ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

DEPARTMENT OF MIDWIFERY

PERSON-CENTERED MATERNITY CARE DURING CHILDBIRTH AND ASSOCIATED FACTORS AT PUBLIC HOSPITALS IN ADDIS ABABA, ETHIOPIA, 2021.

BY: AZEZEW AMBACHEW (BSc)

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

MAY, 2021

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APPROVAL BY THE BOARD OF EXAMINATION

This thesis by Azezew Ambachew Tarekegne is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of masters in Maternity and Reproductive Health Nursing.

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STATEMENT OF DECLARATION

By my signature below, I declare and affirm that this thesis is my 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. 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.

STUDENT

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
BSc	Bachelor of Science
CI	Confidence Interval
ETB	Ethiopian Birr
GMH	Gandhi Memorial Hospital
LMICs	Low and Middle-Income Countries
MDGs	Millennium Development Goals
MSc	Masters of Science
PCC	Person-centered care
PCMC	Person-Centered Maternity Care
SDGs	Sustainable Development Goals
SPHMMC	Saint Paul's Hospital Millennium Medical College
TASH	Tikur Anbessa Specialized Hospital
WHO	World Health Organization
YH	Yekatit 12 Hospital

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ABSTRACT

Background: Person-centered maternity care is respectful and responsive care to individual women's preferences, needs, and values and ensuring that their values guide all clinical decisions during childbirth. It is recognized as a key dimension of the quality of maternity care that increases client satisfaction and institutional delivery. However little research has been conducted about person-centered maternity care in Ethiopia.

Objective: The study aimed to assess the status of person-centered maternity care and associated factors among mothers who gave birth at public hospitals in Addis Ababa city, Addis Ababa, Ethiopia, 2021.

Method: A facility-based cross-sectional study was conducted at public hospitals in Addis Ababa city. A semi-structured questionnaire was used to collect data from post-natal mothers selected by systematic random sampling. The data was coded and entered Epi-data version 4.6 and analyzed using SPSS version 25. Bivariate and multivariate linear regression analysis was used to identify factors associated with person-centered maternity care. The strength of association between independent and dependent variables was reported by using unstandardized β at 95% CI and p-value < 0.05 were considered as statistically significant.

Results: In this study 384 mothers were participated with a response rate of 99.2%. The overall prevalence of person-centered maternity care was 65.8%. Respondents who had no ANC follow-up (β= -5.39, 95% CI: -10.52, -0.26), <4 ANC follow up (β= -3.99, 95% CI: -6.63, -1.36), nighttime delivery (β= -3.95, 95% CI: -5.91, -1.98) and complications during delivery (β= -3.18, 95% CI: -6.01, -0.35) were factors significantly associated with person-centered maternity care.

Conclusion and Recommendations: The finding of this study showed that the proportion of person-centered maternity care among mothers who gave birth in public hospitals of Addis Ababa was high. ANC follow-up, frequency of ANC, time of delivery, and complications during delivery were factors significantly associated with person-centered maternity care. Health care providers should provide person-centered care for all mothers.

Keywords: Person-centered maternity care, Childbirth, Addis Ababa, Ethiopia

1. INTRODUCTION

1.1 Background

Person-centered care (PCC) also referred to as patient-centered care is as responsive and respectful care to individual patient's preferences, values, and needs; ensuring that their values guide all clinical decisions. In 2001 the Institute of Medicine identified person-centered care as a key component of quality of care [1]. It is a concept grounded in strong patient-provider interactions, effective communication, and shared decision-making by enhancing clients to take charge of their health rather than being passive recipients of the care [2, 3].

Person-centered maternity care (PCMC) is defined as providing maternity care that's responsive and respectful to individual women's preferences, values, and needs; ensuring that women's values guide all clinical decisions during labor and childbirth [4]. The world health organization (WHO) recommendations highlighted dignity and respect, communication and autonomy, and supportive care during childbirth as key components of PCMC that should be provided for all mothers during labor and delivery. It aims to improve communication between health care providers and women to promote the utilization of care [5].

Globally, 300 000 women died from pregnancy and childbirth-related causes in 2015, with 99% of those deaths occurred in low-income and middle-income countries [6]. Maternal mortality is higher in counties where the number of births delivered by a skilled birth attendant is low. Recently the number of facility-based childbirths are increasing. However, the involvement of mothers in their health care by health care providers is important for the improvement of quality of care [7, 8].

Person-centered care during childbirth is identified as a key dimension of the quality of maternity care. It recognizes user experience and affects health-seeking behavior [5]. Studies showed that the PCMC approach can lead to decreased maternal and neonatal complications, postpartum depression, and improved patient satisfaction. Moreover, when women feel respected and experience compassion from care providers during labor and delivery they are more likely to return for postpartum maternal health services [9, 10].

Poor person-centered maternity care which is characterized by disrespectful and abusive treatment of women during facility-based childbirth can deter women from giving birth in health facilities and lead to poor maternal and neonatal outcomes [11]. It has psychological effects for mothers, a higher risk of dissolution and risk for families, and the potential poverty of thousands due to high costs of care [7].

A study in low and middle income counties showed that mothers were not receiving person-centered maternity care with 16% of women reported verbal abuse and less than 5% experienced physical abuse. This study showed that person-centered maternity care was affected by the socioeconomic status of the women and by health facility level [12].

A study in Ethiopia showed that person-centered maternity care is one of the factors that increase client satisfaction and influence health-seeking behavior of the women. On the other hand, poor person-centered maternity care results in decreased institutional delivery [13]. Another study found that time of delivery, mode of delivery, and complication during childbirth were factors affecting person-centered maternity care [14].

1.2 Statement of the Problem

Poor quality of care leads directly to high maternal mortality by poor identification and management of pregnancy complications and indirectly by decreased demand for maternal health services. Particularly poor person-centered maternity care contributes both directly to maternal and neonatal outcomes and indirectly can be a barrier for institutional delivery. However, Studies found that women were not experiencing person-centered maternity care in low and middle-income countries [8, 12, 15].

Person-centered maternity care is recognized as a key dimension of quality maternity care by World Health Organization. PCMC contributes to improved communication between care provider and patient, increased adherence to treatments, timely care provision, and better maternal and neonatal outcomes [12]. Other studies showed that improving supportive care can reduce the risk of maternal and neonatal complications whereas communication and autonomy can increase postpartum family planning utilization [9, 16].

Poor person-centered maternity care contributes to high maternal mortality in developing countries, especially in Sub-Saharan. About three-quarters of maternal deaths are due to complications of labor, childbirth, and the first 24 hours postpartum after delivery [8]. Evidence showed that person-centered maternity care plays an important role in the identification of complications during facility-based childbirth thus reducing maternal mortality and morbidity significantly. Moreover, PCMC emphasizes the quality of patient experience by helping the women to feel safe and at ease to communicate how she feels and what she needs to the health care provider [15].

Poor person-centered maternity care is a violation of a mother's right that can lead to decreased institutional delivery [17]. Women who gave birth in health facilities share these experiences in their communities, which results in poor community perceptions of quality care and influences other women from utilizing health facilities during childbirth. In addition, lack of respect from care providers and fear of the cost of using a health facility are factors contributing to decreasing utilization of maternal health services [8, 13].

Advancing PCMC approaches in maternal health services is essential to improve client satisfaction, increase facility-based deliveries and ensure implementation of women's rights [10]. Efforts to increase maternal utilization of health services in low and middle-

income countries are not possible to achieve the desired goals without improving women's experience of care. Other studies showed that women intent to give birth in an environment where they feel safe, valued, and respected [2, 3, 18].

A study conducted in Iran found that a direct relationship between person-centered maternity care and positive childbirth experience [19]. Similarly, a study conducted in Kenya showed that women with a higher PCMC score were less likely to newborn complications than women with a lower PCMC score. In addition, women with a high PCMC score had reported a willingness to return to the health institution for their future childbirth than a women with low PCMC score [10, 16].

A study done in Ethiopia reported that 64.5% of women experienced person-centered maternity care. This study also showed that person-centered maternity care increases maternal satisfaction and improves maternal health service utilization [4]. On the other hand poor PCMC a major factor affecting the quality of care and utilization of maternal health services [20]. Additionally, poor experiences of care at health facilities can also be a barrier for women seeking child health services. Other studies conducted in Ethiopia showed that poor person-centered maternity care is significantly associated with weakened delivery and experience of complications [14, 21].

Several studies have been conducted to identify determinant factors of person-centered maternity care in different countries. However little research has been conducted in Ethiopia about person-centered maternity care during facility-based childbirth. Therefore this study aimed to assess the status of person-centered maternity care during childbirth and associated factors at public hospitals in Addis Ababa, Ethiopia.

1.3 Significance of the Study

Poor person-centered maternity care contributes both directly and indirectly to high maternal death. To reduce maternal death improving the quality of maternity care and utilization of maternal health services is essential. World Health Organization recommended good intrapartum care for a positive childbirth experience care.

Person-centered maternity care is identified as a key component of the quality of maternity care. However, there is a lack of evidence about person-centered maternity care in the study area. This study was proposed to assess the status of person-centered maternity care during childbirth and associated factors in public hospitals of Addis Ababa, Ethiopia, which helps contribute information for hospitals and concerned bodies to improve the quality of maternity care.

