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# Fear of Childbirth Among Pregnant Women Attending Antenatal Care in Debrebirhan Town Public Health Institution , Amhara, Ethiopia, 2022/23

Surafel, Shewatatek

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**BAHIRDAR UNIVERSITY**

**COLLEGE OF MEDICINE AND HEALTH SCIENCE**

**SCHOOL OF HEALTH SCIENCE**

**DEPARTMENT OF MIDWIFERY**

**FEAR OF CHILDBIRTH AMONG PREGNANT WOMEN ATTENDING  
ANTENATAL CARE IN DEBREBIRHAN TOWN PUBLIC HEALTH  
INSTITUTION, AMHARA, ETHIOPIA, 2022/23**

**BY: SURAFEL SHEWATATEK [BSc]**

**A THESIS SUBMITTED TO THE MIDWIFERY DEPARTMENT, SCHOOL OF  
HEALTH SCIENCE, COLLEGE OF HEALTH SCIENCES, BAHIRDAR UNIVERSITY  
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF  
Masters Science in CLINICAL MIDWIFERY**

**April 2023**

**Bahir Dar**

**BAHIRDAR UNIVERSITY**  
**COLLEGE OF HEALTH SCIENCES**  
**SCHOOL OF HEALTH SCIENCE**  
**DEPARTMENT OF MIDWIFERY**

**FEAROF CHILDBIRTH AMONG PREGNANT WOMEN ATTENDING  
ANTENATAL CARE IN DEBREBIRHAN TOWEN PUBLIC HEALTH  
INSTITUTION, AMHARA, ETHIOPIA.2022/23**

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**April,2023**

**BAHIRDAR,ETHIOPIA**

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

This thesis is submitted for partial fulfillment of a Master's of science in Clinical Midwifery from Bahirdar University College of Medicine and Health Science. The thesis will be deposited in the library of Bahirdar University and will be made accessible for readers under the rules of the library. I solemnly declare that this thesis has not been submitted to any other institution anywhere for the award of any academic degree, diploma or certificate.

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Approval of final thesis document I hereby certify that I had advised, supervised, and evaluated this research paper which is entitled

FEAR OF CHILDBIRTH AMONG PREGNANT WOMEN ATTENDING ANTENATAL CARE IN DEBREBIRHAN TOWN PUBLIC HEALTH INSTITUTION, AMHARA, ETHIOPIA, 2022/23. A Institution based study was investigated by Surafel Shewatek with my advice, guidance, and support. Hence, I approve as this thesis can be submitted as the final thesis draft for different purposes.

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I hereby certify that I have examined this thesis report entitled as "FEAR OF CHILDBIRTH AMONG PREGNANT WOMEN ATTENDING ANTENATAL CARE IN DEBREBIRHAN TOWEN PUBLIC HEALTH INSTITUTION, AMHARA, ETHIOPIA, 2022/23. By Surafel Shewataek. We recommend and approve the thesis report for a degree of "Masters of science in Clinical Midwifery".

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## **LIST OF ACRONYMS AND ABBREVIATIONS**

ANC	Ante Natal Care
AOR	Adjusted Odds Ratio
BDU	Bahir Dar University
BOC	Birth Out Come
CI	Confidence Interval
COR	Crude Odds Ratio
CS	Cesarean Section
DBCSH	DebreBirhan Comprehensive Specialized Hospital
DM	Diabetic Mellitus
FOC	Fear OF Childbirth
GA	Gestational Age
HEG	Hyper emesis Gravidarum
MOD	Mode of Delivery
MSc	Masters of Science
PIH	Pregnancy Induced Hypertension
PNC	Postnatal Care
SVD	Spontaneous Vaginal Delivery
WDEQ	Wijma Delivery Expectancy Questionnaire
WHO	World Health Organization

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## ABSTRACT

**Background:** Feelings of uncertainty and concern before, during, or after labor are referred to as fears of childbirth. Women face a variety of worries related to childbirth, from minor ones to serious ones. It has an impact on the health of women during the postpartum period and her family..

**Objective:** The objective of this study was to determine the Fear of childbirth among pregnant women attending antenatal care in Debre Birhan Town Public Health Institution, Amhara, Ethiopia. 2022/ 2023.

**Methods:** A cross-sectional study was carried out among 405 pregnant patients receiving antenatal treatment at four public health facilities in Debre Birhan Town. choose study participants, a methodical random sampling technique was employed. Face-to-face interviews with a structured, previously tested questioner were used to get the data. To measure fear of childbirth, the Wijma Delivery Expectation/Experience Questionnaire was employed. The gathered data were input. Epi-data-4.6 statistical software was used to enter the collected data, and SPSS-25 statistical packages were used for analysis. For multivariate analysis, a P-value of less than 0.05 was deemed significant in multivariate bivariate analysis when it was less than 0.25 in bivariate analysis.

**Results:** Out of the total, 400 respondents took part in the study with a response rate was 98.8%. This study showed that 45(11.3%) of study participants had low fear of childbirth, 225(56.3%) moderate, 93(23.3%) high, 37(9.3%) severe fear of childbirth. Having no formal education (AOR=5, 95%CI:(1.37-18.15)(p=0.02), previous obstetrics complications AOR=3, 95%CI: (1.14-7.8)(p=0.03), mode of delivery preference AOR=3, 95%CI:(1.02-9.03) (p=0.045). Having medical illness AOR=3.6, 95%CI(1.02-9.03)(p=0.02) showed significant association with a fear of childbirth.

**Conclusion and recommendations:** The study setting is one where Fear of childbirth is common. Education level, previous obstetric problems medical illness, and preferred delivery method were all associated with lower levels of fear of childbirth. The women were categorized as having fear of childbirth based on a cut-off value of high and severe fear of childbirth. In the research setting, early detection of women at risk for fear of childbirth is clinically significant to enhance women's health throughout the perinatal period.

**Keywords:** Pregnancy, fear of childbirth, Wijma Delivery Expectancy Questionnaire A, Debre Birhan.

# 1. INTRODUCTION

## 1.1. Background

Fear of childbirth (FOC) is characterized as feelings of unease and apprehension prior to, during, or following childbirth, as well as thoughts about upcoming labor and delivery [1]. It is seeing other people's terrified reactions to labor pain and childbirth. Fear of childbirth, which has an impact on women's health and wellbeing throughout pregnancy and childbirth, appears to be used as a catch-all phrase for all forms of anxieties and fears that women may experience[1]. Tokophobia was formerly defined as an unreasonable fear of childbirth in women, a serious disorder that includes a pathological aversion to childbirth [2]. The North American Nursing Diagnosis Association defines fear as a reaction to a threat that the person consciously recognizes as dangerous [3]. There are perspectives from the psychological, physiological, cognitive, and behavioral fields [4].

FOC is categorized as a primary condition that affects nulliparous people who have experienced sexual abuse in the past, saw a painful birth, or heard or watched stories that make giving birth seem risky or shameful. Multigravida who previously experienced a terrible birth experience develop worry for the upcoming delivery, which is known as secondary FOC. The fear of childbirth was also graded from Mild to severe according to the severity [5]. Due to the adoption of the birthing fear definition, the screening trimester, and the parity of the pregnant women, there were discrepancies in the prevalence of FOC between the nations. Around 14% of pregnant women globally have FOC, and this number has been rising periodically since 2000 [6].

In recent years, there has been an increase in academic interest in tokophobia and perinatal mental health, although different nations have different ways of measuring and defining childbirth phobia. Women experience it differently in terms of severity and underlying causes [1, 6, 7].

A clinical level of worry was experienced by 21 out of every 100 pregnant women in the Eastern area [8]. 1.6% of pregnant women experienced pathological fear, which was linked to episiotomy dread [9]. Prenatal fear of childbirth is associated with higher levels of state anxiety, decreased dyadic adjustment, and increased attachment relationship insecurity. It also led to increased postpartum maternal risk and stress as well as the development of severe labor pain[10,11]. During labor and delivery, mothers who received care from a reputable midwife reported less discomfort and worry. Building a trustworthy relationship between a woman and her midwife improves the quality of care in terms of knowledge, participation in decision-making, and the perception of control. Counseling sessions become more frequent, they prioritize continuity of care more, and they are happier with the counseling [12].

Evidence also suggested that theory-based group psychoeducation with relaxation and cognitive therapy sessions are both useful therapies for antenatal and intrapartum support of expectant mothers with high or severe FOC. To detect and treat women with high to severe FOC, a team approach involving midwives, psychologists, and obstetricians trained in psychotherapy should be created [13]. The companion-integrated birthing preparation for childbirth fear, self-efficacy, and maternal support was successful in Malawi in reducing FOC and improving childbirth self-efficacy [14]. One of the World Health Organization's (WHO) suggestions on interventions targeted at women for the avoidance of needless cesarean sections was psychoeducation for women with FOC throughout pregnancy and after delivery. The instructional materials' informational content covers topics such as pain management, individual reaction stabilization, labor progress, hospital routines, and fear and anxiety associated to childbirth [15]. The WHO's recommendations for a pleasant birthing experience include effective communication, respectful maternity care, and pain relief [16].

