ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING & MIDWIFERY

DEPARTMENT OF MIDWIFERY

HEALTH PROFESSIONAL'S COMMUNICATION AND LABORING MOTHER'S AUTONOMY DURING GIVING BIRTH IN SELECTED GOVERNMENTAL HOSPITALS IN ADDIS ABABA ETHIOPIA: A MIXED STUDY

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This thesis is submitted in partial fulfillment of the requirement for a graduate Master's degree from the Addis Ababa University at College of Health Sciences, School of Nursing and Midwifery.

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LIST OF ABBREVIATIONS AND ACRONYMS

AA-Addis Ababa

AAU--Addis Ababa University

ALERT-all African leprosy TB rehabilitation and training center

EDHS-Ethiopian Demographic and Health Survey

EHSP-essential health service package

FMOH-federal ministry of health

GMH-Gandhi memorial hospital

M-mean

MMR-maternal mortality ratio

MOH-ministry of health

QDA –qualitative data analysis

SDG -Sustainable Developmental Goal

SD-standard deviation

SPHMMC-St Paulo's hospital millennium medical collage

SPSS-statistical package for social science

SSA-sub Saharan Africa

TAH-Tikur Anbessa hospital

WHO-world health organization

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ABSTRACT

Background- effective communication and autonomy between health care professionals and women in labor, is one of the means for increasing the quality of care. It helps women feel informed and could plausibly also empower disadvantaged women to speak up about the care they receive. In this regard, limited information is currently known about communication skills and laboring mother's autonomy in Addis Ababa, Ethiopia. Therefore, the purpose of this study was to determine health professional's communication skills and laboring mother's autonomy in selected governmental hospitals.

Objective -to determine health professionals communication skills and laboring mother's autonomy in selected governmental hospitals in Addis Ababa, Ethiopia, 2022.

Method-Institutional based a convergent mixed study design was used. The data collection was conducted from February, 15 to March 25, 2022, through a structured questioner for quantitative study and in-depth interviews using a semi-structured questioner for qualitative study. A total of 181 health professionals were recruited for quantitative and 12 postpartum women were included for qualitative. The data was analyzed by using SPSS version 25. The descriptive statistics were expressed in tables, graphs and text. Association between the dependent variable and the independent variable was measured using odd ratio and 95%CI by bivariate and multivariate logistic regression. Variable having a p-value <0.05 was stated as statistically significant. The data was analyzed by using thematic analysis with the assistance ATLAS.ti9 software. Data saturation was used as a guide to decide the number of participants.

Result: - In this study overall communication and autonomy of the laboring mother recognized by the provider were 55%, the overall good communication of the provider for labouring mother were 49% and the overall autonomy were 49%. The determinant factor of communication and autonomy of the labouring mother recognized by the provider were the profession of midwife (AOR=4.7, 95%=1.66, 13.57), sex of male (AOR=2.8, 95%CI=1.36, 5.55) and attends 2-4 and >4 labour per day (AOR=2.9, 95%CI=1.33, 6.49 & AOR=3.7, 95%CI=1.23, 10.81 respectively). From the qualitative data, four themes emerged about laboring mother autonomy; Autonomy violation due to care discrimination, informed consent issues, women limited decision-making powers and providers unethical behavior.

Conclusion and recommendation: -: the current study indicated that there is a greater lack of effective communication and respect for autonomy by health professionals. Therefore, actively listening to the laboring mother's concerns, preferences, and questions will enhance health professional's communication and respect the autonomy of laboring mothers.

Keywords -communication, autonomy, laboring mother, health professionals

CHAPTER ONE

1. INTRODUCTION

1.1 Background

Effective communication is the process of exchanging ideas, thoughts, knowledge and information such that the drive or the goal is satisfied in the best possible manner(1). On the other hand, autonomy can be defined as the capacity of a laboring mother to make a decision given that she intends no harm and accepts responsibility for her decision during pregnancy and childbirth, and she has: 1) received unbiased information about available benefits, risks and choices; 2) the ability to understand and decide; and 3) the freedom to make the decision (3).

WHO recommends effective communication between health care professionals and women in labour, by means of methods that is simple and acceptable in cultural terms. As emphasized in the framework of WHO for improving quality of care during childbirth, experience of care (such as effective communication, respectful care and autonomy) is as significant as clinical care provision in accomplishing quality of care (2). Communication skills are critical to the provision of high-quality maternity care services. It is unbearable to guarantee the establishment of the finest possible care without accurate and comprehensive communication with mothers, their families and multi-professionals (3).

The amount of information to be shared and guiding requirements that mandate communication are increasing. Interventions are mandatory, most women would like to obtain pertinent information from technically capable healthcare professionals in a manner they can understand (4). Whereas a woman's autonomy is often overlooked due to the obstetric emphasis on the fetus over the mother during giving birth as well as the history of medical paternalism in Western medicine and Ethiopia as well(5,6).

Effective communication by health care professionals that occurs in partnership with laboring mothers and their families could benefit laboring mother feel informed. It could also enable disadvantaged women to exclaim about the care they obtain (2). Effective communication is predominantly vital in the provision of maternal services. Its impact on laboring women is one of the methods of inspiring to utilize maternal health services and build a therapeutic healthcare professionals-patient relationship (6). Laboring mothers consistently appreciate and value effective communication as one of the key components of quality of care (7).

Labor and delivery are susceptible and stressful times where gaps in communication and autonomy can result in health complications (8). Poor or abusive healthcare professional communication and respect for autonomy could impact decisions about where to give birth in the following pregnancies (7). It can also lead to consequences in misdiagnosis, poor outcome, poor informed consent, re-admission,

misunderstanding about medications and malpractice lawsuits. These can easily lead to preventable health complications and the death of the patient. (7,8,9). Ineffective communication, loss of autonomy and lack of informed consent are the most reported forms of mistreatment(4).

The patient-physician interaction has transformed due to recent drifts in medicine that establish more patient autonomy about their own medical decision-making and the start of numerous sources of medical information outside of the doctor's office. Furthermore, current trends in medicine have shifted away from a relationship that previously involved a paternalistic scenario of the physician commanding the patient what to do, and have advanced into increasing patient participation in their own healthcare decisions, and possible treatment options (13).

The idea that laboring mothers should be presented with options and allowed to make their own medical decisions about potentially life-changing healthcare interventions is significant for quality of care. Effective communication facilitates patient understanding and participation in decision-making. It is therefore a crucial constituent of patient autonomy, which is respect for patients' views of what is suitable and letting them make informed choices without facing unnecessary influence from their healthcare provider (11).

Generally, poor communication skills could potentially have harmful effects on the physical, mental, social, and economic features of healthcare(10). Therefore, the improvement of health professional's communication skills is of key importance to ensure the health of laboring mothers. However, non-clinical intrapartum practices, such as the provision of emotional support through labor companionship, effective communication and respectful care, which may be fairly low-cost to implement, are not viewed as priorities in many settings. These non-clinical aspects of care supplements to enhance the quality of care provided to the woman and her family (2).

1.2 Problem Statement

Communication is a significant clinical skill, if implemented competently and efficiently, facilitates the launch of relationship of trust between the medical staff and the patient, a truly therapeutic union. The technique that health professionals responds to laboring mother needs and requests is an element that enhance performance, contributing to an increase in the prestige of the medical unit and the rising interest of laboring mothers(14).Communication between laboring mother and health professionals lies the soul of the health care .Over 40% of interventions achievement being provided by the health professional laboring mother relationship (17). High-quality obstetric delivery in a health facility reduces maternal and perinatal morbidity and mortality (11).

The World Health Organization (WHO) framework for improving quality of care for mothers and newborns around the time of childbirth in health facilities recognizes two important components of care: the quality of the provision of care and the quality of care as experienced by women and their families The framework contains eight domains of quality, one of which is communication, with the standard that 'communication with women and their families is effective and responds to their needs and preferences'(2).

Several studies on laboring mother experiences highlight poor communication and lack of respect for their autonomy during child birth. (11) And some studies have showed that health care professionals were slow to respond to patients' needs. laboring mothers reported that they felt alone during delivery as health care professionals had poor communication skills and did not provide updates on labor progress (18).

In order to improve quality of care, enhancing person centered care is one of the tools. Effective communication and autonomy is one of the components of person centered care. While several factors might affect quality of care, poor communication and autonomy scores a major point. Despite the highlighted importance of effective communication and respect for autonomy, there is still a gap in achieving these goals.

To the best of the researcher's knowledge, Ethiopia has a limited number of studies on this topic, and the previous studies are rather focused on perception of women. But in this mixed method study will seek to determine health professional's communication and laboring mother's autonomy during giving birth in selected governmental hospitals, Addis Ababa Ethiopia.

1.3 Significance and anticipated output of the study

Improving maternal and newborn health is one of the continuous aims of millennium development and remains a key concern of sustainable development goals (1). This goals will be achieved through quality healthcare services during pregnancy, labor and delivery and postnatal. Effective communication and respect for the autonomy of health professionals will play a vital role in improving the quality of care.

Nowadays researchers worldwide are evaluating the quality of maternity services by assessing women's experiences of respectful care and their sense of autonomy in decision-making. Studies have investigated vital information regarding communications in health facilities but there is still a lack of research on determining the perception of both the laboring mother's autonomy and health professionals' communication during childbirth.

So this mixed method research was conducted to determine health professional's communication and laboring mother's autonomy in the course of giving birth which will alert policymakers to design women-centered practice guidelines that address the need for effective communication and respect for autonomy. The result of the present study will also deliver valuable information for the hospitals, MOH, and other stakeholders to strategize effective plans for sustainable maternal and neonatal health. In addition, this study will be used as a reference for further studies on health professional's communication and laboring mothers' autonomy.

CHAPTER TWO

2. LITERATURE REVIEW

In this chapter different literature mostly, published articles related to communication and autonomy in maternity care will be discussed.

2.1 Introduction

In the medical field, communication signifies a vital clinical skill that includes the establishment of therapeutic relationships, understanding the patient's perspective, discovering thoughts and emotions, and guiding them towards improving their health. The quality of the information gained by the health professionals during consultations is closely linked to the communication skills of the health professionals and the patient. This clinical skill generates fundamental relationships and also provides benefits to those involved, thoughts for which the appropriation of high communicative skills must be importance for health professionals (3).

Visiting hospitals is the source significant extent of anxiety because patients and families may be unclear about the diagnosis, the risk of pain and suffering, financial worries, or procedural ambiguity. Moreover, they may interact with a variety of people in the healthcare setting. Health care professionals can directly reduce laboring mothers anxiety by introducing themselves and stating their role, or position at the medical facility. Laboring mothers and family members most probably feel comfortable with healthcare professionals if they find areas of mutual interest. Thus, it seems vital for health professionals to reduce ambiguity by immediately introducing themselves (2).

In addition to reducing laboring mother’s anxiety, effective skill of communication such as listening, explaining, and empathizing can have an insightful effect on laboring mother’s health status and functioning, as well as on their satisfaction regarding health care service. One of the significant roles of health professionals is to inform the laboring mother about one’s condition. If they are misinformed, they will be uncooperative, confused, dissatisfied and the context in which any medical act becomes stressful (3).

On the other hand, the principle of respect for autonomy is generally related to permitting patients to make their own decisions about which health care interventions they will or will not obtain. Personal autonomy is usually appreciated: most people think it is better to somehow be their own person and shape their own lives than to live under the control of others. Acknowledgement of the particular vulnerability of patients’ autonomy has reinforced the addition of respect for autonomy as a key concern (19).

All patients and clients, have the right to make autonomous decisions about their medical care. This includes the capacity to decline and follow medical advice, guidelines or policy (20).

2.2 communication and autonomy

A study done in Kenya showed that over 80% of health professionals recognized the importance of several aspects of communication and autonomy. Even though this is a significant number, a study with women in the same setting showed that 77% reported that providers never introduced themselves to them and 70% were never allowed to deliver in a position of their choice and also 28% were never told the importance of examinations and procedures and 36% were never asked permission or consent before examinations and procedures. These numbers indicate poor communication and autonomy (11,21).

Another study done assessing the status of disrespect of women in Addis Ababa Ethiopia, showed that the health professionals did not introduce himself/herself to the women and their companions(89%).sixty percent of the women think that the provider did not encourage them to ask questions and also 43.3% said that the provider did not explain to them what is being done and what to expect throughout labor and delivery and this study also reported that 32.9% of women were not given periodic updates on status and progress of labor. Eleven percent and twenty percent of women were not allowed to move and to undertake positions of choice during labour and delivery respectively. Almost half(50.3%) of participants reported that service providers do not generally obtain women's consent before procedures (22).

Research in Australia assessed the perception of health professionals about women's autonomy and they were asked to mark their approval with, "In collaborative practice, working with primary careers, the final decision should always rest with the woman' 'Overall, both midwives ($M= 5.72$, $SD = 1.19$) and doctors ($M= 4.82$, $SD = 1.65$) agreed that the final decision should always rest with the woman, however, midwives agreed significantly more, $t(334) = -3.87$, $p < .001$(23).

