



**ADDIS ABABA UNIVERSITY  
COLLEGE OF HEALTH SCIENCES  
SCHOOL OF PUBLIC HEALTH**

**Assessment of knowledge, desire and preferred choice of antenatal clients about companionship during labour and delivery with associated factors in Addis Ababa**

**By**

**OLUMIDE O. KUKU (MBBS)**

**Advisors:**

**Ms. Meselech Assegid (B.Sc, MPH, Phd Candidate)**

**Mr. Gebretsadik Shibre (B.Sc, MPH)**

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF  
ADDIS ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF MASTERS OF PUBLIC HEALTH  
IN REPRODUCTIVE AND FAMILY HEALTH.

JUNE, 2018

ADDIS ABABA, ETHIOPIA.



## **Acknowledgement**

First and foremost, my acknowledgement goes to God Almighty who gave me this opportunity to enroll for this program.

I am highly indebted to my advisors Ms Meselech Assegid and Mr. Gebretsadik Shibre for their valuable assistance and contribution towards the completion of this thesis. I am expressing my profound gratitude to Postgraduate Academic Mobility for African Physician-Scientists (PAMAPS) organization for awarding me scholarship for this program. I am also grateful to the staffs of the health centers and hospitals where the study was conducted. Furthermore, I am saying a big thank you to the study participants, data collectors and supervisors who made this study a reality.

I am highly indebted and grateful to United Nations Population Fund (UNFPA) for providing financial support for this research.

Lastly, I would like to extend my appreciation to my family for their understanding, encouragement and support, also to all my course-mates and instructors in the School of Public Health for their support and encouragement while working on this thesis.

## TABLE OF CONTENT

Acknowledgement.....	II
I. List of tables and figures.....	V
II. List of acronyms.....	VI
III. Abstract.....	VII
1. Introduction.....	1
1.1. Background.....	1
1.2. Statement of the problem.....	2
1.3. Significance of the study and rationale.....	3
2. Literature review.....	5
2.1. The importance of companion of choice in labour (CCLC).....	6
2.2. Acceptable companion in labour.....	8
2.3. Barriers to implementation of CCLC.....	8
2.4. Conceptual framework.....	13
3. Objectives.....	14
3.1. General objective.....	14
3.2. Specific objectives.....	14
4. Methodology.....	15
4.1. Study design.....	15
4.2. Study area.....	15
4.3. Study population.....	15
4.4. Study period.....	16
4.5. Sample size calculation.....	16

4.6. Sampling procedure.....	17
4.7. Data collection procedure.....	19
4.8. Data quality control.....	19
4.9. Variables.....	19
4.10 Operational definition.....	20
4.11 Data processing and analysis.....	21
4.12 Ethical consideration.....	21
4.13 Dissemination of research finding.....	21
5 Result.....	22
6 Discussion.....	37
7 Strength and limitations.....	41
8 Conclusion.....	41
9 Recommendation.....	42
10 References.....	43
11 Annexes.....	46
1. Information sheet.....	46
2. Consent form.....	47
3. Questionnaire.....	48
4. Information sheet, consent form and questionnaire (In Amharic).....	54

## **I. List of tables and figures**

### **Tables**

Table 1: Sample size calculation for each objective of the study.....	17
Table 2. Socio-demographic characteristics of the antenatal clients in health facilities. Addis Ababa, Ethiopia, June 2018.....	23
Table 3. Past and current Obstetrics history of the antenatal clients in health facilities. Addis Ababa, Ethiopia, June 2018.....	24
Table 4. Knowledge about CCLC among antenatal clients in health facilities. Addis Ababa, Ethiopia, June 2018.....	26
Table 5. Desire of antenatal client to have CCLC and their preferred choice as companion in Addis Ababa health facilities, June 2018.....	28
Table 6. Factors associated with the knowledge of antenatal clients about the right to have CCLC in health facilities. Addis Ababa, Ethiopia, June 2018.....	30
Table 7. Factors associated with the women’s desire to have CCLC in health facilities. Addis Ababa, Ethiopia, June 2018.....	32
Table 8. Factors associated with the women’s preferred choice as companion during labour and delivery in health facilities. Addis Ababa, Ethiopia, June 2018.....	35

### **Figures**

Figure 1: Conceptual framework.....	13
Figure 2: Schematic representation of sampling procedure.....	18
Figure 3: Distribution of respondents based on health facility. Addis Ababa, Ethiopia, June 2018.....	22
Figure 4: Knowledge about the benefit of CCLC among antenatal clients in Addis Ababa health facilities, June 2018.....	27

## II. Acronyms

AAHB	- Addis Ababa Health Bureau
AAU	- Addis Ababa University
BCC	- Behavioral Change Communication
CCLC	- Companion of Choice in Labour and Childbirth
CI	- Confidence Interval
FDGs	- Focused group discussions
FMOH	- Federal Ministry of Health
GH	- Government Hospital
HC	- Health center
MD	- Mean Duration
NGO	- Non-Governmental Organization
RMC	- Respectful Maternity Care
RR	- Relative Risk
SBAs	- Skilled Birth Attendants
SVD	- Spontaneous Vaginal Delivery
WHO	-World Health Organization

### III. Abstract

**Background:** Labour is a period characterized by worries, fear of the unknown, emotional disturbances, excruciating pain and increased potential maternal/newborn morbidity and mortality. As part of effort to improve quality of care provided in health facilities during child birth, companionship in labour was recommended by WHO. The women's knowledge about the right to have a companion in labour, desire and preferred choice as companion needs attention.

**Objective:** To assess the knowledge, desire and preferred choice of antenatal clients about companionship in labour and delivery with associated factors in Addis Ababa health facilities.

**Methodology:** A quantitative facility-based cross-sectional study was carried out in selected public healthcare facilities in Addis Ababa from February 1st to April 30th, 2018. Using multi-stage sampling technique, 477 pregnant women participated in the study. A pretested interviewer administered, structured questionnaire was used to obtain information. Data was entered in Epi-data version 3.1 and was exported to SPSS version 21 for analysis. Logistic regression model was used to assess associations between exposure and outcome variables of the study. P-value of  $< 0.05$  and 95% CI were taken as statistical significance level.

**Result:** The knowledge about the right to have companion of choice in labour and childbirth (CCLC) in facilities was found in only 65 (13.6%) of pregnant women in Addis Ababa. Four hundred and ten (86%) of them were desirous of CCLC in facilities and their predominant preferred choice was husband 245 (59.8%), followed by mother 70 (17.1%), sister 62 (15.1%) and friend 24 (5.9%). Past history of support in last delivery was associated with knowledge about CCLC (AOR=3.392; 95% CI 1.200-9.588). Level of education (AOR=0.515; 95% CI 0.277-0.960) and ethnicity (AOR=2.451; 95% CI 1.126-5.335) were associated with desire for CCLC. Level of education was associated with preference for both husband (AOR=0.141; 95% CI 0.021-0.956) and friend (AOR=2.840; 95% CI 1.099-7.341) as companion, while marital status was statistically associated with the preference for mother as companion (AOR=0.249; 95% CI 0.078-0.794).

**Conclusion and recommendation:** There is a very low knowledge among ANC clients in Addis Ababa public facilities about the right to have companion of choice in labour and childbirth (CCLC) while in facilities. Almost all the women desire to have CCLC with the husbands being their most preferred choice as companion. There is a need to improve women's awareness about their right to have CCLC through mass media and other avenues such as integration into ANC activities. Also, a clearly stated policy about CCLC should be enacted. Other studies to identify possible hindrances to practice, the view of health facilities and providers about CCLC and the view of husband and other potential companions about CCLC should be conducted.

# **1. Introduction**

## **1.1 BACKGROUND**

Labour is a period characterized by worries, fear of the unknown, emotional disturbances, excruciating pain and increased potential maternal/newborn morbidity and mortality. As part of effort to improve quality of care provided in health facilities during child birth, different interventions are being employed. One of such intervention is the practice of companionship in labour (1).

It is an established fact that allowing the presence of a woman's companion of choice during labour and childbirth promotes the respect for the woman's autonomy, which is a very important factor to be considered while improving quality of service delivery (2). Evidence has shown that companionship in labour improves childbirth outcome and labour process (3).

These benefits include shorter duration of labour, increased rate of spontaneous vaginal deliveries (SVDs), decrease need for analgesia and Caesarean Section, increased satisfaction with childbirth, less fear and distress, and reduced risk of low Apgar scores at 5mins amidst other benefits (3).

The support rendered to women in labour can be in the form of advice about how to endure or cope with the stress of labour, comforting the women by touching, massaging, encouraging mobility and warm baths, encouraging adequate fluid intake. Furthermore, continuous presence of a loved one while in labour provides a strong emotional impact of the women. This can be enacted through positive reassuring statements and praising the women while in labour (3). The unpalatable experience encountered during labour and child birth can be neutralized by the positive effect posed by companionship and support while in labour.

Based on scientific evidence, the World Health Organization (WHO) recommends that the parturient should be accompanied by people she trusts and with whom she feels at ease, possibly her partner, a friend, a doula, a nurse or midwife (1). In many low and middle-income countries, it is common for women to give birth with no support and under a medicalized and de-humanized model of care. A highly medicalized model of care is described in the literature as

one that promotes the use of unnecessary interventions, and is unable to meet the woman's emotional needs, and contributes to increasing the cost of health-care services (4).

The knowledge of the women about the benefit and right to have support in health facilities during labour, their desire for a support, and the preferred choice of support are key issues to be addressed in the Ethiopian context. This is important because the value placed on having a companion of choice in labour by the women may influence their choice of delivery place. Moreover, significant numbers of healthcare facilities in many low and middle income countries (Ethiopia inclusive) are yet to fully implement this intervention. Could the reason be due to the fact that the women in Ethiopia are indifferent and are not requesting for the presence of a companion of choice while in healthcare facilities, or are their request for a companion being turned down by the health providers? We need answers to these questions.

According to the EDHS 2016, 62% of Ethiopian women receives antenatal care but only 26% have institutional delivery (5). Supporting delivery process at home is considered to be the responsibility of neighbors, friends, and family members. At home, women in labor are supported, encouraged, prayed for and cheered up by neighbors and relatives (6). Could lack of support from loved one during healthcare facility delivery be one of the contributory factors to this trend? There is a need to know the desire of these women regarding companionship in labour while in health facility so as to advocate for programs and policies that will help in meeting their needs for companionship. This may help in improving the number of institutional deliveries, thereby reducing maternal/neonatal morbidity and mortality in the country.

## **1.2 STATEMENT OF PROBLEM**

Despite clear evidence of benefits and the growing emphasis on Respectful Maternity Care (RMC), many health-care facilities in developing countries still do not promote one of the core components of this subject, which is the practice of companionship in labour (6-8).

The willingness and desire of women to have a companion in labour and the challenges associated with the visibility of acceptance of such desired choice of companion in the resource-limited health care facilities is still a major problem in many developing countries amidst the other numerous problems facing the full implementation of this highly effective intervention (6, 7).

Ethiopia is a country that is so rich in cultural heritages, diversity and believes. There was no study that explored the knowledge of the women about this practice. Also, the magnitude of unmet need for companionship while in labour in health facility setting is yet to be determined. Moreover, the woman's preferred choice as a companion in labour may pose a major challenge for implementation of this practice in view of the current settings of the healthcare delivery system in the country. It is highly imperative to objectively identify this salient challenges and proffer a solution to them.

### **1.3 SIGNIFICANCE AND RATIONALE OF THE STUDY**

Reduction of maternal and newborn mortality is a global challenge requiring multi-facet approach. Promoting the presence of skilled birth attendants (SBAs) at deliveries and use of healthcare facilities with essential obstetrics care is paramount to the achievement of this goal (9). However, there should be an improvement in the quality of care received in the health facility so as to encourage and promote facility-based deliveries (10).

One of the well established interventions that contribute to improvement in quality of service delivery and also leads to increased, scientifically proven benefit to mother and neonate during labour process and may also be highly effective in encouraging facility-based delivery is companionship in labour (11, 12). Although facility delivery is higher in Addis Ababa when compared with other regions within the country (5), it will still be appropriate to address this issue by starting with the urbanized community like Addis Ababa where we ideally should expect the highest level of knowledge, awareness and better quality of health service delivery to the clients. This will help in projecting what the situation is likely to be in the rural communities before embarking on specific regional researches to address this subject.

Therefore, identifying knowledge gap about this subject among the antenatal clients will help in developing and incorporating strategies that will help to enrich and boost their knowledge base about companionship in labour. It is equally highly imperative to determine and objectively assess the magnitude of unmet need for companionship in labour among the women. This will act as a base-line for assessing the outcomes of other measures that will be instituted in other to promote this practice. Furthermore, being able to clearly identify the desired companion of choice of the majority of the antenatal clients will help in development of strategies that the

health facilities can utilize in other to meet with the aspiration of the women. This can be achieved through dialogue with the women on the acceptable companion in the individual health facility right from the antenatal clinic period; while putting into consideration, the physical and infrastructural challenges facing the healthcare delivery system in the country (13, 14).

The findings from this study will act as a baseline upon which health education, health promotion exercises, behavioural change communication (BCC), and advocacies will rest on, so as to improve the practice of this low-cost, yet highly effective intervention in Ethiopia.

## 2. LITERATURE REVIEW

One of the International human rights law includes fundamental commitments of each Country towards enabling women and adolescent girls survive pregnancy and childbirth as part of their enjoyment of sexual and reproductive health and rights and living a life of dignity (15). The World Health Organization (WHO) envisions a world where “every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal period” (2). Companionship in labour has been found to be one of the cogent intervention that is needed in other to achieve the delivery of quality care to pregnant women and also reduce the incidence of maternal and perinatal morbidity and mortality. It has been recommended by the WHO as one of the established method that helps to improve women’s satisfaction with care and labour outcome (10, 16).

This intervention has been given different names such as companion of choice at birth, companion of choice in labour, continuous support during childbirth, emotional support during birth, and others. But in this study, the term “companion of choice in labour and childbirth (CCLC)” will be used. Companionship in labour can be defined as the continuous presence of a support person during labour and birth (3). Allowing women to determine the companion of choice during labour and delivery is a low-cost but highly effective intervention directed towards improving the quality of maternity care. When women evaluate their experience, four factors predominate: the amount of support from caregivers, the quality of relationships with caregivers, being involved with decision-making and having high expectations or having experiences that exceed expectations. In many low-income countries, women are not permitted to have anyone with them during labour and birth (17). Efforts to change policies in these settings have led to questions about the effectiveness of support from spouses/partners or other support people of the woman’s own choosing.

