



**COLLEGE OF HEALTH SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF MIDWIFERY
POSTGRADUATE PROGRAM**

Prevalence and Associated factors of fear of childbirth among pregnant women attending Antenatal care in selected Public Hospitals, Addis Ababa Ethiopia 2021

BY: ABEBE TIBEBE (BSc)

A RESEARCH THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY, DEPARTMENT OF MIDWIFERY, INPARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN MATERNITY AND REPRODUCTIVE HEALTH NURSING.

JUNE 2021

ADDIS ABABA ETHIOPIA

**ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCE
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF MIDWIFERY
POST GRAGUATE PROGRAM**

Prevalence and associated factors of fear of childbirth among pregnant women attending Antenatal care in selected Public Hospitals, Addis Ababa Ethiopia 2021

BY: ABEBE TIBEBE (BSc)

ADVISORS:

- 1. Dr.ENDALEW GEMECHU SENDO (PhD. Ass. Prof)**
- 2. YESHI ASSEFA (BSc, MSc)**

JUNE, 2021

ADDIS ABABA, ETHIOPIA

APPROVAL SHEET

I, the undersigned MSc student, declare that I have submitted my original work on a title Prevalence and risk factors of fear of childbirth among pregnant women attending Antenatal care in selected Public Hospitals, Addis Ababa Ethiopia 202 for the examination.

Submitted by:

Abebe Tibebe

Name of student

Signature

Date

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

Approved by:

Dr. Endalew Gemechu Sendo (PhD. Ass. Prof)

Name of Major Advisor

Signature

Date

Yeshi Assefa (BSc, MSc)

Name of Co-Advisor

Signature

Date

APPROVAL BY THE BOARD OF EXAMINERS

This thesis by Abebe Tibebe is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of Master of Science in maternity and reproductive health nursing.

Examiner:

Full name	Rank	Sig.	Date
Mr. Leul Deribe Kitaw (BSc.MPH/RH, Ass.Prof, PhD Candidate)		_____	_____

Research Advisors

Full name	Sig.	Date
1. Dr. Endalew Gemechu Sendo (PhD. Ass. Prof)	_____	_____
2. Yeshe Assefa (BSc, MSc)	_____	_____

Department Head

Full name _____	Sig. _____	Date ____/____/____
-----------------	------------	---------------------

STATEMENT OF DECLARATION

By my signature below, I declare and affirm that this thesis is my own work. I have followed all ethical principles of scholarship in the preparation, data collection, data analysis and completion of this thesis. All scholarly matter that is included in the thesis has been given recognition through citation. I affirm that I have cited and referenced all sources used in this document. Every effort has been made to avoid plagiarism in the preparation of this thesis.

This thesis is submitted in partial fulfillment of the requirement for a graduate degree from the Addis Ababa University College of Health Sciences, School of Nursing and Midwifery department of Midwifery. The thesis is deposited in the Addis Ababa University Digital Library and is made available to local, national and international scientific community. I solemnly declare that this thesis has not been submitted to any other institution anywhere for the award of any academic degree, diploma or certificate.

Brief quotations from this thesis may be used without special permission provided that accurate and complete acknowledgement of the source is made. Requests for permission for extended quotations from, or reproduction of, this thesis in whole or in part may be granted by the Head of the Department or all advisers of the theses when in his or her judgment the proposed use of the material is in the interest of scholarship and publication. In all other instances, however, permission must be obtained from the author of the thesis.

Student

Name: Abebe Tibebe

Signature: _____ Date: _____

Research Advisors:

1. Dr. Endalew Gemechu Sendo (PhD. Ass. Prof)

Signature

Date

2. Yeshe Assefa (BSc, MSc)

Signature

Date

ACKNOWLEDGEMENT

My heartfelt gratitude goes to Addis Ababa University, College of Health Sciences, School of Nursing and Midwifery, for giving me this great opportunity and I want to extend my gratitude also to St. Peter Specialized Hospital for giving me the chance to attend a postgraduate program.

I am extremely grateful to my advisors to Dr. Endalew Gemechu and Mss. Yeshi Assefa who gave constructive comment and support.

I extend my thanks to AAU librarian and internet center coordinators for their cooperation in providing documented materials and Internet access.

My deepest gratitude also goes to Addis Ababa Public Health Research and Emergency management directorate and Addis Ababa public hospital administrators for facilitating data collection process.

I would like to thank all data collectors, supervisors and respondents for their collaboration for the success of this study. Finally, I would like to thank all my family and friends for their invaluable contribution in my life journey.

Table of Contents

ACKNOWLEDGEMENT	vi
LIST OF ACRONYMS AND ABBREVIATIONS.....	ix
LIST OF TABLES	x
LIST OF FIGURES.....	xi
ABSTRACT.....	xii
1. INTRODUCTION.....	1
1.1. Background.....	1
1.2. Statement of the problems	2
1.3. Significance of Study	3
2. LITERATURE REVIEW	5
2.1. Fear of childbirth.....	5
2.2. Prevalence of fear of childbirth.....	5
2.3. Associated factors of Fear of childbirth	6
2.3.1. Sociodemographic factors	6
2.3.2. Obstetrics related factors	6
2.3.3. Social factors.....	7
2.4. Conceptual framework	9
3. OBJECTIVE	10
3.1. General objective	10
3.2. Specific objectives	10
4. METHODS	11
4.1. Study design, study area, and period.....	11
4.2. Source population and Study population.....	11
4.2.1. Source population.....	11
4.2.2. Study population	11
4.3. Inclusion and Exclusion criteria.....	11
4.4. Sample size determination.....	12
4.5. Sampling procedures	13

4.6.	Variables of the study.....	15
4.7.	Conceptual and operational definitions	16
4.8.	Data collection tools /measurements and procedure	16
4.11.	Ethical Consideration	17
4.12.	Dissemination of Results	17
5.	RESULTS	18
6.	DISCUSSIONS.....	26
7.	STRENGTH AND LIMITATION.....	28
8.	CONCLUSION AND RECOMMENDATION.....	28
8.1.	Conclusion	28
8.2.	Recommendations	28
9.	REFERENCE.....	29
10.	APPENDEX.....	33
10.1.	Annex A: English Information Sheet	33
10.2.	Annexes B: Informed Consent.....	34
10.3.	Annex C: English version questionnaire	35
10.4.	Annex D: Amharic information sheet	39
10.5.	Annex E: Amharic consent form	39
10.6.	Annex F; Amharic version questionnaire	40

LIST OF ACRONYMS AND ABBREVIATIONS

AAU - Addis Ababa University

ANC -Antenatal care

AOR - Adjusted odds ratio

BOC- Birth out come

CI - confidence interval

COR - crude odds ratio

CS - Cesarean section

DM- diabetic mellitus

FOC - Fear of childbirth

GA - Gestational age

GMH - Gandhi Memorial Hospital

HEG - Hyper emesis gravidarum

HTN - Hypertension

MOD - Mode of delivery

MSc - Masters of Science

PIH - Pregnancy induced hypertension

PNC - Postnatal care

SPSH - St. Peter Specialized Hospital

SVD- Spontaneous vaginal delivery

TASH- Tikur Anbessa Specialized Hospital

WDEQ - Wijma Delivery Expectancy Questionnaire

WHO - World Health Organization

LIST OF TABLES

Table 1 Calculated sample size for associated factors of fear of childbirth, using Ep-info version 7.2.2.2.....	12
Table2.Socio demographic characteristics of pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021(n=405).	18
Table 3.Obstetric characteristics of pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021(n=405).....	20
Table4.Bivariate and multivariate logistic regression for factors associated with fear of childbirth (n=405).	24

LIST OF FIGURES

Figure1. Conceptual framework includes dependent and independent variables after reviewing different literatures.....	9
Figure2. Schematic representation of the sampling procedure to select study participants from Addis Ababa public hospitals, 2021.....	14
Figure 3. Social support among pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021(n=405).....	21
Figure4. Prevalence of fear of childbirth among pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021(n=405).	22

ABSTRACT

Background: Fear of childbirth is defined as feelings of uncertainty and anxiety before, during, or after childbirth. It ranges from low to severe fears that women experience in relation with childbirth. It affects the wellbeing of mothers during perinatal life and her family.

Objective: To determine the prevalence of fear of childbirth and associated factors among pregnant women attending antenatal care in selected Public Hospitals Addis Ababa, Ethiopia 2021.

Methods: Institution-based cross-sectional study was conducted among 405 pregnant women attending antenatal care in four selected public Hospitals in Addis Ababa. Simple random sampling and systematic random sampling methods were used to select Hospitals and study participants respectively. Data was collected through face-to-face interviews using a structured pre-tested questioner. Wijma Delivery Expectation/Experience Questionnaire was used to score fear of childbirth. Collected data were entered using Epi-data-4.6 statistical software and analyzed using SPSS-25 statistical packages. In bivariate analysis P-value, less than 0.25 was considered for multi variate analysis, in multivariate analysis of P-value less than 0.05 considered as significant.

Results: Out of the total, 400 respondents took part in the study with a response rate of 98.8%. This study showed that 111(27.7%) of study participants had low fear of childbirth, 176(44.0%) moderate, 68(17.0%) high, 45(11.3%) severe fear of childbirth. Having no formal education(AOR=5,95%CI:(1.37-18.15)(p=0.02), previous obstetrics complications AOR=3,95%CI: (1.14-7.8)(p=0.03), mode of delivery preference AOR=3,95%CI:(1.02-9.03) (p=0.045). Having medical illness AOR=3.6,95% CI (1.02-9.03) (p=0.02) showed significant association with a fear of childbirth. **Conclusion and recommendations:** Fear of childbirth is prevalent in the study setting. Fear of childbirth was linked to educational attainment, previous obstetric problems, medical illness, and mode of delivery preference. Based on a cut-off value of high and severe fear of childbirth, the women were classified as having fear of childbirth. This group included 28.2% of all women with FOC. Early identification of women at risk of childbirth anxiety is clinically significant in the study setting to improve women's health during perinatal periods. **Keywords:** Pregnancy, fear of childbirth, Wijma Delivery Expectancy Questionnaire A, Addis Ababa.

1. INTRODUCTION

1.1. Background

Fear of childbirth (FOC) was defined as feelings of uncertainty and anxiety before, during, or after childbirth, thinking about future labor and giving birth [1]. It is witnessing the fearful reaction of others to childbirth and labor pain. Fear of childbirth seems to be used as a broad term for all types of anxiety and fears that women experience concerning pregnancy and childbirth, it affects women's health and wellbeing in their perinatal life [1]. Tokophobia also used to be characterized as an unreasoning dread of childbirth in women, a specific and harrowing condition including a pathological dread and avoidance of childbirth [2]. According to North American Nursing Diagnosis Association fear defined as a response to a perceived threat that was consciously recognized as a danger [3]. It has psychological, physiological, cognitive, and behavioral perspectives [4].

FOC is classified as primary which occurs in nulliparous that come from traumatic experiences in their past sexual abuse, witnessing a difficult birth or listening to stories or watching programs that portray birth as embarrassing or dangerous. Secondary FOC occurs in multigravida who had a previous traumatic birth experience develop fear for the next childbirth. Based on the degree of severity it also rated from mild to severe fear of childbirth [5]. There were differences in prevalence of FOC among the countries due to childbirth fear definition used, screening trimester and parity of the pregnant women. The overall prevalence of FOC in pregnant women in worldwide it accounts around 14 % and it increasing from time to time since 2000 [6]. Academic interest in perinatal mental health and tokophobia has been increasing over recent years but fear of childbirth was measured and defined varied in different countries. It also varies in severity and contributing factors among women [1, 6, 7].

In the Eastern region 21 out of every 100 pregnant women experienced a clinical level of fear [8]. Pathological fear occurred in 1.6% of pregnant women associated with the fear of having an episiotomy fear [9]. Fear of childbirth in the prenatal period results from higher state anxiety, lower dyadic adjustment, and higher insecurity in attachment relationships, it also resulted in increased postnatal maternal risk and stress, developed severe labor pain [10, 11]. Mothers who received care from a known midwife during labour and birth their perception of pain and fear experienced decreased. Building a trustful midwife–woman relationship increase the quality of care with regards to information, participation in decision making and perception of control, counseling visit becomes increased, they viewed the continuity of care as more important, were more satisfied with the counseling [12].