This study will also provide important information to stakeholders and policymakers to design and implement interventions on person-centered maternity care and health facilities to emphasize factors that influence person-centered maternity care. Moreover, the study can be used as initial data for other researchers.

2. LITERATURE REVIEW

2.1 Person-Centered Maternity Care

Person-centered maternity care is defined as responsive and respectful maternity care to individual women's needs, values, and preferences. It includes system and provider responsiveness, communication between patient and health care provider, and interpersonal treatment. Person-centered maternity care is viewed as a broader construct with respectful maternity care as part of the broader component in person-centered care [7, 12]. PCMC approach is believed to advance communication between women and health care providers, making care empathetic and improve maternal and neonatal health outcomes [3].

Person-centered maternity care is recognized as a key dimension of quality maternity care. The World Health Organization recommendation highlights dignity and respect, communication and autonomy, and supportive care as key components of person-centered maternity care for a positive childbirth experience. These propositions are based on the belief that patient views, input, and experiences can help to decrease maternal mortality and morbidity [5].

2.2 Prevalence of Person-Centered Maternity Care

A study conducted in Nepal revealed that most of the women received person-centered care. However, they are also experienced poor PCMC such as being shouted upon (30%), being slapped (18.7%), delayed service provision (22.7%), and not talking positively about labor pain management (28%) [17].

A cross-sectional study done in Colombo, Sri Lanka found that the mean person-centered maternity score was 42.3 out of 90. This study reported that 91.8% of mothers followed without partograph, 73.3% gave birth in non-supine position, 4.8% did not get labor stimulation, 9.5% had a birth companion and 41.3% had skin-to-skin contact immediately after childbirth [10].

A study conducted in low and middle-income countries showed that women were not experiencing person-centered maternity care. This study reported that women were receiving the highest mean PCMC score (66.9%) in urban Kenya and the lowest PCMC score (51.6%) in rural Ghana. The study reported that health care providers never

introduced themselves for 90% of mothers, 53% of women in Kenya, and 73% of women in India were not asked permission from health care providers before doing procedures. In addition, 58% of women in Ghana and India have not received explanations on the purpose of medications [12].

Another study conducted in East and South Africa reported most of the mothers experienced poor interactions with health care providers and were not well-informed about their care [22]. A systemic review and meta-analysis study conducted at health facilities in Sub-Saharan Africa showed that the prevalence of person-centered maternity care during childbirth was 44% [23].

A qualitative study conducted in Tanzania reported that Midwives provide person-centered maternity care. The study reported that respect for women's privacy, positive interactions between midwives and women, provision of safe and timely midwifery care for delivery, active involvement in women's labor process, and helping of the mother-newborn relationship were observed from Midwives [24].

According to a study conducted in Ghana in the LEKMA hospital, more than 75% of women experienced high person-centered maternity care. From the domains of PCMC, the dignity and respect category received the lowest mean score. The communication and autonomy category recorded the highest percentage mean score [15].

A cross-sectional study conducted in Dessie town, Northeastern, Ethiopia showed that the prevalence of person-centered maternity care was 64.5%. From the sub-scales, the prevalence of dignity and respect was 82%, whereas communication and autonomy score recorded 57% and supportive care recorded 62% [4]. Another study done in Bahir Dar revealed that the prevalence of respectful maternity care re was 57% [14].

A study done in Ethiopia showed that the prevalence of person-centered maternity care was 66% [25]. Another cross-sectional study conducted in the West Shewa zone, Oromia region, Ethiopia showed that only 35.8% were received person-centered maternity care. This study reported that 76.5% of women were experienced physical abuse, and only 39% of mother's right to informed consent were protected [26].

2.3 Factors affecting Person-Centered Maternity Care

2.3.1 Socio-demographic characteristics

Socio-economic status such as age and marital status is the most important factor affecting person-centered maternity care [15, 27]. According to a study conducted in Pakistan, lower socioeconomic status was the main determinant of person-centered maternity care during labor and delivery [28].

A study done in Kenya found that wealthier, employed, literate and married women experienced higher person-centered maternity care scores as compared to poorer, unemployed, illiterate, and unmarried women respectively [8].

Studies done in Ethiopia reported that respondents who live in a rural area and having an average monthly income of ≤3000 birrs were factors significantly associated with decreased person-centered maternity care as compared with respondents who live in the urban area and having an average monthly income of >3000 birrs respectively [4, 14]. Another study conducted in Southwest Ethiopia showed that being non-married was related to a higher likely hood of reporting person-centered maternity care than those mothers who are married. However, having secondary education or more was significantly related to a lower likely hood of person-centered maternity care [14].

2.3.2 Obstetrics related characteristics

A study conducted in Tabriz, Iran showed that time delivery, number of health care providers, delivery attendants, and length of stay in childbirth were factors significantly associated with person-centered maternity care [19].

A cross-sectional study done in Kenya reported that women with higher parity were more likely to be experienced poor person-centered maternity care as compared to women with lower parity. The study also revealed that nighttime deliveries were associated with decreased likely hood of PCMC than those who gave birth at day time [18].

A study done in Ethiopia reported that women received care by male provider were experienced high person-centered maternity care as compared to the female provider. The study also showed that women delivered by Midwives received high PCMC than those women who delivered by other cadres [25].

A community-based cross-sectional study conducted in Dessie town, Northeastern, Ethiopia showed that nighttime delivery and dead fetus outcome were factors significantly associated with decreased person-centered maternity care as compared to day time delivery and alive fetus outcome respectively [4]. Another study done in Bahir Dar reported that previous cesarean delivery, and having complications during childbirth were factors associated with the poor experience of person-centered maternity care [14].

According to a study done in Ethiopia having ANC follow-up, planned pregnancy, labor attended by a male provider, and normal maternal outcome were significantly associated with PCMC [29]. Another study conducted in the North Shewa zone, Oromia region, Ethiopia reported that daytime delivery and unintended current pregnancy were factors significantly associated with respectful maternity care [26].

2.3.3 Facility characteristics

Overcrowded health systems, supply shortage, and the number of staff are major factors affecting person-centered maternity care. According to a study conducted in Ghana uninterrupted water supply, uninterrupted electricity supply, and overcrowding in the hospital were factors significantly associated with person-centered maternity care [15]. Another study done in Nigeria reported that person-centered maternity care was influenced by poor provider training and supervision, and week health systems [30].

A study conducted in Ethiopia showed that women delivered in facilities implementing a quality improvement approach and having a companion during childbirth received high person-centered maternity care [25]. Another study was done in Dessie town, Northeastern, Ethiopia showed that health facility length of stay was significantly related to decreased person-centered maternity care [4]. According to a study conducted in the North Shewa zone, Oromia region, Ethiopia longer duration of stay, the presence of less than 3 care providers during childbirth, and waiting-time were factors significantly associated with PCMC [26].

