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BAHIR DAR UNIVERSITY COLLEGE OF MEDICINE AND HEALTH SCIENCE, SCHOOL OF MEDICINE, DEPARTMENT OF PSYCHIATRY

PREVALENCE, ASSOCIATED FACTORS AND CONTRIBUTING FACTORS OF DEPRESSION AMONG HEALTH PROFESSIONALS IN GOVERNMENTAL HOSPITALS IN BAHIR DAR,2024

BY BEREKET MULU (MSC IN ICCMH CANDIDATE)

JANUARY,2025

BAHIR DAR, ETHIOPIA

PREVALENCE, ASSOCIATED FACTORS AND CONTRIBUTING FACTORS OF DEPRESSION AMONG HEALTH PROFESSIONALS IN GOVERNMENTAL HOSPITALS IN BAHIR DAR,2024

A THESIS RESEARCH TO BE SUBMITTED TO DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, COLLEGE OF MEDICINE AND HEALTH SCIENCES, BAHIR DAR UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN INTEGRATED CLINICAL AND COMMUNITY MENTAL HEALTH

BY BEREKET MULU (MSC IN ICCMH CANDIDATE)

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JANUARY,2025

BAHIR DAR, ETHIOPIA

Declaration

I, the undersigned, MSc Student declare that this thesis is my original work, this thesis is submitted in partial fulfillment of the requirement for a graduate degree from the Bahir Dar University, College of Medicine and Health Sciences, School Medicine, Department of Psychiatry, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

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Approval of Thesis Report

I hereby certify that I have supervised, read, and evaluated this thesis report entitled "Prevalence, associated factors and contributing factors of depression among health professionals in governmental hospitals in bahir dar,2024" by Bereket Mulu prepared under my guidance. I recommend the thesis report be submitted for oral defense.

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Approval of Thesis Report

I hereby certify that I have supervised, read, and evaluated this thesis report entitled "Prevalence, associated factors and contributing factors of depression among health professionals in governmental hospitals in bahir dar,2024". We recommend and approve the thesis report for a degree of "Masters of science in Integrated clinical and community mental health".

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ACRONYMS AND ABBREVIATIONS

CI----------Confidence Interval

DASS----------Depression, Anxiety, Stress Scale

EMR----------Eastern Mediterranean Region

FHCSH----------Felege Hiwot Comprehensive and Specialized hospital

ICCMH ---------- Integrated Clinical and Community Mental Health

HCWS----------Health Care Workers

HIV/AIDS---------- Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome

MDD----------Major Depressive Disorder

PHQ----------Patient Health Questionnaire

SPSS ----------Statistical Package for Social Science

TGSCH---------Tibebe Gion Specialized and Comprehensive Hospital

WHO----------World Health Organization

YLD----------Years Lived with Disability

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ABSTRACT

Background: Depression is a serious mental health condition and a leading cause of disability worldwide. Health care workers are particularly vulnerable due to the high demands of their profession, which can negatively affect their well-being and the quality of care they provide.

Objective: This study aimed to assess the prevalence, associated factors and contributing factors of depression among health professionals at governmental hospitals in bahir dar,2024.

Methods: A mixed-method approach was employed at Tibebe gion and Felege hiwot comprehensive and specialized hospitals involving 421 health professionals selected through stratified sampling. Quantitative data on depression was collected using the DASS-21 questionnaire, while qualitative insights were obtained through in-depth interviews with six participants. Data collection took place from October 1–30, 2024. Quantitative data were analyzed using SPSS version 25, employing Binary logistic regression to identify significant factors ($p<0.05$), while thematic analysis using Atlas.ti 9.1 was applied to qualitative data.

Results: The overall prevalence of depression among health professionals was 37.6%. The study revealed that female health professionals had significantly higher odds of depression compared to males (AOR = 3.09, 95% CI: 1.84–5.19, p = 0.001). Single individuals were more likely to experience depression than married participants (AOR = 1.82, 95% CI: 1.09–3.04, p = 0.032). A family history of mental illness was significantly associated with depression (AOR = 1.83, 95% CI: 1.21–3.18, p = 0.02). Poor social support emerged as a strong predictor of depression (AOR = 2.07, 95% CI: 1.35–3.28, p = 0.04), and individuals aged 35-44 exhibited higher odds of depression compared to those aged 45-54 (AOR = 2.06, 95% CI: 1.23–4.90, p = 0.02). Participants with low burnout levels had lower odds of depression compared to those with high burnout (AOR = 0.54, 95% CI: 0.13–0.74, p = 0.03). Qualitative findings revealed five main themes: experiences in conflict areas, mental health challenges, factors contributing to depression, coping mechanisms, and recommendations for support.

Conclusion: This study identified factors influencing depression among health professionals, with females, single individuals, poor social support and those with a family history of mental illness being at higher risk. These findings underscore the need for targeted mental health interventions to support HCWs in high-stress environments and reduce depression prevalence.

Keywords: Depression, mental health, health care workers, DASS-21, burnout

1. INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Depressive disorder is a severe mental health condition characterized by symptoms such as persistent sadness, lack of interest or enjoyment, feelings of guilt or low self-worth, disturbed sleep or appetite, significant weight loss, fatigue, poor focus, psychomotor agitation or retardation, and recurrent thoughts of death (1). Globally, depression is the fourth most significant contributor to the burden of disease, accounting for 4.4% of total disability-adjusted life years in 2000 and ranking as the second leading cause of global years lived with disability in 2019 (2),(3). Individuals with major depressive disorder (MDD) are at an increased risk of physical illness, pain, decreased social functioning, and a 40–60% higher probability of premature death compared to the general population (4),(5).