Furthermore, it may be difficult for nurses or midwives to provide effective labour support, in the context of modern institutional birth environments while been saddled with multiple job roles. For example, nurses and midwives often have simultaneous responsibility for more than one labouring woman, they need a large proportion of time managing technology and keeping records, ensure adherence to institutional practices and protocols, and begin or end work shifts in the middle of women’s labour. Moreover, they may work in short-staffed environments or lack

labour support skills. Therefore, companions chosen by a woman from her own network, such as spouses/partners and female relatives, usually help to fill this vacuum since they are readily available to assume the role, often without extra cost to families or health systems. It is important to understand their effectiveness as providers of continuous labour support.

## **2.1 THE IMPORTANCE OF COMPANION OF CHOICE IN LABOUR**

Credible evidence has emanated from series of studies on the benefits of companionship in labour (18-21). However, the ground-breaking evidence was gotten from a Cochrane systematic review that was conducted in 2013 involving low-, middle- and high-income countries across the world (USA, Canada, Belgium, France, Greece, Finland, Sweden, South Africa, Botswana, Nigeria, Australia, Brazil, Thailand, Mexico, Guatemala, Chile and Iran). This review included 22 trials involving over 15,000 women with variation in hospital setting (22).

### **2.1.1 Improvement in child birth outcome**

#### **2.1.1.1 Maternal outcomes**

The mean length of labour was reduced for women supported in labour by approximately 35 minutes (MD -0.58 hrs, 95% CI -0.85 to -0.31). The rate of operative deliveries was reduced in women who had support during labour. The rate of caesarean section was reduced by more than 20% (RR 0.78, 95% CI 0.67 to 0.91) and there was a modest reduction in the number of women undergoing instrumental vaginal birth (RR 0.90, 95% CI 0.85 to 0.96), so that the overall number of women with spontaneous vaginal births was increased (RR 1.08, 95% CI 1.04 to 1.12).

In addition, there was a slight reduction in other interventions in labour in the supported group. The use of regional analgesia was reduced by approximately 7% (RR 0.93, 95% CI 0.88 to 0.99) and the number of women requiring other analgesia was also reduced (RR 0.90, 95% CI 0.84 to 0.96). Two trials suggested that continuous support was associated with lower rates of depression in the support group. Furthermore, women were much less likely to report negative feelings about their childbirth experience if they received continuous support (RR 0.69, 95% CI 0.59 to 0.79) (3, 16, 18, 19, 23).

### **2.1.1.2 Infant outcomes**

Infants whose mothers had been supported were less likely to have an Apgar score <7 at five minutes (RR 0.69, 95% CI 0.50 to 0.95) (3, 16).

### **2.1.2 KEY ELEMENT OF BIRTH PREPAREDNESS AND COMPLICATION READINESS (BP/CR).**

For a successful birth preparedness and complication readiness, a companion helps in decision making, arrangement of prompt transportation and also assists with blood donation during emergencies. Birth preparedness and complication readiness (BP/CR) is a comprehensive package aimed at promoting timely access to skilled maternal and neonatal services. It promotes active preparation and decision making for delivery by pregnant women and their families. This stems from the fact that every pregnant woman faces risk of sudden and unpredictable life threatening complications that could end in death or injury to herself or to her infant. Therefore, the presence of a companion designated to be a woman's support during labour will equally assist with preparedness for birth (24-27).

### **2.1.3 KEY ELEMENT OF RESPECTFUL MATERNITY CARE (RMC)**

Women's birth environments should be empowering, non-stressful, respectful of privacy and value women's preferences for companionship. Disrespect and abuse of women during institutional childbirth includes rejecting her demand for a companion during labour and delivery. This is one of the reasons why women are reluctant to have hospital delivery in many low and middle-income countries, Ethiopia inclusive (11, 12, 28, 29). Continuous companionship in labour based on women's choice is a major component of RMC that should be embraced for better maternity service and outcome (30, 31). In comparison with having no companion during labour, support from a chosen family member or friend appears to increase women's satisfaction with their childbearing experience.

### **2.1.4 KEY COMPONENT OF "CARING, RESPECTFUL AND COMPASSIONATE" HEALTH CARE TRANSFORMATION AGENDA IN ETHIOPIA (CRC)**

Ethiopian Government's overall desire is to achieve the highest possible level of health/quality of life for its citizenry by ensuring the highest possible quality of health service delivery in an

equitable manner (32). One of the impact-level target of the Health Sector Transformation Plan (HSTP) is the reduction of maternal mortality rate (MMR) to 199/100,000 live births in 2020. One of the four transformation agendas that was instituted to achieve this is “the caring, respectful and compassionate health workforce” (CRC) which aims to bring about a change in attitude, manner and approach of healthcare delivery (32). CRC healthcare delivery must consider patients as human beings with complex psychological, social and economic needs and provide person-centered care with empathy. In addition, there must be respect for and facilitation of patient’s and families’ participation in decisions and care (32). The principle of CCLC is embedded in the practice of CRC.

## **2.2 ACCEPTABLE COMPANION IN LABOUR**

Based on the Cochrane systematic review (3), all type of labour support are effective, however, the benefits are optimal when the companion is not a staff of that health facility. The companion can be anyone chosen by the woman for the support during labour and delivery. This includes any family member of the woman such as husband/partner, female relatives like, sister, mother, cousin, amidst others. Others are social networks such as female friend, community members such as female community leaders, traditional birth attendants, Doula (A woman who had training in labour support, but is not a staff of the healthcare facility) are also acceptable (3, 17).

It will be good if the facility offers a form of orientation session for the companions, so that they can be intimated with their role while supporting the women during labour and delivery.

## **2.3 BARRIERS TO IMPLEMENTATION OF COMPANION OF CHOICE IN LABOUR**

It is disheartening to know that despite the supporting evidence on the accrued benefit of this intervention, the practice is still not encouraging in many developing countries. Some of the issues that are identified as the barriers are:- the absence of national or institutional policies allowing women to have a companion of choice during labour and childbirth (CCLC), the physical infrastructure of health-care facilities, which limits privacy and contributes to overcrowding in the labour ward and difficulties in maintaining hygiene standards, limited knowledge among health-care providers about the benefits of labour companionship, negative

attitudes of health-care providers towards labour companionship, limited knowledge among women about the benefit and their right to choose a companion of their choice during labour and childbirth, lack of desire to have a companion in labour and also the incompatibility that may exist between a woman's choice of companion and the hospital policy on choice of companion.

### **2.3.1 Absence of National or Institutional policies on CCLC**

The unavailability of policies supporting the practice of CCLC is a major drawback for its implementation in many low and middle-income countries (1). Some of the reasons why policy makers in low-resourced countries are reluctant to institute this policy are because of the fear of the cost of building and the need for physical restructuring of the hospital environment in order to meet up with the environmental demand for implementation.

### **2.3.2 Physical infrastructure of health-care facilities**

Crowding of shared labour rooms was a major concern in resource-constrained facilities (1). In facilities with open wards, midwives can only permit a companion (often at their own discretion) if there is only one woman in the labour ward; her companion would be forced to leave if another labouring woman arrives. In order to combat this challenge, initiatives such as providing separate rooms for delivery, or building cubicles around each bed and having a curtain to create privacy. But, because of financial challenge or space constraints, it may not be applicable in all facilities (1, 17, 33).

### **2.3.3 Limited knowledge about the benefit/ negative attitudes of health-care provider towards CCLC**

Some healthcare providers working in maternity units who are expected to uphold this practice are even the ones hindering it. It is shocking to know that resistance is present even in environments where they should have embraced the practice due to the shortage in labour ward staffs and suboptimal pain control (where epidural analgesia is not available)—that is, situations where companions would be of benefit in supporting and comforting the labouring women.

In many of the studies conducted in high or low income countries, providers carried negative attitudes towards the implementation of companion of choice at birth (1, 34). They reported concerns about cross infection and overcrowding in labour wards. Furthermore, they are afraid of

the possibility of the woman's companion interfering with clinical decisions, and also mounting pressure on the healthcare providers. Also, perceived threat of litigations that might be initiated by the companion as regarding the quality of service delivery in the course of labour and childbirth can also be responsible for the reluctant attitude of the providers towards the practice of CCLC (33). Influencing the attitudes of health care providers is necessary for the successful implementation of the intervention. In other to achieve this, there is a need to carry out sensitization activities including the provision of evidence-based information to the providers.

#### **2.3.4 Ignorant of their right to choose a CCLC.**

It has also been discovered that some of the women are not aware of their right to have a partner during labour and childbirth in healthcare facility. They assume this practice of having their relatives giving them physical, emotional, psychosocial and even spiritual support is limited to home delivery and when been attended to by traditional birth attendants (TBAs). Some of the women have a wrong assumption that while in healthcare facility, there is no place for social interaction and cultural practices that promotes humanized birth experience but rather, pure medicalization is the order of the day (35, 36). According to a study conducted by Asefa et al in Ethiopia in 2015, only 16.2% of the respondents who has been identified to have faced disrespect and abuse during labour and childbirth are aware that they were disrespected and their rights violated (31). There is a need to intimate women about their right to have a choice of companion during labour and childbirth and that this is an integral part of respectful maternity care meant for them.

#### **2.3.5 Lack of desire to have a companion in labour and childbirth**

The choice of having a companion in labour is the sole right of the woman. This intervention will not hold if the woman refuses to have any companion in labour aside the service provider. Such an action is equally a major barrier that needs to be overcome in other to promote the practice of companionship in labour. A study conducted in Nigeria by Morhasen-Bello et al. found that about 25% of women refused having a companion in labour (37). According to this study, for every three women that accept the practice of companionship in labour, one will reject the practice. Another study conducted by Oboro et al. reinforces this finding. It was discovered that 35% of the respondents from that study do not want a companion in labour (38).

Furthermore, a study conducted in Ghana by Alexander et al. (39), reported a higher number of women who rejected having a companion in labour to be 42%. In addition, 54.7% of the women declined having a companion according to the report of a study conducted in Saudi Arabia by Al-Mandeel et al (40). This value is quite worrisome because it is a major threat to the practice of this intervention. This rejection might be due to lack of knowledge about the beneficial effect of this intervention. Other reasons could be cultural believes, feeling of embarrassment, desire for strict privacy, fear of the companion suffering psychological damage while attending a childbirth, fear of an evil-spirited companion and being too shy of a companion (39, 40), amidst other reasons. There is currently no study in Ethiopia that assessed the desire of the antenatal women for a companion during labour and childbirth in health facilities. There is a cogent need for this information as a form of situational analysis for baseline information for action.

### **2.3.6 The challenges accrued to the woman's choice of companion**

Another important barrier to the implementation of CCLC are the challenges facing the choice of companion made by the women. The privacy of other women is equally paramount and cannot be jeopardized while practicing CCLC. This issue is very important especially in developing countries where there is still a major challenge with infrastructural facilities which do not make room for individual privacy during labour or delivery. Significant number of the facilities still practice "open ward system". In this type of hospital setting, there may be a clash between the policy of the healthcare providers and the woman's choice of companion, especially for women who desires to have their spouse/partner as companion. Of a truth, women should be able to choose the companion of their choice. Denial of such women their right to have their husbands as support in labour and childbirth may be interpreted as infringement on their right to a companion of choice and thus taken as poor quality of service delivery.

A pre-knowledge of the women's selected choice of companion in labour while still attending antenatal clinic may help the health provider and the women to reach a consensus that will favour both party before the onset of labour. This may be achieved by either the woman changes her choice of companion to a female relative or the facility will be willing to create an enabling environment for privacy, such as the use of curtain for each delivery cubicle, etc.

There has been conflicting report about the preferred choice as companion in labour and delivery among women. While some strongly desire to have their husband as their companion, some preferred their female relatives or friend at the expense of their husband (37, 38).

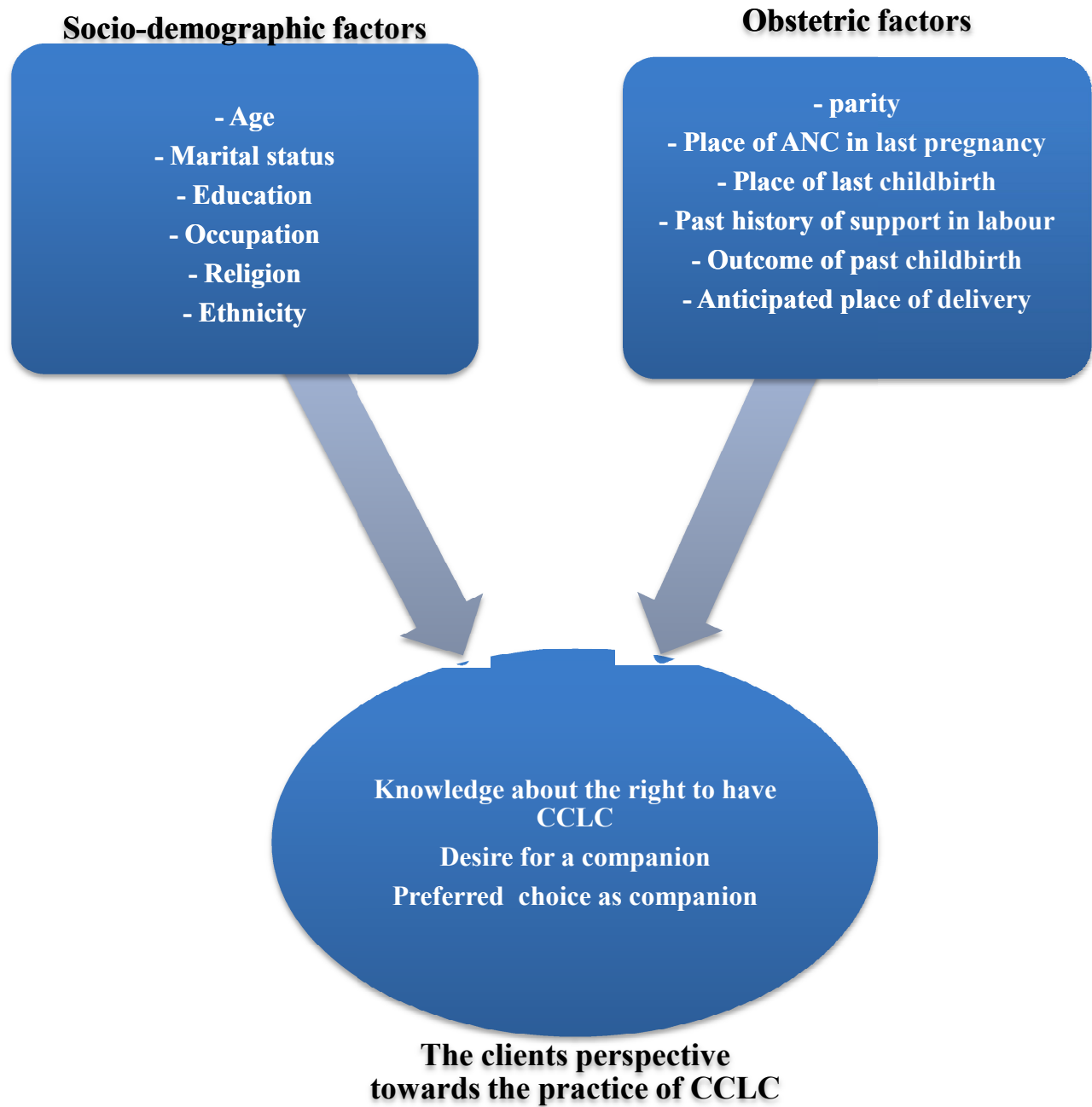
According to Oboro et al (38), some of the reasons being put forward by the women who do not want their husband as their support in labour includes:- personal embarrassment (39.4%), fear of loss of sexual attractiveness (26.8%), concern for their husband/partner (23.9%), and lack of privacy (21.1%).