Evidence also showed that both cognitive therapy sessions and theory-based group psychoeducation with relaxation are effective interventions for both antenatal and intrapartum support of pregnant women with high or severe FOC. Teamwork between midwives, psychologists, and obstetricians qualified in psychotherapy should be established to identify and treat women with high to severe FOC [13]. In Malawi, the intervention done to decrease FOC and improve childbirth self-efficacy the companion-integrated childbirth preparation for childbirth fear, self-efficacy, and maternal support were effective [14]. Psychoeducation for women with FOC during pregnancy and after delivery was one of the world health organization's (WHO) recommendations on interventions targeted at women for the reduction of unnecessary cesarean sections. The content of the teaching materials includes information about fear and anxiety related to childbirth, stabilization of individual reactions, labor progress, hospital routines, the birth process, and pain control and should not cause stress [15]. Effective communication, respectful maternity care, relief labor pain among the recommendation of the WHO for a positive childbirth experience [16].

1.2. Statement of the problems

Fear is corrosive, relentless, and contagious. It limits care provider's potential and prevents them from doing the best of the mothers, midwives, and obstetricians. Fear can cast a dark shadow over pregnancy and birth and inhibit optimal hormonal function. At a time when birth has never been safer, it is sadly ironic that care providers are only just becoming aware of the tragic impact of fear upon mothers and all those involved in birth [17]. Fear of childbirth was not only a common problem among pregnant women but also a perception of a disruptive for the minority of them. A qualitative study revealed, Thailand women did not perceive childbirth as a nature of life but as a life-threatening situation [18]. Women's sense of fear had been linked to their satisfaction with the birth experiences which could ultimately affect women's future decisions for future pregnancy and childbirth [18].

Fear of childbirth could contribute to several unwanted effects on the mothers, her baby, and families that may occur during ANC, labor delivery, and in postpartum periods that includes obstetrics complications, operative vaginal delivery, increased anti-pain use in labor, abnormal labor, request for cesarean section, postpartum depression, and impaired maternal-infant bond, risk of antenatal and postnatal depression increased [5, 19-22]. The impact of maternal mental health disorders on women and their children is significant. Stress and psychological problems during pregnancy have been associated with preterm labour, poor infant outcome, greater cognitive, behavioral, and interpersonal problems in young children. Similarly, postnatal psychological problems harm the woman, child, and family

relationship. The World Health Organization lists psychological illness as a significant indirect cause of maternal death in the first year after birth [23]. In different research factors that contributes on FOC were identified that include, maternal age, parity, gestational age, bad birth outcome, low education, poor economic status, poor social support, instrumental and CS delivery, low self-esteem, and lack of husband support was reported as factors leads to childbirth fear [1, 6, 7, 19, 24].

Different research suggests that psychosocial and psychological interventions, physical exercise, therapeutic, setting standards prenatal screening tools undertaking information, antenatal education, and communication programs to increase awareness of the women, husbands, health providers, and society about childbirth fear necessary to solve and minimize the problem [25, 26]. In childbirth, give explanations on childbirth process, women-centered care, take informed consent in the care given to mothers, positive attitudes of health care providers towards women with childbirth fear reduces the level of fear and negative childbirth outcome [27, 28].

Continuity of care models provides greater opportunities for midwives to develop relationships of trust with women and thus provide more possibilities for women to express their fears. There is a need for high quality and consistent information for women during pregnancy that will not trigger fear particularly in first-time women, biofeedback, hypnosis, internet-based cognitive behavioral therapy are effective treatments for fear of childbirth and also it has a good effect to strengthen women's self-efficacy[25, 29].

Different countries implemented different interventions for improving childbirth experience based on identified factors but the prevalence of its negative consequences still increasing worldwide. So the situation should be investigated to design and implement appropriate intervention programs and provide strategies to promote women's health especially in a developing country like Ethiopia as there is not enough study on psychological aspects of maternal care especially in fear of childbirth.

1.3. Significance of Study

Women with any degree of childbirth fear can be identified and prepared before or during pregnancy to reduce their fear of childbirth, which can improve their childbirth experiences.

Identifying the causes of fear of childbirth can help in the development of strategies for reducing childbirth fear during perinatal period.

To improve the quality of maternity care by address the mother's emotions, thought, and feeling during pregnancy, childbirth, postpartum periods that can also fulfill the psychosocial needs of mothers.

Knowing its prevalence and its factors contributing to them helps the ministry of health, health care institutions, health teaching institution, and Healthcare providers to give more focus on the issue and integrate the assessment and treatment of FOC in the ANC and labor /delivery service

Addressing mothers psychosocial needs is also part of Midwifery care these strengthen mothers with a care provider for continuity of care and positive health outcome

Uses as a reference to explore and understand more about others factors associated with it and its negative implication for future researchers.

2. LITERATURE REVIEW

2.1. Fear of childbirth

Childbirth is a critical experience in the lives of most women, and it is considered a transition phase to motherhood at physical, psychological, and social levels. Although safe birth care is provided in many countries, childbirth may impose a heavy burden on some pregnant women [30]. Fear of childbirth is commonly framed as a phenomenon within the domain of anxiety and clinical descriptions of childbirth fear are often characterized by symptom expressions resembling those of various emotional disorders. However, to our knowledge, findings relating childbirth fear to different parameters of anxiety have never been structurally aggregated and evaluated, and little is known about the psychological mechanisms underlying this problem [31]. The physiological aspects of fear and anxiety include responses such as palpitations, hyperventilation, and dizziness. In the conditioning theory of fear acquisition, the distribution of human fear is not consistent within the theory and can be acquired by three pathways, conditioning, vicarious exposure, and the transmission of information and instruction [32].

2.2. Prevalence of fear of childbirth

A study of meta-analysis the prevalence of fear of childbirth in pregnant women found that 14% worldwide, most of this study is done in developed countries including the USA, Europe, Scandinavia, Asia, and Sweden. In Scandinavia, it accounts for 12%, in the rest of Europe, the prevalence is 8%, Australian 23%, American 11%, and in Asian 25% [6]. In Sweden childbirth-related fear was three times as common in foreign-born women as compared to Swedish women [33]. The study done in Khorramabad showed that 80.8% prime-gravid women had fear of childbirth [34]. The study conducted in Thailand Siriraj Hospital among pregnant women with no medical or obstetric problems, severe fear of childbirth accounts 0.7% [19]. In a cross-sectional study in Ireland overall prevalence of severe and high fear of childbirth was 5.3 and 36.7 percent respectively. Of them, around forty-three percent was high FOC among nulliparous and 33.6 percent were in multiparous women [7]. In a study among Iranian pregnant women around twenty percent of pregnant women develop moderate and six percent develop severe fear of childbirth [35]. In developing countries, severe FOC accounts for eight percent [36]. In Malawi, the prevalence of low degree fear of childbirth was 39 percent, moderate accounts forty-one percent, and high fear of childbirth was twenty percent before delivery, low and moderate almost similar prevalence but high FOC decreased by half after delivery. Both pregnant and postpartum women who were illiterate five times more experience FOC and unemployed twelve times more develop moderate to

high fear of childbirth [37]. From a study in Kenya Approximately 29.5% had low, 40.4% moderate, 22.1% high, and 8% severe fear of childbirth [36]. In a study of Arba-Minch Ethiopia, almost three-fourth of the pregnant women are suffering from moderate to severe degrees of fear of childbirth [38].

2.3. Associated factors of Fear of childbirth

Fear of childbirth was a common feeling among pregnant women, severe forms could affect both the mother's and fetus's well-being so identifying the risk factors helps realize early interventions and treatment for mothers who are suffering from fear of childbirth [39]. A systematic review on fear of childbirth report the causes and outcomes are grouped into population variables, mood-related factors, and pregnancy and birth-related factors. Even though nulliparous and parous women have similar levels of fear the factors may different that contribute to fear of birth, most contributing factors of FOC in parous women were related to past pregnancy, labor, and delivery experiences [28].

2.3.1. Sociodemographic factors

Among the demographic variables asses in different studies; maternal age, marital status, income, and educational status were each found to be associated with fear of childbirth, the higher socioeconomic status and educational status the lower fear of childbirth [7, 40, 41]. In a study conducted in Malawi among pregnant women, there was a significant positive association between fear of childbirth and low educational attainment. women with low educational status were five times more experienced than higher educated women and unemployed were twelve times experienced FOC than employed women [37]. Also, another study described that age, income, and education are negatively related to fear of childbirth [19, 40]. In a study of Kenya, pregnant women's severe childbirth fear is highly associated with marital status and literacy status [36]. In a study conducted Iranian there was no significant association fear of childbirth with maternal age, educational level, employment status, but there was a negative association between FOC and high family income [35].

2.3.2. Obstetrics related factors

Iranian study showed that women whose pregnancy was unwanted were developed a fear of childbirth three times than that of women whose pregnancy was wanted, but gestational age and parity were not significant factors [35]. Other studies showed that the majority of pregnant women had FOC related to a traumatic birth, painful uterine contractions, instrumental delivery, and negative birth experience in a previous pregnancy, history of abortion, and fear of pain [9, 40-43]. In Khorramabad showed that prime-gravid contributes to the major factors of childbirth fear, especially not participating in childbirth preparation education, choice of mode of delivery also another factor for the fear of childbirth [34]. A

study reported in Thailand un-planned pregnancy significantly contributes to the occurrence of childbirth fear [19]. In other studies also women who had unplanned pregnancy were about two times more likely to have severe degree fear of childbirth compared with those with planned pregnancy, women with good knowledge about childbirth and access to childbirth information were associated with a decreased chance of developing a fear of birth, but gestational age was unrelated to fear of childbirth in contradict with a study done in Turkey [21, 40, 44]. In an interview of women and midwives on fear of childbirth key elements were identified in related women's fear of childbirth of those fear of unexpected complications and outcomes, injury to her-self and baby at the time of childbirth, labor pain, being alone, lack of decision making, physical changes during birth and after birth and labour process were reported [45]. In Kenya study report that fear of birth was more severe on prim gravida women than multigravida, also women who had a regular ANC, having trust in healthcare providers, and physical activity during pregnancy had less fear of childbirth as compared to women who do not have [36]. In a study conducted Ethiopia unplanned pregnancy doubles the degree of childbirth fear as compared to planned pregnancy and current pregnancy-related complications are six times more likely to develop severe degree fear of childbirth than pregnancy with no problems, in contrast to these study women with her pregnancy is planned she experience more fear of childbirth in comparison to women with unplanned pregnancy [38, 46].

2.3.3. Social factors

From the study in Thailand lack of family support, lack of witness delivery also significantly contributes to the occurrence of fear of birth [19]. In Iranian women, a study showed that childbirth fear was four times in women who had no emotional support from their husband than women who get support from their husbands [35]. In a study conducted China, there was a significant association between husbands' support and a higher level of childbirth fear. In Ethiopia also women with poor social support twice develop severe degree childbirth fear [38, 41].

In some study suggest that theory-based concepts for antenatal and intrapartum support of pregnant women with high or severe childbirth fear which was piloted, tested, evaluated, and implemented within the given healthcare system, competent health care provider that addresses pregnant women's fears, use of a valid assessment tool to identify the level, cooperative local networks between different health care providers to ensure timely and effective care for women with high or severe fear can decrease the negative impact of fear of childbirth [13]. In different study showed that women who received continuity of care from a known midwife during labour and birth with regards to information, participation in

decision making and perception of control gain relief from a fearful situation and perception of pain and extended birth education can contribute to relieved women from fear of childbirth [47, 48]. It is important that the health care providers especially those directly involve in maternity care ANC, PNC, labor, and delivery should give concern about screening and managing women having fear of childbirth.