## 1.2 Statement of the problems

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

Fear of childbirth may contribute to a number of unfavorable outcomes for mothers, their babies, and families that may occur during prenatal care, labor, and postpartum periods. These outcomes include obstetric complications, surgical vaginal birth, increased use of analgesics in labor, abnormal labor, requests for cesarean sections, postpartum depression, and impaired maternal-infant bonding, as well as an increased risk of both antenatal and postnatal depression [5, 19–22]. Disorders of maternal mental health have a substantial effect on women and their offspring. Preterm labor, poor newborn outcomes, and more severe cognitive, behavioral, and interpersonal issues in early children have all been linked to stress and psychological issues during pregnancy. Postnatal psychological issues are similarly harmful to the mother, child, and family.

Relationship. In the first year following delivery, psychiatric disorders are recognized by the World Health Organization as a substantial indirect cause of maternal death [23]. Maternal age, parity, gestational age, bad birth outcomes, low education, low economic status, poor social support, instrumental and cesarean delivery, low self-esteem, and lack of the husband support were reported as factors that contribute to FOC in various research studies [1, 6, 7, 19, 24].

Numerous studies support the notion that in order to address and reduce childbirth fear, psychosocial and psychological interventions, physical activity, therapeutic standards-setting, prenatal screening tools, undertaking information, antenatal education, and communication programs are essential [25, 26].

Explaining the birthing process, providing treatment that is focused on the needs of women, obtaining informed consent, and the attitude of healthcare professionals toward women who have childbirth fear all help to lessen the fear and adverse effects of childbirth [27, 28].

Continuity of care models give midwives more chances to build trusting connections with women and, as a result, more chances for women to share their anxieties. Biofeedback, hypnosis, and internet-based cognitive behavioral therapy are effective treatments for childbirth fear and also have a positive impact on boosting women's self-efficacy [25, 29]. Developed various efforts to improve the experience of childbirth, but the incidence of its unfavorable effects is still rising globally. Since there is a lack of research on the psychological components of maternal care, particularly in regard to pregnancy anxiety, the issue should be examined in order to design and execute appropriate intervention programs and provide ways to promote women's health, especially in a developing nation like Ethiopia.

### 1.3 Significance of Study

It is possible to identify and prepare pregnant women who have any level of childbirth fear before or during their pregnancies, which can help them have better birthing experiences.

In order to reduce delivery anxiety during the perinatal period, it can be helpful to identify the sources of this worry.

To raise the standard of maternity care by attending to mothers' feelings, thoughts, and emotions throughout their pregnancies, births, and postpartum periods, which can help meet their psychosocial requirements.

serves as a resource to investigate and learn more about related factors, as well as the consequences for future.



## **2. LITERATURE REVIEW**

### **2.1. Fear of childbirth**

For most women, giving birth is a crucial experience that marks the beginning of parenthood on a physical, psychological, and social level. Although safe birthing practices are offered in many nations, some pregnant women may experience a great deal of stress during childbirth [30]. The fear of giving birth is frequently conceptualized as an anxiety-related experience, and clinical presentations of childbirth fear are frequently characterized by symptom manifestations similar to those of different emotional disorders. Although little is known about the psychological mechanisms behind this issue, results linking birthing dread to several anxiety measures have never been formally collected and assessed [31]. Fear and anxiety have physiological components, including reactions like palpitations, hyperventilation, and lightheadedness. Human fear can be acquired through three different mechanisms, including conditioning, vicarious exposure, and the dissemination of knowledge and instruction, according to the conditioning hypothesis of fear acquisition [32].

### **2.2 Prevalence of fear of childbirth**

14% of pregnant women worldwide reported having childbirth fear, according to a meta-analysis study; the majority of this research was conducted in industrialized nations like the USA, Europe, Scandinavia, Asia, and Sweden. It accounts for 12% of cases in Scandinavia, 8% in the rest of Europe, 23% in Australia, 11% in the United States, and 25% in Asia [6]. In Sweden, foreign-born women were three times more likely than Swedish women to experience fear connected to childbirth [33]. According to a study conducted in Khorramabad, 80.8% of prime-gravid women were afraid of giving birth [34]. According to a study done in Thailand's Siriraj Hospital, 0.7% of pregnant women without any obstetric or medical issues reported having a serious dread of giving birth [19]. In a cross-sectional study conducted in Ireland, severe and high levels of antenatal anxiety were shown to be prevalent overall at 5.3 and 36.7 percent, respectively. About 43% of them were high FOC in nulliparous women, and 33.6 % were in multiparous women [7]. According to a survey of pregnant Iranian women, 20% of them experience mild and 6% experience severe birthing phobia [35]. Severe FOC makes for 8% of cases in poor nations [36]. In Malawi, the prevalence of low

FOC before delivery was 39%, that of moderate FOC was 41%, and that of high FOC was 20%. The prevalence of low and moderate FOC was nearly same, but the incidence of high FOC reduced by 50% after delivery. Women experiencing FOC during pregnancy and after delivery are five times more likely to be illiterate, and twelve times more likely to be unemployed. high level of labor phobia [37]. From a research in Kenya, 29.5% reported having a mild fear of childbirth, 40.4% a moderate fear, 22.1% a high fear, and 8% a severe dread [36]. According to a research conducted in Arba-Minch, Ethiopia, between one-third and one-fourth of pregnant women have moderate to severe levels of fear of childbirth [38].

## 2.3 Associated factors of Fear of childbirth

Pregnant women frequently experience fear of giving birth, and severe cases can have an impact on both the health of the mother and the fetus [39]. By identifying the risk factors, it is possible to treat moms who are experiencing this fear early on. The causes and effects of fear of childbirth are categorized into population characteristics, mood-related factors, and pregnancy and birth-related factors in a systematic study. Although the levels of fear in nulliparous and parous women are comparable, distinct factors may contribute to fear of childbirth (FOC). For parous women, the majority of these factors were connected to previous pregnancies, labors, and deliveries [28].

### 2.1.1. Sociodemographic factors

Maternal age, marital status, income, and educational status were all found to be related to dread of childbirth among the demographic factors evaluated in various research, with the lower fear of childbirth being connected with greater socioeconomic status and educational status [7,40,41]. Pregnancy-related labor fear and poor educational attainment were significantly positively correlated in a research among pregnant women in Malawi. Women with lower educational levels had five times more experience than those with higher education, and those who were unemployed had twelve times more experience than those who were in the workforce [37]. Additionally, according to another study, dread of childbirth is adversely correlated with age, income, and education [19,40]. According to a study conducted in Kenya, marital status and level of literacy are strongly correlated with pregnant women's significant childbirth

fear [36]. In a study conducted in Iran there was no significant association between fear of childbirth with maternal age, educational level, employment status, but there was a negative association between FOC and high family income [35]

### **2.1.2. Obstetrics related factors**

According to an Iranian study, gestational age and parity were not important determinants, but women who experienced an unintended pregnancy were three times more likely to have delivery anxiety [35]. According to other research [9,40–43], the majority of pregnant women had FOC connected to a traumatic birth, painful uterine contractions, an instrumental delivery, a bad birth experience in a prior pregnancy, a history of abortion, and a fear of pain. In Khorramabad demonstrated that being in the prime of pregnancy adds to the main causes of birthing anxiety, particularly when pregnant women do not participate in childbirth education, and the manner of delivery is another contributing factor [3]. Unplanned pregnancies greatly increase the likelihood of delivery anxiety, according to a study from Thailand [19]. While gestational age was unrelated to birth phobia in contrast to a study conducted in Turkey [21,40,44], other studies found that women with unplanned pregnancies were roughly twice as likely to have severe degree fear of childbirth compared to those with planned pregnancies. Women with good knowledge about childbirth and access to childbirth information were also associated with a decreased risk of developing a fear of birth. Key variables in women's dread of childbirth were highlighted in an interview with midwives and women, including the fear of unforeseen difficulties and outcomes, damage to the mother or baby during childbirth, labor pain, and other factors. Being by oneself, not making decisions, physical changes before and after birth, and the labor process were all mentioned [45]. According to a study conducted in Kenya, primigravida women were more fearful of giving birth than multigravida women. Additionally, women who received frequent ANC, trusted their healthcare providers, and engaged in physical activity while pregnant felt less fearful of giving birth than those who did not [36]. According to a study conducted in Ethiopia, unplanned pregnancies cause twice as much fear of childbirth as planned pregnancies, and women who are currently experiencing pregnancy-related complications are six times more likely to develop severe levels of fear of childbirth than women whose pregnancies are going smoothly. In contrast to these studies, women whose pregnancies are planned feel more fear of childbirth than women whose pregnancies are unplanned. [38,46].

#### **2.1.4. Social factors**

According to a Thai study, fear of birth is frequently caused by a lack of family support and a lack of witnesses to the delivery [19]. According to a study conducted among Iranian women, those who did not receive any emotional support from their spouses experienced fear of child birth four times as frequently as those who did [35]. A substantial correlation between husband support and a higher level of childbirth fear was found in a study conducted in China. In Ethiopia, women with weak social support experience severe levels of fear of childbirth twice as often [38, 41].