In Ethiopia, there is currently no objective documentation about the women's preferred choice of companion in labour. Based on speculation, some people may predict that majority will prefer their mother, while others may say husband is the preferred choice. There is a need for a study that will shed light on all these grey areas. This is very important as a guide for programme development. It is also of importance while delivering health education session in antenatal clinic, so as to help the women make an informed decision while choosing their choice of companion in labour and delivery, bearing in mind the challenges they may encounter as a result of the hospital setup constraints.

## **2.4 Conceptual framework**

The client (individual) factor which is the main focus of this research is very important for implementation. The knowledge of the women about the practice coupled with their awareness of their right to have a companion of their choice during labour and delivery in health facilities will act as driving force for the practice of this intervention. The desire to have a companion and the preferred companion equally plays a pivotal role.

The client perspective toward CCLC may be influenced by sociodemographic characteristics such as age, marital status, education, occupation, religious and ethnicity. Education has a direct effect on health status, exposure to health risks, access to health services and health seeking behavior of people (32). Furthermore, obstetric variables such as parity, place of antenatal care in last pregnancy, place of last delivery, had support during last delivery, outcome of last delivery and anticipated place of delivery, may also influence the client's knowledge, desire and preferred choice of a companion during labour and childbirth (**Figure 1**).



**Figure 1: Conceptual framework**

Conceptualized and designed based on literature review findings using Smart Art Graphics.

### **3. OBJECTIVES**

#### **3.1 General objective**

To assess the knowledge, desire and preferred choice of antenatal clients about companionship in labour and delivery with associated factors in Addis Ababa healthcare facilities.

#### **3.2 Specific objectives:-**

To assess the pregnant women's knowledge about the right to companionship in labour and delivery in healthcare facility setting with associated factors.

To determine the pregnant women's desire to have a companion of choice in labour and delivery with associated factors.

To determine the pregnant women's preferred choice as companion in labour and delivery with associated factors.

## **4. METHODOLOGY**

### **4.1 STUDY DESIGN**

A multi-centered, facility-based cross-sectional study design was used. Quantitative approach was employed for the study.

### **4.2 STUDY AREA**

This study was conducted in Addis Ababa; the capital and the largest city of Ethiopia. Addis Ababa is also the seat of African Union. It has ten sub-cities and 116 Woreda administrations. The estimated population of the city was 3,195,000 (Females- 1,680,000 and Males- 1,515,000) (41).

There are eleven public hospitals of which six are owned by the Addis Ababa Health Bureau (AAHB), four by the Federal Ministry of Health (FMOH) and one (Tikur Anbesa hospital) which is under the Ministry of Education. There are also 35 privately owned hospital and 3 Non-Governmental Organization (NGO) hospitals. Furthermore, there are 98 functional health centers distributed among the 10 sub-cities (41).

### **4.3 STUDY POPULATION**

#### **4.3.1 Source population**

All pregnant women attending the public health facilities in Addis Ababa for antenatal care were used as the source population.

#### **4.3.2 Study population**

The study populations are the antenatal clients who meet the eligibility criteria in the selected public health care facilities in Addis Ababa.

#### **4.3.3 Inclusion criteria**

All pregnant women attending the antenatal clinic of the selected public health facilities that consented to the study and are anticipating vaginal delivery.

#### 4.3.4 Exclusion criteria

Any pregnant woman with known absolute or relative contra-indication to vaginal delivery, e.g, previous uterine scar, abnormal lie, placenta previa, etc.

#### 4.4 Study period

This study was conducted from February to April, 2018.

#### 4.5 Sample size determination

The study sample size (**n**) was calculated using formula for a single population proportion (**p**).

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

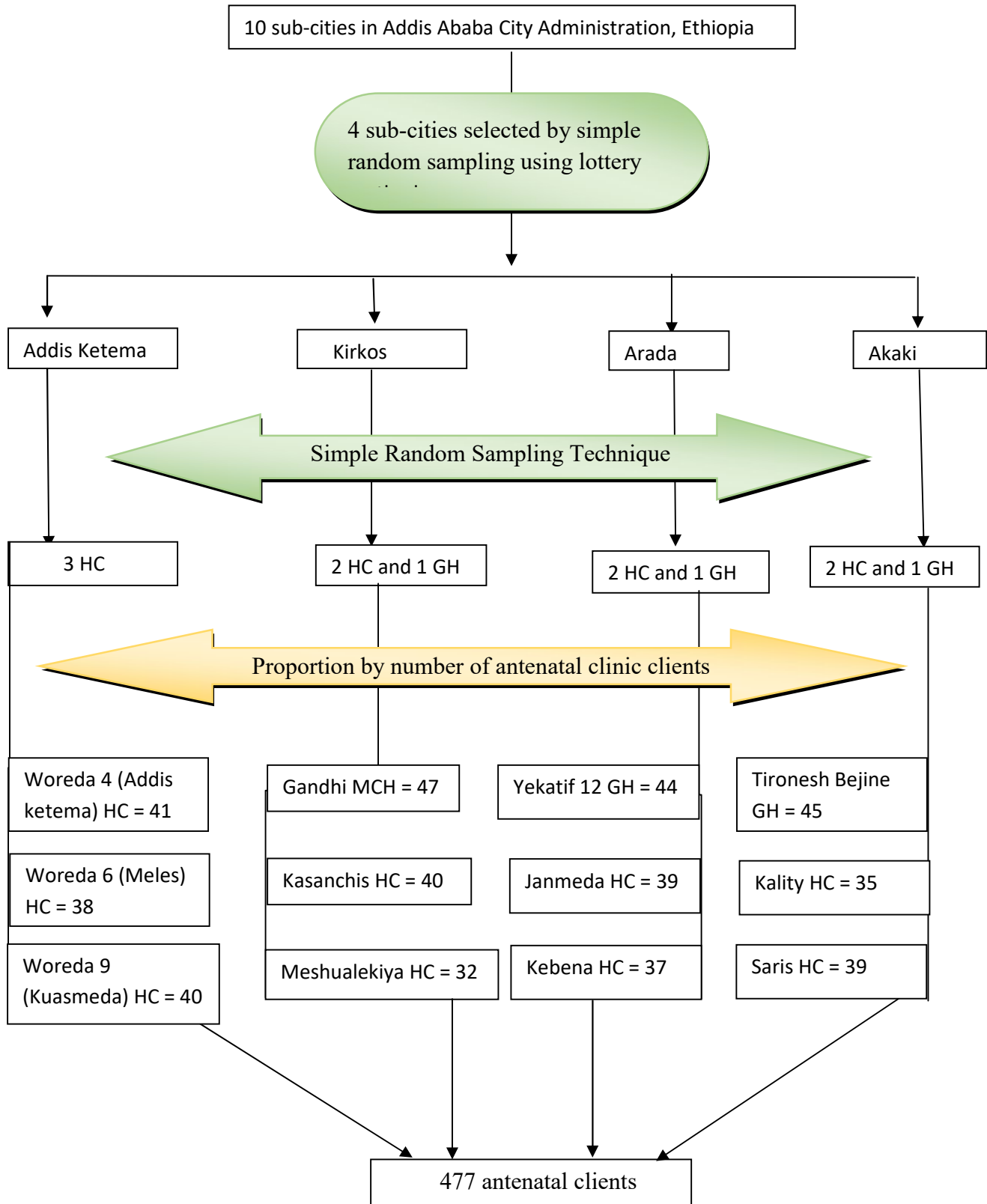
Using a statistical software, open-epi menu (42), while setting the level of significance at 95% and a margin of error (d) of 5%, and population proportion (P) gotten from previous studies for each objective, the sample size was calculated. Considering the variability created by multistage sampling, design effect of 1.5 was used to multiply the calculated sample size and 10% for non-response rate was added to the value. The largest (477) was used as the sample size for this study as shown in the table 1 below.

**Table 1: Sample size calculated for each objective of the study.**

<b>Objectives</b>	<b>Study</b>	<b>Population proportion (P)</b>	<b>Margin of error (d)</b>	<b><math>Z_{\alpha/2}</math></b>	<b>Sample size (n)</b>	<b>Design effect (1.5) X n</b>	<b>Total + 10% attrition rate</b>
Knowledge about CCLC	Malawi study (43)	83.6%	5%	1.96	211	316	348
Desire to have a companion in labour	Nigeria study (37)	75%	5%	1.96	289	433	477
Preference for husband as companion in labour	Nigeria study (37)	86%	5%	1.96	185	278	306

#### **4.6 Sampling procedure**

The participants for this study were selected using multi-stage sampling technique. There are different public health facilities (Health centers and Hospitals) distributed within the ten sub-cities in Addis Ababa. Out of the 10 sub-cities, four were selected randomly using lottery method. The public health facilities (Health centers and Government Hospitals) in the selected sub-cities were listed. The numbers of health centers and hospital to be selected in each sub-city were determined by simple random sampling. The number of study participants to be gotten from each of the selected facility was calculated using population proportion to size of antenatal clinic attendance of the facilities in relation to the total required sample size for the study (Fig 2). All consenting antenatal clients who met the inclusion criteria in each of the selected facilities were recruited until the required proportion was met. To avoid duplication of data collection from a single client, the chart number of recruited clients was recorded and cross-checked. Furthermore, effort was made to confirm possible previous recruitment in the study before including the patient.



**Figure 2: Schematic presentation of sampling procedure**

#### **4.7 Data collection procedure**

A pretested, adapted and structured questionnaire was used to collect information from the pregnant women in the antenatal clinic of each selected health facilities. The questionnaire was administered by trained interviewers after obtaining an informed consent from each pregnant woman. The questionnaire contained information about demographic data, socio-economic status, obstetric history (both past and present), knowledge about companion in labour and childbirth, desire for a companion and choice of preferred companion in labour and childbirth. The questionnaire was developed in English language, and was translated into Amharic language by a professional translator. The Amharic version of the questionnaire was translated back into English language so as to affirm correct and precise interpretation of the questionnaire.

Four data collectors with diploma degree and two supervisors with B.Sc degree were employed for this research. They were fluent in the local language and equally understand English language. Formal training was given to them so as to help them understand the purpose of this research, effective skills and techniques for interview, ethical issues while carrying out the interview, focusing on safety of participant, confidentiality and privacy.

#### **4.8 Data quality control**

To ensure data quality, each completed questionnaire was scrutinized by the study supervisor and the principal investigator on a daily basis to ascertain consistency and completeness of the information. In addition, the principal investigator also made it a point of duty to visit the research site to supervise and oversee the process of interview and data collection.

#### **4.9 Variables**

##### **4.9.1 Dependent variable**

Knowledge about the right to have CCLC in health facility

The desire to have CCLC in health facility

The preferred choice as companion in labour.

#### 4.9.2 Exposure variables

**Socio-demographic variables:** Age, marital status, education, occupation, religion and ethnicity.

**Obstetric variables:** parity, place of ANC in last pregnancy, place of last childbirth, past history of support in labour, outcome of past childbirth and anticipated place of delivery.

#### 4.10 Standard and operational definitions

**Companion of choice in labour and childbirth-** is the process of allowing a woman to be supported by whoever she desires while in labour ward during the process of labour and delivery.

**Labour-** the onset of painful uterine contraction with cervical dilation, with the aim of achieving vaginal delivery.

**Vaginal delivery** - the act of expelling the baby and placenta through the vaginal route.

**Doula** - A woman who had training in labour support, but is not a staff of the healthcare facility.

**Knowledge about CCLC-** In this study, it focuses on awareness of the practice as every woman's right, source of information, their view about the practice and its benefits.

**The desire to have a companion** - The woman who wanted a support of her choice during labour and childbirth.

**The preferred choice of companion** - Refers to the person the woman chooses as her preferred support in labour and childbirth.

#### **4.11 Data processing and analysis**

The filled in questionnaires was coded and entered into Epi-data version 3.1 and analyzed using SPSS version 21. Frequencies, percentages, graphs and tables were generated to present the data. Binary logistic regression analysis model was used to determine the effect of factor(s) on each of the outcome variables. To control for possible confounding factors, variables with p-value < 0.05 and 95% CI on bivariate analysis were subjected to multivariable analysis. Variables with p-value < 0.05 were considered as being statistically significant.

#### **4.12 Ethical consideration**

Ethical clearance was obtained from the Research and Ethics Committee of School of Public Health, Addis Ababa University and the Addis Ababa City Administration Health Bureau public health research and emergency management core process. Permission was obtained from the managers of the various public health facilities that were used for this study. All measure to maintain human rights including informed consent; the right to participate in the study, right to privacy and confidentiality and right to prevention from any form of harm were taken into consideration. All Participants were informed about the objectives of the study and that their participation is on voluntary basis. It was also clearly stated to the participants that the information they will provide will be for research purposes and strictly confidential.