2.4. Conceptual framework

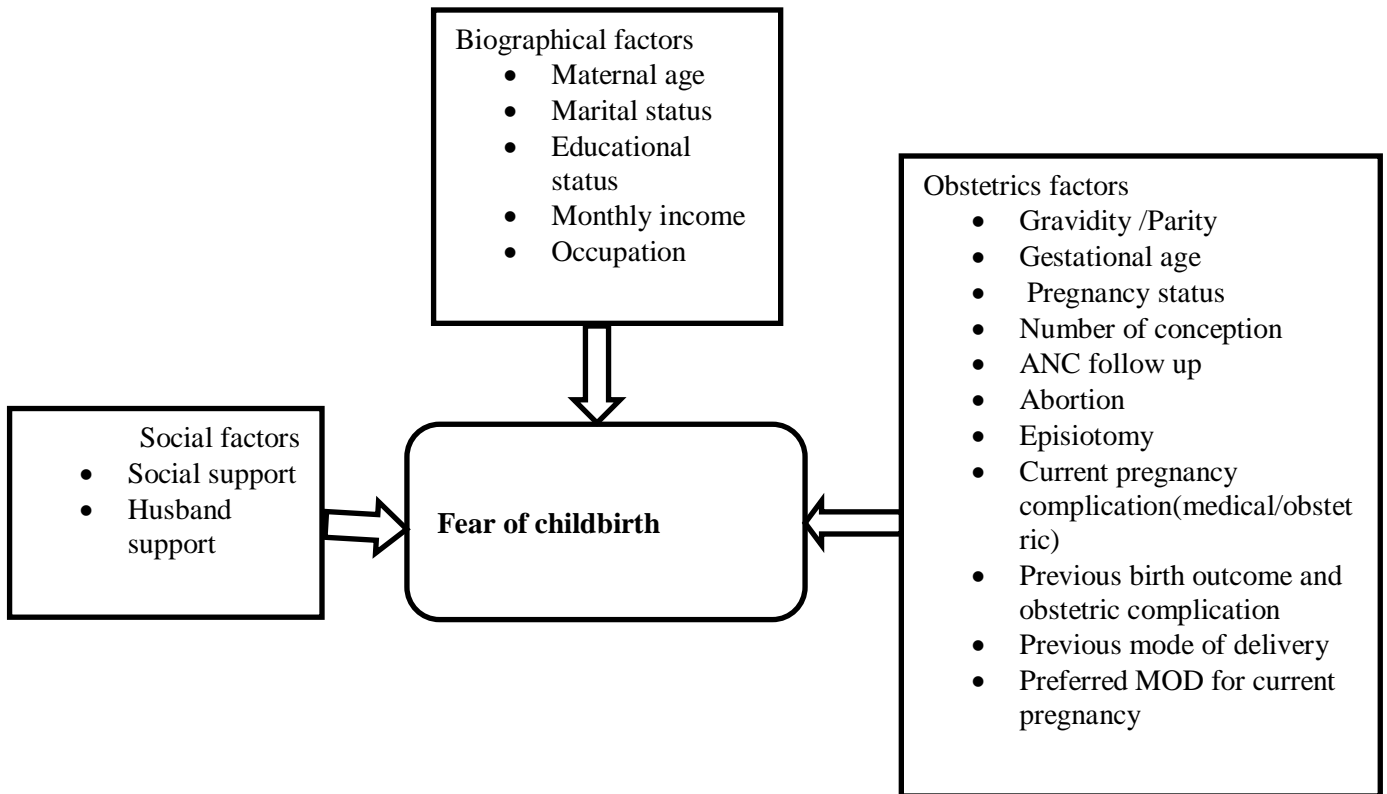


Figure 1. Conceptual framework includes dependent and independent variables after reviewing different literatures.

This framework conceptualizes the relationship between fear of childbirth and socio demographic factors, obstetrics factors and social factors were directly related to fear of childbirth [21, 38-41, 43, 44, 46, 49].

3. OBJECTIVE

3.1. General objective

To determine the prevalence of fear of childbirth and associated factors among pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021.

3.2. Specific objectives

1. To determine the prevalence of fear of childbirth among pregnant women attending ANC in selected Public Hospitals.
2. To identify factors associated with fear of childbirth among pregnant women attending ANC in selected Public Hospitals.

4. METHODS

4.1. Study design, study area, and period

An institution-based cross-sectional study was used to conduct from February 8 - March 8/2021, in selected Public Hospitals in Addis Ababa.

Addis Ababa is the capital city of Ethiopia, which contains 13 government hospitals (5 federals, 6 under Addis Ababa Health Bureau, one owned by the police force, and one owned by armed force) distributed throughout ten sub-cities. All Hospitals provide antenatal care, labour and delivery services, and postnatal care with free care service available during pregnancy up to six week of post-partum period. Four hospitals selected using simple random sampling by lottery method from the list of thirteen hospitals (Tikur Anbessa specialized Hospital, MinillikII Hospital, St. Peter specialized Hospital, and Gandhi Memorial Hospitals) were selected for the study. Tikur Anbessa Specialized hospital the largest referral and teaching hospital in Ethiopia and operated under the ministry of education of Ethiopia, St. Peter specialized Hospital was the other referral and teaching hospital among those operated under the federal ministry of health. However, Gandhi Memorial and MinillikII Hospitals were among the six governmental referral hospitals that were managed under the Addis Ababa Administrative Health office.

4.2. Source population and Study population

4.2.1. Source population

All pregnant women attending ANC in selected public Hospitals Addis Ababa, Ethiopia.

4.2.2. Study population

Sampled pregnant women attending antenatal care at study facilities at the time of data collection and fulfilled the inclusion criteria.

4.3. Inclusion and Exclusion criteria

Inclusion Criteria

Pregnant women who attending ANC service in public Hospitals and available at the time of data collection

Exclusion criteria

Women in emergency conditions either medical or pregnancy-related complications that affect the women's ability to give consent and respond to the questions.

4.4. Sample size determination

Sample size for the first objective was calculated using single population proportion formula;

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

The assumptions used were: Z=standard normal distribution curve value for the 95% with a confidence interval (1.96)

d - Marginal error of 5%,

p – Proportion

n - Sample size

The prevalence of fear of childbirth was taken from a previous similar study to calculate the sample size and to get maximum sample size prevalence of moderate fear of childbirth (0.398) was taken [38]. The sample size taken from the second objective (risk factors) was less than the sample size from that of the first objective (prevalence of fear of childbirth) then the final sample size was (table 1).

$$n = \frac{(1.96)^2 * 0.398(1-0.398)}{(0.05)^2} = 368 = \text{by adding 10\% nonresponse rate the final sample size was 405.}$$

Table 1 Calculated sample size for associated factors of fear of childbirth, using Ep-info version 7.2.2.2

Factors of FOC	Ratio(Unexposed/ Exposed)	%Exposed with Outcome	OR	Power	CI	Sample size	Reference
Pregnancy complication	1:1	25	6.24	80	95	120	[38]
Illiterate	1:1	21	5	80	95	164	[37]
Unemployment	1:1	40	12.6	80	95	54	[37]

4.5. Sampling procedures

Thirteen public hospitals provide Antenatal care, labour and delivery services, and postnatal care in the study area; of them four hospitals namely; Tikur Anbessa, Minelik II, Gandhi, and St. Peter hospitals were selected randomly using the lottery method from the total list. To select 405 pregnant women attending ANC from the total four selected public hospitals first all selected hospitals are listed down with their respective average number of pregnant women attending ANC with three-month report data are taken from each hospitals, and then the number of pregnant women in each hospital was proportionally allocated to sample size, then finally the study participants for each hospital will be selected and interviewee using systematic random sampling in every k^{th} interval of each respective hospitals until the required sample size achieved. The total sample size (405) was allocated proportionally for the four public hospitals based on the three-month average number of pregnant women attending ANC service in each hospital = $\frac{n \times N_j}{N}$, and Interval size; $k_j = \frac{N_j}{n}$ where; n_j = the sample size of the j^{th} hospital, N_j = was population size of the j^{th} hospital, $n = 405$ the total sample size from the selected Hospitals. $N = 2050$, total source population size from four hospitals (got from Health management information system report) $K = 2050/405 = 5$ (Figure 2).

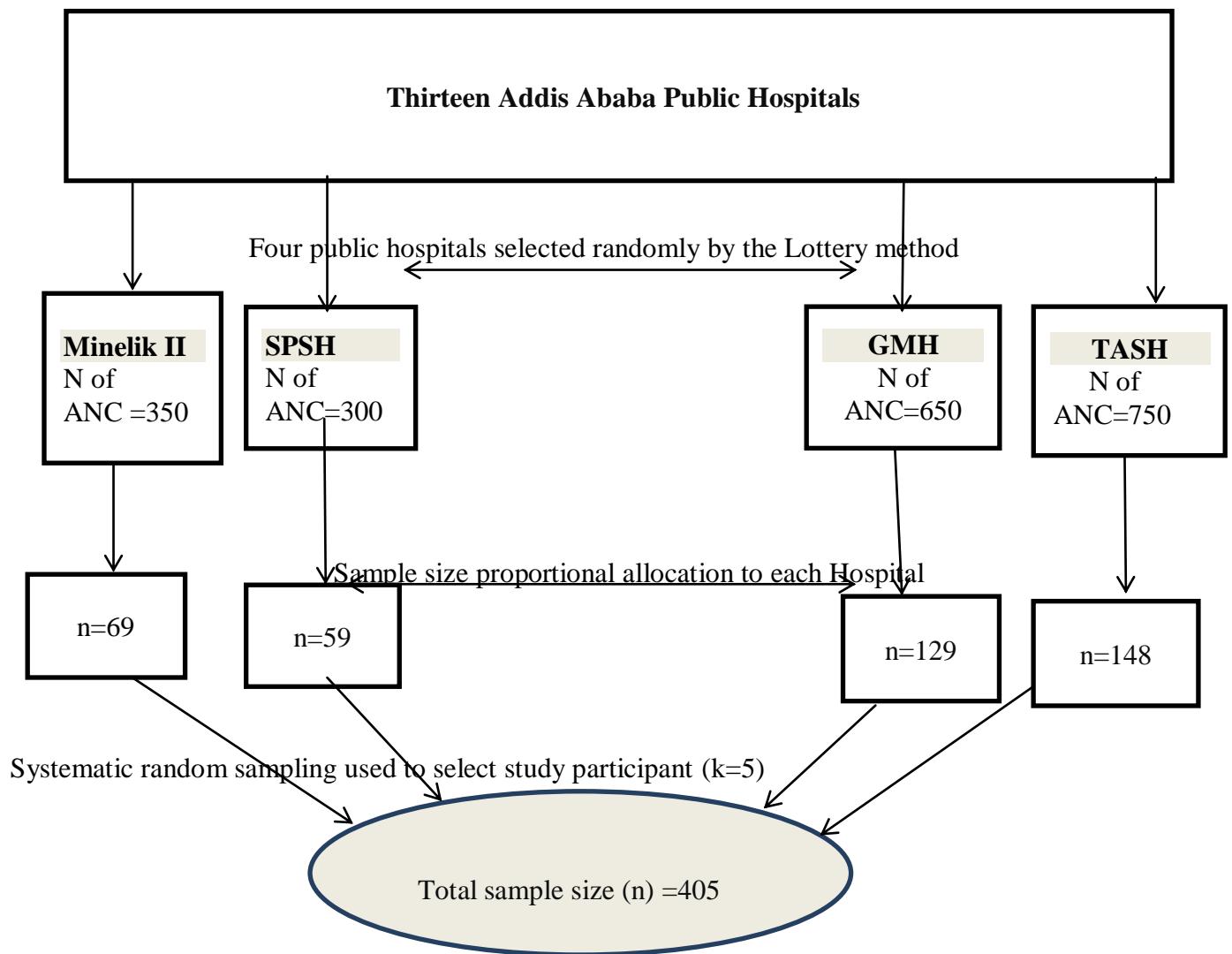


Figure2.Schematic representation of the sampling procedure to select study participants from Addis Ababa public hospitals, 2021

4.6. Variables of the study

Dependent variables

- fear of childbirth

Independent variables

Socio demographic

- Age
- Marital status
- Educational status
- Occupation
- Income

Obstetric related

- Gravidity/Parity
- Previous mode of delivery
- History of episiotomy
- Previous birth outcome and obstetric complication
- History of abortion
- Gestational age
- Number of conception
- Pregnancy status
- ANC follow up
- Mode of delivery preference
- Current pregnancy complication(obstetric/medical)

Social factors

- Husband support
- Social support

4.7. Conceptual and operational definitions

Fear of childbirth is a statement regarding the intensity of emotions and the magnitude of cognition about birth, it also operationalized by the cognitive appraisal of the delivery. **Wijma Delivery Expectation/Experience Questionnaire (W-DEQ)**; It was developed by Wijma and his colleague to measure a construct of fear related to childbirth during pregnancy and after delivery by asking the woman about her expectancies before (version A) and experiences after (version B) childbirth, respectively [50].

