



**COLLEGE OF HEALTH SCIENCES
SCHOOL OF NURSING AND MIDWIFERY**

**PREVALENCE OF DEPRESSION AND ITS ASSOCIATED
FACTOR AMONG WOMEN UNDERGOING ABORTION IN
ADDIS ABABA SELECTED PUBLIC HEALTH FACILITIES,
ETHIOPIA, 2025.**

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**A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY,
COLLEGE OF HEALTH SCIENCE, SCHOOL OF NURSING
AND MIDWIFERY AS PARTIAL FULFILMENT OF
MASTERS DEGREE IN MATERNITY AND REPRODUCTIVE
HEALTH NURSING**

JUNE, 2025

ADDIS ABABA, ETHIOPIA

ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCE
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Duration of the study	Nov 20 – Jun 7/2025 G.C
Study Area	Addis Ababa, Ethiopia
Total cost of the project	21,560.00 Ethiopian birr
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STATEMENT OF DECLARATION

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ACKNOWLEDGMENT

I would like to thank the School of Nursing and Midwifery of Addis Ababa University, who gave me a golden opportunity to do this research, and the College of health science librarians for facilitating the necessary reading resource (internet access) during the development of this thesis.

I would like to extend my special thanks of gratitude to my advisers, Dr. Leul Deribe (Ph. D, Asst. Prof), Ms. Addisshiwot Fantahun (MSc), and Dr. Semarya Berhe (Ph. D, Asst. Prof). For their unreserved support and constructive comment throughout the preparation of this thesis.

My special thanks also extend to the women participating in this study and data collectors for being around me and giving the necessary assistance and encouragement.

ABBREVIATIONS

AAU	Addis Ababa university
AGHC.....	Addisu Gebeya Health Center
AH.....	ALERT hospital
AHC.....	Akaki health center
ALHC.....	Alembank health center
ART.....	Assisted reproductive technology
EHC.....	Efoyita health center
EPDS.....	Edinburg post-natal depression scale
GHC.....	Gotera health center
GMH.....	Gandhi Memorial Hospital
GLHC.....	Gelan health center
HC.....	Health center
KHC.....	Keranio health center
NA	Number of admissions
MA.....	Medical abortion
PA.....	Proportional allocation
PAC	post-abortion care
RPL.....	Recurrent pregnancy loss
R3S.....	Received social support scale
SHC.....	Selam health center
SPHMMC.....	St. paulo's millennium medical collage
SPSS.....	Statistical package for the social sciences
TBH.....	Terunesh Beijing hospital
YLL	years of life lost

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ABSTRACT

Background: Abortion is defined as the loss of an intrauterine pregnancy before fetal viability. Depression is one of the most prevalent mental health issues among women who experience an abortion. Regardless of whether they are from high-income or low-income countries, post-abortion depression poses a significant public health concern, as it adversely affects women's mental well-being and overall health.

Objective: To assess the prevalence of depression and associated factors among women undergoing abortion in Addis Ababa selected public health facility of, Ethiopia, 2025

Method: A facility-based cross-sectional study was conducted between March 01 to April 15, 2025. A total of 422 women seeking abortion services were selected through consecutive sampling. Stratified random sampling was employed to select health facilities, followed by simple random sampling within each facility, with proportional allocation based on facility size. Data were collected via telephone interviews using Kobo-Toolbox, and depression was assessed using the Edinburgh Postnatal Depression Scale (EPDS). The EPDS was pre-tested at Tikur Anbessa Specialized Hospital on 21 women or 5% of the sample. Data analysis was performed using SPSS version 25, with descriptive statistics and logistic regression to identify factors associated with depression.

Result: Of the 422 women approached, 409 (96.9%) completed the interview successfully. The positive depression screening (EPDS score ≥ 13) was 39.9%, with 163 participants scoring 13 or higher. Multivariate analysis identified significant factors associated with depression, including educational level, relationship duration, type of abortion procedure, recurrent pregnancy loss, intimate partner violence, pregnancy intention, and levels of social support.

Conclusion and Recommendation: This study result revealed two in five women were found to likely have depression. These findings highlight the need to screen women after abortion for depression and integrate mental health services into post-abortion care.

Keywords: Abortion, Depression, Mental health, post-abortion depression,

CHAPTER ONE:

INTRODUCTION

1.1 Background

Pregnancy loss refers to the demise of the fetus at any point from conception to birth(1). World Health Organization (WHO) defines, Abortion as the cessation of pregnancy before the 20th week or the delivery of a fetus weighing under 500 grams however in Ethiopian, It is described as the end of pregnancy happening before 28 weeks of gestation and fetal weight is less than 1000 gram (2). Abortion that results from an intervention is frequently referred to as "induced abortion." Miscarriage, often known as "spontaneous abortion," on the other hand, happens naturally(3). Globally, around 38% of pregnancies are unplanned, with 22% resulting in abortion(4). In Ethiopia, there were 28 abortions for every 1,000 women between the ages of 15 and 49 in 2014 (5). Abortion can result in mental health issues for both parents; numerous studies have shown that depression is the first problem to develop following an abortion (6).

Depression, sometimes referred to as Major Depressive Disorder (MDD), affects people's emotions, thoughts, and behaviors and is a major contributor to the global health burden (7). According to WHO predictions, depression will rank as the second most common cause of disability worldwide by 2020(8). Additionally, depression contributed to more than 50 million Years Lived with Disability (YLD) globally in 2015, with low- and middle-income nations bearing more than 80% of this disease burden (9).

Post-abortion depression, which is marked by feelings of grief and anxiety, is a serious mental discomfort that occurs after an abortion or miscarriage. It usually starts weeks after the loss and can persist for months. Women of all ages are affected, although younger women are more likely to experience it, impacting mental health and functioning (10)

1.2 Statement of the problem

Depression can lead to emotional, social, and financial issues as well as disruptions in social or occupational performance (11). It also affects health system utilization. Research indicates that increased mental health issues can result in higher healthcare expenditures, as women may require more frequent medical visits and treatments (12). However, Depression symptoms like lack of pleasure, exhaustion, and low self-worth can affect a person's sexual function; conversely, Sexual dysfunction can indirectly lead to infertility by decreasing the frequency of intercourse (13).

Globally, estimates of the prevalence of post-abortion depression range from 8.6% (14) to 85% (15). Overall, the pooled prevalence of depression after abortion was 34.5%, with significant variation based on geographic location. The highest rate of post-abortion depression, 37.5%, was seen in Asia and Europe had the lowest proportion at 32.7% (13). Notably, lower-middle-income countries demonstrated increased post-abortion prevalence 42.91% relative to high-income countries 24.98%. Studies from African countries have indicated the magnitude of depression in women with spontaneous abortion has been 6.3% in Nigeria (16), and 34.1% in Kenya (17). In Ethiopia, Studies indicate that abortion can lead to psychological disorders such as depression, particularly when the abortion is unsafe (18)

Among the risk factors that could cause perinatal depression in women from LMICs are low socioeconomic status, unintended pregnancies, and gender-based violence. For example, at least one in five Ethiopian women reported experiencing intimate partner violence (IPV), and depression is three to five times more common in women who have experienced IPV (19). Additionally, the Ethiopian Demographic and Health Survey (EDHS) 2016, 26.6% of pregnancies in Ethiopia were unplanned (20) and that women who had unplanned pregnancies were twice as likely to experience perinatal depression symptoms than who had planned pregnancies (21). Furthermore, Cultural beliefs and religious views heavily stigmatize abortion in Ethiopia, influencing community attitudes toward both spontaneous and induced abortions, this stigma creates barriers to accessing safe abortion services and contributes to the persistence of unsafe practices (22). However, Younger age, lower education level, prior mental health condition, a lack of social support, being single, previous pregnancy loss, later

gestational week, recurrent pregnancy loss, and childlessness are listed as key drivers to psychological morbidity after a miscarriage in different literatures (17, 23).

The liberalization of Ethiopia's abortion law in 2005 has resulted in notable progress in expanding access to safe abortion services. The percentage of abortion care provided by the public sector increased from 36% in 2008 to 56% in 2014 as a result of the Ethiopian Ministry of Health's comprehensive guidelines, which empowered public health facilities to provide safe induced abortion and post-abortion care (PAC) that priorities choice, accessibility, and quality(24, 25). At the same time, the growth of medical abortion (MA) and investments in mid-level provider training have significantly improved mother health outcomes (26). Additionally, prior research emphasized the necessity of including psychosocial support services in the PAC package for women who had abortions or miscarried (6).

Most studies on women's physiological morbidity after abortion were conducted in developed countries, However, Ethiopia has a high prevalence of IPV and unintended pregnancy that lead to the development of the problem as well as it is difficult to predict what results should be expected in the Ethiopian sample, as the research data vary a lot. In this regard, there is a need to investigate how much the problem is and what are the associated factors in the development of the problem. So, this study aims to ascertain the prevalence of depression and what variables contribute to it among women getting abortions in Addis Ababa, Ethiopia.

1.3 Significance of the study

The study will determine the prevalence and contributing factors for depression in women undergoing abortion in the community. Furthermore, findings from this study can be used by healthcare professionals, program managers, and researchers working in related maternal care and support.

There are many expected benefits in conducting this study among those benefits; The study's conclusions will offer information to help program managers and healthcare administrators in integrating mental health services into reproductive healthcare programs and post-abortion care and ensuring a holistic approach to women's health.

Additionally, recognizing particular risk factors will help medical professionals use early intervention and tailored screening techniques, which will enhance patient outcomes and lessen psychological issues in the long run. Furthermore, the finding of this study offers baseline data for academics or students and crucial information for additional studies on related topics.

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CHAPTER TWO:

LITERATURE REVIEW

2.1 Prevalence of depression in women undergoing abortion

Several researches have been carried out worldwide to ascertain the prevalence of depression following an abortion. The majority of research is conducted in developed nations including, Germany, Jordan, China, Iran, London, Kenya, and Nigeria. In Germany the prevalence of depression after spontaneous abortion is 3.1%(27). In Nigeria, depression was among 6.3% of the study participants (16). In a cross-sectional study done in Jordan, 22.5% of women experienced depression after miscarriage (28). In Iran, 54% of women suffer from post-spontaneous abortion depression(29). A study in central London found that 28% of women who had miscarriages met the criteria for probable PTSD and 16% for depression at 1 month (30). In Kenya, an estimated 34.1% of women have screened positive for depression after miscarriage (17). and In China, 38% of pregnant women with a history of repeated miscarriages experienced depressive symptoms(31) Among, women seeking an abortion in the first trimester, the prevalence of depression was 22.5%(32).

2.2 Factor contributing to depression in women undergoing abortion

The factors contributing to depression among women undergoing abortion are categorized into three main sections. These factors include Socio-demographic factors, psycho-social factors, and reproductive health related factor

2.2.1 Socio-demographic factor

Various research has shown that the sociodemographic traits of women are responsible for various linked aspects of depression in spontaneous abortion. In relation to the mother's age, most study shows that the younger age group was found to be at high risk of developing depression. In a survey conducted in China, women who experienced recurrent pregnancy loss (RPL) had greater rates of depression, especially those who were older than 36.

(33). In a study done in Kenya, age is also a risk factor for depression following spontaneous abortion. Women over 40 were at the highest risk, followed by those between 30 and 40 years old, compared to the youngest group(34).

Marital status impacts the likelihood of developing depression in women experiencing spontaneous abortion; the study conducted in Nairobi showed that being single is significantly linked to a post-miscarriage positive depression screen, with a p-value = 0.043 in multivariate analysis (23). Another study conducted in Iran showed that the rate of depression was higher among single women with experience of induced abortion compared to married ones ($p < 0.05$)(35).

Education level was one of the clinical factors linked to the incidence of depression following a miscarriage, according to a study done in Nairobi ($p = 0.01$). This means that the more educated one is, the lower the likelihood of a positive depression screen (36). Another study conducted in Brazil found that Poor education (i.e. limited to elementary school) was also linked to depression. $p = 0.0032$ (37).

In terms of employment, one of the risk factors for depression is unemployment, which can cause depression. Approximately 75% of patients in an Indian study who were housewives and not employed had depression, compared to 25% of patients who were employed and paid, and Fisher's exact test proved this difference was statistically significant ($p = 0.0251$)(38).

2.2.2 Psychosocial factor

Social support is crucial for coping emotionally with miscarriage(39). According to the study conducted in India depressed individuals reported less social support from friends and family than non-depressed patients, This difference was statistically significant at $p < 0.05$ additionally, in this study, Spearman's correlation shows that The degree of depression increased. There was a decline in the perceived social support (38).

Women who have poor husband support and childlessness were reported to be more susceptible to depression in women with spontaneous abortion this was evident in different studies According to a cross-sectional survey carried out in Lithuania, 59.1% of women experienced an increased risk of postnatal depression following miscarriage, with impaired

body relationships and childlessness identified as strong predictors of psychological morbidity(40). Another study carried out in Brazil revealed that lack of spouse support was a risk factor for the development of anxiety ($p = 0.0029$)(37).

Prior mental health is one of the associated factors for depression after spontaneous abortion, a review from the University of California, Department of Psychiatry showed that grief, depression, and anxiety are Psychological sequelae after miscarriage, and past psychiatric history is one of the risk factors for this(41)(40)(40). A prospective cohort study done in London found that Psychological illness is more likely to occur one month following a pregnancy loss in women with a history of mental health issues or previous pregnancy loss; however, the overall predictive capacity for predicting psychological suffering was weak(42).