Perceptions of the quality of midwifery care were high during labour and birth: the majority of women believed they were always communicated in a way they could understand (92%). Both (doctors and the midwives) were somewhat less likely to be reported as always listening to women (84% of midwives and 82% of doctors always listened, respectively).More than half of the women (69%) were informed about always being contributed in decisions about their health. Almost a quarter of women (24%) stated sometimes being involved and a few women described not being involved at all (5%). Very few (1%) said that they did not want to be involved in decision-making (24).

In a study done in Damascus Syria, The number of women who agreed or strongly agreed with the term overall satisfaction with doctors' communication skills during labour and delivery ranged from 51% to 83% between hospitals in the control arm and 58% to 85% between hospitals in the intervention arm. Around 40% of the women agreed/strongly agreed that the doctor looked at them when he/she talked to

the woman. Similar percentages were witnessed for whether the doctor listened to the woman with concern and without interruption. Almost 40% of the women agreed/strongly agreed that the doctor displayed an interest in them. Only a quarter of the women agreed/strongly agreed that the doctor described the examination steps before the clinical examinations. A Quarter agreed/strongly agreed that the doctor described the outcomes from the clinical examination(25).

2.2.1 Provider-related barriers

A mixed method study done in Kenya reported that few participants (health professionals) acknowledged that at times, they are incapable of successfully communicating due to the absence of knowledge or skill. This was mainly associated with understanding and answering questions. Some health professionals implied that occasionally they did not answer questions due to their incapability to reply to sensitive questions, fear that their answers may sadden or introduce fear in women, or just because they were unable to understand the women. This indicates a lack of perceptive listening skills among providers, as well as an incompetence to empathically communicate. Another reason health professionals mentioned was that they occasionally overlook certain procedures for instance introducing or explaining themselves or the procedures to the women. This was usually done because it was not something that was frequently done in their workplace. Forgetfulness was also another contributor to stress from the high amount of work or in the case of emergencies(11).

On the other hand, if the provider were not comfortable with the laboring women preferred laboring position, they would not allow it. Many providers stated that they don't typically introduce themselves because the provider thinks that the women already know them or ought to know them, as most of them came from the same community. Some providers admitted that they do not provide women with sufficient information about their procedures or sufficiently gain their consent because of expectations that: women already knew what was happening, may not understand what was being said, or may be terrified by the information. Furthermore, healthcare providers said they supposed that coming to the facility meant a woman had given her consent for all care given at the facility and the care provider, hence, did not require to ask for permission or consent to do something(21).

2.2.2 Work environment-related barriers

Regardless of the acknowledgement of the need to deliver information to the woman in order to understand her care, providers often mention circumstances in which it was acceptable not to do so. Frequently these situations relate precisely to high patient numbers and a lack of staff to accommodate the demand, leading to time limitations that do not allow for caregivers to give inclusive counseling to the woman. Not gaining consent before procedures because of workload and exhaustion (4).

Frequently, providers stated circumstances in their workplace such as workload, which led to a perceived lack of time, stress, and burnout. These barriers, as well as customs and other features of the facility produced a workplace culture that enabled or prevented some behaviors (11).

Many of the participants, either in government or private health facilities, specified that usually the health providers did not give them a chance or sufficient time to ask some questions about concerns they did not understand regarding their pregnancy. When asked why they thought healthcare providers behaved in this way, most of the women said they assumed the healthcare providers feared the workload of being assaulted by inquisitive clients and laboring mothers if they were generous in answering questions (5).

2.2.3 Women- related

Health care providers stated that some women do not ask questions because of fear, embarrassment, and feeling inferior to the professionals. Likewise, some providers recognized a lack of autonomy in women's nonparticipation (21).

In particular, laboring mothers not delivering in their favored positions was attributed to them not demanding. It was also apparent that when women asked, they might be deprived based on the type of positions they had chosen due to the caregiver discomfort or the state of the labor ward. A laboring mother ease or confidence in asking questions was affected by the way in which she was treated by her care provider. For instance, some laboring mothers ask questions when the healthcare provider is not welcoming. Providers stated that it was safe to do the right thing when women are well informed because they know their rights (21).

Also, well-informed laboring women were said to ask more questions and to be more demanding, causing the providers to spend more time with them. Providers in addition highlight that sometimes women simply don't follow medical management that has been given to them due to misconceptions or lack of understanding as to the purpose and importance of the directive. Some participants in the public health facilities felt that they were failing to understand simple instructions or very basic information because of their illiteracy and that the healthcare providers were discriminating against them by not recognizing the need to help them understand. This could clarify why some healthcare providers were not eager to answer questions from some patients if they were not identifying whether patients had not understood instructions or information (26).

2.3 Conceptual framework

The conceptual framework hypothesized that sociodemographic characteristics, Work environment, health professionals related barriers and Laboring mother's related barriers are directly related to Effective communication.

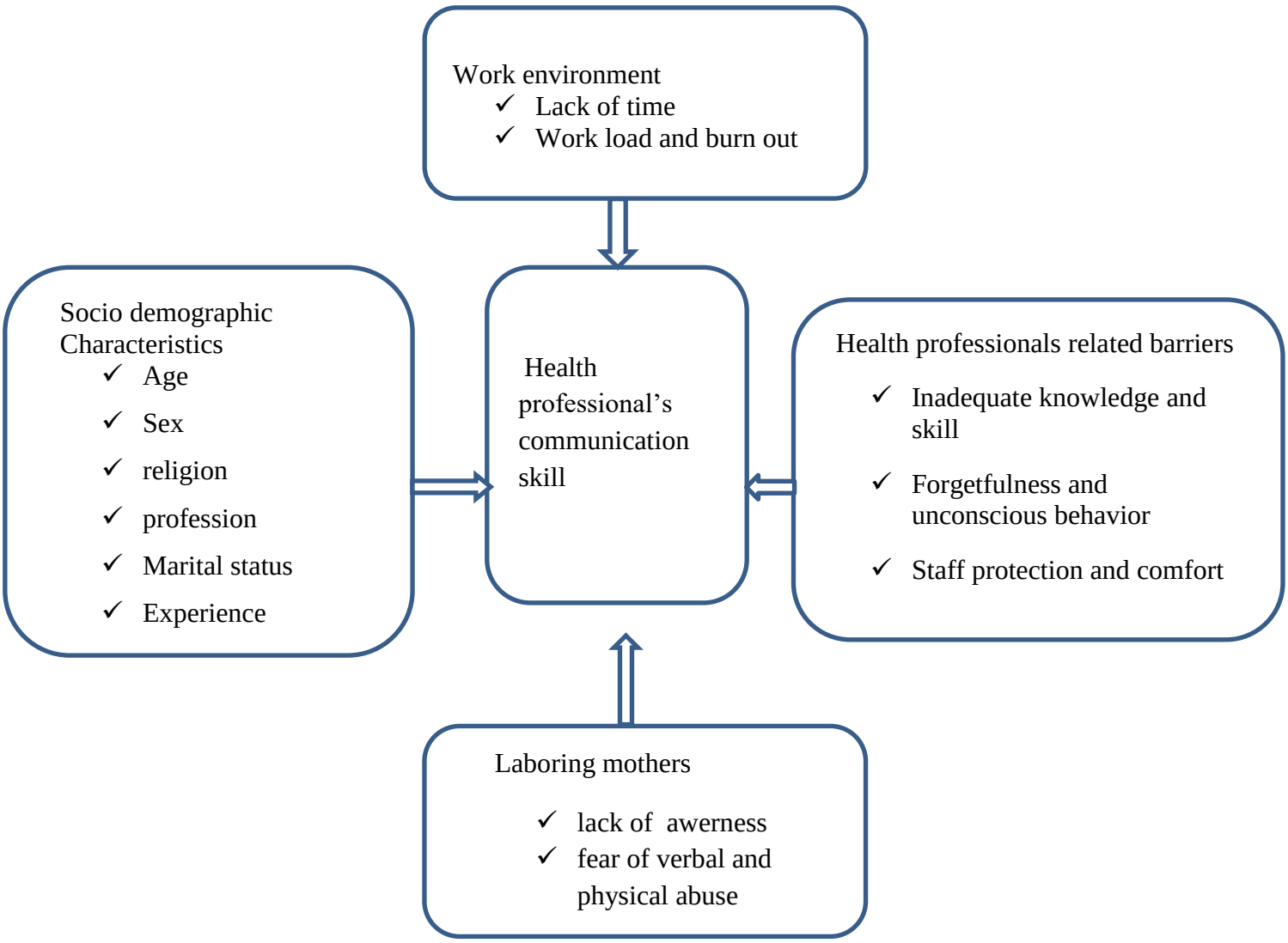

Figure 1.conceptual framework for health professional's communication and laboring mother's autonomy in selected governmental hospitals Addis Ababa, Ethiopia, 2022

CHAPTER THREE

3. OBJECTIVE

3.1. General Objective

To determine health professionals' communication and laboring mother's autonomy in selected governmental hospitals Addis Ababa, Ethiopia, 2022.

3.2. Specific objectives

- To asses health professionals' communication skill during labour and delivery in the selected government hospitals of Addis Ababa.
- To identify barriers that affect health professionals' communication skill during labour and delivery in the selected government hospitals of Addis Ababa.
- To understand laboring mothers' autonomy during labour and delivery in the selected government hospitals of Addis Ababa.

CHAPTER FOUR

4. METHODS AND MATERIALS

4.1. Study area and period

The study was conducted in Addis Ababa (AA), which is the capital city of Ethiopia. The area of Addis Ababa covers about 526.99km^2. According to the 2007 census, it has a population of 3,384,569; however, the city has through recent years seen an increase in annual growth rate, which is believed to be 5,005,524 in 2021, and as of the 2007 census, 34.8% of women of reproductive age are living in Addis (26)(27).

According to the Ministry of Health 2012 report, Addis Ababa has 6 hospitals, 52 health centers, and 650 clinics under the federal administration, and five hospitals are managed by the Addis Ababa Health Bureau Excluding one police and one armed forces hospital are found in the study setting. These health facilities give reproductive health services with different types of family planning methods, antenatal care, delivery and other services (27).The study was conducted in Tikur Anbessa specialized hospital, St. Paulo's hospital millennium medical college, Gandhi Memorial Hospital and Alert Hospital.

Tikur Anbessa specialized hospital is a teaching hospital and a referral under the ministry of Education of Ethiopia. St. Paulo's hospital millennium medical college is specialized and teaching hospital administered by the federal ministry of health, Gandhi Memorial Hospital and Alert Hospital are governmental hospitals administered by the Addis Ababa Health Bureau and the Federal Ministry of Health respectively. The study was conducted from March to May 2022.

4.2 Study approach

This study used a convergent mixed-method design in which quantitative analysis determined health professional's communication skills whereas qualitative analysis tried to understand laboring mother's autonomy during childbirth.

4.3 Quantitative method

4.3.1 Study design

Institutional based cross sectional study design was used in order to determine health professional's communication skills during labor and delivery in selected governmental hospitals in Addis Ababa, Ethiopia, 2022.

4.3.2 Description of the population

4.3.2.1 Source population

All health professionals who work in Addis Ababa governmental hospitals.

4.3.2.2 Study population

All health professionals who work in Addis Ababa city governmental hospitals and are responsible for attending deliveries in labor and delivery wards during the data collection period were included.

4.3.2.3 Sample population

All health professionals who are responsible in labor and delivery wards during the data collection period in the selected governmental hospitals.

4.3.3 Eligibility criteria

4.3.3.1 Inclusion criteria

Health professionals who fulfilled the following criteria were included in the study.

- ✓ Had worked as a health professional in the labor and delivery ward for at least six months.
- ✓ provide written consent to participate in the study

4.3.3.2 Exclusion criteria

- ✓ Who were not available at the time of the data collection period

4.3.4 Sample size determination and sampling technique

4.3.4.1 Sample size determination

The required sample size was calculated by using single population proportion formula considering the following assumptions;

Where

n= required sample size

Z= critical value for normal distribution at 95% confidence level, which equals 1.96 (z value at α =0.05, two-tailed)

Expected proportion (P) = proportion of communication and autonomy to be 50%

Desired precision (d) = 0.05 (5+% margin of error)

Substituting in the single population proportion formula, gives:

$n = \frac{(Z\alpha/2)^2 \times p(1-p)}{d^2} = \frac{(1.96)^2 \times (0.25)}{(0.05)^2} = \mathbf{384}$

Contingency (for non-response & incompletes=10%) =39.

The total sample size was **423**.

4.3.4.2 Sampling technique

From all governmental hospitals found in Addis Ababa, four were selected using purposive sampling method because of high number of health professionals. All health professionals who work in the selected hospital labour and delivery during the data collection period were included in the study.