Degree of childbirth fear is operationalized as

W-DEQ sum score < 38=Low degree fear

W-DEQ of 38–65.9 =Moderate degree fear; W-DEQ of 66-84.9=High degree fear ; W-DEQ \geq 85= Severe degree fear of childbirth[51].

Oslo social support scale: is a three-item question which was used to assess psychosocial distress, the first item were score out of four and the 2nd and 3rd item were score out of five. The total sum ranges from 3 to 14 interpreted as a score of 3–8 (poor), 9–11 (moderate), 12–14 (strong) [52].

4.8. Data collection tools /measurements and procedure

Data were collected using structured and pretested questionnaires from participants. Questionnaires used to assess socio-demographic characteristics, obstetric characteristics; social support and childbirth were adapted from reviewing different literatures [37, 38].

Social support was assessed using Oslo social support scale: a three-item question used to assess psychosocial distress, the sum ranges from 3 to 14. It was developed and validated in different research to assess level of social support [52].

FOC was assessed using Wijma Delivery Expectation/Experience Questionnaire version A. This 33-item rating scale has a 6-point Likert scale as a response format, ranging from not at all = 0 to extremely =5, and internal consistency, and split-half reliability of the W-DEQ was checked and the Cronbach's alpha score was 0.93 done in the developmental process [50]. The questionnaire was first prepared in the English language and translated into Amharic version for interview. Face-to-face interview techniques were used to collect data from pregnant women after they completed their daily ANC service.

4.9. Data quality control

To check the accuracy and its consistency pretest was done on 5% of the total sample size of pregnant women attending ANC in other public Hospital before the actual study period from Feb1-3/2021. Four diploma midwives participated in the data collection after one day of training was given on the objective, relevance of the study, confidentiality of information, respondent's right, and informed consent. The principal investigator and the supervisor were made frequent checks on the data collection process to ensure the completeness and consistency of the gathered information and errors found during the process were corrected.

4.10. Data processing and analysis

After checking the collected data for its completeness and accuracy code was given to the questionnaire, and then data entered using Epi-data-4.6 statistical software and analyzed using SPSS-25 statistical packages. Data cleaning was performed to check for accuracy, consistencies, missed values, and variables to fix errors. Data were re-coded and computed to found the prevalence and finally re-categorized the four categories of FOC into two. The W-DEQ A was treated as a categorical variable (less than 38, 38-65.9, 66-84.9, 85 and above). Binary logistic regression was used to find out the association between the explanatory and outcome variable P value less than 0.25 in binary logistic regression were considered for multivariate logistic regression. P-value less than 0.05 were considered statistically significant. The model goodness of fit was tested using Hosmer and Lemeshow test which was 0.86.

4.11. Ethical Consideration

Ethical clearance was obtained from the Institutional Review Board AAU college of Health science and from Addis Ababa Public Health Research and Emergency management directorate then a support letter was obtained from the Addis Ababa health bureau administration for each selected Hospital. The objective and importance of the study were explained to the study participants then data were collected only after full informed verbal and written consent was obtained. Confidentiality of the information was maintained by anonymous in the interview.

4.12. Dissemination of Results

First, the result of this study will be presented to AAU College of health science school of nursing and midwifery department of midwifery then the report paper will be disseminated to the ministry of health, Addis Ababa Public Health Research and Emergency management directorate, and Hospitals. Publication and online dissemination will be considered.

5. RESULTS

5.1. Socio-demographic characteristics of pregnant women of prevalence of fear of childbirth and associated factors

A total of 400 women participated in the survey, with a response rate of 98.8%. A large number of the 178 (44.5 percent) respondents were between the ages of 26 and 33, with a mean age of $28 \pm 6SD$ years. The majority 352 (88%) of them were married or living together, participants with the secondary education accounted for 141 (35.2%) while college and higher education accounted for 152 (38%) of the total, respectively. Of the total respondents, more than a quarter (29%), were self-employed while 171 (47.75%) were employed by the government. The respondents' average monthly income was 3692.75 Ethiopia birr (Table 2).

Table 2. Socio demographic characteristics of pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021 (n=405).

Variables	Category	Frequency	Percentage (%)
Age	18-25	152	38.0
	26-33	178	44.5
	34-41	55	13.75
	42-49	15	3.75
Marital status	Single	30	7.5
	Married/live together	352	88.0
	Divorced	10	2.5
	Widowed	8	2.0
Educational status	no formal education	23	5.8
	primary (1-8)	84	21.0
	secondary(9-12)	141	35.2
	college and above	152	38.0
Occupation	House wife	74	18.5
	self employed	191	47.75
	Government	116	29.0
	daily laborer	19	4.75
Monthly income	1650 and less	76	19.0
	1651-5250	256	64.0
	5251-10900	58	14.5
	10901 and above	10	2.5

5.2. Obstetric characteristics of the respondents

Among 400 respondents 50.7% and 49.3 % were primigravida and multigravida respectively. Twenty-five percent were prim parous from that 29.8 % were delivered by SVD in the previous childbirth. 22(5.5%) had a stillbirth, 61(15.3%) had obstetric complications in the previous pregnancy and childbirth. The majority were had singletons pregnancy 372(93.0%), planned pregnancy 341(85.3%), had regular Antenatal care follow up 375(93.8%), and 84.5% preferred vaginal delivery. 65(16.3%) had pregnancy-related complications and 42(10.5%) had medical illness/chronic disease. Majority of participant were got support from her husband during pregnancy (Table3).

Table 3. Obstetric characteristics of pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021(n=405).

Variables	Category	Frequency	Percentage (%)
Gravida	Primi-gravida	203	50.7
	multi gravida	197	49.3
Parity	nulli-parous	23	5.8
	primi-parous	102	25.5
	multi-parous	72	18.0
Previous mode of delivery	SVD	119	29.8
	Instrument	23	5.7
	CS	32	8.0
Episiotomy in previous delivery	Yes	91	22.8
	No	83	20.8
Outcome of previous childbirth	Alive	152	38.0
	still birth	22	5.5
History of abortion	Yes	73	18.3
	No	124	31.0
Complication in previous pregnancy/childbirth	Yes	61	15.3
	No	136	34.0
Gestational age	<14 weeks	72	18.0
	14-26weeks	170	42.5
	> 26 weeks	158	39.5
Number of conception in current pregnancy	single	372	93.0
	Multiple	28	7.0
Current pregnancy status	Planned	341	85.3
	Un planned	59	14.8
ANC follow up for the current pregnancy	Yes	375	93.8
	No	25	6.3
Mode of delivery preference of the current pregnancy	SVD	338	84.5
	CS	62	15.5
Pregnancy related complication during current pregnancy	Yes	65	16.3
	No	335	83.8
Had medical problems in the current pregnancy	Yes	42	10.5
	No	358	89.5
Had got support from your husband	Yes	340	85.0
	No	60	15.0

5.3. Social support of the respondents

The respondents' social support based on Oslo social support scale, with poor social support scoring 123 (30.8%), moderate social support 184 (46%) and strong social support scoring 93 (23.2%) (Figure3).

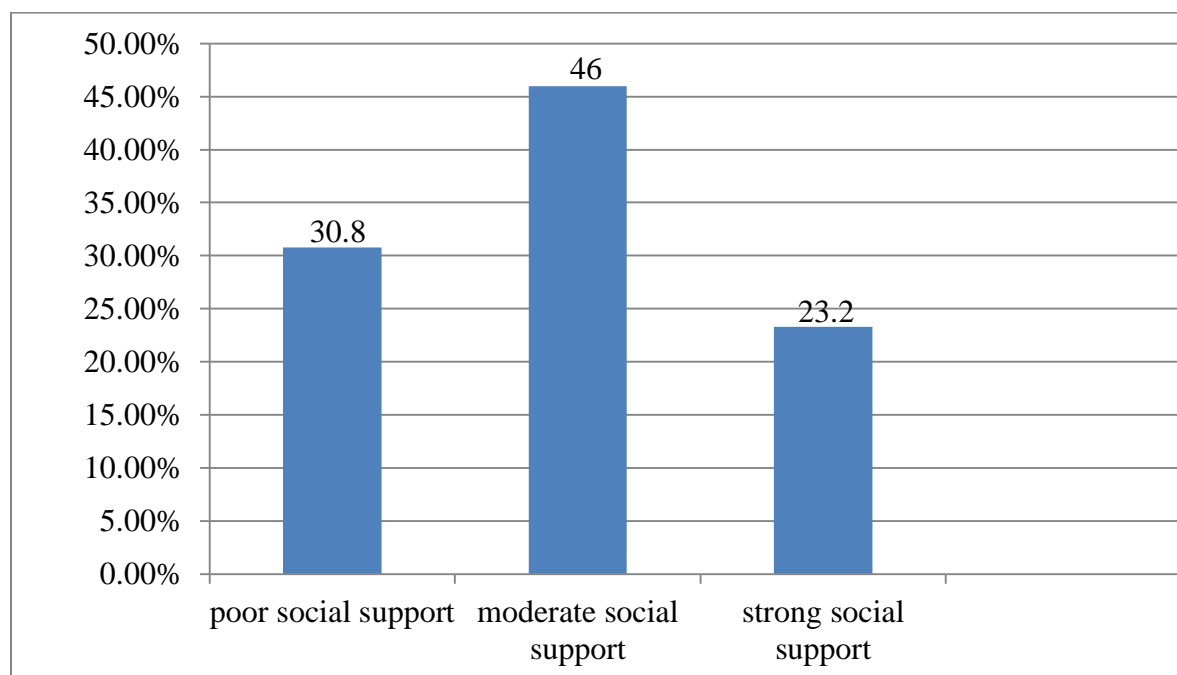


Figure 3 Social support among pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021(n=405).

5.4. Prevalence of Fear of childbirth

Of the total respondents, 111 pregnant women scored WDEQA less than 38, indicating a prevalence of 27.7% with low degree fear of childbirth, 176 pregnant women scored WDEQA 38-65.9, indicating a prevalence of 44 percent with moderate FOC, 68 pregnant women scored W-DEQA 66-84.9, indicating a prevalence of 17.0 percent high FOC, and 45 respondents scored W-DEQA 85 and above, indicating a prevalence of 11.3 percent with severe FOC. The mean fear of childbirth score was 54, with a standard deviation of 23.2. The minimum and maximum scores were 19 and 135 points, respectively (Figure4).

