate

$$n = 337 * 0.1 = 33.7$$

$$n = 337 + 33.7$$

$$n = 371$$

Sample procedure for quantitative study

Out of eleven governmental Hospitals three of them (Black Lion specialized Hospital, Gandhi Memorial Hospital & St Paulo's hospital millennium medical collage) were selected purposively due to they have many (subjective) case flow in labour, ANC & PNC and also they have large catchment area. In the next step the proportional allocation of samples were done on the selected facility based on the total number of Mather who visit postnatal ANC care per month then individuals was selected by random sampling method until the required sample.

- Proportional sample size allocation formula= $ni * nf / N$

Where n_i = number of women receive postnatal and ANC service each hospital.

Black lion =522.

Gandhi memorial=660.

St Paulo's hospital=470

n_f = final sample size

N = total number of women receive postnatal and ANC service in three hospital per month. (1652)

n for black lion hospital=117.

n for Gandhi hospital=148.

n for St Paulo's hospital==106

Then each study participant was selected random sampling technique.

Addis Ababa town public hospitals

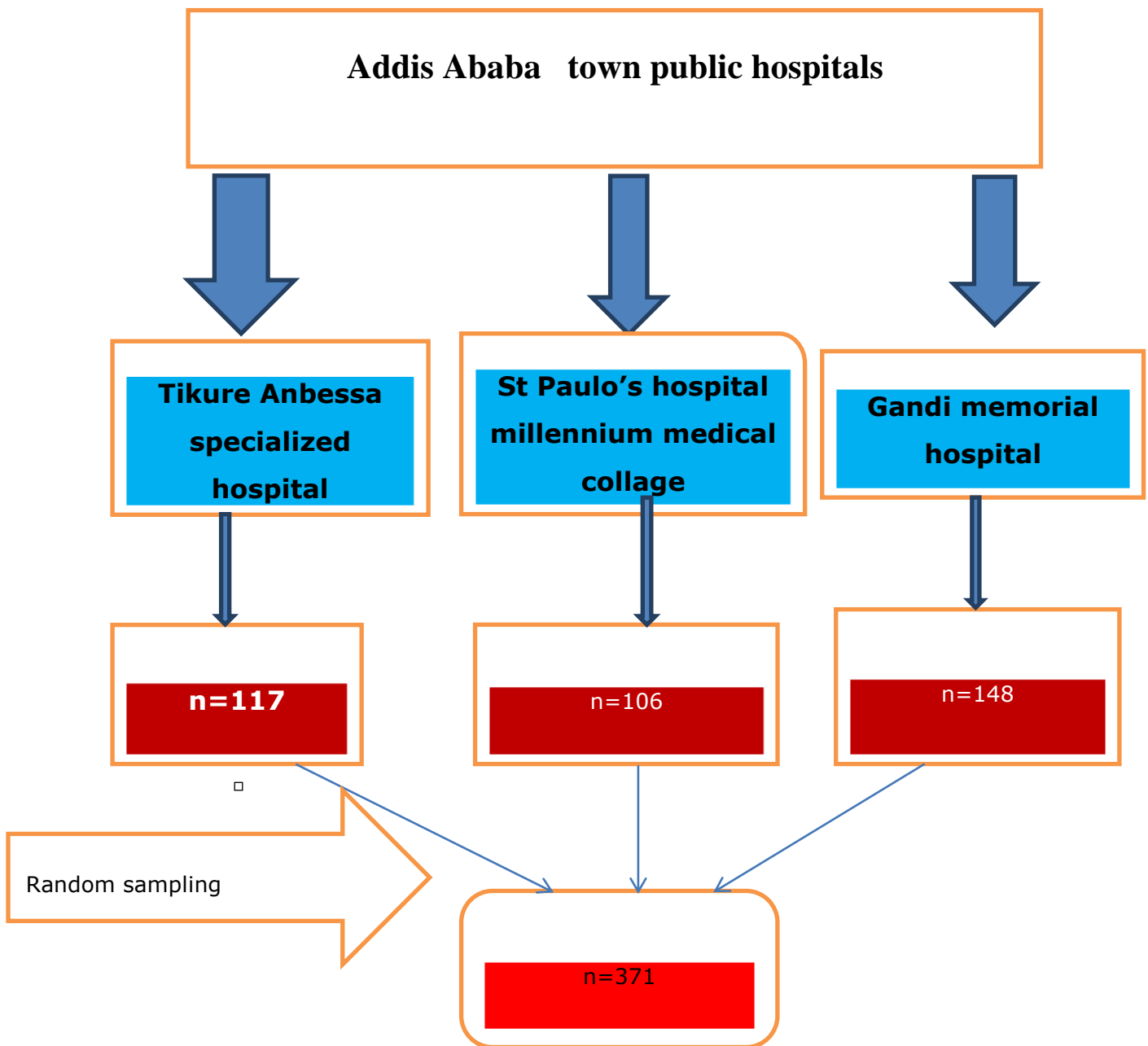


Figure 2 Schematic presentation of sampling procedure on assessment of maternal coping mechanism following perinatal death in selected public hospital.

4.3.2 Qualitative study

The sample size for qualitative study was determined by purposely selecting of women who had history of perinatal death until level of data saturation was achieved in the selected Hospital.

4.4 Study Variable

Dependent Variable

- Maternal coping

Independent Variable

- Desire of pregnancy,
- Maternal factor,
- Parent's cultural characteristics,
- Bereavement support,
- Parent socio-economic and demographic factor,
- Behavioral characteristics of the mothers,
- Pregnancy outcome
- Health behavior

4.5 Operational Definition of Working Concepts of the Research

In this section, we provide working definitions and explanations of the keywords (key terms and concepts) of the research. These working definitions helped to understand the research context and the overall concepts.

Coping

Positive coping: women ability to handles stresses successfully and the way that a person deals with issues.

Constantly changing and behavioral efforts that are believed to be challenging or difficult.

Negatively Coping: Women unable to cope stressful situation

Coping Mechanism

Coping mechanisms are ways to which external or internal stress is managed, adapted to or acted upon.

Perinatal death

A perinatal death is a fetal death (stillbirth) or an early neonatal death. It is also known as perinatal mortality (PNM). It is also the basis to calculate the perinatal mortality rate.

Stillbirth

Stillbirth is typically defined as fatal death at or after 20 to 28 weeks of pregnancy. It results in a baby born without signs of life. A stillbirth can result in the feeling of guilt in the mother.

IUFD

Intrauterine fatal demise is the term for stillbirth used to describe the death of a baby in the uterus. The term is usually applied to losses at or after the 20th-28th week of gestation.

Live Birth

A live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of

the umbilical cord, or any definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

Bereavement:

Bereavement is defined as the entire process precipitated by loss through death. In this research the bereaved are mothers who have lost a pregnancy.

Desire of pregnancy

To need or want to have pregnant and caring baby in maternal womb.

Health behaviour

Health behavior an action taken by a person to maintain, attain, or regain good health and to prevent illness.

4.6 Method of data collection and procedure

4.6.1 Quantitative data collection tool

Data was collected using self-administered and interview a structured questionnaire with seven parts namely, Socio-Economic demographic characteristics, maternal & cultural factor, desire of pregnancy, health seeking behavior, behavioral characteristics of mother and newborn condition.

4.6.2 Qualitative data collection tool

A semi-structured in depth interview was conducted per participant, in the first phase the data was collected through one-on-one a semi-structured In-depth exit interview was done with audio recorded 15-20 min after the mother completed postnatal and ANC checkup & written informed consent was obtained from the study participant, participant were answer question related to situation and setting that could lead to coping mechanism of mother after perinatal loss this interview also creating easiness and developing trust., the interview was done individually in a convenient place to assure confidentiality, privacy as well as to avoid dissemination of information to other study on mother who had experienced perinatal loss the interview was carried out the following, risk factors for perinatal death, cultural norms, access to facilities, their perceptions regarding perinatal loss perinatal grief experience related to difficulties they had encountered strategies that had helped them to cope with their problems, women's experiences and, as well as coping mechanism and the meaning they provide fore there experience follow perinatal loss , was used to gain a detailed picture of accounts of mother until the data saturate.

4.7 Data quality control management

4.7.1 Quantitative study

Data quality was ensured through pre-test was done by using 10 % of the sample size out of study health facility before actual data collection, to test consistency and clarity

of the tool and modifications was made accordingly , first was developed in English and translated to local language (Amharic) and retranslated again to English to check for its consistency and completeness by adapted from different literature. one MSc student supervisor and 3 BSc data collector having at least two years' experience who are working within the study health facility was recruited and a one day training on how to use the study tool, ethical issue, handling participants and communication with supervisor & investigator. Data collectors should check for data completeness and missing values every day before submitting it to the supervisor and if there any ambiguity, they were discussed with the investigator The investigator assign code for data collectors to help the data to enter and data was checked for completeness, consistency, coded and entered into EPI Info (version 3.5.1) and was transferred to (SPSS version 204.00 for analysis).

4.7.2 Qualitative study

The questionnaires were tested to the mother who follows PNC and ANC at out of study area one week prior to the actual data collection period in order to avoid any confusion during actual data collection period. This is helpful for the investigator to screen out vague questions and modify some of the question item as soon as possible.

Check on validity, ongoing interpretation of the data including identification of theme, a topic guide was used to ensure a similar range of topics were discussed with each participant until data was saturated where no new themes during In- depth interview with women who have history of perinatal death, principal investigator was used tape recorder and note was taken. Ethical issue, handling participants and communication were done by principal investigator. The data collected within a day was done after checking its completeness

4.8 Data Analysis

4.8.1 Quantitative Data Analysis

The investigator assign code for data collectors to help the data to enter and data was checked for completeness, consistency, coded and entered into EPI Info (version 3.5.1) and was exported to (SPSS version 24.00 for analysis). Descriptive statics was computed to determine frequencies and summary statistics to describe socio demographic characteristics and other variables. All independent variables with p value less than 0.5 at bivariate analysis was entered into multivariate logistic regression to control for all possible confounders and to test association between independent and outcome variable.

4.8.2 Qualitative Data Analysis

Data analysis of the quantitative analysis are made from the in-depth interview data obtained from the narrative description, as a beginning of the analysis individual interview and audio records was transcribed using the rule of transcription and then was code or identify informant words or phrases in sentence related and relevant to the area of study. An in depth analysis of the thematic analysis was presented in chapter six.

