

ADDIS ABABA UNIVERSITY  
COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES  
SCHOOL OF PSYCHOLOGY

ABORTION RELATED STRESS AND PSYCHOLOGICAL WELL-BEING OF  
HEALTH CARE PROFESSIONALS IN ETHIOPIA PARTNER CLINICS,  
ADDIS ABABA.

BY:  
MELESSE SAMUEL

Sep. 2021  
ADDIS ABABA

ADDIS ABABA UNIVERSITY  
COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES  
SCHOOL OF PSYCHOLOGY

ABORTION RELATED STRESS AND PSYCHOLOGICAL WELL-BEING OF  
HEALTH CARE PROFESSIONALS IN ETHIOPIA PARTNER CLINICS,  
ADDIS ABABA.

A THESIS SUBMITTED TO THE SCHOOL OF PSYCHOLOGY ADDIS  
ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN  
COUNSELING PSYCHOLOGY

BY:  
MELESSE SAMUEL

Sep. 2021  
ADDIS ABABAA

ADDIS ABABA UNIVERSITY  
COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES  
SCHOOL OF PSYCHOLOGY

ABORTION RELATED STRESS AND PSYCHOLOGICAL WELL-BEING OF  
HEALTH CARE PROFESSIONALS IN ETHIOPIA PARTNER CLINICS,  
ADDIS ABABA.

A THESIS SUBMITTED TO THE SCHOOL OF PSYCHOLOGY ADDIS ABABA  
UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE  
OF MASTER OF ARTS IN COUNSELING PSYCHOLOGY

BY  
MELESSE SAMUEL

APPROVED BY:

_____ Chair person, Department of Graduate Committee	_____ Signature	_____ Date
_____ Advisor	_____ Signature	_____ Date
_____ Examiner, Internal	_____ Signature	_____ Date
_____ Examiner, External	_____ Signature	_____ Date

***Declaration***

*I the undersigned, senior counseling psychology student declare that this thesis is my original work in partial fulfillments for the requirements for the degree of master of counseling psychology the source of the materials used for this thesis and all people and institutions who gave support for this work are fully acknowledged.*

*Melesse Samuel*

*Signature* \_\_\_\_\_

*Place of submission School of Psychology, Addis Ababa University*

*Date of Submission* \_\_\_\_\_

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

*Dr. Teka Zewdie* \_\_\_\_\_  
*Advisor Name*

## **Acknowledgements**

This thesis research would not have been possible without the financial support of DKT Ethiopia. My sincere and deepest thanks go to my advisor, Dr. Teka Zewdie for his assistance, advice, critique and encouragements starting from the development of the proposal till the end of the thesis work.

I would like also to acknowledge Sister Hirut Araya DKT Ethiopia Mother and child health department director and her team, for their help during my data collection.

Ever more must forward my great thanks to partner clinics focal persons at DKT Ethiopia, clinic managers and all the study participants.

Finally my sincere gratitude should also go to my friends in AAU for their support particularly to Isayas A, Anemut G, and Meseret for their endless support and encouragements.

## TABLE OF CONTENTS

Acknowledgments.....	i
Table of contents.....	ii
List of Figures.....	vi
List of Tables.....	vii
Acronyms.....	viii
Abstract.....	iv
I. Chapter One: Introduction.....	1
1.1 – Background.....	1
1.2 – Statement of the Problem.....	3
1.3 – Objective of the study.....	6
1.3.1 – General Objective.....	6
1.3.2 – Specific Objectives.....	6
1.4 – Research Questions.....	7
1.5 – Significance of the Study.....	7
1.6 – Operational definition of key concepts.....	8
1.7 – Delimitation of the study.....	9
1.8 – Conceptual framework.....	10
II. Chapter Two: Literature Review.....	12
2.1 – Concepts and Definition.....	12

2.1.1 – Induced Abortion .....	13
2.1.2 – Safe induced abortions .....	14
2.1.3 – Unsafe induced Abortion .....	14
2.1.4 – Reason for Induced Abortion .....	15
2.1.5 – Performed Induced Abortion .....	15
2.2 – Stress .....	16
2.2.1 – Abortion related stress .....	16
2.2.2 – Stress Sources .....	18
2.2.3 – Psychological Well-being .....	19
2.2.4 – Stigma .....	21
2.3 – Stress Management among Health care professionals .....	22
2.3.1 – Social support.....	23
2.3.2 – Emotional Regulation .....	24
2.3 – Empirical Studies .....	25
III. Chapter Three: Methods of study.....	28
3.1 – Research design .....	28
3.2 – Research setting .....	28
3.3 – Population of the study .....	28
3.3.1 – Sample Size Determination.....	29
3.3.2 – Sampling technique.....	30
3.3.3 – Data source .....	30

3.4 – Data gathering instruments .....	30
3.4.1 –Socio Dermographique Data questions questionnaire .....	31
3.4.2 – Self stigma.....	31
3.4.3 – Perceived Stress Scale questionnaire .....	32
3.4.4 – MHC (Emotion, Social and Psychological wellbeing) .....	33
3.5 – Methods of Data Analysis.....	33
3.6 – Data collection Procedures.....	35
3.7 – Validity, reliability and pilot testing of the instruments .....	35
3.7 – Ethical Consideration.....	37
IV. Chapter Four: Data Analysis .....	38
4.1 – Demographic data of Healthcare professionals .....	38
4.2 – Self-stigma: .....	40
4.3 – Health care professionals who provide abortion to leave to other sectors .....	41
4.4 – The prevalence of Perceived stress of health care professionals .....	42
4.5 – The prevalence of Psychological well-being of health care professionals .....	44
4.6 – Correlation (r) Chi-square Analysis.....	46
V. Chapter Five: Discussion .....	50
5.1 – Self-stigma and health care professionals .....	50
5.2 – Level of perceived stress of health care professionals .....	54
5.3 – Level of psychological well-being of health care professionals .....	56
5.4 – Relationship between psychological well-being and perception of stress .....	59

VI. Chapter Six: Summary Conclusions and Recommendations .....62

    6.1 – Summary .....62

    6.2 – Conclusion .....63

    6.3 – Recommendations .....64

Reference .....66

Appendices 1

Appendices 2

**List of Figures**

Figure 1: Conceptual framework .....	10
--------------------------------------	----

## List of Tables

Table 1: Survey Reliability Results (Chronbach's Alpha).....	35
Table 2: Demographic data participant .....	38
Table 3: Health care professionals revealed their workplace identity to people to know .....	40
Table 4: Professionals who provide abortion service and intention to leave .....	41
Table 5: The prevalence of Perceived stress of health care professionals .....	42
Table 6: the prevalence of Perceived stress of health care professionals who intention and do not intention to leave to other sectors by profession group (N = 102 .....	43
Table 7: One way ANOVA perceived stress difference among professionals .....	43
Table 8: Descriptive characteristics of MHC-SF result .....	44
Table 9: One way ANOVA mental health difference among professionals.....	45
Table 10: The prevalence of Mental Health of health care professionals who intention and do not intention to leave to other sectors by profession group .....	45
Table 11: Results of Correlation (r) Analysis .....	46
Table 12: The Association between stress and psychological well-being .....	48
Table 13: The Association between self-stigma and intention to leave.....	49

**ACRONYMS**

AA	Addis Ababa
CSA	Central Statistics Agency
Gyn/Obs	Gynecology or Obstetrician
MLP	Mid-Level Providers
MHC-SF	Maternal Health Continuum Short Form
NGO	Non Governmental Organization
PSS	Perceived Stress Scale (PSS)
PTD	Post Traumatic Disorder
SPSS	Statistical Package for Social Sciences
WHO	World Health Organization

## **Abstract**

*Abortion related services are highly stigmatized in Ethiopia. stigma, stress and psychological well-being for abortion providers are not much studied in Ethiopia. The objective of this study was intended to describe self-stigma, level of perceived stress and relation of stress and psychological well-being among health care professional who provided abortion service in DKT Ethiopia partner clinics in Addis Ababa. The **method** of the research design used in the study is descriptive study designs with a quantitative method of data analysis. Data were collected through self administered questionnaire survey. Frequency percentages were used to analyze the collected data. In addition, analysis of variance (ANOVA), correlation and a chi-square test were used to analyze ordinal and categorical variables. Study data conducted with 102 professionals from DKT partner clinics in Addis Ababa. The result of the study revealed that sixty two percent of health care professionals are having self-stigma. Twenty three percent of study participants are having stressful life event and a majority of the study participants experienced a positive mental health. In addition, a significant correlation was found between self-stigma, stress and psychological wellbeing. Further, the study revealed that health care professionals who intention to leave the profession and professionals who doesn't have intention have a statistically significant different on their perceived stress and psychological well-being. **Conclusion:** self-stigma, stress and poor psychological well-being are presented among health care professionals who provide abortion service in DKT Ethiopia partner clinics. In addition, it can be concluded that the perceived stress in this participant is associated with stigma, intention to leave the profession and psychological well-being.*

**Key words:** Self-stigma, Stress, intention to leave, Psychological Well-being.

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background

Nowadays, more and more employees experience stress at work. This stress may result from work overload, high demands, poor work conditions, longer working hours, lack of control (autonomy) or lack of social supports (Manshor, Fontaine, and Chong, 2003).

Health care professionals are also prone to stress because of the peculiarities of their work situation, stigma and the discrimination at large in a society (Flinkman, Leino-Kilpi, Hasselhorn, and Salantera, 2008). Stress is generally defined as undue, inappropriate or exaggerated response to a situation. Whereas anxiety about a situation could be positive, stress is always negative with attending adverse psychological and physiological changes leading to decreased productivity and sometimes death (Familoni, 2008). Abortion related stress could negative influence healthcare professionals' physical and emotional well-being and overall quality of life.

Abortion related stress is one of a stress at work places. High stress has always been a critical issue for psychological well-being. Medical services especially at abortion services involve taking care of other peoples' lives and mistakes or errors could be costly and sometimes irreversible (Winfield and Lushington, 2006). It is widely expected that health care professionals must be in a perfect state of mind. An abortion service provider may be affected by stress.

There is substantial evidence that stress can lead to various negative consequences for individuals, including somatic diseases, mental health disorders or feeling of exhaustion and burnout (Flanagan & Flanagan, 2002). Lack of abortion professionals and high nurse's turnover represent problems for, the ability to care women seeking quality of abortion care (Clark & Aiken, 2003). Every pregnant woman who is contemplating abortion should receive adequate relevant information and be offered counseling from a trained and well healthcare professionals with comprehensive psychological wellbeing (WHO, 2003).

As far as life is concerned, high stress is a necessary and common problem associated with it. However, stress has undesirable consequences for the emotional, mental and psychological wellbeing of an individual (Flanagan & Flanagan, 2002).. Generally, we can say that stress can be physical and psychological and can lead to decreased quality of life and poor organizational performance

Until 2005, the Ethiopian penal code permitted abortion only to save the pregnant woman's life or to preserve her health from grave danger, and required diagnosis and certification by a medical practitioner, as well as confirmation by an obstetrician or gynecologist. In 2005, the penal code was amended to permit abortion under a much broader set of circumstances: in the case of rape, incest or fetal impairment; if pregnancy continuation or birth would endanger the health or life of the woman or fetus; if the woman has physical or mental disabilities; and if the woman is a minor who is physically or mentally unprepared for childbirth (FMoH, 2006; Emily, Dawit, Astrid and Ingrid, 2019). A legal reform took place fifteen years ago, social norms regarding abortion are

just beginning to change, and the expansion of safe abortion services has progressed quickly.

Ethiopia thus emerges as an interesting site in which to study health care workers' perceptions to measure levels of psychological distress, psychological wellbeing and stigma of abortion service providers (Sarah, Sahai , Dawit, Ryan and Aster, 2018).

Over the years, researchers, especially healthcare researchers have taken interest in studying abortion related stress. Most studies have shown that the situation has certain demands and meeting these demands can lead to stress (Emily et al., 2019; Sarah et al., 2018). Consequently, these studies have shown that abortion related stress is a real problem both to the health care organization and to health care professionals.

In Ethiopian abortion service, abortion related stress and psychological well-being of health care professionals has not been studied well. The aim of the study will be to explore Ethiopian abortion service providers' levels of stress, psychological wellbeing and self-stigma.

## **1.2 Statement of Problem**

Many medical practices and institutions encourage health care professionals for performing abortions. Varieties of ways of stigma and stress are deterred healthcare professionals from providing abortions, resulting in a shortage of professionals (CRR, 2009). The management of abortion related stress has become a topic of increasing concern over the past several decades. The profession of counseling is one area that has promoted the assistance of stress management in others.

Abortion services are frequently characterized by intense stigma and shame associated with moral and religious condemnation. Stigma is a stressor for many people's psychological problem and other mental illnesses. Therefore, stigma related stress is one of clinical and public health issue (Hinshaw, 2007). Abortion care profession is associated with shame, and the abortion service providers are facing stigma and discrimination.

Despite the demand and utilization increase in abortion service but problems are exist in the further expansion of services, a number of healthcare professionals left giving services. DKT Ethiopia report shows that around 50% of trained abortion service providers left the service provision in the last five years from DKT partner clinics particularly trained nurse and midwife who provided abortion services (DKT, 2018).

While the health workers interviewed revealed a high commitment to their work and a conviction that they were saving women's lives and preventing suffering, the religion, stigma and marginalization they experienced from colleagues led to frustration and burnout (Lithur, 2004)

The consequences of abortion related self-stigma and stress for the well-being of abortion providers have not been well studied, but hypothesize effects include stress, professional difficulties with antiabortion colleagues, fears about disclosing one's work in social settings, and burnout (Alison Norris et al., 2010, Emily et al., 2019).

Health workers in Ethiopia experience ethical dilemmas trying to maneuver between the community norm, their personal values, and their genuine concern for the health of women. However, many healthcare workers face a stigma from fellow

colleagues not performing abortions and keep their job secretly from family and friends (Emily et al., 2019).

DKT Ethiopia, have trained mid-level providers (MLP), i.e. health care providers who are doctors, health officers, midwives and qualified nurses, to perform first trimester abortions. However, threats to the lives of abortion providers and their families persuade against some practitioners from providing these services, even though they were trained to perform and the procedure is legal.

The research in the discourses of sexuality, fertility control and abortion which took place in three universities in Ethiopia, namely Addis Ababa, Jimma and Mekelle universities shows that students who decide to have their pregnancy terminated in certain cases, get assistance to have abortion carried out. While Jimma University has a special clinic that provides abortion service to students. The university clinics at Addis Ababa and Mekelle Universities will refer students to clinics outside the campus. Many Ethiopian female university students had faced pregnancy related problems (Emily et al., 2019). In spite of an increased emphasis on abortion even at universities healthcare professionals are expecting a better psychological wellness (Mulumebet and Haldis, 2019).

There is a growing recognition that the issue of healthcare professionals' health (in particular mental health) requires attention (Mészáros V, Cserháti Z, Oláh A, et al, 2013). Poor health including poor mental health can impair performance and reduce the quality of service delivery and patient care. Patient safety has depends on the healthcare professionals' psychological well-being. Thus, the topic of stress, and psychological

wellbeing of healthcare professional having interest both for themselves and its link with the health of others (Winfield and Lushington, 2006; Mészáros, Cserhádi, Oláh, et al, 2013).

The level of stress and psychological wellbeing of abortion providers have not yet been well studied in Ethiopia, but hypothesized effects include professional difficulties with antiabortion colleagues, fears about disclosing one's work in social settings, and burnout effect. Healthcare professionals could not give priority in investigation of stress and psychological wellbeing of Abortion providers in Addis Ababa. In addition the relation between stress and psychological wellbeing among abortion providers has not been fully documented. Thus, this study aims to stud the level of stress and psychological wellbeing of Ethiopian health care professionals who are abortion service providers.