Some studies suggest that theory-based concepts for antenatal and intrapartum support of pregnant women with high or severe childbirth fear, which were tested, evaluated, and implemented within the given healthcare system, qualified healthcare providers who address pregnant women's fears, use of a valid assessment tool to identify the level, cooperative local networks between different healthcare providers to ensure prompt and efficient care for women with high oAn unrelated study revealed that women who received consistent care from a reputable midwife throughout labor and delivery with relation to information, participation in Making decisions and feeling in control help people feel less anxious, and perception of pain and further birth information can help women feel less afraid of giving birth [47, 48]. It is important that the health care providers especially those directly involve in maternity care ANC, PNC, labor, and delivery should give concern about screening and managing women having fear of childbirth.

## 2.2. Conceptual framework

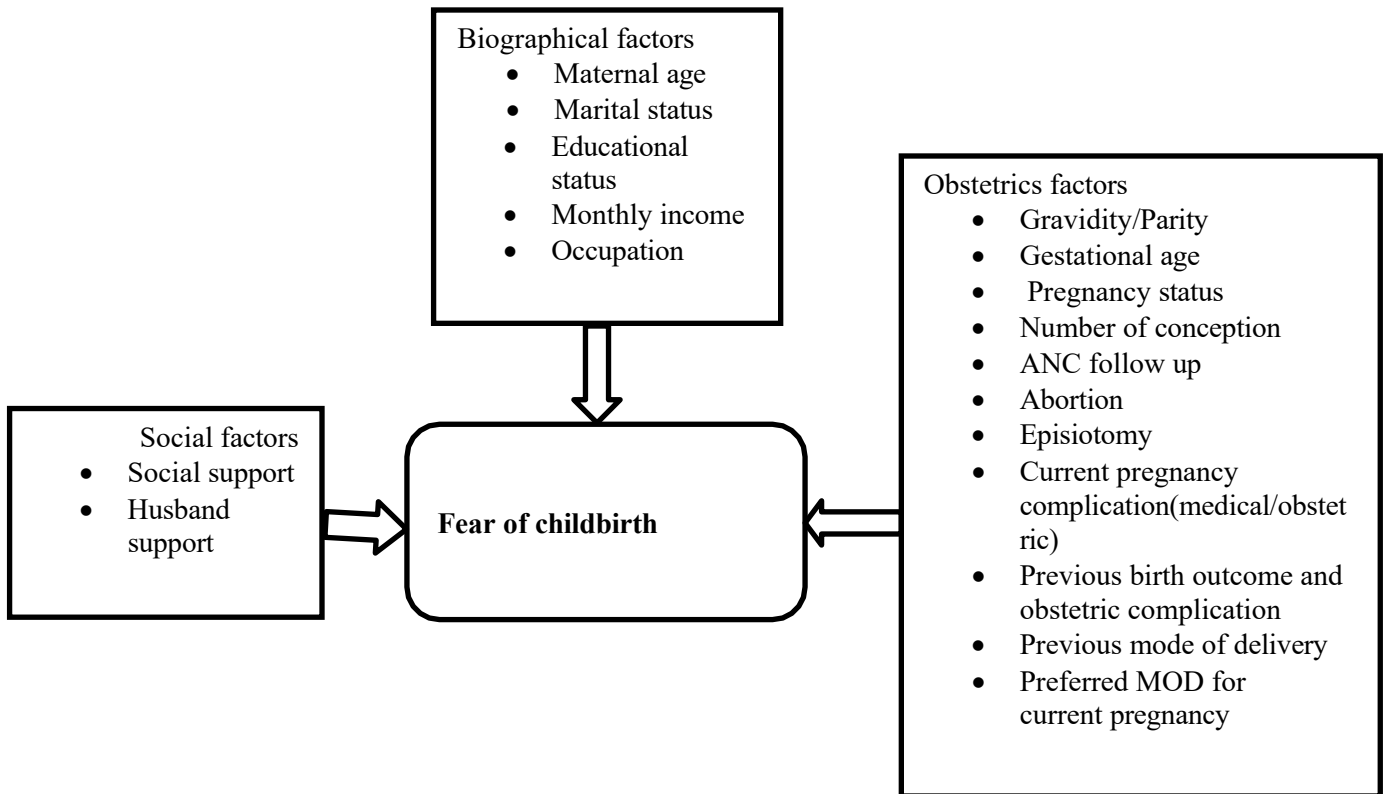


Figure 1. Conceptual framework includes dependent and independent variables after reviewing different literatures.

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

### **3. OBJECTIVE**

#### **3.1. General objective**

To determine the proportion of fear of childbirth and associated factors among pregnant women attending antenatal care in Debre Birhan Town Public Health Institution, Amhara, Ethiopia .2022\23.

#### **3.2. Specific objectives**

1. To determine the prevalence of fear of childbirth among pregnant women attending antenatal care.
2. To identify factors associated with fear of childbirth among pregnant women attending antenatal care

## 4. METHODS

### 4.1. Study design, study area, and period

An institution-based cross-sectional quantitative study was conducted from November 2022 to April 2023. The study was conducted in public health facilities in Debre Birhan town, Amhara national regional state, Ethiopia. The town, which serves as the North Showa Zone's capital, is situated 695 kilometers (km) and 130 kilometers (km) from Addis Ababa, the Ethiopian capital, and Bahir Dar, the capital of the Amara National Regional State, respectively. The town is distributed among 5 sub-cities and has 2 government hospitals and 8 health clinics. Antenatal care, labor and delivery services, and postnatal care are all offered by hospitals and health centers, and all of these services are free from the time of conception until six weeks after childbirth. The total population of the town was estimated to be 97,969 as per the administrative office of Debre Birhan town's report from the 2010 E.C. population census (44,300 men and 53,669 women) [33]. In Debre Birhan, there are 14,437 young girls.

#### 4.1.1 Source population

All pregnant women attending ANC in selected public health facilities in Debre Birhan town, Ethiopia.

#### 4.1.2 Study population

Sampled pregnant women attending ANC at study facilities during the study period and fulfilled the inclusion criteria.

### 4.2. Inclusion and Exclusion criteria

#### Inclusion Criteria

Pregnant women who attending ANC service in selected public health facilities in Debre Birhan town and available at the time of data collection

#### Exclusion criteria

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

### 4.3. Sample size determination

Sample size for the first objective was calculated using single population proportion formula;  $n = \frac{z_{\alpha/2}^2 p(1-p)}{d^2}$

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

d-Marginal error of 5%, p –

Proportion

n-Sample size

To get the maximum sample size possible, the prevalence of moderate fear of childbirth (0.398) was chosen from a prior study that was identical to this one in order to estimate the prevalence of fear of childbirth. Since the sample size from the second objective (risk factors) was smaller than the sample size from the first objective (prevalence of fear of childbirth], the final sample size was  $n = (1.96)^2 * 0.398(1-0.398) / (0.05)^2 = 368$ ; by adding the 10% nonresponse rate, the final sample size was 405. Table 1 Calculated sample size for associated factors of fear of childbirth, using Epi-Info version 7.2.2.2

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



#### 4.4. Sampling procedures

Ten public health facilities serve the study area by offering antenatal care, labor and delivery services, and postpartum care. Of these, four facilities DebreBirhan Comprehensive Specialized Hospital, Keyit Health Center, Chacha Health Center, and Ayertena Health Center—were chosen at random from the entire list using the lottery method. To select 405 pregnant women attending ANC from the four public health institutions that were chosen, first the hospitals were listed down with their respective average number of pregnant women attending ANC and three-month report data were collected from each health institution, and then the number of pregnant women in each hospital was proportionally allocated to sample size. After that, until the desired sample size was reached, the study subjects for each health institution were chosen and interviewed using systematic random sampling at every  $k$ th interval of each day in public health facilities in DebreBirhan town. The four public health institutions were given a total sample size of 405, which was distributed proportionally based on the three-month average number of pregnant women attending ANC services in each institution  $n_j = n \times N_j / N$  and interval size;  $k_j = n \times N_j / N$ , where;  $n_j$  = the sample size of the  $j$ th hospital,  $N_j$  = was population size of the  $j$ th hospital, and  $n=405$  the total sample size from the selected Health institution.  $N=2050$ , total source population size from four healthcare facilities,  $K=1375/405=3$ , obtained from a report on the health management information system. (Figure 2).