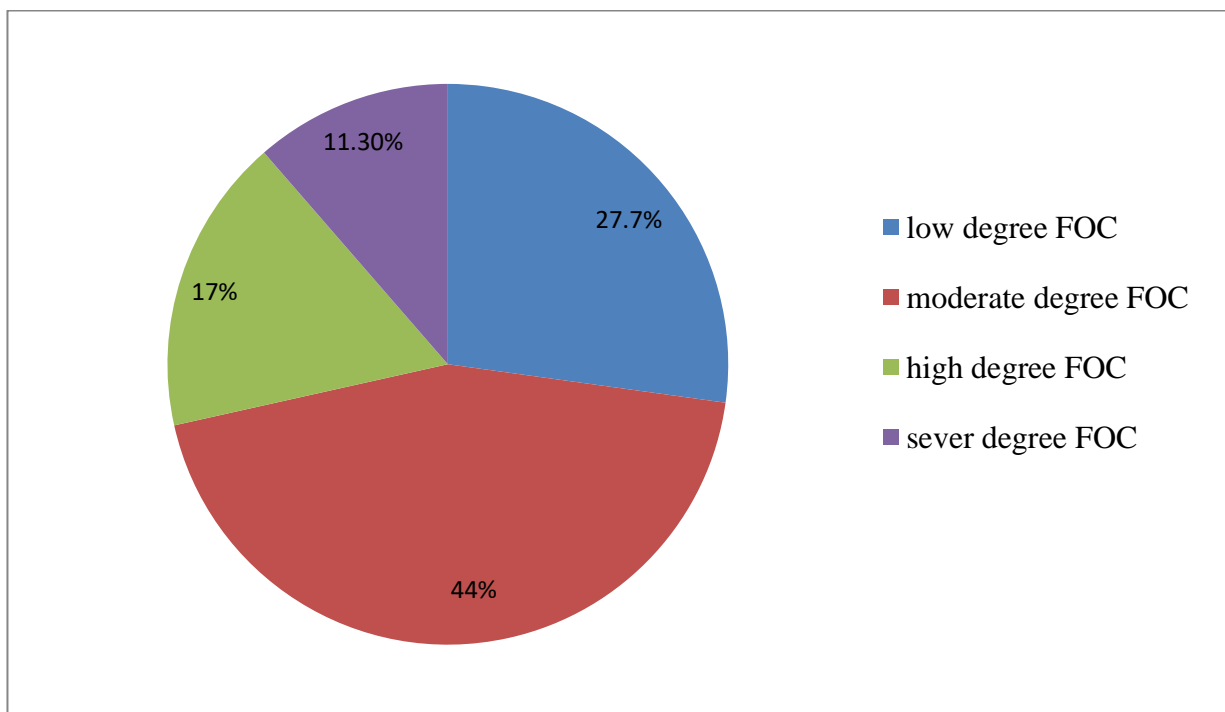


Figure4. Prevalence of fear of childbirth among pregnant women attending ANC in selected Public Hospitals Addis Ababa Ethiopia, 2021 (n=405).

5.5. Factors associated with fear of childbirth

To compute binary logistic regression the four categories of fear of childbirth were recoded into two categories. Low and moderate fear of childbirth was recoded into a new category of no fear of childbirth and high and severe fear of childbirth recoded into fear of childbirth. In bivariate analysis showed educational status, number of previous birth (parity), previous mode of delivery, outcome of previous childbirth, obstetric complication in the previous pregnancy and childbirth, gestational age (in weeks), current number of conception, current pregnancy status, preferred mode of delivery for the current pregnancy, pregnancy-related complication in the current pregnancy, medical illness/chronic disease in the current pregnancy, husband support were factors associated with fear of childbirth (p-value less than 0.25) and added to multivariable logistic regression analysis. In multivariable logistic regressions educational status, obstetric complication in the previous pregnancy and childbirth, mode of delivery preference, and had medical illness/chronic disease were significantly associated with FOC (p-value less than 0.05). The result showed that pregnant women who had no formal education were five times more likely to have fear of childbirth as compared with women who had educational attainment (AOR=5, 95%CI: (1.4-18.2) (p=0.02). Pregnant women who had obstetrical problems in the previous pregnancy and childbirth were three times more likely develop FOC as compared to pregnant women who had no problems (AOR=3,95%CI:(1.14-7.82) (p=0.025). Pregnant women who preferred CS for the current pregnancy mode of delivery, the degree of fear increased three times as compared to women whose preference is SVD as the mode of delivery (AOR=3,95% CI:(1.02-9.03) (p=0.045). The other variable that was found to have significant association were medical illness in the current pregnancy, pregnant women who had a medical problem FOC three time more as compared to having no medical illness(AOR=3.6,95% CI (1.2-10.95)(p=0.02) (Table4).

Table 4. Bivariate and multivariate logistic regression for factors associated with fear of childbirth (n=405).

Variables	Category	Fear of childbirth		COR 95%CI	AOR 95%CI	P value
		Yes (n, %)	No (n, %)			
Education	No formal	12(52.2%)	11(47.8%)	3(1.27-6.97)*	5(1.375-18.154)**	0.02
	Had formal education	101(26.8%)	276(73.2%)	1	1	
Parity	Null parous	11(47.8%)	12(52.2%)	2.55(0.97-6.75)*	1.5(0.64-3.48)	0.35
	Multi parous	45(26%)	129(74%)	1	1	
Previous MOD	SVD	22(18.5%)	97(81.5%)	1	1	
	Instrumental	11(47.8%)	12(52.2%)	4(1.56-10.35)*	1.65(0.5-5.5)	0.42
	CS	12(37.5%)	20(62.5%)	2.6(1.13-6.2)*	1.4(0.4-4.7)	0.6
Birth out come	Alive	33(21.7%)	119(78.3%)	1	1	
	Still birth	12(54.5%)	10(45.5%)	4(1.7-11)*	2(0.67-6.0)	0.21
Obstetric complication in previous childbirth	Yes	28(45.9%)	33(54.1%)	3.3(1.7-6.3)*	3(1.14-7.82)**	0.025
	No	28(20.6%)	108(79.4%)	1	1	
GA	<14 weeks	16(22.2%)	56(77.8%)	0.57(0.3-1.08)*	1.3(0.38-4.9)	0.62
	14-26weeks	44(25.9%)	126(74.1%)	0.7(0.43-1.1)*	1.2(0.35-4.4)	0.72
	> 26 weeks	53(33.5%)	105(66.5%)	1	1	
Number of conception	Single	96(25.8%)	276(74.2%)	1	1	
	Multiple	17(60.7%)	11(39.3%)	4(2.0-9.8)*	2(0.56-7.04)	0.23
Pregnancy status	Planned	76(22.3%)	265(77.7%)	1	1	
	Not planned	37(62.7%)	22(37.3%)	5.8(3.3-10.54)*	1.67(0.48-5.82)	0.42
MOD preference	SVD	76(22.5%)	262(77.5%)	1	1	
	CS	37(59.7%)	25(40.3%)	5.1(2.9-9.0)*	3(1.02-9.03)**	0.045
Pregnancy related complication during this pregnancy	Yes	31(47.7%)	34(52.3%)	2.8(1.63-4.9)*	2(0.6-6.9)	0.193
	No	82(24.5%)	253(75.5%)	1	1	

Had medical illness	Yes	18(42.9%)	24(57.1%)	2.1(1.08-3.4)*	3.6(1.2-11)**	0.02
	No	95(26.5%)	263(73.5%)	1	1	
Had got husband support	Yes	91(26.8%)	249(73.2%)	1	1	0.78
	No	22(36.7%)	38(63.3%)	1.6(0.89-2.8)*	1.2(0.32-4.42)	

Keys:* p value < 0.25 in bivariate, ** p < 0.05 in multivariate, 1=Reference

6. DISCUSSIONS

From this study, it was observed that the prevalence of low degree, moderate, high, and severe fear of childbirth among pregnant women attending ANC in public hospitals were (27.8%), (44.0%), (17.0%), and (11.3%) respectively, and the overall prevalence of FOC was 28.2 %. This finding is two times higher than the prevalence of FOC worldwide (14%). It was also higher than that of Scandinavia (12%), Europe (8%), Australia (23%), American (11%), and Asia (25%) [6]. This difference might be the differences in a care given for psychosocial needs of maternal care between developed and underdeveloped countries. This finding is similar to the study done in Kenya and Malawi [14, 36]. In this study the prevalence of severe fear of childbirth was different from the prevalence from a study in Thailand of low 18.5%, moderate 64.9%, high 16.1%, and severe 0.7%, this difference may be due to difference in the selection of study participants and sample size differences [19]. Other studies using W-DEQA ≥ 85 reported a prevalence of severe childbirth fear was 5.3 percent and high FOC was 36.7 percent in Ireland, and Norway [7, 42]. In the Italian survey the overall prevalence was 20-25% and severe fear of childbirth approximately 6–10% similar to this study but used different W-DEQA cut off point and more than half of the study participant have had a high level of education and the majority of women did not show any complications [53]. In the Iran study, the mean W-DEQ score was 67.6 ± 23.5 , moderate 19.6% (W-DEQA score ≥ 85), and severe 6.1% (mean W-DEQA score ≥ 100) fear of childbirth [35]. This low prevalence as compared to in the current study may be due to a difference in cutoff point in the W-DEQA score. In Slovenia pregnant women fear of childbirth was found low 22%, moderate 53.4%, high 23.1%, and pathological fear (sever) in 1.6% of respondents [9]. In this study severe fear of childbirth (11.3%) that requires clinical treatment a much higher, this difference may be due to the Slovenia study the data were collected after parenting and childbirth classes were given on the progress of labor. The finding of moderate fear of childbirth is similar with the study done in Arbaminch but the high and severe degree of fear of childbirth was low as compared to the prevalence of high (25.3%) and severe (24.5%) fear of childbirth study done in Arbaminch and higher in low fear of childbirth 10.3% [38]. Those levels of variation may be attributed due to the variation among the study area, level of education, and higher utilization of ANC service in this study area.

In this study, FOC was significantly higher among pregnant women who had no formal education (AOR= 5 CI (1.37-18.15) (P=0.02) than pregnant women of formal educational attainment. This finding was consistent with the study done in Malawi (AOR=5.0, CI (1.2- 20.2) p= 0.03) and Kenya [14, 36]. This finding is inconsistent with a study in china; higher education level was a significant determinant of

FOC [30]. This might well-educated nulliparous women were used to planning and structuring their lives in detail. They often believe that everything can be controlled. But, childbirth is an uncontrollable event in many respects, such as the length of labor, degree of pain, and change in body shape. In other studies, the socio-demographic variables including maternal age, marital status, income, and education were each found no significant association with fear of childbirth ($p > 0.05$) [35, 37, 40].

In this study previous obstetric complications were significantly associated with fear of childbirth with AOR=3, 95% CI (1.14-7.82) $P=0.025$, this is inconsistent with Norway study AOR=7.6, CI (3.8–15.2) [42]. The differences might be due to differences in sample size, gestational age, and data collection tools. In other studies, unplanned pregnancy, current pregnancy-related complications, instrumental delivery, GA, number of gravida, ANC follow up, poor social support were factors significantly associated with fear of childbirth [35, 36, 40]. This study did not find a significant association between these variables and fear of childbirth ($p > 0.05$).

Further, according to the findings of this study preference of CS for MOD of the current pregnancy significantly associated with FOC, three times susceptible as compared to vaginal delivery (AOR= 3.635, 95% CI (1.02-9.03) $P=0.045$, this also similar to other study done in Norway (AOR 4.6, 95 % CI 2.9–7.3) [42]. In the Iranian study, mode of delivery preference was also significantly associated with fear of childbirth ($p < 0.032$) [35]. In other studies similar to this study there was a significant relationship between fear of childbirth and cesarean birth for preferred mode of delivery ($P < 0.01$), and it showed that most of the participants choose vaginal delivery [9]. This study in contrast with a study done in Khorramabad health center Iran prim-gravid women indicated that the fear of childbirth among women who preferred vaginal delivery was 6.6 times more than that of those who preferred cesarean-section [34]. This might suggest that these mothers consider cesarean delivery as painless childbirth and safe for their child especially those who had information on negative experience of others on childbirth. The other variables significantly associated variable was pregnant women who had medical illness three times more developed fear than had no illness AOR=3.6 (1.23-10.95) $p=0.02$. In this study medical/chronic illness is less significant as compared with a study done in Arbaminch AOR= 6.24 (2.72, 14.29) [38]. This difference may due to differences in accessibility of different health care facilities. However this finding contradicted with a similar study done in Sakarya University education and research hospital (Turkey), there was a significant association between pregnant women those with no medical or chronic disease, and fear of childbirth ($p < 0.001$) [54]. This might be due to differences in time of data collection, awareness of participants, and study setting.