### **1.3 Objectives of the study**

#### **1.3.1 General Objectives**

To assess levels of psychological distress, psychological wellbeing and self-stigma of healthcare professionals who are delivering abortion service in Ethiopia.

#### **1.3.2 Specific Objectives**

1. Is there self-stigma among abortion healthcare professionals (ie. doctors, health officers and nurses/ midwives).
2. To assess the level of perceptions of stress among abortion healthcare professionals (ie. doctors, health officers and nurses/ midwives).

3. To examine the level of psychological well-being of healthcare professionals providing abortion service (ie. doctors, health officers and nurses/ midwives).
4. To find out relationship between psychological well-being and perception of stress among abortion healthcare professionals.

#### **1.4 Research questions**

1. Dose self-stigma has among abortion healthcare professionals (ie. doctors, nurses and midwives)?
2. What is the level perceived stress among abortion healthcare professionals (ie. doctors, nurses and midwives).
3. What is the level of psychological well-being among healthcare professionals providing abortion service (ie. doctors, nurses and midwives).
4. Is there any significant relationship between psychological well-being and perception of stress among abortion healthcare professionals?

#### **1.5 Significance of the study**

Firstly, the findings of this study would help directly people such as health care professionals, and the DKT Ethiopia collaborate clinic community. This study will provide information about the level of psychological well-being and stress levels among health care professionals. The result therefore, might be used to strengthen the various existing programs that are working towards promoting safe abortion services.

Secondly and indirectly, it would help FMoH and NGOs who can be important stakeholders of the issues to be aware of the situation and explore and assess psychological well being and stress levels among health care professionals specially abortion care providers.

In addition, the data from this survey will provide information about the participants' behavior regarding psychological well being and stress levels. Based on the research findings, DKT Ethiopia administrative organ or FMoH would design an intervention plans to strengthen the psychological well being by reducing stress level of healthcare professionals through training and practice manuals. The result will show the direction of the requirement of health professionals' psychological support needs.

The other use of this research also is intensifying efforts on risk reduction and introduction of intervention activities such as, preparation of IEC/BCC for safe abortion services.

In the educational effort, behavioral change targeted interventions (BCC) will be revised and addressed with the current psychological well being and stress levels of abortion service care professionals.

### **1.6 Operational definition of key concepts**

**Self-stigma:** - is the health professionals who deliver abortion don't revealed their workplace identity to people to know. It is influences abortion related workers from participation in local communities.

**Intention to leave:** - Health care professionals who deliver abortion service and currently intention to leave to other sectors. Whether abortion stigma and stress are leads some physicians to refuse to provide abortions.

**Perceived stress:** -. Is feelings and possible emotional complications regarding medical personnel participating in pregnancy termination procedures. It is the characterized by measuring the overall perception of stress regarding abortion duty.

**Psychological Wellbeing:** - is the combination of emotional, social and psychological functioning effectively or appropriate outcome of individual's physical, social, and psychological development.

**Midwife:** – is midwife nurse with additional training (Abortion care) as a midwife who is health workers' having experiences of abortion-related service in DKT Ethiopia partner clinics.

**Nurse:** – is nurse with additional training (Abortion care) as a nurse who is health workers' having experiences of abortion-related service in DKT Ethiopia partner clinics.

### **1.7 Delimitation of this Study**

Initially, the student researchers planned to make descriptive study stress and psychological well-being health professional that provide abortion service in Addis Ababa. However, such study will demand long time study, high cost of research and much more human resources. Because of these, the study is limited in Addis Ababa and

some partner clinics in organization sites. Therefore, the outcome of the study may not represent all Addis Ababa health care professionals who deliver abortion service.

### **1.8 Conceptual Framework**

Number of factors are influence the relationship of self-stigma related discrimination, stress and well-being. High levels of stigma are not limited to executive level stress. Occupational studies have been conducted on high-stress jobs such as health care professionals which tend to exhibit high levels of stress and low psychological well-being.

The theory behind this descriptive analysis is that perceived stress is a serious problem among health care professionals in high stress occupations, especially in today's controversial abortion service climate (American Institute of Stress). Another aspect of this dimension is that professionals often fail to recognize their work related stress can become related with psychological well-being problem.

The base of this study was that the relation of Self-stigma, Perceived Stress Scale MHC-SF scale. PSS is measures the degrees to which professional abortion delivery are stressful (Cohen, and Mermelstein,1983). The MHC-SF is a 14 item test that assesses three components (i.e., emotional, social, and psychological) of well-being (Heather, Julie, Jennifer and Gayatri, 2017; Donnelly, 2019). Self stigmas measured by a single question respondent evaluate themselves.

Health care professional who deliver abortion service has experienced on abortion stigma and as something that one always salient. The more healthcare professional

experienced stigma, the more likely they were to have perceived stress outcomes. Stress is a well-documented factor in the repeated and cumulative exposure to negative psychological well-being additionally, the reaction of reduction of risk of stress positively influences on mental health and psychological wellbeing.

Conceptual framework has been a hypothesized model identifying the concepts under the study and their relationships. It's a diagrammatic presentation showing the relationship between variables (Dodge, 2003). The framework of the study was to assess and show self-stigma and perceived stress and its relation with psychological well-being among a sample of health care professionals who deliver abortion service in Addis Ababa. Findings of studies demonstrate an inverse association between stress and psychological well-being, but there is direct relation between self-stigma with stress and psychological well-being (Chandra, Batada, 2006; Kumar et al, 2009).

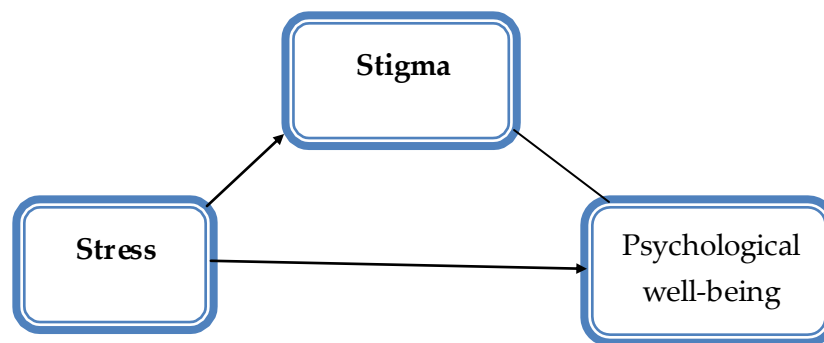


Figure: 1.1 Conceptual framework

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Concepts and Definition

The removal of pregnancy tissue, products of conception or the fetus and placenta from the uterus is call abortion. The word abortion derives from the Latin *aboriri*—to miscarry. Abortion is premature birth before a live birth is possible, and in this sense it is synonymous with miscarriage. It also means an induced pregnancy termination to destroy the fetus. Although both terms are use interchangeably in a medical environment, popular use of the word abortion by laypersons implies a deliberate pregnancy termination. Thus, many prefer miscarriage to refer to spontaneous fetal loss before viability (Gary and Cunningham, 2014). Abortion is a procedure that ends an undesired pregnancy by removing the fetus and placenta from the mother's womb (uterus). Abortion care, however, can be described as “*dirty work*”.

The two chief positions on the morality of abortion can be called the “pro-life” position and the “pro-choice” position. The basic pro-life position holds that induced abortions are morally impermissible (morally wrong, morally prohibited). Abortion involves the killing of a fetus. About killing a fetus is that the fetus is deprived of a future of value. Think of all the things which make our life good and worth living: understanding the world, seeing our children grow into independent, intelligent, and happy people, watching a sunset over the hills, enjoying good times with friends.

The basic pro-choice position holds that induced abortions are morally permissible (morally allowable, not morally wrong). By killing the fetus, we are depriving it of a future life likely to contain these things. The fetus would likely grow to be a person who would have contributed to the world in many ways

Products of conception and Pregnancy tissue refer to tissue produced by the union of an egg and sperm before eight weeks. In general, the terms fetus and placenta have used after eight weeks of pregnancy. Other terms for an abortion include elective abortion, induced abortion, termination of and therapeutic abortion.

In Ethiopia, abortion is used most of time to end an unplanned pregnancy or to end a pregnancy when tests reveal that the fetus is abnormal. Unplanned pregnancies happen when birth control is not used, is used incorrectly or fails to prevent a pregnancy. Therapeutic abortion refers to an abortion recommended when the mother's health is at risk. The majority of abortions are performed during the first 12 weeks of pregnancy.

### **2.1.1 Induced Abortion**

Induced abortion is described as surgical or medical termination of a live fetus before the time of fetus viability (Violetta et al., 2004). According to the World Health Organization (WHO), induced abortion can be safe or unsafe Induced abortion is a termination of fetus/embryo intentionally by medical or surgical technique. It is categorized as safe and unsafe abortion (The Constitution of The Ethiopian Society of Obstetricians and Gynecologists (ESOG), 2010). The practice of induced abortion can adversely affect a woman's health, reduce her chances for further childbearing, and contributes to maternal and prenatal mortality.

### **2.1.2 Safe induced abortions**

Safe induced abortions are largely legal in the majority of countries, both developed and developing. However, in a number of developing countries, even where the practice is legal the criteria for eligibility can be restrictive (e.g. abortion only being available when the life of the mother is endangered).

These legal restrictions and unequal access places severe restrictions on a number of women from gaining access to safe induced abortions (The Constitution of Ethiopian society of obstetricians and gynecologists, ESOG, 2010). Abortion is now legal in cases of rape, incest or fetal impairment (MoH, 2010). In addition, a woman can legally terminate a pregnancy if her life or physical health is in danger, if she has physical or mental disabilities, or if she is a minor who is physically or mentally unprepared for childbirth.

### **2.1.3 Unsafe induced Abortion**

Unsafe abortion, according to the WHO's definition, is a procedure performed in an environment that does not meet minimum medical standards or by persons without the necessary skills, or both, for terminating an unwanted pregnancy (Andre B. Lalonde, 2010).

Unsafe abortions are more likely to occur where access to safe abortion is restricted, or illegal to women. Even in instances where skilled professionals perform the procedure, if the abortion occurs outside the constraints of the law, the procedure may be unsafe to the health and wellbeing of the woman. There are a number of reasons why this may occur. Chief among them are: that procedures may be performed in unsanitary

conditions. Procedures may be performed in facilities without the authority to perform abortions; post-abortion care may not be provided; if there is an emergency during, or after the procedure it is unlikely that medical back-up will be available; and because the procedure is unsafely performed the woman may be reluctant to seek care for complications (ESOG, 2016). Generally, unsafe abortion is as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

#### **2.1.4 Reason for Induced Abortion**

There are reasons for induced abortion to be established in national penal code to assure legality of it. In Ethiopia, following changes to the penal code in 2005 abortion is legal under certain circumstances. These include: instances when pregnancy is the result of rape or incest; when pregnancy endangers the life of the mother; where there is evidence of fetal abnormalities; and in case of minors and women who are physically or emotionally impaired (Chamberlain, McDonagh, Lalonde, Arulkumaran, 2009). While abortion is generally legal in Ethiopia, in a majority of developing countries, complications from unsafe abortion remains a public health challenge.

#### **2.1.5 Performed Induced Abortion**

According to WHO's safe abortion guidance recommended that abortion services be provided at the lowest appropriate level of the health-care system. It states that vacuum aspiration can be provided at primary-care level up to 12 completed weeks of pregnancy and medical abortion up to 9 completed weeks of pregnancy, and that mid-level health workers can be trained to provide safe, early abortion without compromising

safety. It includes as mid-level providers: midwives, nurse practitioners, clinical officers, physician assistants and others (WHO, 2015). In Ethiopia and India have recommended that providers such as auxiliary nurse-midwives should be trained in abortion service delivery to ensure that they provide safe abortions for low-income women.

## **2. Stress**

Stress is defined either as a reaction or as a stimulus (Peplau, 1968). As a reaction, the meaning of stress is consubstantial with specific changes that human biological system is experiencing (Shu-Fen, et al, 2009). As stimulus, the definition of stress is related to environmental events that cause those changes. The stressful events can be acute, chronic, remitting and continuous chronic form (Speileberg, 1965). Stress has been defined as a condition or feeling experienced when an individual perceives that demands exceed his personal and social resources he can mobilize. Stress at any workplace appears to be inevitable, irrespective of the work nature. While a little stress could be performance-boosting, stress beyond control (distress) can bring adverse effect on work performance, delivery and to the individual itself (Sohail and Rehman , 2015).

### **2.2.1 Abortion related stress**

Miscarriage and abortion are both stressful events, but a study suggests that abortion may be associated with more long-term psychological distress. Reality of abortion in medical practice, unconscious fantasies experienced by some abortionists, and the reactions of general practitioners, psychiatrists, and gynecologists to abortion are discussed (Violetta et al., 2004).

Professional literature is devoid of the topic of feelings and possible emotional complications regarding medical personnel participating in pregnancy termination procedures. Ethically controversial medical procedures are frequently associated with a discrepancy between personal attitude and values versus requirements related to a professional situation. Cognitive dissonance is associated with experiencing unpleasant psychological stress induced by undertaking actions inconsistent with personal beliefs, values and expressed views (Nieminen et al., 2015).

Health care professionals, for whom just the participation in abortion delivery is stressful, are expected to deal with the emotions of the patient, their partner and sometimes even other family members. Numerous factors make the participation in an induced abortion a traumatic experience. Studies show that participation in multiple pregnancy termination procedures increased the probability of developing posttraumatic stress disorder (Schmidt, 2010).

Work related stress as the psychological, physiological and behavioral response of individuals when they perceive a lack of equilibrium between the demands placed upon them and their ability to meet those demands which, over a period of time, lead to poor health and psychological well-being (Blaug et al. 2007, Yousaf and Yasmin, 2016).

Health care professionals and workers who experience high occupational stress are at risk for unhealthy behaviors and poor physical health, service delivery, output, outcomes emotional burnout and job turnover (Cox, Griffiths and Rial-Gonzalez, 2000).

Stressors also vary depending on assigned duty and work place characteristics (Blaug et al. 2007). Across occupations, fast-paced and psychologically or physically

draining kind of work produces job stress, a state of high stress (Sohail and Rehman , 2015).

Study findings support a common perception regarding high stress in different work professionals, like those in the military, police, counseling, railways transport and power-grids. Medical care representatives and insurance agents too, who always have difficult business are considered to be another stressed group of work professionals. Abortion care professionals too are not immune from stress (Yousaf and Yasmin, 2016).

In addition, for the caring professions such as health care workers, emotional burnout can occur. The psychological wellbeing of abortion workers may vary depending on stress, workload, pace of work and resources available to accomplish assigned tasks (Sohail and Rehman , 2015).

### **2.2.2 Stress Sources**

One person can assess an event as stressful, while for another person is not. Furthermore, the same person considers one event as stressful sometimes, while under other conditions the same event cannot charge him emotionally (Richardson and Poole, 2001).

According to Ioanna et. al.(2015), on his research study factors of stress is broadly classified to in two categories. Stress factors can broadly be classified as internal or external. Internal stressor is generated within the person, for example a chronic diseases. External stressors are generated outside the individual, for example a death in the family, isolation and stigma. Occupational stigma is one of external source of stress.

Occupational stigma may carry particularly high costs, including social isolation, loss of self-esteem and stress (Lisa, 2011).

The extents to which some of these events can have positive or negative effects depend mainly on the individual's professional duties. Stigma influences abortion related workers from participation in local communities and institutions (Martin, et al. (2014).

### **2.2.3 Psychological wellbeing**

Psychological wellbeing refers to the extent to which people experience positive emotions and feelings of happiness. Sometimes this aspect of psychological wellbeing is referred to as subjective wellbeing (Diener, 2000).