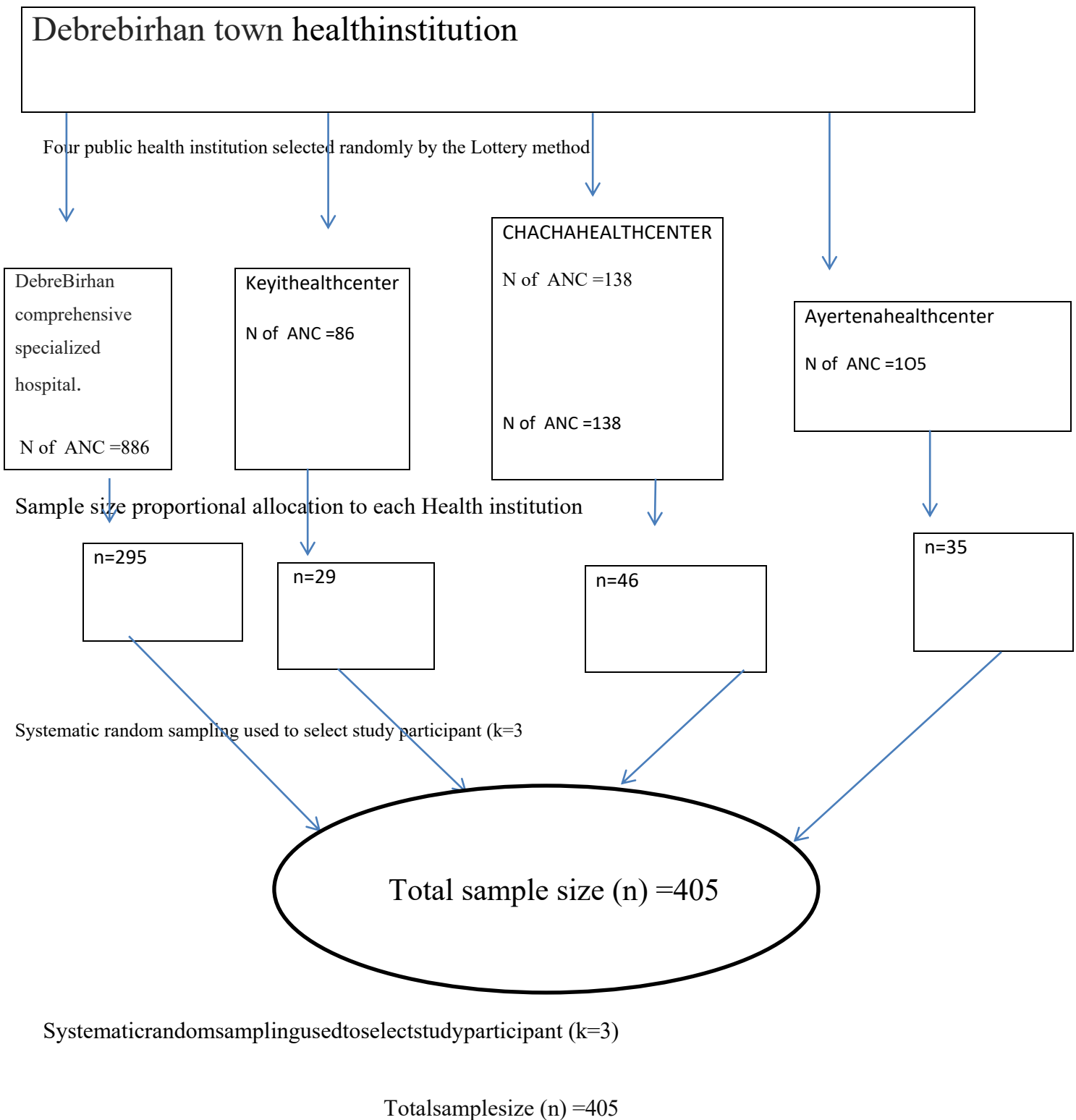


Figure 2. Schematic representation of the sampling procedure to select study participants from Debre Birhan Health institution 2023

#### **4.5. Variables of the study**

Dependent variables

- fear of childbirth

Independent variables

##### **Sociodemographic**

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

##### **Obstetric related**

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

##### **Social factors**

- Husband support
- Social support

#### 4.6. operational definitions

Fear of childbirth is a statement about how strongly people feel and how much they think about birth; it is also operationalized by how they think about the delivery. By asking the woman about her expectations before (version A) and experiences after (version B) childbirth, the Wijma Delivery Expectation/Experience Questionnaire (W-DEQ) was created by Wijma and his colleague to measure a construct of fear related to childbirth during pregnancy and after delivery [50]

Degree of childbirth fear is operationalized as

W-DEQ sum score < 38 = Low degree fear

W-DEQ of 38–65.9 = Moderate degree fear;

W-DEQ of 66–84.9 = High degree fear;

W-DEQ  $\geq$  85 = Severe degree fear of childbirth [51].

**Oslo social support scale:** is a three-item test that was used to measure psychosocial distress. The first item received a score of 4, while the second and third items received scores of 2 and 5, respectively. The overall amount is between 3 and 14, which is translated as a score of 3 to 8 (poor), 9 to 11 (moderate), and 12 to 14 (strong) [52].

#### 4.7. Data collection tools/measurements and procedure

Participants' responses to pretested, structured questionnaires were used to collect data. The questionnaires that were used to evaluate Socio demographic characteristics, obstetric characteristics, social support, and childbirth were adapted after reviewing through several different literatures [37, 38].

Social support was assessed using Oslo social support scale: a three-item question used to assess psychosocial distress, the sum ranges from 3 to 14. It was developed and validated in different research to assess level of social support [52]. Wijma Delivery Expectation/Experience Questionnaire version A was used to evaluate FOC. Internal consistency and split-half reliability of the W-DEQ were examined, and the Cronbach's alpha score was 0.93 during the creation phase [50]. This 33-item rating scale features a 6-point Likert scale as a response format, ranging from not at all = 0 to extremely = 5. The questionnaire was initially written in English before being converted into an Amharic version for use during the interview. After the daily ANC service, data were gathered from pregnant women using face-to-face interviewing approaches.

#### 4.8. Data quality control

Before the real study period from April 14–17, 2023, a pretest was conducted on 5% of the total sample size of pregnant women attending ANC at Another Debre Birhan public hospitals to ensure accuracy and

consistency. After receiving a full day of training on the study's objectives, relevance, confidentiality, respondent rights, and informed consent, four diploma midwives took part in the data collecting. Frequent reviews of the data collection procedure were conducted by the lead investigator and the supervisor to guarantee the accuracy and consistency of the information acquired, as well as the correction of any errors that were discovered. Frequent reviews of the data collection procedure were conducted by the lead investigator and the supervisor to guarantee the completeness and consistency of the information acquired, as well as the correction of any errors that were discovered.

#### **4.9 Data processing and analysis**

After ensuring that the data was accurate and complete, a code was assigned to the questionnaire, and the data were then entered into the Epi-data-4.6 statistical program and analyzed using the SPSS-25 statistical software packages. To verify for accuracy, consistency, missed values, and variables to correct errors, data cleaning was done. Data were recoded, computations were made to determine prevalence, and the four FOC categories were then divided into two. The WDEQ A was categorized into four groups (less than 38, 3865.9, 6684.9, and 85 and above). P values less than 0.25 in binary logistic regression were taken into account for multivariate logistic regression when determining the relationship between the explanatory and outcome variables. Statistics were considered significant for P values under 0.05.

#### **4.10 Ethical Consideration**

A support letter was received from the DebreBirhan health office administration for each chosen public health facility after the Institutional Review Board of the BDU College of Health Science granted ethical approval. The purpose and significance of the study were communicated to the study participants, and only after obtaining their fully informed verbal and written consent were any data actually gathered. In the interview, confidentiality was preserved in regards to the information.

#### **4.11 Dissemination of Results**

The findings of this study will first be delivered to the BDU College of Health Science Medicine School of Health Science and Midwifery Department, after which the ministry of health, the Amhara health bureau, and the DebreBirhan health office administration will receive the report paper. Both print and online distribution will be taken into consideration.

## 5. RESULTS

### 5.1. Socio-demographic characteristics

The survey received 400 responses from women, for a response rate of 98.8%. With a mean age of 28.6SD years, 46.8% of the 187 responders were between the ages of 26 and 33. Participants with a secondary education made up 140 (35.3%) of the group, while those with a college degree or higher made up 152 (38%), or 341 (85.3%) of the group overall. 189 (47.3%) of the total respondents were self-employed, while 115 (28.7%) were employed by the government. The average monthly income of the respondents was 3885.50 Ethiopian Birr. .

Table 2. Socio demographic characteristics of pregnant women attending ANC in selected Debrebirhan public health institution Ethiopia, 2023 (n=400).

Variables	Category	Frequency	Percentage(%)
Age	18-25	138	34.5
	26-33	187	46.8
	34-41	60	15.0
	42-49	15	3.8
Marital status	Single	37	9.3
	Married/live together	341	85.3
	Divorced	14	3.5
	Widowed	8	2.0
Educational status	No formal education	25	6.3
	primary(1-8)	89	21.5
	secondary(9-12)	140	35.3
	College and above	146	37.5
Occupation	Housewife	77	19.5
	Self-employed	189	47.3
	Government	115	28.7
	Daily laborer	19	4.8
Monthly income	1650 and less	60	15.0
	1651-5250	263	65.8
	5251-10900	67	16.8
	10901 and above	10	2.5

## **5.2. Obstetric characteristics of the respondents**

Of the 400 responses, 48.8% and 51.2%, respectively, were primigravida and multigravida. Twenty-five percent were primiparous from that 29.8% were delivered by SVD in the previous childbirth. 22 (5.5%) of the births were stillbirths, while 39 (9.8%) had obstetric complications in the previous pregnancy and childbirth. There were 363 singleton pregnancies (90.8%), 320 planned pregnancies (85.3%), 388 regular follow-up visits for antenatal care (97.0%), and 82.3% preferred vaginal birth. Pregnancy-related complications 71 (17.8%), had medical illness 47 (11.8%). Majority of participants were supported by their husbands during pregnancy.

Table 3. Obstetric characteristics of pregnant women attending ANC in selected selected Debrebirhan public health institution Ethiopia, 2023 (n=400).