2.4 Conceptual Framework

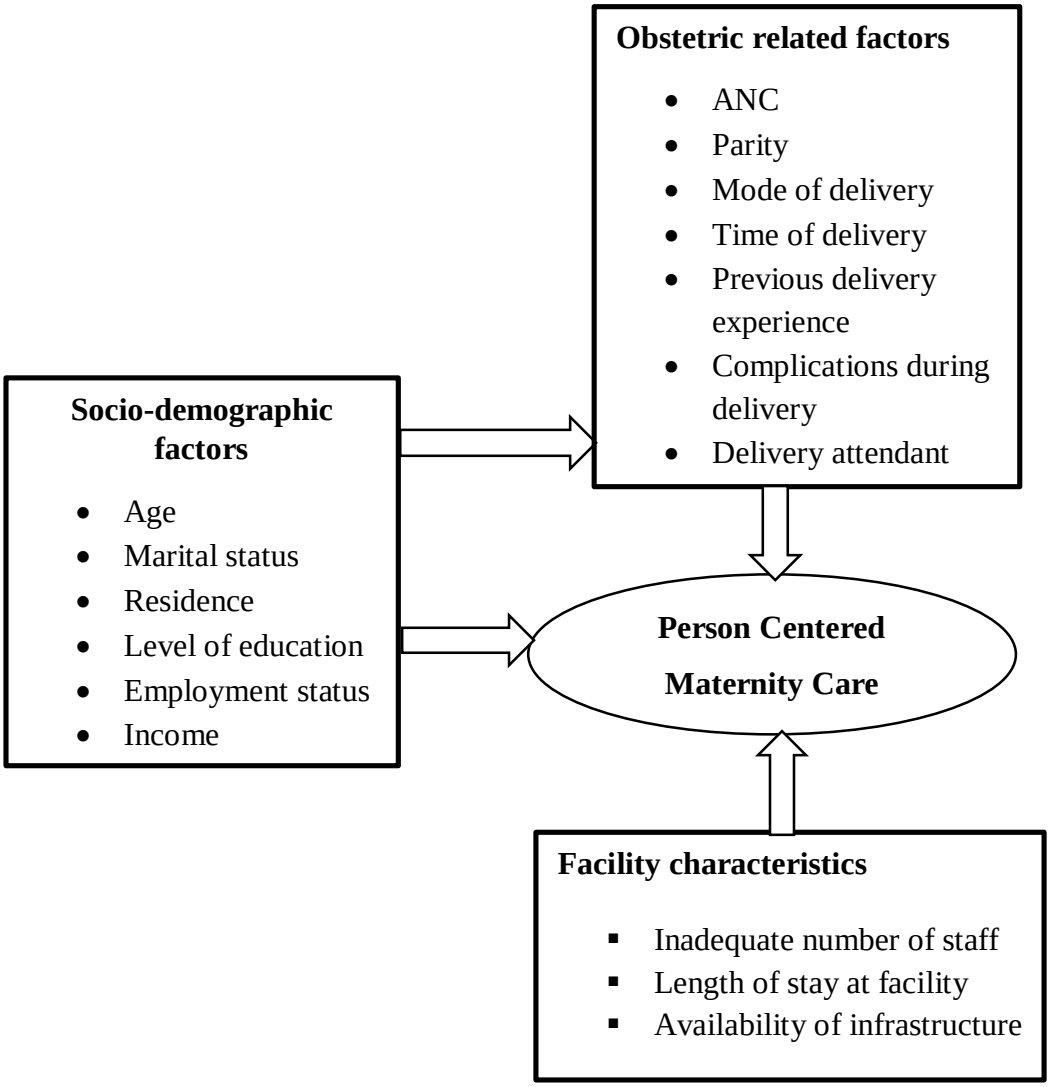


Figure 1: Conceptual framework showing factors associated with person-centered maternity care during childbirth [4, 8, 12, 15].

3. OBJECTIVES

3.1 General Objective

- To assess the prevalence of person-centered maternity care during childbirth and associated factors at public hospitals in Addis Ababa city, Addis Ababa, Ethiopia, 2021.

3.2 Specific Objectives

- To determine the prevalence of person-centered maternity care during childbirth at public hospitals in Addis Ababa city, Addis Ababa, Ethiopia, 2021.
- To identify factors associated with person-centered maternity care during childbirth at public hospitals in Addis Ababa city, Addis Ababa, Ethiopia, 2021.

4. METHODS

4.1 Study Area and Period

The study was conducted in public hospitals of Addis Ababa city from February 15 to March 14/2021. Addis Ababa is the capital city of Ethiopia and covers an area of 527 kilometers. According to the 2007 census the city has a total population of 3,384,569 [31]. There are 13 governmental hospitals in the city. From these five hospitals are administered under the Federal Ministry of Health, six managed by Addis Ababa health bureau, one under the police force, and one governed by the armed force. The study was conducted in Tikur Anbessa Specialized Hospital, St. Paul's Hospital Millennium Medical College, Gandhi Memorial Hospital, and Yekatit 12 Hospital.

Tikur Anbessa Specialized Hospital is a referral and teaching hospital under the Ministry of Education of Ethiopia. St. Paul's Hospital Millennium Medical College is a specialized and teaching hospital managed under the Federal Ministry of Health. Gandhi Memorial Hospital and Yekatit 12 Hospital are governmental hospitals administered under the Addis Ababa health bureau.

4.2 Study Design

A facility-based cross-sectional study was conducted.

4.3 Population

4.3.1 Source Population

All women who gave birth at public hospitals in Addis Ababa.

4.3.2 Study Population

Randomly selected women who gave birth in selected hospitals of Addis Ababa during the data collection period.

4.4 Inclusion and exclusion criteria

4.4.1 Inclusion Criteria

- ✓ Women aged above 18 years who gave birth in selected public hospitals
- ✓ Women who gave consent to participate in the study

4.4.2 Exclusion Criteria

- ✓ Women who were referred from other health institutions after giving birth to those selected public hospitals

4.5 Sample size determination

The sample size was determined by using a single population proportion formula. A previous study conducted to assess the determinants of person-centered maternity care in Dessie town, Ethiopia reported that the prevalence of person-centered maternity care was 64.5% [4]. This study used the assumption of standard normal distribution at a 95% confidence level and a margin of error assumed to be 5%.

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

Where:

n = sample size

p = proportion of PCMC (64.5%)

Z = standard normal distribution curve value for 95% level of confidence with the value of 1.96

D = margin of error to be tolerated (d = 0.05)

$$n = (1.96)^2 \times 0.645 \frac{(1-0.645)}{(0.05)^2} = 352$$

Considering a non-response rate of 10%, the final sample size was 387

4.6 Sampling Procedures

Four hospitals were selected out of thirteen governmental hospitals in Addis Ababa by simple random sampling. Therefore, Tikur Anbessa Specialized Hospital, Gandhi Memorial Hospital, St. Paul's Hospital Millennium Medical College, and Yekatit 12 Hospital were the selected hospitals for this study.

The total sample size (387) was allocated proportionally to each of the selected hospitals by reviewing the number of deliveries attended in each hospital. A systematic random sampling technique was used to collect data using the women's delivery registration logbook during the study period in each hospital. K = N/n = 2050/387 = 5. So every fifth mother was interviewed.

$$ni = \frac{nxNi}{N}$$

Where;

ni = sample size of each hospital

n = final sample size

Ni = number of deliveries in each selected hospital

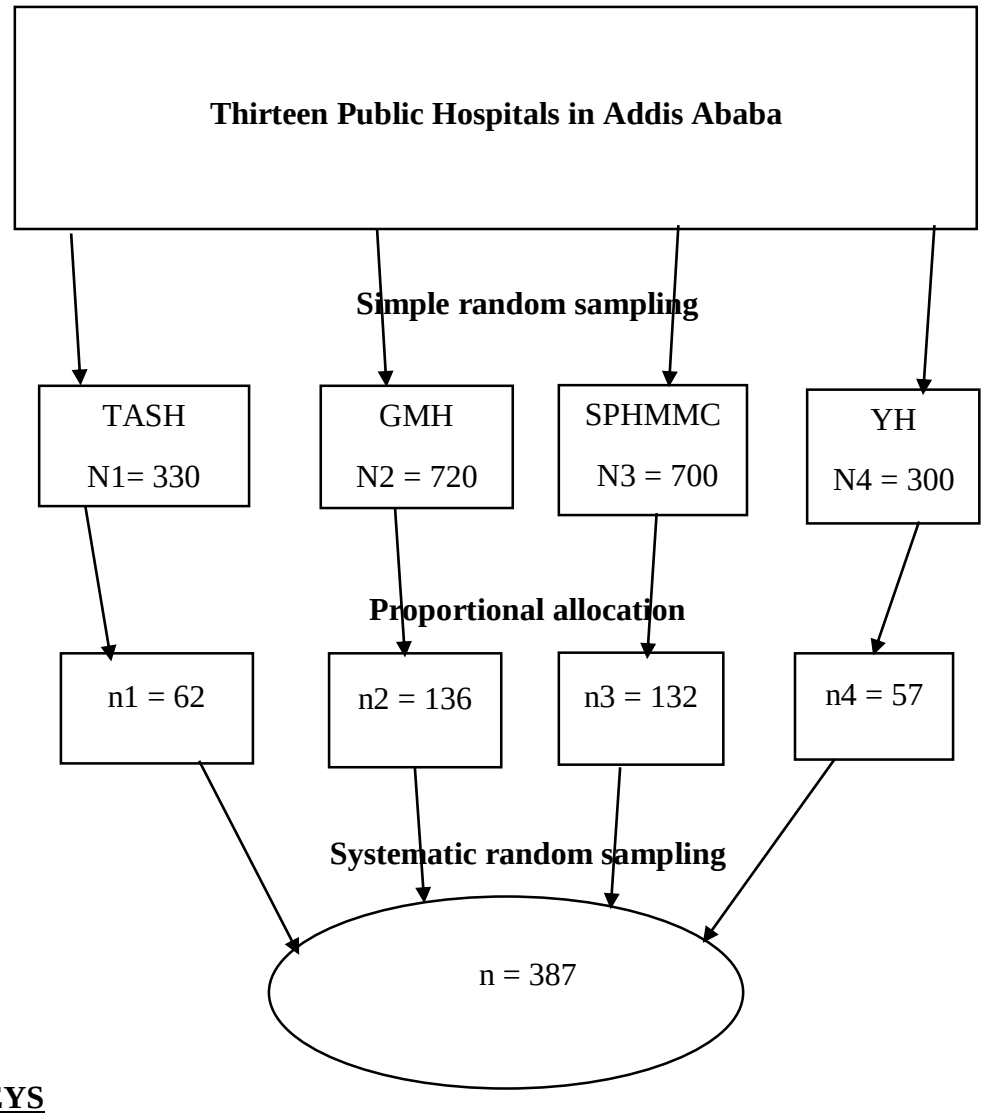
N = total number of deliveries in selected hospitals

1. Tikur Anbessa Specialized Hospital = 387 x 330/2050 = 62

2. Gandhi Memorial Hospital = 387 x 720/2050 = 136

3. St. Paul's Hospital Millennium Medical College = 387 x 700/2050 = 132

4. Yekatit 12 Hospital = 387 x 300/2050 = 57



KEYS

TASH- Tikur Anbessa Specialized Hospital

GMH- Gandhi Memorial Hospital

SPHMMC- St. Paul's Hospital Millennium Medical College

YH- Yekatit 12 Hospital

Figure 2: Schematic presentation of sampling procedures

4.7 Study Variables

4.7.1 Dependent variable

- Person-centered maternity care

4.7.2 Independent variables

- Socio-demographic characteristics: age, marital status, residence, level of education, employment status, monthly income
- Obstetrics related factors: parity, ANC, mode of delivery, time of delivery, previous delivery experience, complication during delivery, newborn outcome, sex of delivery attendant, and profession of delivery provider
- Facility characteristics: availability of infrastructure and length of stay at a health facility

4. 8 Operational Definitions

Person-Centered Maternity Care

Person-centered maternity care was measured by using the PCMC scale. The PCMC scale has three domains: dignity and respect, communication and autonomy, and supportive care and 30 items with each item having a four-point response scale. i.e. 0- 'no, never', 1- 'yes, a few times, 2- 'yes, most of the time' and 3- 'yes, all the time'. The negative items such as physical abuse, verbal abuse, auditory privacy, and crowdedness of the room questions were reversely coded so that the highest score represents good care. The total PCMC score is a summative score from the response to individual items which ranges from 0 to 90 [4, 15].