Evidence indicates that the primary health issue for health care professionals is their mental health care (Kessler et al., 2012; United Nations, 2013). According to the World Health Organization, mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her large community (WHO, 2004).

Wright (2010), defines psychological well-being as, a subjective and worldwide judgment that one is encountering a maximal positive and generally minimal negative emotions or feelings. Psychological well-being is the capability of an individual to feel satisfied and perform effectively regardless of negative or throbbing feelings, which are typically part of life (Huppert, 2009). According to Chaturvedula and Joseph (2007), psychological wellbeing is a person's judgment or assessment of his or her life either regarding life fulfillment (intellectual assessments) or influence (emotional reactions)

which is additionally partitioned into pleasant effect (positive emotions) and unpleasant effect (negative emotions). Moe (2012), considers psychological well-being as the corner stone of emotional wellness. Psychological well-being is simply defined as ultimately about a person satisfaction feeling good and safe livelihood. Psychological well-being is composed of all emotional, social and psychological well-being . In other words it is a functioning of negative well-being (e.g. depression, discouragement, anxiety) and positive well-being (self-confidence, positive affect and morale) (O'Driscoll & Brough, 2003).

Subjective well-being is characterized by the individual's internal subjective assessment, based on cognitive judgments and affective reactions, of their own life as a whole. There are sub dimensions that investigators consider within the domain of subjective well being. These include psychological, social, and spiritual aspects of well-being. Many scales have been developing for use in scientific studies to assess individuals' subjective well-being across the life course.

#### **2.2.4 Stigma**

Stigma is the expectation of stereotypical and discrediting judgment of oneself by others in a particular context. The term originates from Goffman's (1963) definition of stigma, which states that stigma originates when an individual, because of some attributes, is disqualified from full social acceptance.

Public stigma is the reaction that the general population has to people with mental illness. Self-stigma is the prejudice which people with mental illness turn against them.

Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination.

At the individual level, stigma can be classified into three main manifestations: 1) perceived stigma, which are ideas about what others may think about abortion and about what could happen if their own experience is made public (rejection by the family or partner, impaired social relationships, loss of friendships, criticism, abuse, and isolation); 2) experienced stigma, which are actual acts of discrimination, harassment, and aggression by others; and 3) internalized stigma, which refers to the materialization of the two previous forms in feelings of guilt, shame, anxiety, or other negative ideas (Kumar, et al., 2009; Shellenberg, et al., 2011; Sorhaindo et al., 2014). Women who seek abortions challenge localized cultural norms about the “essential nature” of women. Stigma may also apply to medical professionals who provide abortions, friends and family who support abortion patients, and perhaps even to prochoice advocates.

Shellenberg et al. (2011) and Sorhaindo et al. (2014), focus on how internalized stigma was experienced by women who had abortions in Mexico and Peru. Feelings of guilt, sadness, and shame were common, as well as widespread silence and secrecy around abortion, especially in small communities.

In the study of sociology and psychology areas stigma has been found to be a key barrier to health care and can often have negative consequences for the health and well-being of the health care professionals due to stigmatized (Ellison, 2003). For this reason, a number of community health programs, health care service delivery organizations, and

health care advocates are working to address stigma directly to yield better health outcomes for marginalized professional populations (Cockrill et. al., 2013).

Health care professionals their work identity is connected to abortion and exposure to stigmatizing behaviors may be continual (Alison et al.,2011). The concentration of the abortion load on a relatively small number of providers suggests that abortion and its associated stigma may be consistently integrated into the identities of abortion clinic doctors and staff (Harris, 2008). The consequences of abortion stigma for the well-being of health care professionals who provide abortion have not been well understood, but hypothesized effects include stress, professional difficulties with antiabortion colleagues, fears about disclosing one's work in social settings, and burnout (Harris, 2008; Yanow, 2009). The experience of abortion stigma is different for providers than it is for women who have had abortions. Abortion stigma is close at hand for providers (Harris, 2008). Their work identity is connected to abortion, and exposure to stigmatizing behaviors may be continual.

According to Jones et al. (1984), by several dimensions and definition, stigmas can vary from one another by describing stigma as a social process in which individuals are (1) labeled as different, (2) stereotyped or associated with negative attributes, (3) conceived of as an "other" a different and subordinate social group and then (4) subjected to status loss and discrimination.

### **2.3 Stress Management among Health care professionals**

To be able to cope with stress and manage it, it is important to know how stress influences ones performance, having self-awareness and recognition of the symptoms of

stress helps us to use it constructively and avoid its destructive aspect. It's also good to know when people might be getting into the unproductive and destructive end of the stress curve (Afsaneh et al., 2015). There are different strategies identified by Afsaneh et al. (2015), that might be useful in managing and controlling stress and they are as follows.

### **2.3.1 Social support**

Social support is defined as “a social network’s delivery of psychological and emotional resources intended to benefit an individual’s ability to deal with stress. Our inter-personal relationships are linked to our immune function and our ability to fight disease. How well people cope with stress is the might have decided by amount and quality of social support that they receive. Positive relationships with and support from the people can act as a mediator to work related stress. Structural social support comes from being embedded in and connected to a network of people whom we know can potentially provide support (Alonso et al., 2009; Rollinson, 2008).

More so, laughter and positive humor is an important tool that help people handle stress of laughter in the work place can result in a significant and long lasting increase in several different aspect of self efficacy, including self-regulation, positive, emotion and social identification (Falci, and McNeely, 2009). Conclusively, making social connections with others at work can help us to do a better job and cope with stress as they arise. At the same time, it is import to understand how our support, be it emotional, tangible functional can strongly influence other people’s capacity to cope with the

stresses and strains of organizational life. We all need a little of help from friends (Nahavandi et al., 2015).

Social support that health care professionals receive from their immediate social networks, particularly their friends, mitigates the effects of abortion stigma (Kumar et al., 2009). Abortion service providers who perceive community support for the right to deliver abortion service are less likely to feel guilt and shame than those who do not (Kumar et al., 2009).

### **2.3.2 Emotional Regulation**

Under different kind of circumstance Emotional regulation across individuals varies from reappraisal and suppression extent. Emotion regulation often involves changes in emotional responding such as increasing, decreasing, or maintaining of positive and negative emotions (Aldao et al., 2010; Webb et al.,

The emotional reactions concerned in related to stress emotional regulation. When health care professionals encounter stressful events in their daily work, emotion regulation enables them to deal and manage their emotions (Almeida, Wethington and Kessler,. 2002).

Organization managers has set certain rules and duties for behavior while emotional regulation can cause stress when the expression of emotional stress is allowed showing in the different faces at the same time make social interaction quite difficult (Rollinson, 2008).

The effects of emotional regulation are not easy to identify, because emotional regulation happens in a social context and complete information about the nature of occupation prior to hiring, and then they are more likely to have realistic expectations and higher level of work satisfaction. But not all emotional regulation brings about positive responses. Some emotions are hidden, they are not shown in faces and this can increase strain when there is a pretence employed. Despite this, while there are situations in which workers feel stressed because of emotional regulation, organizational heads can still have an important role to play in reducing it (Rollinson, 2008).

## **2.4 Empirical Studies**

The level of stress experienced by health professionals appears to differ from person to person and from one setting to the other work setting. For example, psychotherapists working in agency settings reported higher levels of burnout and fewer instances of personal accomplishment than did those engaged solely in private settings.

A research conducted by Prosser, Johnson, Kuipers, (1996) examined that their “community setting” participants reported higher scores on stress level with the General Health Questionnaire and on the emotional exhaustion scale of the Maslach Burnout Inventory. In explaining this finding, Prosser et al. suggested that increased stress among community-based staff may be a consequence of uncertainty and change rather than of working in the community itself.”

In the United States, stress related stigma has linked with lower job satisfaction and exhaustion among mental health providers, and with burnout and compassion fatigue among abortion care providers (Martin, 2014). The literature on stigma and healthcare

also reveals negative implications for service delivery. Research on stigmatized conditions has shown that providers stigma from abortion has found to reduce physicians 'willingness to obtain related training in South Africa (Harris LH, 2014).

Negative attitudes related to abortion have discouraged trained providers from offering stigmatized but life saving care across multiple countries (Bandewar, 2003; Harris et al., 2014; Lithur, 2014; Martin L, Debbink M and Hassinger, Youatt and Harris 2014).

The British Medical Association (BMA) published a treatise on stress in junior doctors<sup>5</sup> and later in senior doctors. The conclusions were similar, to the effect that stress existed to a significant proportion in both groups and that it is inimical to the doctors' health and service delivery to patients. The magnitude of the problem was further emphasized in the report of the American Foundation for Suicide Prevention<sup>7</sup> which claimed that on the average, death by suicide is about 70% more likely among male physicians than among other professionals and 250–400% higher among female doctors. The major cause is being stress and depression thereof.

Beyond absenteeism or being present physically at work, but working less productively can also be the impact of work stress (Caverley, 2005). In Malaysia, the same phenomenon may hold true because the main objective of this study is to examine the relationship of sources of occupational stress, coping strategies and well being among PTD officers in Malaysia.

Abortion is frequently characterized by intense stigma and shame associated with criminalization of the procedure as well as moral and religious condemnation. Stigma is

an attribute of a profoundly discrediting nature that marks or taints an individual as one who should be socially avoided. A study on, when the law makes doors slightly open: ethical dilemmas among abortion service providers in Addis Ababa, Ethiopia found many health workers face a stigma from fellow colleagues not performing abortions and therefore keep their job a secret from family and friends (Emil et al. 2019).

A study has show in Ethiopia. Professional Pragmatism and Abortion Stigma: Assessing the Performance of the Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) among Ethiopian Midwives. A quantitative analysis of an abortion stigma scale found that, in contrast with results from other countries, a sample of Ethiopian midwives reported low levels of stigma, particularly as regards discrimination and exclusion of women seeking services (Sarah et al., 2018).

Several studies have conducted on level of stress and psychological wellbeing among women's who got abortion services. However, most of the studies focused on the effect of stress over service seek women's (Van & Jonge 2010; Rollinson, 2008; Hayes, et al., 2015), but there is limited research on the health care professionals regarding abortion service providers. Furthermore, the kinds of problems abortion related stressors and psychological well-being didn't study well in Ethiopian health care professionals.

## **CHAPTER THREE**

### **METHODS OF STUDY**

#### **3.1 Research Design**

A quantitative descriptive method of design has been applied for this study due to the nature of the research problem, the researcher's fundamental beliefs about the role of research and the researcher's role in such a study (Creswell, 2009). Questionnaires are used as a quantitative research tools of this study. The data in quantitative research make use of numerical measurements and can be condensed by using statistics (Babbie, 2010). Reconstruction of the research instruments ensure validity of the research and emphasize that the instruments employed measure what it supposed to (Patton, 2002).

#### **3.2 Research Setting**

This research focused on an assessment of Stress level and Psychological Wellbeing of Healthcare professionals in DKT's Partner Clinics. DKT's Partner Clinics are a network of 240 clinics (high-quality Medium, Gynecology & Obstetrics (Gyn/Obs), and Maternal and Child Health (MCH) Clinics that provide family planning and reproductive health services to Ethiopian women and couples (DKT, 2018).

#### **3.3 Population of the Study**

The targeted populations of this study are healthcare professionals who provide abortion services in different partner clinics of DKT Ethiopia. As per DKT Ethiopia's training report document, there is at least one abortion service care provider in each of the partner clinics

### 3.3.1 Sample Size Determination

The quantitative data for this study were collected from healthcare professionals at DKT Ethiopia's partner clinics. And the researcher decided to take the sample from the whole population. Further, whether the sample size is adequate enough to provide accuracy, it is important for a researcher to consider the Cochran formula (Cochran, 1963) to base decisions on the findings with confidence.

The Cochran formula allows us to calculate an ideal sample size of a desired level of precision, desired confidence level, and the estimated proportion of the attribute present in the population.

$$n_0 = Z^2 * P (1-q) / e^2$$

Z=standard normal deviation at the required confidence level e.g. 95% or 1.96

P=proportion of population estimated to have characteristics being measured

q=1-P (proportion of population without the characteristics)

e= tolerated margin of error (to know the real proportion within 5%)

$$n_0 = 1.962 (0.2) (0.8) / 0.0025 = 0.4905 / 0.0025 = 246$$

According to Cochran if the population we are studying is small, we are able to modify the sample size we calculated in the above formula, by using the below equation:

$$n = n_0 / (1 + (n_0 / N)) = n$$

$$n = 246 / (1 + (246 / 240)) = 117.4 = 118$$

### **3.3.2 Simple technique**

This section describes what steps the researcher has taken to conduct the study starting from the techniques used to select the sample participants. The participants were selected from healthcare professionals of DKT Ethiopia partner clinics from Addis Ababa. And the sampling technique used is simple random sampling. In this case each individual has been chosen entirely by chance and each member of the population has an equal chance of selection probability. It is recommended to use random sampling when we don't have any kind of prior information about the target population.

### **3.3.3 Data Sources**

The major sources of data in this study are categorized into primary and secondary data sources. The primary source of data was information collected from healthcare professional, who were addressed by questionnaires. Likewise, the secondary data sources used included reports, documents, archives and review from the clinics and DKT Ethiopia archives.

According to Creswell (2009), for descriptive type of research, primary data can be obtained either through survey questionnaires or through direct communication with respondents. The following data collection instrument has been incorporated into this study.

### **3.4 Data gathering Instruments**

The primary data collecting instruments used for this study has been structured questionnaires. The instruments are modified perceived stress scale (PSS) and Emotional,

Social and Psychological wellbeing scale. To assess the prevalence of psychological distress, depressive and anxiety symptoms and stress and well-being, a number of validated widely used instruments have been selected. As discussed above, the secondary data collecting instruments were reports and archives where documents were reviewed.

The prepared questionnaires included enquiries like abortion related data, details about age, sex, marital status, academic status, specialty, years of work experience and so on. These questionnaires were initially designed in English and then translated to Amharic (the local language) by a language expert. Yet again, this Amharic version was translated back to English to check for consistency.

#### **3.4.1 Socio Demographic Data questions**

Personal information form developed by the researcher included questions aiming to determine some demographical properties of the respondents. In the form, there were the information related to the occupation, age, gender, marital status, employment experience, and educational level of the participants.

#### **3.4.2 Self Stigma**

The questionnaire included a single question, '*I was providing abortions in hospitals but I wouldn't want people to know*', offers the respondent five options from strongly agree to strongly disagree, with lower scores indicating greater levels of self-stigma.

### 3.4.3 Perceived Stress Scale

A structured self administered questionnaire was designed based on the original perceived stress scale by the researcher. This structured questionnaire was developed in English based on perceived stress scale and translated into Amharic. The questionnaire designed to measure abortion service duty related with the degree to which situation in one's life events are appraised as stressful.

Most questions in the PSS ask about feelings and thoughts during the last month, but the modified scale also includes a number of related queries about experienced stress related to abortion service. In each item, respondents are asked how often they felt a certain way ask about feelings and thoughts during the last month related to their abortion service. The PSS-10 scores range from 0 to 13 (low), 14–26 (moderate), and 27–40 (severe perceived stress during their service experiences with abortion (Cohen et al., 1983).

The PSS consisted of 10 items (PSS-10) each item was rated on a five-point scale from 0 = 'never' to 4 = 'very often', covering the preceding month. The PSS scores are obtained by reversing the responses (e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1 and 4 = 0) to the four positively stated items (items 4, 5, 7, and 8) and then summing across all the scale items. The scores ranged from 0 to 40, with the higher scores indicating higher levels of perceived stress and the lower scores indicating lower levels of stress((Cohen et al., 1983).