The researcher describe the structure of the experience based on reflection and interpretation the research participants story was categorization group the data and then look for similarities and differences, in which the identified codes were stored in to relevant categories finally the main themes was identified, then Coding and categorizing was done then thematic analysis was carried out and representative quotes was presented during the analysis. All interviews and audio was recorded and translated into Amharic and then to English.

4.9 Ethical Consideration

Ethical clearance and approval was obtained from the Ethical Committee of department of Nursing and midwifery, college of health science, Addis-Ababa University. Then, letter from the Research Ethics Committee was submitted to Tikure Anbessa, Gandhi memorial hospital & St Paulo's hospital millennium medical college. Letter of permission was obtained from Addis Ababa Health Bureau to selected hospital. Permission letter from Addis Ababa was submitted to each hospital. After explaining the objectives of the study in detail, verbal consent was taken from all study participants. All the participants were reassured of the anonymity, and as personal identifiers was not is used.

4.10 Dissemination of Result

The results of the study was disseminated or communicated to Addis Ababa University College of Health Science school of Allied Health science Department of Nursing and Midwifery, Addis Ababa health bureau and other concerned bodies through reports and publication on an appropriate journal. Efforts were made to present the results of the study on scientific conferences and publications will be considered.

5 RESULT

5.1 Maternal socio-economic and demographic factor

In present study assessment of maternal coping mechanisms following perinatal death in three public hospital (Black Lion specialized Hospital, St. Paulo's Millennium College & Gandhi Memorial Hospital), the mother requested to fill self-administered questioner. 371 of study participants fill the questioner completed, Majority 323 (87.1 %) of respondents were married, 28(7.5%) widowed & 28 (7.5%) single, the age of the mother 6 (1.6%) were less than18year, 47 (12.7%) greater 35 year and 318 (85.7%) were less than 35year Distribution of mother according to education level showed that 127 (34.2%) participant were educated degree and above followed by diploma 97(26.1%), 96(25.9 %) up to secondary the rest is illiterates 51(13.7%). The dominant ethnic group of the study participant were Amhara 127 (34.2 %) followed by 95 (25.6 %), Gurage, 69(18.6%) Oromo & 23 (6.2 %) Tigree the rest other 57(15.4) .majority of the religious of the group was Orthodox 190 (51.2 %) followed Muslim1147 (39.6%) protestant 34 (9.2%) (Table 1).

Table 1: Maternal socio-economic and demographic factor in Black Lion specialized Hospital ,St. Paulo's Millennium College & Gandhi Memorial Hospital , Addis Ababa, Ethiopia, March 1 to March 30 2018/

Variable	Category	Frequency	Percent
Maternal education	Illiterate	51	13.7 %
	high school completed	96	25.9%
	diploma	97	26.1
	Degree and above	127	34.2

	Others		
Age	< 18	6	1.6 %
	<35	318	85.7 %
	>35	47	12.7%
Ethnicity	Amahara	127	34.2%
	Gurage	95	25.6%
	Tigree	23	6.2 %
	Oromo	69	18.6%
	Other(specify)_	57	15.4 %
Religion	Orthodox	190	51.2%
	Islam	147	39.6 %
	Protestant	34	9.2 %
Marital status	Single	20	5.4%
	Married	323	87.1%
	Widowed	28	7.5%

5.2 Maternal cultural characteristics, factors related to pregnancy and desire of pregnancy

96 (25.9%) Participants believed that new-born deaths and stillbirths are hidden the rest 43(11.6%), 232 (62.5%) attend secretly & No need of exaggeration respectively, 61(16.4%) study participant who perceive cause of the of stillbirth and neonatal death malevolent spirits , 310(83.6 %)of the participant were not believe perinatal loss due to malevolent spirits, 166 (44.7%) of mother accepted burial practice depending on the age, 205 (55.3%) not accepted the idea, Mother who participated in this study had experienced obstetrical problem during perinatal loss, (%) prolonged labor,70 (18.9%) Rupture of the uterus, 12 (3.2%) other problem 102 (27.5%) and 187(50.4%) not having problem, two third (more than one third no (%) participants had other living children, while no (%) don't have living children

Table 2: Maternal cultural characteristics, factors related to pregnancy and desire of pregnancy in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital, Addis Ababa, Ethiopia, March 1 to March 30 2018/

Variable	Category	Frequency	Percent
New-born deaths and stillbirths are hidden	.Hidden	96	25.9%
	Attend secretly	43	11.6 %
	No need of exaggeration	232	62.5 %
Burial practice is age-based	Yes	166	44.7%
	No	205	55.3%
Stillbirth and neonatal death are mostly due to malevolent spirits	Yes	61	16.4 %
	No	310	83.6%
have children	Yes	222	59.8%
	No	149	40.2 %
Age during child birth	< 35	354	95.4%
	>35	17	4.6 %
Want another pregnancy	Wanted then	286	77.1 %
	Wanted later	61	16.4 %
	Wanted no more	24	6.5 %
problem for perinatal loss	None	187	50.4 %

during delivery	Prolonged labor	70	18.9 %
	Ruptured uterus	12	3.2 %
	Other	102	27.5 %

5.3 Bereavement support of the mother

positive support present from the husband 333(89%) ,parent 312 (84.1%), friends 289(77.9%), and 307(82.7%) medical following perinatal loss, 64(17.3%) mother who do not get proper medical service, 59(15.9%) not supported by family, 82 (22.1%) Friends, 15.9% parents and 38(10.2%) husband.

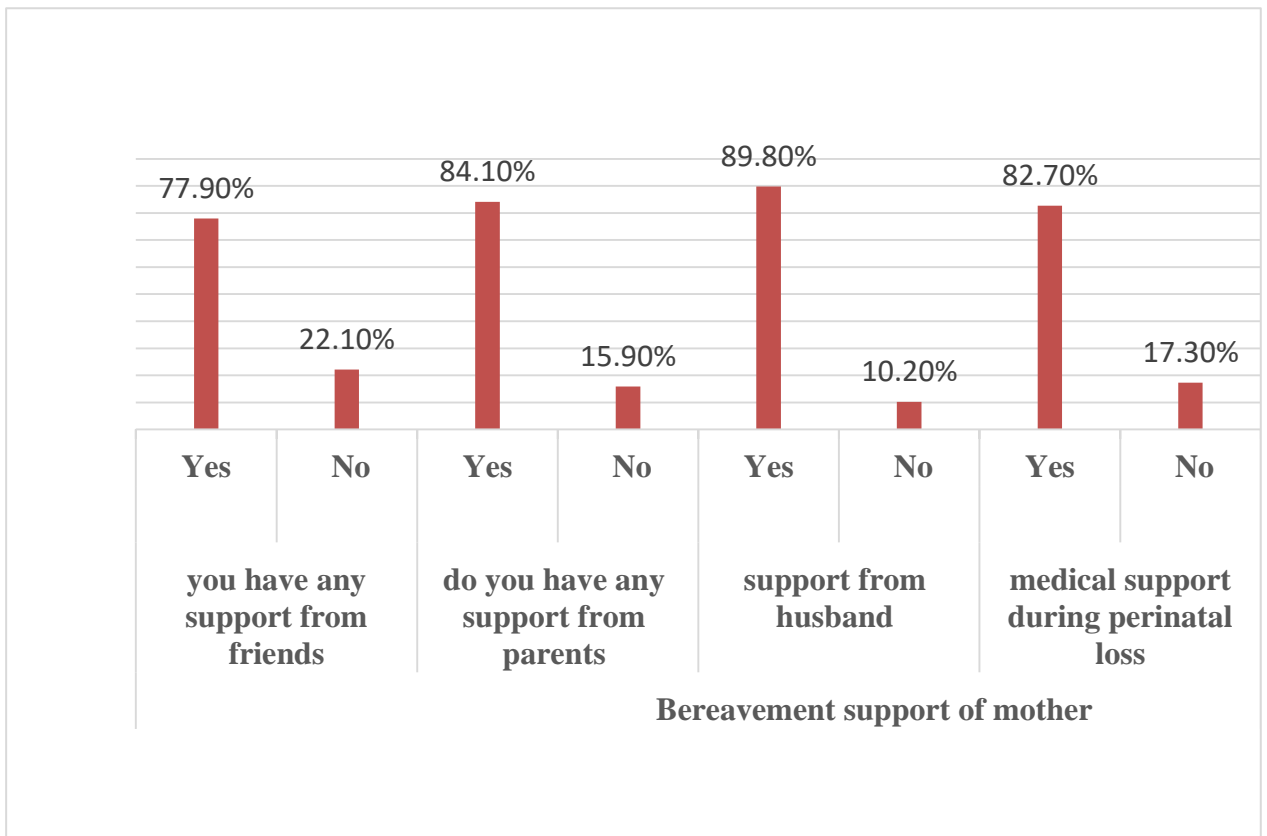


Figure 3 Bereavement support of mother in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital, Addis Ababa, Ethiopia, March 1 to March 30 2018/

5.4 Delivery in institution or home

Out of 371 women, 254(68.5%) delivered by SVD, 117 (31.5%) by Caesarean section as well as 364 (98.1%) gave birth in the Health institute and 7(1.9. %) home delivery, 364(98.1%) managed by trained birth attendant and by 7(1.9%) TBA.