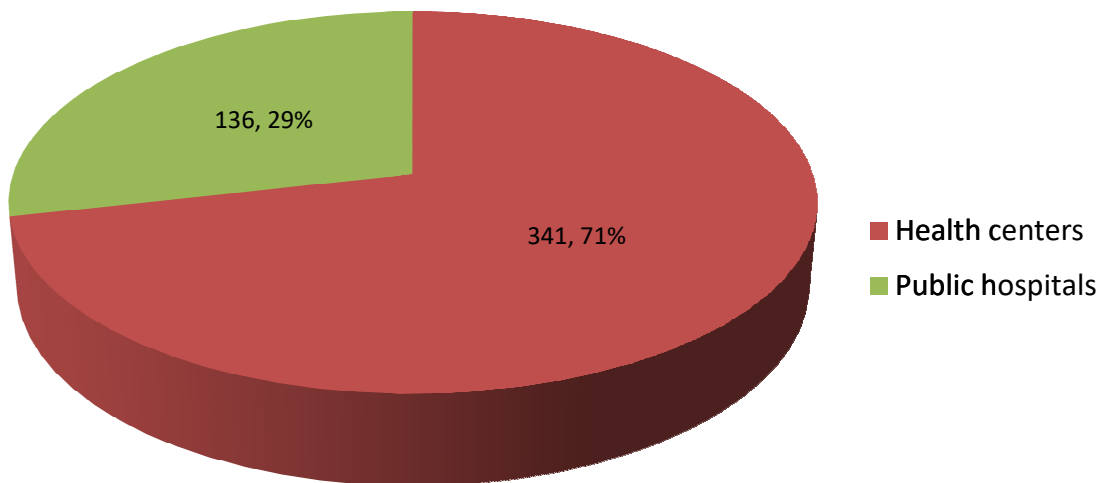
#### **4.13 Dissemination of research finding**

The final result of the study will be presented and submitted to the Addis Ababa University School of Public health. Furthermore, the findings will be disseminated to the Federal Ministry of Health, Addis Ababa City Administration Health Bureau and the managers of the various involved public health facilities in soft and hard copies. Finally, the manuscripts will be considered for publication in peer reviewed scientific journal.

## 5. Result

### 5.1 Socio-demographic characteristics of the respondents

Four hundred and seventy seven (477) antenatal clinic clients participated in the study, with a 100% response rate. Three hundred and forty one (71.5%) were from health centers while 136 (28.5%) were from public hospitals (Figure 3).



**Figure 3: - Distribution of respondents based on health facility. Addis Ababa, Ethiopia, June 2018.**

Majority 216 (45.3%) of the respondent are between the age group of 26-31 years, followed closely by 184 (38.6%), representing those in the age group of 20-25 years. Four hundred and thirty six (91.4%) of the women are married while only 8 (1.7%) are divorced and separated. Majority 376 (78.8%) are Christians while 101 (21.2%) are Muslims. The predominant ethnic group 179 (37.5) among the participant are the Amhara. Majority 158 (33.1%) of the women had secondary education. Only 36 (7.5%) of the respondent do not have any form of formal education. Most of the women 238 (49.9%) are unemployed. One hundred and thirteen (23.7%) were self employed, 63 (13.2%) works with NGO while 62 (13%) are government- employed. (Table 2)

**Table 2. Socio-demographic characteristics of the antenatal clients in health facilities. Addis Ababa, Ethiopia, June 2018.**

<b>Variables</b>	<b>Frequency</b>	<b>Percent</b>
<b>Age of respondents</b>		
16-19	26	5.5
20-25	184	38.6
26-31	216	45.3
32-39	51	10.7
<b>Marital status</b>		
Married	436	91.4
Living together	23	4.8
Divorced/separated	8	1.7
Never married/never lived together	10	2.1
<b>Religion</b>		
Christianity	376	78.8
Muslim	101	21.2
<b>Ethnicity</b>		
Amhara	179	37.5
Oromo	118	24.7
Tigrayan	37	7.8
Others (Welayta, Sidama, Gurage)	143	30.0
<b>Level of education</b>		
None	36	7.5
Primary	156	32.7
Secondary	158	33.1
Technical/vocational	69	14.5
Higher	58	12.2
<b>Occupation</b>		
Unemployed	238	49.9
Government employed	62	13.0
Self-employed	113	23.7
NGO	64	13.4

## 5.2 Past and current obstetrics history of respondents.

Majority 270 (56.6%) of the women are primigravida (first pregnancy) while 207 (43.4%) are multigravida. Among the 207 women who has delivered before, 191 (92.3%) received antenatal care in their last delivery and they all had facility delivery with exception of only 17 (8.2%) respondents who had home delivery. The predominant reason for home delivery was short labour duration. Only 34 (16.4%) women among the multigravid respondents had a companion with them during their last delivery. The majority 19 (55.9) had their mother as companion. One hundred and forty four (83.2%) of those women with no history of companion in the past attributed it to refusal of health provider.

Majority 229 (48.0%) of the respondents booked the current pregnancy within the first trimester while 61 (12.8%) booked in the 6<sup>th</sup> month and beyond. Three hundred and sixty two (75.9%) of the respondent intends to deliver in their current antenatal care facility. (Table 3)

**Table 3. Past and current Obstetrics history of the antenatal clients in health facilities. Addis Ababa, Ethiopia, June 2018.**

Variables	Frequency	Percent
<b>Parity</b>		
Primigravida	270	56.6
Multigravida	207	43.4
<b>Attended ANC during last pregnancy</b>		
Yes	191	92.3
No	16	7.7
<b>Place of ANC in the last pregnancy</b>		
Private hospital	16	8.4
Health center	135	70.7
Public hospital	40	20.9
Total	191	100.0
<b>Place of last (previous) delivery</b>		
At home	17	8.2
Health center	95	45.9
Public hospital	82	39.6
Private hospital	13	6.3
Total	207	100.0

<b>Reason for previous home delivery*</b>		
Preferred TBA	1	5.9
It's a usual practice (cultural)	3	17.6
Pregnancy was said to be normal	1	5.9
Fear of abuse and disrespect by Health provider	1	5.9
Fear of loneliness	1	5.9
Due to short labour duration	9	52.9
Poor transport	5	29.4
<b>Had support in labour during last delivery</b>		
Yes	34	16.4
No	173	83.6
Total	207	100
<b>Type of companionship during last delivery</b>		
Husband	11	32.4
Sister	4	11.8
Mother	19	55.9
Total	34	100
<b>Reason for no companion during last delivery</b>		
Not necessary	5	2.9
Unaware of the practice in health facility	16	9.2
Health providers did not allow support	144	83.2
I don't have a support	6	3.5
Others	2	1.2
Total	173	100
<b>Outcome of last delivery</b>		
Baby alive and well	186	89.9
Baby was sickly	12	5.8
Baby died	9	4.3
Total	207	100
<b>Gestational age of current pregnancy at booking</b>		
1-3 months	229	48.0
4-5 months	176	36.9
6 months and above	61	12.8
I don't know	11	2.3
Total	477	100

<b>Anticipated place of delivery</b>		
Current ANC facility	362	75.9
Public hospital	54	11.3
Health center	47	9.9
Private hospital	14	2.9
Total	477	100

\* indicates variable with multiple response (can't add up to 100%)

### **5.3 Knowledge of respondents about the practice of CCLC in health facility and its benefits.**

Among the 477 respondents, only 65 (13.6%) knows that it is their right to have a companion of their choice during labour and childbirth while in a health facility. However, 406 (85.1%) of the respondents believed that it is a very good practice while the rest either do not believe it is good or are indifferent about it. (Table 4)

**Table 4. Knowledge about CCLC among antenatal clients in health facilities. Addis Ababa, Ethiopia, June 2018.**

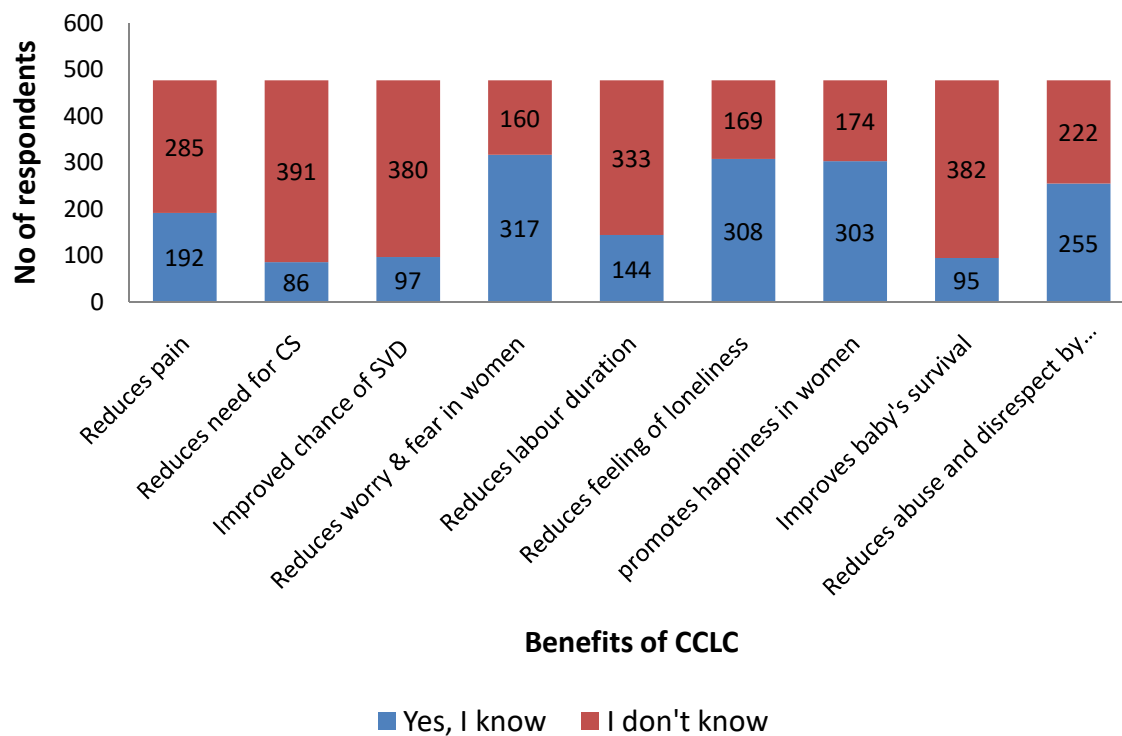
<b>Variables</b>	<b>Frequency</b>	<b>Percent</b>
<b>Knowledge about the right to have CCLC in health facility</b>		
Yes	91	19.1
No	386	80.9
Total	477	100
<b>Level of certainty</b>		
Very sure	65	71.4
Not very sure	26	28.6
Total	91	100
<b>Sources of the knowledge about CCLC</b>		
Heard from people	56	61.5
I experienced it before	14	15.4
Health provider	7	7.7

Read about it	3	3.3
Media	11	12.1
Total	91	100

**Opinion about having CCLC**

A very good practice	406	85.1
Not a good practice	39	8.2
I don't know	32	6.7
Total	477	100

Considering the knowledge of the women about the benefits of CCLC, majority believed that it reduces worry and fear in women (317), combats the feeling of loneliness (308), makes the women happy (303) and also reduces the chance of being abused and disrespected by health care providers (255). (Figure 4)



**Figure 4. Knowledge about the benefit of CCLC among antenatal clients in Addis Ababa health facilities, June 2018.**

#### **5.4 Desire of the respondents to have CCLC and their preferred choice as a companion.**

Four hundred and ten (86.0%) women desire to have a companion of their choice during labour and delivery. Only 16 (3.4%) of the respondent has ever heard their antenatal health care facility making mention of this practice. Three hundred and ninety (81.8%) women believed that allowing the practice of CCLC will further promote the rate of facility delivery.

Two hundred and forty five (59.8%) respondent preferred their husband to be their companion while in labour and during delivery. Others included mother 70 (17.1%), sister 62 (15.1%) and friend 24 (5.9%). The greatest expectation of respondent from their companion is to support and encourage them 341 (83.2%), run necessary errand 244 (59.5%), render prayer 207 (50.5%) and rub their back 154 (37.6%). (Table 5)

**Table 5. Desire of antenatal client to have CCLC and their preferred choice as companion in Addis Ababa health facilities, June 2018.**

<b>Variables</b>	<b>Frequency</b>	<b>Percent</b>
<b>Desire to have CCLC</b>		
Yes	410	86.0
No	67	14.0
<b>Facility notifying women about CCLC</b>		
Yes	16	3.4
No	461	96.6
<b>Women's awareness if there ANC facility supports CCLC</b>		
Yes	49	10.3
No	65	13.6
I don't know	363	76.1
<b>Allowing the practice of CCLC will increase facility delivery</b>		
Yes	390	81.8
No	87	18.2
<b>Preferred choice of companion in labour and delivery</b>		
Husband	245	59.8
Sister	62	15.1
Mother	70	17.1

Friend	24	5.9
Others	9	2.2
Total	410	100
<b>Women's expectation from there companion during labour*</b>		
Encouragement	341	83.2
Rub their back	154	37.6
Pray for them	207	50.5
Run errand	244	59.5
Others	5	1.2

\* indicates variable with multiple response (can't add up to 100%)

### **5.5 The relationship between socio-demographic characteristic and obstetrics history of respondents with their knowledge about the right to have CCLC while in health facilities in Addis Ababa.**

In order to determine association between the respondent's knowledge about the right to have CCLC in health facilities and their characteristics, the following exposure variables were checked against the outcome variable:- Age, marital status, education, occupation, religion, ethnicity, parity, place of ANC in last pregnancy, place of last delivery, had support during last delivery, outcome of last delivery and anticipated place of delivery.

Following bivariate analysis, level of education, place of ANC in last pregnancy and history of companionship in labour during last delivery were significantly associated with the knowledge of the respondents about the right to have CCLC in health facility. Antenatal clients who had secondary education (COR=0.432; 95% CI 0.190-0.980) has lesser knowledge about the right to have CCLC in health facility compared to those with tertiary education. In addition women who had ANC in health center during their previous pregnancy (COR=0.275; 95% CI 0.084-0.900) are less knowledgeable about the right to CCLC in facilities when compared with those who had ANC in private hospitals. Also, women who had support from a companion during their last delivery are about 3 times more knowledgeable about the right to have CCLC (COR=3.016; 95% CI 1.267-7.180) than those who have never had any companion during childbirth before.

