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

Assessment of Antenatal Care Clients Perception of Caring Behavior of Midwives in Fafan Zone, Somali Regional State.

BY: MERON KIBRU (BScM)

A THESIS SUBMITTED TO SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY DEPARTMENT OF NURSING AND MIDWIFERY FOR PRTIAL FULFILMENT TO THE REQUIRMENTS FOR DEGREE OF MASTERS OF SCIENCE IN MATERNITY AND REPRODUCTIVE HEALTH NURSING

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JUNE, 2015
ADDIS ABABA

APPROVED BY THE BOARD OF EXAMINATION

This thesis by Meron Kibru is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of Masters of Science in Maternity and Reproductive Health.

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TABLE OF CONTENT

Acknowledgment I
List of tables IV
List of figures V
List of acronym VI
Abstract VII
CHAPTER ONE: Back ground 1
1.1 Introduction 1
1.2 Statement of the Problem 4
1.3 Significant of the study 6
CHAPTER TWO: Literature review 7
2.1. Conceptual frame work 12
CHAPTER THREE: Objectives 13
3.1. General objective 13
3.2. Specific objective 13
CHAPTER FOUR: Methods and Materials 14
4.1 Study area 14
4.2 Study design and period 15
4.3 Population 16
4.3.1 Source population 16
4.3.2 Study population 16
4.3.3 Inclusion criteria and Exclusion criteria 16
4.4 Sampling 16
4.4.1 Sample size determination 16
4.4.2 Sampling technique 17
4.5 Data collection procedures and management 19
4.5.1 Data collection instrument 19
4.5.2 Data collectors 20
4.5.3 Data quality control 20
4.6 Study variables 20
4.7 Operational definitions 21
4.8 Data processing and analysis 22
4.9 Ethical consideration 22

CHAPTER FIVE: Result....24
5.1 Socio – demographic characteristics....24
5.2 Pregnancy related information....26
5.3 Caring Behavior Assessment Tool....28
5.4 Factors associated with caring behavior....31
5.4.1 Socio-demographic characteristics and caring behavior....31
5.4.2. Pregnancy related information and Caring behavior....33
CHAPTER SIX: Discussion....35
Strengths and Limitation of the study....37
CHAPTER SEVEN:Conclusion and Recommendation....38
Conclusion....38
Recommendation....39
References....40
Annexes....42
Annex I - Consent form (English version)....42
Annex II - Questionnaire (English version)....43
Annex III: Consent form (Amharic version)....47
Annex IV: Questionnaire (Amharic version)....47
Annex V- Consent form (Somali version)....52
Annex VI: Questionnaire (somali version)....54

LIST OF TABLES

Table 1 Sampling scheme for selecting health centers found in particular woreda‟s of Fafan zone. 18

Table 2 Socio-demographic characteristics of mothers in Fafan zone Somali region Ethiopia. ... 25

Table 3 Pregnancy related information of mothers in Fafan zone Somali region Ethiopia 27

Table 4 Mean score of caring behavior assessment tool in Fafan zone Somali region Ethiopia. . 28

Table 5 The mean and standard deviation for the 10 most important midwifery caring behaviors. 29

Table 6 The mean and standard deviation for the 10 least important midwifery caring behaviors 30

Table 7 Bivariate and multivariate analysis of socio demographic characteristics and caring behavior assessment of midwives by ANC attending mothers in Fafan zone, Somalia region Ethiopia. 31

Table 8 Bivariate and multivariate analysis of pregnancy related characteristics and caring behavior assessment of midwives by ANC attending mothers in Fafan zone, Somalia region Ethiopia. 34

LIST OF FIGURES

Figure 1: Conceptual framework 12

Figure 2: Map of Fafan zone 15

Figure 3: Number of ANC visit 26

LIST OF ACRONYM

ANC	Ante natal care
CAT	Caring assessment tool
CSA	Central statistical agency
EDHS	Ethiopian demographic health survey
ESRS	Ethiopian Somali regional state
FIGO	International Federation of Gynecology and Obstetrics
ICM	International confederation of midwives
KM	Kilo meter
MDG	Millennium development goal
MOH	Ministry of health
WHO	World health organization

ABSTRACT

Background: Caring is a popular concept midwifery which forms part of good patient care values. Midwives are those who are responsible in the care for the mothers and their babies. It is fact that provider behavior is the major tool for the optimization of the utilization of maternal care. Utilization of antenatal care often depends on pregnant women‟s perception of provider‟s caring behaviors.

Objective: To assess the antenatal care client‟s perception of caring behavior of midwives in Fafan Zone, Somali Regional State

Methodology: Institution based cross-sectional study was done from March to April 2015. A simple random sampling of health centers was used and nine health centers were selected to involve 384 mothers in the study. A structured questioner was used to collect data and the data was analyzed by using SPSS version 20; involving descriptive statistics as well as bivariate and multivariate statistical tests. Participation in this study was voluntary.

Result: A total 384 clients were participated in this study. The overall rating of positive perception was 48.7%. The highest score from the caring behavior items based on their mean were ”treat me as an individual (4.44±0.683)” and point out the things about me and my condition(4.41±0.683)” were clients scored for their positive perception . The items with which clients have negative perception were “introduce themselves to me (2.88±1.740)” and ,keep my family informed of my progress (3.70±1.260)”. Educational level, no of family member and pregnancy related illness were significant predictor of client‟s negative perception with midwifery caring behaviors.

Conclusion: The result revels that most ante natal attending mothers have negative perception towards to the caring behavior of midwives. But there are also some clients with positive perception of caring behavior of midwives.

Key words: Care, Caring behavior, Antenatal Care, Midwives

CHAPTER ONE

BACK GROUND

1.1 Introduction

Pregnancy is considered a phase in life that makes great demands on the women‟s ability to adapt and adjust physically, psychologically and socially (1). While most pregnancies and births are uneventful, all pregnancies are at risk. Around 15% of all pregnant women develop a potentially life-threatening complication that calls for skilled care and some will require a major obstetrical intervention to survive (2). It‟s believed that this complication should be overcome by early detection of abnormalities and treatment during pregnancy. This will promote maternal health.

Ante natal care is the maternal care during pregnancy that every pregnant women needs for a better outcome. It is also one of the pillars of safe motherhood. Ante natal care is an important determinant of safe motherhood and key strategy for reducing maternal morbidity and mortality (3). ANC is the key entry point of a pregnant woman to receive broad range of health promotion and preventive services which promote the health of the mother and the baby (4).

The antenatal period provides an opportunity for reaching out to pregnant women and providing them with care that will enhance their optimum health and the wellbeing of their unborn infants. The overall goal of antenatal care, as such, is the delivery of healthy babies‟ born of healthy and well prepared parents (1).

The aim of Millennium Development Goal 5 (MDG 5) is to reduce the maternal mortality rate by 75% and achieve universal access to reproductive health care by 2015 (5). In Sub-Saharan Africa

where the maternal mortality is the highest, the annual decline has been 0.1% which seems to be far below the 5.5% annual decline which is required to achieve the MDG 5 on maternal health.

Caring is a popular concept in midwifery which forms part of good patient care values – indeed, caring is frequently described as the core business of nursing and midwifery(6). It involves the relationship in which the carer is committed to the needs of the one cared for.

Some of the concepts suggested with regard to the meaning of caring include empathy presenting, knowing, listening, interacting, sensitivity, giving feedback, teaching and helping. Watson uses ten carative factors of caring to describe Human Caring Science. Caring has a „doing for", a behavioral aspect, as well as a „being with", an emotional aspect.

A midwife"s focus is to enable all women and their families to have a positive and safe experience of pregnancy, birth and early parenting (7). A social model of maternity care where women, rather than the organization, are at the center is a key feature of midwifery-led care.

According to the WHO, ICM and FIGO, skilled care is provided by a skilled attendant who is an accredited health professional like a midwife, doctor or nurse (5).

Client expectations as the most important influence on health care can be conditioned by the service providers themselves or may be influenced by the available stimuli to which the client may adapt, as such, knowledge and exposure to "routine" antenatal care can also guide or influence the pregnant women"s expectations (1).Midwives are the health professionals that play the central role in the care of pregnant mothers in the home, health institutions and community (8). According to the World Health Organization, "quality health care is defined as that care which consists of the proper performance according to standards (9)."

Client satisfaction with the care provided is an important element of quality care, often determining patient‟s willingness to comply with treatment recommendations, thus influencing effectiveness of care (10). It is fact that provider behavior is the major tool for the utilization of maternal care. Utilization of antenatal care often depends on pregnant women‟s perception of care provider‟s caring behaviors. Around the world, quality of care during the antenatal period plays a vital role to promote maternal health, better birth process and a healthy baby.

1.2 Statement of the Problem

The health of mothers and children is central to global and national concerns, and improvements in maternal and child survival are the two important Millennium Development goals (11). Almost 300,000 women died globally in 2013 from causes related to pregnancy and childbirth (12).

Maternal mortality remains high in the developing world where the risk of death from complications related to pregnancy and childbirth over the course of a woman‟s lifetime is one in 76, compared with one in 8000 in the industrialized world (13).

Health care during pregnancy is essential to ensure the normal, healthy evolution of the pregnancy and to prevent, detect or predict potential complications during the pregnancy or delivery. Good quality care must be provided by skilled health personnel equipped to detect potential complications and provide the necessary attention or referral.