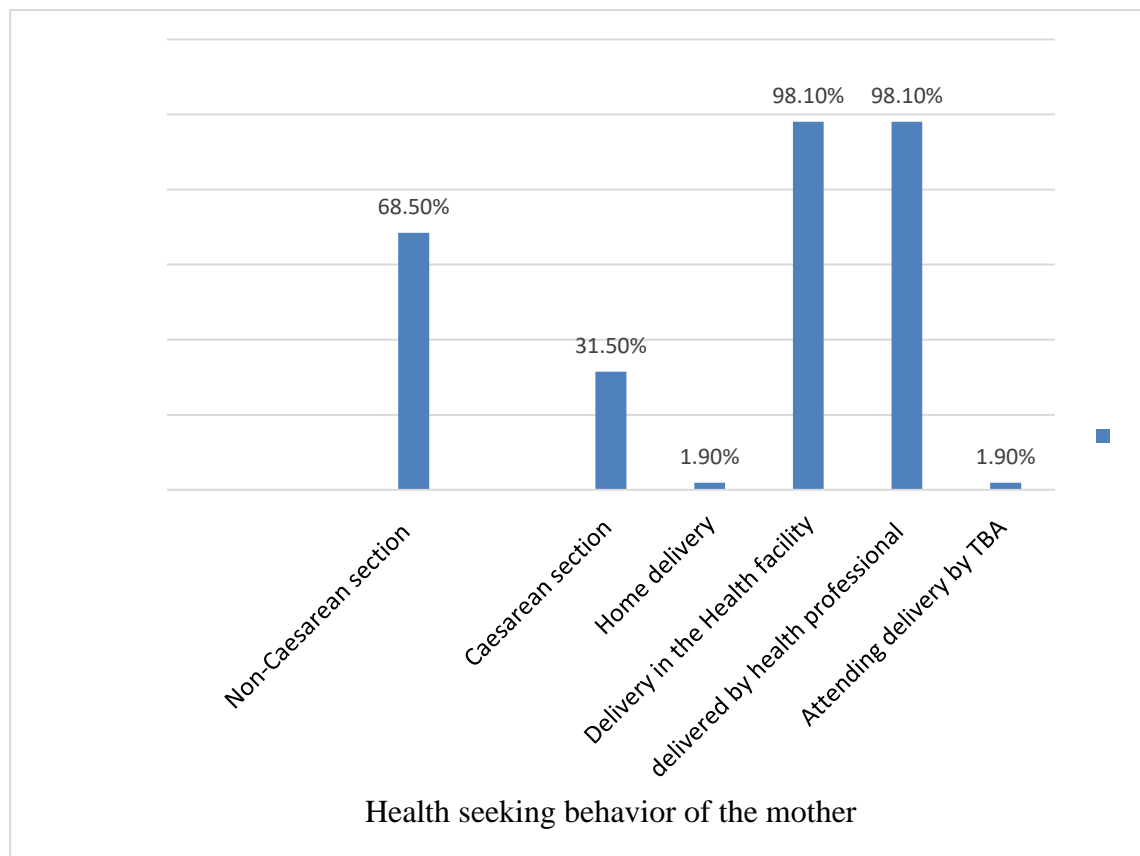


Figure 4 Health seeking behavior of mother in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital, Addis Ababa, Ethiopia, March 1 to March 30 2018/

Among 371 of participant 54 of them reported that they use different type of substance, these include 45 (12.1%) of them were consumed alcohol, 9 2(4%) were smock cigarette, 41 (91.1%) alcohol use before perinatal loss and 4(8.9%) after perinatal loss, smock cigarette 3(33.3) before & 6(66.7) after perinatal loss.

Table 3: Behavioral characteristics of the mothers in Black Lion specialized Hospital ,St. Paulo’s Millennium College & Gandhi Memorial Hospital , Addis Ababa, Ethiopia, March 1 to March 30 2018/

Variable	Category	Frequency	Percent
smoking	Yes	9	2.4%
	No	362	97.6 %
when do you start	After perinatal loss	6	
	Before perinatal loss	3	
alcohol	Yes	45	12.1%
	No	326	87.9%
If yes, when do you start?	After perinatal loss	4	8.9%
	Before perinatal loss	41	91.9 %

--	--	--	--

5.5 Coping mechanism

Lazarus transaction stress model assessing the women by 4 point likert scale a women ability of coping mechanism after perinatal loss, 203(54.7%) has negative effects on mother ability to cope following perinatal loss (< mean score (38)) while 168 (45.3%) had positive effects on mother ability to cope following perinatal loss , women use varies strategy of coping mechanism after perinatal loss and also have different Level of stress , 166 (44.7%) of participant agree and strongly agree 173(46.6%) by concentrating their effort on doing something other than focusing on current stress , 24(6.5%)disagree and 8 (2.2%)strongly disagree on this idea , women with the history of perinatal loss have 177 (47.7%) agree & 107 (28.8%) strongly agree to get emotional support from other 84 (22.6%) disagree & 3 (8 %) strongly disagree on this opinion, majority of the bereaved mother 121(32.6%) agree & 116 (31.1%) strongly agree to take action try to make situation better , bereaved mother 121(32.6) disagree and 13(3.5%) strongly disagree to take action try to make situation better. Among the study participant majority of them 156 (42%) agree and 80 (21.6%) strongly agree perinatal loss was not occur in their real situation, 109 (29.4%) disagree and 26 (7%) strongly disagree they believe of perinatal loss was not occur in real circumstance. although after perinatal loss those parents 113 (30%) agree and 60 (16.2%)strongly agree perinatal loss due to their fault , majority of them 145 (39.1%) disagree and 53(14.3 %) strongly disagree on blaming themselves for the death, 165 (44%) disagree and 9 (2.4%) strongly disagree on feel something good in what is happening , the rest of the study participant 126 (34%) agree and strongly agree , 71 (19.1%) on feel something good in what is happening. Further higher present of study participant use different ways of coping strategy to control or moderate internal and external demands in stress full circumstance after their perinatal loss. Those who were agree and strongly agree on the following strategy 136 (36.7) agree, 117(31.5) strongly agree trying to see it in a different light, to make it seem more positive.

177(47.7%) Agree and 107(28.2%) strongly agree I've been getting help and advice from other people. 174 (46.9) & 96(25.9%) strongly agree I've been getting comfort and understanding from someone. 218 (58.8%) Agree & 87 (23.5%)strongly agree I've been accepting the reality of the fact that it has happened, 192 (51.8%) & 119 (32.1)I've been trying to find comfort in my religion or spiritual beliefs, 99(26.5%)& 19 (5.1%) , 84(22.6%) & 3(8%),86(23.2%) & 15 (4.4%),42(11.3%)& 24 (6.5%), 36 (9.7%) and 24 (6.5%) were disagree and strongly disagree to use these strategy,

Table 4: Coping mechanism of the mother after perinatal loss in Black Lion specialized Hospital ,St. Paulo's Millennium College & Gandhi Memorial Hospital , Addis Ababa, Ethiopia, March 1 to March 30 2018/

Coping strategy			
Variable	Category	Frequency	Percent
I've been concentrating my efforts on doing something about the situation I'm in.	agree	166	44.7 %
	strongly agree	173	46.6 %
	disagree	24	6.5 %
	strongly disagree	8	2.2 %
I've been getting emotional support from others.	Agree	177	47.7 %
	strongly agree	107	28.8 %
	disagree	84	22.6 %
	strongly disagree	3	8 %
Taking action to try to make the situation better.	agree	121	32.6 %
	strongly agree	116	31.3 %

	disagree	121	32.6 %
	strongly disagree	13	3.5 %
I've been saying things to let my unpleasant feelings escape.	agree	159	42.9 %
	strongly agree	107	28.8 %
	disagree	70	18.9 %
	strongly disagree	35	9.4 %
I've been getting help and advice from other people.	agree	177	47.7 %
	strongly agree	107	28.8 %
	disagree	84	22.6 %
	strongly disagree	3	8 %
I've been trying to see it in a different light, to make it seem more positive.	agree	136	36.7 %
	strongly agree	117	31.5 %
	disagree	99	26.7 %
	strongly disagree	19	5.1 %
I've been getting comfort and understanding from someone.	agree	174	46.9 %
	strongly agree	96	25.9 %
	disagree	86	23.2 %
	strongly disagree	15	4 %
I've been looking for something good in what is happening.	agree	126	34 %
	strongly agree	71	19.1 %
	disagree	165	44.5 %

	strongly disagree	9	2.4 %
I've been accepting the reality of the fact that it has happened.	agree	218	58.8%
	strongly agree	87	23.5 %
	disagree	42	11.3 %
	strongly disagree	24	6.5 %
I've been expressing my negative feelings.	agree	217	58.5 %
	strongly agree	70	18.9 %
	disagree	38	10.2 %
	strongly disagree	46	12.4 %
I've been trying to find comfort in my religion or spiritual beliefs.	agree	192	51.8 %
	strongly agree	119	32.1 %
	disagree	36	9.7 %
	strongly disagree	24	6.5 %
I've been trying to get advice or help from other people about what to do	Agree	183	49.3 %
	strongly agree	92	24.8 %
	disagree	71	19.1 %
	strongly disagree	25	6.7 %
I've been learning to live with it.	agree	207	55.8 %
	strongly agree	67	18.1 %
	disagree	80	21.6 %
	strongly disagree	17	4.6 %

I've been praying or meditating.	agree	133	35.8 %
	strongly agree	158	42.6 %
	disagree	24	6.5 %
	strongly disagree	56	15.1 %
Not Coping strategy			
Saying to myself "this isn't real".	agree	156	42 %
	strongly agree	80	21.6 %
	disagree	109	29.4 %
	strongly disagree	26	7 %
Using alcohol or other drugs to make myself feel better.	agree	26	7 %
	strongly agree	19	5.1 %
	disagree	143	38.5%
	strongly disagree	183	49.3 %
I've been giving up trying to deal with it.	agree	148	39.9 %
	strongly agree	88	23.7%
	disagree	107	28.8 %
	strongly disagree	28	7.5 %
I've been refusing to believe that it has happened.	agree	96	25.9 %
	strongly agree	55	14.8 %
	disagree	181	48.8 %
	.strongly disagree	39	10.5 %

I've been criticizing myself.	agree	113	30.6 %
	strongly agree	60	16.2 %
	disagree	145	39.1 %
	strongly disagree	53	14.3 %
I've been giving up the attempt to cope.	agree	85	22.9 %
	strongly agree	76	20.5 %
	disagree	168	45.3 %
	strongly disagree	42	11.3 %
I've been thinking hard about what steps to take.	agree	185	49.9%
	strongly agree	73	19.7 %
	disagree	69	18.6 %
	strongly disagree	44	11.9 %
I've been blaming myself for things that happened.	agree	145	39.1%
	strongly agree	63	17 %
	disagree	115	31 %
	strongly disagree	48	12.9 %
Variable	Category	Frequency	Percent
I've been concentrating my efforts on doing	agree	166	44.7 %
	strongly agree	173	46.6 %
	disagree	24	6.5 %

something about the situation I'm in.	strongly disagree	8	2.2 %
Saying to myself "this isn't real".	agree	156	42 %
	strongly agree	80	21.6 %
	disagree	109	29.4 %
	strongly disagree	26	7 %
Using alcohol or other drugs to make myself feel better.	agree	26	7 %
	strongly agree	19	5.1 %
	disagree	143	38.5%
	strongly disagree	183	49.3 %
I've been getting emotional support from others.	Agree	177	47.7 %
	strongly agree	107	28.8 %
	disagree	84	22.6 %
	strongly disagree	3	8 %
I've been giving up trying to deal with it.	agree	148	39.9 %
	strongly agree	88	23.7%
	disagree	107	28.8 %
	strongly disagree	28	7.5 %
Taking action to try to make the situation better.	agree	121	32.6 %
	strongly agree	116	31.3 %
	disagree	121	32.6 %

	strongly disagree	13	3.5 %
I've been refusing to believe that it has happened.	agree	96	25.9 %
	strongly agree	55	14.8 %
	disagree	181	48.8 %
	.strongly disagree	39	10.5 %
I've been saying things to let my unpleasant feelings escape.	agree	159	42.9 %
	strongly agree	107	28.8 %
	disagree	70	18.9 %
	strongly disagree	35	9.4 %
I've been getting help and advice from other people.	agree	177	47.7 %
	strongly agree	107	28.8 %
	disagree	84	22.6 %
	strongly disagree	3	8 %
I've been trying to see it in a different light, to make it seem more positive.	agree	136	36.7 %
	strongly agree	117	31.5 %
	disagree	99	26.7 %
	strongly disagree	19	5.1 %
I've been criticizing myself.	agree	113	30.6 %
	strongly agree	60	16.2 %
	disagree	145	39.1 %
	strongly disagree	53	14.3 %