In order to control for confounding variables, multivariable analysis was carried out on exposure variables that were significantly associated with the outcome variable on bivariate analysis. Only

“past history of companionship during last delivery” was significantly associated with the knowledge of the women about their right to have CCLC. The antenatal clients who had support from a companion during their last delivery are about 3 times more knowledgeable about the right to have CCLC (AOR=3.392; 95% CI 1.200-9.588) than those who have never had any companion before. (Table 6)

**Table 6. Factors associated with the knowledge of antenatal clients about the right to have CCLC in health facilities. Addis Ababa, Ethiopia, June 2018.**

VARIABLES	KNOWLEDGE		COR(95%CI)	AOR(95%CI)
	Yes	No		
<b>Age</b>				
< 26	26	184	1	
26-31	29	187	1.097(0.622-1.935)	0.748
32-39	10	41	1.726(0.772-3.857)	0.183
<b>Level of education</b>				
No education/Primary	26	166	0.600(0.281-1.281)	1.582(0.351-7.137)
Secondary	16	142	<b>0.432(0.190-0.980)*</b>	1.227(0.253-5.945)
Technical/vocational	11	58	0.727(0.294-1.797)	3.197(0.660-15.480)
Tertiary	12	46	1	1
<b>Occupation</b>				
Unemployed	34	204	0.900(0.418-1.936)	
Government employed	6	56	0.579(0.197-1.702)	
Self employed	15	98	0.827(0.348-1.966)	
NGO	10	54	1	
<b>Religion</b>				
Christianity	48	328	0.723(0.396-1.321)	
Muslim	17	84	1	
<b>Ethnicity</b>				
Amhara	21	158	0.693(0.367-1.312)	
Oromo	16	102	0.818(0.410-1.632)	
Tigray	5	32	0.815(0.287-2.313)	
South	23	120	1	
<b>Parity</b>				
Primigravida	34	236	0.818(0.484-1.382)	
Multigravida	31	176	1	
<b>Place of ANC in last pregnancy</b>				
Private hospital	5	11	1	1
Health center	15	120	<b>0.275(0.084-0.900)*</b>	0.330(0.088-1.237)
Public hospital	8	32	0.550(0.148-2.040)	0.669(0.162-2.752)

<b>Had companionship during last delivery</b>				
Yes	10	24	<b>3.016(1.267-7.180)*</b>	<b>3.392(1.200-9.588)*</b>
No	21	152	1	1
<b>Anticipated place of delivery</b>				
Current ANC facility	50	312	1.051(0.490-2.252)	
Health center	6	41	0.959(0.317-2.903)	
Private/Public hospital	9	59	1	

\* = significant at p-value < 0.05.

### **5.6 The relationship between socio-demographic characteristic and obstetrics history of antenatal clients with their desire for CCLC while in health facility in Addis Ababa.**

To determine association between the respondent's desire for CCLC in health facilities and their characteristics, all the earlier listed 12 exposure variables were checked against the outcome variable. Bivariate analysis showed that, level of education, occupation and ethnicity of the women were significantly associated with the desire for CCLC in health facility. Antenatal clients who had only primary education (COR=0.417; 95% CI 0.230-0.756) has lower desire for CCLC in health facility compared to those with secondary education and above. In addition, women who are unemployed (COR=0.359; 95% CI 0.169-0.764) has lower desire for CCLC in facilities compared with those working with Government and NGOs. It was also discovered that Amhara (COR=2.111; 95% CI 1.141-3.904) and Oromo (COR=2.867; 95% CI 1.337-6.148) women are more desirous of having CCLC compared to women from Welayta, Sidama and Gurage (others).

Following multivariable analysis, level of education and ethnicity were significantly associated with the women's desire for CCLC. The antenatal clients who had only primary education (AOR=0.515; 95% CI 0.277-0.960) has lower desire for CCLC in health facility compared to those with secondary education and above. Also, women from Oromo ethnicity are about 2.5 times more desirous of CCLC (AOR=2.451; 95% CI 1.126-5.335) compared to women from Welayta, Sidama and Gurage (others). **(Table 7)**

**Table 7. Factors associated with the women's desire to have CCLC in health facilities. Addis Ababa, Ethiopia, June 2018.**

VARIABLES	DESIRE FOR CCLC		COR(95%CI)	AOR(95%CI)
	Yes	No		
<b>Age</b>				
< 26	181	29	1	
26-31	186	30	0.993(0.573-1.722)	
32-39	43	8	0.861(0.368-2.016)	
<b>Marital status</b>				
Married	379	57	1	
Living together	18	5	0.541(0.193-1.515)	
Divorce/never married	13	5	0.391(0.134-1.138)	
<b>Level of education</b>				
No formal education	29	7	0.446(0.174-1.142)	0.525(0.200-1.383)
Primary	124	32	<b>0.417(0.230-0.756)*</b>	<b>0.515(0.277-0.960)*</b>
Technical/vocational	62	7	0.954(0.387-2.350)	0.836(0.331-2.110)
Secondary and above	195	21	1	1
<b>Occupation</b>				
Unemployed	196	42	<b>0.359(0.169-0.764)*</b>	0.490(0.220-1.091)
Self employed	97	16	0.466(0.197-1.102)	0.643(0.262-1.581)
Government/NGO job	117	9	1	1
<b>Religion</b>				
Christianity	326	50	1.320(0.724-2.405)	
Muslim	84	17	1	
<b>Ethnicity</b>				
Amhara	159	20	<b>2.111(1.141-3.904)*</b>	1.707(0.902-3.231)
Oromo	108	10	<b>2.867(1.337-6.148)*</b>	<b>2.451(1.126-5.335)*</b>
Tigray	30	7	1.138(0.455-2.843)	0.945(0.369-2.417)
Others	113	30	1	1
<b>Parity</b>				
Primigravida	237	33	1.411(0.841-2.368)	
Multigravida	173	34	1	
<b>Anticipated place of delivery</b>				
Current ANC facility	317	45	1.215(0.579-2.546)	
Health center	35	12	0.503(0.197-1.285)	
Private/Public hospital	58	10	1	

\* = significant at p-value < 0.05.

### **5.7 The relationship between socio-demographic characteristic and obstetrics history of antenatal clients with their preferred choice of person as CCLC while in health facility in Addis Ababa.**

To determine association between the respondent's preferred choice of person for CCLC in health facilities and their characteristics, all the earlier listed 12 exposure variables were checked against the outcome variables which are husband, mother, sister and friend.

Considering the husband as a preferred choice, bivariate analysis showed that, age, marital status, level of education, occupation, religion and place of last (previous) delivery were significantly associated. The preference for husband as a companion for CCLC was higher among women in the age range of 20-25 (COR=2.598; 95% CI 1.030-6.549) and 26-31 years (COR=3.258; 95% CI 1.299-8.170) compared to those aged < 20 years. Also, the selection of husband as a preferred companion for CCLC was higher among married women (COR=4.034; 95% CI 1.808-9.004) compared to the unmarried. In addition, having husband as a preferred choice is lesser among antenatal clients who had no formal education (COR=0.086; 95% CI 0.030-0.249), primary education (COR=0.185; 95% CI 0.084-0.411) and secondary education (COR=0.292; 95% CI 0.133-0.644) compared to those with tertiary education. Moreover, the choice of having husband as companion is lower among the women who are self employed (COR=0.448; 95% CI 0.230-0.870) than those working with NGOs. It was also discovered that the preference for husband is higher among Christian (COR=1.981; 95% CI 1.220-3.215) compared to Muslim women. Furthermore, women who had their last delivery in private or public hospital (COR=2.016; 95% CI 1.077-3.772) has a higher preference for their husband as a CCLC in health facilities compared to those who delivered at home or health center during their previous pregnancies.

However, following multivariable analysis, only level of education was significantly associated. The preference for husband as a choice for CCLC was found to be lower among antenatal clients who had no formal education (AOR=0.141; 95% CI 0.021-0.956) compared to those who had tertiary education. **Table 8**

Considering the mother as a preferred choice, bivariate analysis showed that only age and marital status are significantly associated. The preference for mother as a companion for CCLC is lower among women in the age range of 20-25 (COR=0.281; 95% CI 0.106-0.748) and 26-31 years

(COR=0.364; 95% CI 0.141-0.939) compared to those aged < 20 years. Also, the selection of mother as a preferred companion for CCLC is lower among married women (COR=0.215; 95% CI 0.070-0.663) compared to those who are divorced or has never married before.

However, following multivariable analysis, only marital status remained significantly associated with the choice of mother as CCLC. The selection of mother as a preferred companion for CCLC is lower among married women (AOR=0.249; 95% CI 0.078-0.794) compared to those who are divorced or has never married before. **Table 8**

When the sister was considered as a preferred choice, bivariate analysis showed that only level of education and past history of companionship during last delivery were significantly associated. The preference for sister as a companion for CCLC is higher among women who had no formal education (COR=4.361; 95% CI 1.792-10.615) compared to those with secondary education and above. Also, the selection of sister as a preferred companion for CCLC is higher among women who had a companionship during their last delivery (COR=2.757; 95% CI 1.000-7.599) compared to those who never had any companion while in labour before.

However, following multivariable analysis, the association for both variables faded out. **Table 8**

Finally, considering friend as a preferred choice, bivariate analysis showed that only level of education was significantly associated. The selection of friend as a preferred companion for CCLC is higher among women with pre-secondary education or had technical/vocational skills (COR=2.878; 95% CI 1.118-7.407) compared to those with secondary education or higher.

However, following multivariable analysis involving age, level of education and occupation, only level of education was significantly associated with the friend being chosen as a CCLC. The preference for friend as a companion during labour is higher among women with pre-secondary education or had technical/vocational skills (AOR=2.840; 95% CI 1.099-7.341) compared to those with secondary education or higher. **Table 8**

**Table 8. Factors associated with the women's preferred choice as companion during labour and delivery in health facilities. Addis Ababa, Ethiopia, June 2018.**

VARIABLES	PREFERRED CHOICE		COR (95%CI)	AOR (95%CI)
	Yes	No		
<b>HUSBAND</b>				
<b>Age</b>				
16-19	8	14	1	
20-25	95	64	<b>2.598(1.030-6.549)*</b>	1
26-31	121	65	<b>3.258(1.299-8.170)*</b>	1.310(0.549-3.127)
32-39	21	22	1.670(0.582-4.795)	0.837(0.278-2.520)
<b>Marital status</b>				
Married	236	143	<b>4.034(1.808-9.004)*</b>	0.804(0.161-4.011)
Not married	9	22	1	1
<b>Level of education</b>				
No formal education	9	20	<b>0.086(0.030-0.249)**</b>	<b>0.141(0.021-0.956)*</b>
Primary	61	63	<b>0.185(0.084-0.411)**</b>	0.422(0.088-2.015)
Secondary	84	55	<b>0.292(0.133-0.644)*</b>	0.686(0.145-3.238)
Technical/vocational	44	18	0.468(0.190-1.151)	0.765(0.140-4.174)
Tertiary	47	9	1	1
<b>Occupation</b>				
Unemployed	110	86	0.609(0.333-1.113)	0.633(0.169-2.378)
Government employed	46	9	2.434(0.998-5.933)	3.562(0.347-36.558)
Self employed	47	50	<b>0.448(0.230-0.870)*</b>	0.262(0.067-1.026)
NGO	42	20	1	1
<b>Religion</b>				
Christianity	206	120	<b>1.981(1.220-3.215)*</b>	1.374(0.619-3.048)
Muslim	39	45	1	1
<b>Place of last delivery</b>				
Home/Health center	48	41	1	1
Private/Public hospital	59	25	<b>2.016(1.077-3.772)*</b>	1.269(0.615-2.619)
<b>MOTHER</b>				
<b>Age</b>				
16-19	8	14	1	1
20-25	22	137	<b>0.281(0.106-0.748)*</b>	0.364(0.126-1.048)
26-31	32	154	<b>0.364(0.141-0.939)*</b>	0.464(0.167-1.295)
32-39	8	35	0.400(0.125-1.275)	0.528(0.157-1.772)
<b>Marital status</b>				
Married	59	320	<b>0.215(0.070-0.663)*</b>	<b>0.249(0.078-0.794)*</b>
Living together	5	13	0.449(0.100-2.013)	0.377(0.080-1.778)
Divorced/Never married	6	7	1	1

---

<b>SISTER</b>				
<b>Level of education</b>				
No formal education	10	19	<b>4.361(1.792-10.615)*</b>	2.996(0.614-14.628)
Primary/Vocational	31	155	1.657(0.914-3.004)	1.864(0.610-5.697)
Secondary and above	21	174	1	1
<b>Had companionship during last delivery</b>				
Yes	7	25	<b>2.757(1.000-7.599)*</b>	2.096(0.685-6.414)
No	13	128	1	1
<b>FRIEND</b>				
<b>Age</b>				
< 26	12	169	1.284(0.563-2.930)	1.193(0.518-2.746)
26 and above	12	217	1	1
<b>Level of education</b>				
Pre-secondary/vocational	18	197	<b>2.878(1.118-7.407)*</b>	<b>2.840(1.099-7.341)*</b>
Secondary and above	6	189	1	1
<b>Occupation</b>				
Unemployed	12	184	1.098(0.481-2.504)	0.996(0.433-2.293)
Employed	12	202	1	1

---

\* = significant at p-value < 0.05, \*\*= significant at p-value < 0.001

## 6. Discussion

Traditionally, the practice of having a companion and support from loved ones is an integral component of home delivery, thus making it an enjoyable and comforting experience for women in Ethiopia and some other developing countries (29, 44). However, institutional delivery in many developing countries has deprived women of their values, beliefs, autonomy and choice. One of such is the right to have a companion of choice during labour and childbirth in health facilities (6).

The study revealed that almost 90% of antenatal client in Addis Ababa public health facilities are not aware that having a companion to support them in labour and delivery room during childbirth in health facility is a practice that can be explored. This contrasted sharply with findings in a related study conducted in Malawi; where almost 85% of the respondents are aware of this (43). The reason for the difference may be attributed to the type of facility. In this study, the women were recruited from predominantly health centers with fewer hospitals whereas in the Malawi study, 90% of the respondents were from tertiary health institutions. However, regardless of the level of health facility, the awareness about this intervention ought to be propagated. This implies that the practice of respectful maternity care (RMC) has failed to address at least one of its key component which is to promote the practice of companion of choice in labour and childbirth while in health facility (8). Without creating awareness about the right and benefit accrued to this practice among the women, it will be difficult to overcome other challenges facing its implementation at facility and providers level. This is because without demand, it will be difficult for the service to be made available.