Dignity and Respect

Measured by using six items with each item having a four-point response scale. i.e. 0- 'no, never', 1-'yes, a few times, 2- 'yes, most of the time' and 3- 'yes, all the time'.

Communication and Autonomy

Measured by using nine items with each item having a four-point response scale. i.e. 0- 'no, never', 1- 'yes, a few times, 2- 'yes, most of the time' and 3- 'yes, all the time'.

Supportive Care

Measured by using fifteen items with each item having a four-point scale. i.e. 0- 'no. never', 1- 'yes, a few times, 2- 'yes, most of the time' and 3- 'yes, all the time'.

4.9 Data Collection Tool and Procedures

Semi-structured questionnaires which have socio-demographic characteristics of the mother, obstetrics history, and person-centered maternity care scale were used to collect the data from study participants. The tool was validated in different low and middle-income countries including Ethiopia to assess person-centered maternity care for developing settings. The scale has good internal reliability with Cronbach's alpha above 0.8 [4, 8, 32].

The data was collected from mothers who gave birth in selected public health hospitals using a standardized, pretested, and structured Amharic version questionnaire. Four Diploma Midwives were recruited for data collection and two BSc Midwives were assigned for supervision.

4.10 Data Quality Assurance

The questionnaire for data collection was prepared first in English and translated into Amharic and back-translated to English to keep the consistency of the data. A one-day training was given to data collectors and supervisors by investigators. Additionally, a pre-test of the questionnaire was done on 5% of the sample size (20 women) who gave birth in Zewditu memorial hospital in Addis Ababa City. The data was checked daily for its completeness and consistency by the investigator and supervisors.

4.11 Data Processing and Analysis

The data were checked for completeness, cleaned manually, coded and entered into Epi-data version 4.6 software, and exported to SPSS version 25 for further analysis. Descriptive statistics were presented using tables and figures.

After creating dummy variables simple linear regression analysis was used primarily to check which variables had an association with dependent variable. The assumption of linearity was checked by plotting a P-P plot and normality was checked by using Q-Q plots and histogram. Multicollinearity assumption was checked by Variance Inflation

Factor (VIF) and there is no multicollinearity. Variables having p- value ≤0.25 in simple linear regression were entered into multiple linear regression for controlling the possible effect of confounders by enter method. Factors that had significant association were identified by using unstandardized β, 95% confidence interval (CI), and p-value ≤ 0.05.

4.12 Ethical Considerations

Ethical clearance to conduct this research was obtained from the research review and ethics committee of Addis Ababa University, College of Health Sciences, School of Nursing and Midwifery. Letter of permission to conduct the study was obtained from Addis Ababa Public Health Research and Emergency Management Directorate. Each respondent was informed about the purpose and anticipated benefits of the study by the data collectors. Written consent was taken from the volunteer participants. Confidentiality and anonymity were ensured throughout the process of the study.

4.13 Dissemination of the Result

The findings of the study will be presented to Addis Ababa University, College of health sciences, School of Nursing and Midwifery, Department of Midwifery. The results of the research will be disseminated to the Addis Ababa University College of health sciences library. The findings of the study will also be disseminated to the Federal Minister of Health, and Addis Ababa town public hospitals. Finally, efforts will be made to publish the research in a national or international reputable journal.

5. RESULTS

5.1 Socio-demographic characteristics of the respondents

In this study, 384 mothers have participated with a response rate of 99.2%. Most of the study participants 328 (85.4%) were from Addis Ababa. The mean age of the mothers was 26 (SD, ± 3.87) years. Out of the total respondents, 165 (43%) had a primary level of education. Regarding occupation 226 (58.8) were housewives. The mean monthly income of the respondents was 3384 birr (Table 1).

Table 1: Sociodemographic characteristics of the respondents at public hospitals in Addis Ababa, Ethiopia, 2021 (n= 384)

Variables	Frequency	Percentage (%)
Residence		
Urban	328	85.4
Rural	56	14.6
Age of mothers		
≤24	149	38.8
25-29	160	41.7
≥30	75	19.5
Marital status		
Married	369	96.1
Unmarried	15	3.9
Level of education		
Unable to read and write	23	6
Primary school (grade 1-8)	165	43
Secondary school (grade 9-12)	118	30.7
Diploma and above	78	20.3
Occupation		
Housewife	226	58.8
Government employee	34	8.9
Private employee	124	32.3
Income		
0-1650	62	16.1
1651-3200	174	45.3
>3200	148	38.6

5.2 Obstetrics characteristics of the respondents

From the total 384 study participants, almost all of 369 (96.1%) had antenatal care (ANC) follow-up for current delivery. Besides, nearly a quarter of the respondents 274 (74.3%) had received four and above ANC visits.

About 231 (60.2%) of the mothers were multiparous. Almost half of the mothers 188 (49%) had delivered through spontaneous vaginal delivery and 261 (68%) of deliveries were attended by Doctors. Over half of mothers 211 (54.9%) had gave birth in the daytime. Most of the respondents 329 (85.7%) had no complications during delivery. Among the total respondents, 148 (36.8%) had more than two days of hospital stay (Table 2).

Table 2: Obstetrics characteristics of the respondents at public hospitals in Addis Ababa, Ethiopia, 2021 (n= 384)

Variables	Frequency	Percentage (%)
ANC		
Yes	369	96.1
No	15	3.9
Number of ANC		
<4	95	25.7
≥4	274	74.3
Parity		
Primiparous	153	39.8
Multiparous	231	60.2
Number of facility based delivery		
1	156	40.6
≥2	228	59.4
Mode of delivery		
Spontaneous vaginal delivery	188	49
Cesarean section	176	45.8
Instrumental	20	5.2
Profession of delivery attendant		
Doctor	261	68
Midwife	123	32
Sex of provider conducting delivery		
Male	248	64.6
Female	116	30.2
Both	20	5.2
Time of delivery		
Day	211	54.9
Night	173	45.1
Complication during delivery		
Yes	55	14.3
No	329	85.7
Newborn outcome		
Alive	368	95.8
Died	16	4.2
Length of stay in the hospital		
One day	186	48.4
Two days	50	13
More than two days	148	38.6

5.3 Person-Centered Maternity Care (PCMC) Scales and Sub-scales

Person-centered maternity care during childbirth was defined as a summative score from the response to each item which ranges from 0 to 90. The mean person-centered maternity care score of the respondents was 59.2 (SD= ±10.1) out of 90 with the minimum and maximum PCMC scores of 33 and 82 from 90 respectively. The percentage mean PCMC score of the respondents was 65.8%.

5.3.1 Dignity and Respect

The mean dignity and respect score of the study participants was 15.7 (SD= ±2.15) from 18. From the total respondents, 133 (34.6%) of the study participants were treated with respect by health care providers. About 128 (33.3%) of the study participants were treated in a friendly manner in the facility. Only 15 (3.9%) and 4 (1%) of mothers had experienced verbal or physical abuse at least on times in the facility respectively. In addition, 7 (1.8%) had reported their auditory privacy was not kept and 9 (2.3%) felt their health information was not kept confidential (Table 3).

Table 3: Distribution of dignity and respect items in public hospitals, Addis Ababa, Ethiopia, 2021 (n= 384)

Items	No, never (%)	Yes, a few times (%)	Yes, most of the time (%)	Yes, all the time (%)
Providers treat me with respect	5 (1.3)	41 (10.7)	205 (53.4)	133 (34.6)
Provider treat me in a friendly manner	12 (3.1)	39 (10.2)	205 (53.4)	128 (33.3)
Providers shouted, insulted, scolded, threatened or talked me rudely (RC)	360 (93.7)	15 (3.9)	8 (2.1)	1 (0.3)
Providers pushed, slapped, beaten, pinched or physically restrained (RC)	378 (98.5)	4 (1)	2 (0.5)	0
People not involved in the care hear discussion with the provider (RC)	354 (92.2)	7 (1.8)	19 (5)	4 (1)
Feel health information was or will be kept confidential	17 (4.4)	9 (2.3)	91 (23.7)	267 (69.6)

RC= Reverse Coded

5.3.2 Communication and Autonomy

The mean communication and autonomy score of the study participants was 14.62 (SD= ±4) from 27. Most of the participants, 316 (82.3%) had reported providers never introduced themselves during their stay in the facility. From the total respondents, 124 (32.3%) reported that health care providers never called by their name. Only 24 (6.3%) of the respondents reported that providers never asked consent before doing examinations and procedures, and 88 (22.9%) of respondents had involved in decisions (Table 4).