I've been getting comfort and understanding from someone.	agree	174	46.9 %
	strongly agree	96	25.9 %
	disagree	86	23.2 %
	strongly disagree	15	4 %
I've been giving up the attempt to cope.	agree	85	22.9 %
	strongly agree	76	20.5 %
	disagree	168	45.3 %
	strongly disagree	42	11.3 %
I've been looking for something good in what is happening.	agree	126	34 %
	strongly agree	71	19.1 %
	disagree	165	44.5 %
	strongly disagree	9	2.4 %
I've been accepting the reality of the fact that it has happened.	agree	218	58.8%
	strongly agree	87	23.5 %
	disagree	42	11.3 %
	strongly disagree	24	6.5 %
I've been expressing my negative feelings.	agree	217	58.5 %
	strongly agree	70	18.9 %
	disagree	38	10.2 %

	strongly disagree	46	12.4 %
I've been trying to find comfort in my religion or spiritual beliefs.	agree	192	51.8 %
	strongly agree	119	32.1 %
	disagree	36	9.7 %
	strongly disagree	24	6.5 %
I've been trying to get advice or help from other people about what to do	Agree	183	49.3 %
	strongly agree	92	24.8 %
	disagree	71	19.1 %
	strongly disagree	25	6.7 %
I've been learning to live with it.	agree	207	55.8 %
	strongly agree	67	18.1 %
	disagree	80	21.6 %
	strongly disagree	17	4.6 %
I've been thinking hard about what steps to take.	agree	185	49.9%
	strongly agree	73	19.7 %
	disagree	69	18.6 %
	strongly disagree	44	11.9 %
I've been blaming myself for things that happened.	agree	145	39.1%
	strongly agree	63	17 %
	disagree	115	31 %
	strongly disagree	48	12.9 %

I've been praying or meditating.	agree	133	35.8 %
	strongly agree	158	42.6 %
	disagree	24	6.5 %
	strongly disagree	56	15.1 %

5.6 Factors associated with maternal coping following perinatal loss

Bivariate and multivariate analysis was carried out to identify factors contributing to positive effect of coping following perinatal loss. In the Binary logistic regression analysis variables among maternal socio- economic and demographic factor variables, marital status, education, maternal factor and desire of pregnancy variables, having children, age during child birth, from the bereavement support, medical ,parental, friend and husband support following perinatal loss which were found to be significantly associated with positive effect of coping mechanism after perinatal loss . All variables that have statically significant association with outcome variable in bivariate analysis were included in multivariate logistic regression model.

Multivariate logistic regression analysis was used to minimize the effect of confounding variables and to identify the real factors contributing to maternal coping following perinatal loss, maternal educational status ,marital status, have support from friend and age during child birth. Acordingly, while were depending variable or variable those have 0.05at 95% CI declared to be significantly associated with positive effect of coping mechanism after perinatal loss. The logistic regression analysis found out the mother who have supported from friend 3.86 times more likely cope the grief positively (AOR= 3.86,95%CI (2.087,7.135) compared with those who had no support from friend following perinatal loss , .

Among the factors secondary and more than secondary education was significantly associated with positively coping status following perinatal loss with p-value <0.05.

Bereavement mother Degree and above 1.748 times (AOR=1.748, 95%CI: .887, 3.445) were more likely to be positively coping grief than uneducated.

Table 5: Bivariate and Multivariate logistic regression indicating factors associated with maternal coping in Black Lion specialized Hospital, St. Paulo's Millennium College & Gandhi Memorial Hospital, Addis Ababa, Ethiopia, March 1 to March 30, 2018

Variables	Category	Coping status follow perinatal loss		COR	AOR
		Yes	No		
your age during child birth	< 35	159(44.9)	195(55.1%)	4.074 (1.151, 14.425)	.708 (.130,3.852)
	>35	9(52.9)	8 (47.1)	1	
Have support from friends	Yes	151(89.9%)	17(10.1. %)	4.184(2.339, 7.485)	3.859(2.087,7.135) ***
	No	138(68%)	65(32%)	1	
Education	No education	28(16.7%)	23(11.3%)	1	
	High school completed	28(16.7%)	68(35.5%)	.691 (.357,1.337)	.440 (.231,.997) *

	Diploma	31(18.5%), 66(32.5%)	.234 (.132, .413) , 440 (.216,.893) *
	Degree and above	81(48.2%), 46 (22.7%)	.267 (.152, .467) , 1.748 (.887 , 3.455)
Marital status	Single	5 (3%), 15(7.4%)	1
	Married	160 (95.2%), 163(80.3%)	2.778 (.579, 13.325) , 2.049 (.658,6.383)
	Widowed	3(1.8%), 25 (12.3%)	8.180 (2.422, 27.631), .767 (.140 ,4.215)

Note: Significant at, * ($P < 0.05$), ** $P \leq 0.01$, *** $P \leq 0.001$

6 Qualitative Analysis Result

6.1 Basic Information and Demographic Data

This section presents analysis of the basic information and demographic data. This result showed some similarities among the participants that include their sexual behavior and living status. All the participants are heterosexual, and their living status are quite similar, all have monthly incomes. In terms of occupation two of the participants are house wife and three of them are government workers and one merchant. Considering, their age at the time of the perinatal death, it ranged from 21 to 40. The participants have different religious beliefs that includes Christianity and Islam. We identified that three of the participants have got children after the perinatal event and one have children previously, the other did not get yet. We found out all participants were married and heterosexual relationships at the time of their miscarriage. The time of their perinatal death and the date at which we had interview ranges from a year to six years. Below is a summary of each of the participants:

Mrs xa is married, works fulltime as an accountant, and she has experienced two perinatal loss, two of which occurred during after delivery and 8 month completed (IUFD). She was 22 and 26 years old at the time of her two of perinatal loss respectively.

Mrs xb is married, works full-time workers, and is completing a graduate diploma. Two perinatal death her first death 1st day during delivery and the second loss during eight month pregnancy. She was 23 and 29 years old at the time of pregnancy loss. The rest of the paragraph presented the narration of her experience.

Mrs xc is a married woman who works from home and has experienced three miscarriage at the age of 20, 24, 26 years old. The rest of the paragraph presented the narration of her experience.

Mrs xd is married, she is house wife. Two perinatal death her first death during eight month pregnancy and the second one IUFD during seventh month delivery. She have two child before perinatal lose 31 and 34 years old at the time of pregnancy loss. The rest of the paragraph presented the narration of her experience.

Mrs xe is married and she don't have any children's she teaches in elementary school. She have one perinatal death during her delivery at the age of 33. Currently she adopts a baby boy. When perinatal death happen she was depressed and it last long till she adopt her new baby. The rest of the paragraph presented the narration of her experience.

Mrs xf is married, works fulltime as a nurse, and she has experienced one perinatal loss, occurred during delivery and She was 33 years old at the time of her perinatal loss. The rest of the paragraph presented the narration of her experience.

6.2 THEMATIC ANALYSIS

The approach that is applied to create and organize theme from the interview results is thematic analysis. This thematic analysis gives attention on examining and recording themes within data (22). This themes can be seen as patterns across the interview data that are vital to describe and associate to coping mechanisms used during the perinatal death (23). The data is an in-depth interview with mothers, who had this painful experience. Thematic analysis is good to identify both implicit and explicit ideas within data (23).

The steps in are quite straight forward, first familiarizing with the data (interview results taken from mother who had perinatal death, focusing on pattern that occur), second phase generating initial codes (prepare the data manually to look for repeating issues within the data) and third phase (searching for candidate themes) the fourth

reviewing themes (review the theme emerged) and fifth phases defining and naming themes. Finally, the last phase results in a report that produces a themes as shown in the next section.

6.3 THEME EMERGED

Using thematic analysis, I extract themes from the data collected by the interview from the participants. As thematic analysis prescribes I followed the phases to create a meaningful theme as described below. These phases includes familiarizing with the data after transcribed and then generating codes of thematic analysis. After that searching for themes, reviewing themes, and defining and naming themes. And finally, the last phase producing the report as shown in following section.

Applying thematic analysis of the interviews, as described I discovered seven major themes from the stories of these six women who have coped with perinatal loss. The themes emerged by analyzing the experiences of these women who have had perinatal loss, and more specifically investigate into their responses and coping strategies. The first two themes are (themes one and two) captures on their emotional experiences during and following the perinatal death. The last five themes mainly emerged as (themes three, four, five, and six) their coping responses and the implications involved.

6.3.1 Theme 1: Deep Emotional Response

All of the women have passed difficult time during this time. All the participant described their deep emotional reactions during and just after their perinatal death. When describing their experiences during this period, they used expressive terms including *sadness, depression, fear, isolated, scared, confused, and heartbroken*. This intense emotional response was common to all the six participants what it differ was how long they experience. For some, it lasted a couple of week, while for others it lasted several years since they have more than one encountered. It is believed that

the impact of the pregnancy loss never completely disappeared. This study also demonstrate this when the participants expressed fear, anger, and sadness. It also indicates the level of their emotional experience that they went through including sadness, disappointment, frustration, and anger following their perinatal death. The feelings of loss that women experience following perinatal lose are often not forgotten, whether the perinatal death occurred at any time of pregnancy. The following are some extracts from the data:

Mr xa describes the situation “I was hurt when I lost my baby the first time for about 15 days since the cause of it was unknown.”