2.2.3 Reproductive health factor

The timing of a miscarriage can significantly influence psychological outcomes. Women who experience miscarriages later in gestation report higher levels of distress compared to those who miscarry earlier. Research indicates that a gestational age greater than 8 weeks is more likely to cause depression than a gestational age less than 8 weeks. (43). Another study conducted in Kenya Multivariate analysis showed gestation at miscarriage associated with depression ($p = 0.04$)(23)

The majority of research indicates Psychological morbidity is more common in women who have no live children at the time of pregnancy loss, the study done in Canada stated that the main effect of childlessness was significant, with a p-value equal to 0.004 (44). A study carried out in Jordan found, 48.1 % of women with no previous children have moderate to severe depressive symptoms (28). Another longitudinal study done in Bihar and Uttar Pradesh found that Depressive symptoms were less common in women with one [AOR: 0.69, CI: 0.57–0.84], two [AOR: 0.75, CI: 0.61–0.92], or more [AOR: 0.74, CI: 0.58–0.96] parity than in women without children (45).

According to Herbert et al.'s 2022 systematic review and meta-analysis, women who had perinatal losses were more likely to develop anxiety and depressive disorders and to have higher anxiety or depression scores than women who did not(46). Another study conducted in

Kenya revealed that the contextual variable before miscarriage was significantly associated with depression ($p = 0.011$) (23).

Recurrent pregnancy loss (RPL) is significantly associated with depression in women, as evidenced by various studies. A study conducted in Jordan revealed that 40.3% of women who had 2 or more miscarriages have moderate to severe depressive symptoms (28). Another study conducted in China revealed that The RPL group had a considerably greater prevalence of self-reported depression than the control group (45.3% vs. 30.1% in the chi-squared test, $p < 0.01$)(47). A study conducted in Germany shows that RPL patients exhibit higher Self-Rating Depression Scale scores compared to women with no history of pregnancy loss. Multiple pregnancy losses (≥ 3) further increase the odds of depression in these women (48).

2.3 Conceptual framework

After reviewing different literature about factors associated with depression in Women undergoing abortion, the following conceptual framework is adapted and shows the relationship between socio-demographic, reproductive health, and psychosocial-related factors and how dependent and independent variables are related.

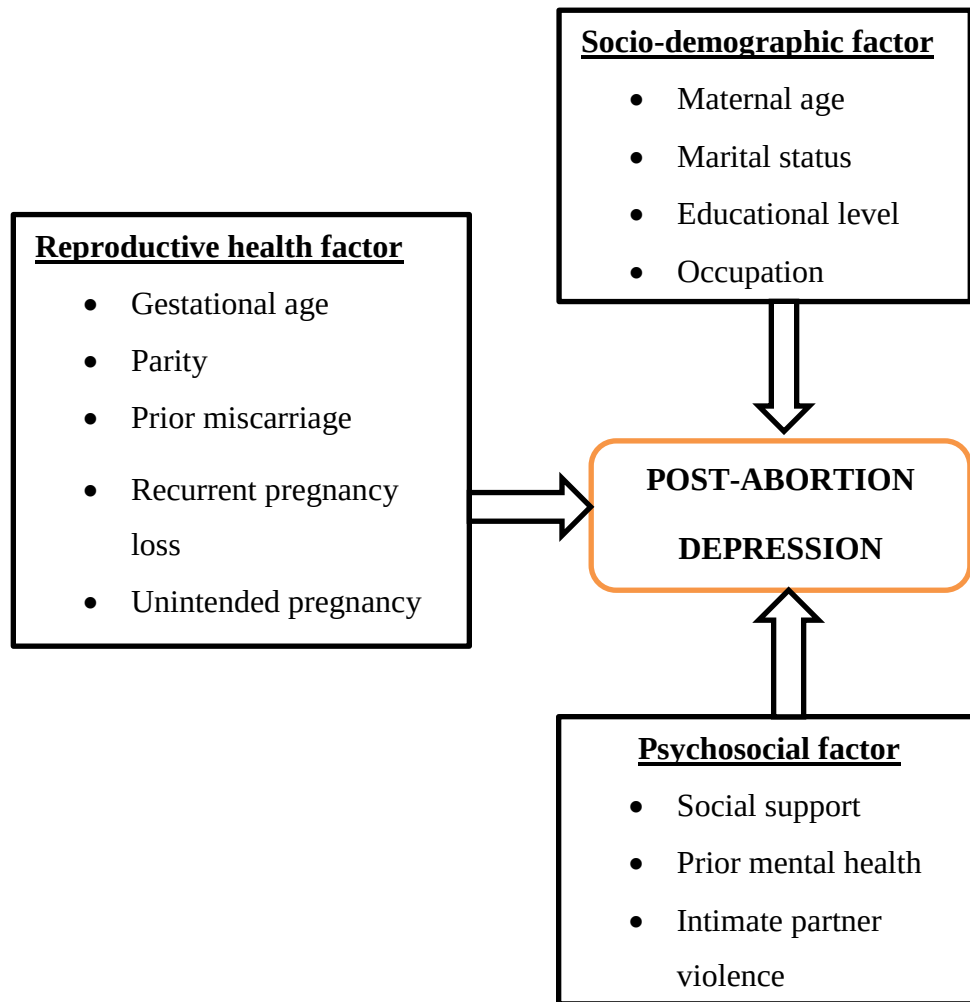


Figure 1: Conceptual framework on the study prevalence of depression and its associated factor among women undergoing abortion in Addis Ababa public health facility, Ethiopia, 2025 (23, 38, 42, 43, 46, 49)

CHAPTER THREE:

OBJECTIVE

3.1 General objective

- ✓ To assess the prevalence and associated factors of depression among women undergoing abortion in Addis Ababa selected public health facilities, Ethiopia 2025.

3.2 Specific objective

- ✓ To determine the prevalence of depression among women undergoing abortion in Addis Ababa selected public health facilities, Ethiopia 2025.
- ✓ To identify the factors associated with depression in women undergoing abortion in Addis Ababa selected public health facilities, Ethiopia 2025.

CHAPTER FOUR:

METHOD AND MATERIAL

4.1 Study area

Addis Ababa is the national capital of Ethiopia, which is a landlocked country in East Africa. The city is located almost in the center of the nation; it covers an area of 527 (50), Eleven sub-cities make up the city. The federal government owns eight hospitals, including three under the Defense Force and Police and five under the Federal Ministry of Health. The Addis Ababa Health Bureau also owns six hospitals and 98 health centers. All the 14 public hospitals and 98 health centers provide post-abortion care (origin: Addis Ababa Health Bureau informally). This study was carried out in Addis-Ababa selected public health institutions located in a randomly chosen sub-city, namely Gulele, Akaki Kality, Kolfe Keraniyo, and Kirkos sub-city.

4.2 Study design and period

A Cross-sectional study was conducted in Addis-Ababa selected public health facility, Ethiopia. This design is ideal for determining the prevalence and identification of associated factors with depression within the constraints of time and resources. The study was conducted from Mar 01/2025- April 15/2025.

4.3 Source population and study population

4.3.1 Source population

All women who undergo abortions and those who receive care in a public health facility in Addis Ababa.

4.3.2 Study population.

All women who had abortions and those, who were treated during the study period in Addis Ababa selected public health institutions.

4.4 Inclusion and exclusion criteria

4.4.1 Inclusion criteria

- ✓ Age between 15-49 (51, 52)
- ✓ Women who are undergoing abortion and willing to participate in the study

4.4.2 Exclusion criteria

- ✓ Women with pre-existing psychiatric conditions diagnosed before the abortion

4.5 Sample size determination and sampling procedure

4.5.1 Sample size determination

A single population proportion calculation was used to calculate the required sample size of eligible study participants.

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

Where

n= the desired sample size

$Z_{\alpha/2}$ = is the standard normal distribution value for the 95% CI = 1.96

D= was the margin of error to be tolerated (5%)

P= by considering 50%, since the prevalence of post-abortion depression in Ethiopia is not known

$$n = \frac{(1.96)^2 0.5(1 - 0.5)}{(0.05)^2}$$

$$n = 384$$

By considering a 10% non-response rate the total sample size was 422.

4.5.2 Sampling procedures

From 11 Sub-cities of Addis Ababa, four sub-cities were selected by a simple random sampling using a random number generator. The selected sub-cities are (Gulele, Akaki Kality, Kolfe Keranio, and Kirkos sub-city). The public health facility in each sub-city was stratified into two categories: public health hospital and public health center. Following this, a list of public health facilities in each selected sub-city was compiled from the list of all health facilities in each sub-city one hospital and two health centers were chosen using stratified random sampling, resulting in twelve health facilities. The number of participants was allocated proportionally by using the population proportion formula based on the previous two-month report data from HMIS. Until the necessary sample size was reached, women who satisfied the inclusion criteria were chosen through consecutive sampling.

Table 1: Proportional allocation of total sample size based on the previous 2 months for the study prevalence of depression and its associated factor among women undergoing abortion in Addis Ababa selected public health facility.

Previous 3 month number of admission and proportio nal allocation	Name of selected hospital and health center											
	SPHM MC	GM H	TB H	AH	AG HC	SHC	EH C	GH C	GLH C	AH C	ALH C	KH C
NA	91	107	80	74	69	78	72	64	71	70	74	68
PA	42	49	37	34	32	36	33	29	33	32	34	31

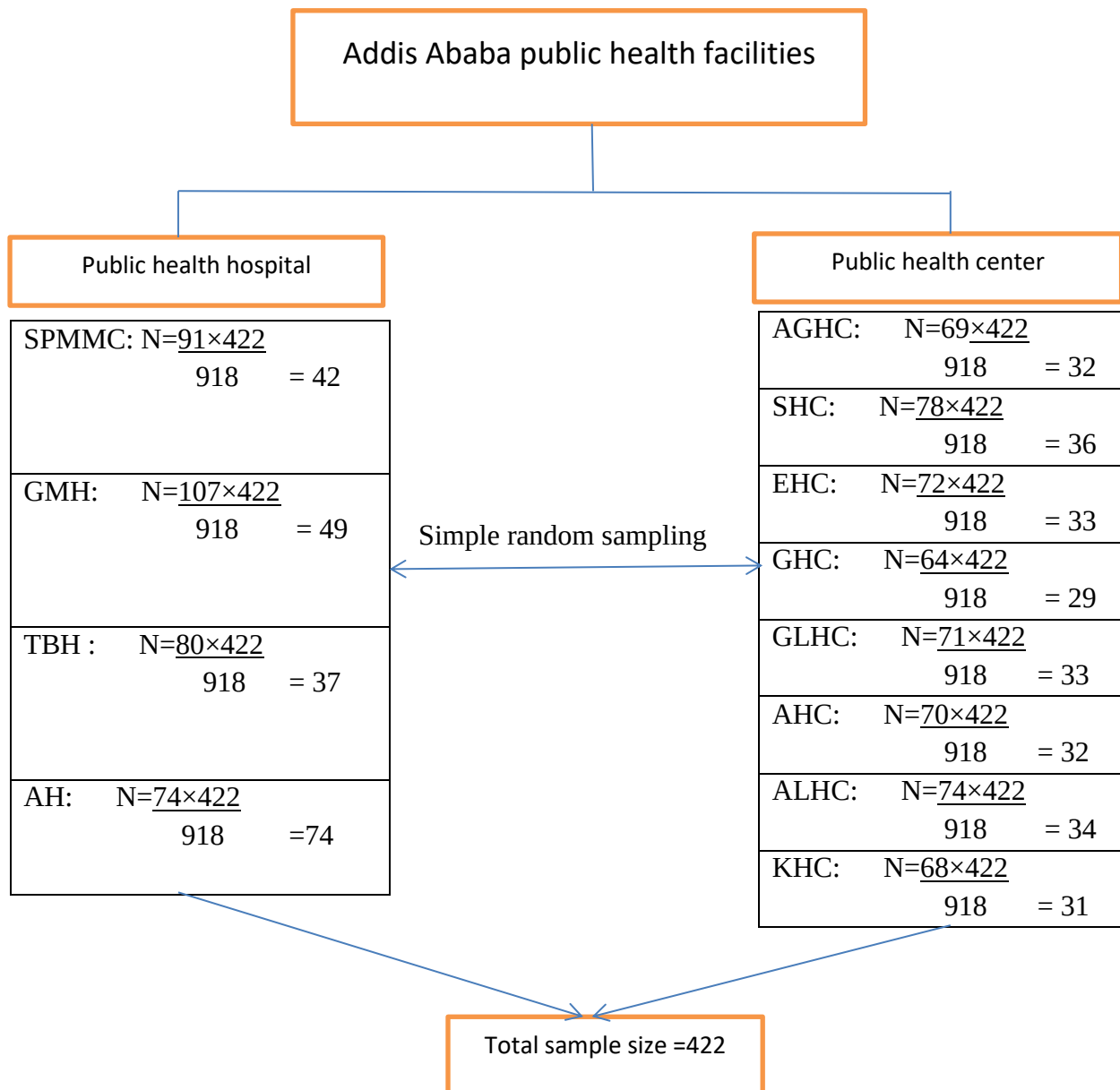


Figure 2: Schematic diagram of sampling procedure on prevalence of depression and its associated factor among women undergoing abortion in Addis Ababa public health facility, Ethiopia, 2025.

4.6 Study variable

4.6.1 Dependent variable

- ✓ Post-abortion depression

4.6.2 Independent variable

Socio-demographic variables, including age, parity, and gestational age, will be continuous variables. Marital status, Educational level, occupation, social support, prior mental health, prior miscarriage, recurrent pregnancy loss, intimate partner violence, and unintended pregnancy are also considered explanatory variables for the mental health status of the women.

4.7 Operational definition

Post-abortion depression: A depressive symptom that can occur following an abortion, whether induced or spontaneous(53)

Recurrent pregnancy loss (RPL): described as two or more consecutive pregnancy losses (54)

Depression: a serious public health issue that presents clinically as chronic depression, disinterest in frequently pleasurable activities, difficulties carrying out daily tasks, issues with eating or sleep, repeated suicidal thoughts, and difficulty focusing (55).

Depressed: The cumulative score from the Edinburgh postnatal depression scale (EPDS) was utilized. A cutoff point for potential depression is often 13 or higher as used in the study (17).

Mental health: WHO defines mental health as “a state of well-being in which every individual realizes his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to their community”(56).