7. STRENGTH AND LIMITATION

This facility-based survey was the first to assess the prevalence of fear of childbirth and associated factors among pregnant women attending antenatal care in the study area. However, the findings of this study could only be generalized to this cohort of pregnant women in the study area. The questionnaires used in this study were based on the W-DEQA, a validated and widely used measure of fear of childbirth that has been used by a variety of researchers [38, 50, 51]. In this cross-sectional study, we can infer association but we cannot infer causation. Different researchers used different cut-off points to classify the degree of fear of childbirth, which may explain the disparity in FOC prevalence.

8. CONCLUSION AND RECOMMENDATION

8.1. Conclusion

Fear of childbirth is prevalent in the study setting. Fear of childbirth was linked to educational attainment, previous obstetric problems, medical illness, and mode of delivery preference. Based on a cut-off value of high and extreme fear of childbirth, the women were classified as having fear of childbirth. This group included 28.2 percent of all women with FOC. Early identification of women at risk of childbirth anxiety is clinically significant in the study setting to improve women's health care during pregnancy and after delivery.

8.2. Recommendations

Health facilities: Pregnant mothers who have had prior obstetric problems should receive psychosocial support counseling from health facilities during ANC visits.

Women should be given emotional support, and complications that arise during childbirth should be treated with evidence-based methods.

Give special attention to all pregnant women with negative experiences of previous pregnancies and childbirth. Childbirth education, pain relief information, and social support information should all be available for women attending ANC follow-up.

Higher education Institutions: As part of ANC, educational institutions should pay special attention to the psychosocial needs of pregnant women and prepare instruction for health care providers in coordination with the Ministry of Health.

Researchers: A qualitative study is also required to better understand women's perspectives toward childbirth fear, especially among mothers who had a pregnancy-related complication and had no educational attainment.

9. REFERENCE

1. Nilsson, C.e.a., *Definitions, measurements and prevalence of fear of childbirth: a systematic review*. BMC Pregnancy Childbirth, 2018. **18**(1): p. 28.
2. Hofberg K, W.M., *Fear of pregnancy and childbirth*. Postgrad Med J., 2003. **79**(935): p. 505-10.
3. Herdman, T.H.K., S., *NANDA International Nursing Diagnoses: Definitions & Classification, 2015–2017*. . 2014, Oxford: Wiley Blackwell.
4. Elisabet Rondung, J.T., Örjan Sundin, *Psychological-perspectives-on-fear-of-childbirth*. Journal of Anxiety Disorders 2016. **44**: p. 80-91.
5. Catriona Jones, F.W., Julie Jomeen, *Tokophobia: what it's like to have a phobia of pregnancy and childbirth*..2018.
6. O'Connell, M.A.L.-W., P.Khashan, A. S.Kenny, L. C.O'Neill, S. M., *Worldwide prevalence of tocophobia in pregnant women: systematic review and meta-analysis*. Acta Obstet Gynecol Scand, 2017. **96**(8): p. 907-920.
7. O'Connell, M.A.L.-W., P.Kenny, L. C.O'Neill, S. M. Khashan, A. S., *The prevalence and risk factors of fear of childbirth among pregnant women: A cross-sectional study in Ireland*. Acta Obstet Gynecol Scand, 2019. **98**(8): p. 1014-1023.
8. Deliktas, A. and K. Kukulcu, *Pregnant Women in Turkey Experience Severe Fear of Childbirth: A Systematic Review and Meta-Analysis*. J Transcult Nurs, 2019. **30**(5): p. 501-511.
9. Demsar, K.S., M.Verdenik, I.Tul, N.Blickstein, I.Globevnik Velikonja, V., *Tokophobia (fear of childbirth): prevalence and risk factors*. Perinat Med, 2018. **46**(2): p. 151-154.
10. Junge, C., et al., *Labor pain in women with and without severe fear of childbirth: A population-based, longitudinal study*. Birth, 2018. **45**(4): p. 469-477.
11. Pazzagli, C.L., L.Capurso, M. Sommella, C. Lelli, F. Mazzeschi, C., *Antecedents and consequences of fear of childbirth in nulliparous and parous women*. Infant Ment Health J, 2015. **36**(1): p. 62-74.
12. Hildingsson, I.K., A.Rubertsson, C.Haines, H., *Women with fear of childbirth might benefit from having a known midwife during labour*. Women Birth, 2019. **32**(1): p. 58-63.
13. Striebich, S.M., E.Ayerle, G. M., *Support for pregnant women identified with fear of childbirth (FOC)/tokophobia - A systematic review of approaches and interventions*. Midwifery, 2018. **61**: p. 97-115.

14. Munkhondya, B.M.J.M., T. E.Chirwa, E.Wang, H., *Efficacy of companion-integrated childbirth preparation for childbirth fear, self-efficacy, and maternal support in primigravid women in Malawi.* BMC Pregnancy Childbirth, 2020. **20**(1): p. 48.
15. *WHO recommendation on interventions targeted at women for the reduction of unnecessary caesarean sections* R.h. library, Editor. 2018. p. 1-12.
16. Organization, W.H., *WHO recommendations: intrapartum care for a positive childbirth experience.* 2018: Geneva.
17. WHO, *WHO recommendations on antenatal care for a positive pregnancy experience.* 2018.
18. Supatra Pinkaew, W.P., *Fear of Childbirth: A Mini Review.* J Gynecol Women's Health, 2020.**18**(2).
19. Phunyammalee, M.B., T. Boriboonhirunsarn, D., *Fear of childbirth and associated factors among low-risk pregnant women.* Obstet Gynaecol, 2019. **39**(6): p. 763-767.
20. Nieminen, K., et al., *Severe fear of childbirth indicates high perinatal costs for Swedish women giving birth to their first child.* Acta Obstet Gynecol Scand, 2017. **96**(4): p. 438-446.
21. Kathrin, S., Joyce , E., and Wendy A. , *Fear of Childbirth and Preference for Cesarean Delivery Among Young American Women Before Childbirth: A Survey Study.* Birth, 2015. **24**: p. 270-276.
22. Adams, S.S., M. Eberhard-Gran, and A. Eskild, *Fear of childbirth and duration of labour: a study of 2206 women with intended vaginal delivery.* BJOG, 2012. **119**(10): p. 1238-46.
23. Ayers, S., *Fear of childbirth, postnatal post-traumatic stress disorder and midwifery care.* Midwifery, 2014. **30**(2): p. 145-8.
24. Toohill, J., et al., *A cross-sectional study to determine utility of childbirth fear screening in maternity practice – An Australian perspective.* Women and birth : journal of the Australian College of Midwives, 2015. **28**.
25. O'Connell, e.a., *Interventions for fear of childbirth (tocophobia).* Cochrane Database of Systematic Reviews, 2019.
26. El-Aziz, S.N.A.M., Suzan El-Said Hassan, Nahed Fikry, *Factors associated with fear of childbirth: It's effect on women's preference for elective cesarean section.* Journal of Nursing Education and Practice, 2016. **7**(1).
27. van Dinter-Douma, E.E., et al., *Screening for trauma and anxiety recognition: knowledge, management and attitudes amongst gynecologists regarding women with fear of childbirth and postpartum posttraumatic stress disorder.* J Matern Fetal Neonatal Med, 2020. **33**(16): p. 2759-2767.

28. Dencker, A., et al., *Causes and outcomes in studies of fear of childbirth: A systematic review*. Women Birth, 2019. **32**(2): p. 99-111.
29. Badaoui, A., S.A. Kassm, and W. Naja, *Fear and Anxiety Disorders Related to Childbirth: Epidemiological and Therapeutic Issues*. Curr Psychiatry Rep, 2019. **21**(4): p. 27.
30. L. Qiu, e.a., *Fear of childbirth in nulliparous women: A cross-sectional multicenter study in China*, Women Birth, 2019.
31. Rondung, E.T., J.Sundin, O., *Psychological perspectives on fear of childbirth*. J Anxiety Disord, 2016. **44**: p. 80-91.
32. Rachman, S., *The conditioning theory of fear-acquisition: A critical examination*. Behaviour Research and Therapy, 1977. **15**(5): p. 375-387.
33. Ternstrom, E., et al., *Higher prevalence of childbirth related fear in foreign born pregnant women--findings from a community sample in Sweden*. Midwifery, 2015. **31**(4): p. 445-50.
34. Pirdadeh Beiranvand, S., Behboodi Moghadam, Zahra Salsali, Mahvash, Alavi Majd, Hamid Birjandi, Mehdi Bostani Khalesi, Zahra, *Prevalence of Fear of Childbirth and Its Associated Factors in Primigravid Women: A Cross- Sectional Study*. hiraz E-Medical Journal, 2017. **18**(11).
35. Mortazavi, F.A., J., *Childbirth Fear and Associated Factors in a Sample of Pregnant Iranian Women*. Oman Med J, 2018. **33**(6): p. 497-505.
36. David O. Vahideh MoghaddamH, c., Margaret K, Ákos Várnagy, *Prevalence of fear of childbirth in a sample of gravida women in Kenya*. Sexual & Reproductive Healthcare 2020. **24**.
37. Khwepeya, M.L., G. T.Chen, S. R.Kuo, S. Y., *Childbirth fear and related factors among pregnant and postpartum women in Malawi*. BMC Pregnancy Childbirth, 2018. **18**(1): p. 391.
38. Gelaw, T., et al., *Fear of childbirth among pregnant women attending antenatal care in Arba Minch town, southern Ethiopia: a cross-sectional study*. BMC Pregnancy and Childbirth, 2020. **20**(1): p. 672.
39. Molgora, S., et al., *Fear of childbirth in primiparous Italian pregnant women: The role of anxiety, depression, and couple adjustment*. Women Birth, 2018. **31**(2): p. 117-123.
40. Fairbrother, N.T., D. S. Stoll, K., *Fine tuning fear of childbirth: the relationship between Childbirth Fear Questionnaire subscales and demographic and reproductive variables*. Reprod Infant Psychol, 2018. **36**(1): p. 15-29.
41. Gao, L.-l., Xiao JunFu, Bai LingXie, Wen, *Predictors of childbirth fear among pregnant Chinese women: A cross-sectional questionnaire survey*. Midwifery, 2015. **31**(9): p. 865-870.

42. Storksens, H.T.G.-N., S. Adams, S. S. Vangen, S. Eberhard-Gran, M., *Fear of childbirth and elective caesarean section: a population-based study*. BMC Pregnancy Childbirth, 2015. **15**: p. 221.
43. Dönmez, S.K., Sezer Özberk, Hülya, *Investigation of Fear of Childbirth, Attitude and State Anxiety among Primigravid Women*. Studies on Ethno-Medicine, 2017. **10**(4): p. 488-497.
44. Karabulutlu O, Y.C.K., Akar N., *Fear of childbirth and related obstetric variables*. Nurs Pract Today, 2016. **3**(4): p. 161-170.
45. Slade, P.B., K.Sheen, K.Houghton, G., *Establishing a valid construct of fear of childbirth: findings from in-depth interviews with women and midwives*. BMC Pregnancy Childbirth, 2019. **19**(1): p. 96.
46. Prelog, P.R., et al., *Individual and Contextual Factors of Nulliparas' Levels of Depression, Anxiety and Fear of Childbirth in the Last Trimester of Pregnancy: Intimate Partner Attachment a Key Factor?* Zdr Varst, 2019. **58**(3): p. 112-119.
47. Hildingsson, I.R., C.Karlstrom, A. Haines, H., *A known midwife can make a difference for women with fear of childbirth- birth outcome and women's experiences of intrapartum care*. Sex Reprod Healthc, 2019. **21**: p. 33-38.
48. Haapio, S., et al., *Effects of extended childbirth education by midwives on the childbirth fear of first-time mothers: an RCT*. Scand J Caring Sci, 2017. **31**(2): p. 293-301.
49. Citak Bilgin, N.C., H.Coskuner Potur, D.Ibar Aydin, E.Uca, E., *Psychosocial predictors of the fear of childbirth in Turkish pregnant women*. Psychosom Obstet Gynaecol, 2020: p. 1-9.
50. K. Wjma', B.W.a.M.Z., *Psychometric aspects of the W-DEQ; a new questionnaire for the measurement of fear of childbirth*. J Psychosom Obstet Gynecol 1998. **19**: p. 84-97.
51. Garthus-Niegel, S.S., H. T.Torgersen, L.Von Soest, T. Eberhard-Gran, M., *The Wijma Delivery Expectancy/Experience Questionnaire: a factor analytic study*. Psychosom Obstet Gynaecol, 2011. **32**(3): p. 160-3.
52. Dalgard OSDC, L.V., Vazquez-Barquero JL, Casey P, Wilkinson G., *Negative life events, social support and gender difference in depression*. Soc Psychiatry Psychiatr Epidemiol, 2006. **41**(6): p. 444-51.
53. S. Molgora, e.a., *Fear of childbirth in primiparous Italian pregnant women: The role of anxiety, depression, and couple adjustment*, .Women Birth 2017.
54. Zengin, H., et al., *Childbirth and postpartum period fear and the related factors in pregnancy*. Journal of the College of Physicians and Surgeons Pakistan, 2020. **30**(2): p. 144-148.