Mr. xb also mentioned “At the beginning but when they told me I was shocked and panicked so much.....”

Mr xc. Says “...I panicked, I didn’t expect it . She was very normal, there was no problem I just gave birth and she just died (“I just lost her”), after three days,...”

6.3.2 Theme 2: Obsessed and Loss Hope

Following their loss, the participants described ideas of life being so unpredictable, unknown and uncertain. Most of the participants was looking the transition from womanhood to motherhood upon the discovery of being pregnant. Since from the date they were aware of their pregnancy, they have started, imagined, and thought themselves as a different woman who started new chapter of her life. One participant describes her perinatal death as “*I never thought this could happen and confused on what the future holds, am I have another one?*”. Other participant, once she found out she was pregnant, she started to create and dream a future and imagine the child. The other thought I did not use any contraceptive, “*I always ask myself why is this happening?*”. “*I begin to think about my loss and then I imagined those who have babies at the same time and then I started to feel very sad.*” Other participants also brought a lot of things in their minds connecting to their pregnancy, for example when they would be visibly pregnant, when they would share the news of their pregnancy

with others, and when they would go on leave from their job. It then also create what holds the future. Perinatal loss also involves a lot of questions, uncertainty, and confusion surrounding fertility, and apprehension about future pregnancies. One participant mentioned, *"I wasn't sure how I felt about my next child"*. They mentioned how emotionally attached with the to be baby, now they were losing this pregnancy and the way they viewed the upcoming future with this child, their excitement was growing for the possibility of another pregnancy is blurred.

6.3.3 Theme 3: No Single Coping Mechanism fits all

All the participants had their own a unique and individualized way of coping. Their mechanism includes the following strategies: private time/being alone, traveling to other places, being busy by work /or other stuff, speaking with loved ones, a subsequent pregnancy shortly after the perinatal death. While one strategy worked for one participant, it may not have worked for another. For instance, while mr xa did not discuss her experience with any friends or family, however other participants spoke to other loved one to develop their coping response. They are making trial and error and eventual they might end up with the one that will work for them and participating more in the coping strategies that were bringing comfort. Coping is not one time action, it involves handling stress at that particular time and also in a long-term. Identifying and individual coping strategies is very important since everyone goes to some difficult time, stress, and hardships in their own individual ways. In all, coping is largely influence by several other factor like culture, religion, family, individual personality, and also personal behavior. Moreover, it is also associated with the day to day activities that we do. The participants' day to day activities also had made a big impact in their overall coping strategy.

Mr xf said "The support I get from my family really helped me a lot, helped me greatly to comfort myself. In doing so I didn't find any people who know about it therefore there was no chance of discussion about the miscarriage."

Mr xa “It was my personal effort which pulled me out of that bad grief, I used to listen to religious Music (hymens) and I use to pray.”

Mr xe “My trust on my God is very strong, I am a strong Religious person and, God has its own time for hope,..”

6.3.4 Theme 4: Spiritual Faith Matters

The six participants I interviewed had different background, religious practice and levels of practice. Three of the participant were orthodox and the other three were Muslim. A common response that came up amongst the participants who considered themselves religious or practicing of their religion was whether "God was good," especially in times of crisis. The unanimous answer amongst the three Christian participants and three Muslim participants was “YES”. All of them felt that even at that difficult time, God/Alah was with them and give them the strength. Despite the fact went through the process of grieving. These six women all commented that their faith was strengthened during their perinatal death. Moreover, the participants reaffirm their faith is one of the factors that helped them get through their experience. All six participants stated, their believe were intact. *"My belief in God was not affected"*, *"My relationship with God wasn't affected in when I was angry"*. All the women in my study who self-identified as practicing their religion very well and also the other stated that their spirituality and faith was strengthened. This implied that participation in religious practice generally provide an opportunity for interpersonal support and to make progress in the coping.

“My trust on my God is very strong, I am a strong Religious person and, As I told you that are psychological things, God has its own time for hope, If it was meant to be it would have been given to me, what has happened, happened for a reason, God foresee things before us so I never complain about situation.”

“...and my faith on Alah was firm. I never complained about the happening I just accepted it since it is his will...”

6.3.5 Theme 5: Another Chance Another Baby

Only one of the participants had children prior to her miscarriages, five of them participants did not yet have children at the time of their only or first perinatal death. The differences in their responses to their miscarriages, more specifically their concerns and fears, are quite notable. All participants describe the importance being a mother and experiencing motherhood as one big purpose of their life, and expressed that their strong desire to have children may have been compromised with their sadness following their perinatal death. Following perinatal death, one of the participants had developed an added sense of wonder towards fertility and the birth of a child, which they no longer viewed as unthinking occurrence.

Mrs xa “I was hurt when I lost my baby the first time since the cause was fetal disterus....thinking that will happen again and might not get a child ...”

Mrs xc “When I lose my second child, I lost hope. I didn’t feel sad as the first time. And now, I tried for the third time and it didn’t work.”

6.3.6 Theme 6: Loved ones Share

All of the participants were married at the time of their pregnancy and miscarriage. Four of the participants referred to their husbands as a strong source of encouragement, support, and therapist throughout their experience with perinatal loss. Among the six participant discussed about marriages, four participants felt their relationship was strong; two of the participant relationship was weak they didn’t get support with husband. For others, it meant that the husband contributed to a lot of the support and responsibility during and after perinatal death. The support they get from their husbands are varied among the different. However, they shared on what is considered supportive, their husband understood what she was going through, and being there to help in a way that she needed and their own preferences. Each of the participants also had several other loved ones being there during this difficult time to give them all the support and comfort they needed. Among these, the mentioned her

parents, sisters, brothers, close relatives, friends, colleagues. One participant stated that her mother's and other family member showed a lot of support she took her from Addis Ababa for relaxation and separate from bad memory. It meant a lot to her that there were so many people who cared. Regardless of the source of the support, all participants found having support to be an important part of their coping and healing it valuable and helpful.

Mrs xf “My family send me out of town not to discuss that issue with others in doing so It helped me to forget that grief.

Mrs xd said “...Alahm dilulaha my husband was supporting and support me to overcome that bad feeling and you shouldn't be sad and think your loss. And my family supporting in every direction...”

6.3.7 Theme 7: Informed and Involved in Health Care

Two of them has a weak and one has strong involvement with the health care services and these also had impact on their experience of coping. One participant who had a strong relationship describe her experience, the consultancy service I get from the health care providers were tremendous. After that helps which we followed informed us what to do and helps us to recover and to think future. Another participant also described, though, I felt helped alleviate some of the stress were gone and was somehow reassuring.

Mrs. xb “...but the health officers told me not to worry about perinatal loss again and assure me that it will not happen again...”

Mrs. xf “from the doctors I get some assistance when that happened the doctor comfort me a lot, but I didn't find any psychologist after the incident. There was no one in that hospital.”

7 Discussion

Coping are ways to which external or internal stress is managed, adapted to or acted upon, ways to manage stress there are positive coping mechanism and negative coping mechanism, Positive coping mechanism are strategies that people use in order to deal with stress and natural changes, grief is a natural non pathological phenomenon and personal process often cause reactions that risk negatively affecting psychological and physical wellbeing, women who experience perinatal loss use different strategies to cope with grief events, positive coping has significant personal and public health benefits particularly for those women who have perinatal loss ,

This study has assessed maternal coping mechanisms following perinatal death in selected public hospital, Addis Ababa, Ethiopia, 2018. The study had revealed women ability to cope following perinatal loss 168(45.3%) had positively coping and 203 (54.7%) had negatively coping.

This study revealed that majority of mother were negative coping status when compared with other study done on similar topic, this finding is relatively higher than a study conducted India such difference in socio demographic characteristics study population and post counseling method.

According to this study some of the participant were believed that new born death & still birth are hidden, burial practice were age based and death are due to malevolent sprit This finding was similar with a study done in Rural Amhara and Oromia region (16) In this study, women who have support from friends were more likely to cope positively than those who have no friend support (AOR= 3.859, 95% CI: 2.087, 53, 7.13), this may be because sharing grief event to friends give relief. Other studies done outside Ethiopia, in Malaysia also showed that women who have support from friends have positive coping towards grief after perinatal loss (20)

In this study were Degree and above 1.748 times (AOR=1.748, 95%CI: .887, 3.445) were more likely to be positively coping grief than uneducated mother, this finding was almost similar with study done in India (21). Educated mother have a good capacity to analyze things and also use different strategy to cope positively.

8 Conclusion and recommendation

8.1 Conclusion

The finding of this study, the assessment of coping mechanism following perinatal loss among the selected government hospital, 168(45.3%) had positively coping & the rest of the study participant was negatively coping .This study had revealed that significant number of women were found an effective method of coping to resolve their grief and delay adaptation to loss , this lead to serious negative health outcome that affect their mental health and other aspect of their life ,understanding of positive and negative coping is the fundamental element for intervention for those who were not able to cope that are working in the area counseling, social worker and health professional.

8.2 Recommendation

Perinatal death been recognized as a grief induced events has a potential to have large impact to the mother mental, psychological & physically

Crucial for health to intervention as early as possible not lead to serious negative impact on physical & psychological impact

Integrated effort needs to be initiated to address for women with difficult coping a following a perinatal death, appropriate intervention could promote physical and emotional healing

- Need professional counselor such as mental health professional, social worker & midwife
- Health provider's better to strengthen ANC follow up and adequate counselling at each visit based on focused antenatal care guideline including each component of birth preparedness and complication readiness to build pregnant women knowledge on obstetric danger signs.
- Need support from friends , community , family & husband
- Develop health system polices & Vital registration

9 STRENGTH AND LIMITATION OF THE STUDY

9.1 Strength of the study

- The study tool was standardized and adapted from literatures
- The study has tried to identify Coping status following perinatal loss

9.2 Limitation

- The study was cross-sectional where cause and effect relationship cannot be established.
- Since the study was conducted in public health hospital, health center and private institutions were not addressed and not possible to infer the whole population.
- Recall bias may affect the reported

10 REFERENCES

1. World Health Organization. Global health observatory data repository, 2014.
2. Khasakhala A, Ndavi P. Factors associated with perinatal deaths in Kenya. Kenya Demographic and Health Survey. 2003.
3. Central Statistical Agency (Addis Ababa). Ethiopia Demographic and Health Survey 2016. 2016.
4. Adekanbi AO, Olayemi OO, Fawole AO, Afolabi KA. Scourge of intra-partum foetal death in Sub-Saharan Africa. World Journal of Clinical Cases: WJCC. 2015 Jul 16;3(7):635.
5. Shurack EL. Pregnancy loss: women's experiences coping with miscarriage (Doctoral dissertation, University of British Columbia). 2015.
6. Miller HS. Major Coping Strategies. 2012.
7. Berhan Y, Berhan A. Perinatal mortality trends in Ethiopia. Ethiopian journal of health sciences. 2014;24:29-40..
8. Lee L, McKenzie-McHarg K, Horsch A. The impact of miscarriage and stillbirth on maternal–fetal relationships: an integrative review. Journal of Reproductive and Infant Psychology. 2017 Jan 1;35(1):32-52.
9. Oji OS. *Risk factors for perinatal mortality in Nigeria: the role of place of delivery and delivery assistants* (Doctoral dissertation). 2008
10. Vandresse M. A conceptual model of feto-infant mortality in late and low fertility context. Département des sciences de la population et du développement, Université catholique de Louvain; 2006.
11. Silman M. Loss of a Baby in Cultural Context. 2014
12. Mihiretu A, Negash T, Elazar T. Perinatal Death and Associated Factors in Wolaita Sodo Referral Hospital, Southern Ethiopia: a Facility Based Cross-Sectional Study. Prim Health Care 2017; 7: 269.