Financial self-efficacy: is assessed using the financial self-efficacy scale(FSES), which measures an individual’s confidence in managing their financial situation. In this study, participants are categorized based on the mean FSES score of 12, with those scoring ≥ 12

classified as financially confident and those scoring below 12 classified as financially insecure.

4.8 Data collection instrument

For the study, a socio-demographics and associated factors instrument was developed to gather information about the patient's socio-demographics and other factors that may influence the likelihood of post-abortion depression. Both closed-ended and open-ended questions are included in the questionnaire's design. The survey was first created in English, then translated into Amharic, and returned again to look for any discrepancies.

Financial self-efficacy scale (FSES)

A tool captures an individual self-confidence, optimism, and belief system as related to their financial planning and practice. It includes items adapted from the general self-efficacy scale. Respondents rate the statement on a scale from 1 (exactly true) to 4 (not true at all). Scores on the six financial self-efficacy items ranged from 6 to 24 with the higher scores indicating greater financial self-efficacy and Cronbach's alpha reliability of the tool is 0.76(57).

London measure of unplanned pregnancy (LMUP)

A tool that assesses the recent or current pregnancy was planned and it was validated in Ethiopia with Cronbach's alpha of 0.799(58). It consists of six questions and each has a scoring system from 0 to 12 with a cut-point between 9 and 10 where, a score of 10+ being "planned", and a score of 0-9 being "unplanned"(59).

Humiliation, afraid, rape, kick (HARK)

A four-question self-reported yes or no instrument that represents different forms of IPV including emotional, sexual, and physical abuse. Each 'yes' response is assigned 1 point and a cutoff score of ≥ 1 is considered optimal for identifying IPV. The sensitivity and specificity of this cutoff score from the composite abuse scale (CAS) were 81% and 95% respectively meaning HARK effectively identifies the true positive(60).

Received social support scale (R3S)

Social support obtained by individuals seeking abortion care is measured by a 9-item questionnaire with three subscale scoring tools (informational, instrumental, and emotional). Its reliability coefficient is outstanding (Cronbach's $\alpha > 0.85$) (61). Subscale summed scores (range: 3-15 each), overall summed score (range: 9-45), or compute the average of the summed scores for the total scale or subscales (scoring range: 1-5). Usually, respondents use a Likert scale to grade the things, ranging from "strangely agree" to "disagree." A higher sum or average score indicates that those seeking abortion care received more social support.

Edinburgh Postnatal Depression Scale (EPDS)

This tool is a 10-item questionnaire that inquires about the presence of depressive symptoms, and its reliability study confirms the good internal consistency of the global scale (Cronbach's $\alpha: 0.76$) and its good short-term test-retest reliability (0.98)(62). Participant's responses regarding the frequency of symptoms are scored from 0 to 3. The overall score might range from zero and thirty. According to previous studies, a score of 13 or more was considered screen-positive and suggestive of a high probability of depression (17). This study utilizes EPDS to screen the participant for potential depression.

4.9 Data collection procedure

Four hundred twenty-two participants were recruited at the gynecology emergency in the triage room following the completion of the triage. The participant's socio-demographic characteristics information and consent were taken on the day of recruitment in the office in the facility if she is willing to participate. Tell her that the interview takes place seven days after the occurrence of abortion. Before that, the interviewer calls her and schedules the date and time. Data will be collected by telephone by using structured questionnaires and for participants, who did not respond initially, follow-up calls were made up to three times, and women who did not respond after three attempts were considered as non-responses. Before the interview, ensure that participants have a private and comfortable setting and build rapport over the phone. Data collection was conducted by an online data collection tool known as Kobo Collector. The supervisor and principal investigator checked the collected data daily for Completeness.

4.9 Data Quality Assurance

The questionnaire was translated from English to Amharic using a language expert. To confirm that meaning was not altered in the translation process, the translated questions were pre-tested in Tikur Anbesa Hospital among 21 (5%) women a week before data collection that was not included in the study. Three Data collectors and one supervisor were recruited; they are experienced in data collection. For one day, the supervisor and data collectors received training on the study's purpose, significance, method for gathering data, client confidentiality, eligibility requirements, informed consent, and approaches to take during the data collection period. Every day following data collection, the lead investigator and supervisor reviewed the gathered data for completeness, accuracy, and clarity. Any necessary modifications were addressed before the subsequent data collection measure. Finally, data cleanup and cross-checking were done before analysis. Incomplete questionnaires were excluded from the study and counted as non-respondents.

4.10 Data analysis

First, calculate missed data. Replace the missing value with the mean or median of the non-missed value for continuous variables, and for categorical variables, listwise deletion was used. SPSS software version 25 was used for the entry of statistical data analysis. Descriptive statistics was used as a statistical analysis method and expressed as frequency and percentage. Continuous variables were represented as means, standard deviation, minimum and maximum, and categorical variables as frequencies. The study employed both multivariate and bivariate logistic regression analysis to determine the association between the dependent and each independent variable. Variables with a p-value of 0.25 in the bivariate analysis were entered into multiple logistic regression models to adjust the effect of confounders on the prevalence of depression in abortion. Results were presented by using COR and AOR with 95% confidence intervals, and a p-value of less than 0.05 was considered statistically significant.

4.11 Ethical Consideration

The Addis Ababa University (AAU) Nursing and Midwifery School Ethical Review Committee gave its approval to the thesis and sent an official letter to the Addis Ababa Health Bureau. The objective of the study was explained to the members of the Addis Ababa Health Bureau's ethical committee as well as the relevant medical facilities. Gets an official letter to each selected hospital from Addis Ababa Health Bureau. After getting permission from each hospital, consent was obtained from participants for willingness, and then Study participants were frequently given a brief description of the study's goal before their informed verbal agreement was requested. For women aged 15-17, voluntary assent for participation was ensured, along with strict confidentiality measures to protect their privacy and prevent stigma. Respondents were informed that there would be no benefits or risks associated with participating in this study, that their information would be kept private by not including their names on the questionnaire, and that they could withdraw from the study at any time during the interview.

4.12 Dissemination Plan of Study Results

The findings of this study were shared with the nursing department at Addis Ababa University's College of Health Sciences, School of Nursing and Midwifery. Additionally, the Addis Ababa Health Bureau received it. In addition, the findings were discussed with specific stakeholders during the yearly review meeting. Ultimately, efforts were intended for publication in scholarly journals.

CHAPTER FIVE:

RESULTS

5.1 Socio-demographic Characters

A total of 422 women were interviewed and out of them 409 correctly completed the interview making the response rate 96.91% despite three follow-up calls, 13 women were unavailable and did not respond, leading to their being considered as non-response. The mean age of the participants was 27.93 with ± 5.989 years and 28.4% of the participants were in between 20-24 years. Three hundred twenty-two (78.7%) women were married or cohabited, 148(36.2%) women had secondary education, and 151(36.9) were housewives. The number of individuals living in each household ranges from 1 to 10, 204(49.9%) had small family size (<3) and 318(77.8%) exhibited financially insecure. (See table 2)

Table 2: Socio-demographic characteristics of the women undergoing abortion in selected public health facilities of Addis Ababa Ethiopia, 2025(n=409).

Variables	Frequency(n=409)	Percent (%)
Age		
15-19	23	5.6
20-24	116	28.4
25-29	111	27.1
30-34	91	22.2
>35	68	16.6
Marital status		
Living apart	87	21.3
Living together	322	78.7
Educational status		
No formal education	61	14.9
Grade 1-8	118	28.9
Grade 9 -12	148	36.2
College and above	82	20
Employment		
unemployed or student	112	27.4
Housewife	151	36.9
Employed	146	35.7
Crowding index		
Small	204	49.9
Medium	186	45.5
Large	19	4.6
financial self-efficacy		
financially confident	91	22.2
financially insecure	318	77.8

5.2 Reproductive characteristics of the respondent

Among 409 respondents 257(62.8%) had a history of pregnancy, 233(57%) had children and 89 (21.8%) had a history of previous pregnancy loss. Three hundred fourteen (76.8%) women were in the first trimester with an average gestational age of 21 weeks. Seventy-two (17.6%) of women had Recurrent pregnancy loss history. Two hundred ninety-one (71.1%) of women indicated their pregnancy as unintended. (See Table 3)

Table 3: Reproductive health characteristics of the women undergoing abortion in selected public health facilities of Addis Ababa, Ethiopia, 2025(n=409)

Variables	Category	(f)	(%)	(μ)	St. D
previous pregnancy history	Yes	257	62.8	1.37	0.484
	No	152	37.2		
previous live-born	Yes	233	57	1.43	0.496
	No	176	43		
pregnancy loss history	Yes	89	21.8	1.78	0.413
	No	320	78.2		
current pregnancy loss status	Spontaneous	296	72.4	1.28	0.448
	Induced	113	27.6		
RPL history ¹	Yes	72	17.6	1.82	0.381
	No	337	82.4		
Gestational age	first trimester	314	76.8	1.23	0.423
	second trimester	95	23.2		
Current abortion procedure	Medical Abortion	250	61.1	1.39	0.488
	Surgical Abortion	159	38.9		
pregnancy intention	Unplanned	291	71.1	1.29	0.454
	Planned	118	28.9		

¹ RPL: Recurrent pregnancy loss

5.3 Intimate partner violence (IPV) and its association with depression

In this study IPV was assessed using the HARK questionnaire among 409 participants 96(23.5%) of women reported experiencing IPV in some form. The distribution of the response shows 54(13.2%) women feeling humiliated by a partner, 12(2.9%) feeling afraid of a partner, 28(6.8) forced sexual acts, and 65(15.9%) experiencing physical violence.

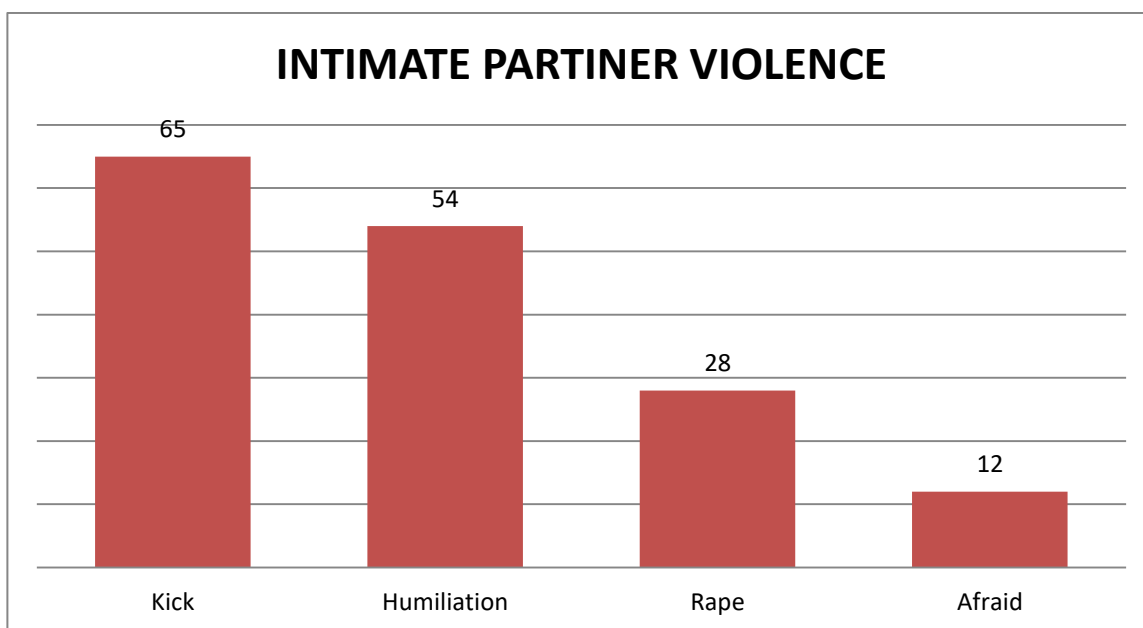


Figure 3 Intimate partner violence among women undergoing abortion in Addis Ababa selected public health facilities Ethiopia 2025

5.4 Social support and its association with depression

The participant's social support was assessed based on the received social support scale categorizing support into three sub-scales, emotional support, instrumental support, and informational support. The mean score of social support was 1.48 ± 0.5 with 70.2% of the participants having low emotional support, 42.8% of women having low instrumental support, and 51.6% of women having low informational support.

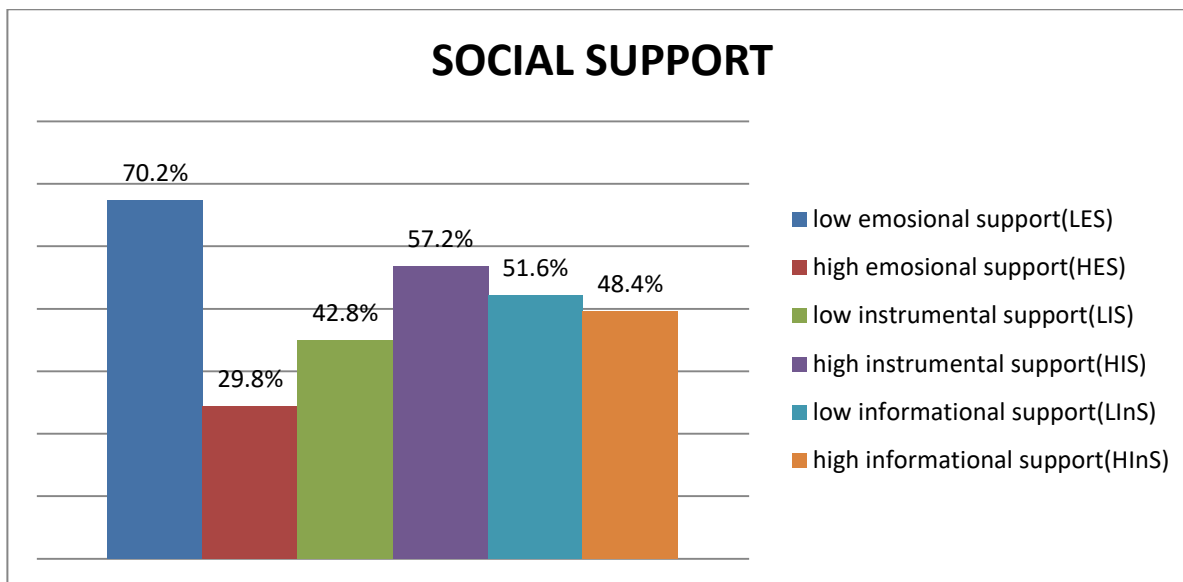


Figure 4 Social support received by women undergoing abortion in Addis Ababa selected public health facilities Ethiopia, 2025

5.5 Prevalence of depression

The prevalence of positive depression screening in women undergoing abortion from the present study is estimated at 39.9%, while 60.1% were not likely to develop depression. Among the recruited women 163 scored 13 or more in the EPDS indicating, a high likelihood of developing depression. The mean depression score was 11.58 with a standard deviation of 6.23.