4.3.5 Study variables

4.3.5.1 Dependent variable

Health professional's communication skills and laboring mother autonomy

4.3.5.2 Independent variable

Sociodemographic characteristics

- ✓ Age
- ✓ Sex
- ✓ Profession
- ✓ Education
- ✓ Marital status
- ✓ Religion
- ✓ Experience

Provider related

- ✓ Inadequate knowledge and skill
- ✓ Forgetfulness and unconscious behavior
- ✓ Staff protection and comfort

Work environment

- ✓ Lack of time
- ✓ Work load and burn out

Laboring mothers

- ✓ lack of awareness
- ✓ fear of verbal and physical abuse

4.3.6 Operational definition

Communication: - is the transfer of information from the health provider to the laboring mother by writing, speaking, or using a medium that delivers a means of understanding**.**

Autonomy: - A woman has the right to obtain all pertinent information on accessible choices, risks, and benefits, is able to understand and process the information, and chooses birth in the absence of pressure, providing she means no harm to others and is accountable for the consequence.

Communication skill refers to the ability and techniques that medical professionals use to effectively convey information, understand patients and clients' needs, and foster a therapeutic relationship. In this study, communication skills measured by using two parts, which are communication and autonomy, each having 16 and 6 items, respectively. Out of the total twenty-two items, with each eighteen-item having a four-point response scale, i.e. never-0 sometimes-1 usually-2 always-3 and the other 4 items have three-point response scale which is 0 not important, 1 somewhat important and 2 very important. Study participants who scored above mean value were considered to have good communication skill.

Health professionals –health care providers (i.e, midwives, residents, general practitioners, and gynecologists) who work in the selected study setting

Laboring mothers- a women who gave birth in the selected study area and who are in immediate postpartum care.

4.3.7 Data collection

The data collection was conducted through self-administered questioners for quantitative data and interviews for qualitative data by using a structured questionnaire adapted through literature (28). Which consists of three-part sociodemographic, work-related information, and communication. A structured survey questionnaire was prepared in English. Informed consent was acquired from all eligible study participants after explaining the objectives of the study. Three data collectors (BSc midwives) and two supervisors (mph in public health and mph in nutrition) were employed for data collection. The interviewers were from another hospital. The responsibility of data collectors was to make sure the questionnaire was filled out after gaining consent from the study participants. The supervisors were providing all items essential for the data collection on each data collection day, checking the questionnaire

for wholeness and consistency, and solving problems during the data collection. Any doubt on data collection process was handled by the principal investigator timely.

4.3.8 Data quality assurance

The data gathering instrument was pre-tested in another hospital (Yekatit 12) which is not included in the main study setting. Depending on the result, possible changes were made. For the pretest, about ten percent, which is 39 participants, were included. Furthermore, data collectors got one-day training on how to administer the questionnaire and check for completeness.

The principal investigator and supervisors were strictly following the data collector on a daily basis to ensure that the data is complete. During the research, data coding and data entry were double-checked. At the end of the data entry process, data was cleaned.

4.3.9 Data analysis

Data were cleaned and entered using Epi-Data version 4.2.0 and exported to SPSS version 26 for analysis. Summary statistics of mean and percentages were used to describe the study. The fitted bivariate logistic regression models were used to assess the association between each of the study outcomes and the different potential risk-factors. Then, multivariable logistic models were fitted to identify independent determinants of communication skill. For the multivariable regression modeling, the covariates were included in a model that was selected based on their bivariate association with the outcome, where variables with a P-value< 0.25 will be included. The adequacy of the models to predict the outcome variables was checked using the Hosmer–Lem show test. The strength of association between the different risk factors and the study outcomes was reported using crude and adjusted odd ratios, and the presence of statistically significant association was considered at p-value less than 0.05.

4.4 Qualitative methods

4.4.1. Study design

Descriptive, qualitative study was used; this study aims to gain a deeper understanding of laboring mother’s autonomy during giving birth.

4.4.2. Study participants

Purposive sampling was used with laboring mothers in selected hospitals during the data collection period. The study participants were selected on account of the researcher's assessment of people that are representative of the study phenomenon and the ability of the participant to provide information. A total of twelve (12) post-partum women were selected.

4.4.3. Eligibility criteria

4.4.3.1 Inclusion criteria

- ✓ who had given birth attended by a midwife/doctor within the data collection period
- ✓ provide written consent to participate in the study

4.4.3.2 Exclusion criteria

- ✓ Those who were not willing to participate.
- ✓ Those who were not adequately healed for the interview

4.4.4 Data collection tools and procedure

The data collection was conducted through in-depth interviews using semi-structured interview guide by the principal investigator. In addition to the principal investigator, one MSc. midwife who had qualitative data collection experience has been hired to take field notes. Before the interview, the interviewer and note-taker were discussing each question to verify that the notes and the interview were in sync.

The interview guide was prepared in English and translated into Amharic and translated back to English by a third person to check for consistency. Matching was made on the exact fitness of the two versions. Throughout the interviews, probes were used to offer clarification and encourag elaboration from the participants on specific issues or topics that are domains of interest to the researcher. Instead of relying on the number of participants, the research was focused on the quality of information from the participants and different perspectives and opinions of participants.

The laboring mothers who meet the eligibility criteria were contacted through the supervisor to discuss the purpose of the study, and requested participation in the study. The researcher was ensuring that all study participants who agreed to take part in the interviews were reminded of the purpose of the study, expected benefit, their right to withdraw from the study and protection of confidentiality before they signed consent forms. With participant approval, face-to-face interviews were used and audio-recorded prepared for analysis, which ensures a complete transcript and notes to capture the original accounts of the participant’s responses. We saw nonverbal clues from participants' actions, using this strategy, gave us a rich form of data. The interview guide contained a set of questions with probes to help drive the interview in a conversational manner in a specific direction. The interviews were held in the postnatal area; by using screens, we made sure the place was private as possible.

4.4.5 Trust worthiness

Credibility

To ensure credibility, the researcher discussed data coding, data analysis, and interpretations continuously throughout the research process with peers. Member checking with participants was also carried out by probing questions, and these occurred by reiterating statements made by participants.

Dependability

Reviewing the audio recording and writing notes allowed facilitation to confirm the manual transcription. The procedure of data collection, processing, and study findings were assessed by peers who did not participate in data analysis.

Transferability

The investigator provided details to explain the entire research procedure, starting from data collection to the final report.

Conformability

In order to achieve conformability, field notes were taken; furthermore, each interview was tape-recorded, therefore the raw data is available. By refining the data collection instrument in the course, by using codes and categorization and by developing themes from the coded data, the data was analyzed without personal biases by using participants' own words instead of the researchers' opinions and biases.

4.4.6 Data analysis

Data collection and analysis were carried out in conjunction with each other. Data was evaluated immediately after each in-depth interview. After frequently listening to the tape recorder to grasp each respondent's concepts, the audio record data was transcribed verbatim in Amharic of each interview at the same time. The researcher was making sure that transcriptions were precise and that they reliably reflect the interview experiences.

Furthermore, field notes were taken concerning the participant's gesture, tone, and language in doing so. To explore participant autonomy a thematic analysis was conducted, translate the data into English and write it down. The translated data was imported to qualitative data analysis software ATLAS 9. And inductively analyzed following the principles of thematic analysis.

4.5 Ethical consideration

Ethical clearance was acquired from the institutional review board of the department of nursing and midwifery, college of health sciences, Addis Ababa University. The letter was attained from the department of nursing and midwifery to the ministry of health bureau and to each selected hospital administrative office. The respondents were informed about the study's objective and aim, and written consent was obtained from each individual. The participant right to refuse to participate in the study or

to withdraw at any moment was stated at the beginning of the interview and was respected as an individual decision if one wants to withdraw or refuse to participate in the study. The information was collected anonymously and kept confidential.

4.6. Plan for dissemination

The findings of this study will be presented to the Addis Ababa University School of Nursing and Midwifery, the College of Health Science Post-Graduate Study, the Postgraduate Library, and the Addis Ababa Health Office, A strong effort will be made to present findings at scientific conferences and to publish in peer-reviewed publications.

CHAPTER FIVE

5. RESULT

5.1 Quantitative result

5.1.1 Sociodemographic characteristics of the study participants

In this study 181 study participants were involved quantitatively, making a response rate of 98.4%. Almost eighty-two percent of the study participants (148) were midwives, and 54.7 % (99) were male. Seventy percent of the study participants were in the age group of 21-30 years with a mean and SD of 28.56±3.10 years. Fifty-five percent of the study participants were single, 50.3% had 2-4 years of experience, 77.3% were degree holders and 43.1% of the participants had 3.6 years of experience in the current workplace.

Table 1. The sociodemographic characteristics of the study participants who work in the government hospitals of Addis Ababa

Variable	Frequency	Percent
Position		
Gynecologist	2	1.1
General practitioner	6	3.3
Midwife	148	81.8
Residents	24	13.8
Sex		
Male	99	54.7
Female	82	45.3
Age in years		
21-30	126	69.6
31-40	55	30.4
Current marital status		
Married	78	43.1
Single	100	55.2
Divorced	3	1.7
Work experience		
<2	32	17.7
2-4	91	50.3
>4	58	32
Highest educational status		
Degree	140	77.3
MSc	18	9.9
Doctoral degree	23	12.7
Experience in current work place		
≤2	64	35.4
3-6	78	43.1
>6	39	21.5

5.1.2 Work environment related characteristics of the study participants

Almost fifty-two percent of the study participants worked>5 days per week, and 63% were working 41-89 hours in a week. Forty-six percent of the participants were conducting 2-5 deliveries per day, and 91.2% of the participants believe that there is a work load during labour follow up and conducting delivery. Seventy-six percent of the study participants agreed that communication was affected by workload.

Table 2. Work environment related characteristics of the study participants

Variable	frequency	Percent
worked days per week		
≤5	87	48.1
>5	94	51.9
Number of hours worked per week		
≤40	52	28.7
41-89	114	63
90-100	15	8.3
Number of deliveries conducted per day		
≤2	73	40.3
2-5	84	46.4
>5	24	13.3
Presence of work load when you follow and conduct delivery of the baby?		
Yes	165	91.2
No	16	8.8
work load during delivery affects the communication with the laboring mother?		
Yes	138	76.2
No	43	23.8

5.1.3 The study participants awareness on labouring mother communication and autonomy

Ninety-nine percent of the study participants believe that good communication skills are important for enhancing quality of care and 97.2% of the participants know the need for knowledge and communication skills for better interacting with labouring mothers. Ninety-six percent of the participants believe that they have the necessary knowledge and skills to interact with the laboring mothers, and 50.3% of the study participants had training on better interaction with labouring mothers.

Twenty-one percent of the study participants never forget calling labouring mother by their name, and 50.8% of the study participants inform laboring mothers about every intervention performed most of the time. Sixty- seven percent of the study participants forgot few time to inform the labouring mother about the types of procedures performed, and 49.2% of the study participants did not feel uncomfortable when the labouring mother called them by his/her name.

Table 3. The study participants' awareness on laboring mother communication and autonomy

Variable	frequency	Percent
Good communication skill is important for enhancing quality of care?		
Yes	179	98.9
No	2	1.1
knowledge and skill of communication is needed to better interact with labouring mothers		
Yes	176	97.2
No	5	2.8
believe that you have the necessary knowledge and skill to interact with the laboring mothers?		
Yes	174	96.1
No	7	3.9
Ever had training on how to better interact with laboring mothers?		
Yes	91	50.3
No	90	49.7
Do you think it is necessary to have training on how to better interact with patients		
Yes	162	89.5
No	19	10.5
Do you forget to call laboring mothers by their name?		
Never	38	21
few times	139	76.8
most of the time	4	2.2
Do you think it is necessary to inform laboring mother about every intervention you performed?		
Never	7	3.9
few times	38	21
most of the time	92	50.8
all the time	44	24.3
Do you forget to inform laboring mother about procedure you performed?		
Never	42	43
few times	121	66.9
most of the time	16	8.8
all the time	1	0.6
Do you feel un comfortable when laboring mother calls you by your name?		
Never	89	49.2
few times	85	47
most of the time	6	3.3
all the time	1	0.6
Do you feel comfortable when laboring mother does not know your name /position?		
Never	90	49.7
few times	86	47.5
most of the time	3	1.7
all the time	2	1.1

5.1.4 Laboring mother related characteristics on communication and autonomy

Fifty-eight percent of the study participants believe that laboring mother wants to be informed about every intervention most of the time, 77.3% of the participants think that the laboring mother understands what the providers says most of the time, and 73.5% of the participants answered that a lack of understanding on the mother's side affects communication a few times.

Table 4. Laboring mother-related characteristics on communication and autonomy

Variable	frequency	Percent
Do you think laboring mothers want to be informed about every intervention?		
Never	12	6.6
few times	19	10.5
most of the time	105	58
all the time	45	24.9
During communication, does the laboring mother understand what you are saying?		
Never	5	2.8
few times	19	11
most of the time	141	77.3
all the time	16	8.8
Does lack of understanding on the mother's side affects your communication		
Never	16	8.8
few times	133	73.5
most of the time	27	14.9
all the time	5	2.8

5.1.5 Communication and labouring mother autonomy related characteristics of the study participants

The findings of the study showed that 45% of the study participants had good communication and respects a laboring mother autonomy; as shown in the figure below.