13. Begum LN, Azad K, Akhter S, Nahar N, Abdullah AH. Assessment of perinatal mortality in a tertiary care hospital by using Wigglesworth classification. *Bangladesh Journal of Child Health*. 2007;31(1):32-9..
14. Vandresse M. A conceptual model of feto-infant mortality in late and low fertility context. Département des sciences de la population et du développement, Université catholique de Louvain; 2006.
15. Kint EL. Women's experiences of pregnancy loss: An interpretative phenomenological analysis. 2015
16. Sisay MM, Yirgu R, Gobeze AG, Sibley LM. A qualitative study of attitudes and values surrounding stillbirth and neonatal mortality among grandmothers, mothers, and unmarried girls in rural Amhara and Oromiya regions, Ethiopia: unheard souls in the backyard. *Journal of Midwifery & Women's Health*. 2014;59(s1).
17. Mayo Clinic Staff, Pregnancy loss: How to cope, June 25, 2016
18. Human M, Green S, Groenewald C, Goldstein RD, Kinney HC, Odendaal HJ. Psychosocial implications of stillbirth for the mother and her family: A crisis-support approach. *Social Work*. 2014;50(4):563-80.
19. *Europe's Journal of Psychology* 2015, Vol. 11(2), 295–310
doi:10.5964/ejop.v11i2.935
20. Rosnah SUTAN, etl. d Psychosocial impact of mothers with perinatal loss and its contributing factors: an insight, Dec. 11, 2009
21. Sangeeta patil clinical instructor, Krishns institute of Nursing science Karad , India, *International Journal of science and research (IJSR)* volume 3 issue 4 April 2014 level of stress and coping strategies seen among parents of neonate.
22. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.

23. Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods*, 5(1), 80-92.

11 APPENDICES

a. For Qualitative

Tools adapted different literature (5, 19)

A. Overarching Research Questions and Sub-Questions

Overarching Research Questions:

1. I'd like to ask you, in your own words, what has been your coping mechanism experiences following perinatal loss.
2. Can you please share with me your experiences of coping following your perinatal loss? What I mean by this is the things you did to respond, carry on, survive, and thrive following your perinatal loss, and this can include actions, thoughts, ideas, teachings, etc.

Sub-Questions:

1. How did the perinatal loss have an effect on you, immediately and long-term?
2. What was your initial response and how did it change over time? Ie: step by step if possible.
3. What were your experiences following the perinatal loss, both positive and negative?
4. Can you share with me how you managed following your loss?
5. What did you find to be of comfort throughout your experience? Ie: what brought a smile to your face? What did you find helpful in your coping?
6. How did you come to develop your coping response/strategies? Was it something that fell into place or did you seek it out?
7. Tell me about your support system during your experience? You can mention any people that apply to your experience, whether it be your partner, family, friends, community, spiritual leader, colleagues, medical team, etc.
8. Can you share whether you feel your relationship with your partner was

affected?

9. If applicable, would you say your spirituality, religious practice, and/or belief in God, were affected? If yes, how so?
10. If applicable, can you share if having children prior to the perinatal loss affected your coping?
11. To this day, do you think about the perinatal loss? If so, in which ways, when?
12. If applicable, has the perinatal loss had an effect on your outlook of future pregnancies?
13. Did you receive the support of any professionals? Ie: doctor, OB, specialist, case manager, social worker, clinician, etc? If you didn't, do you wish you had?
14. What was your relationship like with your doctor? And do you think it affected your coping?
15. Were there any strategies or actions that you found not to be helpful during the experience?
16. What are the recommendations you would make to women in the future who experience pregnancy loss?
17. What are the recommendations you would make to doctors who are involved in a woman's care during and following pregnancy loss?
18. I'm wondering if there is there anything else you'd like to share with me? Or something you think may be applicable to my study.
19. Can you tell me how you felt about participating in this study and the process involved?

b. For Quantitative

Information sheet and consent form

Research Project: ASSESSMENT OF MATERNAL COPING MECHANISMS FOLLOWING PERINATAL DEATH IN SELECTED PUBLIC HOSPITAL

Name of Principal Investigator: - Esete Ayalew

Introduction

This information sheet and consent form is prepared by the investigator whose main aim is to study Assessment of coping mechanism following perinatal death in selected public hospital.

Purpose

The purpose of this study is to assess the magnitude and factors associated with perinatal death. The information you give will be used in contribution to promote coping mechanism strategies of mother following perinatal loss hopefully preventing and coping from experiencing serious negative and positive consequences from perinatal loss.

Procedures

You are kindly invited to take part in our research because we believe you can provide the necessary information for the research. Participation into the study is on voluntary basis. If you are willing to participate in our project, you need to understand and sign the consent form. Then, you will be asked to give your response by the data collectors. All the responses given by the participants and the result so obtained will be kept anonymous and confidential. No one outside the research team will have access to your responses.

Risk and/or Discomfort

The procedure does not bear any physical or psychological trauma. Furthermore, you will not be forced to respond to information you do not know

Benefits

Participation to contribute for the coping mechanism and associated factor follows perinatal loss.

Incentives

You will get the indirect benefit from the research about the reduction of the problem in relation to associate factor and to prevent coping mechanism following perinatal death.

Confidentiality and Anonymity

The information that we will collect from this research project will be kept confidential. Information about you that will be collected from the study will be stored in a file, which will not have your name on it, and it will not be revealed to anyone except the principal investigator. We would greatly appreciate your help in responding to this study. The interview will take about 30 - 40 minutes. Would you be willing to participate?

Right to Refuse or Withdraw

You have the full right to refuse from participating in this research (you can choose to respond some or all of the questions) if you do not wish to participate; and this will not affect you. You have also the full right to withdraw from this study at any time you wish to, without losing any of your rights as a resident of this site.

Persons to contact for further information

If you have any question you can contact the principal investigator in the following address:

Name: Esete Ayalew

Tel: 09 11 48 04 13

Email: eseteaya@gmail.com

Contact information for complaint

If you have any concern that the research team is conducting their activities unethically or inappropriately please contact AddisAbaba university college of health Sciences School of Allied Health

CONSENT FORM FOR POSTNATAL FOLLOW UP MATHER (ENGLISH VERSION)

If you agree to participate in this study, I appreciate your truthfulness. In addition, after having this consent form read to you, please put a sign below to show if you are willing to participate (No need of writing your name).

Are you willing to participate in this study?

Yes [] No []

I would greatly appreciate your help in responding to this survey to indicate your response please encircle or fill on the space provided for the question that require written responses.

Section 1. Maternal socio-economic and demographic factor

<i>No.</i>	<i>Question</i>	<i>Response</i>	<i>Skip</i>
<i>101</i>	<i>Maternal education</i>	<i>Illiterate</i> <i>high school completed</i> <i>diploma</i> <i>Degree and above</i> <i>Others</i>	
<i>102</i>	<i>How old are you?</i>	<i>Age in years</i>	

103	What is your ethnic Group?	1.Amahara 2.Gurage 3.Tigere 4.Oromo 5.Other(specify)_____	
104	What is your religion?	1.Orthodox 2.Islam 3.Protestant 4.Catholic 5.Other(specify)_____	
105	Marital status?	1.Single 2.Married 3.Widowed 4.Other(specify)_____	
<i>Section 2.parents cultural characteristics</i>			
106	new-born deaths and stillbirths are hidden?	1.Hidden 2.Attend secretly No need of exaggeration	
107	Burial practice is age-based?	Yes No	

108	Stillbirth and neonatal death are mostly due to malevolent spirits?	1.Yes 2.No	
Section.3. maternal factors & desire of pregnancy			
109	How old are you during child birth?	Age in years	
110	Do you want another pregnancy?	1 Wanted then 2 Wanted later 3 Wanted no more	
111	Is there any problem for perinatal loss during delivery?	1 None 2 Prolonged labor 3 Ruptured uterus 4 Other	
112	Do you have children?	1 Yes 2 No 3 If your answer is yes mention how many-----	
Section.4. Health seeking behaviour (for previous pregnancy)			
113	In what way to deliver the baby?	1 Non-Caesarean section 2 Caesarean section	
114	Where do you deliver?	Home	

		Health facility	
115	Who attend Delivery?	Health professional TBA Others	
Section.5. Bereavement support of mother			
116	Did you get medical support during perinatal loss?	Yes No	
117	Do you have any support from husband?	Yes No	
118	Do you have any support from parent?	Yes No	
119	Do you have any support from friend?	Yes No	
Section,6. Behavioural characteristics of the mothers			
120	Do you use smoking?	1.Yes 2.No	

121	If yes, when do you start?	After perinatal loss Before perinatal loss	
122	Do use alcohol?	Yes 2.No	
123	If yes, when do you start?	After perinatal loss Before perinatal loss	

Section 6. Coping mechanism

1 = I haven't been doing this at all; 2 = I've been doing this a little bit; 3 = I've been doing this a medium amount; 4 = I've been doing this a lot).