Furthermore, among the few pregnant women who are aware, majority of them got to know informally by hearing from other people. This may explain why the place of antenatal care in last pregnancy has significant association with the women's knowledge about CCLC on bivariate analysis, although the association was lost following further analysis. According to this study, women who had antenatal care in health center during their last pregnancy are less likely to be aware of CCLC when compared with their counterpart who had it in private hospital. This may probably be due to the fact that private hospitals are patronized by variety of people that differs in educational attainment, exposures, knowledge, ideas and perhaps wealthier as against health

center that caters for those in a closely related specified location. Thus, during the course of interaction among these women, there can be exchange of knowledge, ideas and information. Also, low level of educational attainment among the respondents may also be accountable for the scanty knowledge about the right to CCLC, although this was found not to be significantly associated following multivariable analysis. The study revealed that women who had a support from a companion during labour in health facilities in the past are about three times more knowledgeable than those who do not. This is not unexpected based on the fact that such women had been practically exposed to the practice in the past.

In addition, the health providers and facilities which ideally should have been the main source of information about the subject are silent about it. The study revealed that only 7 women among the respondents got the knowledge about this highly effective practice from health providers while only about 3% were notified in their ANC health facilities. It is also worthwhile to mention that majority of the respondents are aware of the social and emotional benefits accrued to the practice of companionship in labour which includes; reduced worry and fear, reduced feeling of loneliness, reduced chance of abuse and disrespect by health providers and overall promotion of happiness in the women. This is so because they have enjoyed or witness those who have enjoyed these benefits in the course of ancient traditional practices of home delivery that encourages support and care by loved ones from labour till even the postpartum period (29). With the knowledge about the benefits, it is not unexpected that about 85% of the respondents rated CCLC as a very good practice. However only few of the women are aware of the health benefits of this intervention which includes reduction in the need for caesarean section, reduction in labour duration, and improvement in the survival of newborn, amidst other health benefits. This still emphasizes the vacuum created by inaction of health providers and facilities regarding this intervention.

This study further showed that a very large number of antenatal clients in Addis Ababa health facilities are suffering in silence regarding this subject. Eighty six percent strongly desire to have a companion of their choice during labour and delivery in health facility. This value is almost similar (83.6%) to findings among Malawian women according to Banda et al (43), but higher than that of studies conducted in Nigeria by Morhason-Bello et al (37) and in Saudi Arabia by Al-Mandeel et al (40), where 75% and 45.3% respectively wanted a companion. This large

proportion of antenatal clients longing to have a companion in labour during facility delivery is not unexpected because they long to uphold and institutionalize the age-long beneficial cultural practice of companionship which unknown to many of them, has a strong, evidence-based scientific backing in modern maternal and child health care (3). Moreover, 76% of these women do not know if their current antenatal care facility and healthcare providers are in support of CCLC despite their strong desire to experience it while in health facilities. This implies that the quality of care being rendered in the health facilities are still inadequate since it fails to address one of the WHO recommended intervention that is needed in other to encourage and promote facility-based delivery (10, 17, 23). This is reinforced by the finding of this study in which 82% of the respondent expresses their mind that if this practice of CCLC is widely allowed, it will encourage and further increase the rate of facility delivery.

Furthermore, according to this study, the desire to have CCLC while in health facility was statistically associated with level of education and ethnicity of the women. This has similarity with the finding from a study conducted in Ghana where higher educational attainment increases the desire of women for CCLC in health facilities (39). In addition, ethnicity was also found to affect the desire for CCLC according to Morhason-Bello et al study in Ibadan, Nigeria (37). The practice of companionship in labour is already an integral part of home delivery which is a cultural/traditional practice among Ethiopian women. The cultural diversity might explain the reason why Oromo women are almost 3 times more desirous of a companion as support during labour in health facilities compared to those from the Southern part (Welayta, Sidama and Gurage) of the country. There is no doubt that the more educated an individual is, the more informed and inquisitive such becomes. Thus, the desire for CCLC in facility is higher among those who are more educated.

Furthermore, almost 60% of the women preferred their husband as their companion during facility delivery before considering their mother or sister. This is close to finding in a study conducted in Nigeria where the women predominantly (86%) wanted their husband as companion in labour (37), followed by mother and sibling. However, the reverse is the case based on study conducted in Saudi Arabia where the mother is the first preferred choice accounting for 58% before the husband is being considered (40). Also, a study conducted in Malawi by Banda et al showed a very low preference (11.4%) for husband as support. Female

companions which are mother, sister, grandmother, aunt, mother in-law and friend were preferred in that order before the husband was considered (43).

In this study, higher preference for husband was found to be statistically significant among women who are between the age group of 20-31 years, married, tertiary education, NGO employee, Christians and those who delivered in private or public hospital in their last pregnancy. This finding mimics findings from another study (37). However, following further analysis, only the level of education was significantly associated with the preference for husband as preferred companion. The preference for husband as a choice for CCLC was found to be lower among antenatal clients who had no formal education compared to those who had tertiary education. The reason for this may be due to the fact that the uneducated women is likely to be unemployed, thus the working husband may be the source of livelihood for the family. It may be difficult for such woman to choose her husband as a preferred support in labour and delivery. It is however important to know that this finding of husband being the preferred choice by the majority of the women in Addis Ababa may pose a major challenge to implementation because significant number of health facilities in developing countries still practice open ward system, thus privacy of other women might be jeopardized. There is therefore a need for the respondent and the service provider to reach an agreement on the type of choice that will fit in to the context of the facility right from ANC period. This will promote the practice of CCLC while ensuring satisfaction in both the women and service providers.

From this study, the preference for mother as a CCLC in health facility is associated more with single women who have never married before or who are divorcees. This is because, unmarried women will be eager to have their mother as their companion. Although level of education and history of support in health facility in the past were statistically significant for the choice of sister as companion ab initio, following further analysis, the significance was lost. Finally, the study revealed that the preference for a friend as a companion is higher among women with no or primary education and those with technical/vocational skill when compared with those having secondary or tertiary education.

## **7. Strength and limitation of the study**

### **7.1 Strength**

1. This study made use of a large sample size so as to minimize sampling error as much as possible.
2. The study subject has received little or no attention in the Ethiopian maternal and child health service delivery. It may help to fill some knowledge gap and act as a baseline for further future studies since there is paucity of information or studies on this subject in Ethiopian context.

### **7.2 Limitation**

1. Since the study was conducted only in Addis Ababa, which is the capital of Ethiopia, the findings may not be applicable to other women outside the city.
2. The findings do not apply to private facilities because only public facilities are included in the study.
3. The health facilities practices and providers opinion about CCLC was not included in the study.

## **8. Conclusion**

This study identified that about nine out of ten women attending ANC in Addis Ababa public health facilities are unaware of their right to have a companion of their choice to support them while in labour and during delivery in the health facilities. Only those women who has had a companion during childbirth in the past are more aware of there right to have CCLC.

It also pointed out that almost nine out of ten antenatal clients in Addis Ababa public facilities are craving to have a companion who will be by their side to encourage, support, run errand and pray for them while in labour in health facilities. Level of education and ethnicity were found to affect desire for CCLC in facilities.

In addition, there is a higher preference for husband as a companion in labour and delivery among the antenatal clients in Addis Ababa public health facilities. Educated women are more desirous of their husband as companion compared to the uneducated women.

## **9. Recommendation**

Based on the findings of this study, the following recommendations are made:-

### **Maternal and child health directors/programmers**

- There is a need to improve the awareness of women about their right to have a CCLC while in health facilities and the health benefits this confers. This can be achieved through health campaign, publicity through media such as television and radio programs on health matters, videos and drama in the rural communities.

### **Health facilities and service providers**

- Integrating information about the practice of CCLC into antenatal clinic will help the provider to have a pre-knowledge of the women's preferred choice and appropriate long term planning before onset of labour.

### **Government/policy makers**

- There should be a clearly stated national and institutional policy about the practice of CCLC in health facilities in Ethiopia.

### **Researchers**

More studies should be conducted on the subject employing mixed approach so as to identify more gaps and possible approach to solve them. Some of the research can focus on knowledge and perception of health facilities and providers about CCLC, the peculiar challenges that may hamper its full implementation in Ethiopian facilities, the view of husband and other potential companion about participating in CCLC, why do some women oppose having CCLC in Ethiopian context.

## REFERENCES

1. Kabakian-Khasholian T, El-Nemer A, Bashour H. Perceptions about labor companionship at public teaching hospitals in three Arab countries. *International Journal of Gynecology & Obstetrics*2015;129(3):223-6.
2. Tuncalp Ó, Were WM, MacLennan C, Oladapo OT, Gulmezoglu AM, Bahl R, et al. Quality of care for pregnant women and newborns - the WHO vision. *Bjog*2015;122(8):1045-9.
3. Bohren MA HG, Sakala C, Fukuzawa RK, Cuthbert A. . Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* 2017(Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6).
4. Tracy SK, Tracy MB. Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data. *Bjog*2003;110(8):717-24.
5. Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF. .
6. Kaba M, Bulto T, Tafesse Z, Lingerh W, Ali I. Sociocultural determinants of home delivery in Ethiopia: a qualitative study. *International Journal of Women's Health*2016;8:93-102.
7. Raven J, van den Broek N, Tao F, Kun H, Tolhurst R. The quality of childbirth care in China: women's voices: a qualitative study. *BMC Pregnancy and Childbirth*. [journal article]. 2015 May 14;15(1):113.
8. White Ribbon Alliance, Respectful Maternity Care: The Universal Rights of Childbearing Women (WRA 2011). In.
9. Gülmezoglu AM, Lawrie TA, Hezelgrave N, et al. Interventions to Reduce Maternal and Newborn Morbidity and Mortality. In: Black RE, Laxminarayan R, Temmerman M, et al., editors. *Reproductive, Maternal, Newborn, and Child Health: Disease Control Priorities, Third Edition (Volume 2)*. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2016 Apr 5. Chapter 7. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK361904/> doi: 10.1596/978-1-4648-0348-2\_ch7.
10. WHO recommendations on health promotion interventions for maternal and newborn health. Geneva: World Health Organization;. 2015.
11. Bohren MA, Hunter EC, Munthe-Kaas HM, Souza JP, Vogel JP, Gulmezoglu AM. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. *Reproductive Health*. [journal article]. 2014 September 19;11(1):71.
12. Sipsma H, Thompson J, Maurer L, Bradley E, Curry L. Preferences for home delivery in Ethiopia: Provider perspectives. *Global Public Health*2013;8(9):1014-26.
13. Chaya N. Poor access to Health Services: Ways Ethiopia is overcoming it. *Population action international*April 2007;vol 2(issue 2. <http://idp-uk.org/OurProjects/Health/Poor%20Access%20to%20Health%20Services.pdf>).
14. Richard G. Wamai. Reviewing Ethiopia's health system development. *International medical community JMAJ*2009;52(4):279-86. [https://www.med.or.jp/english/journal/pdf/2009\\_04/279\\_286.pdf](https://www.med.or.jp/english/journal/pdf/2009_04/279_286.pdf).

15. Office of the United Nations High Commissioner for Human Right (OHCHR). Technical guidance on the application of a human right-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality., (A/HRC/21/22; (2012).
16. WHO recommendations for augmentation of labour. Geneva: World Health Organization. 2014.
17. World Health Organization (WHO): Companion of choice during labour and childbirth for improved quality of care. In.; 2016. <http://apps.who.int/iris/bitstream/10665/250274/1/WHO-RHR-16.10-eng.pdf>.
18. Bruggemann OM, Parpinelli MA, Osis MJ, Cecatti JG, Neto ASC. Support to woman by a companion of her choice during childbirth: a randomized controlled trial. *Reproductive Health*. [journal article]. 2007 July 06;4(1):5.
19. Bruggemann OM, Parpinelli MA, Osis MJD. Evidence on support during labor and delivery: a literature review. *Cad Sade Publica*2005;21.
20. Dickinson JE, Paech MJ, McDonald SJ, Evans SF. The impact of intrapartum analgesia on labor and delivery outcomes in nulliparous women. *Aust N Z J Obstet Gynaecol*2002;42.
21. Morhason-Bello IO, Adedokun BO, Ojengbede OA, Olayemi O, Oladokun A, Fabamwo AO. Assessment of the effect of psychosocial support during childbirth in Ibadan, south-west Nigeria: a randomised controlled trial. *Aust N Z J Obstet Gynaecol*2009 Apr;49(2):145-50.
22. Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*2013(7).
23. World Health Organization (WHO): Standards for improving quality of maternal and newborn care in health facilities. In.; 2016.
24. Agarwal S, Sethi V, Srivastava K, Jha PK, Baqui AH. Birth Preparedness and Complication Readiness among Slum Women in Indore City, India. *J Health Popul Nutr*;28.
25. Hailu M, Gebremariam A, Alemseged F, Deribe K. Birth Preparedness and Complication Readiness among Pregnant Women in Southern Ethiopia.
26. Hiluf M, Fantahun M. Birth Preparedness and Complication Readiness among women in Adigrat town, north Ethiopia. *Ethiop J Health Dev*2007;22.
27. Markos D, Bogale D. Birth preparedness and complication readiness among women of child bearing age group in Goba woreda, Oromia region, Ethiopia. *BMC Pregnancy and Childbirth*. [journal article]. 2014 August 18;14(1):282.
28. Sheferaw ED, Bazant E, Gibson H, Fenta HB, Ayalew F, Belay TB, et al. Respectful maternity care in Ethiopian public health facilities. *Reproductive Health*. [journal article]. 2017 May 16;14(1):60.
29. Shiferaw S, Spigt M, Godefrooij M, Melkamu Y, Tekie M. Why do women prefer home births in Ethiopia? *BMC Pregnancy Childbirth*2013;13.
30. USAID. Respectful Maternity Care Toolkit, Maternal and Child Health Integrated Program. Published on K4Health (<http://www.k4health.org>).
31. Asefa A, Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia2015.
32. Helath sector Transformation Plan 2015-2020. <http://www.moh.gov.et/documents/26765/0/Health+Sector+Transformation+Plan/5542a23a-9bc7-46a2-8c1f-8b32c2603208?version=1.0>. Accessed 6 May 2017.