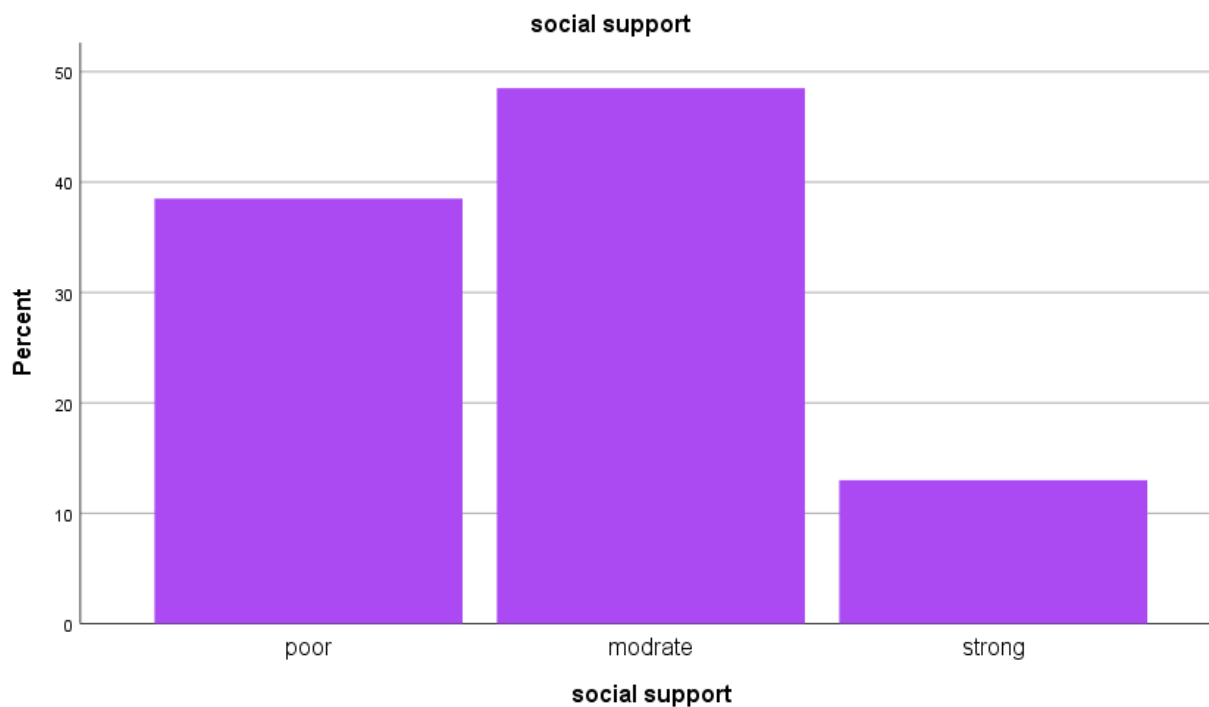
Variables	Category	Frequency	Percentage (%)
Gravida	Primi-gravida	195	48.8.
	multi gravida	205	51.2
Parity	nulli-parous	22	5.5
	primi-parous	103	25.8
	multi-parous	80	20.0
Previous mode of delivery	SVD	125	68.3
	Instrument	33	18.0
	CS	25	13.7
Episiotomy in previous delivery	Yes	102	25.5
	No	81	20.3
Outcome of previous childbirth	Alive	162	40.5
	stillbirth	21	5.3
History of abortion	Yes	76	19.0
	No	129	32.3
Complication in previous pregnancy/childbirth	Yes	39	9.8
	No	144	36.0
Gestational age	<14 weeks	78	19.5
	14-26 weeks	164	41.0
	> 26 weeks	158	39.5
Number of conception in current pregnancy	single	363	90.8
	Multiple	37	9.3
Current pregnancy status	Planned	320	85.3
	Unplanned	80	14.8
ANC follow up for the current pregnancy	Yes	388	97.0
	No	12	3.0
Mode of delivery preference of the current pregnancy	SVD	329	82.3
	CS	71	17.8
Pregnancy related complication during current pregnancy	Yes	71	17.8.
	No	329	82.3
Had medical problems in the current pregnancy	Yes	47	11.8
	No	353	88.3
Had got support from your husband	Yes	337	84.3
	No	63	15.8



### 5.3. Social support of the respondents

According to the Oslo Social Support Scale, the respondents' social support was weak and scoring 154 (38.5%), moderate, scoring 194 (48.5%) and strong, scoring 52 (13.0%).

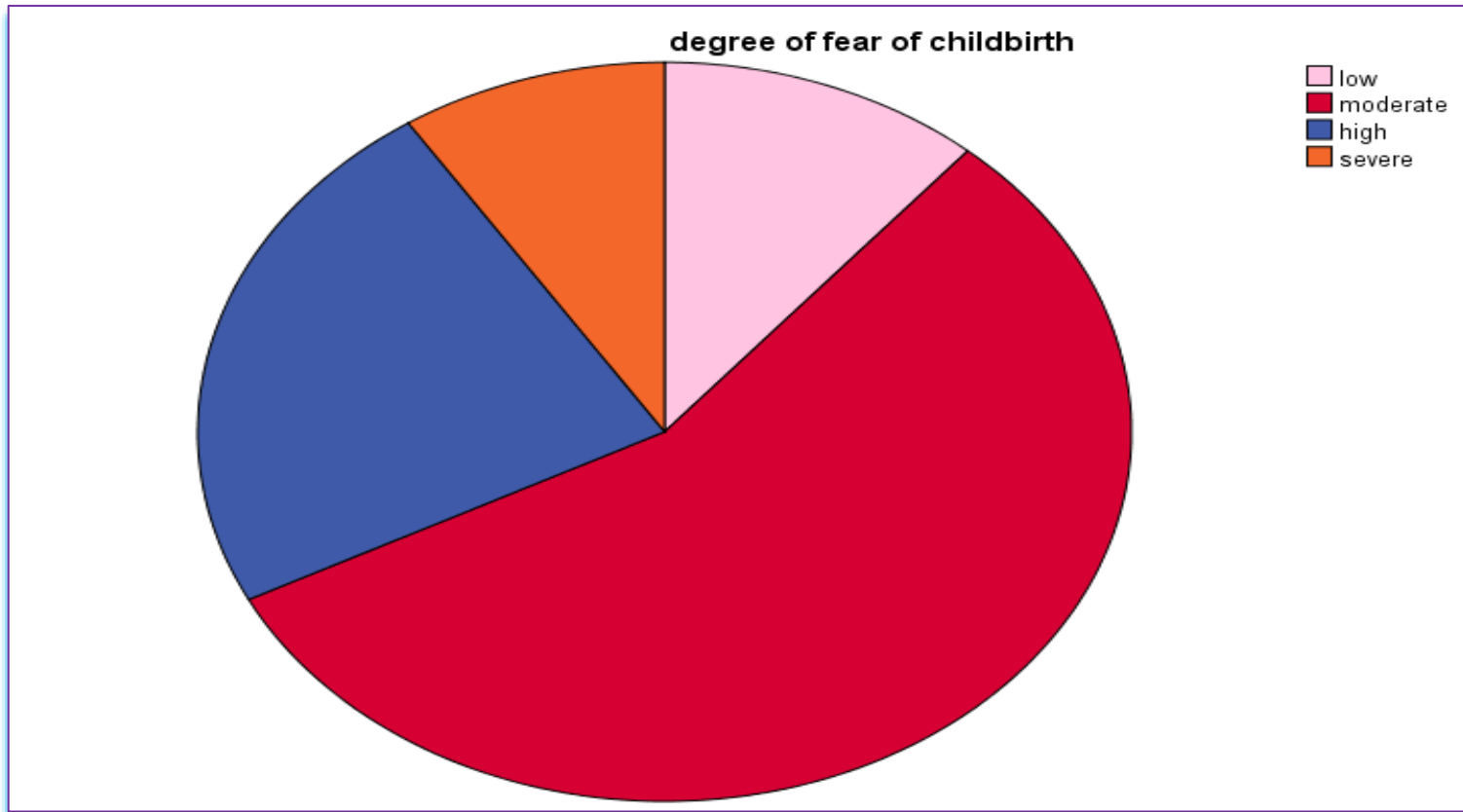
Figure 3 Social support among pregnant women attending ANC in selected health institution in Debre Birhan Ethiopia, 2023 (n=400).



#### 5.4. Prevalence of Fear of Childbirth

Of the total responders, 45 had low FOC (11.3%), 225 had moderate FOC (56.3%) high FOC 93 (23.3%), and 45 had severe FOC 37 (9.3%) The mean fear of childbirth score was 54, with a standard deviation of 23.2. 19 was the minimum score while 135 was the maximum score.

Figure 4. Prevalence of fear of childbirth among pregnant women attending ANC in selected Debre Birhan public health institution Ethiopia, 2023 (n=400).