No	Question	Response	Coding Categories code Number	Skip
124	I've been concentrating my efforts on doing something about the situation I'm in.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	Q 124 New 2..agree 2. strongly agree 1.disagree 1.strongly disagree	
125	I've been saying to myself "this isn't real".	1.agree 2.strongly agree 3. disagree	1..agree 1.. strongly agree 2.disagree	

		4.strongly disagree	2..strongly disagree	
126	I've been using alcohol or other drugs to make myself feel better.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	1..agree 1.. strongly agree 2.disagree 2..strongly disagree	
127	I've been getting emotional support from others.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.strongly agree 1. disagree 1.strongly disagree	
128	I've been giving up trying to deal with it.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	1.agree 1.strongly agree 2. disagree 2.strongly disagree	
129	. I've been taking action to try to make the situation better.	1.agree 2.stronglly agree 3. disagree 4.strongly disagree	2.agree 2.stronglly agree 1. disagree 1.strongly disagree	
130	I've been refusing to believe that it has happened.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	1.agree 1.stronglly agree 2. disagree 2.strongly disagree	

131	I've been saying things to let my unpleasant feelings escape.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.strongly agree 1. disagree 1.strongly disagree	
132	I've been getting help and advice from other people.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.strongly agree 1. disagree 1.strongly disagree	
133	I've been using alcohol or other drugs to help me get through it.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	1.agree 1.strongly agree 2. disagree 2.strongly disagree	
134	I've been trying to see it in a different light, to make it seem more positive.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.strongly agree 1. disagree 1.strongly disagree	
135	I've been criticizing myself.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	1.agree 1.strongly agree 2. disagree 2.strongly disagree	
136	I've been trying to come up with a strategy about	1.agree 2.strongly agree	2.agree 2.strongly agree	

	what to do.	3. disagree 4.strongly disagree	1. disagree 1.strongly disagree	
137	I've been getting comfort and understanding from someone.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.strongly agree 1. disagree 1.strongly disagree	
138	I've been giving up the attempt to cope.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	1.agree 1.strongly agree 2. disagree 2.strongly disagree	
139	I've been looking for something good in what is happening.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.strongly agree 1. disagree 1.strongly disagree	
140	I've been doing something to think about it less, such as going to movies ,watching TV ,reading, day dreaming, sleeping, or shopping.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.strongly agree 1. disagree 1.strongly disagree	
141	I've been accepting the reality of the fact that it	1.agree 2.strngly agree	2.agree 2.strongly agree	

	has happened.	3. disagree 4.strongly disagree	1. disagree 1.strongly disagree	
142	I've been expressing my negative feelings.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2..agree 2.stronglly agree 1. disagree 1.strongly disagree	
143	I've been trying to find comfort in my religion or spiritual beliefs.	1.agree 2.strongly agree 4. disagree 5.strongly disagree	2.agree 2.stronglly agree 1. disagree 1.strongly disagree	
144	I've been trying to get advice or help from other people about what to do	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.stronglly agree 1. disagree 1.strongly disagree	
145	I've been learning to live with it.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.stronglly agree 1. disagree 1.strongly disagree	
146	I've been thinking hard about what steps to take.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	1.agree 1.stronglly agree 2. disagree 2.strongly disagree	

147	I've been blaming myself for things that happened.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	1.agree 1.strongly agree 2. disagree 2.strongly disagree	
148	I've been praying or meditating.	1.agree 2.strongly agree 3. disagree 4.strongly disagree	2.agree 2.strongly agree 1. disagree 1.strongly disagree	

አጠቃላይና እና ዝርዝር የጥናት ጥያቄዎች

አጠቃላይ የጥናት ጥያቄ

- 1 አሁን የምጠይቅ እስከ በአንቺ አነጋገር ልጅሽን ካጣሽ በኋላ ያንን ጊዜ ለመውጣት ያስቻሉሽን ዘዴዎችና ልምድሽን ንገረኝ
- 2 ልጅሽን/በማነጻጻሽ የነበረውን ልጅ ስታጩ የተወጣሽበትን ዘዴ ልታካፍይኝ ትችላላሽ ምን ለማለት ነው ያንን ጊዜ ለማለፍ ያደረግሻቸው ነገሮች፤ የሰራሻቸው፤ የተለያዩ ነገሮች ለምሳሌ በሃሳብ፤ በድርጊት፤ በትምህርት፤ በማሳሰሉት ነገሮች

ዝርዝር ጥያቄዎች

- 1 ልጅሽን/በማነጻጻሽ የነበረውን ልጅ በማጣት ለምን ያህል ጊዜ ተፅእኖ አሳደረብሽ፤ ወዴያው እና ለረጅም ጊዜ
- 2 ለመጀመሪያ ጊዜ የነበረሽ ምላሽ ምንድን ነበር በረጅም ጊዜ እንዴት እየተሻሻለ መጣ
- 3 በዚህ ጊዜ የነበረሽ በጎ ምይሁን ክፉ ልምድ ግለጭን
- 4 እንዴት ይህንን ጊዜ ልትወጩ እንደቻልሽ ልታካፍይን ትችላላሽ
- 5 በዚህ ጊዜ ምንድን ነበር ዘና የሚደርግሽ; ለምሳሌ ፈገግ የሚደርግሽ ፤ ከዚህ ስሜት ለመውጣት የረዳሽ ዘዴ
- 6 የራስሽን ከዚህ ስሜት የሚወጣ ዘዴ እንዴት አገኘሽ፤ በወቅቱና በቦታው የነበረ ነው ወይስ አንቺ ፈልገሽ ያመጣሽው

- 7 በዚያን ወቅት የነበሩትን የተለያዩ ድጋፍ ግለጫኝ፤ ማንኛውንም ድጋፍ ልትገልጹትችታለሽ ለምሳሌ ከእናት/አባት ከቤተሰብ ከጓደኛ፤ ከሚበረሰብ፤ ከሚፈሳሳዎት አባቶች፤ ከባልደረባ፤ ከጠፍባለሞያ፤ ከሚሰሉት
- 8 ከቤተሰቦች ጋር የነበረውን ጉዳት ተጽእኖ አድርጎ ብሽ እንደነበረ ልትገልጹትችታለሽ
- 9 ለንቺ የሚሰሩ ከሆነ ፤ ያንቺ ማፈሳሰብ ፤ የሀይማኖት ተግባር ወይም ደግሞ እምነት በአምላክ ላይ ያለው ተግባር ነበር ከሆነ እንዴት
- 10 ለንቺ የሚሰሩ ከሆነ ፤ ከዚህ በፊት የነበሩት ልጆች ከአሁን ማጣት ጋር ከዚህ ለመውጣት እንድትችሉ አግዘሻል
- 11 እስካሁን ድረስ ስለዛ ታስቢያለሽ ከሆነ በምን ማክኩሜት
- 12 ለንቺ የሚሰሩ ከሆነ ፤ ከዚህ በኋላ በሚኖርሽ እርግዝና ላይ ተጽእኖ ፈጥሯል
- 13 ከባለሞያዎች እርዳታ አግኝተሻል ፤ ከዶክተር፤ ከሚህጻን ስፔሻሊስት፤ እርግዝናሽን ከሚታተለው፤ ከሚበረዳህ ሰራተኛ፤ ከሚሰሉት ካላገኘሽ ባንኛ ኖሮትችታለሽ
- 14 ከዶክተር ጋር የነበረሽ ግንኙነት ምንድን ነበር፤ ያ ከዚያ እንጽወጫለሁ ረዳሽ ይመስልሻል
- 15 በዚህን ጊዜ ከተሞክረ ዘዴ ወይም ደግሞ የተሞክረ ተግባር በዚህ ጊዜ የሚያጠቅም የምትይውሉ
- 16 ከዚህ በኋላ እንደዚህ ዓይነት ለሚያጠቅም ጉዳት ለማስታወቅ ስትችሉ
- 17 ይህንን ጊዜ ለሚያሳልፍ እናቶችን ለሚታተሉ ሐኪሞች ምን ጉዳት ለማስታወቅ ስትችሉ
- 18 ከዚህ ወጪ ጉዳት ጋር የምትፈልገውን ገር ካለ፤ ለጥናቱ ይጠቅሙል የምትይው
- 19 በዚህ ጥናት ላይ በመሳተፍ እና በሂደቱ ላይ የተሰማሽን ልትነግረኝ ትችላለሽ

ፍቃደኝነት መጠየቂ ቅፅ

ስሜ እሴተ አያሌው ይባላል በአሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ የሁለተኛ ድግሪ ትምህርቱን እየተከታተልኩ እገኛለሁ የሁለተኛ ድግሪዬን ለመጨረስ ይረዳኝ ዘንድ እናቶች የወሊድ ጊዜ ልጃቸውን በሚያጡበት ጊዜ ከሚደርስባቸው ሀዘን ለመወጣት የሚጠቀሙትን ዘዴዎች ለማጥናት መረጃዎችን ለመሰብሰብና በዚህ አቅታጫ ሌሎች ተመሳሳይ ችግር ለሚያጋጥማቸው የሚሆን መፍትሄ ለማምጣት የሚያስችል ጥናት ሂሆን ነው ፤ የማይመለከታችሁ ጥያቄ ካለ ባዶ መተው ትላላችሁ፤

ስለሆነም ከላይ ተዘረዘሩትን የጥናቱን አላማዎች ያሳኩ ዘንድ በእናተ በኩል በእውነት ላይ የተመሰረተና ትክክለኛ የሆኑ መረጃ እንድትሞሉ እየጠየኩ መጠየቁ በግላችሁ ስለሆነ የምትመልሱት መልስ ግላዊና ስማችሁን ያላካተተ በመሆኑ አርሶ የሚሰጡት መረጃ በከፍተኛ ደረጃ ሚስጥራዊነቱ የተጠበቀ ነው ስለሆነም እባክዎ ትክክለኛ መረጃ እንዲሰጡ በትህትና እጠይቃለሁ በዚህ ጥናት ላይ በመሳተፋችሁ በቀጥታ የምታገኙት ጥቅም ባይኖርም ከጥናቱ በሚገኘው ግኝት መንግስትና ሌሎች በለድርሻ አካላት በዚህ ሁኔታ ልጆቻቸውን ለሚያጡ እናቶች ከሚደርስባቸው ሀዘን ለመወጣት በተለያዩ አካላት መወሰድ የሚገባቸውን ነገር ለማመላከት የሚረዳ ነው ፤