### **3.4.4 MHC- Emotional, Social and Psychological wellbeing**

The MHC-SF (the Mental Health Continuum Short Form) is comprised of 14 items measuring emotional (items 1–3), social (items 4–8), and psychological well-being (items 9–14) (Appendices :1). Respondents rate their feelings over the previous month on a six-point Likert scale ranging from 0 to 5 (never to every day), meaning the range in continuous scores is 0–70 (emotional wellbeing 0–15; social well-being 0–25; psychological wellbeing 0–30). Higher scores indicate higher levels of well-being (Heather, Julie, Jennifer and Gayatri (2017); Donnelly, 2019).

### **3.5 Methods of Data Analysis**

The quantitative data were collected and compiled then the results presented. All analysis had performed using statistical software SPSS version 20 and Microsoft Excel 2007.

Further preliminary data analyses were conducted to test the single concepts and the scales we used. One question, which is evaluated self-stigma was coded with a dimension of “agree” and “disagree” groups for their perceiving of self-stigmatized.

In addition, the variable “intention to leave” was recorded in to two groups as a dummy variable. Therefore there is the variable (Leave) with a dimensions of “Yes” and “No” groups. These will identify those health care professionals whose intention is to leave there profession from those who intend to continue their professional service.

The analysis of the scale of Perceived Stress, the first thing that had to be done was to recode the respondents data into useful variables for further statistical analyses

item 4,5,7 and 8 had to be reversed because of their positive formulation. After the items code were reversed and were summed up, which yields a continuous total stress score (PSS\_Cont) ranging from 0 to 40. Scores ranging from 0-13 would be considered low stress. Scores ranging from 14-26 would be considered moderate stress. Scores ranging from 27-40 would be considered high perceived stress.

Similarly to calculate the scale of Mental Health Continuum-Short Form was. The first way was to calculate a total mental health score, adding up all the single scores from the 14 items. This results in a total mental health score ranging on a continuum from 0 to 70, expressing the amount of positive mental health.

Model for analyses for the first, second and the third research question have descriptive characteristics model. Descriptive statistical measures (frequency, percentage, means scores and standard deviation) were used to describe the general pattern of self-stigma, stress and psychological well-being of the respondents in line with the demographic backgrounds and the results were presented in tables.

Correlations model was used to answer the other research questions aimed to analyze the relationships between the continuous variables of total perceived stress score with other variables.

For the variables with more than two dimensions (profession, age group), an one way ANOVA and chi-square test was used to compare the stress and MHC-scores between the groups (categorical variables). Therefore, a correlation analysis was used to look how the variables such as stigma, stress, intention to leave among health care professionals correlate with their psychological well-being score.

### **3.6 Data Collection Procedures**

Based on the sampling procedure the survey questionnaires were distributed for 118 abortion service providers for the study in different DKT Ethiopia partner clinics from Addis Ababa city. For the selected samples to be reliable the researcher used simple random (lottery method) sampling technique with the help and supervision of DKT Ethiopia officials. The lists of 240 clinics from Addis Ababa city were presented by DKT officials and we categorized the list by odd and even numbers. Then we selected from the two categorized group of clinics by lottery method, groups of even numbers are chosen as a sample of study. The 118 professionals were selected from their respective partner clinics from DKT Ethiopia partner clinics list from Addis Ababa city. The study self-administered questionnaires were distributed for abortion service providers at the conference DKT Ethiopia partner clinics in Addis Ababa City annual meeting in mid of April 2021. They returned the completed questionnaires to their respective DKT partner clinics representative and majority of the completed questionnaires were submitted to the researcher the next morning.

### **3.7 Validity, reliability and pilot testing of the instruments**

To assure the validity and reliability, the study tools was translate in to Amharic and back in to English by English language professionals. After translating, three psychologists were reviewing on the instrument for validity and the psychologist agreed the validity of the questionnaire. For the aim of pilot study, the researcher has selected 27 health professionals who working safe abortion care in Gandhi memorial hospital. Manual vacuum aspiration (MVA) has been recently introduced in Ethiopia and Gandhi

Memorial hospital is currently serving abortion in its ward. The questionnaire was pre-tested with twenty seven providers working in abortion facilities and was subsequently revised based on pre-test results.

In the current study, the pilot study was conducted mainly for testing the reliability of the Amharic version standardized scale. Participants for the pilot study were selected from government owned hospital to avoid contagion of information. The instruments of data collection were administered to pilot participants in exactly similar way as they would be administered in the main study. In pilot survey, after obtaining verbal informed consent, participants were asked to complete the Amharic versions of a demographic and PSS scale (10 item) and MHC-SF psychological wellbeing scale (14 items). The result of the sub subscale Cronbach alpha results are presented in table 3.1.

The pilot study has been conducted on a convenient sample of 27 (female and male) healthcare professionals who provided abortion service in government health center. Pilot data were examined using SPSS V.20 and internal consistency analysis. Chronbach's alpha scores were used to assess internal consistency. A determinant had a .70 or higher reliability score have retained to the final study (Roger and Victor, 2006).

*Table 3.1. Survey Reliability Results (Chronbach's Alpha)*

<b>Scales and Subscales (Determinants)</b>	<b>No. Items</b>	<b>Pilot Alpha score (N=27)</b>	<b>Main study Alpha score (N=102)</b>
Total MHC (Continuous)	5	0.748	0.72
Emotional	3	0.753	0.85
Social	5	0.710	0.75
Psychological	6	0.770	0.83
Total PSS (Continuous)	10	0.708	0.73

### **3.8 Ethical Considerations**

Support letter was obtained from Addis Ababa University School of psychology to the DKT Ethiopia in order to have appropriate support during data collection. Subsequently, permission to carry out the study received from DKT Ethiopia Partner clinics coordinator. The study participants were orally informed the purpose of the study and were asked their willingness to participate in the study. Measures were taken to ensure the respect, dignity and freedom of each individual. Participants were informed that the information they provide would be kept confidential and would not be disclosed to anyone else. Additionally, maintained for all obtained information and no names written on the questioner instead numbers assigned.

## CHAPTER FOUR

### DATA ANALYSIS

#### 4.1 Demographic data of Healthcare professionals

**Table: 4.1** Demographic data Distribution and univariate analyses of Stress and well-being

Variables		Frequency	%	Stress mean	PWB mean
Sex	Male	30.00	0.29	18.37	39.03
	Female	72.00	0.71	13.63	43.07
F				3.466	0.704
Age	20 or below	0.00	0.00	0	
	21-25	5.00	0.05	22.60	19.20
	26-30	8.00	0.08	19.75	33.00
	31-35	30.00	0.29	21.47	30.07
	36-40	41.00	0.40	13.22	50.37
	41-45	13.00	0.13	5.54	51.38
	46-50	2.00	0.02	1.00	58.00
	51-55	1.00	0.01	0.00	54.00
Above 56		2.00	0.02	0.50	53.50
F				5.318**	4.534**
Marital status	Single		0.00		
	Married	89.00	0.87	13.34	18.64
	Divorced	12.00	0.11	26.91	45.54
	Widow/ Widower	2.00	0.02	24.5	7.00
F			0.00	7.991**	11.910**
Education level	Diploma	14.00	0.14		50.36
	Degree	76.00	0.15		40.41
	MA and above	12.00	0.12		41.33
F				6.775**	1.207
profession	Health officer	44.00	0.43		41.66
	Nurse/ Midwife	53.00	0.52		41.72
	Doctor	5.00	0.05		45.60
F				4.801**	0.73

\*\* significant at the 0.05 level

The main sources of information were Healthcare professionals in DKT's Partner Clinics who provide abortion service for women's. In this regard, 118 respondents were involved in filling out the questionnaires. Accordingly, out of the total of 118 questionnaires distributed to professionals in DKT's Partner Clinics who provide abortion service in Addis Ababa, 102 (85%) were filled and returned.

Out of a total of 102 respondent health care professionals who have academic profession health officer were 43. % and those who have midwife/ nursing profession were 52.0 %, while the remaining 4.9 % was doctors.

One hundred two health professionals were voluntarily completed the survey instruments. 8 professionals submitted incomplete questionnaires and were excluded from the analysis. Therefore, a total of 102 health care professionals formed the basis for all the analyses. The mean age  $\pm$  standard deviation (SD) of the study health care professionals was  $36.3 \pm 6.5$  years, with a range of 22 - 60 years.

The summary of the socio-demographic characteristics of the sample are included in (Table: 4.1). Out of the 102 participants, 30 (29%) were male professionals and 72 (71%) were female health care professionals.. All the professionals belonged to the marital status. The respondents were no single, while the rest 87.2% and 11% married and divorced respectively.

Univariate analyses indicated that age, marital status, educational level, profession and number of delivered abortion with perceived stress ( $P < 0.05$ ). Age Marital statuses were related to well-being ( $P < 0.05$ ).

Regarding gender, the analyses showed that female perceive more stress than their male fellow professionals. This is in accordance with the literature, which shows that women perceive more stress than men (Misra & Castillo, 2004). Although female health care professionals perceive more stress, the relationship between stress and mental health is not as big as among their male 25 fellow professionals. A better understanding of the study the results are socio demographic dependent, it might thus be critical to use the data from this study as an indicator for the amount of stress and PSW that is perceived by health care professionals. Age or Marital status can increase the level of stress and psychological wellbeing.

**4.2 Self-stigma:** Health care professionals revealed their workplace identity to people to know

**Table 4.2** *Health care professionals revealed their workplace identity to people to know*

		Revealed their workplace identity to people to know		
		Yes	No	Total
	Health Officers	14 (3.4%)	30 (29.7%)	44(43.1%)
Profession	Midwives/Nurse	20 (19.6%)	33 (32%)	53 (52%)
	Doctor	4 (3.9%)	1 (1.1%)	5 (4.9%)
	Total	38 (37.3)	64 (62.7%)	102

The above table 4.2 shows that respondent were 64 (62.7%) were health care professionals doesn't willing to reveal their workplace identity to people to know. Whereas 38 (37.3%) were health care professionals willing to revealed their workplace identity to people to know. It shows that majority of health care professionals who

delivered abortion service couldn't want others to know their duty and duty station. It implies that majority of abortion service providers are self-stigmatized them.

The present study results have shown that only one percent of respondents was doctors and agreed or strongly agreed that they wouldn't want people to know if they were giving abortion service to women's. Midwives were more likely to respond they don't want to people to know if they were giving abortion service to women's (32 %, than health officers (29.76%). Pearson chi-square confirmed no significant differences in self-stigma between the health care professionals ( $X^2(0.20)$  p value is greater than 0.05).

#### 4.3 Health care professionals who provide abortion to leave to other sectors

**Table: 4.3** *Professionals who provide abortion service and intention to leave*

		professionals who provide abortion service and leave to other sectors	
		No(continue) Count	Yes (leave) Count
Profession	Health Officers	34 (33.33%)	10 (9.80%)
	Midwives/ Nurse	41 (40.20%)	12 (11.76%)
	Doctor	5 (4.90%)	0(%)
	Total	80 (78.43%)	22 (21.7%)

Similar question was asked to respondents for the intentions to leave their abortion service delivery. The above table 4.3 shows that were 80 (78.43%) respondent were not agreed that health care professionals who provide abortion service don't leave to other sectors. Whereas 22 (21.7%) were has intention to leave to other sectors. It shows that majority of health care professionals who delivered abortion service couldn't want to leave to other sectors and stayed on their profession for current time

Only one percent (1%) of respondents is doctors agreed that they want to leave there abortion service delivery profession. Midwife's were more likely to respond to want to leave there profession (11.76 %, than health officers (9.8%). Pearson chi square test confirmed significant differences between the midwife-nurse doctors and health officers groups over intention to leave their profession ( $X^2(1.446) p=(0.045)$ ).

#### 4.4 The prevalence of Perceived stress of health care professionals

**Table: 4.4** *The prevalence of Perceived stress of health care professionals by profession group (N = 102).*

		PSS_level			PSS_Cont	
		Low stress	Moderate stress	High stress	Mean	SD
Profession	Health Officers	26 (25%)	8 (7.8%)	10 (9.8%)	14.45	11.98
	Midwifes/Nurse	28 (27.5%)	12 (11.8%)	13 (12.7%)	16.87	11.49
	Doctor	5 (4.9%)	0	0	0.4	0.55
	Total	59(57.8%)	20(19.6%)	23(22.5%)	15.01	11.89i

The above table 4.4 shows that almost twenty three percent of the participants perceived health professional as being stressful. The rest of health professionals 19.5% moderate and 57.8 % low stressful.

The overall mean perceived stress scale score in the study participants was 15.01, with a standard deviation of 11.89. The mean perceived stress scale score was higher (16.87) in the, midwives followed by health officers (14.45) and doctors (.55), and the

higher score among midwives indicated that the perceived stress was highest among them as compared to other health professionals doctors and health officers.

**Table: 4.5** *the prevalence of Perceived stress of health care professionals who intention and do not intention to leave to other sectors by profession group (N = 102)*

		Health care professionals intention to leave to other sectors					
		No (N=80)			Yes (N=22)		
Profession		Low stress	Moderate stress	High stress	Low stress	Moderate stress	High stress
		Count	Count	Count	Count	Count	Count
Health Officers		26 (31.7)	8 (9.8)	1 (1.2)	0 (0)	0 (0)	9 (40.9)
Midwives/ Nurse		28 (34.1)	9 (11.1)	3 (3.7)	0(0)	3 (13.7)	10(45.45)
Doctor		5 (6.1)	0(0)	0(0)	0(0)	0(0)	0(0)

The present study results (Table: 4.5) have shown that 86.3% (40.9% health officers and 45.45 % midwives Nurse) out of a total of 22 professionals who intention to leave to other sectors were high in perceived stress but (13.7% and 0%) of professionals who intention to leave to other sectors were moderate level of perceived stress. Contrast to the above result from out of professionals who don't have intention to leave the majority 71.9% (34.1% midwives Nurse 31.7% health officers and 6.1% Doctors) were low in perceived stress.

**Table: 4.6** *One way ANOVA perceived stress difference among professionals*

Perceived stress _Total					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1263.776	2	631.888	4.801	0.000
Within Groups	13030.185	99	131.619		
Total	14293.961	101			

As presented in table 4.7, the computed one way ANOVA finding of the study indicated that there was a statistically significant relationship was found between professional group and perceived stress continuous score at  $F = (4.801) = P = 0.010$  among health care professionals.

#### 4.5 The prevalence of Psychological well-being of health care professionals

**Table: 4.7** *Descriptive characteristics of MHC-SF result*

		MHC-SF Three Category Diagnosis of Positive Mental Health			MHC Total	
		Languishing	Moderate	Flourishing	Mean	SD
		Count (%)	Count(%)	Count(%)		
Profession	Health Officers	10 (9.78%)	14 (13.73%)	20 (19.63%)	41.66	22.32
	Midwives/ Nurse	16 (15.71%)	10 (9.80%)	27 (26.45%)	41.72	22.42
	Doctor	1 (.98%)	3 (2.94%)	1 (.98%)	45.60	20.62
	Total	27 (26.47%)	27 (26.47)	48 (47.05%)	42.80	21.78

Based on the Mental Health Continuum Short Form (MHC-SF), Scores are added together for a total mental health score that can range from 0 to 70, with positive mental health represented by a score of 46 or more, average mental health represented by a score of 25 to 45, and poor mental health represented by a score of less than 25 (Keyes, 2005)

A majority of the study participants (48, (47.05%)) experienced a levels of flourishing (positive mental health) well-being, and 26.47%, 26.47% experienced moderate and languishing (poor mental health) well-being respectively. Midwife/ Nurse (n = 27, 26.4%) flourishing well-being (10, (9.8%)), moderate levels and (n = 16, 15.71%) languishing well-being respectively. Health officers (n = 20, 19.6%) flourishing well-being (14, (13.7%)), moderate levels and (n = 10, 9.7%) languishing well-being

respectively With relatively few reporting were by Doctors with a level languishing and flourishing 1 (98%) and 2.9% moderate well-being.