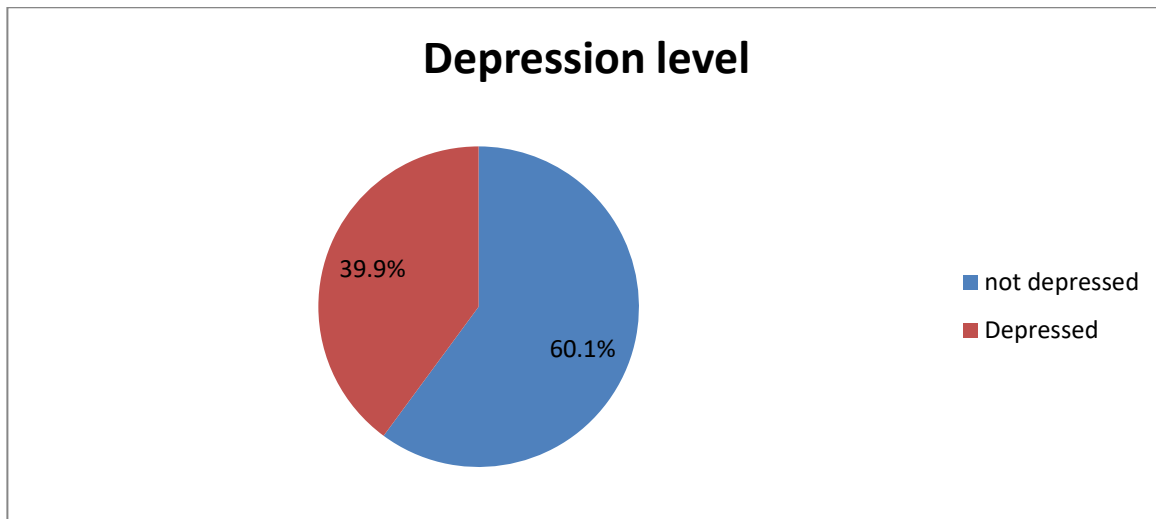


Figure 5 prevalence of depression among women undergoing abortion in Addis Ababa selected public health facilities, Ethiopia 2025.

The frequency distribution of responses to the ten items in the Edinburgh postnatal depression scale shows, that the item “Have you felt sad or miserable” had a higher mean score of 2.29 ± 0.76 conversely, the item addressing thought of self-harm scored mean and standard deviation of indicating none of the participants reported self-harm thought. However, the highest variability was observed in the question that addressed “anxiety and worry for no good reason” with a standard deviation of 1.03. (See table 4)

Table 4 Edinburgh postnatal depression scale (EPDS) response to assess depression in the past 7 day

Edinburgh postnatal depression scale(EPDS)	0	1	2	3	μ	St. D
Have you been able to laugh and see the funny side of Things?	25	236	108	40	1.4	0.748
Have you looked forward with enjoyment to things?	15	236	79	79	1.54	0.842
Have you blamed yourself unnecessarily when things went wrong?	257	62	50	40	0.69	1.024
Have you been anxious or worried for no good reason?	215	93	58	43	0.83	1.03
Have you felt scared or panicky for no good reason?	146	135	78	50	1.08	1.016
Have things been getting on top of you?	22	236	109	42	1.42	0.747
Have you been so unhappy that you have had difficulty sleeping?	134	142	76	57	1.14	1.027
Have you felt sad or miserable?	7	53	162	187	2.29	0.755
Have you been so unhappy that you have been crying?	114	174	60	61	1.17	0.998
Has the Thought of harming yourself occurred to you	409	0	0	0	0	0

5.6 Factors associated with the development of depression

To identify the factor associated with the development of depression in women undergoing an abortion, we exported variables that showed $p < 0.25$ during binary logistic regression into a multivariate regression model. A total of thirteen variables were fitted into the multivariate regression model using the enter method and seven variables were found to be significantly associated with the development of post-abortion depression. (See table 5)

The study showed women who had undergone abortion by surgical intervention were two times more likely to develop depression than women undergone medical abortion [**AOR= 2.04(95% CI: 1.22-3.40)**]. Those women who have a history of recurrent pregnancy loss were nearly nine times more likely to develop depression than women who did not have a history of recurrent pregnancy loss [**AOR= 8.74 (95% CI: 3.84-19.88)**]. In addition, women who experience intimate partner violence were around two times more likely to develop depression than women not experience it [**AOR= 1.81 (95% CI: 1.01-3.22)**]. Furthermore, women who carry unplanned pregnancies were two times more likely to develop depression than women who carry planned pregnancies [**AOR= 2.32 (95% CI: 1.32-4.09)**]. Moreover, in this study, 56% [**AOR= 0.44 (95% CI: 0.21-0.97)**] and 48% [**AOR= 0.52(95% CI: 0.31-0.88)**] of women with relationships greater than two years and those who have lesser social support were more likely to develop depression respectively.

Table 5: Factors associated with post-abortion depression among women undergoing abortion in Addis Ababa selected public health facilities Ethiopia, 2025 (n=409)

Variable	Depression level		COR 95% CI	AOR 95% CI	Sig
Age	Depressed	Not depressed			
<25 year	65(46.8%)	74(53.2%)	1.54(1.02-2.34)	1.26(0.65-2.43)	0.489*
≥25 year	98(36.3%)	172(63.7%)	1	1	
Education					
No formal education	24(39.3%)	37(60.7%)	0.44(0.22-0.86)	0.65 (0.29-1.47)	0.303
Grade 1-8	41(34.7%)	77(65.3%)	0.36(0.20-0.64)	0.26(0.13-0.52)	.000**
Grade 9-12	49(33.1%)	99(66.9%)	0.33(0.19-0.58)	0.28(0.14-0.54)	.000**
Collage and above	49(59.8%)	33(40.2%)	1	1	
Marriage					
Live apart	46(52.9%)	41(47.1%)	1	1	
Live together	117(36.3%)	205(63.7%)	0.51(0.31-0.82)	1.13(0.51-2.54)	0.78*
Relationship duration					
<2 year	72(51.1%)	69(48.9%)	1	1	
≥2 year	91(34.0%)	177(66.0%)	0.49(0.33-0.75)	0.44(0.21-0.97)	0.042**
Previous live born					
Yes	78(33.5%)	155(66.5%)	1	1	
No	85(48.3%)	91(51.7%)	1.86(1.24-2.77)	1.24(0.63-2.43)	0.542*
Previous pregnancy loss					
Yes	41(46.1%)	48(53.9%)	1.39(0.86-2.23)	0.92(0.44-1.91)	0.813*
No	122(38.1%)	198(61.9%)	1	1	
RPL???					
Yes	54(75.0%)	18(25.0%)	6.28(3.51-11.21)	8.74(3.84-19.88)	.000**
No	109(32.3%)	228(67.7%)	1	1	
Current pregnancy loss					
Spontaneous	109(36.8%)	187(63.2%)	1	1	
Induced	54(47.8%)	59(52.2%)	1.57(1.01-2.43)	0.94(0.47-1.91)	0.873*
Abortion procedure type					
Medical	85(34.0%)	165(66.0%)	1	1	
Surgical	78(49.1%)	81(50.9%)	1.87(1.25-2.81)	2.04(1.22-3.40)	0.007**

Partner violence(IPV)					
Negative for IPV	108(34.5%)	205(65.5%)	1	1	
Positive for IPV	55(57.3%)	41(42.7%)	2.55(1.61-4.06)	1.81(1.01-3.22)	0.048**
Pregnancy intention					
Unintended	135(46.4%)	156(53.6%)	2.78(1.72-4.51)	2.32(1.32-4.09)	0.003**
Intended	28(23.7%)	90(76.3%)	1	1	
Social support					
Lesser	64(30.2%)	148(69.8%)	0.43(0.29-0.64)	0.52(0.31-0.88)	0.014**
Gretter	99(50.3%)	98(49.7%)	1	1	
Gestational age					
First trimester	125(37.9%)	205(62.1%)	1	1	
Second trimester	38(48.1%)	41(51.9%)	1.52(0.93-2.49)	1.16(0.64-2.11)	0.621*

Keys: * p value < 0.25 in bivariate, ** p < 0.05 in multivariate, 1 = Reference

CHAPTER SIX

DISCUSSION

The present study aims to investigate the prevalence of depression in women faced with abortion and to identify factors associated with it. The finding from several studies shows variations in the prevalence of depression due to geographical location, the tool and method they used, and the sample size. The result of this study indicates a high prevalence of women undergoing abortion suffering from depression at 39.9% and the result is nearly similar to the study finding conducted in Kenya where the prevalence of positive depressive screening in post miscarriage women was 34.1%(17). On the other hand, this proportion was higher when compared to other studies where the prevalence of depression was 8.9% in Germany, 22.5% in China (32), 15.6% in Iran (63), 6.3% in Nigeria (16) conversely, this proportion is somewhat lower when compared with the study conducted in Bangladesh the prevalence of depression was 77.50% (64) the difference is maybe the assessment time.

In several studies, there was a relationship between sociodemographic characteristics in the development of depression like maternal age, marital status, educational level, and occupation or economic status. In our study, only educational level and relationship duration with the father of current pregnancy are associated with the development of depression. Our findings stated that women with an educational level limited in primary or secondary education were less likely to develop depression meaning the higher the education level the higher the chance of a positive depression screen. The result may be that if the woman is more educated increases the possibility of overestimating the risk and underestimating the benefit of abortion which may lead to depression.

Our study found that women in relationships lasting over two years were more likely to develop depression after abortion, with a prevalence of 51% in this group. To the best of our knowledge, no previous studies have explored this specific association. This finding may be influenced by cultural factors, particularly in Ethiopia, where fertility is highly valued. In such contexts, the desire to have children is central to family formation, and the loss of a pregnancy can be an emotionally devastating experience. This cultural emphasis on childbearing may

contribute to increased emotional distress and, consequently, a higher risk of depression following abortion.

In the current study, depression was more significant in women experiencing a surgical abortion procedure than a medical one. This finding was consistent with the study conducted in Turkey where women who underwent surgical abortion were found to have a significantly elevated risk of post-abortion depression (65) this might be due to surgical abortion is often perceived as more invasive which can lead to higher emotional distress and feelings of loss.

In several studies, recurrent pregnancy loss is significantly associated with the development of depression, compared to those with successful pregnancy outcomes. Our study also shows an odds ratio of 8.74 for depression among women experiencing RPL. This study finding is in line with the study conducted on Kazakhstani women with RPL had significantly higher scores of depression (66) this result may be due to RPL being a significant reproductive health issue that increases gynecologic complication and impacts mental well-being meaning the emotional toll of RPL is compounded by a feeling of grief, guilt, and uncertainty about the future pregnancy because it may be depression significantly increase the risk of recurrent pregnancy loss (67).

According to the findings of this study, women with intimate partner violence were approximately two times more likely to develop depression on the other hand women with unintended pregnancy were also two times more likely to have depression. Previous research extensively documented the association between IPV and unintended pregnancy with depression during pregnancy and postpartum for instance the study conducted in Vietnam Women who experienced sexual violence or physical violence had approximately 2 to 3 times higher odds of presenting with signs of depression (68) Similarly unplanned pregnancy is significantly associated with depression, as evidenced by a meta-analysis showing that it escalates the risk of antenatal depression (69) another study conducted in Uttar Pradesh found that women with unintended pregnancies had a 44% prevalence of depressive symptoms(45). So our study shed light on the impact of IPV and unintended pregnancy in abortion cases and the result may be women with IPV often face emotional abuse that leads to stress and when combined with unintended pregnancy the emotional burden increases making depression more likely.

Further according to the findings of this study around half of the participants (48%) of women with less social support were likely to develop depression this is also consistent with the finding in Turkey which indicate Social support significantly decreases depression levels, support from family and friends was crucial in reducing depression scores among the participants (15). In this study less significant compared to the turkey result this difference may be due to the population or the tool we used.

6.1 Strength of the study

This facility-based survey is the first study of its kind conducted in Ethiopia. A key strength of our research is the use of validated and widely recognized tools for data collection. Additionally, this study uniquely examines the impact of intimate partner violence (IPV) and unintended pregnancy on abortion cases, aspects that have not been explored in previous studies.

6.2 Limitations of the study

The limitations of the study included not being able to confirm clinical depression using a psychiatric consult which was due to financial constraints and a limited budget. Another limitation it is possible to infer the association but not infer causation however the data is collected through telephone interviews which may have introduced biases related to participant availability

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATION

7.1 Conclusion

In conclusion, about two in five women were found to likely have depression seven days after the occurrence of abortion. Moreover, factors associated with the development of depression include, higher educational level, relationship duration, the type of abortion procedure, history of recurrent pregnancy loss, intimate partner violence, unintended pregnancy, and social support. The prevalence documented in this study outlines the importance of screening women after abortion for depression.

7.2 Recommendation

Based on the findings of this study, we recommended the Addis Ababa Health Bureau, health professionals, and researchers.

To Addis Ababa Health Bureau

Strengthen post-abortion care service by integrating mental health screening into post-abortion care and Develop a training program for health care professionals to recognize and address post-abortion mental health outcomes.