The World Health Organization has recommended a minimum of four antenatal care visits to ensure the well-being of mothers and newborns (12). During these visits, women should receive at least a minimum care package, and be monitored for warning signs during their pregnancy. Notwithstanding, only 52 per cent of pregnant women had four or more antenatal care visits during pregnancy in 2012. The proportion of women in developing regions of the world who were attended at least once during their pregnancy by skilled health-care personnel increased from 65 per cent in 1990 to 83 per cent in 2012. In most developing regions, about 80 per cent of pregnant women visited a skilled health-care provider at least once.

Around twenty three percent of the population found in Ethiopia Somalia region is in reproductive age with 4.8% total fertility rate in the region (12). EDHS 2011 shows that 74.4% of women did not receive ANC, (14) this may be related with the mother‟s perception towards the care given at the health institution may be poor and also the providers may not give them enough attention which lead to poor communication between them. So the mother‟s may not visit the health institution for this service.

So far no study has been conducted in any of the health facilities of Ethiopia Somali as a region to investigate the perception of client‟s about the caring behavior of midwives who attend in ante natal clinic, what challenges and problems are experienced or how they are, if any. It is still new ground for research.

Therefore it became necessary to investigate client‟s perception about the caring behavior of midwives who attend in ante natal clinic.

1.2 Significant of the study

The study was designed to analyze and explain the ante natal client‟s perception about midwives caring behavior. Finding of the study will help to guide for better improvement of ante natal care service provision by midwives. It will additionally help the respective health providers and institution to identify and address the gaps in midwives caring behaviors in the provision of antenatal care. Furthermore, improving caring behavior of midwives at ante natal care clinics would not only contribute to the health of mothers and their babies, but also to the image of midwifery profession.

CHAPTER TWO

LITERATURE REVIEW

Theoretical critiques surrounding the concept of caring abound. Some have questioned or advocated the view of caring as an ethic, or moral principle (15). Others have opposed viewing caring in any way that may lead to a duty or an obligation; still others have opposed viewing caring in any way that encourages emotional attachment, dependency, inefficiency, or burnout. Nevertheless, it is also noted that caring involves an expression of openness, receptiveness, and authenticity within a personal context. And caring is increasingly posited as one of the core concepts for an evolved nursing science.

Different ideas were given on the caring but the most accepted definitions of care were given by Jean Watson and Madeleine Leininger. Leininger, caring must be placed in a cultural context since caring patterns have similarities and differences transculturally (16). Watson has focused on the philosophic (existential--phenomenological) and spiritual basis of caring and sees caring as the ethical and moral ideal of nursing. Both Leininger and Watson have demonstrated their artistry in their individual portraits of caring and in their contributions to the development of nursing knowledge.

Caring, once glimpsed through empirical measures, whether qualitative or quantitative, may help us to see what has been long hidden from the public consciousness as well as science (15). More specifically, the purposes for the use of formal measurement tools in nursing research on caring include:

- Continuous improvement of caring through the use of outcomes and more mindful interventions to improve practices;
- The benchmarking of structures and settings and environments in which caring is more manifest;
- The tracking of levels and models of caring in care settings against routine care practices;
- Evaluation of the consequences of caring versus non-caring for both nurses and patients;
- Creation of a "report care" model of a unit or an institution in a critical area of practice;
- Identification of areas of weakness and strength in caring processes and interventions in order to stimulate self-correction and models of excellence in practice;
- Increased development of our knowledge and understanding of the relationship between caring relationships and health and healing;
- Empirical validation of extant caring theories, as well as the generation of new theories of caring, caring relationships, and healing-health practices; and
- The stimulation of new directions for curriculum and pedagogies in nursing and caring and health sciences, including interdisciplinary/ Trans disciplinary education and research.

The American Nurses Association's Agenda for the Future held in 2002 acknowledges that nursing is "highly valued for its special knowledge, skill and caring in improving the health status of the public" (15). Further, of the 10 domains the American Nurses Association identified as key for nursing's agenda, at least 5 have direct relevance to the need for knowledge of caring and its effects. These are delivery systems/nursing models, a professional nursing culture, a work environment, economic recruitment/retention, and leadership. Each of these categories is associated with a need for attention to knowledge, skills, and research related to caring.

In the study that was done in private and state hospitals in Tshwane, Gauteng, South Africa explores midwives‟ perspective of caring during midwifery clinical practice. A qualitative exploratory research design was used; the study has two themes patient care related incidents and Midwife related incident. The themes of caring and uncaring related to patient care and midwives emerged. The findings illustrated that the midwives had excellent theoretical knowledge of caring, but some of them did not display caring behavior during clinical practice (6).

A South African study explored health-seeking behaviors of antenatal women. A notable theme emerging from the study was the abuse of antenatal women by midwives, described as an overall deterrent to seeking healthcare services (6). Smith went on to identify five constitutive meanings of caring from the perspective of Rogerian science of unitary human beings (15): manifesting intentions, appreciating patterns, attuning oneself to dynamic flow, experiencing the infinite, and inviting creative emergence. Two were used as the basis for this study.

One of the constitutive meaning of caring is Expressions of Caring(15) ,Manifesting Intentions includes person-centered intention, Preserving dignity and humanity, Committed to alleviating vulnerability, Giving attention and concern, Reverence for person and human life, Love and co-presence, Authenticity and availability, Being with, Attention, compassion, focus, Feeling compassion, Regard, Intentional presence, Being with the other, Intention of knowing, acknowledging, affirming, celebrating the other .

The second constitutive meaning of caring is Expressions of Caring: Appreciating Patterns which includes Placing value on the other as lovable, worthy of being loved, Cherishing the wholeness of the human being, Assuming the subjectivity of other to be valid and whole, Acknowledging the emerging pattern without trying to change it, Confirming human dignity, Seeing the other as

perfect in the moment, Unfolding possibilities for becoming, Yearning for a deeper understanding and appreciation of the natural healing resources, life force, pattern, and paradox, Sensitivity to pattern manifestations that give identity to each unique person, Transcending judgment, Seeing underneath fragmentation, to existence of wholeness.

A study on the perception of pregnant women towards midwives attitude and practice during child delivery in health institutions in Ogbomosho, south west, Nigeria (8) states that e positive respond regarding on the midwives have attitude and practice during delivery, there is also positive impression on the effect of midwives during delivery.

A qualitative study with phenomenological approach aimed to explore women‟s experiences in interaction with their midwives during their antenatal checks and during labor in Taiwan express their feelings and reactions about choosing a midwife (17). During labor, the women were cared for by a midwife, and were stimulated to achieve a natural birth. The women accepted the social value of midwifery care in terms of feelings of safety, care and being accompanied. They agreed with the midwife‟s decision, and confirmed her professionalism.

Another descriptive study about Caring Behaviors by Nurses: Women's Perceptions during Childbirth that will help to detect nursing behaviors perceived as caring by women during childbirth (18).In these study Women‟s perceptions of caring behaviors used by nurses were measured via the Caring Behavior Assessment. This study used an instrument that lists 63 nursing behaviors in seven subscales and is congruent with Watson's caring factors. Mothers who had uncomplicated vaginal births were asked to rate behaviors of their nurses. Behaviors in the human needs assistance subscale, which included items such as "help me with my care until I'm

able to do it for myself," "give my treatments and medication on time," and "check my condition closely," were perceived as the most caring.

A study done on the evaluation of quality of care midwives provide during the post natal period in northern, Botswana (19). Most nurses provide equality care during immediate postpartum period. A majority of nurses have good knowledge and practice in management of postpartum activities but there are some areas that are not well done.

In conclusion, it is clear that caring behavior is a back bone for midwifery and nursing profession in terms of improving the quality of services provided and enhancing client satisfaction. Nevertheless, we are able to find limited literature sources concerning the caring behavior of midwives from the perception of mothers who attend at ante natal care clinics. This unquestionably implies the need to conduct empirical research in order to generate scientific evidence and contribute to the knowledge base of caring science in midwifery.