10. APPENDIX

10.1. Annex A: English Information Sheet

Good morning/ afternoon

My name is ____I am working as a data collector on behalf of Abebe Tibebe who is currently a postgraduate student on Maternity and Reproductive health at AAU, College of Health Sciences, School of nursing and midwifery, Department of Midwifery. I kindly request you to give me your attention to explain you about the study and be selected as the study participant.

Objective of this study was to assess prevalence and associated factors of FOC among pregnant women attending ANC in selected public hospitals Addis Ababa, Ethiopia 2021.

Procedure and duration: I will ask you questionnaire that are prepared by investigator all questions of which are to be answered by you while I am interviewing you. The interview will take around 30-45 minutes for each participant, so I kindly request you to give me this precious time for the interview.

Risks and benefits: there is no any risk to participate in this study but only taking few minutes from your time. There is no payment in the participation but the findings from this research will give important information for the hospital, ministry of health, for health planners and improve quality maternity care.

Confidentiality and rights: Information that you will give will be put confidentially, no information identify you're in particular identity. Have the right to participate or not in this study, participation for this study is fully voluntary, have the right to withdraw from the study at any time or you do have the right to not respond any question that you don't want to answer.

Contact address: If you have any questions or idea any time about the survey and way of participation, you can contact by the following address.

Investigator name: Abebe Tibebe, Address +251923163988; abebetibebe00@gmail.com

10.2. Annexes B: Informed Consent

I herewith declare that:

The objectives of this study and the contents of the consent were explained and clearly verified to me to participate in the study.

I understand that participation in this study will be completely voluntary and that should be withdraw at any time without supplying reasons. I agree to participate in this study to be interviewed, provided my privacy is guaranteed.

Signature of the participant _____ date _____

Signature of the interviewer _____ date _____

10.3. Annex C: English version questionnaire

No.	Part I. Socio demographic characteristics	Response	Skip
101	How old are you in (years)?	
102	What is your marital status?	1. Single 2. Married /live together 3. Divorced 4. Separated	
103	What is your educational status?	1.No formal education 2. Primary school(1-8) 3. Secondary school(9-12) 4. College and above	
104	What is your occupational status?	1. House wife 2. Self-employed 3. Government-employed 4. Daily laborer 5. Others specify...	
105	What is your monthly average income in Ethiopian birr?	----	
2	Part II Obstetrical characteristics of the study participants		
201	Your number of pregnancy	1. Prim gravida 2. Multi gravida	If answer is 1 Skip to Q209
202	What is the number of your previous birth (parity)?	1. Nulliparous 2. Prim parous 3. Multi parous	
203	What was your previous mode of delivery?	1.SVD 2.Instrumental delivery 3.C/S	
204	Have perineal cut (episiotomy) on your previous delivery?	1.Yes 2.No	
205	Outcome of previous childbirth	1. Alive 2.Still birth	
206	Did you have history of abortion?	1.Yes 2.No	
207	Did you have obstetric complication in your previous pregnancy and childbirth?	1.Yes 2.No	
208	If yes for Question 207 which one?	1.Bleeding 2.Prolonged labor 3.Pregnancy induced hypertension 4.All	

		5. Others specify.....	
209	Gestational age (in weeks)	1. less than 24 week 2. 24-26 weeks 3. above 26 weeks	
210	Currently number of conception	1. Single pregnancy 2. Multiple pregnancy	
211	Current pregnancy status?	1. Planned 2. Not planned	
212	Do you have regular ANC follow up for the current pregnancy?	1. Yes 2. No	
213	Preferred mode of delivery of the current pregnancy	1. Vaginal delivery 2. Caesarean delivery	
214	Do you have pregnancy related complication during this pregnancy?	1. Yes 2. No	
215	If yes for Q 214 which one	1. vaginal bleeding 2. HEG 3. PIH 4. All 5. Others specify.....	
216	Did you have known medical illness /chronic disease in the current pregnancy	1. Yes 2. No	
217	If yes for q no 216 which one?	1. Heart disease 2. HIV 3. DM 4. HTN 5. Others ...specify	
218	Have you got support from your husband?	1. Yes 2. No	
Part III. social support questioner			
301	How many people are so close to you that you can count on them if you have great personal problems?	1. None 2. 1-2 3. 3-5 4. >5	
302	How much interest and concern do people show in what you do?	1. None 2. Little 3. Uncertain 4. Some 5. A lot	
303	How easy is it to get practical help from neighbors if you should need it?	1. Very difficult 2. Difficult 3. possible 4. Easy 5. Very easy	

Part IV Questions to assess childbirth fear using WDEQ

Instruction ; The questionnaire about feelings and thoughts women may have at the prospect of labor and delivery. The answers to each question appear as a scale from 1 to 6. The outermost answers (1 and 6 respectively) correspond to the opposite extremes of a certain feeling or thought. .

s/no		1/ extremely	2	3	4	5	6/
I. How do you think your labor and delivery will turn out as a whole?	1.	extremely Fantastic	2	3	4	5	Not at all fantastic
	2	extremely frightful	2	3	4	5	Not At All frightful
II. How do you think you will feel in general during the labor and delivery?	3.	extremely Lonely	2	3	4	5	Not at all lonely
	4.	extremely Strong	2	3	4	5	Not at all strong
	5.	extremely Confident	2	3	4	5	Not at all confident
	6.	extremely Afraid	2	3	4	5	Not afraid at all
	7.	extremely deserted	2	3	4	5	Not at all deserted
	8.	Extremely weak	2	3	4	5	Not Weak at all
	9.	Extremely safe/protected	2	3	4	5	Not at all safe
	10.	Extremely independent	2	3	4	5	Not at all independent
	11.	Extremely desolate/miserable	2	3	4	5	Not miserable at all
	12.	Extremely tense / nervous	2	3	4	5	Not Nervous at all
	13.	Extremely glad	2	3	4	5	Not at all glad
	14.	Extremely proud	2	3	4	5	Not at all proud
	15.	Extremely Abandoned	2	3	4	5	Not at all abandoned
	16.	Extremely composed	2	3	4	5	Not at all composed
	17.	Extremely relaxed	2	3	4	5	Not at all relaxed
	18.	Extremely happy	2	3	4	5	Not at all happy
III.How do you think you will feel during the labor and the delivery?	19.	Extremely panic /frightened	2	3	4	5	Not panic at all
	20.	Extremely hopelessness	2	3	4	5	Not hopeless at all
	21.	Extremely longing for the child	2	3	4	5	No longing at all

	22.	Extreme self –confident	2	3	4	5	No self confident at all	
	23	extremely trust	2	3	4	5	No trust at all	
	24	Extreme pain	2	3	4	5	No pain at all	
IV. What do you think will happen when labor is most intense	25	I will behave extremely badly/ act awfully	2	3	4	5	I will not behave badly/ act awfully	
	26	I will dare to totally surrender control to my body	2	3	4	5	I will not dare to totally surrender control to my body at all	
	27	I will totally lose control of myself	2	3	4	5	I will not totally lose control of myself	
V.How do you imagine it will feel the very moment you deliver the baby?	28.	Extremely funny/ joyful	2	3	4	5	No joyful at all	
	29	Extremely natural	2	3	4	5	no natural at all	
	30.	Extremely self-evident	2	3	4	5	No self-evident at all	
	31	Extremely dangerous	2	3	4	5	Not at all dangerous	
VI. Have you, during the last month, had fantasies about the labor and delivery, for example	32	...fantasies that your child will die during labour/delivery	1/Never	2	3	4	5	Very often
	33	...fantasies that your child will be injured during labor/delivery	Never	2	3	4	5	Very Often

Thank You

10.4. Annex D: Amharic information sheet

የመረጃ መስጫ ቅጽ

ጤና ይስጥልኝ ስሜ _____ እባላለሁኝ እኔ የመረጃ ሰብሳቢ ስሆን፤ይህንን መረጃ የምሰበስበው አበበ ጥበበበ አዲስ አበባ ዩኒቨርስቲ የህክምና ሳይንስ ኮሌጅ፤ የነርቪንግ እናሚድዋይሬሪ ትምህርት ክፍል፤የድህረምረቃ ተማሪ የማስተርስ ትምህርታቸውን ለማጠናቀቅ የመመረቁያ ጽሁፋቸውን ለማዘጋጀት እንዲረዱቸው ሲሆን የእርስዎን ታማኝ እና ቀና የሆነ ትብብር ለጥያቄዎቹ መልስ እንፈልጋለን።

ዓላማ: ይህ ጥናት በተመረጡ የህዝብ ሆስፒታሎች ውስጥ የቅድ መወሊድ እንክብካቤ በሚከታተሉ ነፍሰጡር ሴቶች ላይ የወሊድፍርሃት እና አጋላጭ ምክንያቶች ለማወቅ ይረዳ ዘንድ የተዘጋጀ ነው፤

አካሌድ እና የሚፈጀው ጊዜ፤ ይህ መጠይቅ የሚያካትተው የጥናቱን ተሳታፊ ነፍሰጡር ዕናት ማህበራዊ-ስነ-ህዝብ ባህሪዎች፣ የእርግዝና እና ወሊድ መረጃ፣ ማህበራዊ እርዳታ እንዲሁም ልጅ ከመውለድ ጋር ተያይዞ ያላትን ፍራቻ የሚዳስስ ጥያቄዎች አሉት። እርስዎም ለዚህ ጥናት ስለ ተመረጡ ፍቃደኛ ከሆኑ፣ ቃለመጠይቁ ከ30-45 ደቂቃ ስለሚፈጅ፣ ይህንን ዉድ ጊዜዎችን እንዲተባበሩን በትህትና እጠይቃለሁ።

ጉዳት/ጥቅም: በጥናቱ ላይ በመሳተፍዎ ምንም አይነት ጉዳት አይርስባችሁም። ቀጥተኛ የሆነ ጥቅምም በዚሁ ጥናት ላይ በመሳተፍ ላያገኙ ይችላሉ። ቢሆንም ግን የጥናቱ ውጤት ቀጣይ የእናቶች ህክምና ጥራቱን ለማሻሻል ለመረጃነት ያገለግላል።

ምስጢራዊነት፤ በዚሁ ጥናት ላይ የሚገኘው መረጃ በሙሉ ምስጢራዊነት የተጠበቀ ነው። የእርስዎም መረጃ በፋይል ከእርስዎ ስም ውጪ በኮድ ተደርጎ ይቀመጣል።

10.5. Annex E: Amharic consent form

የስምምነት ማረጋገጫ ቅጽ

ከላይ የተጠቀሱትን በሙሉ ተረድቻለሁ። በዚህ ጥናት ላይ የምሳተፈው በሙሉ ፍቃደኝነት ነው። እንደተነገረኝ ከሆነ የምሰጠው መልስ ለሌላ ለማንም ሰው አይሰጥም እንዲሁም ስለኔ ማንነት ለማንም አይገለፅም። ስለሆነም በጥናቱ ላይ ለመሳተፍ ፍቃደኛ ነኝ።

ተሳታፊው ፍቃደኛ ከሆኑ ይቀጥሉ።

የተሳታፊው ፊርማ _____

ቃል መጠይቁን ያደረገው ባለሙያ ፊርማ _____

ቃል መጠይቅ የተደረገበት ቀን....