### **5.5. Factors associated with fear of childbirth**

The four categories of fear of childbirth were recoded into two categories in order to compute binary logistic regression. High and severe fear of childbirth were recoded as fear of childbirth, while low and moderate fear of childbirth were recoded into a new category of no fear of delivery. In bivariate analysis showed Educational status, the number of previous births (parity), the previous mode of delivery, the outcome of the previous pregnancy and delivery, obstetric complications in the previous pregnancy and delivery, gestational age (in weeks), the current number of conceptions, the status of the current pregnancy, the preferred mode of delivery for the current pregnancy, pregnancy-related complications in the current pregnancy, medical conditions or chronic diseases in the current pregnancy, and the support of the husband were factors associated with fear of childbirth (p-value less than 0.25) and included in the study of multivariable logistic regression. Education level, obstetric complications from previous pregnancies and deliveries, preferred mode of delivery, and having a medical condition or chronic disease were significantly linked with FOC in multivariable logistic regressions (p-value 0.05). According to the findings, pregnant women without formal education were four times more likely to experience fear of childbirth than educated women (AOR=4, 95%CI: (1.37-15.15), p=0.04). AOR=3, 95%CI:(1.16-7.56) (p=0.05) showed that pregnant women who experienced obstetrical complications during their last pregnancy and delivery were three times more likely to experience FOC than pregnant women who did not. Pregnant women who had a medical problem FOC were three times more likely to have one than those who did not (AOR=3.2, 95% CI (1.1-9.8)(p=0.04)). Medical illness in the current pregnancy was also found to have a significant association.

Table 4. Bivariate and multivariate logistic regression for factors associated with fear of childbirth (n=400).

Variables	Category	Fear of childbirth		COR 95% CI	AOR 95% CI	P value	
		Yes (n, %)	No (n, %)				
Education	No formal	13 (56.5%)	10 (43.5%)	2.1 (0.9-4.92)*	4 (1.375-15.154)**	0.04	
	Had formal education	144 (38.2%)	233 (61.8%)	1			
Parity	Nulliparous	11 (50.0%)	11 (50.0%)	0.95 (0.39-2.29)*	1.2 (0.64-2.48)	0.512	
	Multiparous	94 (51.4%)	89 (48.6%)	1	1		
Previous MOD	SVD	55 (44.0%)	70 (56.0%)	1	1	0.508	
	Instrumental	16 (48.0%)	17 (52.0%)	4.04 (1.56-10.35)*	1.45 (0.5-3.5)		
	CS	8 (32.0%)	17 (68.0%)	2.6 (1.13-6.2)*	1.6 (0.4-5.6)		0.476
Birth outcome	Alive	78 (48.0%)	84 (52.0%)	1	1	0.249	
	Stillbirth	13 (62.0%)	8 (38.0%)	4.02 (1.7-11)*	2 (0.70-5.8)		
Obstetric complication in previous childbirth	Yes	18 (46.0%)	21 (54.0%)	1.79 (0.70-4.56)*	3 (1.16-7.56)**	0.050	
	No	34 (24.0%)	110 (76.0%)	1	1		
GA	<14 weeks	18 (23.0%)	60 (77.0%)	0.57 (0.3-1.08)*	1.4 (0.58-5.1)	0.503	
	14-26 weeks	54 (33.0%)	110 (67.0%)	0.7 (0.43-1.1)*	1.5 (0.65-5.3)		0.469
	>26 weeks	65 (41.0%)	93 (59.0%)	1	1		
Number of conception	Single	142 (38.0%)	230 (62.0%)	1.06 (0.53-2.14)*	1.3 (0.74-5.04)	0.489	
	Multiple	16 (57.0%)	12 (43.0%)	1	1		
Pregnancy status	Planned	131 (38.0%)	210 (62.0%)	1	1	0.455	
	Not planned	35 (59.0%)	24 (41.0%)	1.78 (1.04-3.04)*	1.65 (0.43-5.68)		
MOD preference	SVD	130 (38.5%)	208 (61.5%)	0.85 (0.51-1.44)*	1.6 (1.02-8.08)**	0.488	
	CS	36 (58.0%)	26 (42.0%)	1	1		
Pregnancy related complication during this pregnancy	Yes	20 (31.0%)	45 (69.0%)	0.75 (0.43-1.29)*	1.9 (0.4-6.6)	0.23	
	No	110 (33.0%)	225 (67.0%)	1	1		

Hadmedicalillness	Yes	18(42.8%)	24(57.2%)	1.566 (0.85-2.88)*	3.2(1.1-9.8)**	0.045
	No	140(39.1%)	218(60.9%)	1	1	
Hadgothusband support	Yes	125(36.8%)	214(63.2%)	1	1	0.501
	No	54(36.7%)	46(63.3%)	0.45(0.26-0.78)*	1.5(0.43-4.64)	

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Keys:\*pvalue<0.25inbivariate,\*\*p<0.05inmultivariate,1=Reference

## 6. DISCUSSIONS

According to this study, there were (11.3%), (56.3%), (23.3%), and (9.3%) accordingly, low degree, moderate, high, and severe fear of childbirth (FOC) prevalence among pregnant women attending ANC in public health institutions, and the total prevalence of FOC was 32.5%. This figure is twice as high as the global prevalence of FOC, which is 14%. Additionally, it was higher than that of Australia (23%), America (11%), Asia (25%) [6, Scandinavia (12%), Europe (8%), Australia, and America (11%). This disparity could be due to variations in the organization of health institutions and the standard of ANC between developed and undeveloped nations when it comes to the psychosocial needs of pregnant women. The finding is consistent with research conducted in Kenya and Malawi [14, 36]. The prevalence of severe fear of childbirth in this study was different from that in a study conducted in Thailand, where the prevalence was low 18.5, moderate 64.9, high 16.1, and severe 0.7. This variation could be explained by disagreement in the way study actors were chosen as well as difference in sample sizes. These difference might affect from varying cultural generalizations of childbirth (19). Other studies using W- DEQA  $\geq 85$  reported a prevalence of severe childbirth fear was 5.3 percent and high FOC was 36.7 percent in Ireland, and Norway (7,42). In the Italian survey the overall prevalence was 20-25 and severe fear of childbirth roughly 6 – 10 analogous to this study but used different W- DEQA cut off point and further than half of the study party have had a high position of education and the maturity of women didn't show any complications (53). In the Iran study, the mean W- DEQ score was  $67.6 \pm 23.5$ , moderate 19.6 (W- DEQA score  $\geq 85$ ), and severe 6.1 (mean W- DEQA score  $\geq 100$ ) fear of parturition (35). This low prevalence as compared to in the current study may be due to a difference in arrestment point in the W- DEQA score.. Pregnant women's fears about fear of childbirth ranged from low (22%), moderate (53.4%), high (23.1%), to pathological (severe) in 1.6% of respondents in Slovenia [9]. The Slovenia study's data were obtained after parenting and birthing lessons were offered on the progress of labor, which may account for the study's substantially higher rate of severe fear of childbirth of childbirth (11.3%) requiring clinical care. The findings regarding moderate fear of childbirth are consistent with those of the Arbaminch study, but the prevalence of high (25.3%) and severe (24.5%) fear of childbirth was lower and the rate of low fear of childbirth was higher (10.3%) [38]. These degrees of variation could be explained by differences in the study area, level of education, and higher ANC utilization of services in this study area.

In this study, pregnant women without formal education had considerably higher FOC than pregnant women with formal education. This result was in line with research conducted in Kenya [14,36] and

Malawi (AOR=5.0, CI (1.2- 20.2),  $p=0.03$ ). Higher education level was a key driver of FOC in a study conducted in China, which contradicts this finding [30]. These possibly well-educated nulliparous women were accustomed to meticulously organizing and planning their lives. They frequently think that everything is under our control. However, childbirth is an unpredictable occurrence in many ways, including the duration of labor, intensity of the pain, and more. Other studies reported no statistically significant relationship between fear of delivery and socio-demographic factors such as maternal age, marital status, income, and education ( $p>0.05$ ) [35, 37, 40]. This study found a significant association between prior obstetric complications and fear of childbirth (AOR=3, 95% CI 3(1.16-7.56),  $P=0.050$ ), which contrasts with a study from Norway that found a similar association (AOR=7.6, CI (3.8-15.2) [42]. The variations could result from variations in sample size, gestational age, and data collection methods. Other studies found a strong relationship between characteristics associated with fear of childbirth and unplanned pregnancy, current pregnancy-related problems, instrumental delivery, GA, number of gravida, ANC follow-up, and poor social support [35,36,40]. This study found no evidence of a significant relationship between these factors and fear of childbirth ( $p>0.05$ ).

Additionally, the preference for CS for MOD of the current pregnancy was found to be significantly associated with FOC, making it three times more susceptible than vaginal delivery (AOR= 3.635, 95% CI (1.02-9.03)); this was also found in a study conducted in Norway (AOR 4.6, 95% CI 2.9-7.3) [42]. The preferred delivery method and fear of childbirth were both found to be strongly correlated in the Iranian study [35]. The majority of participants in research that are similar to this one select vaginal delivery, and there is a significant link between fear of childbirth and cesarean birth for preferred mode of delivery ( $P 0.01$ ) [9]. Contrary to a study conducted in Iran's Khorramabad Health Center, this study found that women who selected vaginal delivery had childbirth fear 6.6 times more frequently than those who preferred cesarean section [34]. This could imply that these mothers, particularly those who were informed about other people's poor experiences with childbirth, view cesarean delivery as a painless and safe method of birthing. Pregnant women with medical illnesses experienced greater levels of worry than women who were healthy, according to the other substantially linked variable. AOR=3.2 (1.1-9.8)  $p=0.04$ . Medical/chronic disease is less important in this study than it was in Arbaminch's study (AOR= 6.24 (2.72, 14.29) [38]). This variation may result from the accessibility of various types of healthcare.