Table 4: Distribution of communication and autonomy items in public hospitals, Addis Ababa, Ethiopia, 2021 (n= 384)

Items	No, never (%)	Yes, a few times (%)	Yes, most of the time (%)	Yes, all the time (%)
Providers introduced themselves	316 (82.3)	45 (11.7)	21 (5.5)	2 (0.5)
Providers call me by my name	124 (32.3)	95 (24.7)	117 (30.5)	48 (12.5)
Involved in decisions	20 (5.2)	55 (14.3)	221 (57.6)	88 (22.9)
Consent before doing examinations and procedures	24 (6.3)	50 (13)	215 (56)	95 (24.7)
Allowed position of choice	233 (60.7)	83 (21.6)	62 (16.1)	6 (1.6)
Providers speak in a language that I could understand	5 (1.3)	12 (3.1)	104 (27.1)	263 (68.5)
Purpose of examinations and procedures were explained	15 (3.9)	53 (13.8)	222 (57.8)	94 (24.5)
Purpose of medicines explained	24 (6.3)	45 (11.7)	219 (57)	96 (25)
I could ask any questions I had	10 (2.6)	77 (20.1)	230 (59.9)	67 (17.4)

5.3.3 Supportive Care

The mean supportive care score of the respondents was 28.84 (SD= ±5.78) out of 45. Most of the respondents, 200 (52.1%) and 329 (85.7%) were not allowed to have companions during labor and delivery respectively. Out of the total respondents, 114 (29.7%) of them had reported that there were enough health care providers to care for them. In addition, 17 (4.4%) of mothers felt that the rooms were crowded during their stay in the facility.

Over half of the respondents, 203 (52.9%) reported that there was water in the facility and most of participants 331 (86.2) reported that there was electricity. Nearly half of the study participants, 198 (51.8%) reported that they felt safe in the facility. From the total respondents, only 49 (12.8%) of mothers reported that they thought the general environment of the facility was very clean (Table 5).

Table 5: Distribution of supportive care items in public hospitals, Addis Ababa, Ethiopia, 2021 (n= 384)

Items	No, never (%)	Yes, a few times (%)	Yes, most of the time (%)	Yes, all the time (%)
Allowed a labor companion	200 (52.1)	59 (15.4)	72 (18.7)	53 (13.8)
Allowed a delivery companion	329 (85.7)	25 (6.5)	20 (5.2)	10 (2.6)
Providers talk to me about my feeling	21 (5.5)	119 (31)	212 (55.2)	32 (8.3)
Providers supported anxieties and fears	16 (4.2)	73 (19)	255 (66.4)	40 (10.4)
Providers try to control when I have a pain	5 (1.3)	73 (19)	256 (66.7)	50 (13)
Providers paid attention when I need help	6 (1.5)	59 (15.4)	248 (64.6)	71 (18.5)
Providers took best care for me	8 (2.1)	42 (10.9)	214 (55.7)	120 (31.3)
I trust providers regards to care	4 (1)	16 (4.2)	84 (21.9)	280 (72.9)
There was enough providers	6 (1.5)	29 (7.6)	235 (61.2)	114 (29.7)
The rooms were crowded (RC)	103 (26.8)	118 (30.8)	146 (38)	17 (4.4)
There was water in the facility	38 (9.9)	68 (17.7)	75 (19.5)	203 (52.9)
There was electricity in facility	2 (0.5)	2 (0.5)	49 (12.8)	331 (86.2)
Feel safe in the facility	1 (0.3)	18 (4.7)	167 (43.5)	198 (51.5)
Waiting time	Very long	Somewhat long	Little long	Very short
	11 (2.9)	105 (27.3)	196 (51)	72 (18.8)
The general environment of the facility	Very dirty	Dirty	Clean	Very clean
	0	8 (2.1)	327 (85.1)	49 (12.8)

RC= Reverse Coded

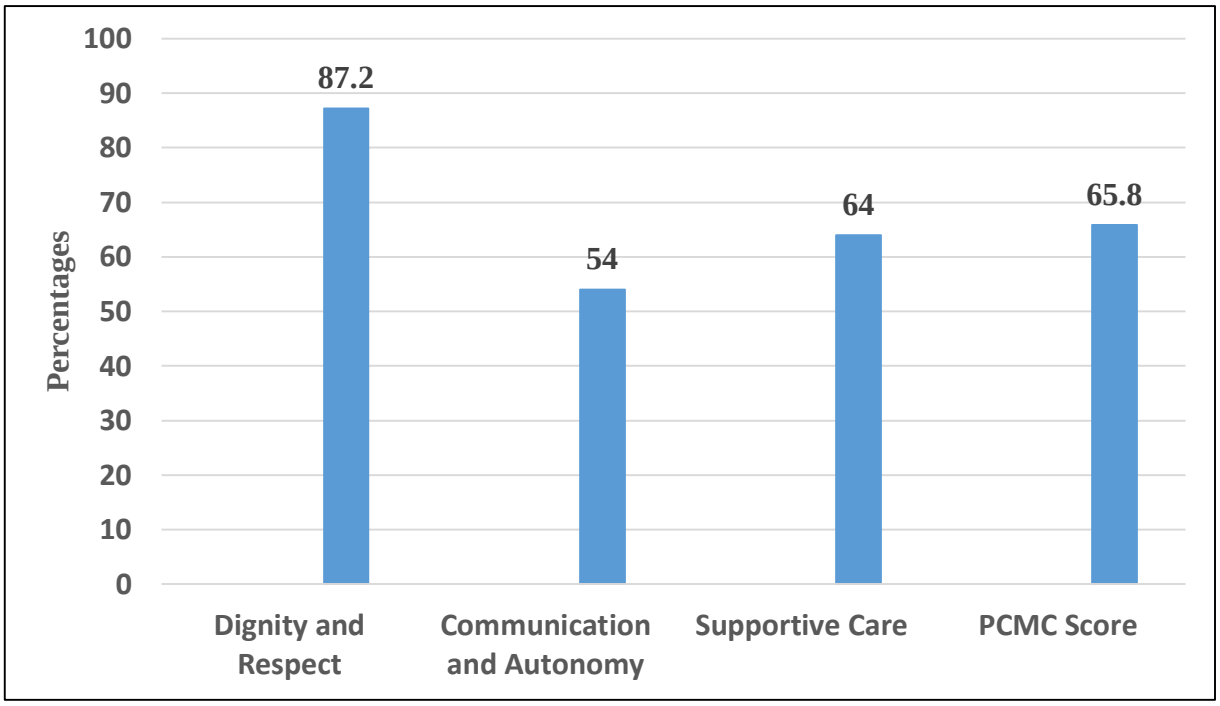


Figure 3: Distribution of percentage mean score of person-centered maternity care scale and subscales in public hospitals, Addis Ababa, Ethiopia, 2021

As shown in the figure above the percentage mean person-centered maternity care score of the respondents was 65.8%. The percentage mean PCMC score for sub-scales was 87% for dignity and autonomy, 54% for communication and autonomy, and 64% for supportive care. The figure also showed that from the components of person-centered maternity care dignity and respect recorded the highest percentage mean score followed by supportive care while communication and autonomy received the lowest mean score.

5.4 Factors associated with Person-Centered Maternity Care

The results of simple linear regression analysis showed that residence, educational level, ANC follow-up, number of ANC, time of delivery, and complication during delivery were factors significantly associated with PCMC score.

In multiple linear regression having no ANC follow up, <4 ANC follow up, nighttime delivery, and complications during delivery were factors significantly associated with PCMC score.

By controlling the effect of all other variables in the model, mothers who have no ANC follow-up had decreased person-centered maternity care score by a factor of five times as compared to mothers having ANC follow-up (β= -5.39, 95% CI: -10.52, -0.26). Similarly, mothers having <4 ANC visits had decreased person-centered maternity care score by a factor of four times as compared to mothers having four or more ANC visits (β= -3.99, 95% CI: -6.63, -1.36).

Respondents who gave birth at night time had decreased person-centered maternity care score by a factor of four times as compared to their counterparts (β= -3.95, 95% CI: -5.91, -1.98). Additionally, mothers who had complications during delivery had decreased PCMC score by a factor of three times as compared to mothers delivered without complications (β= -3.18, 95% CI: -6.01, -0.35) (Table 6).