To healthcare professionals

Recommend health care professionals to screen and earlier pick up of those women, especially high-risk women, and Provide clear information on the emotional response after abortion and available coping strategies for women coming for the service.

To researchers

Recommend researcher carry out further research by using different designs.

Implication to nursing and midwifery practice

Enhancing the capacity of nursing and midwifery staff to address these sensitive topics can improve maternal mental health, promote safer reproductive choices, and contribute to better overall health outcomes for women.

REFERENCE

1. Zegers-Hochschild F, Adamson GD, Dyer S, Racowsky C, De Mouzon J, Sokol R, et al. The international glossary on infertility and fertility care, 2017. *Human reproduction*. 2017;32(9):1786-801.
2. Wayessa ZJ, Boneya BA, Hadona EA. Knowledge, Attitude and Associated Factors Toward Ethiopian Abortion Law Among Reproductive Age Women in Bule Hora Town, Southern Oromia, Ethiopia, 2022. *Health Services Research and Managerial Epidemiology*. 2023;10:23333928231220493.
3. Quenby S, Gallos ID, Dhillon-Smith RK, Podsek M, Stephenson MD, Fisher J, et al. Miscarriage matters: the epidemiological, physical, psychological, and economic costs of early pregnancy loss. *The Lancet*. 2021;397(10285):1658-67.
4. Bearak J, Popinchalk A, Alkema L, Sedgh G. Global, regional, and subregional trends in unintended pregnancy and its outcomes from 1990 to 2014: estimates from a Bayesian hierarchical model. *The Lancet Global Health*. 2018;6(4):e380-e9.
5. Moore AM, Gebrehiwot Y, Feters T, Wado YD, Bankole A, Singh S, et al. The estimated incidence of induced abortion in Ethiopia, 2014: changes in the provision of services since 2008. *International perspectives on sexual and reproductive health*. 2016;42(3):111.
6. Farren J, Mitchell-Jones N, Verbakel JY, Timmerman D, Jalmbrant M, Bourne T. The psychological impact of early pregnancy loss. *Human reproduction update*. 2018;24(6):731-49.
7. Bourque V-R, Poulain C, Proulx C, Moreau CA, Joober R, Forgeot d'Arc B, et al. Genetic and phenotypic similarity across major psychiatric disorders: a systematic review and quantitative assessment. *Translational Psychiatry*. 2024;14(1):171.
8. Marcus M, Yasamy M, Shekhar Saxena MVO. Depression: A Global Public Health Concern, WHO Department of Mental Health and Substance Abuse. World Health Organization. Pabrano z: https://www.who.int/mental_health/management/depression/who_paper_depression_wfmh_2012.pdf. 2012.
9. Dicker D, Nguyen G, Abate D, Abate KH, Abay SM, Abbafati C, et al. Global, regional, and national age-sex-specific mortality and life expectancy, 1950–2017: a

systematic analysis for the Global Burden of Disease Study 2017. *The lancet*. 2018;392(10159):1684-735.

10. Tiwari A. Impact of missed abortion & early pregnancy loss on mental health of women: A thematic narrative review.
11. Kessler RC, Bromet EJ. The epidemiology of depression across cultures. *Annual review of public health*. 2013;34(1):119-38.
12. Studnicki J, Longbons T, Fisher J, Reardon DC, Skop I, Cirucci CA, et al. A cohort study of mental health services utilization following a first pregnancy abortion or birth. *International Journal of Women's Health*. 2023:955-63.
13. Gebeyehu NA, Tegegne KD, Abebe K, Asefa Y, Assfaw BB, Adella GA, et al. Global prevalence of post-abortion depression: systematic review and Meta-analysis. *BMC psychiatry*. 2023;23(1):786.
14. Kolte A, Olsen LR, Mikkelsen E, Christiansen O, Nielsen HS. Depression and emotional stress is highly prevalent among women with recurrent pregnancy loss. *Human reproduction*. 2015;30(4):777-82.
15. Akdag Topal C, Terzioglu F. Assessment of depression, anxiety, and social support in the context of therapeutic abortion. *Perspectives in psychiatric care*. 2019;55(4):618-23.
16. Umar H, Ajuwon AJ. Depression and post-traumatic stress disorder among women experiencing spontaneous abortion in Katsina, North Western Nigeria. *African Journal of Reproductive Health*. 2024;28.
17. Mutiso SK, Murage A, Mukaindo AM. Prevalence of positive depression screen among post miscarriage women-A cross sectional study. *BMC psychiatry*. 2018;18:1-7.
18. Teferi B, Tufa MK, Metselo MM, Mihiretie AM. Utilization of post Abortion contraceptives and associated factors among Women seeking Abortion services at St. Paul Hospital Millennium Medical College in Addis Ababa, Ethiopia, 2023. *Millennium Journal of Health*. 2024;3(2).
19. Tsai AC, Tomlinson M, Comulada WS, Rotheram-Borus MJ. Intimate partner violence and depression symptom severity among South African women during pregnancy and postpartum: population-based prospective cohort study. *PLoS medicine*. 2016;13(1):e1001943.

20. Teshale AB, Tesema GA. Magnitude and associated factors of unintended pregnancy in Ethiopia: a multilevel analysis using 2016 EDHS data. *BMC pregnancy and childbirth*. 2020;20:1-8.
21. Abajobir AA, Maravilla JC, Alati R, Najman JM. A systematic review and meta-analysis of the association between unintended pregnancy and perinatal depression. *Journal of affective disorders*. 2016;192:56-63.
22. Chekol BM, Dijkerman S, Muluye S, Wondimu D. Community-based intervention improves abortion knowledge and reduces abortion stigma among women in Oromia, Ethiopia: a quasi-experimental mixed methods evaluation. *BMC Women's Health*. 2022;22(1):463.
23. Mutiso SK, Murage A, Mwaniki AM. Factors associated with a positive depression screen after a miscarriage. *BMC psychiatry*. 2019;19:1-6.
24. Chekol BM, McCaffrey S, Dijkerman S, Acre V, Biru DD, Mehary AB, et al. Person-centered abortion care in public health facilities across four regions of Ethiopia: a cross-sectional quantitative study of client experiences. *Front Reprod Health*. 2024;6:1331682.
25. Gebrehiwot Y, Feters T, Gebreselassie H, Moore A, Hailemariam M, Dibaba Y, et al. Changes in morbidity and abortion care in Ethiopia after legal reform: national results from 2008 and 2014. *International perspectives on sexual and reproductive health*. 2016;42(3):121.
26. Gebrehiwot Y, Feters T, Gebreselassie H, Moore A, Hailemariam M, Dibaba Y, et al. Changes in Morbidity and Abortion Care in Ethiopia After Legal Reform: National Results from 2008 and 2014. *Int Perspect Sex Reprod Health*. 2016;42(3):121-30.
27. Jacob L, Polly I, Kalder M, Kostev K. Prevalence of depression, anxiety, and adjustment disorders in women with spontaneous abortion in Germany—A retrospective cohort study. *Psychiatry research*. 2017;258:382-6.
28. Basha A, Abuosba N, Alkharabsheh R, AbuGhaluon I, Tashtoush TTH, Obeidat M, et al. Anxiety and depression among women after miscarriage at Jordan University Hospital. *Jordan Medical Journal*. 2020;54(3).
29. Moafi F, Momeni M, Tayeba M, Rahimi S, Hajnasiri H. Spiritual intelligence and post-abortion depression: A coping strategy. *Journal of religion and health*. 2021;60:326-34.

30. Farren J, Jalmbrant M, Ameye L, Joash K, Mitchell-Jones N, Tapp S, et al. Post-traumatic stress, anxiety and depression following miscarriage or ectopic pregnancy: a prospective cohort study. *BMJ Open*. 2016;6(11):e011864.
31. Gao L, Qu J, Wang AY. Anxiety, depression and social support in pregnant women with a history of recurrent miscarriage: a cross-sectional study. *Journal of reproductive and infant psychology*. 2020;38(5):497-508.
32. Zhang Q, Wang N, Hu Y, Creedy DK. Prevalence of stress and depression and associated factors among women seeking a first-trimester induced abortion in China: a cross-sectional study. *Reproductive Health*. 2022;19(1):64.
33. Gao R, Qin L, Bai P. Self-Reported Depression among Chinese Women with Recurrent Pregnancy Loss: Focusing on Associated Risk Factors. *J Clin Med*. 2022;11(24).
34. Kung'u Kagereki E, Wanjoya A, Mageto T. Modelling Cases of Spontaneous Abortion Using Logistic Regression. *International Journal of Data Science and Analysis*. 2019;5(6).
35. Aghdam NG, Khosravi Z, Tavoli A, Tehrani FR, Nazarpour S. The comparison of anxiety and depression in women with the experience of induced abortion and delivery of unwanted pregnancy. *Medical Journal of Tabriz University of Medical Sciences*. 2022;44(4):305-16.
36. Mutiso SK, Murage A, Mwaniki AM. Factors associated with a positive depression screen after a miscarriage. *BMC Psychiatry*. 2019;19(1):8.
37. Tenorio PJ, Katz L, Amorim MMR. Symptoms of anxiety and depression in women with gestational trophoblastic disease compared to women who had a miscarriage: a cross-sectional study. *J Psychosom Obstet Gynaecol*. 2023;44(1):2210747.
38. Maghade MA, Singh DA, Faye AD, Gawande S, Tadke R, Bhavé SH, et al. A study of depressive features and perceived social support in patients with miscarriage. *Indian Journal of Mental Health*. 2018;5(4):412-18.
39. Steinberg JR, Tschann JM, Furgerson D, Harper CC. Psychosocial factors and pre-abortion psychological health: The significance of stigma. *Social science & medicine*. 2016;150:67-75.

40. Kukulskienė M, Žemaitienė N. Postnatal depression and post-traumatic stress risk following miscarriage. *International journal of environmental research and public health*. 2022;19(11):6515.
41. <risk factor and psychological sequelae.pdf>.
42. Farren J, Jalmbrant M, Falconieri N, Mitchell-Jones N, Bobdiwala S, Al-Memar M, et al. Prognostic factors for post-traumatic stress, anxiety and depression in women after early pregnancy loss: a multi-centre prospective cohort study. *BMJ Open*. 2022;12(3):e054490.
43. Huffman CS, Schwartz TA, Swanson KM. Couples and miscarriage: The influence of gender and reproductive factors on the impact of miscarriage. *Women's Health Issues*. 2015;25(5):570-8.
44. Demontigny F, Verdon C, Meunier S, Dubeau D. Women's persistent depressive and perinatal grief symptoms following a miscarriage: the role of childlessness and satisfaction with healthcare services. *Archives of women's mental health*. 2017;20:655-62.
45. Sharma H, Maurya C. Unintended pregnancy and mental health among women in Uttar Pradesh and Bihar: Evidence from UDAYA survey. 2022.
46. Herbert D, Young K, Pietrusińska M, MacBeth A. The mental health impact of perinatal loss: A systematic review and meta-analysis. *Journal of Affective Disorders*. 2022;297:118-29.
47. Gao R, Qin L, Bai P. Self-Reported Depression among Chinese Women with Recurrent Pregnancy Loss: Focusing on Associated Risk Factors. *Journal of Clinical Medicine*. 2022;11(24):7474.
48. He L, Wang T, Xu H, Chen C, Liu Z, Kang X, et al. Prevalence of depression and anxiety in women with recurrent pregnancy loss and the associated risk factors. *Archives of gynecology and obstetrics*. 2019;300:1061-6.
49. Tenório PJ, Katz L, Amorim MMR. Symptoms of anxiety and depression in women with gestational trophoblastic disease compared to women who had a miscarriage: a cross-sectional study. *Journal of Psychosomatic Obstetrics & Gynecology*. 2023;44(1):2210747.
50. Eshetu T. Evaluation of introducing light rail transit into urban median street at grade crossing (A case of Addey Ababa intersection): Thesis, Addis Ababa, Ethiopia; 2019.

51. Bantie GM, Aynie AA, Assefa Mk, Kasa AS, Kassa TB, Tsegaye GW. Knowledge and attitude of reproductive age group (15–49) women towards Ethiopian current abortion law and associated factors in Bahir Dar city, Ethiopia. *BMC women's health*. 2020;20:1-10.
52. Gilano G, Hailegebreal S. Determinants of abortion among youth 15–24 in Ethiopia: A multilevel analysis based on EDHS 2016. *PloS one*. 2021;16(3):e0248228.
53. Foster DG, Steinberg JR, Roberts SC, Neuhaus J, Biggs MA. A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. *Psychological medicine*. 2015;45(10):2073-82.
54. Medicine PCotASfR. Definitions of infertility and recurrent pregnancy loss: a committee opinion. *Fertility and sterility*. 2020;113(3):533-5.
55. Marcus M, Yasamy MT, van Ommeren Mv, Chisholm D, Saxena S. Depression: A global public health concern. 2012.
56. Organization WH. The WHO special initiative for mental health (2019-2023): universal health coverage for mental health. The WHO special initiative for mental health (2019-2023): universal health coverage for mental health 2019.
57. Lown JM. Development and validation of a financial self-efficacy scale. *Journal of Financial Counseling and Planning*. 2011;22(2):54.
58. Olani AB, Bekelcho T, Woldemeskel A, Tefera K, Eyob D. Evaluation of the Amharic version of the London measure of unplanned pregnancy in Ethiopia. *PLoS One*. 2022;17(6):e0269781.
59. Geraldine Barrett J. London Measure of Unplanned Pregnancy (LMUP) ANALYSIS GUIDANCE. 2016.
60. Sohal H, Eldridge S, Feder G. The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC family practice*. 2007;8:1-9.
61. <R3S-Research-Brief-final.pdf>.
62. Guedeney N, Fermanian J. Validation study of the French version of the Edinburgh Postnatal Depression Scale (EPDS): new results about use and psychometric properties. *European psychiatry*. 1998;13(2):83-9.