However, this result conflicts with a related study conducted at Turkey's Sakarya University Education and Research Hospital, which found a significant association between fear of childbirth and pregnancy in women who did not have any medical or chronic conditions ( $p 0.001$ ) [54]. This could be as a result of variations in data collection periods, participant awareness, and study context.

## 7. STRENGTH AND LIMITATION

The results of this study, however, could only be applied to the cohort of expectant women in the study area. The W-DEQA is a validated and frequently used measure of childbirth fear that has been utilized by a number of researchers [38, 50, 51]. It was the basis for the questionnaires used in this investigation. We can infer relationship but not causality from this cross-sectional study. The variation in FOC prevalence may be explained by the varying cut-off points utilized by different investigations to categorize the level of dread of delivery.

## 8. CONCLUSION AND RECOMMENDATION

### 8.1. Conclusion

The prevalence of Fear of childbirth among pregnant women is high in the study setting. Education level, previous obstetric problems, medical illnesses, and preferred mode of delivery were identified to be associated to fear of childbirth. There should be special attention and counseling for pregnant women who have an unplanned pregnancy and pregnancy-related complications such as pregnancy-induced hypertension, gestational diabetes mellitus, antepartum hemorrhage, and multiple gestation. Family planning providers as well as ANC providers should give appropriate information about how to avoid unplanned pregnancies and what to do when this happens.

### 8.2. Recommendations

**Health facilities:** Health facilities should provide psychosocial support counseling to pregnant women who have previously had obstetric problems during ANC visits.

The management of complications that emerge during childbirth should use evidence-based practices, and women should get emotional support.

Pay close attention to any pregnant mothers who have had difficult pregnancies and deliveries in the past. Women attending ANC follow-up appointments should have access to information on childbirth, pain treatment, and social support.

**Higher education Institutions:** Educational institutions should focus particularly on the psychosocial needs of pregnant women as part of ANC and, in collaboration with the Ministry of Health, develop training for healthcare professionals.

**Researchers:** A qualitative study is also necessary to comprehend women's perspectives on childbirth fear, particularly those of mothers who experienced a pregnancy-related problem and had no formal education.



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## 10. APPENDIX

### 10.1. AnnexA:EnglishInformationSheet

Good morning/afternoon

My name is \_\_\_\_\_ I am working as a data collector on behalf of Surafel Shewatek who is currently a postgraduate student on clinical midwifery at Bahirdar University, College of Health Sciences, School of health science, Department of Midwifery. I kindly request you to give me your attention to explain you about the study and be selected as the study participant.

**Objective of this study** was to assess the assessment Fear of childbirth among pregnant women attending antenatal care in Debrebirhan town public health institution, amhara, Ethiopia.

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

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

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

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

**Investigator name:** Surafel Shewatek, **Address** +251926877555; [surafelshewatek26@gmail.com](mailto:surafelshewatek26@gmail.com)

Annexes B: Informed Consent

I herewith declare that:

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

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

Signature of the participant \_\_\_\_\_ date \_\_\_\_\_

\_\_\_\_\_  
Signature of

the interviewer \_\_\_\_\_ date \_\_\_\_\_

## 10.2. Annex C: English version questionnaire

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

		5. Others specify.....	
209	Gestational age (in weeks)	1. less than 24 weeks 2. 24-26 weeks 3. above 26 weeks	
210	Currently number of conception	1. Single pregnancy 2. Multiple pregnancy	
211	Current pregnancy status?	1. Planned 2. Not planned	
212	Do you have regular ANC follow up for the current pregnancy?	1. Yes 2. No	
213	Preferred mode of delivery of the current pregnancy	1. Vaginal delivery 2. Caesarean delivery	
214	Do you have pregnancy related complication during this pregnancy?	1. Yes 2. No	
215	If yes for Q214 which one	1. vaginal bleeding 2. HEG 3. PIH 4. All 5. Others specify.....	
216	Did you have known medical illness / chronic disease in the current pregnancy	1. Yes 2. No	
217	If yes for Q216 which one?	1. Heart disease 2. HIV 3. DM 4. HTN 5. Others... specify	
218	Have you got support from your husband?	1. Yes 2. No	
<b>Part III. Social support questioner</b>			
301	How many people are so close to you that you can count on them if you have great personal problems?	1. None 2. 1-2 3. 3-5 4. >5	
302	How much interest and concern do people show in what you do?	1. None 2. Little 3. Uncertain 4. Some 5. A lot	
303	How easy is it to get practical help from neighbors if you should need it?	1. Very difficult 2. Difficult 3. possible 4. Easy 5. Very easy	

**Part IV Questions to assess child birth fear using WDEQ**



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

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

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

Thank You

**10.3. AnnexD:Amharicinformation sheet**

የመረጃ መስጫ ቅጽ

ጤና ደስጥ ልኝስጫ

\_\_\_\_\_ እባላለሁኝ እኔ የመረጃ ሰብሳቢ ስሆን፤ ይህንን መረጃ የምሰበስበው በባህር ዳር ዩኒቨርሲቲ የህክምና ሳይንስ ኮሌጅ፤ እና ሚዲያ ወይን ስም ህርት ክፍል፤ የድህረ መረቃት ማሪያ ስተር ስትም ህርታቸውን ለማጠናቀቅ እንዲረዳቸው ሲሆን የእርስዎን ታማኝ እና ቀና የሆነ ትብብር ለጥያቄዎቼ መልስ እንፈልጋለን።

ዓላማ:

ይህ ጥናት በተመረጡ የህዝብ ሆስፒታሎች ውስጥ የቅድመ ወሊድ እንክብካቤ በሚከታተሉ ነፍሰ ጡር ሴቶች ላይ የወሊድ ፍርሃት እና አጋላጭ ምክንያቶች ለማወቅ ይረዳዎታል።

አካሌድ እና የሚፈጀው ጊዜ፤ \_\_\_\_\_ ይህ መጠይቅ የሚያካትተው የጥናቱን ተሳታፊ ነፍሰ ጡር ዕናት ማህበራዊ-ስነ-ህዝብ ባህሪዎች፤

የእርግዝናት ወሊድ መረጃ፤

ማህበራዊ እርዳታ እንዲሁም ልጅ ከመውለድ ጋር ተያይዞ የላትን ፍራቻ የሚዳስስ ጥያቄዎች አሉት።

እርስዎም ለዚህ ጥናት ስለተመረጡ ፍቃድ ስሆኑ፤ ቃለ መጠይቁ ከ30-45 ደቂቃ ስለሚፈጅ፤

ይህንን ውድ ጊዜዎችን እንዲተባበሩን በትኩረት ማስታወሻዎቻችን ላይ ቃለ መጠይቅ ለሁሉ።

ጉዳት/ጥቅም፤ በጥናቱ ላይ በመሳተፍ ዎንም አይነት ጉዳት አይኖርም።

ቀጥተኛ የሆነ ጥቅምም በዚህ ጥናት ላይ በመሳተፍ ላይ የሚገኙ ይችላሉ።

ቢሆንም ግን የጥናቱ ጤንነት ለማረጋገጥ የሚያስፈልገው ለመረጃ ትያያገ ላይ ማለት።

ምስጢራዊነት፤ \_\_\_\_\_ በዚህ ጥናት ላይ የሚገኘው መረጃ በሙሉ ምስጢራዊነት የተጠበቀ ነው።

የእርስዎ መረጃ በፋይል እርስዎ ስም ውጪ በኮሌጁ ተደርጎ ይቀመጣል።

**10.4. AnnexE:Amharic consent form**

የስም ምንት ማረጋገጫ ቅጽ

ከላይ የተጠቀሱትን በሙሉ ተረድቻለሁ። በዚህ ጥናት ላይ የምሳተፈው በሙሉ ፍቃድ ነኝ ትነው።

እንደ ተነገረኝ ከሆነ የምሰጠው መልስ ለሌላ ላለ ማንም ሰው አይሰጥም እንዲሁም ስለኔ ማንንት ለማንም አይገለፅም።

ስለሆነም በጥናቱ ላይ ለመሳተፍ ፍቃድ ስሆኝ።

ተሳታፊው ፍቃድ ስሆኑ ይቀጥሉ።

የተሳታፊው ፊርማ \_\_\_\_\_

ቃል መጠይቁን ያደረገው ባለሙያ ፊርማ \_\_\_\_\_

ቃልጭጥይቅየተደረገበትቀን....