33. Kabakian-Khasholian T, Portela A. Companion of choice at birth: factors affecting implementation. *BMC Pregnancy Childbirth* Aug 31;17(1):265.
34. The right to have a companion during childbirth is a key element of respectful care (Malawi) <https://familyincluded.com/companion-childbirth-respectful-care-malawi/> [database on the Internet]Jan 2017.
35. Esposito NW. Marginalized women's comparisons of their hospital and freestanding birth center experiences: a contrast of inner-city birthing systems. *Health Care Women Int.* 1999;20(2):111–126. doi: 10.1080/073993399245827.
36. Behruzi R, Hatem M, Goulet L, Fraser W, Misago C. Understanding childbirth practices as an organizational cultural phenomenon: a conceptual framework. *BMC Pregnancy and Childbirth*2013;13:205-.
37. Morhason-Bello IO, Olayemi O, Ojengbede OA, Adedokun BO, Okuyemi OO, Orji B. Attitude and preferences of nigerian antenatal women to social support during labour. *J Biosoc Sci*2008 Jul;40(4):553-62.
38. Oboro VO, Oyeniran AO, Akinola SE, Isawumi AI. Attitudes of Nigerian women toward the presence of their husband or partner as a support person during labor. *Int J Gynaecol Obstet*2011 Jan;112(1):56-8.
39. Alexander A, Mustafa A, Emil SAV, Amekah E, Engmann C, Adanu R, et al. SOCIAL SUPPORT DURING DELIVERY IN RURAL CENTRAL GHANA: A MIXED METHODS STUDY OF WOMEN'S PREFERENCES FOR AND AGAINST INCLUSION OF A LAY COMPANION IN THE DELIVERY ROOM. *Journal of Biosocial Science*2014;46(5):669-85.
40. Al-Mandeel HM, Almufieh AS, Al-Damri JT, Al-Bassam DA, Hajr EA, Bedaiwi NA, Alshehri SM. Saudi women's acceptance and attitudes towards companion support during labor: Should we implement an antenatal awareness program? *Ann Saudi Med* 2013; 33(1): 28-33
41. Addis Ababa Health Bureau 2007 E.C Annual Report.
42. open-epi menu software. <http://www.openepi.com/SampleSize/SSPropor.htm>.
43. Banda G, Kafulafula G, Nyirenda E, Taulo F, Kalilani L. Acceptability and experience of supportive companionship during childbirth in Malawi. *BJOG*2010 Jul;117(8):937-45.
44. Bedford J, Gandhi M, Admassu M, Girma A. 'A Normal Delivery Takes Place at Home': A Qualitative Study of the Location of Childbirth in Rural Ethiopia. *Matern Child Health J*2013;17.

## 1. Information sheet

Addis Ababa University  
School of public health

Study on “*Assessment of knowledge and desire of antenatal clients about companionship in labour and childbirth in Addis Ababa*”.

Greetings, first of all I would like to thank you for your time.

Good morning /Good afternoon, I am.....working as data collector in this study. Dear respondents, here are lists of questions with different sections, which are designed for Research work to be conducted in partial fulfillment of Masters Degree in public health by Olumide Kuku with collaboration of Addis Ababa university school of Public Health. The main purpose of the study is to assess “*the knowledge and desire of antenatal clients about companionship in labour and childbirth in Addis Ababa*”. We are inviting pregnant women attending antenatal clinic in the public healthcare facilities to contribute to the study. The study will not cause any harm to you but rather empower you with important information.

I will ask you some questions about yourself. An aspect of the study may require recording of our conversation, but you will be duly informed if that is applicable to you. The interview will take about 30 minutes. There are no anticipated problems but in case some questions make you feel uncomfortable; you are free to express your discomfort or decide not to respond. If you choose not to participate or withdraw from the interview at any point, the support given to you by the hospital will not be affected in any way.

Your name will not be recorded and all the information you give will be kept strictly confidential and will be used only for the purpose of this study.

At this time, you are free to ask me question about the study? If you have any questions at any time even after the interview, feel free to ask. If you want to know more information you can contact Olumide Kuku through the phone no 0989739722 or [thecooldoctorkuku@yahoo.com](mailto:thecooldoctorkuku@yahoo.com)

## 2. Consent form

This consent form has been read and explained to me and I have understood, and my questions have been addressed. I therefore willingly agree to take part in the study.

1, Yes; continue to the consent form

2, NO; skip to the next participant

Participant signature/ finger print \_\_\_\_\_

Name of public healthcare facility \_\_\_\_\_

Interviewer name \_\_\_\_\_ Signature \_\_\_\_\_

Date of interview \_\_\_\_\_ Time started \_\_\_\_\_ Time finished \_\_\_\_\_

Supervisor name \_\_\_\_\_ Signature \_\_\_\_\_

### 3. Questionnaire in English

ID. No. \_\_\_\_\_ Date of Interview \_\_\_\_\_ Public facility \_\_\_\_\_

#### A. SOCIO - DEMOGRAPHIC DATA

Questions	Coding category
101. How old were you at your last birthday?	_____ years (age in complete years)
102. What is your marital status?	1)Married _____ 2)Living together _____ 3)Divorced/Separated _____ 4)Widowed _____ 5)Never married/Never lived together _____
103. Religion	1) Orthodox _____ 2) Catholic _____ 3) Protestant _____ 4) Moslem _____ 5) Traditional _____ 6) Others (Specify) _____
104. Ethnicity	1) Amhara _____ 2) Oromo _____ 3) Trigray _____ 4) Somali _____ 5) Others (Specify) _____
105. What is the highest level of education you attained?	1) None _____ 2) Primary _____ 3) Secondary _____ 4)Technical/Vocational _____ 5) Higher _____
106. What is your occupation?	1)Housewife _____ 2)Government employed _____ 3)Self-employed _____ 4)NGO _____

	5)Others (specify) _____
107. How much does your family make in a monthly (Birr)?	1)Less than 1,000 _____ 2)1,001 – 2,500 _____ 3)2,501 – 3,999 _____ 4) 4,000 and above _____

### B. PAST OBSTETRICS DATA

Questions	Coding category	Skip
201. How many times have you delivered a baby before whether alive or dead?	1) 0 _____ 2) 1 _____ 3) 2 _____ 4) 3 _____ 5) 4 _____ 6) 5 or more _____	If 0, skip to section C
202. Did you attend antenatal clinic?	1) Yes _____ 2) No _____	If NO, skip to question 204.
203. Where did you attend antenatal clinic?	1)Public hospital _____ 2) Health centre _____ 3) Health post _____ 4)NGO health facility _____ 5) Private hospital or clinic _____ 6) Others (Specify) _____	
204. Where did you deliver your baby then?	1)Where I had antenatal care _____ 2) At Home _____ 3) Health post _____ 4) Health center _____ 5) Public hospital _____ 6)Private hospital or clinic _____ 7) Others (specify) _____	If not home delivery, then skip to question 206.

<p>205. If you delivered at home, why? (you can pick more than 1 answer if applicable)</p> <p>For each reason write '1' or '2'.</p> <p>1= Yes 2= No</p>	<p>1) Prefer traditional birth attendants _____</p> <p>2) It is a usual practice _____</p> <p>3) My pregnancy was said to be normal _____</p> <p>4) Fear of being abused and disrespected by health provider _____</p> <p>5) Fear of being lonely in labour _____</p> <p>6) Short labour duration _____</p> <p>7) Poor transport _____</p> <p>8) Others (specify) _____</p>	
<p>206. Did someone support you during labour and delivery then?</p>	<p>1) Yes _____</p> <p>2) No _____</p>	<p>If No, skip to question 208.</p>
<p>207. Who supported you then?</p>	<p>1) Husband _____</p> <p>2) Sister _____</p> <p>3) Mother _____</p> <p>4) Friend _____</p> <p>5) Others (Specify) _____</p>	
<p>208. If, no support, why?</p>	<p>1) Not necessary _____</p> <p>2) Unaware of the practice in health facilities _____</p> <p>3) Health provider did not allow support _____</p> <p>4) I don't have a support _____</p> <p>5) Others (specify) _____</p>	
<p>209. Outcome of the delivery</p>	<p>1) Baby alive and well _____</p> <p>2) Baby was sickly _____</p> <p>3) Baby died _____</p>	

### C. CURRENT OBSTETRICS DATA

Questions	Coding category	Skip
301. When was your last menstrual period?	1) _____ date (dd/mm/yyyy) 2) I don't know _____	
302. How many months was the pregnancy when you registered?	1) 1 _____ 2) 2 _____ 3) 3 _____ 4) 4 _____ 5) 5 _____ 6) 6 or more _____ 7) I don't know _____	
303. Where do you want to deliver this baby?	1) The current facility _____ 2) Public hospital _____ 3) Health centre _____ 4) Health post _____ 5) NGO health facility _____ 6) Private hospital or clinic _____ 7) Others (specify) _____	

### D. KNOWLEDGE ABOUT COMPANIONSHIP IN LABOUR

Questions	Coding category	Skip
401. Do you know that a woman in labour has a right to choose the person she likes to stay and support her while in labour till delivery in health facility?	1) Yes _____ 2) No _____	If No, skip to question 403
401b. If yes to the above, how sure are you?	1) Very sure _____ 2) Not sure _____	
402. How did you know?	1) Heard from people _____ 2) I have experienced it	

	before _____ 3) From health providers _____ 4) Read about it _____ 5) Others (Specify) _____	
403. What can you say about having a companion to support you during labour and delivery?	1) It is a very good practice _____ 2) It is not a good practice _____ 3) I don't know _____	
404. What benefit do you know can be derived from having a companion during labour and childbirth? (You can choose more than 1 answer)  For each benefit write '1' or '2' or '3'. 1= Yes, I am very sure 2= I don't know 3= No	1) Reduced pain in labour _____ 2) Reduced need for C/S _____ 3) Increased chance of vaginal delivery _____ 4) Reduce worry and fear in the woman _____ 5) Makes the woman happy _____ 6) Reduces the duration of labour _____ 7) Survival of the baby is better _____ 8) Reduces feeling of loneliness in mothers _____ 9) Reduces the chance of abuse and disrespect of the woman by the health providers _____	

**SECTION E. DESIRE AND PREFERRED COMPANION OF CHOICE IN LABOUR**

<p>501. Do you wish to have a companion during your labour and delivery?</p>	<p>1) Yes _____                  2) No _____                  3) I am not sure yet _____</p>	
<p>502. In this facility, has the health provider ever mentioned about you choosing your companion of choice in labour?</p>	<p>1) Yes _____                  2) No _____</p>	
<p>503. Do you know if you will be allowed to bring someone to stay with you in the labour room till delivery in this facility?</p>	<p>1) Yes _____                  2) No _____                  3) I don't know _____</p>	
<p>504. If this facility allow you to choose someone to stay with you when you are in labour, will that make you more eager to deliver here?</p>	<p>1) Yes _____                  2) No _____</p>	
<p>505. When in labour, who will you prefer to stay and support you till delivery?</p>	<p>1) Husband _____                  2) Sister _____                  3) Mother _____                  4) Friend _____                  5) Others                  (Specify) _____</p>	
<p>506. What will you expect your companion to do for you when in labour?                  (you can choose more than 1 answer)                  For each expectation, write '1' or '2'.                  1= Yes                  2= No</p>	<p>1) Encourage _____                  2) Rub your back _____                  3) Pray _____                  4) Run errands _____                  5) Others (Specify) _____</p>	

**Thank you for participating.**

4. Information sheet, consent form and questionnaire (In Amharic).

1. የመረጃ መሰብሰቢያ

አዲስ አበባ ዩኒቨርሲቲ

ስኩል ኦፍ ፐብሊክ ሄልዝ

“በአዲስ አበባ በምጥ እና በልጅ መውለድ ወቅት አብሮ/ራ ስለሚሆን/ስለምትሆን ግለሰብ የቅድመ ወሊድ ደንበኞች ያላቸው እውቀትና ፍላጎትን የሚመለከት ጥናት።”

ሰላም ለእርስዎ ይሁን በመጀመሪያ ጊዜ ስለሰጡኝ ማመስገን እፈልጋለሁ።

እንደምን አረፈዱ/እንደምን ዋሉ እኔ ..... በዚህ ጥናት እንደ መረጃ ሰብሳቢ ሆኜ የምሰራ ነኝ። ውድ መላሽ በአዲስ አበባ ዩኒቨርሲቲ ስኩል ኦፍ ፐብሊክ ሄልዝ ጋር በመተባበር ኦሎሚዲዎ ኩኩ በፐብሊክ ሄልዝ የማስትሬት ዲግሪ ጥናቱን በከፊል ለማጠናቀቅ ለሚያከናውነው የምርምር ስራ እንዲጠቅሙ በተለያዩ ክፍሎች የተመደቡ የጥያቄዎችን ዝርዝሮች በዚህ ሰነድ ላይ ያገኛሉ። የዚህ ጥናት ዋና አላማ “በአዲስ አበባ በምጥ እና በልጅ መውለድ ወቅት አብሮ/ራ ስለሚሆን/ስለምትሆን ግለሰብ የቅድመ ወሊድ ደንበኞች ያላቸው እውቀትና ፍላጎትን” ማጥናት ነው። ለዚህ ጥናት አስተዋጾ ለማድረግ በህዝብ ጤና አጠባበቅ ፋሲሊቲዎች የቅድመ ወሊድ ክሊኒክ አገልግሎት በማግኘት ላይ ያሉ ነፍሰጡር ሴቶችን እንጋብዛለን። ጥናቱ በአንቺ ላይ ምንም አይነት ጉዳት አያስከትልም ነገር ግን አስፈላጊ የሆነ መረጃ እንድታገኙ ይረዳላል።

ስምሽ አይመዘገብም እንዲሁም አንቺ የምትሰጪው ማንኛውም መረጃ በሙሉ በጥብቅ ሚስጥራዊ ሆኖ ይያዛል። እንዲሁም መረጃው ለዚህ ጥናት ዓላማ ብቻ ይውላል።

በዚህ ወቅት እኔን ስለጥናቱ ጥያቄ ለመጠየቅ ነጻነት ይሰማሽ። በማንኛውም ጊዜ ከቃለመጠይቁ በኋላ ጭምር ጥያቄዎች ካሉሽ ለመጠየቅ ነጻ ሁኔታ። ለበለጠ መረጃ ኦሎሚዲዎ ኩኩን በሞባይል ስልክ ቁጥር 0989739722 ወይም thecooldoctorkuku@yahoo.com ማግኘት ትችላለሽ።

## 2. የፍቃደኝነት መግለጫ ቅጽ

ይህ የፍቃደኝነት መግለጫ ቅጽ ለእኔ ከተነበበልኝ እና ከተብራራልኝ በኋላ ስለጉዳዩ ተረድቻለሁ። ለጥያቄዎቼም ምላሽ አግኝቻለሁ ስለሆነም በዚህ ጥናት ላይ በፍቃደኝነት ለመሳተፍ ተስማምቻለሁ?