Table 6: Bivariate and multivariate linear regression analysis for factors affecting Person-Centered Maternity Care, Addis Ababa, Ethiopia, 2021

Variables	Mean (SD)	Crud β	Adjusted β
Residence			
Urban	59.8 (10.2)	1.00	1.00
Rural	55.2 (8.5)	-4.63(-7.45, 1.79)**	-1.65(-4.82, 1.51)
Level of education			
Diploma and above	60.3 (11.2)	1.00	1.00
Unable to read and write	55.0 (9.6)	-5.28(-9.96, -0.59)*	-1.27(-5.96, 3.42)
Primary (grade 1-8)	58.4 (9.5)	-1.93 (-4.64, 0.78)	-0.50(-3.22, 2.22)
Secondary (grade 9-12)	60.3 (10.0)	0.01(-2.90, 2.86)	-0.29 (-2.48, 3.06)
ANC			
Yes	59.4 (10.0)	1.00	1.00
No	53.8 (11.0)	-6.14(-11.34, -0.95)*	-5.39(-10.52, -0.26)*
Number of ANC			
Four and above	60.7 (9.8)	1.00	1.00
Less than four	55.6 (9.7)	-4.96(-6.99, -2.39)***	-3.99(-6.63, -1.36)*
Time of delivery			
Daytime	61.1 (10.2)	1.00	1.00
Nighttime	56.8 (9.5)	-4.3(-6.29, -2.31)***	-3.95(-5.91, -1.98)*
Complication during delivery			
Yes	59.6 (9.6)	1.00	1.00
No	56.5 (12.2)	-3.09(-5.97, -0.21)*	-3.18(-6.01, -0.35)*

Keys: 1= Reference**,** CI= Confidence Interval

*= p- value< 0.05, **= p- value< 0.01, ***= p- value< 0.001

6. DISCUSSION

Person-centered maternity care is identified as the key aspect of quality of maternity care that contributes to improved maternal and neonatal outcomes and increased institutional delivery [5]. This study investigated the prevalence of person-centered maternity care and associated factors among mothers who gave birth at public hospitals in Addis Ababa city.

The study reported that the prevalence of person-centered maternity care was 65.8%. The findings of this study indicated that health care providers rarely introduced themselves, asked permission before performing examinations and procedures, involved women in decisions about their care, allowed a position of choice during delivery, explained procedures and the purpose of medications. Most of the mothers were also not allowed to have labor and delivery companions.

The finding of this study is relatively consistent with the studies done in Kenya where the proportion of person-centered maternity care was 66.9% and a community-based cross-sectional conducted study in Dessie town where the percentage mean person-centered maternity care score was 64.5% [4, 12]. This might be due to the similarity in study design and the nature of study participants.

However, the result of this study is lower than a study conducted in Ghana where more than 75% of women experienced high person-centered maternity care scores [15]. This possible reason could be due to socio-cultural and socio-economic differences. The variation might also be due to improved quality of health care and staff training in Ghana.

On the other hand, the finding of this study was higher than a cross-sectional study done in Colombo, Sri Lanka where the mean person-centered maternity care score was 42.3 out of 90. The reason might be due to the variation in the study setting and the participant's level of reporting the care. The results of this study also showed that a higher level of person-centered maternity care than a study conducted in Bahir Dar town where the prevalence of person-centered maternity care was 57%. The difference might be due to the study period and data collection procedure variation. In addition, it might be due to service improvement in Addis Ababa public hospitals.

The current study found that respondents who had no ANC follow-up, less than four ANC visits, nighttime delivery, and complications during delivery were factors significantly associated with person-centered maternity care.

Respondents who had no ANC follow-up had significantly decreased person-centered maternity care scores as compared to respondents who have ANC follow-up. This finding is consistent with the study done in Eastern Ethiopia [29]. This is due to mothers who had no ANC might not have experience with services and they might not develop the confidence to communicate with health care providers in the facility.

Mothers who have fewer than four ANC visits had negative association with person-centered maternity care as compared to mothers who have four or more visits. It is because when ANC follow-up is not completed the mothers might not be familiar with health care providers that could affect person-centered maternity care. In addition, having infrequent ANC follow-up might decrease utilization of maternal health services that affect the interaction of clients with health care providers and the mothers might perceive that they did not receive person-centered care.

Women's who delivered at nighttime had experienced poor person-centered maternity care as compared to women's who delivered during the daytime. This is congruent with a study conducted in Dessie town [4]. The possible justification could be due to the effect of work overload, physical exhaustion and the small number of health professionals at nighttime. Hence, health care providers might not focus on PCMC. Additionally, there might be a lack of resources or weak supervision during the nighttime that could affect the mother's experience of person-centered care.

Respondents who had complications during delivery had significantly decreased person-centered maternity care scores as compared to repondents without complications. This is in line with a study done in Bahir Dar [14]. The reason might be due to mothers who had a complication during delivery might perceive that they experienced complications due to poor quality of care they received from health care providers. Moreover, mothers with a complication during childbirth are stayed in the facility for a long time without getting support from their families. Besides, they may not satisfied with the services they received from providers.

7. STRENGTH AND LIMITATIONS

7.1 Strength of the Study

- ✓ To our knowledge the study is the second of its kind in Ethiopia to assess the prevalence and factors affecting person-centered maternity care using a standard validated tool in different countries.
- ✓ This study can be an indicator of the quality of maternity care in the study area.

7.2 Limitation of the Study

- ✓ The limitation of this study was the cross-sectional nature of the study design does not assess the cause-effect relationship of different variables with person-centered maternity care.
- ✓ The study was conducted only in public health hospitals which may not represent the proportion of person-centered maternity care in private health institutions and government health centers.

8. CONCLUSION

The finding of this study showed that the proportion of person-centered maternity care during childbirth in public hospitals of Addis Ababa was 65.8%. ANC follow-up, number of ANC follow-up, time of delivery, and complications during delivery were factors significantly associated with person-centered maternity care.

9. RECOMMENDATIONS

To policymakers and Stakeholders

- Policymakers should develop and implement guidelines about person-centered maternity care.
- Training should be given to health care providers on the importance of person-centered maternity care and patient and provider rights.
- Hospital managers should increase the number of staff numbers, especially during nighttime to improve the provision of person-centered maternity care.

To Health care providers

- Health care providers should provide person-centered maternity care for all mothers who gave birth in the facility.
- Health care providers need to improve the awareness of women about the importance of ANC follow-up that could improve their interactions with clients.
- Emphasis should also be given on provision person-centered maternity care when complications happen during delivery.

For researchers

- Further qualitative and quantitative studies are recommended to identify factors that affect person-centered maternity care in both governmental and private health facilities.

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11. ANNEX

Annex I: Participant Information sheet

My name is _____. I am a data collector for the study being conducted in four hospitals and this hospital is one of this hospital. The study is done by Azezew Ambachew who is studying for his Master's degree at Addis Ababa University, College of Health Science Department of Nursing and Midwifery. I kindly request you to give me your attention to explain to you about the study and be selected as the study participant.

Purpose of the study: This study is aimed to assess the prevalence of person-centered maternity care during labor and delivery among women who gave birth at public hospitals in Addis Ababa, Ethiopia, 2021.

Risk: There is no physical or psychological risk during the procedure.

Benefits: There is no payment in the participation. But the findings of this research play a vital role in the effort made to improve labor and delivery care so that maternal mortality can be reduced.

Confidentiality: All information that you give us will be kept confidential and private. Only the principal investigator and data collectors will access your information. Your name won't be mentioned anywhere. The information you give is only used for research purposes.

Rights: Your participation in this study is fully voluntary. You have a right to refuse, to take part, or to stop giving information at any time.

If you have a question at any time you can contact me with the following addresses

Azezew Ambachew

Mobile phone: +251923233893

E-mail- azezewambachew@yahoo.com

Annex II: Informed Consent form

I herewith declare that:

The purposes of this study are explained to me and are clear. The contents of the consent are verified to me to participate in the study. I understand that participation in this study is completely voluntary and that I may withdraw at any time without supplying reasons. I agree to participate in this study to be interviewed. When signing this consent form to participate in the study, I promise to answer honestly to all reasonable questions and not provide any false information or in any other way purposely mislead the researcher.

Signature of the participant_____ date _____

Signature of the investigator_____ date _____

Annex III: Questionnaire

Part I: Socio-Demographic Characteristics

S. No.	Questions	Responses	Skip
101	Residence	1.Urban 2. Rural	
102	Age in years	_____	
103	Marital status	1. Single 2. Married 3. Widowed 4. Divorced	
104	Mothers educational level	1. Unable to read and write 2. Primary (grade 1-8) 3. Secondary (grade 9-12) 4. Certificate/Diploma 5. Degree and above	
105	Mothers occupation	1. Housewife 2. Private employee 3. Government employee 4. Merchant 5. Student 6. Other	
106	Average monthly income (ETB)	_____	

Part II: Obstetrics Characteristics

S. No.	Questions	Responses	Skip
201	Have you followed antenatal care for the last pregnancy?	1. Yes 2. No	
202	How many times did you follow antenatal care?	1. One 2. Two 3. Three 4. Four and above	

203	Place of ANC?	1. Hospital 2. Health Center 3. Private Clinic	
204	No. of live births?	_____	
205	The total number of facility-based childbirth?	_____	
206	Type of last delivery	1. Spontaneous vaginal delivery 2. Instrumental delivery 3. Cesarean delivery	
207	The profession of delivery attendant	1. Doctor 2. Midwife 3. Others	
208	Sex of delivery provider	1. Male 2. Female 3. Both	
209	Time of delivery	1. Day time 2. Night time	
210	Complication during delivery	1. Yes, for mother 2. Yes, for neonate 3. Yes, for both the mother and neonate 4. No	
211	Newborn outcome	1. Alive 2. Dead	
212	How many days did you stay in the hospital?	1. One day 2. Two days 3. More than two days to one week 4. More than a week	