63. Jamali B, Zare O, Nabavian M, Rezaei F. The prevalence of perceived stress and depression in women facing abortion and related obstetric and non-obstetric risk factors: a cross-sectional study. *Reproductive Health*. 2025;22(1):50.
64. Koly KN, Saba J, Billah MA, McGirr A, Sarker T, Haque M, et al. Depressive symptoms and anxiety among women with a history of abortion living in urban slums of Bangladesh. *BMC psychology*. 2023;11(1):197.
65. Yilmaz N, Kanat-Pektas M, Kilic S, Gulerman C. Medical or surgical abortion and psychiatric outcomes. *The Journal of Maternal-Fetal & Neonatal Medicine*. 2010;23(6):541-4.
66. Issakhanova A, Issanov A, Ukybassova T, Kaldygulova L, Marat A, Imankulova B, et al. Depression, anxiety, and stress in Kazakhstani women with recurrent pregnancy loss: a case–control study. *Journal of Clinical Medicine*. 2023;12(2):658.
67. Wang Y, Meng Z, Pei J, Qian L, Mao B, Li Y, et al. Anxiety and depression are risk factors for recurrent pregnancy loss: a nested case–control study. *Health and Quality of Life Outcomes*. 2021;19:1-9.
68. Tho Nhi T, Hanh NTT, Hinh ND, Toan NV, Gammeltoft T, Rasch V, et al. Intimate partner violence among pregnant women and postpartum depression in Vietnam: a longitudinal study. *BioMed research international*. 2019;2019(1):4717485.
69. Salsabilla DA, Prasetya H, Murti B. The effect of unplanned pregnancy on postpartum depression: A meta-analysis. *Journal of Maternal and Child Health*. 2020;5(5):500-13.

ANNEXES

Annex I: English version of the information sheet

Hello, my name is _____ I am a member of a research team working to assess depression and its associated factors among women experiencing spontaneous abortion from public facilities of Addis Ababa, Ethiopia, 2025, by feruza shamil, who is studying for her Master's degree at Addis Ababa University, Collage of Health Science Department of Nursing and Midwifery. For this study, you are selected as a participant, and before getting your consent to participate in the study, all the necessary information that you need to know related to the study is stated as follows.

Objective: to assess the prevalence of depression and its associated factors among women experiencing spontaneous abortion in Addis Ababa selected public health facilities, Ethiopia, 2025.

Significance of the study: By understanding the prevalence and significant contributing factors of depression in women with spontaneous abortion, effective interventions can be designed to improve emotional well-being by integrating mental health with post-abortion care and ensuring a comprehensive approach to women's health, Identifying specific risk factors will help medical professionals implement early interventions, and The results will also provide valuable baseline data for further research.

Confidentiality: the collected information will be kept confidential and used only for research purposes. No one except the members of the research team will have access to the information collected. The personal information of the respondents will not be notified. The findings of the study will be generalized for the study population, and it will not reflect anything specific to individual participants.

Benefits of the study: For your participation in the study, no payment will be granted or no special privilege to you. But, participating in the study and giving your genuine information will provide great input to this study.

Risks of the study: The procedure does not bear any physical or psychological trauma but only takes a few minutes of your time. Furthermore, you will not be forced to respond to information you do not know.

Rights: Participation in this study is fully voluntary. You have the right to declare whether to participate or not in this study. If you decide to participate, you are given the right to withdraw from the study at any time, and also, you have the right not to answer that you do not want to answer.

Contact address: If you have any questions or inquiries at any time about the study or procedures, please contact the principal investigator at the following address

- Principal investigator: Feruza Shamil
- E -mail: feruzashamil@gmail.com
- Mobile phone: +251-922945720

Annex II: consent

ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCE SCHOOL OF NURSING AND MIDWIFERY

QUESTIONNERY PREPARED TO ASSESS THE PREVALENCE OF DEPRESSION AND ITS ASSOCIATED FACTORS AMONG WOMEN EXPERIENCING SPONTANEOUS ABORTION IN ADDIS ABABA SELECTED PUBLIC HEALTH FACILITIES, ETHIOPIA, 2025.

Consent

My name is _____ I am a member of a research team to assess depression and its associated factors among women experiencing spontaneous abortion from public facilities of Addis Ababa 2025, by feruza shamil who is studying for her Master's degree at Addis Ababa University, Collage of Health Science Department of Nursing and Midwifery. If you decide to participate in the study you will be asked some questions. Any information you provide will be kept confidential. Your name will not appear on the questionnaires. Any information you provide will not be used against you. Your response will not bring any harm to you.

Having stated the information above, would you like to participate in this study?

Yes ☐ No ☐

Thank you for your collaboration!

Name of interviewer _____ signature _____ date _____

Name of supervisor _____ signature _____ date _____

Annex III: English version questioner

Question related to prevalence and associated factors of depression and grief in women experiencing spontaneous abortion

Facility code name _____ interview Date _____

Women code _____

Part I: women's socio-demographic and associated factors for depression-related equation

S. No	Question	Response option	Skip
Part I Sociodemographic			
101.	How old were you at your last birthday?	_____ Years	
102.	What is your educational status?	1. No formal education 2. Grade 1-8 3. Grade 9-10 4. Grade 11 -12 5. College and above	
103.	What is your current employment status?	1. Unemployed 2. Housewife 3. Private business 4. Government employee 5. Student 6. Daily laborer 7. Others _____	
104.	Aside from your housework, are you currently participating in any work in which you paid in cash or kind?	1. No 2. Yes, in cash 3. Yes, in kind 4. Yes, both in cash and in-kind	
105.	Do you currently have a regular sexual partner	1. Yes (I am in regular sexual relations) 2. No (I am engaged in multiple sexual relations)	
106.	What is your marital status?	1. Living apart 2. Living together, not formally married 3. Currently married 4. Divorced/Separated/broken up 5. Widowed/partner died	
107.	For how long you have been in a relationship with the father of your current pregnancy?	1. Not living together 2. Less than 6 months 3. 6 months to 1 year 4. 2-5 years 5. More than 5 years	
108.	What is your family		

	size? Number of individuals permanently living in your household. (Crowding index)	Family size _____			
109.	Do you have frequent contact with religious leaders	1. Yes 2. No			
110.	In the past 12 months have you used any substance?	1. No 2. Yes Alcohol 3. Yes Chat 4. Yes cigarette 5. Yes Others _____			
111.	During the past 12 months, how often do you drink alcohol? Would you say:	1. Every day or nearly every day 2. Once or twice a week 3. 1 – 3 times a month 4. Occasionally, less than once a month 5. Never			
112.	In the <u>past 12 months</u> , have you experienced any of the following problems, related to your drinking?	1. Money problems 2. Health problems 3. Conflict with family or friends 4. Problems with authorities (bar owner/police, etc) 5. Other, specify. _____			
113.	Regarding the expense of your income and expenses. From the provided choices select a statement that best describes your houses use of income	1. Your household can save money 2. Your household spends what it earns 3. Your household eats into its assets and savings 4. Your household gets into debt			
114.	Financial Self-Efficacy Scale  ssrn-2006665.pdf  1-s2.0-S016748701500094X-main.pdf	Not true at all	Hardly true	Moderately true	Exactly true
	a. It is hard to stick to my spending when unexpected expenses arise	1	2	3	4
	b. It is challenging to make progress toward my financial goals	1	2	3	4

	c. When unexpected expenses occur, I usually have to use credit	1	2	3	4
	d. When faced with a financial challenge, I have a hard time figuring out a solution	1	2	3	4
	e. I lack confidence in my ability to manage my finances	1	2	3	4
	f. I worry about having enough money	1	2	3	4
Part II: Reproductive Health					
201.	Have you ever been pregnant before your current pregnancy?	1. Yes 2. No			
202.	When you found out you were pregnant, how did you feel?	1. Very happy 2. Sort of happy 3. Mixed happy and unhappy 4. Sort of unhappy 5. Very unhappy			
203.	Have you told your partner about your current pregnancy?	1. Yes 2. No			
204.	If yes at the time you told your partner about your pregnancy; what was his first reaction?	1. He was supportive 2. He was abusive or violent 3. He throws me out of home/He left me 4. Happy 5. Mixed happy and unhappy 6. Unhappy 7. Others _____			
205.	If you did not tell your partner about pregnancy what is/was your main reason?	1. Fear of rejection or abandonment 2. Fear of violence or abuse 3. Lack of support 4. Uncertainty about the partner's reaction 5. Infidelity or paternity concerns 6. Financial dependency 7. Others _____			
206.	Do you have a child	1. Yes 2. No			
207.	How many children do	Number of children _____			

	you have, who are alive now?		
209	Have you had a pregnancy that miscarried, was aborted, or ended in a stillbirth?	1. Yes 2. No	
210	If yes what was the type of abortion	1. Spontaneous 2. Induced	
211	If induced have you informed your partner of your plan to have an abortion	1. Yes 2. No	
212	If yes what was his reaction to you having an abortion	1. He was supportive 2. He was abusive or violent 3. He throws me out of home 4. He was unsupportive 5. Others _____	
213	Have you experienced recurrent pregnancy loss?	1. Yes 2. No	
214	How many times have you experienced abortion?	Spontaneous _____ Induced _____	
215	Is your current abortion induced or spontaneous?	1. Spontaneous 2. Induced	
216	How many months pregnant were you at the time of abortion?	_____ months	
217	What type of abortion procedure do you have?	1. Medical Abortion 2. Surgical Abortion	
218	Where did you initiate the abortion?	1. In this health facility 2. In another health facility and referred 3. Bout drug by myself 4. Other nonmedical methods	
219	Have you been diagnosed with a mental illness in the past and have received any medical treatment (history of mental health)	1. Yes 5. No	
220	Which of the following is discussed with your	1. Post-abortion mental health 2. Return to fertility	

	healthcare providers?	3. Healthy timing and spacing of pregnancies 4. Long-acting method options 5. Family planning methods 6. None of the above	
Part III London Measure of unplanned pregnancy(LMUP) response to assess pregnancy intention			
301	In the month that I become pregnant 0. I always used contraception 1. I were using contraception, but not on every occasion 2. I were not using contraception		
302	In terms of becoming a mother, I feel that my pregnancy happened at the 0. Wrong time 1. Ok, but not quite the right time 2. Right time		
303	Just before I became pregnant 0. I did not intend to get pregnant 1. My intention kept changing 2. I intended to get pregnant		
304	Just before I became pregnant 0. I did not want to have a baby 1. I had mixed feelings about having a baby 2. I wanted to have a baby		
305	Before I became pregnant..... 0. We never discussed having children together. 1. My partner and I discussed having children together but hadn't agreed for me to get pregnant. 2. My partner and I had agreed that we would like me to be pregnant.		
306	Before you become pregnant, did you do anything to improve your health in preparation for pregnancy? 0. No preparatory lifestyle changes 1. Did one preparatory lifestyle changes 2. Did two or more preparatory lifestyle changes If the answer is "I had preparation" what kind of preparation did you make 1. Took folic acid 2. Stopped or cut down on smoking 3. Stopped or cut down on drinking alcohol 4. Ate more healthily 5. Sought medical/ health advice		
Part IV Humiliation, afraid, rape, kick(HARK) response to assess Intimate partner violence			
	Question	Yes	
401	H: Have you been humiliated or emotionally abused by your partner or ex-partner within the last year?		
402	A: Have you been afraid of your partner or ex-partner within the last year?		

403	R: Have you been raped or forced to have any kind of sexual activity by your partner or ex-partner within the last year?	
404	K: Have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner within the last year?	
Part V Received social support scale (R3S) response to assess the level of social support received by the women.		
	Question	Strangely agree Agree Neutral Disagree Strangely disagree
501	Someone was available to listen openly when you wanted to talk about your abortion decision.	1 2 3 4 5
502	Someone was available with whom you could share your private worries and fears about your pregnancy.	1 2 3 4 5
503	Does someone express empathy about or understand your situation?	1 2 3 4 5
504	Someone was available who helped you pay for costs associated with abortion service.	1 2 3 4 5
505	Someone was available who assisted you with transportation to seek care.	1 2 3 4 5
506	Someone was available to help you with things you were not able to do on your own while seeking care?.	1 2 3 4 5
507	Someone was there for you who helped you get your mind off things?	1 2 3 4 5

508	Someone encouraged you not to give up on your desire to end your pregnancy?.	1	2	3	4	5
509	Someone was there for you to turn to for suggestions about how to make decisions about your pregnancy?.	1	2	3	4	5

Part VI: Edinburgh postnatal depression scale (EPDH) response to assess depression in the past 7 day

	Question	0	1	2	3
601	In the last week, have you been able to laugh and see the funny side of Things?	As much as I always used to	Not as much as I used to	Certainly not as much as I used to	Not at all
602	In the week, have you looked forward with enjoyment to things?	As much as I always used to	Rather less	certainly less	Never looked forward
603	In the week, have you blamed yourself unnecessarily when things went wrong?	Never	Not often	sometimes	Most of the time
604	In the last week, have you been anxious or worried for no good reason?	Never	Not often	Sometimes	Most of the time
605	In the last week, have you felt scared or panicky for no good reason?	Never	Rarely	Sometimes	Most of the time
606	In the last week, have things been getting on top of you?	Coping as usual	Mostly able	Sometimes unable	Most of the time unable to cope
607	In the last week, have you been so unhappy that you have had difficulty sleeping?	Never	Rarely	Sometimes	Most of the time

608	In the last week, have you felt sad or miserable?	Never	occasionally	Sometimes	Most of the time
609	In the last week, have you been so unhappy that you have been crying?	Never	Occasionally	Sometimes	Most of the time
610	In the last week, Has the Thought of harming yourself occurred to you	Never	Not often	Sometimes	Frequently