በዚህ ጥናት ውስጥ ለመሳተፍ ፍቃደኛ መሆኑን በፊርማዎት ያረጋግጡ ስለ ትብብርዎ በቅድሚያ እናመሰግናለን

በጥናቱ ላይ ለመሳተፍ ፍቃደኛ ነዎት

- 1. አዎ
- 2. አይ

በጥናቱ ላይ በመሳተፍዎ ከፍተኛ ምስጋናዬን በቅድሚያ እያቀረብኩ እባክዎትን መልስዎ ላይ ያክቡ ወይም ከተዘረዘሩት አማራጭ ውጭ ሌላ መልስ ካላችሁ ሌላ በሚለው ስር መልሳችሁን ገለፁ ጥናቱን በተመለከተ የምትፈልጉት ጥያቄ ካላችሁ በሚመለከተው አድራሻ ደውላችሁ ወይም ኤሜል አድርጋችሁ መጠጠየቅ ትችላላችሁ

ስም እሴተ አያሌው

ስልክ 09 11 48 04 13

Email: eseteaya@gmail.com

ተራ ቁጥር	ጥያቄ	መጻሕፍት	ይገባ
101	የትምህርት ዝግጅት	ዲግሪና ከዚያ በላይ ዲፕሎማ ሁለተኛ ደረጃ የጨረሰ ሌላ	
102	እድሜያችሁ ስንት ነው	እድሜያችሁ	
103	ብሔርህ ምንድን ነው	አማራ ጉራጌ ትግሬ አረብ ሌላ ከሆነ ይግለጹ__	
104	ሐይማኖትሽ ምንድን ነው	ኦርቶዶክስ መስጊድ ፕሮቴስታንት ካቶሊክ ሌላ ከሆነ ይግለጹ__	
105	የጋብቻ ሁኔታ	ያላገባች	

		<p>□ገባች</p> <p>አ□ብታ□ገፈታች</p> <p>ሌላ ከሆነ ይግለጹ_____</p>	
<p>ክፍል 2. ከቤተሰብ ባህል ጋር የተያያዘ</p>			
106	<p>አዲስ የተወለደ እና በማንኛው ወሰን እያለ የሚገኝ ልጅ ይደበቃል/አይወራም</p>	<p>ይደበቃል</p> <p>በሚገኘው ተይዞ ይፈጸማል</p> <p>ምንምምንንን እያስፈልገውም</p>	
107	<p>የቀጠረ አፈጻጸም እድሜን ማሳረት ያደረገ ነው</p>	<p>አዎ</p> <p>አይደለም</p>	
108	<p>አዲስ የተወለደ እና በማንኛው ወሰን እያለ የሚገኝ ልጅ በአጠቃላይ በርኩስ መንፈስ ነው</p>	<p>አዎ</p> <p>አይደለም</p>	
<p>ክፍል 3 - የእርግዝና እና ከመላኪያ ጋር የተያያዘ</p>			
109	<p>ልጅዎ በመላኪያ ጊዜ እድሜዎን ስንት ነው</p>	<p>እድሜ በዓመት</p>	
	<p>ሌላ ልጅ መላኪያ ይፈልጋሉ</p>	<p>አዎ አሁን</p> <p>አዎ ሌላ ጊዜ</p> <p>አልፈልገውም/ከዚህ በኋላ</p>	

110	ልጅዎን ባጡ ጊዜ የወለድ ችግር ገጥሞት ነበር	አልነበረም የተራዘመም የመሀዳን ችግር ሌላ	
111	ልጆች አለዎት	አዎ የለኝም አለኝ ካሉ ስንት ልጅ-----	
ክፍል 4 - ከጤና ፍላጎት ጋር የተያያዘ			
112	የትነው የተገለገሉት	በቤት በጤና ተቋም	
113	ማን ውያዎለደዎት	የጤና ባለሙያ አልተወሰነም ሌላ	
114	ልጅዎን በምንድን ነው የወለዱት	በምጥ በቀይ ጥገና	
ክፍል 5 - እናቶችን ከሙሉ ፍጥነት ጋር የተያያዘ			
115	ልጅዎን በጤና ጊዜ የሀክምና ድጋፍ አግኝተዋል	አዎ አላገኝሁም	

116	<p>ልጅዎን ባጠች ጊዜ አዎ</p> <p>ከባለቤትዎ ድጋፍ አላገኘሁም</p> <p>አግኝተዋል</p>	
117	<p>ልጅዎን ባጠች ጊዜ አዎ</p> <p>ከቤተሰብዎ ድጋፍ አላገኘሁም</p> <p>አግኝተዋል</p>	
118	<p>ልጅዎን ባጠች ጊዜ አዎ</p> <p>ከጓደኛዎ ድጋፍ አግኝተዋል</p> <p>አላገኘሁም</p>	
<p>ክፍል 6 - ከእናት ባህሪይ ጋር የተያያዘ</p>		
119	<p>ያጨሳሉ</p>	<p>አዎ</p> <p>አላጨሳም</p>
120	<p>የሚያጨሳኩ ከሆነ መቼ ጀመሩ</p>	<p>ልጄን/ያረገ ዝክትን ከማጣቴ በኋላ</p> <p>ልጄን/ያረገ ዝክትን ከማጣቴ በፊት</p>
121	<p>አልከል ይጠቀማሉ</p>	<p>አዎ</p> <p>አልጠጣም</p>
122	<p>አልከል የሚጠቀሙ ከሆነ መቼ ጀመሩ</p>	<p>ልጄን/ያረገ ዝክትን ከማጣቴ በኋላ</p> <p>ልጄን/ያረገ ዝክትን ከማጣቴ በፊት</p>

ክፍል 6. ከጭቀት የመጨመር ደረጃዎች

ተ. ቁ ጥረ	ጥያቄ		
123	የሚደረገውን ነገር ሁሉ በተፈጠረው ሁኔታ ላይ አዘንገድ ነበር፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
124	ለራሴ ለይህ በእውን አልሆነም እል ነበር	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
125	አልከልና ተዛማጅነትን ያላቸው እዳችን በመጠቀም የተሻለ ስሜት እንዲሰማኝ አደርግ ነበር	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
126	ከሌሎች ለስሜት የሚጠቀሙ እርዳታ አገኝ ነበር	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
127	ሁሉንም ጉጅ ከዚህ ስሜት ጋር እታገል ነበር	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ	

		3.xLS¥M 4.bÈM xLS¥M	
128	የተለያዩ ነገሮችን በማድረግ ሁኔታው የተሻለ ለማድረግ እጥር ነበር፡፡ አልሆነም በማለት እራሱን ለማስመን እጥር ነበር፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
129	የተለያዩ ነገሮችን በማለት ደስ የማይለው ስሜት እንዲጠፋ ለማድረግ እጥር ነበር፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
130	በተለየ መንገድ በማየት ነገሩ በጎ እንዲመጣል ለማድረግ ጥሪያለሁ፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
131	እራሱን እወቅስ ነበር፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
132	የተሻለ የመወጫ ዘዴ ለማግኘት እጥር ነበር፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	

133	ከአንድ ሰው የተሻለ ምቹትና መረዳትን አገኝነበር፡፡	<p>1.XS¥¥lhÖ</p> <p>2.bÈM XS¥¥lhÖ</p> <p>3.xLS¥M</p> <p>4.bÈM xLS¥M</p>	
134	ከዚህ ስሜት ለመውጣት በሚደረገው ጥረት ተስፋ ቆርጫነበር፡፡	<p>1.XS¥¥lhÖ</p> <p>2.bÈM XS¥¥lhÖ</p> <p>3.xLS¥M</p> <p>4.bÈM xLS¥M</p>	
135	በተፈጠረው ነገር አንድ ጥሩ ነገር ለመጥጥ ጥሪያለሁ፡፡	<p>1.XS¥¥lhÖ</p> <p>2.bÈM XS¥¥lhÖ</p> <p>3.xLS¥M</p> <p>4.bÈM xLS¥M</p>	
136	በሁኔታው ለመቀለድ ምክንያት ጥሪያለሁ፡፡	<p>1.XS¥¥lhÖ</p> <p>2.bÈM XS¥¥lhÖ</p> <p>3.xLS¥M</p> <p>4.bÈM xLS¥M</p>	
137	ስለሱ የማንበውን ለመቀነስ ፈልጎት ተሻክሮ አይመጣኛል አነብኩት እና ወደገበያ እሌድነበር፡፡	<p>1.XS¥¥lhÖ</p> <p>2.bÈM XS¥¥lhÖ</p> <p>3.xLS¥M</p> <p>4.bÈM xLS¥M</p>	
138	የተፈጠረውን ነገር በውን መሆኑን ተቀብያለሁ፡፡	<p>1.XS¥¥lhÖ</p> <p>2.bÈM XS¥¥lhÖ</p>	

		3.xLS¥M 4.bÈM xLS¥M	
139	የተሰማኝን መጠፎ ስሜት ገልጻለሁ፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
140	በእምነቴና በመንፈሳዊ እምነቴ ምኞት ለመገኘት ጥረት አድርጌያለሁ፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
141	ከሌሎች ምክርና እርዳታ ምን ማድረግ እንዳለብኝ ለመገኘት ጥረያለሁ፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
142	ከሌሎች ምክርና እርዳታ ምን ማድረግ እንዳለብኝ ለመገኘት ጥረያለሁ፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
143	ምን ማድረግ እንዳለብኝ ምክርና እርዳታ ከሌሎች ለመገኘት እጥረኝ ስለሆነ፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.XLS¥M 4.bÈM xLS¥M	

144	ከተፈጠረው ሁኔታ ጋር መኖር እንደ ምቹል እንደ ነበር፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
145	ምን መድረግ አንዳለብኝ በጣም አስብ ነበር፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
146	በተፈጠረው ገር እራሴን እወቅስ ነበር	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
147	ፀሎት አደርግ ነበር	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	
148	በተፈጠረው ገር ቀልጃለሁ፡፡	1.XS¥¥lhÖ 2.bÈM XS¥¥lhÖ 3.xLS¥M 4.bÈM xLS¥M	

Appendix II- Declaration

The undersigned, declare that this thesis is my original work in partial fulfilment of the requirement for the degree of masters of maternity and reproductive health and has not been presented in this or any other university and all source of materials used for this thesis have been duly acknowledged.

Name: Esete Ayalew

Signature: _____

Date: _____

Place: Addis Ababa University, school of Allied Health Sciences, Department of Nursing and midwifery

This thesis has been submitted for examination with my approval as the university advisors.

Primary advisor Hawenii adego (Bsc, Msc)

Signature: _____

Date: _____

Co-Adviser: Sr. Fekertemariam (BSc, MSc)

Signature: _____

Date: _____

Place: Addis Ababa University, school of Allied Health Sciences, Department of Nursing and midwifery