Part III: Person-Centered Maternity Care Scale

Subscale 1: Dignity and Respect

S. No.	Questions	Responses	Skip
301	Did the health care provider in the facility treat you with respect?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
302	Did the health care provider in the facility treat you in a friendly manner?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
303	Did you feel the health care providers shouted at you, scolded, insulted, threatened, or talked to you rudely?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
304	Do you feel like you were treated roughly like pushed, beaten, slapped, pinched, or physically restrained?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
305	Did you feel other people not involved in the care could hear the discussion with the health care provider?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
306	Did you feel like your health information was or will be kept confidential in this facility?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	

Subscale 2: Communication and Autonomy

S. No.	Questions	Responses	Skip
307	During your time in the health facility, did the health care providers introduced themselves to you when they first come to see you?	0. No, none of them 1. Yes, a few of them 2. Yes, most of them 3. Yes, all of them	
308	Did the health care providers call you by your name?	0. No, none of them 1. Yes, a few of them 2. Yes, most of them 3. Yes, all of them	
309	Do you feel like the health care providers in the facility involved you in decisions about your care?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
310	Did the health care providers in the facility ask your permission/consent before doing procedures and examinations on you?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
311	During the delivery, do you feel like you were able to be in the position of your choice?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
312	Did the health care providers in the facility speak to you in a language you could understand?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
313	Did the health care providers explain to you why they were doing examinations or procedures on you?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	

314	Did the health care providers explain to you why they were giving you any medicine?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
315	Do you feel you could ask the health care providers in the hospital any questions you had?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	

Subscale 3: Supportive Care

S. No.	Questions	Responses	Skip
316	Were you allowed to have someone you wanted such as family or friends to stay with you during labor?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
317	Were you allowed to have someone you wanted to stay with you during delivery?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
318	Did the health care providers in the facility talk to you about how you were feeling?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
319	Did the health care providers in the facility support your anxieties and fears?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
320	Did you feel the health care providers did everything they could to help manage your pain?	0. No, never 1. Yes, a few times 2. Yes, most of the time	

		3. Yes, all the time	
321	When you need help, did you feel the health care providers in the facility paid attention?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
322	Did you feel the health care providers in the health facility took the best care for you?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
323	Did you feel you could completely trust the health care providers in the health facility with regards to your care?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
324	Do you think there were enough providers to care for you in the facility?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
325	Did you feel like the facility was crowded?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
326	Was there water in the hospital?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
327	Was there electricity in the hospital?	0. No, never 1. Yes, a few times 2. Yes, most of the time 3. Yes, all the time	
328	Do you say you feel safe in the facility	1. No, never 2. Yes, a few times	

		3. Yes, most of the time 4. Yes, all the time	
329	What is your feeling about waiting time?	0. Very long 1. Somewhat long 2. Little long 3. Very short	
330	Thinking about the general environment of the health facility; the facility was clean?	0. Very dirty 1. Dirty 2. Clean 3. Very clean	

Annex IV: Amharic version Participant Information sheet

የተሳታፊዎች መረጃ መስጫ ቅጽ- በአማርኛ

እንደምንአደሩ/ ዋሉ? _____እባላለሁኝ። በአዲስአበባ ዩኒቨርሲቲ፣ ጤና ሳይንስ ኮሌጅ፣ ነርሲንግና ሚድዋይፍሪ ትምህርት ክፍል የማስትሬት ዲግሪ ተመራቂ ተማሪ በሆነው አዘዘዉ አምባቸዉ በሚያደርገው ጥናት ላይ መረጃ ሰብሳቢ ሆኜ እየሰራሁ ነው። እናቶች በጤና ተቋም ሲወልዱ የሚደርሰውን እናቶችን ማዕከል ያደረገ የወሊድ አገልግሎት መጠን ላይ ጥናት እያደረግን ነው። ጤና ተቋም ለወለዱ እና ፍቃደኛ ለሆኑ እናቶች የመረጃ መስጫ እና የስምምነት መግለጫ ቅጽ ተዘጋጅቷል። የእርስዎን ታማኝ እና ቀና የሆነ ትብብር ለጥያቄዎቹ መልስ እንፈልጋለን።

ዓላማ: እናቶች በጤና ተቋም ሲወልዱ እናቶችን ማዕከል ያደረገ የወሊድ አገልግሎት መጠንና ተዛማጅ ችግሮችን በአዲስ አበባ ሆስፒታሎች ላይ ለማወቅ ነዉ።

የአሰራር ሂደትና ቆይታ፡ ጥናቱ በዚህ ሆስፒታል በወለዱ እናቶች ላይ ይካሄዳል። ይህ መጠይቅ የጥናቱን ተሳታፊ እናት ሥነ- ህዝብ፤ ማህበራዊ እና ኢኮኖሚያዊ ጉዳዮች፣ የእናትየዋ የወሊድ ታሪክ እንዲሁም እናቶችን ማዕከል ያደረገ የወሊድ አገልግሎት የሚዳስስ ጥያቄዎች አሉት። ቃለ-መጠይቁ **30** ደቂቃዎችን ይዎስዳል፤ ስለዚህ ለቃለ-መጠይቁ ይህን ዉድ ጊዜዎትን እንዲሰጡኝ በትህትና እጠይቃለሁ።

ስጋት: በዚህ ጥናት ላይ በመሳተፍዎ ምንም አይነት ጉዳት አይደርስብዎትም።

ጥቅም: በጥናቱ ላይ በመሳተፎ የተለየ ጥቅም ወይም ክፍያ አያገኙም። ቢሆንም ግን የጥናቱ ውጤት ምጥ ላይ ላሉ እና በሚወልዱ እናቶች ላይ ለሚደረጉ እንክብካቤዎች መሻሻል ያመጣል ተብሎ ይታሰባል።

ሚስጢራዊነት: በዚሁ ጥናት ላይ የሚገኘው መረጃ በሙሉ ሚስጢራዊነት ተጠብቆ ይቀመጣል። የእርስዎም መረጃ በፋይል ከእርስዎ ስም ውጪ በኮድ ተደርጎ ይቀመጣል። በተጨማሪም ከጥናቱ ውጪ ለማንም ሰው አይሰጥም።

በጥናቱ ያለመሳተፍ መብት: በጥናቱ ያለመሳተፍ ወይም በማንኛውም ጊዜ ራስዎን ከጥናቱ የማግለል ሙሉ መብት አለዎት። መልስ መስጠት የማይፈልጉትን ማንኛውንም ጥያቄ ያለመመለስ መብት አለዎት። ማንኛውም ጥያቄ ካለዎት በሚከተለው አድራሻ ማግኘት ይችላሉ።

አዘዘዉ አምባቸዉ

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Annex VI: Amharic version Consent form

የስምምነት መግለጫ ፎርም- በአማርኛ

የዚህ ጥናት ዓላማ በደንብ የተብራራልኝ ሲሆን የጥናቱንም ዓላማ ተረድቻለሁ። በዚሁ ጥናት ላይ መሳተፍ በሙሉ ፈቃደኝት ላይ የተመሰረተ መሆኑን በሚገባ የተረዳሁ ሲሆን በማንኛውም ጊዜ ከጥናቱ ራሴን የማግለል መብት እንዳለኝ አውቄአለሁ። ስለሆነም የምሰጠው መረጃ እስከተጠበቀ ድረስ በዚህ ጥናት ለመሳተፍ ተስማምቻለሁ። በዚህ ጥናት ለመሳተፍ ስምምነቴን ስገልፅ ለምጠየቀው ጥያቄ በእውነት ላይ የተመሰረተ መልስ ለመስጠት የተስማማሁ መሆኔን አረጋግጣለሁ።

የተሳታፊዉ ኮድ_____

በጥናቱ ለመሳተፍ ፍቃደኛ ኖት

1. አዎ_____መልሱ አዎ ከሆነ ወደሚቀጥለዉ ጥያቄዉ እለፍ/ፊ

2. የለም_____መልሱ የለም ከሆነ አመስግነህ/ሽ ጥያቄዉን አቋርጥ/ጭ

የመረጃ ሰጪው ፊርማ _____ ቀን_____

የመረጃ ሰብሳቢዉ ፊርማ _____ ቀን_____

Annex VII: Amharic version Questionnaire

መጠይቅ- በአማርኛ

ክፍል አንድ፡- ሥነ- ህዝብ፤ ማህበራዊ እና ኢኮኖሚያዊ ጉዳዮችን በተመለከተ የተዘጋጁ ጥያቄዎች

ተ. ቁ	ጥያቄዎች	መልስ	እለፊ/ ፍ
101	የትነው የሚኖሩት?	1. ከተማ 2. ገጠር	
102	እድሜዎ ስንት ነው?	_____ዓመት	
103	የጋብቻ ሁኔታዎ?	1. ያላገባች 2. ያገባች 3. ባሏ የሞተባት 4. የፈታች	
104	የትምህርት ደረጃዎ?	1. ማንበብ እና መፃፍ የማትችል 2. የመጀመሪያ ደረጃ (1-8) 3. ሁለተኛ ደረጃ (9-12) 4. ሰርተፍኬት / ዲፕሎማ 5. ዲግሪ እና ከዚያ በላይ	
105	ስራዎ ምንድን ነው?	1. የቤት እመቤት 2. የግል ተቀጣሪ 3. የመንግስት ሰራተኛ 4. ነጋዴ 5. ተማሪ 6. ሌላ ይገለጽ_____	
106	ወርሃዊ አማካይ ገቢ ምን ያህል ነው?	_____ብር	