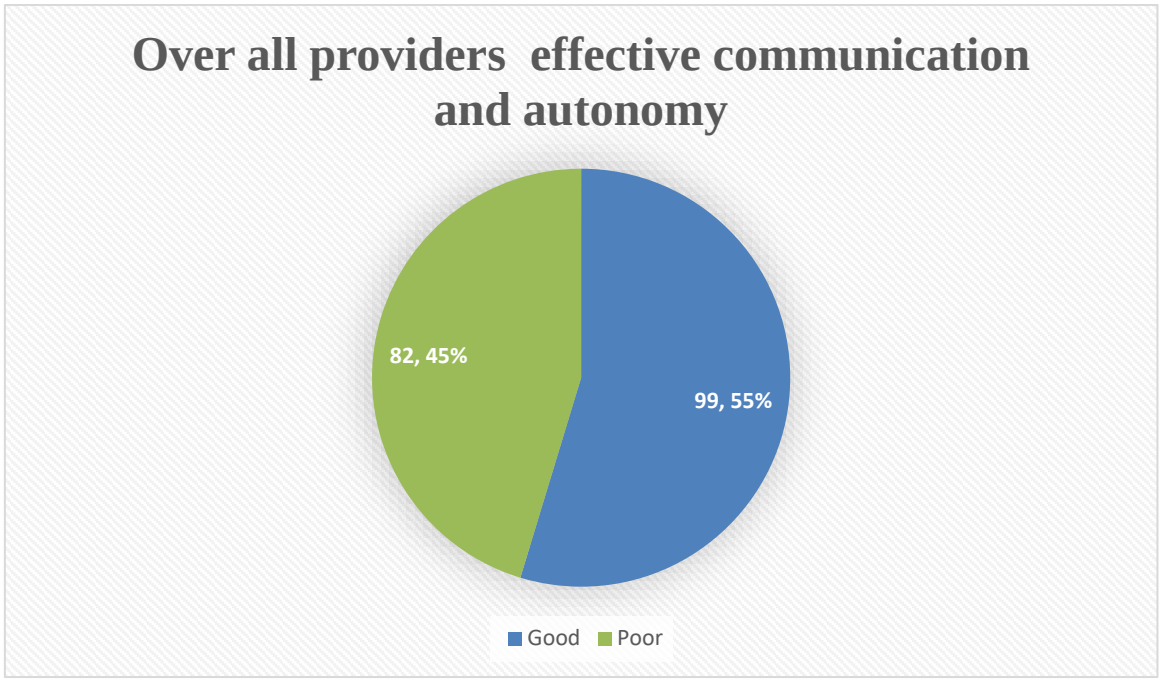

Figure 2. Overall providers' effective communication and autonomy.

5.1.6 Communication related characteristics of the study participants

In this study, 49% of the study participants had good communication with labouring mothers, while 51% had poor communication, as shown in the figure below.

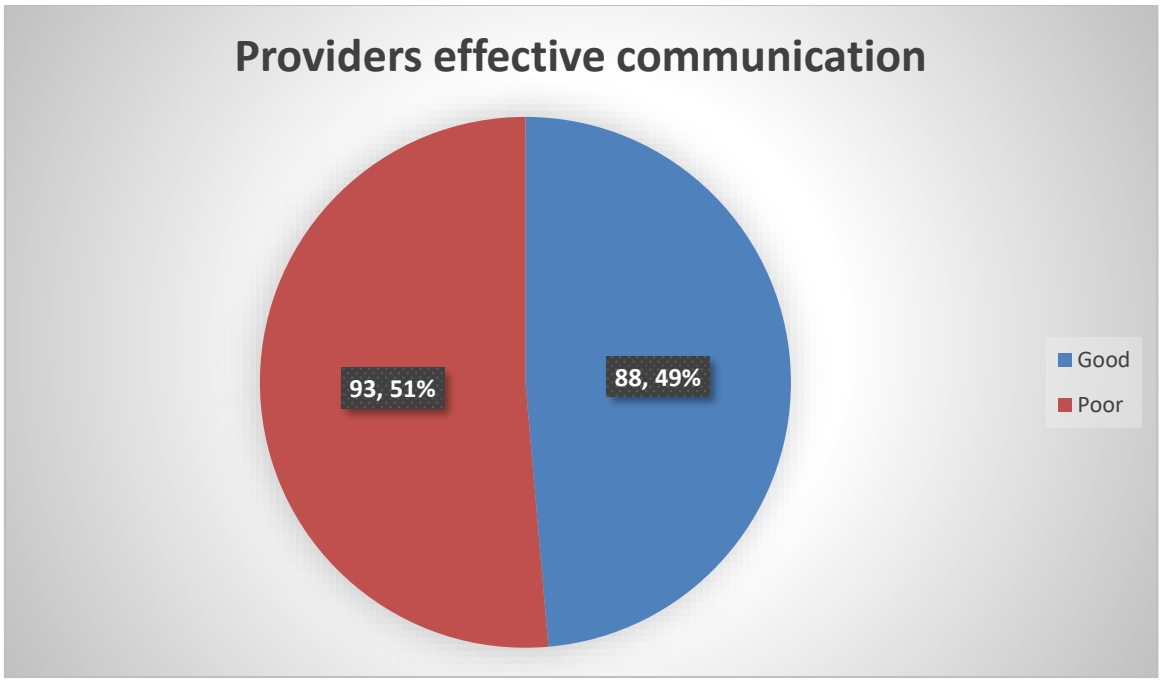

Figure 3. Providers' effective communication

Concerning the specific communication measurement, eighty-five percent of the study participants were thinking laboring mothers fear of abuse affects communication a few times, and 9.9% of the study participants thinks they never introduce their profession and themselves to laboring mothers. Forty percent of the study participants introduced themselves most of the time when they first saw the laboring

mother and 10.5% of the study participants called the woman by her name all of the time. Almost half of the study participants referred to the woman by her name most of the time, and 47% of the participants explained the place and time of the procedure most of the time.

Forty-six percent of the study participants most of the time explain why they give laboring mothers medication, and 42% of the participants explain the side effect most of the time. Forty-one percent of the study participants were asking permission/consent for a procedure a few times, and 43.1% of the participants had an experience of informing the family about the care of the women few times. Fifty-eight percent of the health professionals speak to women in a language they understand most of the time, and 61.3% of the participants believe that it is very important to introduce themselves, as shown in the table below.

Table 5. Communication related characteristics of the study participants

Variable	Response	frequency	percent
Do you think laboring mother's fear of abuse by the health professional'saffect communication?	Never	13	7.2
	few times	153	85.1
	most of the time	11	5.5
	all the time	5	2.2
Do you think the doctors, midwifes, or other health care providers introduce themselves?	Never	18	9.9
	few times	88	48.6
	most of the time	64	35.4
	all the time	11	6.1
Do you introduce yourself to the women when you first see them?	Never	22	12.2
	few times	72	39.8
	most of the time	73	40.3
	all the time	14	7.7
Do the doctors, midwives, or other health care providers call women by their name?	Never	4	2.2
	few times	83	46.4
	most of the time	74	40.9
	all the time	20	10.5
Do you refer to women by their names?	Never	7	3.9
	few times	53	29.3
	most of the time	90	49.7
	all the time	30	16.6
Do you explain to women why when you are doing examinations or procedures on them?	Never	2	1.1
	few times	58	32
	most of the time	85	47
	all the time	35	19.9
Do you explain to women why you are giving them medicines?	Never	2	1.2
	few times	62	34.3
	most of the time	84	46.4
	all the time	33	18.2

Do you describe possible side effects in a way that a patient could understand?	Never	7	3.9
	few times	77	42.5
	most of the time	76	42
	all the time	21	11.6
Do the doctors, midwives or other staff at the facility ask women's permission/consent before examinations and procedures?	Never	7	3.9
	few times	74	40.9
	most of the time	71	39.2
	all the time	29	16
In your experience, are women or families given information about their care?	Never	7	3.9
	few times	78	43.1
	most of the time	72	39.8
	all the time	24	13.3
Do you feel women can ask you any questions they have?	Never	4	2.2
	few times	67	37
	most of the time	76	42
	all the time	34	18.8
Do the doctors, midwives or other staff at the facility answer questions family have?	Never	3	1.7
	few times	53	29.3
	most of the time	105	58
	all the time	20	11
Do the doctors, midwives or other staff at the facility speak to women in a language they understand?	Never	3	1.7
	few times	73	40.3
	most of the time	105	58
Do you think it is important to introduce yourself to patients?	not important	3	1.7
	somewhat important	67	37
	very important	111	61.3
Do you think it is important to call women by their names?	not important	4	2.2
	somewhat important	46	25.4
	very important	131	72.4
Do you feel it is important for doctors, nurses or other staff at the facility to ask permission or consent before procedures	not important	3	1.7
	somewhat important	46	25.6
	very important	131	72.8

5.1.7 Laboring mother autonomy related characteristics of the study participants

The findings of the study showed that 49% of the study participants perceived good maternal autonomy respect, while 51% of the study participants had poor respect for autonomy.

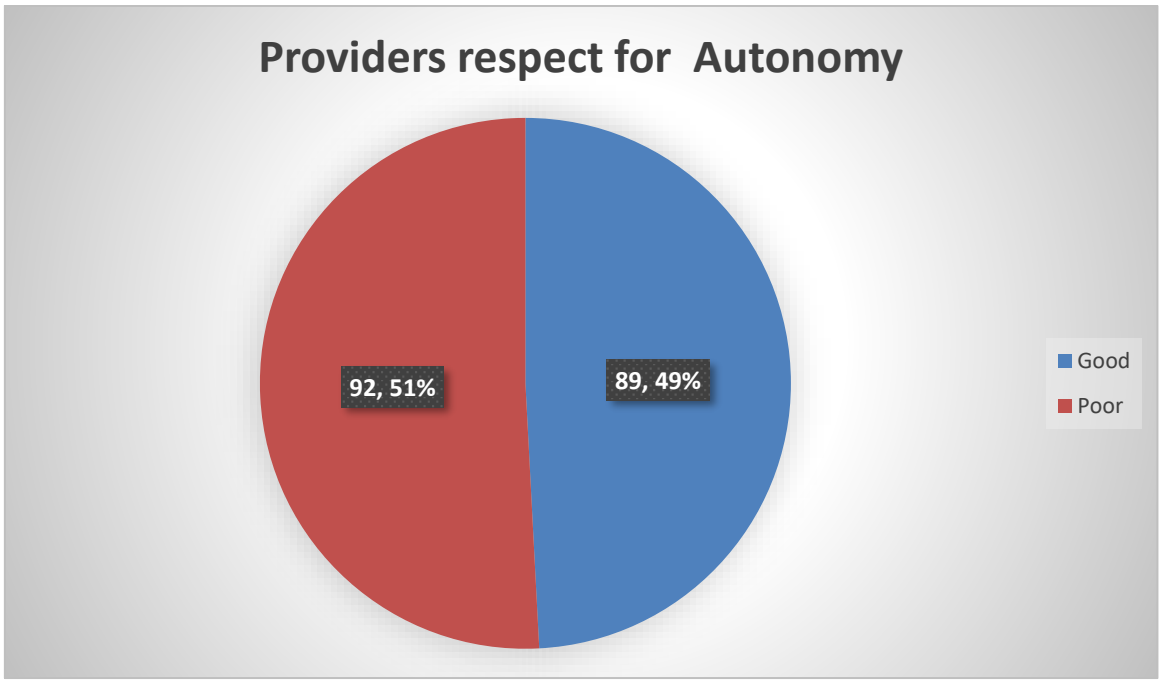

Figure 4. Providers' respect for autonomy.

Forty-eight percent of the study participants thinks most of the time the final decision should always rest with the women, and 49.7% of the participants think few of the time override the needs of the mother for the safety of the neonate, and 43.6% of the participants believe encouraging women to have more control over their child bearing compromises safety a few times. Fifty-seven percent of the study participants think it is very important to involve women or their families in decisions about their care. Almost nineteen percent of the study participants feel like women are able to be in the position of their choice during delivery all the time, and 21% of the participants were involved in all decision making in receiving care.