**Table: 4.8** *One way ANOVA MHC mental health difference among professionals*

mhc_Total	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	72.747.529	2	36.374	0.073	0.930
Within Groups	49261.841	99	497.591		
Total	49334.588	101			

Total contentious scores on Mental Health Continuum Short Form (MHC-SF) had an average mean of 42.80 with standard deviation of 21.78 which was categorized as a moderately quality of well-being (Table 4.6). As presented in table 4.7, the computed one way ANOVA finding of the study indicated that there was no statistically significant mean difference was found between professional group(doctors , health officers and nurse) and psychological wellbeing at  $F(0.141) = 7.83$ , at  $\alpha = 0.008$ .

**Table: 4.9** *The prevalence of Mental Health of health care professionals who intention and do not intention to leave to other sectors by profession group (N = 102)*

		MHC-SF Three Category of Positive Mental Health					
		No (N=22)			Yes (N=80)		
		Languishing	Moderate	Flourishing	Languishing	Moderate	Flourishing
		Count	Count	Count	Count	Count	Count
Profession	Health Officers	1(1.25%)	14 (17.25%)	20 (25.61%)	9 (40.9%)	0 (0.0%)	0 (0.0%)
	Midwives/ Nurse	3 (3.75%)	10 (12.25%)	27 (33.75%)	13 (59.1%)	0 (0.0%)	0 (0.0%)
	Doctor	1(1.25%)	3 (3.75%)	1(1.25%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Total	5(6.25%)	27 (33.75%)	48(.60%)	22 (21.60%)	0 (0.0%)	0 (0.0%)

The present study results (Table: 4.9) have shown that out of a 22 professionals who intention to leave to other sectors all of them (40.9% health officers and 59.1% midwives Nurse) were poor mental health represented. Contrast from the above result out of a total of 80 professionals who don't have intention to leave to other 48 (33.75% midwives Nurse, 25.61% health officers and 1.25%) of professionals were positive mental health, 6.25% were represented poor mental health and 33.75% were represented moderate mental health among professionals who don't have intention to leave to other sectors. That confirm that all health care professionals who have intention to leave to other sectors were poor mental health represented.

#### 4.6 Correlation (r) and Chi-square Analysis

**Table: 4.10** Results of Bivariate Correlation (r) Analysis

Correlations								
	1	2	3	4	5	6	7	8
PSS_Con	1	-.580**	-.559**	-.574**	-.550**	.373**	.672**	.147
MHC_Total		1	.882**	.984**	.987**	-.293**	-.793**	-.310**
Emotional			1	.812**	.838**	-.268**	-.820**	-.304**
Social				1	.960**	-.277**	-.740**	-.286**
Psychological					1	-.297**	-.774**	-.313**
Revealed their workplace identity to people to know						1	.404**	.267**
Health care professionals intention to leave to other sectors							1	.359**
Experience								1

\*\* . Correlation is significant at the 0.01 level (2-tailed).

Pearson correlation test was conducted to know the relationship between the variable, which is self-stigma, stress and MHC-sf total score. The results of the

correlation between these variables are shown in table 4.9. Cohen and Holliday (as cited by Bryman and Cramer (1999)) proposed the range of correlation coefficient as 0.39 = low; 0.40 to 0.69 = modest; 0.70 to 1 = high. For this study the researcher used correlation coefficient range of Cohen and Hollidays (1982).

As depicted above, Table 4.9 shows that the four self-stigma, health care professionals intention to leave, perceived stress and psychological wellbeing correlated with each other. Self-stigma ( $r = .373$ ,  $p = 0.01$ ) has significant positive correlation with perceived stress. Health care professionals who delivered abortion service high self-stigmatized have the higher the possibility to get perceived stress.

The highest correlation was between mental health and Health care professional's intention to leave to other sectors ( $r = -.793$ ,  $p = 0.01$ ). This it indicates that there is a strong negative relationship between mental health and Health care professional's intention to leave to other sectors.

Also self-stigmatized negative relation with mental health score ( $r = .580$ ,  $p = 0.01$ ). The implication is that health care professionals who delivered abortion service have higher self-stigmatized were less expected for mental health.

Similarly total perceived stress negative relation with total mental health score ( $r = -.580$ ,  $p = 0.05$ ), with emotional ( $r = -.559$ ,  $p = 0.05$ ), with social ( $r = -.574$ ,  $p = 0.05$ ) and with psychological ( $r = -.550$ ,  $p = 0.05$ ). The implication is that health care professionals who delivered abortion service have positive mental health score are less expectation for perceived stress.

Result indicates that there is a strong positive relationship between social and psychological subscale. Next to perceived stress, revealed their workplace identity to people to know and health care professionals intention to leave to other sectors moderet and significantly correlated,  $r = .404$ ,  $p < .01$ . After that Personal Growth and purpose in life strongly and significantly correlated,  $r = .883$ ,  $p < .01$ .

Results of the Pearson correlation also revealed that a significant negative correlation between MHC total score and revealed their workplace identity to people to know  $r = -.293$ ,  $p < .01$ . A Strong significant negative correlation between MHC total score and Health care professionals intention to leave to other sectors  $r = -.793$ ,  $p < .01$  showing that higher in MCH has associated with low health care professionals intention to leave to other sectors. In general, Stigma, stress and psychological well-being has negatively and significantly correlated each other. But health care professionals intention to leave to other sectors revealed their workplace identity to people to know positively correlated  $r = -.293$ ,  $p < .01$ .

**Table: 4.11** *The Association between levels of stress and sub-scale pf psychological well-being*

Chi-Square Tests			
	Value	df	P-value
Pearson Chi-Square	64.068	4	.000
Likelihood Ratio	69.673	4	.000
Linear-by-Linear Association	29.138	1	.000
N of Valid Cases	102		

As presented in table 4.10, a chi-square test of independence was performed to examine the relation between three level of stress and sub-scale of psychological well-

being. The finding of the study indicated that there was statistically significant relationship was found between perceived stress level and psychological wellbeing,  $X^2$  (64.068, N = 102)  $p > 0.05$ .

Numbers of abortion delivery were negatively related to emotional social, psychological and well-being.

**Table: 4.12** *The Association between self-stigma and intention to leave*

Chi-Square Tests			
	Value	df	P-value
Pearson Chi-Square	16.655 <sup>a</sup>	1	.000
Likelihood Ratio	23.997	1	.000
Linear-by-Linear Association		1	.000
N of Valid Cases	102		

As presented in Table 6.1, the computed chi-square test of independence finding of the study indicated that there was statistically significant relationship was found between self-stigma (nominal variable) and intention to leave for health care professionals (nominal variable). Hence, stigma can be considered as one of the determinant factors of health care professionals have intention to leave their profession.

## **CHAPTER FIVE**

### **DISCUSSION**

According to the World Health Organization, safe abortion is a procedure for terminating a pregnancy that is performed by an individual with the necessary skills, or in an environment that conform to have a minimal medical facility, (WHO,2012). In Ethiopia, safe abortion contributes to minimize maternal morbidity and mortality, especially among adolescents. However, still availability and access to safe abortion services is limited leading to clandestine, unsafe abortions with their attendant complications including maternal mortality.

Health care professionals providing abortion services were highly stigmatized in developing society with untold ramifications. There was lack of research to clarify the heavy burden stigma and stress places on women and health care professionals who provide abortion services (Patience, Beverley and Susannah, 2016).

#### **5.1 Self-stigma and health care professionals**

Our study result show that majority of health care professionals who provides abortion service at DKT Ethiopia partner clinics are having self stigma. They believe that they are stigmatized by the wider community. Health care professionals who are known in participating in abortion service in Africa are generally not respected. They may be called informally as murderers and sometimes hated and discrediting from their communities (Norris, 2011; Patience, Beverley and Susannah, 2016).

The result indicates that two out of three health care professionals who deliver abortion service are having experience stigma. We have seen in our study many providers

share these self-stigmatizing attitudes. Stigmatization also affects health care professionals who provide abortions as well as people who support seeking abortions (DKT, 2018). The present finding is consistent with the study of Norrist et al. (2011), Health care providers who dispense abortion medication and work in facilities that provide abortion services are also affected by stigma.

Some health care professionals were less concerned about community members' negative attitudes towards abortion service and deliver abortions because they believed it was their duty. A study in Ghana, those health care professionals who conducted abortions considered themselves as "brave people" doing important work for the community (Donnell, and Freedman, 2011). Health care professionals put more emphasis on the positive aspects of abortion, while avoiding those negative complainers.

However, studies have shown how such stigma is manifested in providers nurse/midwives spoke of ethical dilemmas they faced regarding their professional obligations and untold beliefs, it has been reported elsewhere that professional difficulties with anti-abortion colleagues was some of the effects of stigma associated with abortion (Sarah, Sahai, Dawit, Ryan and Aster, 2018).

In this study, result shows majority of nurse-midwives appeared more guilt and their views may be reflected the cultural/religious values of their surrounding communities (Emily et al., 2019). Ethiopian midwives are typically socialized in a cultural milieu that denounces abortion so they have inculcated in their minds that abortion is sinful (Emily et al., 2019; Sarah, et al, 2018). In contrast medical doctors were

less self-stigmatized themselves and less influenced by health care workers not involved in abortion provision.

Studies conducted Clarke et al. (2000), also evaluated the influence of stigma with abortion providers where abortion is illegal reveal that they frequently feel isolated from their friends and that they are afraid to speak openly about their abortion duty.

Stigma prevents many educated, trained, abortion health care providers from speaking about their abortion related work. The present finding 65.28 % of participant doesn't want to revealed their workplace identity and speck about their duty.

Therefore, the image of the abortion provider is circulated by those who oppose abortion as heartless and merciless. Providers do not identify with this image, will not prefer to speak about their duty (Lisa, Michelle and Lisa, 2011).

Results revealed that almost one fourth of study participants who provide abortion service in DKT Ethiopia partner clinics had intentions to leave their service provision. The loss of trained professionals might hold severe cost and productivity implications for current abortion health care system (DKT, 2018; Son, Kim & Kim, 2014). The intention to leave by health care professionals, the so-called brain drain, was found in studies in higher medical service environment (Theron et al., 2014).

Effects of abortion self-stigma also were found among health care professionals who provide abortion service. Providers of abortion service reported that they perceived self-stigma related to their care service, which had the potential to reduce the quality of their professional continuity (Alison et al.,2011). It might keep health care professionals

from providing abortion services, thus increasing the barriers women face in trying to obtain safe and timely abortion related treatment.

Social support is defined as a provision of physical and psychological resources that increased person's ability to deal the stress (Alonso et al., 2009). Thus, social support incorporated the provisions of instrumental support, task assistance, informational support, guidance that facilitates the individual's coping or problem-solving etc. Further social support is a provision of emotion and provision of concern and empathy to an individual (Malecki and Demaray, 2006).

In other words, social support is functional to moderate the relationship between stigmatization and mental health problems. When social support is goes down from positive to negative stress anxiety, and depression are goes high (Alison et al.,2011). As such, for the health care professionals who came from abortion service delivery, social support more likely played an important role in minimizing the negative effects of stigmatization on health care professional's mental health.

Moreover, social support can enhance emotional health, which is very important to alleviate psychological distress (Donenberg, 2005). When the level of social support is increased the negative effects of stigmatization on one's psychological health can be weakened. The high level of social support means individual can get have more and better social support, such as emotional support from subordinate and colleagues. This can help health care professionals who affected by stigma to develop positive self-awareness and reduce unhelpful emotions (Thompson, Noel and Campbell, 2004).

## 5.2 The level of perceived stress among health care professionals

Stress might be measured from different perspectives, like as the environmental, biological and psychological ones (Dawe Montgomery, 2016). The Perceived Stress Scale (PSS) used in this study is a psychological model characterized by measuring the overall perception of stress. Some documents indicate that self-reported questionnaire are generate evidence of self-knowledge level and stress management, as well as provide a significant number of health and wellness indicators (Brown and Ryan, 2003; Lopes and Martin, 2011).

The overall mean perceived stress scale score in the study participants was 15.01, with a standard deviation of 11.89. The mean perceived stress scale score was higher (16.87) in the, midwives followed by health officers (14.45) and doctors (.55). As presented in table 4.7, the computed one way ANOVA finding of the study indicated that there was a statistically significant relationship was found between professional group (Doctors, Health officers and midwife nurse) and perceived stress continuous score at  $F = (4.801) = P = 0.010$  among health care professionals.

The study result shows that there is a significant difference between health care professionals who provide abortion service in DKT Partner clinics. In face of so many work demands, it has been observed that the health care professionals who provide abortion services are exposed to psychosocial and environmental hazards related to work generating psychological symptoms associated with abortion related stress (Marcelo, 2017).

Results obtained from this study were higher levels of perceived stress were observed among midwives/ nurses in relation to health officers and doctors. Still in relation to the category, there were statistical differences in perceived stress levels of doctors, nurses and health officers. A document supported that midwifery/ nurses, which could be explained by having high perception of work overload as from the abortion care team (DKT, 2018; Sarah, Sahai, Dawit, Ryan and Aster, 2018; Alison et al.,2011). Among the symptoms of the stress, people report feeling hopelessness, overwhelmed, exhausted, lonely, sad, and so depressed that it was difficult to function.

This study is similar result with a study done by Susmita, Akash and Mahato (2013), Stress and psychological well being status among health care professionals. Stress level was obtained in varying degree among different health care professionals, while nurses and technicians had stress at high level. (Susmita, Akash and Mahato,, 2013).

The present finding shows higher perceived stress levels were also found among professionals with intention to leave there abortion delivery service compeered to those who continue their service provision in DKT partner clinics. Excessive stress is a means for emotional, physical and mental exhaustion of burnout and termination. As the stress continues, health care professionals who provide abortion service begin to lose the interest and motivation on a certain level of duty (Alison et al.,2011).

Considering the risks of burnout tend to be highest for midwifery, it would stand to reason that the doctors group of health care professionals in the current study reported experiencing less stress on average than the midwifery. Those who experienced high

levels of stress early in their abortion service provision may have previously left the profession due to burnout or attrition (Kornelia, Jolanta, Hanna, Michał and Grzegorz, 2020). As a result, might keep potential professionals from offering abortion services, thus contribute to increasing the barriers obtain safe and timely abortion care for needy (Marcelo, 2017). Stress among health care professionals is having the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment.

### **5.3 level of psychological well-being of health care professionals**

The three dimensional perspective of flourishing at work confirmed the inclusion of the feeling well (emotional well-being) and functioning well (psychological and social well-being) dimensions, as adopted in the model of Keyes (2008).

The main objective of the current study is to examine psychological wellbeing of health officer's doctors and midwives/ nurses in DKT Ethiopia partner clinics, Addis Ababa city. The research question states that: 'level of psychological well-being of health care professionals in Psychological wellbeing. Statistical method of one way ANOVA has been applied to measure between professional groups.

Result of the study it was found that overall score of doctors and nurses didn't significantly differ in their psychological wellbeing. Midwife/ Nurse are 26.4% flourishing well-being and 16, 15.71% languishing well-being. Health officers are 19.6% flourishing well-being and 10, 9.7% languishing well-being. With relatively few reporting were by Doctors with a level languishing and flourishing 98% and 2.9% moderate well-being.

This study result is similarly supported by Vicenta & Santiago (2007), in their study entitled Psychological wellbeing at work place characteristics among emergency medical and nursing staff? The finding of the study shows that Doctors demonstrated a greater prevalence of poor mental health, and emotional exhaustion related to nurses.

In contrast to the current study, in some researches there were conducted in Bangalore City, India. The study examines the level of psychological well being among doctors and nurses it was found that overall score of doctors and nurses did not differ significantly in their psychological wellbeing (Madhuchandra and Srimathi, 2016).