Annex IV : Amharic version information sheet and consent

ሃይ ስሜ _____ ይባላል በአዲስ አበባ ዩኒቨርሲቲ በጤና ሳይንስ ዲፓርትመንት ነርሲንግ እና አዋላጅነት ሁለተኛ ዲግሪዋን በምትማረው ፌሩዝ ሻሚል ፣ ከመንግስት ጤና ተቋማት ድንገተኛ ውርጃ በሚያጋጥማቸው እናቶች ላይ ያለውን የመንፈስ ጭንቀት እና ተያያዥነት ያለውን ሁኔታ ለመገምገም የሚሰራ የምርምር ቡድን አባል ነኝ ፣ እርሶም ለዚህ ጥናት እንደ ተሳታፊ ተመርጠዋል እና በጥናቱ ላይ ለመሳተፍ ፈቃድዎን ከመግለፅዎ በፊት ከጥናቱ ጋር በተገናኘ ማወቅ ያለብዎት ሁሉም አስፈላጊ መረጃዎች እንደሚከተለው ተቀምጠዋል ።

የጥናቱ አስፈላጊነት፡- ድንገተኛ ፅንሰ ማስወረድ ባለባቸው ሴቶች ላይ ያለውን ስርጭት እና ጉልህ አስተዋፅዖ የሚያደርጉ የድብርት መንስኤዎችን በመረዳት፣ የአእምሮ ጤናን ከፅንሰ ማስወረድ በኋላ እንክብካቤን በማቀናጀት ውጤታማ ስራዎችን ለመንደፍ ያስችላል በተጨማሪም ከድንገተኛ ፅንሰ ማስወረድ በኋላ ለድብርት መንስኤዎችን በመረዳት የጤና ባለሙያው ትክክለኛውን እርምጃ እንዲወስድ ያስችለዋል እንደዚሁም የጥናቱ ውጤት ለተጨማሪ ምርምር ጠቃሚ የመነሻ መረጃ ይሆናል ።

ሚስጥራዊነት፡- የተሰበሰበው መረጃ በሚስጥር ይጠበቃል እና ለምርምር ዓላማዎች ብቻ ጥቅም ላይ ይውላል. ከጥናት አድራጊው ቡድን አባላት በስተቀር ማንም የተሰበሰበውን መረጃ ማግኘት አይችልም። የእርስዎ የግል መረጃ አይታወቅም። የጥናቱ ግኝቶች ለጥናቱ ህዝብ አጠቃላይ ይሆናል ነገር ግን የእርስዎን የግል መረጃን የሚያንፀባርቅ አይሆንም።

የጥናቱ ጥቅሞች፡- በጥናቱ ውስጥ ለሚያደርጉት ተሳትፎ ምንም አይነት ክፍያ አይሰጥዎትም ወይም ለእርስዎ ምንም ልዩ መብት አይኖረውም. ነገር ግን በጥናቱ ውስጥ መሳተፍ እና የእርስዎን እውነተኛ መረጃ መስጠት ለዚህ ጥናት ትልቅ ግብአት ይሆናል።

የጥናቱ አደጋዎች፡- ጥናቱ ምንም አይነት አካላዊ እና ስነ ልቦናዊ ጉዳዮችን አያስከትልም ነገር ግን ጥቂት ደቂቃዎችን ብቻ ነው የሚወስደው። በተጨማሪም ስለማያውቁት መረጃ ምላሽ ለመስጠት አይገደዱም።

መብቶች፡- በዚህ ጥናት ውስጥ መሳተፍ ሙሉ በሙሉ በፈቃደኝነት ነው. በዚህ ጥናት ለመሳተፍም ሆነ ላለመሳተፍ የማወጅ መብት አልዎት። ለመሳተፍ ከወሰኑ በማንኛውም ጊዜ ጥናቱን የማቋረጥ መብት አልዎት እንዲሁም መልስ ለመስጠት የማትፈልጉትን ያለመመለስ መብት አለዎት።

የእውቂያ አድራሻስለ፡ በጥናቱ ወይም በአካሄዱ ማንኛውም ጥያቄ ካሉዎት፣ እባክዎን ዋናውን የጥናቱ አድራጊ በሚከተለው አድራሻ ያነጋግሩ።

- የጥናት አድራጊው ስም : ፌሩዝ ሻሚል
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Annex V : ፍቃድ

የአዲስ አበባ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ የነርቭና አዋላጆች ዲፓርትመንት

በአዲስ አበባ ከተማ በተመረጡ የህዝብ ጤና ተቋማት ውስጥ ከድንገተኛ ፅንሰ ማስወረድ ጋር በተያያዘ የድብርት መስፋፋትን እና ተያያዥ ምክንያቶችን ለመገምገም የተዘጋጀ መጠይቅ

ፍቃድ

የኔ ስም _____ ይባላል። በአዲስ አበባ ዩኒቨርሲቲ በጤና ሳይንስ ዲፓርትመንት ነርቪንግ እና አዋላጅነት ሁለተኛ ዲግሪዎን በምትማረው ፌሩዛ ሻሚል ፣ ከመንግስት ጤና ተቋማት ድንገተኛ ውርጃ በሚያጋጥማቸው እናቶች ላይ ያለውን የመንፈስ ጭንቀት እና ተያያዥነት ያለውን ሁኔታ ለመገምገም የሚሰራ የምርምር ቡድን አባል ነኝ። በዚህ ጥናት ላይ ለመሳተፍ ከወሰኑ አንዳንድ ጥያቄዎች ይጠየቃሉ። የሚያቀርቡት ማንኛውም መረጃ በሚስጥር ይጠበቃል። ስምዎም በመጠይቁ ላይ አይፃፍም የሚያቀርቡት ማንኛውም መረጃ በእርስዎ ላይ ጥቅም ላይ አይውልም። የሚሰጡንም ምላሽ በእርስዎ ላይ ምንም ጉዳት አያስከትልም።

ከላይ ባለው መረጃ መሰረት በዚህ ጥናት ላይ ለመሳተፍ ፍቃደኛ ነዎት?

አዎ ☐ አይ ☐

ስለ ትብብርዎ እናመሰግናለን!

የጠያቂው ስም ፊርማ _____ ቀን _____

የተቆጣጣሪው ስም ፊርማ _____ ቀን _____

አባሪ III: የአማርኛ እትም ጥያቄ

ድንገተኛ ፅንሰ መቋረጥ በሚያጋጥማቸው ሴቶች ላይ ከሚታዩ የድብርት እና የሀዘን መንስኤዎች ጋር የተያያዘ ጥያቄ የመገልገያ ኮድ ስም _____ ቃለ መጠይቅ ቀን _____

የሴቶች ኮድ _____

ክፍል I: የሴቶች ማህበራዊ-ስነ-ሕዝብ እና ተያያዥ ምክንያቶች ለዲፕሎሽን-ነክ እኩልታ

ኤስ. አይ	ጥያቄ	የመልስ አማራጭ	ዝላል
ክፍል I ሶሲዮኢኮኖሚክ			
101.	እድሜሽ ስንት ነዉ?	_____ ዓመት	
102.	የትምህርት ደረጃሽ ምን ያህል ነው?	1. መደበኛ ትምህርት አልተማርኩም 2. ከ1-8ኛ ክፍል 3. 9-10 ክፍል 4. 11 -12 ክፍል 5. ኮሌጅ እና ከዚያ በላይ	
103.	አሁን ያለሽበት የስራ ሁኔታ ምንድን ነው?	1. ሥራ ፈላጊ 2. የቤት እመቤት 3. የግል ንግድ 4. የመንግስት ሰራተኛ 5. ተማሪ 6. የቀን ሰራተኛ 7. ሌሎች _____	
104.	ከቤት ስራ በተጨማሪ በአሁኑ ሰአት በጥሬ ገንዘብ ወይም የተለያየ ጥቅማጥቅም የምታገኝበት ማንኛውም ስራ አለሽ?	1. አይ 2. አዎ፣ በጥሬ ገንዘብ 3. አዎ ፣ በተለያየ ጥቅማጥቅም 4. አዎ ፣ በሁለቱም	
105.	በአሁኑ ሰአት መደበኛ የትዳር ወይም የወንድ ጓደኛ አለሽ?	1. አዎ (መደበኛ የሆነ የትዳር ወይም የወንድ ጓደኛ አለኝ) 2. አይ (ከተለያዩ ወንዶች ጋር ግንኙነት አለኝ)	
106.	አሁን ያለሽበት የጋብቻ ሁኔታ ምንድን ነው?	1. ለየብቻ ነው የምንኖረው 2. መደበኛ ጋብቻ የለንም ግን አብረን ነው የምንኖረው 3. ባለትዳር ነኝ 4. ተፋተናል 5. ባለቤቴ ህይወቱ አልፏል	
107.	አሁን ከነበረሽ እርግዝና አባት ጋር ለምን ያህል ጊዜ በግንኙነት ቆይተሃል?	1. ቋሚ/መደበኛ ግኑኝነት አልነበረንም 2. ከ6 ወር በታች 3. ከ 6 ወር እስከ 1 ዓመት 4. 2-5 ዓመታት	

		5. ከ 5 ዓመታት በላይ			
108.	በቤተሰብሽ ውስጥ በቋሚነት የሚኖሩ ሰዎች ብዛት ስንት ነው።	የቤተሰብ ብዛት _____			
109.	ከሀይማኖት መሪዎች ጋር በተደጋጋሚ/ቋሚ ግኑኝነት ታደርግያለሽ?	1. አዎ 2. አይ			
110.	ባለፉት 12 ወራት ውስጥ ከሚከተሉት ውስጥ የትኛውን ንጥረ ነገር ተጠቅመሻል?	1. የቱንም አልተጠቀምኩም 2. አልኮል 3. ጫት 4. ሲጋራ 5. ሌሎች _____			
111.	ባለፉት 12 ወራት ውስጥ የነበረሽ የአልኮል አጠቃቀም እንዴት ትገልጫለሽ፡-	1. በየቀኑ ማለት ይቻላል 2. በሳምንት አንድ ጊዜ ወይም ሁለት ጊዜ 3. በወር 1-3 ጊዜ 4. አልፎ አልፎ በወር ከአንድ ጊዜ ያነሰ 5. በጭራሽ ተጠቅሜ አላውቅም			
112.	ባለፉት 12 ወራት ውስጥ ከመጠጥ ጋር በተያያዘ ከሚከተሉት ችግሮች ውስጥ የትኛው አጋጥሞሻል?	1. የገንዘብ ችግር 2. የጤና ችግር 3. ከቤተሰብ ወይም ከጓደኞች ጋር ግጭት 4. ከሌሎች ሰዎች ጋር ያሉ ችግሮች (የባር ባለቤት/ፖሊስ፣ ወዘተ) 5. ሌላ ይግለጹ. _____			
113.	ስለ ገቢ እና ወጪ በተመለከተ ከተሰጡት አማራጮች ያንቺን ቤተሰብ የገቢ አጠቃቀም በተሻለ ሁኔታ የሚገልፀው የትኛው ነው	1. የእኔ ቤተሰብ ገንዘብ መቆጠብ ይቻላል። 2. የእኔ ቤተሰብ የሚያገኘውን በሙሉ ለአለት ወጪ ያወጣል። 3. የእኔ ቤተሰብ ያለውን ሐብትና ንብረት በሙሉ ለምግብ ነዉ የሚያወለዉ 4. ቤተሰቤ ዕዳ ውስጥ እየገባ ነዉ የሚኖረዉ			
114.	የፋይናንሺያል እራስ-ውጤታማነት መለኪያ	በፍፁም እውነት አይደለም።	እውነት ነው ለማለት ይከብዳል	በመጠኑ እውነት ነው	በትክክል እውነት
	a. ያልተጠበቁ ወጪዎች በሚገጥሙኝ ጊዜ መወጣት ይከብደኛል ።	1	2	3	4
	b. የገንዘብ ገቢዬ ላይ ማሻሻያ (ጭማሬ) ማድረግ ከባድ ነው።	1	2	3	4
	c. አብዛኛውን ጊዜ ያልተጠበቁት	1	2	3	4

	(ያላሰብኩት) ወጪዎች ሲያጋጥሙኝ መበደር ይኖርብኛል።				
	d. ከገንዘብ ጋር በተያያዘ ችግር ሲያጋጥመኝ፣ መፍትሄ ለማግኘት እቸገራለሁ።	1	2	3	4
	e. የገንዘብ አጠቃቀም ችሎታዬ ላይ እምነት የለኝም	1	2	3	4
	f. በቂ ገንዘብ ስለማግኘት እጨነቃለሁ	1	2	3	4
ክፍል II፡ የስነ ተዋልዶ ጤና					
201.	ከአሁኑ እርግዝና በፊት ፀንሰሽ ታውቂያለሽ?	1. አዎ 2. አይ			
202.	ነፍሰ ጡር መሆንሽን ስታውቁ ምን ተሰማሽ?	1. በጣም ነው ደስ ያለኝ 2. በትንሹ ደስ ብሎኛል 3. የተቀላቀለ ስሜት ነበረኝ 4. ደስ የማይል ዓይነት ስሜት ነበረኝ 5. የሓዘን ስሜት ነበረኝ			
203.	ስለአሁኑ እርግዝናሽ ለባለቤትሽ ነግረሽዋል ወይም ለወንድ ጓደኛሽ ነግረሽዋል?	1. አዎ 2. አይ			
204.	ስለ እርግዝናሽ ለባለቤትሽ ወይም ለወንድ ጓደኛሽ በነገርሽው ጊዜ ምላሹ ምን ነበር?	1. ተሳዳቢ ወይም ጠበኛ ነበር። 2. ጥሎኝ ሄደ 3. ደስተኛ/ደጋፊ ነበር 4. የተቀላቀለ ስሜት ነበረው 5. ደስተኛ አልነበረም 6. ሌሎች_____			
205.	ስለ እርግዝናሽ ለባለቤትሽ ወይም ለወንድ ጓደኛሽ ካልነገርሽው ዋናው ምክንያትሽ ምን ነበር?	1. አለመቀበልን ወይም እንዳይተወኝ በመፍራት 2. ጥቃትን በመፍራት 3. ላይደግፈኝ ይችላል ብዬ በመፍራት 4. ስለ ሚስጠኝ ምላሽ እርግጠኛ ባለመሆኔ 5. ስለማያምነኝ ወይም አባትነቱን በመጠራጠፊ 6. በገንዘብ ራሴን ስላልቻልኩ 7. ሌሎች_____			
206.	ፅንሰ የማቋረጥ እቅድሽን ለባለቤትሽ ወይም ለወንድ	1. አዎ			