2.1.Conceptual frame work

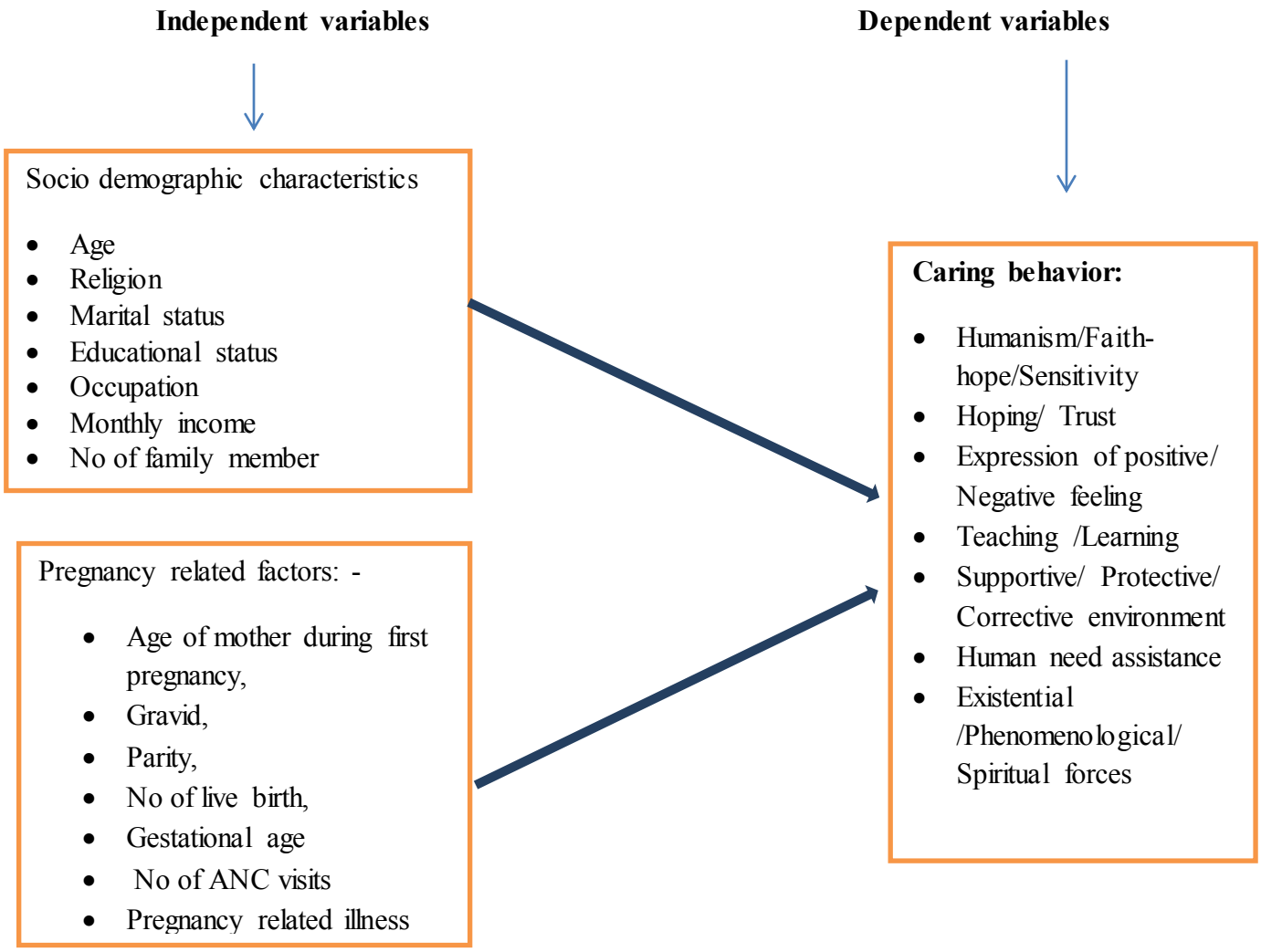

Figure 1: Conceptual framework of the study

CHAPTER THREE

OBJECTIVES

3.1. General objective

1. To assess the antenatal care client perception of caring behavior of midwives in Fafan Zone, Somali Regional State

3.2. Specific objective

1. To describe the caring behaviors of midwives as perceived by mothers attending antenatal care services.

2. To find out the association between socio-demographic factors and mothers‟ perception of midwives caring behaviors.

3. To analyze the association between pregnancy-related factors such as (gravida, parity, gestational age, trimester, Number of ANC visits, pregnancy related illness) and mothers‟ perception of midwives caring behaviors.

CHAPTER FOUR

METHODS AND MATERIALS

4.1 Study area

Somali region is one of the nine regional states that make up the Federal Democratic Republic of Ethiopia. The region is located in the eastern part of the country. It lies over an area of about 350,000 $Km^{2.}$ It is bordered by Oromia Regional State in the West and Southwest, and Afar National Region State in the Northeast. It has border with Kenya in the South, Somali in the East, and Djibouti in the northwest.

Somali region is divided into nine zones namely Jigjiga/Fafen, Shinela/Siti, Fiq/Nogob, Deghabur/Jerer, Korrahey/kebridahar, Warder/Dollow, Gode/Shebele, Afder and Liban zones. The nine zones are further divided into 68 woreda"s and four city administration. Fafan zone is one of the zones found in ESRS. It assumed that most of the population is live here. According to the population projection of the Central Statistical Authority (CSA) based on the 2007 Population and Housing Census, the total population of Somali region is 5.04 million in 2007. Of the total population, 44, 4% and 55, 6% are females and males respectively.

Among the zones of the region, the population densities are highest in agro-pastoral zones including Shablea/gode, Jijiga/fafan and Liben. A large proportion of women (23.54%) are in the reproductive age group.

Potential health service coverage in Somali region is estimated to be 34.64% (1997) and at this time it reaches to 70-73 %. Currently there are ten hospitals and 142 health centers in the region.

Fafan zone have 8 woreda, one council and 29 health centers which are functional. At present there are around 679 midwives who work on hospitals and health centers at the region.

Figure 2: **Map of Fafan zone**

4.2 Study design and period

Institution based cross-sectional study with quantitative methods was conducted to assess the antenatal care client"s perception of caring behavior of midwives in Fafan Zone, Somali Regional State from January to May 2015

4.3 Population

4.3.1 Source population

All mothers who are pregnant at Fafan zone.

4.3.2 Study population

All mothers who are pregnant and attend ante natal care in randomly selected health center on the study period.

4.3.3Inclusion criteria and Exclusion criteria

***4.3.3.1 Inclusion criteria*:** All mothers who are pregnant and attend ante natal care at the selected health center and those who are willing to participate.

***4.3.3.2 Exclusion criteria*:** All mothers who are pregnant found in the selected woreda who did not come for ANC and those who are critically sick and not willing to participate.

4.4 Sampling

4.4.1Sample size determination

The study used a single population proportion formula of a sample size. Since there is no studies is done regarding the caring behavior of midwives nationally, it is expected that the prevalence of caring behavior of midwives is 50% and assuming 5% margin of error and 95% confidence interval (∂ (alpha)=0.05). An additional 10% was added as a contingency to increase power and compensate for possible non response.

$$n=\frac{\left(Z\frac{\alpha}{2}\right)^2 p(1-p)}{d^2}=\frac{Z^2 p(1-p)}{d^2}=\frac{(1.96)^2 X\,0.5(1-0.5)}{(0.05)^2}=384$$

Where:

n = the required sample size

z = the value of the standard normal curve score corresponding to the given confidence interval=1.96

p = Assumed proportion of fertility desire= 50%

d = the permissible margin of error (the required precision) =5%.

The calculated sample size= 384

Adding 10% of non-response rate the sample size=422 n=384+10% which is 38.4=422.4 ~ 422

4.4.2 Sampling technique

A simple random method was used to select the health centers found in the zone. Out of the 29 health center located in the zone 9 health center were selected to represent Fafan zone. Then to allocate the sample size it was proportionate to the selected health centers.

Woreda"s of the Fafan zone was listed and health centers found in each woreda were identified and by using a simple random sampling (lottery) four woreda"s were selected and all health centers (nine) in the selected woreda was included in the study area. Based on the number of pregnant mothers available in the selected woreda, samples were being proportionate to each health center. All mothers fulfilling the inclusion criteria were recorded as eligible for the for data collection.

Table 1 Sampling scheme for selecting health centers found in particular woreda's of Fafan zone.

Babile woreda	N = 4,441	Based on the number of pregnant mothers in the woreda it was proportionated to each health center	n = 99
Gursum woreda	N = 1,574		n = 35
Jigjiga Council	N = 6,807		n = 152
Jigjiga Zuria	N = 6,090		n = 136

N = number of pregnant mother who are available in the selected woreda.

n = number of pregnant mother who are proportionate to each health center

4.5 Data collection procedures and management

4.5.1 Data collection instrument

The data collection instrument was questionnaires that assess the midwives caring behavior and adopted from Jean Watson"s caring behavior assessment tool (15), and it has been frequently used as a valid and reliable tool to measure this variable. Though there are some questionnaires that was taken out from the tool that does not have relevance on the study that will decrease the validity of the tool, in order to avoid that expertise assess the validity of the questionnaires .The original scale is a 63-item and reduced to 48 items, with 5-point Likert scale that measures caring behavior of midwifes. From 1 = Very dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, 5 = Very satisfied. Part I and Part II are socio demographic questionnaires and pregnancy related information respectively. Part-III: is caring behavior assessment with Likert scale modified and adapted from Jean Watson"s behavior assessment tool.

The questionnaire consist all the variables that directly meet the objective of the study. English prepared questionnaire were translate in to Amharic and decoded into Somali language. It then back translated to English to make sure the accuracy of the translated versions. Data collection was conducted by the trained data collectors. Training was given to data collectors and supervisors for two day. In the training session, the data collectors were orient on the objectives of the study, and on keeping confidentiality of respondents. Modification also done based on feedback from the pretest. The principal investigator and the supervisor were strictly followed the overall activities and completeness of the questionnaire.

Five percent of the questionnaire was pre-tested out of the selected health centers and clarity, sequence, consistency, understandability and total time were assessed. Then necessary comments

and feedbacks were incorporated in the final tool and the final questionnaire was used for data collection.

4.5.2 Data collectors

The data collectors were nine female midwives and nurses who does not work in the selected health center, have good communication skill and speak the local language fluently with good data collection experience. Since all data collectors were females, respondents were able to freely respond to sensitive issues. Two supervisors were selected and they follow strictly. Orientation about the general aims of the study was part of the training session.

4.5.3 Data quality control

To assure the data quality high emphasis were given in designing data collection.