Table 6. Laboring mother autonomy related characteristics of the study participants

Variable	Response	percent	frequency
In collaborative practice, do you think the final decision should always rest with the women	Never	3	1.7
	few times	53	29.3
	most of the time	87	48.1
	all the time	38	21
For the safety of the baby do you think the maternity care team needs to override the needs of the women	Never	24	13.3
	few times	77	49.7
	most of the time	58	29.8
	all the time	22	7.2
Do you think encouraging women to have more control over their child bearing compromises safety	Never	16	8.8
	few times	79	43.6
	most of the time	53	29.3
	all the time	33	18.2
Do you think is important to involve women or their families in decisions about their care	not important	3	1.7
	somewhat important	75	41.4
	very important	103	56.9
	Never	18	9.2
	few times	73	40.3

During delivery, do you feel like women are able to be in the position of their choice?	most of the time	56	30.9
	all the time	34	18.8
Do you feel like the doctors, midwives or other staff at the facility involves women in decisions about their care?	Never	5	2.8
	few times	60	33.1
	most of the time	78	43.1
	all the time	38	21

5.1.8 The determinant factors of health providers communication and keeping laboring mothers autonomy

The strength of association was measured using the odd ratio and 95%CI. Accordingly, sex of the study participants, number of working days per week, and working hours per week, number of deliveries attended per day had an association by bivariate logistic regression. The multivariate logistic regression revealed that study participants whose profession is midwife were 4.7 folds had good perception on communication and autonomy of labouring mother compared to those of resident (AOR=4.7, 95%=1.66, 13.57) and study participants whose sex of male were 2.8 times had good perception on communication and autonomy compared to female (AOR=2.8, 95%CI=1.36, 5.55). Study participants who attend 2-4 and, >4 labour per day were 2.9- and 3.7-times had good communication and autonomy compared to those of who attend <2 labour per day (AOR=2.9, 95%CI=1.33, 6.49 & AOR=3.7, 95%CI=1.23, 10.81 respectively).

Table 7. The bivariate and multivariate logistic regression of association between dependent and independent variable among health provider work in government hospital Addis Ababa

Variable	communication and Autonomy		p-value	COR with 95%CI	P-Value	AOR with 95%CI
	good	poor				
Profession						
Gynecologist	2	0				
GP	4	2	0.187	3.6(0.54, 23.39)	0.166	4.3(0.54, 34.57)
Midwife	84	64	0.059	2.3(0.97, 5.62)	0.004	**4.7(1.66, 13.57)**
Resident	9	16	1		1	
Sex						
Male	63	36	0.008	2.2(1.23, 4.067)	0.005	**2.8(1.36, 5.55)**
Female	36	46	1		1	
Working days per week						
≤5	41	46	1		1	
>5	58	36	0.050	1.8(1.00, 3.27)	0.323	1.4(0.71, 2.82)
Working hours per week						
≤40	23	29	1		1	
41-89	66	48	0.103	1.7(0.89,3.36)	0.528	1.3(0.58, 2.89)
>90	10	5	0.132	2.5(0.76, 8.41)	0.959	0.96(0.23, 3.98)

Number of deliveries attended per day						
≤2	30	43	1		1	
2-4	53	31	0.006	2.5(1.29, 4.66)	0.008	**2.9(1.33, 6.48)**
>4	16	8	0.033	2.9(1.09, 7.55)	0.019	**3.7(1.23, 10.81)**
Follow labour and conduct delivery is a work load						
Yes	93	72	0.155	2.2(0.75, 6.20)	0.697	1.2(0.39, 4.02)
No	6	10	1		1	
Training necessary for interact with patient						
Yes	92	70	0.105	2.3(0.84, 6.02)	0.062	3.0(0.95, 9.65)
No	7	12	1		1	

5.2 Qualitative result

5.2.1. Participants characteristics

A total of twelve (12) postpartum women were recruited for the qualitative research. The mean age of the women was 27.1 (±4.48 SD) ranging from 19-35 years. Regarding the numbers of children they gave birth, almost half of them had 2 children, and only one mother had 4 children as a maximum. Concerning the marital status 89% of them were married women, and only one woman was single mom. The socio-demographic characteristics has shown in (table 8).

Table 8.Socio-demographic characteristics of the study participants (Qualitative).

Participants code	Age	Marital Status	Numbers of children	Religion
Participant 1	35	Married	2nd	Protestant
Participant 2	30	Married	3rd	protestant
Participant 3	28	Married	2nd	orthodox
Participant 4	25	Married	1st	orthodox
Participant 5	22	Married	2nd	Muslim
Participant 6	19	Single	1st	orthodox
Participant 7	30	Married	4th	orthodox
Participant 8	26	Married	2nd	Muslim
Participant 9	29	Married	3rd	protestant
Participant10	30	Married	2nd	Muslim
Participant 11	24	Married	2nd	Orthodox
Participant 12	32	Single	3rd	Orthodox

5.2.2. Emerged Themes

Four themes and eight sub-themes emerged from the analysis of the client's in-depth interview. The themes were identified as rich and detailed accounts of the perspectives of health professional's communication and laboring

mother's autonomy during giving birth in selected governmental hospitals in Addis Ababa, Ethiopia. These themes, with their respective sub-themes, have been summarized by the following table.

Table 9. Themes and sub-themes constructed from postpartum women in-depth interviews about their autonomy during labor and delivery

Theme	Sub-theme	Codes
Autonym violation due to care Discrimination	Care discrimination based on perceived merit	Care discrimination based on relationship
		discrimination for knowledgeable woman
	Care discrimination for un-cooperative woman	Care discrimination for a care complainer woman
Autonomy violation due to Informed consent issues	Inadequate information	provider self-introduction
	Doing procedures without client permission	client permission
Autonomy violation due to limited decision-making powers	Maternal side decision making constraints	Woman Under labour pain
		Laboring mother with no birth companion
	Health care provides attitude and practice	provider exclude woman in decision making process
		woman's being knowledge deficits Relying on care provider for decision making
Autonomy violation due to providers unethical behavior	Bodily physical infringement	provider discourage woman not to ask questions
	Disrespecting the labouring woman	provider not keeping physical privacy

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Theme I: Autonomy Violation Due To Care Discrimination

Autonomy violation due to health care discrimination, according to this study includes care discrimination based on the merit of labouring mother and care discrimination for an un-cooperative woman.

Care discrimination based on perceived merit

According to the data in this research, healthcare providers prioritize the care of a labouring mother who has a close relationship with them and is perceived as more educated over another who is considered less deserving due to her knowledge or lifestyle choices

'…Yes, there was a mother who is a staff member at the hospital, they were explaining things to her. Talking to her, encouraging her a lot, checking the baby a lot. They allowed her mother to be there with her all the way. But for us, if a family enters, they just call the security to let them (the family members) out. They didn't treat us the same way as her' (interview7, 30 years old)

Another 28 year old lady confirms that health care providers are doing better treatment for labouring women who have know-how about their treatment than those who were unaware of their care processes.

'Yes, after making sure that I understand what they are doing, but they are not doing the same for others; they were giving me information not all but most of them.'(interview 3, 28 years old).

Care discrimination for uncooperative women

Labouring mothers in this study felt pressured to conform to what healthcare providers think is best rather than what she genuinely preferred. This can include pressure to accept certain medical interventions that do not align with the mother's wishes. Otherwise, she would refuse or complain about this intervention, and health care providers would not volunteer to do further treatments for her.

They (healthcare providers) *were angry because I wasn't cooperating, and they were also saying they are very busy and have no time for this nonsense. They told me to stop these jokes and so to continue what they are doing. They refuse to give me any other treatment if I don't get the medication. At the end, I agree to receive the medication (interview 3, 28 years old).*

The other 25 year old lady also added, while she refused her frequent vaginal examination, the healthcare providers insulted her and they would not see her any more.

'When I was admitted to the labour ward, they told me the labour is just starting and they are going to see my uterus after 4 hours. But after 1 hour and 30 minutes they went home, and the night shift just started, so they came to check my uterus again, and I told them it had only been 2 hours, so I refused. They were angry at me, one of them even told me he does not even want to see me if it was up to him. He said do not act like I have an addiction to see your uterus (interview 1, 25 years old).

THEME II: AUTONOMY VIOLATION DUE TO INFORMED CONSENT ISSUES

Informed consent is a fundamental ethical and legal principle in healthcare, requiring that patients receive adequate information about the risks, benefits, and alternatives of any procedure or intervention. In this

study Healthcare providers failed to fully explain their profile of the procedures and obtain voluntary informed consent.

Inadequate information

Even though effective communication is a key to ensuring autonomy, this study revealed healthcare providers do not explain procedures, the care plans, or even who they are to the labouring mother**.**

'…the specialist doesn't talk to you, he talks to the midwife, he gave her the instruction to prepare for a caesarean section and I just heard them. Since I didn't have other choice, I agreed with their decision. Overall, they don't explain things well, and they don't consider you or your feelings (interview 6, 19 years old).

They are a lot in number who speak to me, I didn't even know which one is responsible for me, and they just do what they have to do. They do not speak to you. If there is a new thing, they will talk and discuss it with each other not with me. They just tell you what to do. They don't wait for your response. They don't involve you. They think you know what comes next, the whole process. The doctors said to me, you're already a mom, how do you not know when the baby comes. How could I? She continues… *they don't tell you much in the hospital. You get more information from other moms who go through these process (interview 7, 30 years old).*

Doing procedures without client permission

Informed consent is a fundamental ethical and legal principle in healthcare, requiring that patients receive adequate information about the risks, benefits, and alternatives of any procedure or intervention. But some health care providers in the study breach these principles.

'Some of them tell you what they are doing and others do not. But mostly they make the decision by themselves and inform you just for you to allow it. Some of them even do not tell you what is going on, they just do what feels right to them without even asking you' (interview 4, 25 years old).

The 19 and 30 year old ladies, respectively, elaborate the idea more about why and how healthcare providers breach these consent principles.

'….They do not listen when you say no. They do not respect you. They just do everything without your approval. They did not inform you even. They want us to listen to them' (interview 6, 19 years old).

Because they think we do not know anything. They think they are better. and also they think they are responsible for what is going to happen to us, so they just take all the decisions for themselves. I didn't decide anything (interview 7, 30 years old).

THEME III: AUTONOMY VIOLATION BY LIMITED DECISION MAKING POWERS

Several factors have contributed to the violation of labouring mothers by limiting their ability to participate fully in decision making in their labour and delivery: Maternal side decision making constraints and health care provides attitude and practice have emerged as sub-themes.

Maternal side decision making constraints

The absence of a supportive partner, family, and friends significantly affects a woman's confidence and ability to make decisions. In addition to the absence of the birth campaign, the intense pain and exhaustion associated with labour could impair cognitive function and the ability to make clear decisions.

'...yes, because when you are in pain and alone you might decide or do things that are not beneficial either to you or the baby. So in this case, if someone decides something that is dangerous to the health of the baby, the doctors must intervene and override there decision' (interview 3, 28 years old)

They left me with the doctors, I was crying a lot because I felt lonely; if my family were with me, they would have done something…. (Interview 4, 25 years old).

'....but I would have liked even more if my mother could have been with me, she would have kept my spirits up and the midwife to attend to the delivery' (interview 6, 19 years old).

Health care provides attitude and practice

Some healthcare providers, according to this research, have paternalistic approach, believing that they know what is best for the labouring mother without adequately involving her in the decision making processes.

They just do what they feel like is the right thing to do. They assume we do not know anything, and they think it is very hard to make us understand. They just make the decision for us (interview 3, 28 years old).

The other postpartum woman supports the idea by saying they were occasionally included in decision processes.

'.... if you have been told what is going on and what your choices are .I will make a good decision too. I didn't want to stress out the midwives by asking them what they were doing, I didn't want to be seen as if I was not trusting them because they say that the more you complain, the worse they treat you, so because of that, I wanted to avoid that' (interview 6, 19 years old.)

THEME IV: AUTONOMY VIOLATION DUE TO PROVIDER'S UNETHICAL BEHAVIOUR

Disrespecting the laboring woman

Disrespecting the labouring woman could manifest as healthcare providers insult the woman, ignore her requests, fail to communicate with her, and so on.

'Before coming here, a mother told me they will disrespect and insult you…. don't go there …go to private hospital;I didn't listen to her; I thought she was just exaggerating things, and the system has changed. I heard what a good job they are doing. Now I regret my decision a lot. I wish I had gone to private… at least they would check me'(Interview 7, 30 years old).

Another labouring woman added: *Before coming here, I was told that some nurses are rude and that they shout at patients, but for me, all has been well. (Interview 8, 26 years old).*

Bodily physical infringement (breaching physical privacy)

Bodily physical infringement on labouring woman occurred during performing vaginal examination in a condition where many health care providers watching, the woman without her informed consent.

'When they did my pelvic exams, there were like four people watching, and they didn't close the curtains. I felt very embarrassed. I just want them to go away .I could not ask any question in that situation. I could not even speak .I was very demotivated to talk' (interview 6, 26 years old).

CHAPTER SIX

6. DISCUSSION

In this study the overall communication and autonomy of the laboring mother recognized by provider were 55%, the overall good communication of the provider for labouring mother were 49% and respect for autonomy were 49%. This finding was lower than the study done in Kenya (11). This was may be due to high patient loads and time pressures limit the amount of time providers spend with each patient, leading to poor communications and decisions. Strict adherence to institutional protocols and guidelines can sometimes override individual patient preferences and autonomy. Under-resourced healthcare settings may lack the necessary infrastructure or staffing to support personalized care and effective communication and medical education often prioritizes clinical skills over communication skills, leaving providers less equipped to engage in effective, empathetic communication with laboring mothers.