10.6. Annex F; Amharic version questionnaire

ለጥያቄዎቹ መልስ ከተቀመጡት አማራጮች ያክብቡ የመጠይቁ ክፍል I. ማህበራዊ-ስነ-ህዝብ ባህሪዎች		ከድ	እለፊ/ፍ
101	እድሜዎን ስንት ነው?	
102	የጋብቻ ሁኔታ ምንድን ነው?	1. ያላገቡ 2. ያገቡ / አብረው የሚኖሩ 3. የፈታች 4. በሞት የተለየ/ተለያይቷል	
103	የትምህርት ደረጃዎ ስንት ነው?	1. መደበኛ ትምህርት የለም 2. የመጀመሪያ ደረጃ (1-8) 3. ሁለተኛ ደረጃ (9-12) 4. ኮሌጅ እና ከዛበላይ	
104	ስራዎ ምንድን ነው?	1. የቤት እመቤት 2. የግል ተቀጣሪ 3. የመንግስት ሰራተኛ 4. የቀን ሰራተኛ 5. ሌላ ካለ (ይገለጹ).....	
105	በወር የሚያገኙት ገቢ ምን ያህል ነው? በኢትዮጵያ ብር	በወር-----ብር	
ተ.ቁ	II የእናት የዋጅ ግዝና እና ወሊድ ታሪክ		
201	ይህ እርግዝና ስንተኛ ነው?	1. የመጀመሪያ 2. ሁለተኛ እና ከዛበላይ	መልሱ 1ከሆነ ጥ.ቁ 20 9 ይሂዱ
202	እስከ አሁን ስንት ጊዜ ወልደው ነበር? (የሞት ተንጠቅቆ ከ 28 ሳምንት በላይ)	1. ምንም 2. አንድ ጊዜ 3. ሁለት እና ከዛበላይ	
203	ካሁን በፊት በምን ነበር የወለዱት?	1. በ ምጥ 2. በመሳርያ ታግዝ 3. በአፕሬሽን	
204	ሲወለዱ ብልትዎን ተቀደው /ስቲች/ ተደርገው ነበር?	1. አዎ 2. አልተደረሱም	
205	የተወለደው ህፃን ሁኔታ	1. በሂወት ያለ 2. ሞቶ የተወለደ	
206	ከዚህ በፊት ወርጃ ነበረዎት?	1. አዎ	

		2. የለኝም	
207	ከዚህ በፊት በነበረው እርግዝና እናወሊድ ጊዜ ችግር ገጥሞቻት ነበር	1. አዎ 2. አልነበረም	
208	ለጥያቄ 207 መልስዎ አዎ ከሆነ የትኞቹ	1. ደምመፍሰስ 2. ብዙሰአትማማጥ 3. ከእርግዝና ጋር ተያይዞ የመጣ ደምግፊት 4. ሁሉንም 5. ሌላካለይገለጽ...	
209	የዚህ እርግዝና ዕድሜ ስንት ነው (በሳምንታት)	1. ከ 14 ሳምንት በታች 2. ከ 14 – 26 ሳምንታት 3. ከ 26 ሳምንት በላይ	
210	ስንት ልጅ ነው ያረገዙት / በማህጸን ያለው የጽንሰ ብዛት	1. አንድ 2. ሁለት እና ከዛ በላይ	
211	አቅደውበት ነው ያረገዙት?	1. አዎ 2. አይደለም	
212	ቀጠርዎን ጠብቀው የእርግዝና ክትትል አያደረጉ ነው?	1. አዎ 2. አይደለም	
213	የመዉለጃ መንገድ ምርጫዎ የቱ ነው	1. በማህጸን አምጦ መዉለድ 2. በአፕሬሽን	
214	ከዚህ እርግዝና ጋር ተያይዞ የመጣ ችግር/ሀመም አለብዎት /አጋጥሞቻታል?	1. አዎ 2. የለብኝም	
215	ለጥያቄ 214 መልስዎ አዎ ከሆነ የትኞቹ	1. ደም መፍሰስ 2. ከባድ የሆነ የማያቋርጥ ትውከት 3. ከእርግዝና ጋር ተያይዞ የመጣ ደም ግፊት 4. ሁሉንም 5. ሌላካለይገለጽ...	
216	በህክምና የተረጋገጠ የጤና ችግር አለብዎ	1. አዎ 2. የለብኝም	
217	ለጥያቄ 217 መልስዎ አዎ ከሆነ የትኞቹ	1. የልብህመም 2. ኤችአይቪ /ኤድስ 3. የስኳርህመም 4. ደምግፊት 5. ሌላካለይገለጽ..	
218	ከትዳር አጋር ዎድጋፍ/እርዳታ ያገኛሉ?	1. አዎ 2. አላገኝም	
	III ማህበራዊ እርዳታ		
301	ከባድ የግል ችግሮች ቢደርስብዎት እና ሊረዱዎት የሚችሉ ለእርስዎ በጣም ቅርብ፤	1. ምንም ሰው የለ 2. 1-2 ሰው	

	የሚተማመኑባቸው ስንት ሰዎች አሉ	3. 3-5 ሰዎች 4. ከ 5 ሰዎቹ በላይ	
302	ሰዎች እርስዎን በሚያደርጉት ነገር ምን ያህል ፍላጎት እና አሳቢነት ያሳያሉ?	1. የለም 2. አነስተኛ 3. እርግጠኛ አይደለም 4. አንዳንድ 5. ብዙ	
303	ከጎረቤቶች አስፈላጊ እርዳታ ለማግኘት ምን ያህል ቀላል ነው?	1. በጣም ከባድ 2. አስቸጋሪ 3. ማግኘት እችላለሁ 4. በቀላሉ 5. በጣም ቀላል	

ክፍል IV የወሊድ ፍራቻን የሚዳስሱ መጠይቅ

I.	ልጅ መውለድ በአጠቃላይ እንዴት ይሆናል ብለው ያስባሉ?	ተቁ.	1/እጅግ	2	3	4	5	6/በጭራሽ
		1	እጅግ በጣም ድንቅ	2	3	4	5	በጭራሽ ድንቅ አይደለም
		2	እጅግ በጣም አስፈሪ	2	3	4	5	በጭራሽ አያስፈራም
II.	በወሊድ ጊዜ በአጠቃላይ የሚሰማሰሙት ምን ያህል ስልጣን አለው?	3	እጅግ በጣም ብቸኝነት	2	3	4	5	በጭራሽ ብቸኝነት የለውም
		4	እጅግ በጣም ጥንካሬ	2	3	4	5	በጭራሽ ጥንካሬ አይሰማም
		5	እጅግ በጣም በራስ መተማመን	2	3	4	5	በጭራሽ በራስ መተማመን አይደለም
		6	እጅግ በጣም የሚያስፈራ	2	3	4	5	በጭራሽ አልፈራም
		7	እጅግ በጣም የተራቆተ	2	3	4	5	በጭራሽ የተተዉኩ እና ዳልሆነ
		8	እጅግ በጣም ድካም	2	3	4	5	በጭራሽ ድካም አይኖርም
		9	እጅግ በጣም የተጠበቀ	2	3	4	5	በጭራሽ ደህና አልሆንም
		10	እጅግ በጣም ገለልተኛ	2	3	4	5	በጭራሽ ገለልተኛ አይደለም
		11	እጅግ በጣም ባዶነት	2	3	4	5	በጭራሽ አሳዛኝ አይደለም
		12	እጅግ በጣም የሚያስደነግጥ	2	3	4	5	በጭራሽ የሚያስደነግጥ አይደለም
		13	እጅግ በጣም ደስተኛ	2	3	4	5	በጭራሽ ደስተኛ አይደለም
		14	እጅግ በጣም ኩራት	2	3	4	5	በጭራሽ አያኩራም
15	እጅግ በጣም የተተዉ	2	3	4	5	በጭራሽ አልተዉም		

		16	እጅግ የተዋቀረ	2	3	4	5	በጭራሽ አልተቀናበረም	
		17	በጣም ዘና ያለ	2	3	4	5	በጭራሽ ዘና አልልም	
		18	እጅግ በጣም ደስተኛ	2	3	4	5	በጭራሽ ደስተኛ አልሆንም	
III.	ልጅ በሚወልዱበት ጊዜምን ይሰማኛል ብለው ያስባሉ?	19	እጅግ በጣም ፍራቻ	2	3	4	5	በጭራሽ አልደናገጥም	
		20	እጅግ በጣም ተስፋቢ ስነት	2	3	4	5	በጭራሽ ተስፋ አልቆረጠም	
		21	ለልጁ እጅግ በጣም ናፍቆት	2	3	4	5	በፍጹም ናፍቆት የለኝም	
		22	እጅግ በጣም በራስ መተማመን	2	3	4	5	ምንም በራስ መተማመን የለኝም	
		23	እጅግ በጣም እምነት	2	3	4	5	በጭራሽ እምነት የለኝም	
		24	እጅግ በጣም ከፍተኛ ሥቃይ	2	3	4	5	በጭራሽ ህመም የለም	
IV.	ልጅ መውለድ በጣም ኃይለኛ በሚሆንበት ጊዜምን ይሆናል ብለው ያስባሉ	25	እኔ እጅግ በጣም መጥፎ ጠባይ እፈጽማለሁ	2	3	4	5	በጭራሽ መጥፎ በህረ / ድርጊት አልፈጽምም	
		26	ለሰውነቴ ሙሉ በሙሉ ቁጥጥር ለመስጠት እደፍራለሁ	2	3	4	5	በጭራሽ ለሰውነቴ ሙሉ ቁጥጥርን ለመስጠት አልደፍርም	
		27	እራሴን ሙሉ በሙሉ አጠላለሁ	2	3	4	5	እኔ እራሴን ሙሉ በሙሉ ቁጥጥር አላጣም	
V.	ሕፃኑን በምትወልጁ በትቅጽበት ምንስሜት ይሰማል ብለው ያስባሉ?	28	እጅግ በጣም አዝናኝ / ደስተኛ	2	3	4	5	በጭራሽ ደስታ የለም	
		29	እጅግ በጣም ተፈጥሯዊ	2	3	4	5	ተፈጥሮ አዊ ነው	
		30	እጅግ በጣም ግልፅ ነው	2	3	4	5	በጭራሽ በራስ-አይታይም	
		31	እጅግ በጣም አደገኛ	2	3	4	5	በጭራሽ አደገኛ አይደለም	
VI.	እርስዎ ባለፈው ወር ውስጥ ስለልጅ መውለድ ቅዠቶችን በሩዎት? ለምሳሌ	32	ልጅዎ በምጥ/በወሊ ጊዜ እንደሚሞት	በጭራሽ	2	3	4	5	በአብዛኛው ጊዜ
		33	ልጅዎ በምጥ/ በወሊ ድ ጊዜ ጉዳት እንደሚደርስበት	በጭራሽ	2	3	4	5	በአብዛኛው ጊዜ

1=እጅግ በጣም፣ 2 =በጣም፣ 3 =መካከለኛ፣ 4 =ዝቅተኛ ፣5 =በጣም ዝቅተኛ ፣ 6 =በጭራሽ

አመሰግናለሁ!!

Plagiarism Report



Document Information

Analyzed document	Abebe Tibebe thesis final 16.6.docx (D109072277)
Submitted	6/16/2021 6:20:00 PM
Submitted by	
Submitter email	endalew.gemechu@aaau.edu.et
Similarity	16%
Analysis address	endalew.gemechu.aauni@analysis.orkund.com