Data quality control was assured through the following: -

- Careful modification of the data collection tool (CAT) according to ANC context.
- The data collection tool was pre-tested,
- Data collectors and coordinators were trained,
- The data collection procedure was checked frequently, through supervision and frequent checking of information collected for its consistency, regular meetings were held between the data collectors and the principal investigator.
- Coding and data cleaning were done (checked frequencies and cross-tab for each item)

4.6 Study variables

Dependent variables

- Caring behavior assessment tool

Independent variables

- Age
- Religion
- Marital status
- Education level
- Occupation
- Monthly income
- Number of family member
- Age of mother during first pregnancy
- Gravida
- Parity
- Number of live birth
- Gestational age,
- No of ANC visits,
- Pregnancy related illness

4.7 Operational definitions

Care - The provision of what is necessary for the health, welfare, maintenance, and protection

Caring behavior – It is how the midwife behaves or acts to provide an essential care for someone who need it and fulfills the measurement that will be described in the CAT which have a five point Likert scale that measures 1 = Very dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, 5. Very satisfied, based on the midwives caring behavior and mean value was calculated then those who are greater than the mean consider as "clients who have positive

perception about caring behavior of midwives" and those who are less than the mean value are considered as "clients who have negative perception about the caring behavior".

Midwife – A person qualified to deliver babies and to care for women before during and after child birth.

4.8 Data processing and analysis

Data were entered into Epidata-3.1 and exported to SPSS 20.0 for analysis. The Statistical Package for the Social Sciences/Personal Computer (SPSS/PC) was used for computing Statistics. Frequency distributions were obtained to check for data entry errors (e.g. unrecognized or missing codes). Descriptive statistics was computed and binary logistic regression was also conducted to examine the effect of selected variables on clients‟ perception with midwifery care. Clients‟ perception score was computed as follows, first recoded the scale as 1=1, 2=2, 3=3, 4=4 and 5=5; Mean scores and standard deviations were calculated for each questionnaire item to find the positive and negative perception about midwifery caring behaviors and item variability. All items were then grouped into subscales and the overall mean was calculated for each subscale. Overall item means for each of the subscales were also calculated to determine the rank distribution of the subscales. Midwifery caring behavior perception importance was broadly classified as positive and negative perception which refers to responses for the greater than the mean value is positive perception of caring behavior of midwives and negative perception refers to those whose value is less than the mean.

4.9. Ethical consideration

Ethical clearance was initially obtained from Addis Ababa University Faculty of Medicine College of health sciences, school of allied nursing and midwifery ethical review committee.

Further, written consent was secured from Somalia Regional Health Bureau. Also woreda administrators were communicated through formal letters from Ethiopian Somali Health Bureau in addition to personal communication. Each mother (the study unit) was informed about the study to obtain their written consent before starting the interview. They were assured that an individual data (information) would be kept confidentially. Unwilling mothers were not encountered during data collection.

CHAPTER FIVE

RESULT

5.1 Socio – demographic characteristics

A total of 384 women respond to the questioner which yields a 100% respondent rate. The mean age of the respondents was 26.64± 6.0(SD) years. Most (30.5%) of the women who respond to the questioner were within the age group of 21 to 25 years. Majority (95.1%) were married at the time of data collection. And 2.6% were widowed.

Majority (78.4%) of the respondents were Muslims followed (17.7%) were orthodox Christians. Most (46.9%) of the respondents never attend school. Eleven (2.9%) of them were 12 and above.

Majorities (68.8%) of the respondents were house wives and (2.3%) were students. The mean monthly income of the respondents was 1671.61 ±1267(SD) ETB. (Table 1)

Table 2 Socio-demographic characteristics of mothers in Fafan zone Somali region Ethiopia. (n = 384), 2015

Variables	Frequency	Percent
Age category		
15-20	73	19
21-25	117	30.5
26-30	103	26.8
31-35	57	14.8
>35	34	8.9
Religion		
Muslim	301	78.4
Orthodox	68	17.7
Catholic	2	.5
Protestant	13	3.4
Marital status		
Married	365	95.1
Divorced	9	2.3
Widowed	10	2.6
Educational level		
Never attend	180	46.9
Only read and write	48	12.5
Elementary school	91	23.7
Secondary school	54	14.1
12+	11	2.9
Occupation		
House wife	264	68.8
Maid servant	20	5.2
Civil servant	54	14.1
Merchant	37	9.6
Student	9	2.3
Monthly income		
≤1000	137	35.7
1001-2000	159	41.4
>2001	88	22.9
No of family member		
≤ 2	104	27.1
3-5	177	46.1
≥ 6	103	26.8

5.2 Pregnancy related information

Majority (75.8%) of the mothers have their first pregnancy at the age of 15 -20 years. Out of the respondent (20.8%) of them are primi gravida and the remaining (79.2%) were multi gravida. Most (54.9%) of the respondents have more than delivery and (20.8%) of the respondents were nulli Para.

Considering alive birth delivery, (52.9%) of the respondents give alive birth more than once. During the course of data collection, most (46.4%) were found in third trimester and (39.6%) were in second trimester.

Most (44%) were on their first antenatal visit and (33.9%) of mothers were during second antenatal visit. Majority (84.6%) of respondents have no any pregnancy related illness

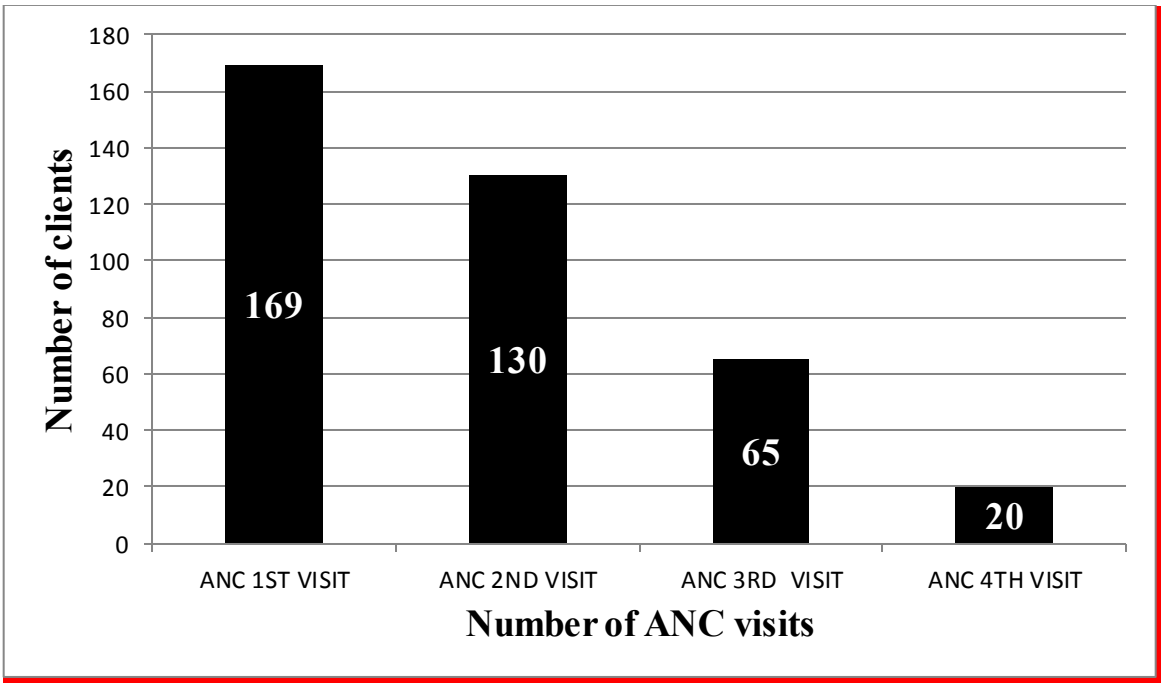

Figure 3 Number of ANC visit

Table 3 Pregnancy related information of mothers in Fafan zone Somali region Ethiopia. (n=384), 2015

Variables	Frequency	Percent
Age during 1st pregnancy		
15-20	291	75.8
21-25	82	21.4
26-30	11	2.9
No of pregnancy		
Primi gravida	80	20.8
Multi gravida	304	79.2
No of delivery		
Nulli Para	80	20.8
Primi Para	93	24.2
Multi Para	211	54.9
No of live birth		
0	95	24.7
1	86	22.4
>1	203	52.9
Gestational age		
1st trimester	54	14.1
2nd trimester	152	39.6
3rd trimester	178	46.4
ANC visits		
1st visit	169	44.0
2nd visit	130	33.9
3rd visit	65	16.9
4th visit	20	5.2
Any pregnancy related illness		
Yes	59	15.4
No	325	84.6

5.3 Caring Behavior Assessment Tool

The caring assessment tools have seven subscales that includes Humanism/Faith-hope/Sensitivity, Helping/ Trust , Expression of positive/ Negative feeling, Teaching /Learning, Supportive/ Protective/ Corrective environment, Human need assistance, Existential /Phenomenological/ Spiritual forces that contains different number of items which help to measure caring behavior of midwives in the health institutions.

Table 4 Mean score of caring behavior assessment tool in Fafan zone Somali region Ethiopia. (n=384), 2015.