Ten percent the study participants never introduced themselves. This finding was better than the study done in Kenya. These is as evidenced by in Kenya 77% reported that providers never introduced themselves to them (21). This difference was may be due to the study participants' knowledge and awareness difference on patient communication and autonomy. On the other had in the current study 9.2% of the study participants never allowed to deliver in a position of their allowed. The finding was lower than the study done in Kenya (21). This was may be due to cultural beliefs and norms about childbirth can influence communication and autonomy. For example, some cultures prioritize medical authority and compliance, while others emphasize personal autonomy and natural birthing practices. Healthcare systems and practices vary widely between countries and regions. Studies conducted in different geographic locations may reflect these systemic differences.

Sixty one percent of the participants knows the very importance of introducing themselves for the women. This finding was supported by the study done in Addis Ababa (22). This may be due to the fact that in high-volume settings or emergency situations, providers might give brief introductions to focus more on immediate medical needs. Some hospitals have standard procedures that require detailed introductions, including the role and qualifications of each staff member. Some providers and mothers prefer a direct, straightforward approach, while others might favor a more indirect and conversational style, impacting the length and depth of introductions.

The study participants whose profession is midwife were 4.7 folds had good perception on communication and autonomy of labouring mother compared to those of resident (AOR=4.7, 95%=1.66, 13.57). This finding was congruent with the study done in Australia (23).This may be due to the fact that midwifery care typically emphasizes a holistic, woman-centered approach that focuses on empowering

the mother, providing continuous support, and respecting her preferences and choices. Midwives often provide continuous care throughout pregnancy, labor, and postpartum, which helps build a strong, trusting relationship with the mother. Midwives are trained extensively in effective communication skills, including active listening, empathy, and providing clear, understandable information. Midwives are trained to advocate for the mother's wishes and to support her in making informed choices about her care, which enhances their autonomy and ability to communicate effectively.

Study participants whose sex was male had 2.8 times better perception of communication and autonomy compared to females (AOR=2.8, 95%CI=1.36, 5.55). When considering why male healthcare providers might exhibit good communication and autonomy in supporting laboring mothers, it's essential to understand that these qualities are influenced by individual skills, training, and experience rather than gender alone. On the other hand male providers are dedicated to offering the highest standard of care, focusing on the needs and preferences of the mother, which involves excellent communication and respecting her autonomy.

Study participants who attend 2-4 and >4 labour per day had 2.9- and 3.7-times better communication and autonomy compared to those who attend <2labour per day (AOR=2.9, 95%CI=1.33, 6.49 & AOR=3.7, 95%CI=1.23, 10.81 respectively). This may be due to years of experience in delivering babies, and managing labor can enhance a provider's confidence and autonomy, allowing them to make informed decisions and communicate effectively. Over time, providers refine their communication techniques, learning how to convey information in an accessible and reassuring manner. Experience helps providers develop greater empathy and active listening skills, which are crucial for understanding and addressing the concerns of laboring mothers.

Similarly, findings from the qualitative parts of this study revealed that, postpartum women experienced various autonomy violations during their labour and delivery time; including autonomy violations in terms of care discrimination, informed consent issues, limited decision making power, and unethical behaviors on the side of healthcare providers. However, according to the, International Planned Parenthood Federation Charter on Sexual and Reproductive Rights, 1996, Article 2 and 6 declaration, “Every woman has the right to autonomy, self-determination, and freedom from coercion” and “Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during labour and delivery care” ,respectively (28).

This research indicates that healthcare providers violate labouring woman autonomy by offering biased care to them. They provide enhanced care for labouring women who they perceive as knowledgeable and with whom they share a close relationship. Women who lack knowledge or a close relationship with their providers we received less attention, potentially affecting their birthing experience and outcomes. Unequal care significantly influenced the autonomy of the labouring mother and inadvertently led to the

development of sense of discrimination for those who received less care. This care discrimination might happen due to health care providers' perception that knowledgeable women know when wrong care is provided to them and would accuse them, whereas uneducated women wouldn't do such a thing.

The other persuasive point is that many postpartum women described the violation of their autonomy during labouring time as the issue of informed consent. They were mistreated by healthcare providers both in terms of adequate information provision and performing medical procedures without their full approval. This finding was supported by a mixed-method systematic review of 65 studies from 34 countries. Which found that women did not provide consent for medical procedures, and they were not always adequately informed for the risks and benefits and felt that the health worker only went through the gesticulations of obtaining consent. (29). This failure to meet professional standards of care could be due to the exhaustion of healthcare providers, as these huge hospitals accept numbers of patients with few healthcare providers who work without adequate rest.

Based on this finding, the limited maternal decision making process was another aspect of to the infringement of laboring woman autonomy. These constraints emanate from both the maternal side; like labor pain and lack of birth companionship, and the healthcare provider sides; providers exclude labouring mothers from participating in decision making processes, and women themselves leave the decision for the healthcare providers. This might be an incorrect perception held by health care providers that non-medical women have not enough knowledge to participate in medical care decisions. However, American College of Obstetricians and Gynecologists (ACOG) stated that even during the pain, medications, and emotional roller coaster of childbirth, a labouring woman retains the right to control her body. Interventions during childbirth, whether on the mother's behalf or on behalf of her fetus, cannot be performed without her participation in the decision-making course and informed consent (30).

7. LIMITATION OF THE STUDY

- This study did not asses women's communication skill.
- The other limitation is the effect of social desirability bias, as providers were requested to state on their personal behaviors. I did not have the resources to conduct observational study.
- Selection bias is also a potential bias, as the data represents the views of providers from high number of delivery hospitals, which might not be representative of all facilities in the city. As a result work load may be exaggeratedly represented because of these busier facilities.

8. CONCLUSION

Clear and compassionate communication from health providers plays a pivotal role in laboring mother's experience. But in these study the overall communication and autonomy of the laboring mother recognized by provider were only 55% and het determinant factor of communication and autonomy of the labouring mother recognized by the provider were profession of midwife (AOR=4.7, 95%=1.66, 13.57), sex of male (AOR=2.8, 95%CI=1.36, 5.55) and attends 2-4 and >4 labour per day (AOR=2.9, 95%CI=1.33, 6.49 & AOR=3.7, 95%CI=1.23, 10.81 respectively.

From these study, there was a lack of good communication skill and respect for autonomy. There were privation of autonomy which was revealed by autonomy violation due to care discrimination, Informed consent issues, maternal limited decision-making powers and providers' unethical behavior. Therefore, enhancing communication skill and respect the autonomy of laboring mothers by actively listening to concerns, preferences, and questions and using clear, jargon-free language when explaining procedures, options, and potential outcomes is needed from health professionals.

9. RECOMMENDATION

Clear and compassionate communication from health providers plays a pivotal role in a laboring mother's experience. Therefore, recommendations for each stakeholder are listed below.

For health care providers

To enhance communication and respect the autonomy of laboring mothers by actively listening to the laboring mother’s concerns, preferences, and questions.

Use clear, jargon-free language when explaining procedures, options, and potential outcomes. Maintain a compassionate tone and empathetic demeanor to create a supportive environment.

Ensure that the mother receives comprehensive information about her options, including the benefits, risks, and alternatives of any proposed interventions.

Respect the mother’s birth plan and preferences, adapting care to align with her individual needs and values whenever possible.

Engage in shared decision-making by involving the mother in discussions about her care. Encourage her to express her preferences and participate actively in the decision-making process.

Participate in regular training sessions focused on enhancing communication and interpersonal skills. Develop cultural competency to effectively communicate with and support mothers from diverse backgrounds.

Women should receive education/information from the professional’s on how the laboring process is going to take over.

For ministry of health and health facilities

Must prepare and update on-the-job training sessions that are regular and that focus on enhancing communication and respect for autonomy.

Increase the number of hospitals and health centers in order to reduce workload to the health professionals.

Increase the number of health professionals in order to reduce workload and improve quality of care by maintaining effective communication.

For educational institutions

Must plan and hold trainings that aim to make health care providers effective communicators who respect their patients and clients autonomy.

Must be included in every curriculum about good communication and respect for autonomy.

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APPENDIX - I

INFORMATION SHEET AND CONSENT FORM

ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING & MIDWIFERY

1. English version

Topic: Health professional's communication and laboring mother's autonomy during giving birth in selected governmental hospitals in Addis Ababa Ethiopia

Investigator Bezawit Worku

Introduction

My name is Bezawit Worku I am postgraduate student on maternity and reproductive health nursing at Addis Ababa University, collage of health science and school of nursing and midwifery. Currently I am conducting a research partial fulfillment of Master's Degree in maternity and reproductive health at Addis Ababa University. on Health professional's communication and laboring mother's autonomy during giving birth in selected governmental hospitals in Addis Ababa Ethiopia.

Purpose of the research

Questionnaires prepared to study Health professional's communication and laboring mother's autonomy during giving birth in selected governmental hospitals in Addis Ababa Ethiopia

Study procedure

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

The risks and benefits

The research will be carried out with no risk for the subjects. We would fully respect the individual, and the culture.

Confidentiality

Your name will not be written on any of the questionnaires forms. No individual response will be reported to anybody that is; your responses are completely confidential. You do not have to answer any questions that you do not want to response .It is true that the success of this study will depend on your response. Therefore, we thank you in advance and greatly admire your help.

Contacts

If you have any question, suggestion comments or anything that is not clear; please contact me;

Phone number: +251-911075036

Email: beziiiwork@gmail.com.

Finally, we would like to express gratitude for taking time to hear the information given and willing to participate in the study. If you are clear with the information provided and agree to participate, please sign the next page on the consent form

Consent form

Health professional's perception towards effective communication and laboring mother's autonomy during giving birth in selected governmental hospitals in Addis Ababa Ethiopia: a mixed method

1. English version

I, the undersigned individual, am oriented about the objectives of the study. I have informed that all of my information will be kept confidential and used solely for this study. In addition, I have been well informed that my name will not be asked and unique identification is not required. If I want to withdraw from the study anytime along the process, I will not be obliged to continue or give reasons for doing so. However, my agreement to participate in this study is with the assumption that, the information I provide will help greatly by providing information about Health professional's communication and laboring mother's autonomy during giving birth in selected governmental hospitals in Addis Ababa Ethiopia.

Signature; _____ Date; _____

No	Questions	Response
101.	Position	Gynecologist General practitioner Midwife Residents Others
102	Sex	Male Female
103	Age	
104	Current marital status	Single Married Widowed Others
105	religion	
106	How long have you been working in your profession	less than 2 years 2 to 4 years More than 4 years
107	Highest education status	
108	Experience in your current facility	0 to 2 years 3 to 6 years More than 6 years

Part two work environment related information

no	Questions	Response
201	Number of days worked per week	5 or fewer days More than 5 days
202	Number of hours worked per week	40 or fewer hours 90 to 100 hours More than 100hours
203	How many delivery do you conduct per a day?	2 or less than 2 deliveries 2 to 5 deliveries Greater than 5 deliveries
204	Do you think there is a work load when you follow and conduct delivery of the baby?	Yes no
205	Does work load during delivery affect your communication with the laboring mother?	Yes no

Part three health care professional's awareness

no	Questions	Response
301	Do you think good communication skill is important for enhancing quality of care?	Yes no
302	Do you think knowledge and skill of communication is needed to better interact with labouring mothers	Yes no
303	Do you believe that you have the necessary knowledge and skill to interact with the laboring mothers?	Yes no
304	Ever had training on how to better interact with laboring mothers?	Yes No
305	Do you think it is necessary to have training on how to better interact with patients	Yes no
306	Can you mention the elements of good communication skill	1.active listening

		2.carity 3soothing 4.show empathy 5 honesty and respect 6others specify
307	Do you forget to call laboring mothers by their name?	Yes no
308	Do you think it is necessary to inform laboring mother about every interventions you performed?	Yes no
309	Do you forget to inform laboring mother about procedure you performed?	Yes no
310	Do you feel un comfortable when laboring mother calls you by your name?	Yes no
311	Do you feel comfortable when laboring mother does not know your name /position?	Yes no

Part four laboring mother related

no	Questions	response
401	Do you think laboring mothers want to be informed about every intervention?	Yes no
402	During communication, does the laboring mother understand what you are saying?	Yes no
403	Does lack of understanding on the mothers side affects your communication	Yes no
404	Do you think laboring mother's fear of abuse by the health professional's affect communication?	Yes no

Part five-communication

no	Questions	Response
501	Do you think the doctors, midwifes, or other health care providers introduce themselves?	0 No, none of them 1 Yes, a few of them 2 Yes, most of them 3 Yes, all of them
502	Do you introduce yourself to the women when you first see them?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time
503	Do the doctors, midwives, or other health care providers call women by their name?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time
504	Do you refer to women by their names?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time

505	Do you explain to women why you are doing examinations or procedures on them?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time
506	Do you explain to women why you are giving them medicines?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time
507	Do you describe possible side effects in a way that a patient could understand?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time
508	Do the doctors, midwives or other staff at the facility ask women's permission/consent before examinations and procedures?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time
509	In your experience, are women or families given information about their care?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time
510	Do you feel women can ask you any questions they have?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all of the time
511	Do you feel women can ask you any questions they have?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all the time
512	Do the doctors, midwives or other staff at the facility answer questions family have?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all the time
513	Do the doctors, midwives or other staff at the facility speak to women in a language they understand?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all the time
514	Do you think it is important to introduce yourself to patients?	0 No, not important 1 Yes, somewhat important 2 Yes, very important
515	Do you think it is important to call women by their names?	0 No, not important 1 Yes, somewhat important 2 Yes, very important
516	Do you feel it important for doctors, nurses or other staff at the facility to ask permission or consent before procedures	0 No, not important 1 Yes, somewhat important 2 Yes, very important

Part six autonomy

no	Questions	Response
601	In collaborative practice ,do you think the final decision should always rest with the women	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all the time
602	For the safety of the baby do you think the maternity care team needs to override the needs of the women	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all the time
603	Do you think encouraging women to have more control over their child bearing compromises safety	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all the time
604	Do you think is important to involve women or their families in decisions about their care	0 No, not important 1 Yes, somewhat important 2 Yes, very important
605	During the delivery, do you feel like women are able to be in the position of their choice?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all the time
606	Do you feel like the doctors, midwives or other staff at the facility involves women in decisions about their care?	0 No, never 1 Yes, a few times 2 Yes, most of the time 3 Yes, all the time

This is all I want to ask you. Thank for spending your time and valuable information you gave us. Do you have any question that I can I address for you.