1. አዎ ከሆነ ወደ ፈቃደኝነት መግለጫ ቅጽ ይግቡ

2. አልተስማማሁም ከሆነ ወደሚቀጥለው ተሳታፊ ይሂዱ

የተሳታፊ ፊርማ/የጣት አሻራ \_\_\_\_\_

የጤና ጥበቃ አገልግሎት መስጫ ተቋም ስም \_\_\_\_\_

የቃለመጠይቅ አድራጊ ስም \_\_\_\_\_ ፊርማ \_\_\_\_\_

የቃለመጠይቅ ቀን \_\_\_\_\_ የተጀመረበት ጊዜ \_\_\_\_\_ ያበቃበት ጊዜ \_\_\_\_\_

የተቆጣጣሪ ስም \_\_\_\_\_ ፊርማ \_\_\_\_\_

3. መጠይቆች በአማርኛ

የመታወቂያ ቁጥር \_\_\_\_\_ የቃለመጠይቁ ቀን \_\_\_\_\_ የጤና ተቋም \_\_\_\_\_

ሀ. የማህበራዊ የስነህዝብ ጥናት መረጃ

ጥያቄዎች	የመለያ ምድብ
101 በቅርቡ ባከበርሽው የልደት ቀንሽ እድሜሽ ስንት ነበር?	_____ ዓመታት (ዕድሜ በሙሉ ዓመታት ይገለጹ)
102 የጋብቻ ሁኔታሽ እንዴት ነው?	1) አግብቻለሁ _____ 2) አብሬ እኖራለሁ _____ 3) ፈትቻለሁ/ተለያይተናል _____ 4) ባሌ ሞቶብኛል _____ 5) በፍጹም አግብቼ አላውቅም/በፍጹም አብሬ ኖራ አላውቅም _____
103 ሃይማኖት	1) ኦርቶዶክስ _____ 2) ካቶሊክ _____ 3) ፕሮቴስታንት _____ 4) ሙስሊም _____ 5) ባህላዊ _____ 6) ሌሎች (ይግለጹ) _____
104 ብሔር	1) አማራ _____ 2) አሮሞ _____ 3) ትግራይ _____ 4) ሱማሌ _____ 5) ሌሎች (ይግለጹ) _____
105 የተማርሽው ከፍተኛው የትምህርት ደረጃ ምንድነው?	1) አልተማርኩም _____ 2) የመጀመሪያ ደረጃ ት/ቤት _____ 3) ሁለተኛ ደረጃ ት/ቤት _____ 4) ቴክኒክ/ሙያ _____ 5) ከፍተኛ _____

106 ስራሽ ምንድነው?	1) የቤት እመቤት _____ 2) የመንግስት ሰራተኛ _____ 3) ራሴን ቀጥራ አሰራሪ _____ 4) መንግስታዊ ያልሆነ ድርጅት _____
107 ቤተሰብሽ በየወሩ ምን ያህል ገቢ (ብር) ያገኛል?	1) ከ1000 በታች _____ 2) ከ1,001-2,500 _____ 3) ለ2,501-3,999 _____ 4) 4,000 እና ከዚያ በላይ _____

**ለ. የቀድሞ የጽንሰ (ከመውለድ ጋር የተገናኘ) ህክምና መረጃ**

ጥያቄዎች	የመለያ ምድብ	ይለፉ
201. ከዚህ በፊት ህያው የሆነ ወይም ህይወት የሌለው ጨቅላ ለምን ያህል ጊዜ ወልደሻል?	1) 0 _____ 2) 1 _____ 3) 2 _____ 4) 3 _____ 5) 4 _____ 6) 5 ወይም ከዚያ በላይ _____	መልሱ 0 ከሆነ ወደ ክፍል ሐ እለፉ
202. በቅድመ ወለድ ክሊኒክ ህክምና ተከታትለሽ ነበር?	1) አዎ _____ 2) አልተከታተልሁም _____	መልሱ አልተከታተልሁም ከሆነ ወደ ጥያቄ 204 ይለፉ
203. የቅድመ ወለድ ክሊኒክ የተከታተልሽው የት ነበር?	1) የመንግስት ሆስፒታል _____ 2) የጤና ማዕከል _____ 3) የጤና ጣቢያ _____ 4) የመያድ የጤና ተቋም/ፋሲሊቲ _____ 5) የግል ሆስፒታል ወይም ክሊኒክ _____ 6) ሌሎች (ይገለጽ) _____	

<p>204. በዚያን ጊዜ ልጅሽን የወለድሽው የት ነበር?</p>	<p>1) የቅድመ ወሊድ የጤና እንክብካቤ ባገኘሁበት _____</p> <p>2) በቤቱ _____</p> <p>3) ጤና ጣቢያ _____</p> <p>4) ጤና ማዕከል _____</p> <p>5) የመንግስት ሆፒታል _____</p> <p>6) የግል ሆስፒታል ወይም ክሊኒክ _____</p> <p>7) ሌሎች (ይገለጹ) _____</p>	<p>If not home delivery, then skip to question 206.</p>
<p>205. በቤት ውስጥ ከወለድሽ ለምን? (ተገቢ ከሆነ ከ1 በላይ መልስን መስጠት ትችላለሽ)</p> <p>For each reason write '1' or '2'.</p> <p>1= Yes</p> <p>2= No</p>	<p>1) ባህላዊ አዋላጆችን ስለምመርጥ _____</p> <p>2) የተለመደ ስለሆነ _____</p> <p>3) እርግዝናዬ ጤናማ ነበር ስለተባልሁ _____</p> <p>4) በጤና አገልግሎት ሰጪ እንዳልጠቃና ክብራን እንዳላጣ _____</p> <p>5) በምጥ ወቅት ብቻዬን መሆን ስለምፈራ _____</p> <p>6) ያማጥሁት ለአጭር ጊዜ በመሆኑ _____</p> <p>7) የትራንስፖርት ችግር ስላለ _____</p> <p>8) ሌሎች (ይገለጹ) _____</p>	
<p>206. በወቅቱ በምጥ እና በውልደት ወቅት የረዳሽ ሰው ነበር?</p>	<p>1) አዎ _____</p> <p>2) የለም _____</p>	<p>መልሱ የለም ከሆነ ወደ ጥያቄ 208 እለፊ</p>
<p>207. በወቅቱ የረዳሽ ሰው ማን ነበር?</p>	<p>1) ባሌ _____</p> <p>2) እህቱ _____</p> <p>3) እናቱ _____</p>	

	4) ንደኛዬ _____ 5) ሌሎች (ይግለጹ) _____	
208. የረዳሽ ሰው ከሌለ ለምን?	1) አስፈላጊ ስላልሆነ _____ 2) በጤና ተቋሙ ውስጥ ስላለው አሰራር ባለማወቅ _____ 3) የጤና አገልግሎት አቅራቢ ድጋፍ እንዳገኝ ባለመፍቀዱ _____ 4) የሚረዳኝ ስለሌለ _____ 5) ሌሎች (ይግለጹ) _____	
209. የመውለድሽ ውጤት	1) ጨቅላው በህይወት ያለ እና ደህና ነበር _____ 2) ጨቅላው የታመመ ነበር _____ 3) ጨቅላው ሞቶ ነበር _____	

**ሐ. የወቅቱ የጽንሰ ህክምና መረጃ**

<b>ጥያቄዎች</b>	<b>የመለያ ምድብ</b>	<b>ይለፉ</b>
301. የመጨረሻውን የወር አበባ ያየሽው መቼ ነበር?	1) ቀን _____ (dd/mm/yyyy) 2) አላውቅም _____	
302. ስትመዘገቡ እርግዝናሽ የምን ያህል ወራት እድሜ ነበረው?	1) 1 _____ 2) 2 _____ 3) 3 _____ 4) 4 _____ 5) 5 _____ 6) 6 or more _____ 7) I don't know _____	
303. ይህንን ጨቅላ መውለድ የምትፈልገው የት ነው?	1) ባለሁብት የህክምና ተቋም _____	

	2) የመንግስት ሆስፒታል _____ 3) የጤና ማዕከል _____ 4) የጤና ጣቢያ _____ 5) የመያድ የጤና ተቋም _____ 6) የግል ሆስፒታል ወይም ክሊኒክ _____ 7) ሌላ (ይገለጹ) _____	
--	---	--

**መ. በምጥ ወቅት ሊኖርዎት ስለሚችል ረዳት/ድጋፍ ሰጪ ያለዎት እውቀት**

ጥያቄዎች	የመለያ ምድብ	ይለፉ
401. በምጥ ላይ ያለች ሴት በአንድ የጤና ተቋም ውስጥ ልጇን እስክትገላገል ድረስ አብሯት እንዲቆይ እና እንዲደግፋት የምትፈልገውን ሰው የመምረጥ መብት እንዳላት ታውቁዋለሽ?	1) አዎ _____ 2) አላውቅም _____  1) በጣም እርግጠኛ ነኝ _____ 2) በጣም እርግጠኛ አይደለሁም _____	አላውቅም ከሆነ ወደ ጥያቄ 403 እለፊ
401b. ለ. ከላይ ላለው ጥያቄ መልስሽ አዎ ከሆነ ምን ያህል እርግጠኛ ነሽ?		
402. እንዴት ልታውቁ ቻልሽ?	1) ከሰዎች ሰምቼ _____ 2) ከዚህ በፊት ተሞክሮ ስላለኝ _____ 3) ከጤና አገልግሎት ሰጪዎች _____ 4) አንብቤ _____ 5) ሌሎች (ይገለጹ) _____	
403. በምጥ እና በመውለድ ወቅት የሚረዳሽ አንድ ሰው አብሮ ስለመሆኑ የምትይው ነገር ምንድነው?	1) በጣም ጥሩ አሰራር ነው _____ 2) ጥሩ አሰራር አይደለም _____ 3) አላውቅም _____	

<p>404. በምጥ እና ልጅ በመውለድ ወቅት የሚረዳሽ አንድ ሰው ቢኖር ሊያስገኘው ስለሚችለው ጥቅም የምታውቁው ነገር አለ? (ከአንድ በላይ መልስ መምረጥ ይችላሉ)</p> <p>For each benefit write '1' or '2' or '3'.</p> <p>1= Yes, I am very sure 2= I don't know 3= No</p>	<p>1) በምጥ ጊዜ ስቃይ ይቀንሳል _____</p> <p>2) በቀዶ ጥገና የመውለድ አስፈላጊነት ይቀንሳል _____</p> <p>3) በሴት ብልት (ቫጂይና) የመውለድ እድል እንዲጨምር ያደርጋል _____</p> <p>4) በሴቷ ውስጥ ያለ ጭንቀትና ፍርሃት እንዲቀንስ ይረዳል _____</p> <p>5) ሴቷን ደስያሰኛታል _____</p> <p>6) የምጥ ጊዜ እንዲቀንስ ያደርጋል _____</p> <p>7) የጨቅላውን በህይወት የመቆየት እድል የተሻለ ያደርጋል _____</p> <p>8) እናቶች የሚሰማቸውን የብቸኝነት ስሜት ይቀንሳል _____</p> <p>9) ሴቷ በጤና አገልግሎት ሰጪዎች የመጠቀሱን ክብሯን የማጣት እድልን ይቀንሳል _____</p>	
---	---	--

**ክፍል ሰ: በምጥ ወቅት የሚደግፍ ሰው እንዲኖር መፈለግና መምረጥ**

<p>501. በምጥሽና በምትወልጁበት ወቅት የሚረዳሽ ሰው አብሮሽ እንዲኖር ትፈልገላለሽ?</p>	<p>1) አዎ _____</p> <p>2) የለም _____</p> <p>3) እርግጠኛ አይደለሁም _____</p>	
<p>502. በዚህ ተቋም ውስጥ የጤና አገልግሎት አቅራቢ በምጥ ወቅት አብሮሽ የሚሆን ሰው መምረጥ እንደምትችይ ገልጸልሽ ያውቃል?</p>	<p>1) አዎ _____</p> <p>2) የለም _____</p>	
<p>503. በዚህ ተቋም ውስጥ እስከምትወልጁ ድረስ በምጥ ክፍል ውስጥ አብሮሽ የሚቆይ ሰውን</p>	<p>1) አዎ _____</p> <p>2) የለም _____</p>	

ለማምጣት እንደሚፈቀድልሽ ታውቂያለሽ?	3) አላውቅም _____	
504. በዚህ ተቋም ውስጥ በምጥ ወቅት አብሮሽ እንዲቆይ የምትፈልገውን ሰው እንድትመርጩ በፈቀድልሽ ይህ በጤና ተቋሙ ውስጥ ለመውለድ የበለጠ ፍላጎት ሊያሳድርብሽ ይችላል?	1) አዎ _____ 2) የለም _____	
505. በምጥ ወቅት አብሮሽ እንዲሆን እና እስክትወልጁ ድጋፍ እንዲሰጥሽ ማንን ትመርጫለሽ?	1) ባሌን _____ 2) እህቴን _____ 3) እናቴን _____ 4) ጓደኛዬን _____ 5) ሌሎች (ይገለጹ) _____	
506. በምጥ ወቅት አብሮሽ ያለ/ያለች ግለሰብ ምን እንዲያደርጉልሽ ትጠብቂያለ? (ከአንድ በላይ መልስ መምረጥ ይቻላል) For each expectation, write '1' or '2'. 1= Yes 2= No	1) እንዲያበረታታኝ/ እንድታበረታታኝ _____ 2) ጀርባሽን አሽት አሽት እንዲያደርግልሽ /እንድታደርግልሽ _____ 3) እንዲጸልይልሽ/ እንድትጸልይልሽ _____ 4) የምትፈልገውን ነገር እንዲያቀርብልሽ _____ 5) ሌላ (ይገለጹ) _____	

**ስለተሳተፎሽ አመሰግናለሁ**