Variable	Mean	Std .deviation	Variance
Humanism/Faith-hope/Sensitivity	64.67	8.627	74.426
Helping/ Trust	19.59	3.944	15.554
Expression of positive/ Negative feeling	12.82	1.916	3.671
Teaching /Learning	27.90	5.935	35.226
Supportive/ Protective/ Corrective environment	33.72	5.071	25.717
Human need assistance ,	29.11	4.463	19.922
Existential /Phenomenological/ Spiritual forces	12.92	2.071	4.291
Caring assessment behavior total	200.73	27.142	736.663

On the basis of a single item analysis, participant mean scores on caring behavior were calculated, with a range that fell between 2.88 and 4.44. As shown in Table 6 and 7, the range of mean scores of the top 10 caring behaviors was ranked in terms of most important and fell in a narrow range (4.30 to 4.44). The range of mean scores for the 10 caring behaviors ranked as least important was considerably wider (2.88 to 4.15).

Table 5 The mean and standard deviation for the 10 most important midwifery caring behaviors.

Items	Mean(SD)
Treat me as an individual	4.44(0.683)
Point out positive things about me and my condition	4.41(0.683)
Help me with my care until I'm able to do it for myself	4.40(0.678)
Know what they're doing.	4.39(0.746)
Be sensitive to my feelings and moods.	4.36(0.796)
Really listen to me when I talk.	4.35(0.763)
Treat me with respect.	4.34(0.768)
Seems to know how i feel	4.34(0.751)
Answer my questions clearly.	4.31(0.708)
Help me see that my past experiences are	4.30(0.793)

Five of the top 10 important items for caring behaviors, ranked first, second, fourth, fifth, and seventh, corresponded with humanism/faith-hope/sensitivity subscale.

Four of the 10 least important items for caring behaviors, ranked third, fourth, fifth, and sixth, correspond with the teaching learning sub scale

Table 6 The mean and standard deviation for the 10 least important midwifery caring behaviors

Items	Mean(SD)
Introduce themselves to me	2.88(1.740)
Keep my family informed of my progress.	3.70(1.260)
Ask me what I want to know about my health/ illness.	3.72(1.265)
Help me plan ways to meet those goals	3.73(1.355)
Ask me questions to be sure I understand.	3.77(1.210)
Help me set realistic goals for my health.	3.91(1.183)
Give me their full attention when with me.	4.01(1.008)
Explain safety precautions to me and my family.	4.09(0.846)
Respect my modesty (for example, keeping me covered).	4.13(0.871)
Know how to give shots, IVs, etc.	4.15(0.802)

5.4 Factors associated with caring behavior

5.4.1 Socio-demographic characteristics and caring behavior

Crude analysis of socio demographic variable on binary logistic regression shows that religion, marital status, educational status, occupations, monthly income and number of family member of the respondents were not significantly associated with caring behavior. Mothers with the age of (21-25 years) were three times more likely to have positive perception than mothers with other age groups **[AOR=3.043, 95% CI (1.042, 8.892); p-value ≤ 0.05]**. Mothers who never attend school were nine times less likely to have positive perception than those who are 12 and above after controlling the confounders **[AOR= 0.109, 95% CI (0.019, 0.61)].** Likewise, mothers who had elementary school education level were five times less likely to have positive perception on the caring behavior of midwives than those who had 12 and above education level **[AOR=0.151, 95%CI (0.027,0.850)].** Mothers with less than three family members were five times less likely to have positive perception with the caring behavior than those who had greater than seven family members [**AOR = 0.212, 95%CI (0.065, 0.697)].**

Table 7 Bivariate and multivariate analysis of socio demographic characteristics and caring behavior assessment of midwives by ANC attending mothers in Fafan zone, Somalia region Ethiopia. (n=384), 2015.

Variables	CAT			
Age category	**+ve Perception**	**-ve Perception**	**COR = 95%CI**	**AOR = 95%CI**
15-20	32	41	1.431(.617, 3.320)	2.870(0.780,0.562)
21-25	65	52	2.292(1.038,5.061)*	**3.043(1.042, 8.892)** **
26-30	54	49	2.020(2.020,0.905)	1.980(0.766,5.117)
31-35	24	33	1.333(0.554,3.209)	1.125(0.416,3.045)
>35	1	22	1	
Religion				
Muslim	142	159	2.009(0.606,6.667)	0.998(0.232,4.297)
Orthodox	41	27	3.417(0.956,12.215)	2.407(0.558,10.388)
Catholic	0	2	0.000(0.000)	0.000(0.000)
Protestant	4	9	1	
Marital status				
Married	178	187	0.952(0.271,3.344)	0.662(0.143,3.072)
Divorced	4	5	0.800(.131,4.874)	0.443(0.048,4.077)
Widowed	5	5	1	
Educational level				
Never attend	84	96	0.328(.084,1.277)	0.109(0.019,0.618) **
Only read and write	28	20	0.525(0.124,2.228)	0.202(0.034,1.211)
Elementary school	43	48	0.336(0.084,1.348)	0.151(0.027,0.850) **
Secondary school	24	30	0.300(0.072,1.255)	0.167(0.028,0.992) **
12+	8	3	1	
Occupation				
House wife	138	126	1.369(0.36,5.212)	2.361(0.530,10.516)
Maid servant	14	6	2.917(0.574,14.824)	4.290(0.651,28.257)
Civil servant	11	43	.320(0.073,1.394)	0.261(0.049,1.393)
Merchant	20	17	1.471(0.340,6.365)	2.281(0.444,11.727)
Student	4	5	1	
Monthly income				
≤1000	73	64	1.249(0.731,2.136)	1.047(0.550,1.994)
1001-2000	72	87	0.906(0.538,1.528)	0.912(0.499,1.667)
>2001	42	46	1	
No of family member				
≤ 2	40	64	0.745(0.428,1.295)	0.212(0.065,0.697)**
3-5	100	77	1.547(0.949,2.522)	0.777(0.401,1.505)
≥ 6	47	56	1	

**** = significant at p-value < 0.05**

5.4.2. Pregnancy related information and Caring behavior

A multivariate analysis was performed to recognize the independent predictors of caring behavior. The bivariate and multivariate analysis shows that age of the mother during her first pregnancy, number of pregnancy, number of delivery, number of live birth, gestational age, and ante natal care visits have no significant association with caring behavior of midwives. Among the pregnancy related information pregnancy related illness shows to have a significant association with caring behavior of midwives, those who have pregnancy related illness were two times less likely to have positive perception than those who have no pregnancy related illness. **[AOR= 0.444, 95%CI (0.224, 0.651)]**

Table 8 Bivariate and multivariate analysis of pregnancy related characteristics and caring behavior assessment of midwives by ANC attending mothers in Fafan zone, Somalia region Ethiopian. (n=384), 2015

Variables	CAT			
Age at 1st pregnancy	**+ve perception**	**-ve perception**	**COR = 95%CI**	**AOR = 95%CI**
15-20	139	152	0.523(0.150,1.824)	0.175(0.029,1.077)
21-25	41	41	0.571(0.155,2.102)	0.221(0.037,1.311)
26-30	7	4	1	
No of pregnancy				
Primi gravida	32	48	0.641(0.388,1.057)	6.947(0.112,429.074)
Multi gravida	155	149	1.040	
No of delivery				
Nulli Para	32	48	0.726(0.431,1.224)	0.062(0.001,6.377)
Primi Para	54	39	1.508(0.921,2.468)	1.155(0.304,4.389)
Multi Para	101	110	1	
No of live birth				
0	41	54	0.846(0.518,1.382)	2.058(0.363,11.655)
1	50	36	1.548(0.930,2.576)	0.800(0.218,2.935)
>1	96	107	1	
Gestational age				
1st trimester	26	28	1.063(0.578,1.955)	1.323(0.555,3.154)
2nd trimester	78	74	1.206(0.782,1.861)	1.563(0.218,2.935)
3rd trimester	83	95	1	
ANC visits				
1st visit	83	86	0.643(0.250,1.654)	0.543(0.162,1.819)
2nd visit	56	74	0.505(0.193,1.317)	0.470(0.148,1.489)
3rd visit	36	29	0.828(0.299,2.294)	0.725()
4th visit	12	8	1	
Any pregnancy related illness				
Yes	19	40	0.444(0.247,0.799)	0.444(0.224,0.651) **
No	168	157	1	

**** = significant at p-value < 0.05**

CHAPTER SIX

DISCUSSION

Client‟s satisfaction with midwifery care is considered as an important factor in explaining clients' perceptions of service quality on midwifery profession. According to O'Connor et al.: It's the patient's perspective that increasingly is being viewed as a meaningful indicator of health services quality and may, in fact, represent the most important perspective (20).

Satisfied client usually trust their health care providers, and as a return they comply with medical and nursing orders. Then, eventually, the client‟s physical and psychological healing process is enhanced and at the same time, they disseminate their experiences to others which increase the number of clients who uses the services. If not satisfied the reverse may happen.

In a study done in Northern Botswana on the quality of care midwives provide during postnatal period says that most of nurses provide equality care during immediate postnatal period and majority of the nurses have good knowledge and practice. In present study 51.3% of mothers have negative perception about caring behavior that was provided by the midwives. Among the CAT items “treat me as an individual (mean sore = 4.44)” and “point out the things about me and my condition (mean sore = 4.41)” which belongs to humanism/faith /hope/sensitivity scored highest this could be caused, since ANC needs a passionate and caring service this categories of items consists items related with giving faith, hope and sensitivity and “introduce themselves to me (mean sore = 2.88)” belongs to helping/trust scored the lowest as single item this also may resulted from most midwives had not the habit of the introducing themselves to the clients but clients need it as a way to trust their providers. Humanism/faith/hope/sensitivity (64.97±8.627) and supportive/protective/corrective environment (33.72±5.071) rated highest as a subscale.