ክፍል ሁለት፡- የእናትየዋ የወሊድ ታሪክ

ተ. ቁ	ጥያቄዎች	መልስ	እለፊ/ ፍ
201	የእርግዝና ክትትል አድርገው ነበር?	1. አዎ 2. የለም	2 ከሆነ ወደ ቁ. 204 እለፍ

202	የእርግዝና ክትትል አድርገው ከሆነ አገልግሎቱን ያገኙት ከየትኛዉ የጤና ተቋም ነበር?	1.ሆስፒታል 2. ጤና ጣቢያ 3. የግል ክሊኒክ	
203	በአጠቃላይ ስንት ግዜ የእርግዝና ክትትል አድርገው ነበር?	1. አንድ ግዜ 2. ሁለት ግዜ 3. ሶስት ግዜ 4. አራት ግዜ	
204	እስከ አሁን ስንት ጊዜ ወልደሻል?	_____	
205	እስከ አሁን ስንት ጊዜ በጤና ተቋም ወልደሻል?	_____	
206	በምን አይነት ሁኔታ ነበር የወለዱት?	1.በምጥ 2. በመሳሪያ ድጋፍ 3. በቀዶ ጥገና	
207	በዋነኛነት ሲያዋልድ የነበረው ባለሙያ ማን ነበር?	1. ዶክተር 2. ሚድዋይፍ 3. ሌላ ይገለጽ_____	
208	በዋነኛነት ሲያዋልድ የነበረው ባለሙያ ፃታ?	1. ወንድ 2. ሴት	
209	የወለዱበት ሰዓት?	1. ቀን 2. ማታ	
210	አሁን ሲወልዱ ችግር አጋጥሞት ነበር?	1. አዎን (ለእራሴ) 2. አዎን (ለልጄ) 3.አዎን (ለእራሴ እና ለልጄ) 4.የለም	
211	እንደተወለደ የልጅዎ ሁኔታ እንዴት ነበር?	2. በህይወት የተወለደ 2. ሞቶ የተወለደ	
212	ከወሊድ በኃላ ለስንት ቀን ሆስፒታል ቆይተዋል?	1. አንድ ቀን 2. ሁለት ቀን 3. ከሁለት ቀን እስከ አንድ ሳምንት 4. ከሳምንት በላይ	

ክፍል ሦስት ፡- እናቶችን ማዕከል ያደረገ የወሊድ አገልግሎት

ንዑስ ክፍል 1 ፡- ግላዊነትንና አክብሮትን ማዕከል ያደረገ አገልግሎት

ተ. ቁ	ጥያቄዎች	መልስ	እለፊ ፍ

301	በጤና ባለሙያዎች ተገቢውን የሆነ አክብሮት ተደርጎልኛል?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
302	በተቋሙ ውስጥ ያሉ ባለሙያዎች በወዳጅነት ያስተናግዱዎት ነበር?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
303	በምጥና በወሊድ ጊዜ ጤና ባለሙያዎች ሲጮሁብዎት፣ ሲሰድቡዎት ወይም ሲያስፈራሩዎት ነበር?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
304	በምጥና በወሊድ ጊዜ በጤና ባለሙያዎች አካላዊ ጉዳት ደርሶብኛል? (ሃይል መጠቀም፣ መደብደብ፣ ማጋጨት፣ መግፈተር...)	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
305	ጤና ባለሙያዎቹ የእርስዎን ሚስጥራዊ መረጃ ሌሎች በሚሰሙት ሁኔታ ሲወያዩ ነበር?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
306	በሆስፒታል ቆይታዎ የእርስዎ ግላዊ ምስጢር ተጠብቆለዎታል?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	

ንዑስ ክፍል 2፡- መግባባት እና ፍቃደኝነትን ማዕከል ያደረገ አገልግሎት

ተ. ቁ	ጥያቄዎች	መልስ	እለፊ ፍ
307	ጤና ባለሙያው ለእናትዬው እና አብሮአት ላለው ሰው እራሱን አስተዋውቆ ነበር?	**0.** የለም፣ አንዳቸዉም **1.** አዎ፣ ጥቂቶቹ **2.** አዎ፣ አብዛኛዎቹ **3.** አዎ፣ ሁሉም	
308	ጤና ባለሙያው በስም ይጠራዎት ነበር?	**0.** የለም፣ አንዳቸዉም **1.** አዎ፣ ጥቂቶቹ **2.** አዎ፣ አብዛኛዎቹ **3.** አዎ፣ ሁሉም	
309	ጤና ባለሙያው እናትየዋን ያሳተፈ ዉሳኔ ይሰጥ ነበር?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት	

		2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
310	ጤና ባለሙያዎቹ በእርሶዎ ላይ ምርመራዎችን ከማድረጋቸዉና አገልግሎት ከመስጠታቸዉ በፊት የእርስዎን ፍቃድ ይጠይቁ ነበር?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
311	ጤና ባለሙያው በወሊድ ሰዓት እናትየዋ በመረጠችዉ አቅጣጫ ሆና እንድትወልድ ይፈቅድ ነበር?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
312	ጤና ባለሙያቹ ርስዎ ሊረዱት በሚችሉት ቋንቋ አነጋግረዎታል?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
313	ጤና ባለሙያዎቹ በምጥ ሰዓት ለምን በእርሶዎ ላይ ምርመራዎችን እንደሚያደርጉ ያስረዱዎት ነበር?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
314	ጤና ባለሙያዎቹ ማንኛዉንም መድሀኒት ለምን እንደሚሰጡ ያብራሩ ነበር?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
315	ጤና ባለሙያውን ማንኛዉንም አይነት ጥያቄ መጠየቅ ይችሉ ነበር?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	

ንዑስ ክፍል 3፡- ድጋፍ ሰጪ አገልግሎቶች

ተ. ቁ	ጥያቄዎች	መልስ	እለፊ/ ፍ
316	በምጥ ወቅት እንደቤተሰብ ወይም ጓደኞች ያሉ የሚፈልጉት አንድ ሰው አብሮዎት እንዲቆይ ተፈቅዶልዎታል?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
317	በወሊድ ወቅት ከእርስዎ ጋር ሊቆይ የሚፈልጉት አንድ ሰው አብሮዎት እንዲቆይ ተፈቅዶልዎታል?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	

318	ጤና ባለሙያዎቹ ምን እንደተሰማዎት አነጋግረዎታል?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
319	ጤና ባለሙያዎቹ ጭንቀትና ፍርሃት ሲያጋጥምሽ አስፈላጊዉን ርዳታ አድርገዉልሽ ነበር?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
320	ጤና ባለሙያዎቹ ህመምዎን ለመቆጣጠር እንዲችሉ የተቻላቸውን ሁሉ አድርገዉለዎታል?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
321	እርዳታ በሚፈልጉበት ጊዜ ጤና ባለሙያቹ ለርስዎ ጥያቄ ትኩረት ይሰጡ ነበር?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
322	ጤና ባለሞያዎቹ ለእርስዎ የተሻለውን እንክብካቤ አድርገዋል ብለው ያስባሉ?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
323	አገልግሎት አሰጣጥን በተመለከተ ጤና ባለሞያዎቹ ሙሉ በሙሉ ታማኝ ናቸው ብለው ያስባሉ?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
324	ርስዎ በሚዎልዱበት ጊዜ በሆስፒታል ውስጥ በቂ የጤና ባለሙያዎች ነበሩ ብለው ያስባሉ?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
325	የሆስፒታሉ ማዋለጃና ድህረ-ወሊድ ክፍሎች የተጨናነቁ ናቸዉ ብለው ያስባሉ?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
326	በሆስፒታሉ ዉስጥ ውሃ ነበር?	**0.** የለም፣ ፈጽሞ **1.** አዎ፣ ጥቂት ጊዜያት **2.** አዎ፣ ብዙ ጊዜ **3.** አዎ፣ ሁል ጊዜ	
327	በሆስፒታሉ ዉሰጥ ኤሌክትሪክ ነበር?	**0.** የለም፣ ፈጽሞ	

		1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
328	በአጠቃላይ በሆስፒታል ቆይታዎ ደህንነት ተሠምቶዎታል?	0. የለም፣ ፈጽሞ 1. አዎ፣ ጥቂት ጊዜያት 2. አዎ፣ ብዙ ጊዜ 3. አዎ፣ ሁል ጊዜ	
329	ለምን ያህል ጊዜ እንድትጠበቂ ይደረግ ነበር?	0. በጣም ረጅም 1.በተወሰነ ደረጃ ረጅም 2. ትንሽ ረጅም 3. በጣም አጭር	
330	አጠቃላይ የሆስፒታሉ አካባቢ ንጽህና ምን ይመስላል?	0. በጣም ቆሻሻ 1. ቆሻሻ 2. ንፁህ 3. በጣም ንፁህ	