	ጓደኛሽ አሳውቀሻል	2. አይ	
207.	አዎ ከሆነ ስለ ፅንሰ መቋረጡ የሰጠው ምላሽ ምን ነበር?	1. ሀሳቤን ደግፎት ነበር። 2. ተሳዳቢ ወይም ጠባቂ ነበር። 3. ጥሎኝ ጠፋ 4. ሀሳቤን አልተቀበለም ነበር 5. ሌሎች___	
208.	ልጅ አለሽ?	1. አዎ 2. አይ	
209.	አሁን በህይወት ያሉ ስንት ልጆች አሉሽ?	የልጆች ብዛት ___	
210.	እርግዝናው የተቋረጠ ወይም ሞቶ ተወለደ ልጅ ነበረሽ?	1. አዎ 2. አይ	
211.	አዎ ከሆነ ለመጨረሻ ጊዜ ምን አይነት የፅንሰ መቋረጥ ነበር የገጠመሽ?	1. ድንገተኛ የፅንሰ መቋረጥ 2. በማሸን የታገዘ የፅንሰ መቋረጥ	
212.	ተከታታይ የሆነ የፅንሰ መቋረጥ ያጋጥመሽ ነበር?	1. አዎ 2. አይ	
213.	ስንት ተከታታይ የፅንሰ መቋረጥ አጋጥመሽ ያውቃል?	ድንገተኛ ___ በህክምና የታገዘ___	
214.	አሁን የነበረሽ እርግዝና ሲቋረጥ የስንት ወር ነፍሰ ጡር ነበረሽ?	___ ወራት	
215.	የአሁኑ ፅንሰ መቋረጥ ምክንያት ባንቺ ፍላጎት ነዉ ወይስ ድንገተኛ ነበር?	1. ድንገተኛ 2. እኔ ፈልጌ ነዉ የጀመረዉ	
216.	በምን አይነት መንገድ ነበር ፅንሱ የተቋረጠው?	1. በመድሀኒት ፅንሰ የማቋረጥ ሂደት 2. በማሸን የታገዘ ፅንሰ የማቋረጥ ሂደት	
217.	ፅንሰ የማቋረጡ ሂደት የት ነው የጀመረው?	1. በዚህ የጤና ተቋም ውስጥ 2. በሌላ የጤና ተቋም ተጀምሮ ሪፈር ተደረኩ 3. በራሴ መድኃኒት ወስጄ 4. ሌሎች ከክምና ዉጪ ዘዴዎች _____	
218.	ከዚህ ቀደም ከአእምሮ ሕመም ጋር በተገናኘ በህኪም የተረጋገጠ እና	1. አዎ 5. አይ	

	ማንኛውንም ዓይነት ሕክምና የወሰድሽበት አጋጣሚ ነበር?(ያለፈው የአእምሮ ጤና ታሪክ)		
219.	ከሚከተሉት ውስጥ ከጤና ባለሙያዎች ጋር የተነጋገርሽበት ጉዳይ የትኛው ነው?	1. ከፅንሰ መቋረጥ በኋላ ስላለው የአእምሮ ጤና 2. እንዴት ወደ ማርካዝ እና መውለድ ሂደት መመለስ እንደምችል 3. ስለ ጤናማ የእርግዝና ጊዜ እና አራርቆ ስለመውለድ 4. ስለተለያዩ የረጅም ጊዜ የወሊድ መቆጣጠሪያ ዘዴዎች 5. ስለ ቤተሰብ ምጣኔ ዘዴዎች 6. ከላይ ከተጠቀሱት ውስጥ አንዳቸውም ላይ አልተወያየሁም	
ክፍል III የለንደን ልኬት ያልታቀደ እርግዝና (LMUP) የእርግዝና ዓላማን ለመገምገም ምላሽ			
301	ባረገዝኩበት ወር 0. የወሊድ መከላከያ መንገዶችን ሁሉ እጠቀም ነበረ። 1. አልፎ አልፎ እጠቀም ነበረ። 2. የወሊድ መከላከያ መንገዶችን እየተጠቀምኩ አልነበረም		
302	እናት መሆንን በተመለከተ፣ ይህ እርግዝና የተከሰተው 0. በትክክለኛ ጊዜ ነው 1. ይሁን ግን ፍጹም ትክክለኛ ነው የሚባል ጊዜ አይደለም 2. በትክክለኛ ጊዜ አይደለም		
303	እርግዝና ከመከሰቱ በፊት የማርገዝ ፍላጎትን በተመለከተ... 0. ለማርገዝ አላሰብኩም ነበር 1. በየጊዜው ፍላጎቴ ይቀያየር ነበር 2. የማርገዝ ፍላጎት ነበረኝ		
304	እርግዝና ከመከሰቱ በፊት ልጅ የመውለድ ፍላጎትን በተመለከተ... 0. ልጅ የመውለድ ፍላጎት አልነበረኝም ነበር 1. ለመውለድም ለመተወም መወሰን አቅዮኝ ነበር 2. ልጅ ለመውለድ እፈልግ ነበር		
305	እርግዝና ከመከሰቱ በፊት ልጅ ስለመውለድ በተመለከተ ከባልሽ/ከወንድ ጓደኛሽ ጋር ተወያይተሻል ?		

	0. ልጅ ስለመውለድ በጭራሽ ተወያይተን አናቅም					
	1. ተወያይተናል ግን እንዳረግዝ አልተስማማንም ነበር					
	2. ከባለቤቴ/ከወንድ ጓደኛዬ ጋር ተስማምተን ነዉ ያረግዝኩት					
306	ከማርገዝሽ በፊት ለእርግዝናሽ ለመዘጋጀት የሚረዳ ያደረግሽዉ የጤና ዝግጅት አለ?					
	0. ምንም ለዝግጅት የሚረዳ የኑሮ ዘይቤ ለዉጥ አልነበረኝም					
	1. 1 አይነት ለርግዝና ዝግጅት የሚረዳ የኑሮ ዘይቤ ለዉጥ ነበረኝ					
	2. 2 የተለያየ አይነት ለርግዝና ዝግጅት የሚረዳ የኑሮ ዘይቤ ለዉጥ ነበረኝ					
	ጥያቄ ምላሽሽ “ዝግጅት ነበረኝ” ከሆነ ምን ምን አይነት ዝግጅት ነበረሽ?					
	1. የፎሊክ አሲድ (ደም ማነስ መከላከያ) እንክብሎችን እወስድ ነበር					
	2. ሲጋራ ማጨስ ለመቀነስ ወይም ለማቆም ሞክሬ ነበር					
	3. አልኮል መጠቀም ለመቀነስ ወይም ለማቆም ሞክሬ ነበር					
	4. ጤናማ የአመጋገብ ዘዴን እጠቀም ነበር					
	5. የህክምና ክትትል/ምክር አደርጌ ነበር					
ክፍል IV ውርደት፣ ፍርሃት፣ መደፈር፣ መምታት(HARK) የቅርብ አጋር ጥቃትን ለመገምገም						
	ጥያቄ		አዎ		አይ	
401	ባለፈው ዓመት ውስጥ የአሁኑ(በቀድሞ) የትዳር አጋርሽ ወይም የወንድ ጓደኛሽ አንቺን የሚያዋርድ ወይም ስሜትሽን የሚጎዳ ነገር አድርጎብሽ ያዉቃል?					
402	ባለፈው ዓመት ውስጥ የአሁኑ(የቀድሞ) የትዳር አጋርሽን ወይም የወንድ ጓደኛሽን ፈርተሽዉ ታዉቂ ነበር?					
403	ባለፈው ዓመት ውስጥ የአሁኑ(የቀድሞ) የትዳር አጋርሽ ወይም የወንድ ጓደኛሽ አስገድዶ የግብረሰጋ ግኑኝነት አድርጎ ወይም ማንኛውንም ዓይነት ወሲባዊ ድርጊት እንድትፈፅሟ አስገድዶሽ ያዉቃል?					
404	ባለፈው ዓመት ውስጥ በአሁኑ(በቀድሞ) የትዳር አጋርሽ ወይም የወንድ ጓደኛሽ የመመታት፣ የመደብደብ፣ በጥፊ የመመታት ወይም ሌላ አይነት የአካል ጉዳት አድርሶብሽ ያዉቃል?					
ክፍል V በሴቶች የተቀበሉትን የማህበራዊ ድጋፍ ደረጃ ለመገምገም የማህበራዊ ድጋፍ ልኬት (R3S) ምላሽ አግኝቷል						
	ጥያቄ	በጣም እስማማለዉ	እስማማለዉ	ገለልተኛ	አልስማማም	በጣም አልስማማም።
501	ስለ ፅንሰ መቋረጥ ስታወሪ	1	2	3	4	5

	በግልፅ ሊያዳምጥሽ የሚችል ሰው ነበረሽ።					
502	ስለ እርግዝናሽ ያለሽ ጭንቀቶችን እና ፍራቻዎች የምታካፍይው ሰው ነበረሽ?	1	2	3	4	5
503	ያለሽበትን ሁኔታ ተረድድቶ የሃዘኔታ ወይም ላንቺ የማሰብ ስሜት ያሳየሽ ሰው ነበረሽ?	1	2	3	4	5
504	ከፅንሰ ማቋረጥ አገልግሎት ጋር በተያያዙ ያሉ ወጪዎች እንድትከፍይ የረዳሽ ሰው ነበር?	1	2	3	4	5
505	ህክምና ለማግኘት በምትንቀሳቀሹበት ወቅት በትራንስፖርት/በመጓጓዣ አቅርቦት የረዳሽ ሰው ነበር?	1	2	3	4	5
506	ህክምና በምታገኝበት ወቅት አንቺ ማድረግ ያልቻልሽውን ነገር ሌላ የሚረዳሽ ሰው ነበር ?	1	2	3	4	5
507	ከሚያስጨንቁሽ ሃሳቦች እንድትወጪ የሚረዳሽ ሰው አለ?	1	2	3	4	5
508	እርግዝናሽን ለማቋረጥ ያለሽን ፍላጎት እንዳትተይ ያበረታታሽ ሰው አለ?	1	2	3	4	5
509	ስለ እርግዝናሽ በተመለከተ እንዴት መወሰን እንዳለብሽ	1	2	3	4	5

	ጥቆማዎችን እንዲሰጥሽ የምትጠይቁዉ ሰው አለ?					
ክፍል VI፡ የኤድዝበርግ የድህረ ወሊድ ድብርት ሚዛን (EPDH) ባለፉት 7 ቀናት ውስጥ የመንፈስ ጭንቀትን ለመገምገም ምላሽ						
	ጥያቄ	0	1	2	3	ኮድ
601	ባለፈው ሳምንት ውስጥ፣ መሳቅ ወይም የነገሮችን አስደሳች ጎን መመልከት ትችይ ነበር?	ሁልጊዜ እንደተለመደዉ	እንደበፊቱ አይደለም።	በእርግጠኝነት እንደበፊቱ አይደለም	በፍፁም እንደበፊቱ አይደለም	
602	ባለፈው ሳምንት ውስጥ፣ በነገሮች ለመደሰት ሞክረሽ ነበር ?	ሁልጊዜ እንደተለመደዉ	ከተለመደዉ ያነሰ	በእርግጠኝነት ያነሰ	መንም አልሞከርኩም	
603	ባለፈው ሳምንት ውስጥ፣ ነገሮች ሲበላሹብሽ አላስፈላጊ ቢሆን መልኩ እራሰሽን ትወቅሺ ነበር?	በጭራሽ	ብዙ ጊዜ አይደለም	አንዳንዴ	አብዛኛውን ጊዜ	
604	ባለፈው ሳምንት ውስጥ፣ ያለ በቂ ምክንያት እራሰሽን ታስጨንቂ ነበር?	አብዛኛውን ጊዜ	አንዳንዴ	ብዙ ጊዜ አይደለም	በጭራሽ	
605	ባለፈው ሳምንት ውስጥ ፣ ያለ በቂ ምክንያት ፍርሃት ወይም የመደንጋጥ ስሜት ይሰማሽ ነበር?	በጭራሽ	አልፎ አልፎ	አንዳንዴ	አብዛኛውን ጊዜ	
606	ባለፈው ሳምንት ውስጥ ካቅምሽ በላይ የሆኑ ነገሮችን መቋቋም አስቸግሮሽ ነበር?	እንደተለመደው እቋቋማለዉ	በአብዛኛው እችላለዉ	አንዳንድ ጊዜ አልችልም	አብዛኛውን ጊዜ መቋቋም አልችልም	
607	ባለፈው ሳምንት ውስጥ፣ እንቅልፍ ለመተኛት እስክትቸገሪ ድረስ ያላመደሰት ስሜት ተሰምቶሽ ነበር?	አልፎ አልፎ	በጭራሽ	አንዳንዴ	አብዛኛውን ጊዜ	
608	ባለፈው ሳምንት ውስጥ አነስተኛ ወይም ከፍተኛ የሀዘን ስሜት ይሰማሽ ነበር?	በጭራሽ	አልፎ አልፎ	አንዳንዴ	አብዛኛውን ጊዜ	
609	ባለፈው ሳምንት ውስጥ፣ እስከማልቀስ የሚያደርስ	በጭራሽ	አልፎ አልፎ	አንዳንዴ	አብዛኛውን	

	የመከፋት/የላመደሰት ስሜት ተሰምቶሽ ነበር?				ጊዜ	
610	ባለፈው ሳምንት ውስጥ፣ እራስሽን የመጉዳት ሀሳብ መቶብሽ ነበር?	በጭራሽ	ብዙ ጊዜ አይደለም	አንዳንዴ	በተደጋጋሚ	