A study conducted in South Africa states health seeking behaviors of antenatal women. A notable theme emerged from the study was the abuse of antenatal mothers by the midwives. And also a In the study that was done in private and state hospitals in Tshwane, Gauteng, South Africa explores midwives‟ perspective of caring during midwifery clinical practice. The findings illustrated that the midwives had excellent theoretical knowledge of caring, but some of them did not display caring behavior during clinical practice. In the finding of this study mother who never attend school found to have a significant association with midwifery caring behavior**.** This could be resulted from mothers who never attend school may not have the knowhow of caring behavior of midwives.

In study at hand, mother with the age of (21-25 years) found to have a significant association with midwifery caring behavior and religion, occupation, marital status age of mother seemed to be irrelevant in clients‟ perception on caring behavior. These implies that clients with medium age group have noble perspective of the care delivered by the midwives and among the pregnancy related information pregnancy related illness were one of the indicator for caring behavior of midwives as perceived by the clients which found to have a significant association with midwifery caring behavior, these implies that those who have pregnancy related illness needs extra care and comfort and midwives should be curious with these mothers.

Another descriptive study about Caring Behaviors by Nurses: Women's Perceptions during Childbirth that will help to detect nursing behaviors perceived as caring by women during childbirth (18). This study used an instrument that lists 63 nursing behaviors in seven subscales and is congruent with Watson's caring factors. Mothers who had uncomplicated vaginal births were asked to rate behaviors of their nurses. Behaviors in the human needs assistance subscale, which included items such as "help me with my care until I'm able to do it for myself', "give my

treatments and medication on time (mean sore = 4.94),” and "check my condition closely," were perceived as the most caring.

Since this study participants were mother who attend at ANC the behaviors in the Humanism/Faith-hope/Sensitivity subscale, which include items like “treat me as an individual (mean sore = 4.44)”, “point out the things about me and my condition (mean sore = 4.41)”, “Help me with my care until I‟m able to do it for myself‟(mean sore = 4.40)” were perceived as most caring; Whereas “introduce themselves to me (mean sore = 2.88)”, „keep my family informed of my progress (mean sore = 3.70)” and “ask me what I wanted to know about my health/illness (mean sore = 3.72)” were considered as less cared.

STRENGTHS AND LIMITATION OF THE STUDY

Strengths

1. The study utilized a valid and standardized instrument (CBAT).
2. The study is the first in its kind, so it will create a way for further investigation.
3. This study has high response rate.

Limitation

1. Since it was an exit interview the respond may have bias.
2. Since the study was conducted in health centers, pregnant mothers who did not come to the health center may not include.
3. There were limitations of literature regarding the perception of antenatal attending mother on caring behavior of midwives.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATION

Conclusion

The results are useful in their own and in similar settings because they can be used by staff midwives to improve practice in various ways. The result revels that most midwives practice client could have negative perception. Those mothers who came with pregnancy related illness is one of the indicators for the negative perception about midwives caring behavior. Thus, examined items with negative clients‟ perception will enable midwives to identify the defects in midwifery care and to establish applicable adjustment. Items with positive clients‟ perception need to be sustained and improved by midwives.

Finally, this study may be the first in its kind so it will be support other researchers to do further studies in midwifery care.

Recommendation

- ✓ The results substantial to administrators of the study area in finding new opportunities of service that reassure investigation of what ANC clients consider important with regard to acceptable caring behavior.
- ✓ Regardless of clients‟‟ written reports, uncaring behavior must be further investigated and managed as a matter of determination.
- ✓ There need to conduct professional caring behavior assessment for the midwives to identify the measurable gaps.
- ✓ There is a need to conduct inclusive research with midwives to gain more understanding of the link between support, burnout and staff turnover.
- ✓ Based on the findings. Midwifery training should include and underline the emotional aspect of caring in the curriculum and assess caring behavior.
- ✓ Further studies that use CAT are recommended to recognize mothers who receive care from midwives.
- ✓ This study should also replicated in a wide range

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ANNEXES

Annex I - CONSENT FORM

Greeting

Hello, my name is ---------- from Addis Ababa University, College health science Department of Nursing and Midwifery; we are conducting a study on assessment of antenatal care client‟s perception of caring behavior of midwives in Fafan Zone, Somali Regional State. You are kindly requested to be included in the study, which will have importance in improving maternal health service delivery. The interview will take _____ minutes. Your participation is voluntarily and you have the right to withdraw the study fully or partially. This decision will never affect you in any ways. If you agree to be included in the study, I will start my questions by asking general identification points. Only honest questions would contribute to the improvement of health planning.

Could I have your permission to continue?

1. Yes, continue with the questions.
2. No, Stop and thank the respondent.

Witness‟s signature certifying that the informed consent has been given.

Witness: Signature_____

Dated _____ Data collector:

Name_____ Signature _____ Dated_____

Result:

1. Questionnaire completed _____
2. Questionnaire partially completed _____
3. Participant refused _____
4. Others (please Specify) _____

Checked by Supervisor:

Name _____

Supervisor‟s Signature _____

Date _____

Annex II - Questionnaire (English version)

Section 1: Socio demographic characteristics and other related questions		
No	Questions	Coding category
101	How old are you?	_____ (age in years)
102	What is your religion?	1. Muslim 2. Orthodox 3. Catholic 4. Protestant 5. Other(specify)
103	Marital status	1. Married 2. Divorced 3. Widowed
104	Educational Level	1. Never attend 2. Only read and write 3. Elementary school 4. Secondary school 5. 12 + 6. Other specify
105	What is your occupation?	1. House wife 2. Maid servant 3. Civil servant 4. Merchant 5. Student 6. Other specify
106	What is Your monthly income?	_____ per month
107	Number of family member	_____
Part two: Maternal and obstetric care		
201	Age of mother on first pregnancy	_____ years
202	Number of pregnancy	_____ in number
203	Number of delivery	_____ in number
204	Number of live birth	_____ in number
205	Gestational age	_____ in number
206	Any pregnancy-related illness? Yes/No	If yes, please specify _____

Part three: Caring behavior assessment tools						
Humanism/Faith-hope/Sensitivity						
301	Treat me as an individual.	5	4	3	2	1
302	Try to see things from my point of view.	5	4	3	2	1
303	Know what they‘re doing.	5	4	3	2	1
304	Reassure me.	5	4	3	2	1
305	Make me feel someone is there if I need them.	5	4	3	2	1
306	Encourage me to believe in myself.	5	4	3	2	1
307	Point out positive things about me and my condition.	5	4	3	2	1
308	Praise my efforts.	5	4	3	2	1
309	Understand me.	5	4	3	2	1
310	Ask me how I like things done.	5	4	3	2	1
311	Accept me the way I am.	5	4	3	2	1
312	Be sensitive to my feelings and moods.	5	4	3	2	1
313	Be kind and considerate.	5	4	3	2	1
314	Maintain a calm manner.	5	4	3	2	1
315	Treat me with respect.	5	4	3	2	1
Hoping/ Trust						
316	Really listen to me when I talk.	5	4	3	2	1
317	Accept my feelings without judging them.	5	4	3	2	1
318	Introduce themselves to me.	5	4	3	2	1
319	Give me their full attention when with me.	5	4	3	2	1
320	Do what they say they will do.	5	4	3	2	1
Expression of positive/ Negative feeling						
321	Encourage me to talk about how I feel.	5	4	3	2	1
322	Help me understand my feelings.	5	4	3	2	1
323	Don‘t give up on me when I‘m difficult to get along with.	5	4	3	2	1

Teaching /Learning						
324	Encourage me to ask questions about my illness and treatment.	5	4	3	2	1
325	Answer my questions clearly.	5	4	3	2	1
326	Teach me about my illness.	5	4	3	2	1
327	Ask me questions to be sure I understand.	5	4	3	2	1
328	Ask me what I want to know about my health/ illness.	5	4	3	2	1
329	Help me set realistic goals for my health.	5	4	3	2	1
330	Help me plan ways to meet those goals.	5	4	3	2	1
Supportive/ Protective/ Corrective environment						
331	Understand when I need to be alone.	5	4	3	2	1
332	Explain safety precautions to me and my family.	5	4	3	2	1
333	Give me pain medication when I need it.	5	4	3	2	1
334	Encourage me to do what I can for myself.	5	4	3	2	1
335	Respect my modesty (for example, keeping me covered).	5	4	3	2	1
336	Consider my spiritual needs.	5	4	3	2	1
337	Are gentle with me.	5	4	3	2	1
338	Are cheerful.	5	4	3	2	1
Human need assistance						
339	Help me with my care until I'm able to do it for myself.	5	4	3	2	1
340	Know how to give shots, IVs, etc.	5	4	3	2	1
341	Know how to handle equipment (for example, monitors).	5	4	3	2	1
342	Keep my family informed of my progress.	5	4	3	2	1
343	Check my condition very closely.	5	4	3	2	1
344	Help me feel like I have some control.	5	4	3	2	1
345	Know when it's necessary to refer	5	4	3	2	1

Existential /Phenomenological/ Spiritual forces						
346	Seem to know how I feel.	5	4	3	2	1
347	Help me see that my past experiences are	5	4	3	2	1
348	Help me feel good about myself	5	4	3	2	1