10.5. AnnexF;Amharicversionquestionnaire

ለጥያቄዎቹ መልስ ከተቀመጡት አማራጮች ያከብቡ የመጠይቁ ኮድ.....			
ተ.ቁ	ክፍል I. ማህበራዊ-ስነ-ህዝብ ባህሪዎች	መልስ	አለፈ/ፍ
101	እድሜዎትስንትነው?	.....	
102	የጋብቻ ሁኔታዎን ድንገት?	1. ያላገቡ 2. ያገቡ/አብረው የሚኖሩ 3. የፈታች 4. በሞት የተለየ/ተለያይቷል	
103	የትምህርት ደረጃዎስንትነው?	1. መደበኛ ትምህርት የለም 2. የመጀመሪያ ደረጃ (1-8) 3. ሁለተኛ ደረጃ (9-12) 4. ኮሌጅ እና ከዛ በላይ	
104	ስራዎን ድንገት?	1. የቤት አመቤት 2. የግል ተቀጣሪ 3. የመንግስት ስራ ተኛ 4. የቀን ስራ ተኛ ሌላ ካለ (ይገለጽ).....	
105	በወር የሚያገኙት ገቢዎን ያህልነው? በኢትዮጵያ ብር	በወር ----- ብር	
ተ.ቁ	ዘየእናት የዋእር ግዝና እና ወሊድ ታሪክ		
201	ይህ እርግዝና ስንተ ነው?	1. የመጀመሪያ 2. ሁለተኛ እና ከዛ በላይ	መልስ-1 ከሆነ ጥ.ቁ 20 9 ይሂዱ
202	እስከ አሁን ስንት ጊዜ ወልደው ነበር? (የሞት ተኩም ጨምሮ ከ 28 ሳምንት በላይ)	1. ምንም 2. አንድ ጊዜ 3. ሁለት እና ከዛ በላይ	
203	ካሁን በፊት በምንነበር የወለዱት?	1. በምጥ 2. በመሳርያ ታግዞ 3. በአፕራሽን	
204	ሲወልዱ በልት ያንተ ቀደደው/ስተች/ተደርገው ነበር?	1. አዎ 2. አልተደረሰም	
205	የተወለደው ህፃን ሁኔታ	1. በሂወት ያለ 2. ሞቶ የተወለደ	
206	ከዚህ በፊት ወርጃ ነበረዎት?	1. አዎ	

		2.የለኝም	
207	ከዚህበፊትበነበረውእርግዝናእናወሊድጊዜ ችግርገጥሞዎትነበር	1. አዎ 2. አልነበረም	
208	ለጥያቄ207መልስዎአዎከሆነየትኞቹ	1.ደምመፍሰስ 2. ብዙሰአትማማጥ 3.ከእርግዝናጋርተያይዞየመጣደምግፊት 4. ሁሉንም5. ሌላካለይገለጽ...	
209	የዚህእርግዝናዕድሜስንትነው(በሳምንታት)	1. ከ14ሳምንትበታች 2. ከ14-26ሳምንታት 3. ከ26ሳምንትበላይ	
210	ስንትልጅነውያረገዙት/በማህጸንዎያለውየጽንሰ-ብዛት	1. አንድ 2. ሁለትእናከዛበላይ	
211	አቅደውበትነውያረገዙት?	1. አዎ 2. አይደለም	
212	ቀጠርዎንጠብቀውየእርግዝናክትትልአያደረጉነው?	1. አዎ 2. አይደለም	
213	የመውለጃመንገድምርጫዎየቱነው	1. በማህጸንአምጦመውለድ 2. በአፕሬሽን	
214	ከዚህእርግዝናጋርተያይዞየመጣችግር/ህመም አለብዎት/አጋጥሞዎታል?	1. አዎ 2. የለብኝም	
215	ለጥያቄ214 መልስዎአዎከሆነየትኞቹ	1.ደምመፍሰስ 2.ከባድየሆነየማያቋርጥትወከክት 3.ከእርግዝናጋርተያይዞየመጣደምግፊት 4. ሁሉንም 5.ሌላካለይገለጽ...	
216	በህክምናየተረጋገጠየጤናችግርአለብዎ	1. አዎ 2. የለብኝም	
217	ለጥያቄ217 መልስዎአዎከሆነየትኞቹ	1. የልብህመም 2.ኤችአይቪ/ኤድስ 3.የስኳርህመም 4.ደምግፊት 5. ሌላካለይገለጽ..	
218	ከትዳርአጋርዎድጋፍ/እርዳታያገኛሉ?	1. አዎ 2. አላገኝም	
	IIIማህበራዊእርዳታ		
301	ከባድየግልችግሮችቢደርሱብዎትእናሊረዱዎት የሚችሉ ለእርስዎ በጣም ቅርብ፤	1.ምንምሰውየለ 2. 1-2ሰው	

	የሚተማመኑባቸው ስንት ሰዎች አሉ	3. 3-5 ሰዎች 4. ከ5 ሰዎች በላይ	
302	ሰዎች እርስዎ በሚያደርጉት ነገር ምን ያህል ፍላጎት እና አሳቢነት ያሳያሉ?	1. የለም 2. አነስተኛ 3. እርግጠኛ አይደለም 4. አንዳንድ 5. ብዙ	
303	ከጎረቤቶች አስፈላጊ እርዳታ ለማግኘት ምን ያህል ቀላል ነው?	1. በጣም ከባድ 2. አስቸጋሪ 3. ማግኘት እችላለሁ 4. በቀላሉ 5. በጣም ቀላል	

ክፍል IV የወሊድ ፍራቻን የሚዳስሱ መጠይቅ

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

		16	እጅግየተዋቀረ	2	3	4	5	በጭራሽአልተቀናበረም	
		17	በጣምዘናያለ	2	3	4	5	በጭራሽዘናአልልም	
		18	እጅግበጣምደስተኛ	2	3	4	5	በጭራሽደስተኛአልሆንም	
III.	ልጅበሚወልዱበትጊዜምንይሰማኛልብለውያስባሉ?	19	እጅግበጣምፍራቻ	2	3	4	5	በጭራሽአልደናገጥም	
		20	እጅግበጣምተስፋቢስነት	2	3	4	5	በጭራሽተስፋአልቆረጠም	
		21	ለልጁእጅግበጣምናፍቆት	2	3	4	5	በፍጹምናፍቆትየለኝም	
		22	እጅግበጣምበራስ መተማመን	2	3	4	5	ምንምበራስመተማመን የለኝም	
		23	እጅግበጣምእምነት	2	3	4	5	በጭራሽእምነትየለኝም	
		24	እጅግበጣምከፍተኛ ሥቃይ	2	3	4	5	በጭራሽህመምየለም	
IV.	ልጅመውለድበጣምኃይለኛበሚሆንበትጊዜምንይሆናልብለውያስባሉ	25	እኔእጅግበጣምመጥፎ ጠባይአፈጽማለሁ	2	3	4	5	በጭራሽመጥፎባህሪ/ ድርጊትአልፈጽምም	
		26	ለሰውነቴሙሉበሙሉቁጥጥርለ መስጠት እደፍራለሁ	2	3	4	5	በጭራሽለሰውነቴሙሉቁጥ ጥርንለመስጠት አልደፍርም	
		27	እራሴንሙሉበሙሉአጠላለሁ	2	3	4	5	እኔእራሴንሙሉበሙሉቁጥጥርአላ ጣም	
V.	ሕፃኑንበምትወልጁበትቅጽበትም ንስሜትይሰማልብለውያስባሉ?	28	እጅግበጣምአዘናኝ/ ደስተኛ	2	3	4	5	በጭራሽደስተኛየለም	
		29	እጅግበጣምተፈጥሯዊ	2	3	4	5	ተፈጥሮአዊነዉ	
		30	እጅግበጣምግልፅነው	2	3	4	5	በጭራሽበራስ-አይታይም	
		31	እጅግበጣምአደገኛ	2	3	4	5	በጭራሽአደገኛአይደለም	
VI.	እርስዎባለፈውወርውስጥስለልጅ መውለድቅዠቶችንበሩዎት? ለምሳሌ	32	ልጅዎበምጥ/በ ወሊ ጊዜእንደሚሞት	በጭራሽ	2	3	4	5	በአብዛኛውጊዜ
		33	ልጅዎበምጥ/ በወሊድጊዜጉዳትአንደ ሚደርስበት	በጭራሽ	2	3	4	5	በአብዛኛውጊዜ

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

አመሰግናለሁ!!



		15	አጅግብጥዋ ተተወ	2	3	4	5	በግጥም አጠቃቀም
		16	አጅግብጥ ጥፋት	2	3	4	5	በግጥም አጠቃቀም
		17	በግጥም ስራ	2	3	4	5	በግጥም ስራ አጠቃቀም
		18	አጅግብጥ ማሳሰቢያ	2	3	4	5	በግጥም ማሳሰቢያ
III.	ልጅ በግጥም ስራ ላይ ስራ ለማድረግ	19	አጅግብጥ ማሳሰቢያ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		20	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		21	ለልጅ አጅግብጥ ማሳሰቢያ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		22	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		23	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		24	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
IV.	ልጅ በግጥም ስራ ላይ ስራ ለማድረግ	25	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		26	ለልጅ አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		27	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
V.	ለልጅ በግጥም ስራ ላይ ስራ ለማድረግ	28	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		29	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		30	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		31	አጅግብጥ ማሳሰቢያ ስራ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
VI.	ለልጅ በግጥም ስራ ላይ ስራ ለማድረግ	32	ልጅ በግጥም ስራ ላይ ስራ ለማድረግ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ
		33	ልጅ በግጥም ስራ ላይ ስራ ለማድረግ	2	3	4	5	በግጥም ስራ ላይ ስራ ለማድረግ

1=አጅግብጥም 2=በግጥም 3=መከላከያ 4=ገደብ 5=በግጥም ስራ 6=በግጥም

አጠቃላይ!!