Results revealed that almost a one fourth of health professionals had intentions to leave their service provision. All respondents reported who intention to leave there professional duty have poor psychological well-being. Flourishing well-being, relates to employees' aspects of their current duty in relation to their desires and job satisfaction. Health workers having languishing well-being are having unpleasant emotions experienced in the duty context, because of events such as stress and guilt (Rojas & Veenhoven, 2013). According to Dinener and Biswas (2008), happy people tend to live longer, healthier, have more satisfying in jobs, and have social support.

Poor mental health at work associated with a large percentage of variance in intention to leave, which suggests that health care professionals who do languishing might think of leaving their professional duty. This result is supported by findings that low intentions to leave are explained by languishing at work (Diedericks & Rothmann, 2014; Swart & Rothmann, 2012). Languishing is characterized by low levels of social, psychological and emotional well-being. Research showed that languishing individuals

are at equal risk of physical disease, healthcare utilization, work productivity, and psychosocial functioning as people who are mentally ill

The possibility to influence wellbeing through the use of simple psychological interventions, have increased the popularity of wellbeing and mental health promotion within the professional duty (Bonde, 2008). Social support makes difference for mental health such positive mental health is a valuable component for both individual and organizational outcomes (Liewellyn Ellardus Van zyl and Chantal Olckers, 2019). Poor mental health is related to lower academic achievement, eating disorders, mood disorders, substance abuse, higher risk for sexual diseases, and violence. Adolescents suffer from mental health problems at some point in their lives

With respect to the professional level, persons with high amounts of psychological wellbeing were among others found to function much better at the workplace. This excellent functioning is illustrated through the increased efficiency and capacity to perform at work, through the enhanced initiative, interest and responsibility, as well as through a heightened concern for the organization and the colleagues (Fairbrother and Warn, 2003).

Emotion regulation components (reappraisal and suppression) and mental health in various different samples shows positive relation. They separately investigated the link with symptom-related outcomes depression and anxiety and indicators of psychological well-being. Significant negative relationships between Emotion regulation suppression and well-being were found. Emotion regulation reappraisal was found to be positively correlated with well-being outcomes and similar inverse correlations were found with

symptom-related outcomes (Hu, 2014). Although results suggest that emotion regulation might also be relevant in the context of positive psychological well-being.

In general, research indicates that emotion regulation is an important factor in the context of psychopathology and suggests that it might also be related with well-being. Study findings indicate that emotion regulation plays an important role in the context of well-being. Several specific strategies as well as overall deficits in emotion regulation have been found to be related with well-being. (Hu, T. , 2014; Aldao A. and Nolen Hoeksema S, 2012; Gratz and Roemer, 2004). Furthermore, my study was cross-sectional and the results do not account for mental health of health care professionals in general.

#### **5.4 The relationship between psychological well-being and perception of stress among abortion healthcare professionals.**

Result analysis revealed that the research question, asking that a significant statistical relationship exists between psychological well-being and perceived stress in health care professionals. The results showed that overall psychological wellbeing had correlated with perceived stress ( $r=-.580$ ,  $p<01$ ). The results also revealed that MHC-SF instrument three subscale (emotional, social and psychological) scores had a statistically significant relationship with perceived stress. Scores on overall psychological well-being, as well as on the three subscales of emotional, social, and psychological seem strongly negatively related to perceived stress. High perceived stress was contributing significantly to negative relations with the subscales emotional ( $r=-.559$ ), social ( $r=-.574$ ), and psychological well-being( $r=-.550$ ).

A moderate and high scorer on the emotional well-being subscale would have a sense of life direction, and find meaning in today and tomorrow's purpose to life. A low scorer on emotion cannot find importance or logic of satisfaction and happiness in life, lacks goals, and does not hold beliefs that provide life with sense.

A low scorer on social well-being would have few close relationships and have difficulty showing concern for community, and be isolated due to frustration with social and interpersonal relationships.

Our result points out that perceived stress significantly correlates and decreases psychological well-being. In other words, high perceived stress makes health care professionals who provide abortion service more reactive to negative events.

The findings in this case go in line with a study at Sofia University, Department of Psychology. Perceived stress was significantly and negatively correlated with psychological well-being among health-related work environments with higher risk groups (Biserka, and Sonya, 2018). Results suggest that perceived stress has a direct correlation on psychological well-being among DKT Ethiopia partner clinic professionals. We believe that perceived stress and emotional, social and psychological stability share well-being components and through this shared component perceived stress reveals significant associations with psychological well-being.

High status of stress has an adverse and negative effect on each subscale of psychological well-being of health care professionals who provide abortion service in DKT Ethiopia partner clinics. It means that psychological well-being is negatively

affected by the stress which leads to various negative consequences and affects the professional achievements and organizational goal.

With respect to what was learned from the literature, it appears that helping professionals is a crucial aspect in the training of health care professionals (Roach & Young, 2007). One finding of this study was to rule out inaccurate perception in about stress and psychological well-being during training for abortion providers.

Health care professionals are help women who seeking abortion deal with a countless of issues in order to guide their clients toward an abortion and healthier life. The research is abundant when it comes to demonstrating the positive effects counseling can have on the lives of clients (Hunsley & Lee, 2007; Minami et al., 2007). Research on the psychological wellness of healthcare professionals, who delivering abortion often bring with them unresolved stress and stigma issues from their community or from some past experience, and they need to be addressed.

Moreover, and importantly, the current study also showed that there was indirect effect of self stigma on psychological well-being. Based on the existing literature, we suggest that stigma might exert such effects on both psychological by increasing levels of stress. Stigma itself has been identified as a stressor (Springer, 2009; Link and Phelan, 2006). The present study showed that stress and mental health are related with each other and that abortion health care providers who perceived more stress had a worse positive mental health score than those who didn't perceive that much stress. This should be seen as a motivation to offer the prevention of mental ill health.

## CHAPTER SIX

### CONCLUSION RECOMMENDATION

#### 6.1 Summary

The current study set out to measure the level and association of self-rated stigma, level of psychological well-being and level of perceived stress along with intention to leave the abortion delivery profession in a population of DKT Ethiopia partner clinics doctors, both midwife nurse and health officers, working within a abortion delivery service.

The following major findings were found from the analysis of the quantitative data: Using descriptive technique on that respondent were 64 (62.7%) were health care professionals doesn't willing to reveal their workplace identity to people to know. Whereas 38 (37.3%) were health care professionals willing to revealed their workplace identity to people to know.

Further study findings shows that almost twenty three percent of the participants perceived health professional as being stressful. The rest of health professionals 19.5% moderate and 57.8 % low stressful.

A majority of the study participants 47.05% experienced flourishing (positive mental health) well-being, and 26.47%, 26.47% experienced moderate and languishing (poor mental health) well-being respectively. Midwife/ Nurse (n = 27, 26.4%) flourishing well-being (10, (9.8%)), moderate levels and (n = 16, 15.71%) languishing well-being respectively.

Pearson' correlation was applied to examine the correlation between the perceived stress and dimensions of psychological well-being among health care professionals in DKT partner clinics. A moderate negative correlation was found between perceived stress and all the dimensions of psychological well-being. Furthermore, based on the correlation analysis findings show stigma, stress, emotional, social and psychological well-being had an association with intention to leave.

## **6.2 Conclusion**

The outcomes of this research study direct us to conclude that self-stigma and stress is shown in health care professionals who provide abortion service in DKT Ethiopia partner clinics. Guilt is might be one of the stressor of perceived stress among abortion service providers. Self-stigma and perceived stress are correlated. Further, we can conclude there is a relationship exists between psychological well-being and perceived stress in health care professionals at DKT Ethiopia partner clinics.

In addition, the study also concludes that these health care professionals who provide abortion service their perceived stress level were related with psychological well-being.

One destructive effect of stigma may be that health care professionals are unable to receive social support and stress is a barrier to providing abortions. We can conclude that that stigma and stress leads some health care professionals to refuse to providing abortions and intention to leave this profession.

We have been able to confirm the model, where self stigma related with perceived stress. Thus we can observe that the intensity of perceived stress is associated with initial

characteristics of one's self-stigmatization. This result pushes us to conclude that self-stigmatized people may be as vulnerable to negative effects of stressful events and unstable psychological well-being. Result revealed that high perceived stress and emotional, social and psychological well-being has correlated.

Generally, Health care professionals didn't have intention to leave to other sectors was more inclined to have moderate and positive emotional, social and physical psychological well-being. Therefore, DKT Ethiopia needs to conduct a psychological, social, and academic counseling for the health care professional's intention to leave to other sectors in order to reduce stress among them.

### **6.3 Recommendations**

This recommendation is made in light of myacknowledgement that more than two third of abortion providers also face stigma and one fourth of stressed while making abortion services. These providers are to be commended for working diligently to ensure continued access to abortion, particularly in challenging times when stigma is prominent.

Health care providers silence in response to abortion stigma unwittingly reproduces stereotypes. Interventions such as the providers training and workshop, might eventually foster a more open dialog in which stereotypes are shattered, community status will grow, and attitudes and discourse may be revised and revitalized.

Therefore, we should strengthen social support and emotional enhancing behavioral education for this can bring a positive influence on self-stigma, stress and create enabling environment for health care professionals to improve the motivation to use current profession. In general the following are recommended.

- Training in abortion care systematically integrated stigma and stress counseling and coping strategies. Provide training and counseling service regarding of providers counter the negative effects of abortion stigma with positive beliefs.
- Facilitate workshops and experience exchanging platform for abortion providers actively support each other. It is that nurses and midwives, especially in DKT partner clinics, be encouraged to document best practices and publish these so that knowledge can be shared
- Improving access to counseling and better health care support for those stigmatized. Such as like, partnerships with different counseling agencies can increase the psychological competency of healthcare professionals. In terms of improving access DKT Ethiopia should partnerships with counseling service provider and a key in decreasing stress and improving psychological well-being among abortion health care providers.
- To study a larger sample of abortion service providers from other institutions across the country that would also be beneficial and enhance generalization.

Another recommendation would be to conduct a qualitative study. A qualitative study that focused on the self stigma and perceived stress of abortion service providers would provide valuable information on the psychological history of health care professionals as well as their own experiences.

## Reference

- Adamu, R., Mulatu, M. and Haile, S. (2003). Patterns and correlates of sexual initiation, sexual risk behaviors and condom use among secondary school students in Ethiopia. *Ethiopian Medical Journal*, 14, 163-177.
- Aldao, A. (2013). The future of emotion regulation research: capturing context. *Perspect. Psychol. Sci.* 8, 155–172. doi: 10.1177/1745691612459518
- Aldao A. and Nolen S. The influence of context on the implementation of adaptive emotion regulation strategies *Behav Res Ther*, 50 (2012), pp. 493-501
- Alison N, Danielle B, Julia R. Megan L. Kavanaugh, Silvia De Zordo, PhDe, Davida B Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences , Received 23 October 2010; Received in revised form 25 January 2011; Accepted
- Almeida, D. M., Wethington, E., and Kessler, R. C. (2002). The daily inventory of stressful events. *Assessment* 9, 41–55.
- Afsaneh N, Robert b., Janet V. Denhardt A, Maria P. Aristigueta (2015). *Organizational behavior*.
- Alonso, J.; Buron, A.; Rojas-Farreras, S.; Graaf, R.D.; Haro, J.M.; Girolamo, G.D.; Bru\_aerts, R.; Kovess, V.;Matschinger, H.; Vilagut, G.(2009) Perceived stigma among individuals with common mental disorders.*J. A\_ect. Disord.* 2009, 118, 180–186. [CrossRef] [PubMed]
- Babbie, E., & Mouton, J. (2004). *The practice of social research*. Cape Town: Oxford University Press.

Bandewar S. Abortion Services and Providers' Perceptions: Gender Dimensions.

Econ Polit Wkly. 2003;38(21):2075–81.

Best, John W. and Kahn J.V. (2005). *Research in Education*. New Delhi. Prentice

Hall of India.

Biserka Z, and Sonya K, (2018) Stress and well-being “St. Kliment Ohridski, Faculty

of Philosophy, All content following this page was uploaded by Biserka

Zarbova on 22 January 2018

Bonde, J.P.E. (2008) ‘Psychosocial Factors at Work and Risk of Depression: A

Systematic Review of the Epidemiological Evidence’, *Occupational and*

*Environmental Medicine* 65, 438–445

(<http://doi.org/10.1136/oem.2007.038430>).

Brown KW, Ryan RM. The benefits of being present: Mindfulness and its role in

psychological well-being. *J Pers Soc Psychol* 2003; 84: 822-48.

CRR (2009) *Defending Human Rights, Abortion Providers Facing Threats,*

*Restrictions, and Harassment* © 2009 Center for Reproductive Rights

Printed in the United States Center for Reproductive Rights.

Chandra A and Batada A (2006) Exploring stress and coping among urban African

American adolescents: the Shifting the Lens study. *Prev Chronic Dis* 3:

A40.

Chaturvedula S, and Joseph C.(2007) Dimensions of psychological well-being and

personality in military aircrew: A preliminary study. *Indian Journal of*

*Aerospace Medicine*, 2007; 51(2): 17–27.

- Cockrill K., Herold, S., Blanchard, K., Grossman, D., Upadhyay, U., Baum S.  
(2013). Addressing Abortion Stigma through Service Delivery White Paper authored by Sea Change, Ibis Reproductive Health, and ANSIRH
- Cohen, L. and Manon, L. (1994). *Research Methods in Education*. 4<sup>th</sup> .ed. London and New York: Routledge. Crawford. [https://www.ansirh.org/sites/default/files/publications/files/addressing\\_abortion\\_stigma\\_through\\_service\\_delivery.pdf](https://www.ansirh.org/sites/default/files/publications/files/addressing_abortion_stigma_through_service_delivery.pdf)
- Cohen S, Kamarck T, Mermelstein R.(1983). A global measure of perceived stress. *J Health Soc Behav*. 1983;24(4):385–396. doi:10.2307/2136 404
- Creswell, J.W. (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches (3rd ed.)*. London: SAGE Publications Inc.
- Cox T, Griffiths A, Rial-Gonzalez E (2000). *Research on Work-Related Stress*. Luxembourg: Office for Official Publications of the European Communities.
- Dawe K, Montgomery A, Mcgee H, Panagopoulou E, Morgan K, Hackshaw L, et al. The effects of perceived stress on biological parameters in healthcare professionals: a systematic review. *J Health Psychol* 2016; 21(5): 607-18.
- Diener, E. (2000) Subjective wellbeing: The science of happiness and a proposal for a national index. *American Psychologist*, 55, 34-43.
- Diener , E., and Biswas Diener.(2008) DIENER, E. & R. BISWAS-DIENER (2008) *Rethinking Happiness: The Science of Psychological Wealth* (Malden, MA: Blackwell).

- DKT (2018) Baseline survey on unsafe abortion in Ethiopia, Dkt Ethiopia, 45-50  
Published online MM DD 2014.
- Donenberg, G.R.(2005) Youths and HIV/AIDS: Psychiatry's role in a changing epidemic. *J. Am. Acad. ChildAdol. Psychiatry* 2005, 44, 728–747.  
[CrossRef] [PubMed]
- Donnell J, and Freedman LR (2011). Resistance and vulnerability to stigmatization in abortion work. *Social Science and Medicine*. 2011;73:1357–64.
- Donnelly A., O'Reilly A., Dolphin L., O'Keeffe L., and Moore1 J. (2019).  
Measuring the performance of the Mental Health Continuum-Short Form (MHC-SF) in a primary care youth mental health service *Irish Journal of Psychological Medicine* (2019) doi:10.1017Access Volume 36, Issue 3September 2019 , pp. 201-205
- Dornyei, Z. (2007). *Research Methods in Applied Linguistics: Quantitative, qualitative and Mixed Methodologies*. Oxford: Oxford University Press.
- Ellison, M. A. (2003). Authoritative knowledge and single women's unintentional pregnancies, abortions, adoption, and single motherhood: social stigma and structural violence. *Medical Anthropology Quarterly*, 17(3), 322-347.
- Emily McLean, Dawit Nima Desalegn, Astrid Blystad and Ingrid Miljeteig (2019)  
When the law makes doors slightly open: ethical dilemmas among abortion service providers in Addis Ababa, Ethiopia. *BMC Medical Ethics* (2019) 20:60 <https://doi.org/10.1186/s12910-019-0396-4>.