Annex III: የሚ ስጥር አጠባበቅ ስምምነት

ጠ ይስጥልኝ እኔ _____ እባላለሁ፡፡ በአዲስ አበባ ዩንቨርስቲ የህክምና ፋካሊቲ የነርስና ሚድዋይፈሪ ትምህርት ክፍል የደህረ ምረቃ ፕሮግራም ተማሪ ነኝ፡፡ የዚህ ጥናት አላማ ለእርግዝና ክትትል የሚመጡ እናቶች በአዋላጅ ነርሶች የእንክብካቤ ባህሪያት ላይ ያላቸውን አመለካከት ላይ ጥናት ማካሄድ ነው፡፡ እርስዎም በዚህ ጥናት ላይ እንዲሳተፉ በትህትና ይለመኖሉ፡፡ ይህም የእናቶችን የጠ አሰጣጥ አገልግሎት ለማሻሻል ይረዳል፡፡

ይህ የጥናት ጥያቄ ቃለ መጠየቅ _____ ደቂቃዎችን ይፈጃል፡፡ በዚህ ጥናት ለመሳተፍ ፈቃደኛነትዎን እንጠይቃለን፡፡ ከዚህም በተጨማሪ በዚህ ጥናት ላይ በከፊልም ሆነ በሙሉ ያለመሳተፍ መበትዎ የተጠበቀ ነው፡፡ በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ከሆኑ ጥያቄዎችን በአጠቃላይ ነጥቦች በማነሳት እጀምራለሁ፡፡ ትክክለኛ ሚጃ መስጠት ለጠ መሻሻል እንዲሚዳ ለማሰብ እወዳለሁ፡፡

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት?

1. አዎ – መልሱ አዎን ከሆነ ወደሚቀጥለው ጥያቄ እለፍ/ፊ
2. የለም– መልሱ የለም ከሆነ አመሰግነህ/ሽ/ ጥያቄውን አቋርጪ/ጭ/

ለጥናቱ ፈቃደኝነቱን ያረጋገጠው ፊርማ በሚስጥር አጠባበቅ ስምማት እንደሰጠ ያረጋግጣል፡፡

ምስክር _____ ፊርማ_____ ቀን_____

<u>የጉብኝቱ ወጤት</u>

1. ተሟልቷል
2. በከፊል ተሟልቷል
3. ተቃውሞ
4. ሌላ ካለ ይገለፅ

Annex IV: መ ጠ ይ ቅ (አማርኛ)

ክፍል 1 ማህበራዊ ስነ -ህዝብ ባህሪያት እና ሌላ ተያያዥ ጥያቄዎች		
ቁጥር	ጥያቄዎች	የኮድ ምድብ
101	እድሜዎ ስንት ነው ?	_____ (እድሜ በአመት)
102	ሃይማኖትዎ ምንድነ ወ?	5.1.1.1. ሙስሊም 5.1.1.2. ኦርቶዶክስ 6. ካቶሊክ 7. ፕሮቴስታንት 8. ሌላ ይገለጽ
103	የጋብቻ ሁኔታዎ	1. ያገቡ 2. የፈቱ 3. የመት ባለቤት
104	የትምህርት ደረጃዎ	1. ፊደሞ አልተማርኩም 2. ማንበብ እና መጻፍ ብቻ 3. 1ኛ ደረጃ ት/ቤት 4. 2ኛ ደረጃ ት/ቤት 5. 12 + 6. ሌላ ይገለጽ
105	ስራዎ ምንድነ ወ?	ነ. የቤት እመቤት 2. የቤት ሰራተኛ 3. ሲቪል ሰራተኛ 4. ነጋዴ 5. ተማሪ 6. ሌላ ይገለጽ
106	ወርሃዊ ገቢዎ ምን ያህል ነ ወ?	_____ በወር
107	የቤተሰብ አባላት ብዛት	_____
ክፍል 2 የእናቶች እና የሚወልን እንክብካቤ		
201	በመጀመሪያ እርግዝና ወቅት የእናት እድሜ ምን ያህል ነበር	_____ አመት
202	የእርግዝና ብዛት	_____ በቁጥር
203	የወለዱት ብዛት	_____ በቁጥር

204	በህይወት ተወለዱ ብዛት	_____ በቁጥር
205	የእርግዝና እድሜ	_____ በቁጥር
206	ከእርግዝና ጋር ተያይዞ የመጣ ህመም ካለ	መልሱ አዎን ከሆነ ይገለጽ

ክፍል 3፡ የእንክብካቤ ባህሪ ምዘና መላሪያዎች						
ሰብዓዊነት/እምነት–ተስፋ/ ንቁነት						
301	እንደግለሰብ ይቆጥሩኛል	5	4	3	2	1
302	ነገሮችን ከኔ አሚላካከት አኳያ ለመሚልከት ይሞክራሉ	5	4	3	2	1
303	ምን እንደሚሰሩ ያወቃሉ	5	4	3	2	1
304	ያረጋጉኛል	5	4	3	2	1
305	ካስፈለጉኝ ሰዎች አጠገቤ እንዳሉ እንዲሰማኝ ያደርጉኛል	5	4	3	2	1
306	በራሴ እንዳምን ያበረታቱኛል	5	4	3	2	1
307	ስለእኔ እና ሁኔታዬ በጎ ነገሮች ይገልጻሉ	5	4	3	2	1
308	ጥረቴን ያሞግናሉ	5	4	3	2	1
309	ይረዳኛል	5	4	3	2	1
310	ነገሮች እንደት እንዲሰሩ እንደምፈልግ ይጠይቁኛል	5	4	3	2	1
311	እንደሁኔታዬ ይቀበሉኛል	5	4	3	2	1
312	ስለስሜቴ እና መዴ ንቁ ናቸው	5	4	3	2	1
313	ደግ እና ከግምት የሚስገቡ ናቸው	5	4	3	2	1
314	የተረጋጋ ሁኔታ ይጠቡቃሉ	5	4	3	2	1
315	በክብር ይይዙኛል	5	4	3	2	1
ተስፋ ሞድረግ / እምነት						
316	ስናገር በደንብ ያዳምጡኛል	5	4	3	2	1
317	ያለፍርድ ስሜቴን ይቀበላሉ	5	4	3	2	1
318	እነርሱን ለእኔ ያስተዋወቁኛል	5	4	3	2	1
319	ከእኔ ጋር ሲሆኑ ማሉ ትኩረታቸወን ይሰጡኛል	5	4	3	2	1
320	እነርሱ እንሰራለን የሚሉትን ይሰራሉ	5	4	3	2	1
በጎ /በጎ ያልሆነ ስሜት መግለጽ						
321	ምን እንደሚሰማኝ እንድናገር ያበረታቱኛል	5	4	3	2	1
322	ስሜቴን እንድረዳ ይረዱኛል	5	4	3	2	1
323	አስቸጋሪ ስሆን ስለእኔ ተስፋ አይቆርጡም	5	4	3	2	1
ሚስተሞር /መሚር						
324	ስለ ህመሜ እና ህክምናዬ ጥያቄ እንድጠይቅ ያበረታቱኛል	5	4	3	2	1
325	ጥያቄዬን በግልጽ ይመልሳሉ	5	4	3	2	1

326	ስለ በሽታዬ ያስተምሩኛል	5	4	3	2	1
327	ሚዳቴን ለሚጋገጥ ጥያቄዎች ይጠይቁኛል	5	4	3	2	1
328	ስለጠፍ /በሽታዬ ምን ማመቅ እንደምፈልግ ይጠይቁኛል	5	4	3	2	1
329	ስለጠፍዬ እውተኛ ግቦች እንዲኖረኝ ያግዙኛል	5	4	3	2	1
330	እነዚህን ግቦች ለማሳካት እንዳቅድ ይርዱኛል	5	4	3	2	1
ደጋፊ/ተከላካይ/አስተካካይ አካባቢ						
331	ለብቻዬ መሆን ስፈልግ ይረዱኛል	5	4	3	2	1
332	ለእኔ እና ለቤተሰቤ የደህንነት ጥንቃቄዎች ያብራሩልናል	5	4	3	2	1
333	ሲያስፈልገኝ የህመም ህክምና ይስጡኛል	5	4	3	2	1
334	ለራሴ ምን ማድረግ እንዳለብኝ እንድፈጽም ያበረታቱኛል	5	4	3	2	1
335	ምኞቴን ያከብራሉ (ለምሳሌ እንደሸፈን ማድረግ)	5	4	3	2	1
336	መንፈሳዊ ፍላጎቶቼን ከግምት ያስገባሉ	5	4	3	2	1
337	ከእኔ ጋር በጎ ናቸው	5	4	3	2	1
338	ከእኔ ጋር ደስተኛም ናቸው	5	4	3	2	1
የሰው ፍላጎት እገዛ						
339	ለራሴ ሜጸም እስክችል እኔን ይንከባከባሉ	5	4	3	2	1
340	ሞር፣ አይቪ ወዘተ እንዴት እንደሚከጡ ያውቃሉ	5	4	3	2	1
341	መሳሪያ እንዴት መጠቀም እንዳለባቸው ያውቃሉ (ለምሳሌ ሞኒተሮች)	5	4	3	2	1
342	ስላለኝ ሂደት ለቤተሰቤ ያሳውቃሉ	5	4	3	2	1
343	ያለኝን ሁኔታ በጣም በቅርብ ያረጋግጣሉ	5	4	3	2	1
344	ቁጥጥር እንዳለኝ እንዲሰማኝ ያግዛሉ	5	4	3	2	1
345	ሪፈር ሞድረግ አስፈላጊ ሲሆን ያውቃሉ	5	4	3	2	1
ያሉ/ክስተታዊ/መንፈሳዊ ሃይሎች						
346	ምን እንደሚሰማኝ ለመወቅ ይሞክራሉ	5	4	3	2	1
347	ያለፉ ልምዶቼ ምን እንደሆኑ ለሞጀት እንድችል ያግዙኛል	5	4	3	2	1
348	ስለራሴ ጥሩ እንዲሰማኝ ይረዱኛል	5	4	3	2	1