English version interview guide for qualitative

In depth interview for laboring mothers

After we get their permission we turn on the recorder and begin our conversation initial by thanking the interviewee.

Interview number: _____

Participant unique number_____

Interviewer name: _____

Code: _____

Start time: _____

End time: _____

Date of interview: _____

[Guidance for interviewer: PLEASE START RECORDING IMMEDIATELY AFTER you have received the consent of the respondent and she has given consent

1. Please tell me about yourself? A. How old are you? _____ B. What is your marital status? _____ C. What is your religion? _____ D. Where do you live? _____ E. How many years of schooling have you had? _____ F. How many children have you had? _____ Profession: _____
2. Do health professionals at the hospital involve you in decisions making about your health? (Probing importance in decision making?
3. Do you think the final decision about your condition during labour should rest with you? Why?
4. How do health professionals respect your autonomy when you gave birth? (tell me your experience)
5.Why do you think, some health professional's violate women's right for autonomy during labour?(probing; lack of knowledge women's side)
6. Do you think encouraging women to have more control over their child bearing compromises safety? Why?
7. Do you think that some laboring mothers are treated better or worse than other laboring mothers in terms of autonomy at health facilities? (Probe for issues related to age of woman, language or ethnicity, income, education, occupation etc.).
8.Do you think health professional's needs to override the decision of the laboring mother?(probe for issues related to position of their choice during delivery, For the safety of the baby)
9. In your opinion, what could be done so that the laboring mother's autonomy is respected during labor and childbirth at facilities?

Conclusion

I have finished my questions I am very happy with our interview You are very welcome if you have anything to add Before I turn off the recorder. Thank you very much for your time!!

አዲስ አበባ ዩኒቨርስቲ የጤና ሳይንስ ኮሌጅ

የነርሲንግና የሚድዊፈሪ ትምህርት ክፍል

የመረጃና የፈቃደኝነት ማረጋገጫ

የአማርኛ፡ትርጉም

በአዲስ አበባ ከተማ በተመረጡ የመንግስት ሆስፒታሎች ውስጥ በወሊድ ወቅት ጤና ባለሙያዎች ስለውጤታማ ተግባቦት እና እናቶቸ እራስን በራስ ስለማስተዳደር ግንዛቤ በሚል ርዕስ ላይ ጥናት በመስራት እንገኛለን።

የዋና፡አጥኚዉ፡ስም በዛዊት ወርቁ

መግቢያ

ይህ፡የመረጃ፡ወረቀት፡እና፡የስምምነት፡ቅጽ፡የተዘጋጀው፡ዋና፡ዓላማ በወሊድ ወቅት ጤና ባለሙያዎች ስለውጤታማ ተግባቦት እና እናቶቸ እራስን በራስ ስለማስተዳደር ግንዛቤ ለመልየት :ጥናት :እያደረግን: ነው።።።ዋና፡አጥኚዋ፡በአዲስ፡አበባ፡ዩኒቨርስቲ፡በነርሲንግ፡ትምህርት፡ቤት፡ውስጥ፡የማስተርስ፡ተማሪ፡ናት።

ዓላማውውስጥ በወሊድ ወቅት ጤና ባለሙያዎች ስለውጤታማ ተግባቦት እና እናቶቸ እራስን በራስ ስለማስተዳደር ግንዛቤ ለማወቅ ሲሆን ለማሻሻል :ይረዳል :ተብሎ :ይታመናል። ስለዚህ በዚህ ጥናት እንዲሳተፉ እንጋብዞታለን።

ሂደት

ለምርምር፡ሂደቱ፡አስፈላጊውን፡መረጃ፡መስጠት፡ይችላሉ፡የሚል፡እምነት፡ስላለን፡በምርምራችን፡ውስጥ፡

ንዲሳተፉ፡በአክብሮት፡ተጋብዘዋል።በጥናቱ፡ውስጥ፡መሳተፍ፡በፈቃደኝነት፡ላይ፡የተመሠረተ፡ነው።በመጠይቁ፡

ውስጥ፡ለመሳተፍ፡ፈቃደኛ፡ከሆኑ፡የስምምነት፡ቅጹን፡በመረዳት፡እና፡መፈረም፡ያስፈልግዎታል።ከዚያ

ምላሽዎን፡ለሚሰበስቡት፡ሰብሳቢዎች፡እንዲሰጡ፡ይጠየቃሉ።በተሳታፊዎች፡የተሰጠው፡ምላሾች፡እና፡

የተገኙት፡ውጤቶች፡ሁሉ፡በሚስጥር፡ይያዛሉ።ከአጥኝዎች፡ውጭ፡ማንም፡የእርሶን፡ማንነት፡ማወቅ;አይችልምበአሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ በወሊድና ስነ ተዋልዶ ጤና የማስተርስ ዲግሪ በከፊል ሙላት እያደረግኩ ነው።

ስጋት፡ወይም፡ምቾት፡የሚነሳ፡ነገር፡-በዚህ፡ጥናት፡ውስጥ፡በሚሳተፍበት፡ወቅት፡ምንም፡ዓይነት፡ችግር፡

አያጋጥምዎትም፡ነገር፡ግን፡ትንሽ፡ጊዜዎን፡ሊወስድ፡ይችላል፡እና፡ይህ፡ደግሞ፡ምቾት፡ላይኖረው፡ይችላል።

ምስጢራዊነት፡እና፡ማንነትን፡መደበቅ፡-ከዚህ፡ምርምር፡ፕሮጀክት፡የምንሰበስበው፡መረጃ፡በሚስጥር፡

ይጠበቃል።ከጥናቱ፡የሚሰበሰበው፡መረጃዎ፡በፋይሉ፡ውስጥ፡ይከማቻል፣እና፡ስም፡አይኖረውም፣ከዋና፡

መርማሪው፡በስተቀር፡ለማንም፡አይገለጥም።

የመቃወም፡ወይም፡የማስወገድ፡መብት፡-በዚህ፡ጥናት፡ውስጥ፡ላለመሳተፍ፡ሙሉ፡መብት፡አለዎት፡

(ለመሳተፍ፡ካልፈለጉ፡የተወሰኑ፡ወይም፡ሁሉንም፡ጥያቄዎች፡ላለመመለስ፡መምረጥ፡ይችላሉ)እና፡ይሄ፡

እርስዎን፡አይጎዳዎትም።እንዲሁም፡የዚህ፡ሆስፒታል፡ተገልጋይ፡እንደመሆኖ፡ምንም፡አይነት፡መብቶችን፡

ሳያጡ፡ከዚህ፡ጥናት፡የመገለል፡ሙሉ፡መብት፡አልዎት።

ለበለጠ፡መረጃ፡-ማንኛውም፡ጥያቄ፡ካለዎት፡በሚከተለው፡አድራሻ፡ዋና፡አጥኚዉን፡ማነጋገር፡ይችላሉ::

ስም በዛዊት ወርቁ

ስልክ:+251-911075036

ኢሜል: beziiiwork @gmail.com.

በዚህ፡ጥናት፡ውስጥ፡ለመሳተፍ፡ከተስማሙ፡እውነተኛነትዎ፡አደንቃለሁ።ይህ፡የስምምነት፡ቅጽ፡ለእርስዎ፡

ከተነበበልዎት፡በኋላ።ለመሳተፍ፡ፈቃደኛ፡መሆንዎን፡ለማሳየት፡ከዚህ፡በታች፡ፊርማዎን፡ያኑሩ(ስምዎን፡መጻፍ፡

አያስፈልግም)።

ስለተሳተፍእናመሰግናለን።

የስምምነት ማረጋገጫ

ይህ ስምምነት የተዘጋጀውበወሊድ ወቅት ጤና ባለሙያዎች ስለውጤታማ ተግባቦት እና እናቶች እራስን በራስ ስለማስተዳደር ግንዛቤ በሚል ርዕስ ላይ ለሚደረግ ጥናት የተዘጋጀ የስምምነት መግለጫ ቅፅ ነው።

ማብራሪያ

እኔ ስሜ ሳይጠቀስ በመለያ ኮድ ብቻ የምለየዉ የምርምሩ ተሳታፊ ስለምርምሩ በቂ ገለጻ ክተደረገልኝ

በሃላ የምስጠው መረጃ በሚስጥር እንደሚጠበቅ ተገልፆልኛል። ከሁሉም በላይ በጥናቱ ላይ መሳተፍ

በፍቃደኝነት ላይ የተመሠረተ መሆኑና ለመሳተፍ ፍቃደኛ ከመሆኔ በፊት እንዳስብበት በቂ ጊዜ ተሰጥቶኛል

። ከጥናቱም መውጣት ብፈልግ ምንም ምክኒያት ሳላቀርብ ከጥናቱ መውጣት እንደምችል ተነግሮኛል።

ስለዚህ በጥናቱ ለመሳተፍ የወሰንኩት ስለሁኔታው በሚገባ ከተረዳሁ በኋላ በጥናቱ ሂደት ውስጥ

በፍቃደኝነት ለመሳተፍ ተስማምቻለሁ ።

ፊርማ _____ ቀን _____

የቃለ መጠይቁ አማረኛ ትርጉም

አዲስ አበባ ዩኒቨርሲቲ የህክምና ሳይንስ የነርሲንግና ፤ ሚድዋይፈሪትምህርት ኮሊጅ

ክፍል አንድ፡ ሶሺዮ-ስነ-ሕዝብ ተለዋዋጮች ባህሪያት

101	ስራ ሁነታ	የማህፀን ሐኪም አጠቃላይ ባለሙያ አዋላጅ የማህፀን ሐክምና ተማሪ ሌሎች
102	ሶታ	
103	ሃይማኖት	
104	እድሜሽ/ህ ስንት ነው?	_____ ዓመት
105	የጋብቻ ሁኔታሽ እንዴት ነው	1. ያገባች 2. ያላገባች 3. የፈታች 4. በሞት የተለየ
106	የስራ ልምዶ ፡ _____	ከ 2 ዓመት በታች ከ 2 እስከ 4 ዓመታት ከ 4 ዓመታት በላይ
107	ከፍተኛ የትምህርት ደረጃ	
108	አሁን ባለው ተቋምዎ ውስጥ ስንት ዓመት ሰሩ	ከ 2 ዓመት በታች ከ 3 እስከ 6 ዓመታት ከ 6 ዓመታት በላይ

ክፍል ሁለት ከስራ አካባቢ ጋር የተያያዘ መረጃ

201	በሳምንት የሚሰሩ ቀናት ብዛት	5 ወይም ከዚያ ያነሱ ቀናት ከ 5 ቀናት በላይ
202	በሳምንት የሚሰሩ ሰአታት ብዛት	40 ወይም ከዚያ በታች ሰዓታት ከ 90 እስከ 100 ሰአታት ከ 100 ሰአታት በላይ
203	በቀን ስንት ዋልዳሉ?	2 ወይም ከ 2 በታች ከ 2 እስከ 5 ከ 5 በላይ
204	ህፃኑን ሲከተሉ እና ሲሰወልዱ የስራ ጫና አለ ብለው ያስባሉ?	አዎ አይ
205	በወሊድ ጊዜ የሥራ ጫና ከ እናቶቸ ጋር ያለዎትን ግንኙነት ይነካል?	አዎ አይ