- Falci, C.D.; McNeely, C. (2009) Too many friends: Social integration, network cohesion and adolescent depressive symptoms. *Soc. Forces* **2009**, 87, 2031–2061. [CrossRef]
- Fairbrother K. & Warn J. (2003) ‘Workplace Dimension: Stress and Job Satisfaction’, *Journal of Management Psychology* 18, 8–21 (<http://doi.org/10.1108/02683940310459565>).
- Familoni OB (2008) An overview of stress in medical practice. *Afr Health Sci.* 2008 Mar; 8(1): 6–7. PMID:19357725
- Flinkman M, Leino-Kilpi H, Hasselhorn H., and Salanterä S. (2008) Explaining young registered Finnish nurses intention to leave the profession.
- Flanagan & Flanagan (2002), an analysis of the relationship between Job satisfactions and Job stress in correctional nurses. *Research in Nursing and Health* 25 (4), 282 – 294
- FMoH (2006). Ethiopian Ministry of Health, *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia*, Addis Ababa, Ethiopia: Ministry of Health, 2006.
- Gratz K.L. and Roemer L. (2004) Multidimensional assessment of emotion regulation and dysregulation: development, factor structure, and initial validation of the difficulties in emotion regulation scale *Journal of psychopathology and behavioral assessment*, 26 (2004), pp. 41-54
- Goffman E. (1963). *Stigma: notes on the management of spoiled identity*. New York: Simon and Schuster;

- Harries J, Cooper D, Strebel A and Colvin CJ. (2014). Conscientious Objection and its Impact on Abortion Service Provision in South Africa: A Qualitative Study. *Report Health*. 2014;11(16):1–7
- Hayes B, et al.(2015). What's up doc? A national cross-sectional study of psychological wellbeing of hospital doctors in Ireland. *BM Journal Open* 2017;7:e018023. doi:10.1136/bmjopen-2017-018023
- Heather O, Julie V, Jennifer D,; Gayatri J (2017). Measuring positive mental health in Canada: construct validation of the Mental Health Continuum—Short Form. *Health Promotion and Chronic Disease Prevention in Canada Vol 37, No 4, April 2017*
- Hinshaw SP.(2007) *The mark of shame: Stigma of mental illness and an agenda for change*. Oxford University Press; Oxford: 2007. [Google Scholar]
- Huppert FA (2009). Psychological well-being: Evidence regarding its causes and consequences. *Applied Psychology: Health and Well-Being*, 2009; 1(2): 137–164.
- Hunsley, J., & Lee, C. M. (2007). Research-informed benchmarks for psychological treatments: Efficacy studies, effectiveness studies, and beyond. *Professional Psychology: Research and Practice*, 38, 21-33. doi: 10.1037/0735-7028.38.1.21
- Hu, T. Zhang, D. Wang J., Mistry R. , Ran G. , Wang X. (2014) Relation between emotion regulation and mental health: a meta-analysis review *Psychol Rep*, 114 (2014), pp. 341-362

Ioanna V. Papathanasiou<sup>1</sup>, Konstantinos Tsaras<sup>1</sup>, Anna Neroliatsiou, Aikaterini

Roupa (2015) Stress: Concepts, theoretical models and nursing interventions *American Journal of Nursing Science* 2015; 4(2-1): doi:11648/j.ajns.s.2015040201.19 ISSN: 2328-5745 (Print); ISSN: 2328-5753

Johnson, W. B., Elman, N. S., Forrest, L., Robiner, W. N., Rodolfa, E., & Schaffer, J. B. (2008). Addressing professional competence problems in trainees: Some ethical considerations. *Professional Psychology: Research and Practice*, 39(6), 589-599. doi: 10.1037/a0014264

Joffe CE (1995). Doctors of conscience: the struggle to provide abortion before and after roe v. Wade. Boston: Beacon Press; 1995.

Jones, E. E., Farina, A., Hastorf, A., Markus, H., Miller, D., & Scott, R. (1984). *Social Stigma: The Psychology of Marked Relationships*. New York: Freeman.

Kessler RC, Avenevoli S, Costello EJ, Georgiades K, Green JG, Gruber MJ, He JP, Koretz D, McLaughlin KA, Petukhova M, Sampson NA, Zaslavsky AM, Merikangas KR (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry* 69, 372–80.

Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, 11, 625–639.

- Liewellyn Ellardus Van zyl and Chantal Olckers (2019) THE MENTAL HEALTH CONTINUUM-SHORT FORM IN ORGANISATIONAL CONTEXTS Factorial Validity, Invariance, and Internal Consistency (Received: 16 November 2018; accepted: 15 June 2019)
- Link, B. G., and Phelan, J. C. (2006). Stigma and its public health implications. *Lancet* 367, 528–529. doi: 10.1016/S0140-6736(06)68184-1  
CrossRef Full Text | Google Schola
- Lisa Hope Harris, Michelle Debbink , Lisa Martin (2011) Dynamics of stigma in abortion work: Findings from a pilot study of the Providers Share Workshop *Social Science & Medicine* 73 (2011) 1062e1070
- Lithur NO (2004). Destigmatising Abortion: Expanding Community Awareness of Abortion as a Reproductive Health Issue in Ghana. *Afr J Reprod Health*. 2004;8(1):70.
- Liu C., Wang Z., Chen J. (2011) Psychometric Properties of the Chinese Version of the Perceived Stress Scale in Policewomen. doi: 0.1371/journal.pone.0028610. (Google Scholar)
- Lopes VR, Martins MCF. Relato de Pesquisa Empírica Validação Fatorial da Escala de Resiliência de Connor- Davidson (Cd-Risc-10) para Brasileiros *Rev Psi Org Trab* 2011; 11(2): 36-50.
- Madhuchandra, M. K. and Srimathi, N. L.(2016) Psychological Well-being among Doctors and Nurses: A Comparative Study *The International Journal of Indian Psychology* ISSN 2348-5396 (e) | ISSN: 2349-3429 (p) Volume 3,

Issue 4, No. 68, DIP: 18.01.212/20160304 ISBN: 978-1-365-39398-3

<http://www.ijip.in> | July-September, 2016

Major B and O'Brien LT (2005). The Social Psychology of Stigma. *Annu Rev Psychol.* 2005;56(1):393–421.

Marge B (2008) Provision of abortion by mid-level providers: international policy, practice and perspectives *Reproductive Health Matters Journal*, 53–79  
Highgate Road, London NW5 1TL, England. Correspondence to Marge Berer (e-mail: [mberer@rhjournal.org.uk](mailto:mberer@rhjournal.org.uk)). (Submitted: 4 December 2007 – Revised version received: 3 June 2008 – Accepted: 4 June 2008 – Published online: 4 November 2008 ).

Manshor, A. T., Fontaine, R. and Chong, S. C. (2003). Occupational stress among managers: A Malaysian survey. *Journal of Managerial Psychology*, 18, 622-628. DOI: 10.1108/02683940310494412

Marcelo Marcos (2017) Perceived stress among Primary Health Care Professionals in Brazil *REV BRAS EPIDEMIOL ABR-JUN 2017*; 20(2): 286-298  
DOI: 10.1590/1980-5497201700020009

Martin LA, Debbink M, Hassinger J, Youatt E and Harris LH. (2014) Abortion Providers, Stigma and Professional Quality of Life. *Contraception.* 2014;90(6):581–587.

Mészáros V, Cserháti Z, Oláh A, et al (2013). Coping with work-related stress in health care professionals: strategies for the prevention of burnout and depression. *Orv Hetil* 2013;24;154:449-54.

- Mimura, C. and Griffiths, P. (2003). The effectiveness of current approaches to workplace stress management in the nursing profession: an evidence based literature review. *Occupational and Environmental Medicine*, 60, 10-15. doi:10.1136/oem.60.1.10.
- Minami, T., Wampold, B. E., Serlin, R. C., Kircher, J. C., Brown, G., & George, S. (2007). Benchmarks for psychotherapy efficacy in adult major depression. *Journal of Consulting and Clinical Psychology*, 75(2), 232-243. doi: 10.1037/0022-006X.75.2.232
- Moe K. (2012) Factors influencing women's psychological well-being within a positive functioning framework. Unpublished doctoral thesis, University of Kentucky, Lexington, United States; 2012.
- MoH( 2010). Ethiopia Ministry of Health, *Health Sector Development Program IV in Line with GTP, 2010/11–2014/15*, Addis Ababa, Ethiopia: Federal Democratic Republic of Ethiopia, 2010.
- Moustaka E, Constantinidis T C. (2010) Sources and effects of Work-related stress in nursing. *Health Science Journal* Volume 4(4).
- Mulumebet Zenebe & Haldis Haukanes (2019) When abortion is not within reach: Ethiopian university students struggling with unintended pregnancies *International Journal for Equity in Health* **18**, Article number: 23 (2019).
- Nieminen P., Lappalainen S., Ristimäki P., Myllykangas M., Mustonen A.M. Opinions on conscientious objection to induced abortion among Finnish medical and nursing students and professionals. *BMC Med.*

*Ethics*. 2015;**16**:17. doi: 10.1186/s12910-015-0012-1. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]

Norris A Bessett D.(2011). Abortion stigma: a reconceptualization of constituents, causes, and Consequences *Womens Health Issues* May 2011;21 Suppl 3 : 49–54.

Patience A, Beverley O'Brien and Susannah H. Mayhew (2016) Stigmatized by association: challenges for abortion service providers in Ghana Aniteye et al. *BMC Health Services Research* (2016) 16:486 DOI 10.1186/s12913-016-1733-7

Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods* [3rd Edition], Thousand Oaks, SAGE

Peplau H.(1968) *A working definition of anxiety*. Some clinical approaches to psychiatric nursing. New York: Macmillan, 1968.

Prosser D, Johnson S, Kuipers E, (1996): Mental health, “burnout” and job satisfaction among hospital and community-based mental health staff. *Br J Psychiatry* 1996; 169:334–337.

O'Driscoll M, & Brough P. (2003) Job stress and burnout. *Organisational Psychology in Australia and New Zealand*,2003;188–211.

Richardson C., Poole H.(2001) Chronic pain and coping: A proposed role for nurses and nursing models. *Journal of Advanced Nursing* 2001; 34: 659-667.

Rojas, M., & Veenhoven, R. (2013). Contentment and affect in the assessment of happiness. *Social Indicators Research*, 110, 415–431.  
<https://doi.org/10.1007/s11205-011-9952-0>

Rollinson Derek (2008) Organizational behavior and analysis

Sarah H , Sahai Bs , Dawit H , Ryan Scott and Aster Berhe (2018). Professional Pragmatism and Abortion Stigma: Assessing the Performance of the Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) among Ethiopian Midwives DOI: 10.29063/ajrh2018/v22i2.3. *African Journal of Reproductive Health* .June 2018; 22 (2): 26

*Sarah H, Sahai Bs, Dawit H, Ryan S Aster B.* (2018) Professional Pragmatism and Abortion Stigma: Assessing the Performance of the Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) among Ethiopian Midwives *African Journal of Reproductive Health* June 2018; 22 (2): DOI: 10.29063/ajrh2018/v22i2.3

Schmidt, C. (2010). Care during the termination of pregnancy-a midwife's perspective. *S. Afr. J. Obstet. Gynaecol.* 2010, 16, 2. Available online: <https://go.gale.com/ps/anonymous?id=GALE%7CA225792447&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=00382329&p=HRC&sw=w> (accessed on 3 Sep 2020)

Shellenberg KM, Moore AM, Bankole A, Juarez F, Omideyi AK, Palomino N, et al. Social stigma and disclosure about induced abortion: results from an exploratory study. *Glob Public Health* September 2011;6 Suppl 1:111–125.

Sohail M, Rehman CA 2015. Stress and health at the workplace-A review of the literature. *Journal of Business Studies Quarterly*, 6: 2152-1034.

- Sorhaindo AM, Juárez-Ramírez C, Díaz Olavarrieta C, Aldaz E, Mejía Piñeros MC, Garcia S. Qualitative evidence on abortion stigma from Mexico City and five states in Mexico. *Women Health*. 2014;54:622–40.
- Souza TS, Virgens LS. Saúde do trabalhador na Atenção Básica: interfaces e desafios. *Rev Bras Saúde Ocup* 2013; 38(128).
- Speileberg C.(1965) *Anxiety and stress*. Psychogios Editions. Athens, 1980.
- Springer, K. W. (2009). Childhood physical abuse and midlife physical health: testing a multi-pathway life course model. *Soc. Sci. Med.* 69, 138–146. doi: 10.1016/j.socscimed.2009.04.011
- Susmita H, Akash K Mahato A (2013) Stress and psychological well being status among health care professionals. *International Journal of Occupational Safety and Health*, Vol3 No 1 (2013) 32 – 35
- United Nations (2013). Social Inclusion of Youth with Mental Health Conditions. United Nations: New York. World Health Organisation (2001). Strengthening Mental Health Promotion. World Health Organisation: Geneva.
- Vicenta E, & Santiago P. (2007). Psychological well-being and psychosocial work environment characteristics among emergency medical and nursing staff. *Stress and health*, 23 (3), 153-160.
- Violetta S, Agnieszka D, Krzysztof N, Wioletta R, Aneta W, Bogusława P, Dariusz Z (2004) Family planning--the role of general practitioner in abortion prophylaxis *Wiad L Affiliations expand*. 2004;57 Suppl 1:290-4. National Library of Medicine 8600 Rockville Pike PMID: 15884260

- WHO, (2003) *Safe abortion: technical and policy guidance for health systems*. Geneva: World Health Organization; 2003 Retrieved from
- WHO (2004). World, Health Organization, Raising Awareness of Stress at Work in Developing Countries A modern hazard in a traditional working environment. Irene Houtman Karin Jettinghoff. ISBN 92 4 159165
- WHO (2015). Health worker roles in providing safe abortion care and post-abortion contraception Web Supplement 1 Evidence to Decision (EtD) Frameworks © World Health Organization 2015
- Wiersma, W. (2000) *Research Methods in Education: An Introduction*. USA: Chestnut Hill Enterprises, Inc.
- Winfield V and Lushington D (2006) Coping strategies, work environment, *Nursing journal*. June 2006; 22 (2): DOI: 10.29063/nj2006/v22i2.3
- Wright TA.(2010) The role of employee wellbeing in organizational research. In Linley P.A., Harrington S. &Garcea N. (eds.), *Oxford handbook of positive psychology and work* (pp. 143–154). New York, USA: Oxford University Press; 2010.