Annex V-Foomka ogolaan shaha
Salaam bixin

Ak magacaygu waa_____ waxaan kasocdaa jaamacada addis ababa,gaar ahaan kuliyada caafimaadka waaxda kalkaalinta caafimaadka iyo umulisada. Waxaan daraa sad kasamaynayaa qiimaynta hooyada uurka leh iyo argitida macaamishu kaqabaan habkla xanaano bixinta umulisooyinka gobalka faafan ee DDSI. Hadaba, waxaa si sharaf leh lagaaga codsanayaa in aad kaqaybqaadato daraasadan,taaso ahmiyad balaadhan uyeelan doonta kor uqaadida adeeg bixinta caafimadka hooyada uurka lehkulan waraysigani waxaa uu qaadan doonaa _____ daqiiqado. Waad umadax banaantahay ka qaybqaadashada daraasadan,waxaad xaq mudantahay inaad qaayb ahaan ama si buuxda uga tanaasusho kaqaybgalka daraasadan.

Gobankaaga habayaraata wax saamayn ah kuyeelan maato hadii aad raali kanoqoto inaad kaqayb qaadato daraasadan. Waxan kubilaabi aniga oo kuwaydiin doona su'aalo qodobo guud. Waxaa waxtan ukeeni kora kor uqaadista qorshaha caafimaa kaliya hadii lahelo jawaab cadaalad kusalaysan.

Fadlan ma bilaabi kartaa? Fadlan ii ogolaw inaan bilaabo su'aalda

- Haa waad bilaabi kartaa su'aasha
- Maya, jooji dheh,una mahadnaqo kaqayb qaataha

Saxee xa goobjoogaha oo cadayn u ah in lahelay dulucda warbixinta

Saxee xa goobjoogoha_____

Taariika_____ xog uruuriye

Magaca _____ saxeexa_____taarika_____

Natiijo / Jawaab

1. Dhamaystirka xog uruurinta_____
2. Dhamaystirka qayb kamid ah xaq urrrinta_____
3. Ka qayb qaataha katanaasulay_____
4. Waxyaa bo kali(fadlan cadee)_____

Korrneeraho hubiyay

Magaca _____

Saxeexa kormeeraha_____

Taariikh_____

Annex VI: Af somaliga

Section 1: Socio demographic characteristics and other related questions		
No	Questions	Coding category
101	IMisa Sano baad tahay?	_____ jir
102	Waa maxay Diintaadu?	6. Muslim 7. Orthodox 8. Catholic 9. Protestant 10. Other(specify)
103	Xaalada guur	4. Guursadey 5. Gala tagay 6. Carmali
104	Heer ka waxbarasho	7. Ma dhiganing 8. waxna qora waxna akhriya 9. Dugsi hoose 10. Dugsi sare 11. 12 + 12. Sheeg hadii heer kala aad wax u baratay
105	Waa maxay shaqadadu?	7. Huri joog 8. Maid servant 9. Shaqalo dowladed 10. Ganacsade 11. Arday 12. waxii kale cadee
106	Waa imisa dakhliga bishii kusoo gala?	_____ Bil ahaan
107	Tirade Qoyskaaga	_____

Part two: Maternal and obstetric care		
201	Da‟da hooyada uurka koowaad	_____ years
202	Tirada uurka leh	_____ in number
203	Number of delivery	_____ in number
204	Tirade nolol ku dhasha	_____ in number
205	Da‟da Uurka	_____ in number

Part three: Caring behavior assessment tools						
Humanism/Faith-hope/Sensitivity						
301	Iila dhaqan sidii qof.	5	4	3	2	1
302	isku day inaad wax u aragto sidayda.	5	4	3	2	1
303	Way garanayaan waxay qabanayaan.	5	4	3	2	1
304	II hubi.	5	4	3	2	1
305	I, ag joog waxkastoon u baahdo.	5	4	3	2	1
306	I dhiiri gali sidaan naftayda u aamino.	5	4	3	2	1
307	Sheeg dhankayga wanaagsan & caafimaadkaygaba.	5	4	3	2	1
308	Amaan dadaalkayga.	5	4	3	2	1
309	I fahan.	5	4	3	2	1
310	I waydii sidaan u jecelahay waxa laqabto.	5	4	3	2	1
311	Igu yeel sidaan ahay.	5	4	3	2	1
312	Haku damaqdo dareenkayga & muudhka aan ku jiro.	5	4	3	2	1
313	Noqo mid xaadhan oo tixgaliya.	5	4	3	2	1
314	Is Daji had & Jeer.	5	4	3	2	1
315	Iila dhaqan si tixgalin leh.	5	4	3	2	1
Hoping/ Trust						
316	Xaqiiqdii Way I dhagaystaan markaan hadlaayo.	5	4	3	2	1
317	Aqbal dareenkayga adigoon xukumahayn iyaga.	5	4	3	2	1
318	Way iskay baraan.	5	4	3	2	1
319	Isiiyaan dareenkooda markay ila joogaan.	5	4	3	2	1
320	Maqabtaan waxay yidhaden waan qaban doonaa.	5	4	3	2	1
Expression of positive/ Negative feeling						
321	Igu dheeri galiyaan inaan ka hadlo waxaan dareemaayo.	5	4	3	2	1
322	Igu caawiyaan inaan fahmo dareenkayga.	5	4	3	2	1
323	Iskama kay daayaan xitaa haday ku adkaato inay	5	4	3	2	1

	ila jaan qaadaan.					
Teaching /Learning						
324	Igu dhiirigaliyaan inaan su‘aalo kawaydiiyo xanuunkayga iyo sida loola tacaalayo/daawaynayo.	5	4	3	2	1
325	Si fiican ayey uga jawaabaan su‘aalahayga.	5	4	3	2	1
326	I baraan xanuunkayga.	5	4	3	2	1
327	I waydiiyaan su‘aalo ay ku xaqiijinayaan inaan fahmay.	5	4	3	2	1
328	i waydiiyaan waxaan uga baahnahay caafimaadkayga/ xanuunkayga.	5	4	3	2	1
329	Igu caawiyaan inaan u jeexo himilo caafimaadkayga.	5	4	3	2	1
330	Iga caawiyaan qorshahaan ku gaadhi lahaa himiladayda caafimaad.	5	4	3	2	1
Supportive/ Protective/ Corrective environment						
331	I fahanmaan hadii aan doonayo inaan kaliyeysto.	5	4	3	2	1
332	Ii sharaxaan badbaadada taxadarka, Aniga iyo Qoyskayga	5	4	3	2	1
333	Isiiyaan xumad jabiye hadaan u baahdo.	5	4	3	2	1
334	Igu dhiiri galiyaan inaan qabsado waxaan qaban karo.	5	4	3	2	1
335	Ixtiraamaan jidhkayga (tusaale ahaan, asturaan cawradeyda)	5	4	3	2	1
336	Tixgaliyaan waxa nafsadeydu u baahan tahay.	5	4	3	2	1
337	Ii maskax furan yihiin aniga.	5	4	3	2	1
338	Waa waji faraxsananayaal.	5	4	3	2	1
Human need assistance						
339	Iga caawiyaan xanaaneyntayda ilaa aan ka awooda inaan qabsan karo.	5	4	3	2	1

340	Way ogyihiin circadian,ayfiiga,IVs,side layku siiyo	5	4	3	2	1
341	Way yaqaaniin sida loo qabto qalabka	5	4	3	2	1
342	Lasocod siiyaan markasta xaaladayda qoyskayga.	5	4	3	2	1
343	U hubiyaan xaaladayda si dhow/ hoose.	5	4	3	2	1
344	Igu caawiyaan inaan dareemo inaan ku jiro gacantooda.	5	4	3	2	1
345	Way ogsooniyihiin inay muhiim tahay tixraac sameegn	5	4	3	2	1
Existential /Phenomenological/ Spiritual forces						
346	I muuqdaan inay garanayaan waxaan dareemaayo.	5	4	3	2	1
347	Way iga caawiyaan ayitusaan waxii hoary caadada iiahayd	5	4	3	2	1
348	Iga caawiyaan inaan is dareensiiyo inaan wanaagsanahay	5	4	3	2	1

DECLARATION

I, the undersigned, declared that this thesis is my original work and has not been presented for a degree in this or any other university, and all source materials used for the thesis have been fully acknowledged.

Name of the student: Meron Kibru Abzaw

Signature: _____

Place: Addis Ababa

Date of submission: _____

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

Advisor Name: Ato Fekadu Aga (RN, BSc, MSc, Assistant professor)

Signature _____

Date _____