ክፍል ሶስት የጤና እንክብካቤ ባለሙያ ግንዛቤ

301	የእንክብካቤ ጥራትን ለማሻሻል ጥሩ የመግባቢያ ችሎታ ጠቃሚ ነው ብለው ያስባሉ?	አዎ አይ
302	ከእናቶች ጋር በተሻለ ሁኔታ ለመግባባት እውቀት እና የመግባቢያ ክህሎት የሚያስፈልግ ይመስላችኋል	አዎ አይ
303	ከእናቶች ጋር ለመግባባት አስፈላጊው እውቀት እና ክህሎት እንዳለዎት ያምናሉ?	አዎ አይ
304	ከእናቶች ጋር እንዴት በተሻለ ሁኔታ ለመግባባት እንደሚቻል ስልጠና ወስደዋል? ጥሩ የመግባቢያ ክህሎት ክፍሎችን መጥቀስ ትችላለህ	አዎ አይ
305	ከእናቶች ጋር እንዴት በተሻለ ሁኔታ መግባባትእንደሚቻል ሥልጠና መውሰድ አስፈላጊ ነው ብለው ያስባሉ	አዎ አይ
306	እናቶችን በስማቸው መጥራትን ትረሳለህ?	አዎ አይ
307	ለምትመረምራት እናት ስለ እያንዳንዱ ምርመራ ማሳወቅ አስፈላጊ ነው ብለው ያስባሉ?	አዎ አይ
308	የጥሩ የመግባቢያ ክህሎት ክፍሎችን መጥቀስ ትችላለህ	1.ንቁ ማዳመጥ 2. ጥንቃቄ 3 ማረጋጋት 4. ርኅራኄን አሳይ 5 ታማኝነት እና አክብሮት 6 ሌሎች ይገልጻሉ።
309	ያደረከውን ምርመራ እናት ማሳወቅ ትረሳለህ?	አዎ አይ
310	ምጥ ያለባት እናት በስምህ ስትጠራህ ምቾት አይሰማህም?	አዎ አይ
311	የምታጠባ እናት ስምህን ሳታውቅ ስትክር ምቾት ይሰማሃል?	አዎ አይ

ክፍል አራት ምጥ እናት ተዛማጅ

401	እናቶች ስለ እያንዳንዱ ምርመራ እንዲያውቁት ይፈልጋሉ ብለው ያስባሉ?	አዎ አይ
402	በምታወራት ጊዝ እናት የምትናገረውን ትረዳለች?	አዎ አይ
403	በእናቶች በኩል አለመግባባት በእርስዎ ግንኙነት ላይ ተጽዕኖ ያሳድራል?	አዎ አይ
404	በጤና ባለሙያው የሚደርስባትን እንግልት ፍራቻ መግባባት ላይ ተጽእኖ ያሳድራል ብለው ያስባሉ?	አዎ አይ

ክፍል አምስት - ተግባቦት

1 ዶክተሮቹ፣ አዋላጆች ወይም ሌሎች የጤና እንክብካቤ አቅራቢዎች እራሳቸውን ያስተዋውቃሉ ብለው ያስባሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

2 በመጀመሪያ ሲያያቸው ከሴቶቹ ጋር እራስዎን ያስተዋውቃሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

3ዶክተሮች፣ አዋላጆች ወይም ሌሎች የጤና እንክብካቤ አቅራቢዎች ሴቶችን በስማቸው ይጠራሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

4 ሴቶችን በስማቸው ትጠቅሳለህ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

5 በእነሱ ላይ ምርመራዎችን ወይም ሂደቶችን ለምን እንደምታደርግ ለሴቶች ታስረዳቸዋለህ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

6.ለምን መድሃኒት እንደምትሰጣቸው ለሴቶች ታስረዳቸዋለህ?

. 0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

7. ሊከሰቱ የሚችሉ የጎንዮሽ ጉዳቶችን አንድ ታካሚ ሊረዳው በሚችል መንገድ ይገልፃሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

7. በተቋሙ ውስጥ ያሉ ዶክተሮች፣ ነርሶች ወይም ሌሎች ሰራተኞች ከምርመራ እና ከሂደቱ በፊት የሴቶችን ፍቃድ/ፍቃድ ይጠይቃሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

8. በእርስዎ ልምድ፣ ሴቶች ወይም ቤተሰቦች ስለ እንክብካቤው መረጃ ተሰጥቷቸዋል?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

9. ሴቶች በተቋሙ ውስጥ ያሉ ዶክተሮችን ፣አዋላጆችን ወይም ሌሎች ሰራተኞችን ማንኛውንም ጥያቄ ሊጠይቁ እንደሚችሉ ይሰማዎታል?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

10. ሴቶች ማንኛውንም ጥያቄ ሊጠይቁዎት እንደሚችሉ ይሰማዎታል?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

11. በተቋሙ ውስጥ ያሉት ዶክተሮች፣ አዋላጆች ወይም ሌሎች ሰራተኞች ቤተሰብ ላነሱት ጥያቄ መልስ ይሰጣሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

12. በተቋሙ ውስጥ ያሉት ዶክተሮች፣ ነርሶች ወይም ሌሎች ሰራተኞች ሴቶችን በሚረዱት ቋንቋ ይነጋገራሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

13. በተቋሙ ውስጥ ያሉ ዶክተሮች፣ ነርሶች ወይም ሌሎች ሰራተኞች ሴቶችን በእንክብካቤ ላይ በሚወስኑ ውሳኔዎች ላይ እንደሚያሳትፉ ይሰማዎታል?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

14. በወሊድ ጊዜ ሴቶች በመረጡት ቦታ ላይ መሆን እንደሚችሉ ይሰማዎታል?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

15 እራስዎን ለታካሚዎች ማስተዋወቅ አስፈላጊ ነው ብለው ያስባሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

16. ሴቶችን በስማቸው መጥራት አስፈላጊ ነው ብለው ያስባሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

17. በተቋሙ ውስጥ ያሉ ዶክተሮች፣ ነርሶች ወይም ሌሎች ሰራተኞች ከሂደቶቹ በፊት ፈቃድ ወይም ስምምነት መጠየቃቸው አስፈላጊ ሆኖ ይሰማዎታል?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

18. ሴቶችን ወይም ቤተሰቦቻቸውን ስለእነርሱ እንክብካቤ በሚወስኑ ውሳኔዎች ላይ ማሳተፍ አስፈላጊ ነው ብለው ያስባሉ?

0 አይ፣ በጭራሽ

1 አዎ፣ ጥቂት ጊዜ

2 አዎ፣ ብዙ ጊዜ

3 አዎ፣ ሁል ጊዜ

ክፍል ስድስት ራስን መቸሃል

601	በምርመራ ወቅት, የመጨረሻው ውሳኔ ሁልጊዜ በሴቶች ላይ መቀመጥ አለበት ብለው ያስባሉ	0 አይ፣ በጭራሽ 1 አዎ፣ ጥቂት ጊዜ 2 አዎ፣ ብዙ ጊዜ

		3 አዎ፣ ሁል ጊዜ
602	ለሕፃኑ ደህንነት ሲባል የወሊድ እንክብካቤ ቡድን የሴቶችን ፍላጎት መሻር አለበት ብለው ያስባሉ	0 አይ፣ በጭራሽ 1 አዎ፣ ጥቂት ጊዜ 2 አዎ፣ ብዙ ጊዜ 3 አዎ፣ ሁል ጊዜ
603	ሴቶች ልጃቸውን በመውለድ ላይ የበለጠ ቁጥጥር እንዲኖራቸው ማበረታታት ደህንነትን ይጎዳል ብለው ያስባሉ	0 አይ፣ በጭራሽ 1 አዎ፣ ጥቂት ጊዜ 2 አዎ፣ ብዙ ጊዜ 3 አዎ፣ ሁል ጊዜ
604	ሴቶችን ወይም ቤተሰቦቻቸውን ስለእነርሱ እንክብካቤ በሚወስኑ ውሳኔዎች ላይ ማሳተፍ አስፈላጊ ነው ብለው ያስባሉ	0 አይ፣ በጭራሽ 1 አዎ፣ ጥቂት ጊዜ 2 አዎ፣ ብዙ ጊዜ 3 አዎ፣ ሁል ጊዜ
605	በወሊድ ጊዜ ሴቶች በመረጡት ቦታ ላይ መሆን እንደሚችሉ ይሰማዎታል?	0 አይ፣ በጭራሽ 1 አዎ፣ ጥቂት ጊዜ 2 አዎ፣ ብዙ ጊዜ 3 አዎ፣ ሁል ጊዜ
606	በተቋሙ ውስጥ ያሉ ዶክተሮች፣ አዋላጆች ወይም ሌሎች ሰራተኞች ሴቶችን እንክብካቤን በሚመለከት ውሳኔ ላይ እንደሚያሳትፉ ይሰማዎታል?	0 አይ፣ በጭራሽ 1 አዎ፣ ጥቂት ጊዜ 2 አዎ፣ ብዙ ጊዜ 3 አዎ፣ ሁል ጊዜ

ማጠቃለያ ጥያቄዎቼን ጨርሻለው በቆይታችን በጣም ደስተኛ ነኝ።መቅጃውን ከማጥፋቴ በፊት የምትጨምሩት ነገር ካላችሁ።ለጊዜዎት በጣም አመሰግናለሁ!!

የአማረኛው ትርጉም የኪሊቴቲፍ መጠይቅ

ክፍል አንድ፤ አንድ: ለአንድ: የሚደረግ :መጠይቅ ለነፍሰጡ:እናት::

ስምምነታቸውን: ካገኘን :በኋላ :መቅረጸ -ድምጽን እና;በራዋለ ፡ ፡ ነግግራችንን: ተስታፊዋን ;ለፈቃደኝነቷ

በማመስገን; እንጀምራን ፡

የቃለ ምልልሱ ቁጥር : _____

የተሳታፍዋ መለያ ቁጥር : _____

ቃለምልልሱን ያካሄደዉ ሰው :_____

ኮድ: _____

የቃለ ምልልሱ ቀ ን : _____

1. እሺ: አሁን :ስለአንቺ እንወያያለን::

1. እዴሜ ስንት ነው? _____

2. የጋብቻ ሁኔታዋ ምን ይመስሊሌ? _____

3. የምን ሀይማኖቶ ተከታይ ኖት ?_____

4. የ ት/ት ዯረጃዎን ቢገሌፁሌኝ ?_____

5. የት አካባቢ ነው ሚኖሩት ? _____

6. ምን ያህሌ ሌጆች አሌዎት ?

2 በሆስፒታሉ ውስጥ ያሉ የጤና ባለሙያዎች ስለ ጤንነትዎ በሚወስኑት ውሳኔዎች ውስጥ እርስዎን ያካትታሉ?

3.ሴቶችን ወይም ቤተሰቦቻቸውን ስለእነርሱ እንክብካቤ በሚወስኑ ውሳኔዎች ውስጥ ማሳተፍ አስፈላጊ ነው ብለው ያስባሉ?አስፈላጊነቱ ለምን ይመስልዎታል?

4.በምጥ ወቅት ያለዎትን ሁኔታ በተመለከተ የመጨረሻ ውሳኔ በእርስዎ ዘንድ ማረፍ ያለበት ይመስልዎታል? ለምን?

5.በምትወልዱበት ጊዜ የጤና ባለሙያ በራስ የመመራት መብቶን እንዳከበረ ሆኖ ይሰማዎታል?

ስለተፈጠረው ነገር የበለጠ ንገረኝ

6. ሴቶች፣ ልጃቸውን በመውለድ ላይ ለሉ ስለራሳቸው በለጠ ቁጥጥር እንዲኖራቸው ማበረታታት ደህንነትን ይጎዳል ብለው ያስባሉ?

7.አንዳንድ እናቶች በጤና ተቋማት ራስን በራስ ከማስተዳደር አንፃር ከሌሎች እናቶች በተሻለ ወይም በከፋ ሁኔታ ይስተናገዳሉ ብለው ያስባሉ?ሀ. አዎ ከሆነ፣ እባክዎን ይግለጹ።

8.የጤና ባለሙያዎች የምታጠባውን እናት ውሳኔ መሻር አለባቸው ብለው ያስባሉ? በወሊድ ወቅት ከመረጡት ቦታ ጋር በተያያዙ ጉዳዮች ላይ ምርመራ ፣ ለህፃኑ ደህንነት)

9. በናንተ አስተያየት፣እናት ልጅ በምትወልድበት ወቅት በራስ የመመራት መብቶ እንዲከበር ምን መደረግ አለበት?

ማጠቃለያ ጥያቄዎቼን ጨርሻለው በቆይታችን በጣም ደስተኛ ነኝ።መቅጃውን ከማጥፋቴ በፊት የምትጨምሩት ነገር ካላችሁ።ለጊዜዎት በጣም አመሰግናለሁ!!

Examiner Approval Sheet

I undersigned, Examiner have read, evaluate and attend defense prepared by Bezawit Worku entitled with "Health professional's communication and laboring mother's autonomy during giving birth in selected governmental hospitals in Addis Ababa Ethiopia: a mixed study"

This is to verify that these thsis has been accepted in partial fulfillment of the requirements for the Masters of Degree in Maternity and Reproductive health.

_____	_____	_____	_____
NAME	RANK	SIGNATURE	DATE
_____	_____	_____	_____
NAME	RANK	SIGNATURE	DATE