**Appendixes 1**

**አዲስ አበባ ዩኒቨርሲቲ**

**የሰነ-ትምህርት እና የሰነ-ባህሪ ኮሌጅ**

**የሳይኮሎጂ ትምህርት ክፍል**

**መረጃ መስጫ ቅፅ**

**የፈቃደኛነት መረጃ መስጫ ሥምምነት**

ውድ የጥናቱ ተሳታፊ

የአዲስ አበባ ዩኒቨርሲቲ የሰነ ባህሪ እና ትምህርት ኮሌጅ የሁለተኛ ድግሪ ተማሪ የመመረቂያ ጥናት ጥሁፍ ላይ እንዲሳትፉ ተጋብዞታል። እባክዎ በዚህ ጥናት ለመሳተፍ ከመስማማትዎ በፊት ከዚህቀጥሎ ያለውን ቅጽ በጥሞና ያንብቡና ወይም (ያዳምጡና) ግልጽ ያልሆነልዎትን ማንኛውንም ሃሳብ ይጠይቁ። የጥናቱ አላማ እርሶና በተመሳሳይ ህጋዊ እና በፈቃደኛነት ጽንሰ ማቆረጥ ሙያ ላይ በተሰማራችሁ ባለሙያዎች ያላችሁን የሰነልቦና እና ውጥረት ደረጃ በሚመለከት ለመጠየቅ ነው። ስለዚህ እርስዎ በዚህ ሙያ ውስጥ ስላሉ መልስ በመስጠት እንዲተባበሩን እንጠየቃለን። በዚህ ጥናት ላይ የሚያደርጉት ተሳትፎ ሙሉ በሙሉ በበጎ ፈቃደኛነትዎ ላይ የተመሰረተ ነው። በዚህ ጥናት ውስጥ ላለመሳተፍ ወይም ለመሳተፍ ከወሰኑ በኋላ ለማቆረጥ ከፈለጉም ፍላጎትዎ የተከበረ ይሆናል። በዚህ ጥናት ላይ የመሳተፎ ሚስጥራዊነቱ የተጠበቀ ሲሆን ለሚሰጠራዊነቱ ሲባል ስሞንም ሆነ ሌላ የግሉዎን መለያ መጻፍ አይጠበቅብዎትም። ግልጽ ያልሆነ ጥያቄ ካሎት ሞባይል ቁ. 0911 632433 ተማሪ መለስ ሳሙኤል ይበሉና ደውለው ይጠይቁ።

ለትብብርዎ በቅድሚያ ምንጋናችንን እንገልጻለን።

ቅድመ ናሙና መለያ ጥያቄ

**ማሳሰቢያ:** የብድኤቲ ኢትዮጵያ አማካኝነት በተዘጋጀ ህጋዊ እና በፈቃደኛነት ጽንሰ ማቆረጥ ሙያ ላይ ስልጠና ላይ ተካፍለው ከሆነ በቻ ነውይህንን መጠየቅ መሙላት የሚጠበቅብዎት

**ክፍል 1: የመሠረታዊ መረጃዎች :**

1. ጾታ ወንድ  ሴት

2. ዕድሜዎ

- 25 — 30 ዓመት
- 36 — 40 ዓመት
- 46 — 50 ዓመት
- 56 — 60 ዓመት
- 31 — 35 ዓመት
- 41 — 45 ዓመት
- 51 — 55 ዓመት
- 60 ዓመት ና በላይ

**3፣ ከፍተኛ የትምህርት ደረጃዎ**

- ዲፕሎማ
- መጀመሪያ ድግሪ
- ሁለተኛ ድግሪ
- ዶክተር

**4. የጋብቻ ሁኔታ**

- ያገባች
- ያላገባች
- የፈታች
- ባል የሞተባት /ሚስቱ የሞተችበት

**5. የስራ ሁኔታ / የተሰማሩበት ሙያ አይነት**

- ነርስ
- አዋገጅ ነርስ
- ዶክተር

**6. በጽንሰ ማቆረጥ ሙያዎ ላይ ምን ያህል አመታት አገልግለዋል ? \_\_\_\_\_**

**ክፍል 2: የስነልቦና ጭንቀት እና የስነልቦና ደህንነት የተመለከቱ መጠይቆች**

**2.1. በአለፈው አንድ ወር ውስጥ ምን ያህል ጊዜ የጽንሰ ማቆረጥ አገልግሎት ለሚፈልጉ እናቶች የጽንሰ ማቆረጥ አገልግሎት ሰጥተዋል ?**

.....ጊዜ

**2.2. የጽንሰ ማቆረጥ ሙያዎን በቅርቡ ለመተው ይፈልጋሉ ወይ ?**

- በፍጹም
- እያሰብኩበት ነው / አዎን

አዎን ካሉ ምክንያቱን ባጭሩ ቢገልጹልን.....

.....

.....

**2.3. የጽንሰ ማቆረጥ ሙያዎን በተመለከተ በሆሰፒታል ወይም በክሊኒክ ጽንሰ ማቆረጥ አገልግሎት ከሰጡ በኋላ ሰዎች እንዲያወቁበት ይፈልጋሉ ?**

- እፈልጋለሁ
- አልፈልግም

መልካም፡ እፈልጋለሁ ከሆነ ምክንያቱን ባጭሩ ቢገልጹልኝ.....

**Mental Health Continuum—short form (MHC—SF)**

<b>4. በአለፈው አንድ ወር ውስጥ በየቀኑ ምን ያህል ጊዜ እነዚህ ስሜቶች ተሰማዎት</b>						
በቀረቡት አማራጮች ውስጥ አነድ መልስ ይስጡ :: መልሱንም በቁጥር ተወክለዋል						
5-ሁል ጊዜ	4-አብዛኛውን ጊዜ	3-ገሚሱን ጊዜ				
2-ጥቂቱን ጊዜ	1-በወር አንድ ጊዜ	0- በፍጹም				
<b>የስሜት ደረጃዎን በተመለከተ</b>						
1. በህይወቴ ደስተኛ ነኝ	0	1	2	3	4	5
2. ለህይወቴ ፍላጎት አለኝ	0	1	2	3	4	5
3. በህይወቴ እረካለሁ	0	1	2	3	4	5
<b>የማህበራዊ ግንኙነት ደረጃዎን በተመለከተ</b>						
4. ለህብረተሰብ/ ማህበረሰብ ሚጠቅም ያበረክቱት አስተዋፅኦ እንዳለ	0	1	2	3	4	5
5. ማህበረሰባዊ አንቅስቃሴዎች ላይ ተሳተፈው ከሆነ (እንደ ማህበራዊ አንቅስቃሴ ፣ ትምህርት ቤት ወይም ከአካባቢዎ ነዋሪ ጋር)	0	1	2	3	4	5
6. ህብረተሰባችን ለሁሉም ሰው ጥሩ ነው ወይም የተሻለ ቦታ እየሆነ ነው	0	1	2	3	4	5
7. ነዋሪዎቼ/የአካባቢዬ ሰዎች በመሠረቱ ጥሩ ናቸው	0	1	2	3	4	5
8. ማህበረሰባችን/ህብረተሰባችን የሚሰራበት መንገድ ለእርስዎ ሚስጦት ትርጉም አለ	0	1	2	3	4	5
<b>የስነ-ልቦናዎን ደረጃዎን በተመለከተ</b>						
9. አብዛኛዎቹ የግል ባህሪዎችን ይወዱታል	0	1	2	3	4	5
10. በዕለት ተዕለት ሕይወትዎ ውስጥ ያሉትን ኃላፊነቶች በጥሩ ሁኔታ ያስተዳድራሉ	0	1	2	3	4	5
11. ከሌሎች ጋር ሞቅ ያለ እና እምነት የሚጣልበት ግንኙነት ነበርዎት	0	1	2	3	4	5
12. እንዲያድጉ እና የተሻሉ ሰው እንዲሆኑ የገጠሞት ፈተና አነዲሁም ልምዶች ነበሩ	0	1	2	3	4	5
13. የራስዎን ሀሳቦች እና አስተያየቶች ለማሰብ ወይም ለመግለጽ ያለዎት በራስ መተማመን	0	1	2	3	4	5
14. ሕይወትዎ አቅጣጫ ወይም የሕይወት ትርጉም እንዳለው ይሰማዎታል።	0	1	2	3	4	5

**ንዑስ ክፍሎች፡** U. የስሜት ደረጃዎን ፡ ቁጥር 1፣2፣3፣

ለ. የማህበራዊ ግንኙነት ደረጃዎች : ቁጥር 4፣5 ፣6፣7፣8

ሐ. የስነ-ልቦናዊን ደረጃዎች: ቁጥር 9፣10፣11፣12፣13፣14፣

**Perceived Stress Scale**

5. በ ከዚህ በታች በተዘረዘሩት ጥያቄዎች በአለፈው አንድ ወር ውስጥ እርሶ የተሰማዎትን ስሜት እና ሃሳብ ለማወቅ መጠይቆች ቀርበዋል ስለሆነም ምን ያህል ጊዜ የዚህ አይነት ስሜት በአለፈው አንድ ወር ውስጥ አንደተሰማዎት በቀረቡት አማራጮች ውስጥ አንድ መልስ ይስጡ :: መልሶትም በቁጥር ተወክለዋል

0 = በፍጹም አብዛኛውን ጊዜ                      1 = እምብዛም                      2 = አንዳንዴ                      3 =  
4 = ሁል ጊዜ

1. ባለፈው ወር ውስጥ ከጽንስ ማቆረጥ አገልግሎትዎ ጋር በተገናኘ በትንሽ እና ባልተጠበቀ ነገር የተነሳ ምን ያህል ጊዜ ተቆጥተው ነበር?	0	1	2	3	4
2. ባለፈው ወር ውስጥ የጽንስ ማቆረጥ አገልግሎትዎ ጋር በተያያዘ በሕይወትዎ ውስጥ አስፈላጊ የሆኑትን ነገሮች ለመቆጣጠር እንዳልቻሉ አይነት ስሜት ምን ያህል ጊዜ ተሰምቶዎታል	0	1	2	3	4
3. ባለፈው ወር ውስጥ ከጽንስ ማቆረጥ አገልግሎትዎ ጋር በተቆራኘ ምን ያህል ጊዜ ከጽንስ ማቆረጥ አገልግሎትዎ ጋር በተቆራኘ ፍርሃት እና ጭንቀት ተሰምቶዎታል	0	1	2	3	4
4. ባለፈው ወር ውስጥ የግል ችግሮችዎን ለመቋቋም በለዎት ችሎታዎ ላይ ጽንስ ማቆረጥ አገልግሎትዎ ሳያውኩዎ ምን ያህል ጊዜ በራስ የመተማመን ስሜት ተሰምቶት ነበር?	0	1	2	3	4
5. ባለፈው ወር ውስጥ ከጽንስ ማቆረጥ አገልግሎትዎ ጋር በተጎዳኝ ነገሮች በሚፈልጉት መንገድ አየሄዱ እንዳለ ተሰምተዎታል	0	1	2	3	4
6. ባለፈው ወር ውስጥ ከጽንስ ማቆረጥ አገልግሎትዎ ጋር በተቆራኘ ምን ያህል ጊዜ ማድረግ ያለብዎትን ነገሮች ሁሉ መቋቋም እንደማይችሉ ያውቃሉ?*	0	1	2	3	4
7. ባለፈው ወር ውስጥ ከጽንስ ማቆረጥ አገልግሎትዎ ጋር በተያያዘ በሕይወትዎ ያጋጠምዎትን ብስጭት ለመቆጣጠር ምን ያህል ጊዜ ቻሉ?	0	1	2	3	4
8. ባለፈው ወር ውስጥ ከጽንስ ማቆረጥ አገልግሎትዎ ጋር በተቆራኘ ነገሮችን በቁጥጥር ስር እንዳደረጉ	0	1	2	3	4

የሚሰማዎት ጊዜ ምን ያህል ነበር?					
9. ባለፈው ወር ውስጥ ከጽንሰ ማቆረጥ አገልግሎትዎ ጋር በተገናኘ ከቁጥጥርዎ ውጭ በሆኑ ነገሮች የተነሳ ምን ያህል ጊዜ ተቆጥተው ነበር?	0	1	2	3	4
10. ባለፈው ወር ውስጥ ከጽንሰ ማቆረጥ አገልግሎትዎ ጋር በተዛመደ ምን ያህል ጊዜ ያጋጠሞት ችግሮች ከመግዘፋቸው የተነሳ ማሸነፍ እንደማይችሉ ተሰምቶዎት ያወቃል	0	1	2	3	4

**አመሰግናለሁ!!**

**APPENDICES 2**

**QUESTIONNAIRE FOR RESIDENTS**

**Community Participation on Inner-city renewal**

**Informed Consent Form**

Dear Colleague,

Thank you so much for your willingness to complete this questionnaire. This research is being conducted by a student of Addis Ababa University, in order to comply with the requirements of my studies for the Master of Art Degree in Counseling Psychology. Your participation in this study is strictly confidential. To guarantee the anonymity of your response, you should NOT write your name in the questionnaire. The questionnaire involves two major parts. The first part poses questions concerning your social and demographic background. The second part questions related to your data on Stress and Psychological wellbeing of Healthcare Professionals who Provides Abortion Service. The information I gather from you today will be used to improve Healthcare Professionals abortion health providers psychological level DKT Ethiopia partner clinics community. Kindly respond frankly, accurately and if you face any difficulty in completing this questionnaire, please call me (Mr. Melesse Samuel) on +251 911 632433.

NB> Did you received training on save abortion training from DKT Ethiopia in the last5 years ?

Yes  No

**Section 1: Dermographie Information:**

1. Please indicate your gender Male  Female

2. Indicate the house hold head age

25 – 30 years  31 – 35 years

36 – 40 years  41 – 45 years

46 – 50 years  51 and above

## 3. Educational Status

Diploma  Degree  MSc  PhD

## 4. Marital Status

Single  Married  Divorced  Window

## 5. Profession;

Health officer  Midwife/ Nurse  Doctor/ physician

6. How long do you gave abortion service? \_\_\_\_\_ Years

**2 Questions regarding working condition, stress and psychological well-being**

2.1 during the past month how many times do you performed/ or participated in abortion case

.....times

2.2 Do you have intention to leave the delivery of abortion service profession in short period of time?

Agree / strongly agree  Disagree

2.3 I was providing abortions in hospitals but I wouldn't want people to know?

Agree / strongly agree  Disagree

Emotional Well-Being: Flourishing requires “almost every day” or “every day” and languish requires “never” or “maybe once or twice” during the past month on 1 or more of the 3 symptoms of emotional well-being.						
1. Happy/	0	1	2	3	4	5
2. Interested in Life/	0	1	2	3	4	5
3. Satisfied/	0	1	2	3	4	5
<b>Positive Well-Being:</b> Flourishing requires “almost every day” or “every day” and languishing requires “never” or “maybe once or twice” during the past month on 6 or more of the 11 symptoms of positive functioning.						
4. that you had something important to contribute to society.	0	1	2	3	4	5
5. that you belonged to a community (like a social group, your school, or your neighborhood).	0	1	2	3	4	5
6. that our society is a good place, or is becoming a better place, for all people	0	1	2	3	4	5
7.that people are basically good.	0	1	2	3	4	5

8. that the way our society works made sense to you.	0	1	2	3	4	5
9. that you liked most parts of your personality.	0	1	2	3	4	5
10. good at managing the responsibilities of your daily life.	0	1	2	3	4	5
11. that you had warm and trusting relationships with others.	0	1	2	3	4	5
12. that you had experiences that challenged you to grow and become a better person.	0	1	2	3	4	5
13. confident to think or express your own ideas and opinions.	0	1	2	3	4	5
14. that your life has a sense of direction or meaning to it.	0	1	2	3	4	5

### Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.

**0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often**

1. In the last month, related to abortion service how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life regarding your abortion service?	0	1	2	3	4
3. In the last month, how often have you felt nervous and “stressed regarding your abortion duty”?	0	1	2	3	4
4. In the last month, without trouble of abortion duty how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. In the last month, related to your abortion service delivery how often have you felt that things were going your way?	0	1	2	3	4
6. In the last month, related to your abortion service delivery how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. In the last month, how often have you been able to control irritations in your life regarding your abortion	0	1	2	3	4

duty?					
8. In the last month, related to your abortion service delivery how often have you felt that you were on top of things?	0	1	2	3	4
9. In the last month, related to your abortion service delivery how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them related to your abortion service?	0	1	2	3	4