Health professionals maintain health in humans through the application of the principles and procedures of evidence-based medicine and caring. Health professionals study, diagnose, treat and prevent human illness, injury and other physical and mental impairments in accordance with the needs of the populations they serve. They advise on or apply preventive and curative measures, and promote health with the ultimate goal of meeting the health needs and expectations of individuals and populations, and improving population health outcomes (3). Health care workers (HCWs), including doctors, nurses, and allied professionals, are especially vulnerable to depression due to the demanding nature of their roles (6),(7),(8).

In Ethiopia, the burden of depression among health professionals is significant yet often overlooked. Several studies have reported high prevalence rates, particularly among nurses, physicians, and midwives, due to excessive workloads, low salaries, limited resources, and inadequate mental health support (16). Work-related stressors, such as job dissatisfaction, poor work-life balance, and exposure to traumatic medical cases, further contribute to depression among Ethiopian health workers (17). Additionally, societal stigma and a lack of institutional mental health programs prevent many professionals from seeking psychological help, leading to untreated mental health conditions and increased burnout (9).

Despite growing awareness of mental health issues, interventions to address depression among Ethiopian health professionals remain inadequate. Existing workplace support programs, if available, are often underutilized due to stigma and a lack of integration into hospital systems (18),(19).

1.2 STATEMENT OF THE PROBLEM

Depression is a major public health concern, significantly affecting the well-being and productivity of health professionals. Globally, studies indicate that healthcare workers experience higher rates of depression compared to the general population due to prolonged exposure to stress, high workloads, and emotionally demanding environments (2),(3). A systematic review reported that the prevalence of depression among health professionals ranges from 22% to 38%, with even higher rates during public health crises such as the COVID-19 pandemic (7),(8),(20).

In Ethiopia, studies have found that depression among healthcare workers is a growing concern, with prevalence rates varying between 30% and 45% depending on the study setting (16). Despite these alarming figures, mental health issues among health professionals remain underdiagnosed and undertreated due to stigma, lack of resources, and limited access to psychological support services (2),(3).

The burden of depression among health professionals is driven by several factors, including excessive workloads, long working hours, lack of social support, job dissatisfaction, and exposure to traumatic patient outcomes (16). Additionally, factors such as female gender, younger age, poor coping mechanisms, and lack of mental health awareness have been associated with a higher risk of depression among healthcare workers (6). The consequences of untreated depression in health professionals are severe, leading to decreased job performance, increased absenteeism, higher turnover rates, and compromised patient care quality (7). Furthermore, depression has been linked to higher risks of medical errors, burnout, and even suicidal ideation among health professionals (21).

Several interventions have been implemented to address depression among healthcare workers, including workplace mental health programs, resilience training, and employee assistance programs (2),(3). However, in low-resource settings like Ethiopia, mental health support systems remain inadequate due to limited funding, workforce shortages, and cultural stigma surrounding

mental illness (9). While existing research has explored the prevalence of depression among health professionals, there remains a gap in understanding the specific workplace-related and personal factors contributing to depression in Ethiopian hospital settings. Moreover, there is limited evidence on the effectiveness of current interventions in mitigating depression among health professionals. Therefore, this study aims to determine the prevalence and associated factors of depression among health professionals in Tibebe Ghion and Felege Hiwot Comprehensive and Specialized Hospitals, providing evidence to inform targeted interventions and mental health policies.

1.3 SIGNIFICANCE OF THE STUDY

Depression among health professionals is a critical issue that affects both individual well-being and healthcare service quality. Identifying the prevalence and associated factors of depression in Ethiopian healthcare settings is essential for improving mental health outcomes and ensuring a resilient workforce. This study will provide valuable data on the extent of depression among health professionals at Tibebe Ghion and Felege Hiwot Comprehensive and Specialized Hospitals, helping to bridge the existing knowledge gap in Ethiopia's healthcare sector. Understanding the factors contributing to depression will enable policymakers and hospital administrators to develop targeted interventions that address workplace stressors, improve job satisfaction, and promote mental well-being.

The findings of this study will have significant implications for both healthcare professionals and the broader health system. By identifying key risk factors, the study can inform hospital-based mental health programs, encourage institutional support mechanisms, and guide policy reforms aimed at reducing the burden of depression. Additionally, the study will contribute to the growing body of evidence on occupational mental health in Ethiopia, supporting future research and advocacy efforts. Ultimately, this research aims to enhance the overall quality of healthcare by promoting the mental well-being of those who deliver essential medical services.

2. LITERATURE REVIEW

2.1 PREVALENCE OF DEPRESSION

Depression among healthcare professionals has been widely studied across different countries and healthcare settings, revealing significant variations in prevalence rates. A systematic review and meta-analysis conducted in Spain (2021) analyzed 57 studies from 17 countries and found that the pooled prevalence of depression among healthcare workers was 24% (95% CI: 20–28%). Among specific professional groups, the prevalence was 25% for nurses (95% CI: 18–33%), 24% for medical doctors (95% CI: 16–31%), and 43% for frontline professionals (95% CI: 28–59%).(23). and Another systematic review conducted in the United Kingdom (2020) analyzed 65 studies involving 97,333 healthcare workers across 21 countries during the COVID-19 pandemic and reported a pooled prevalence of depression of 21.7% (95% CI, 18.3%–25.2%).(24). Similarly, a study in Bangladesh (2021) examining the global prevalence of depression, anxiety, stress, and insomnia among health professionals during the COVID-19 pandemic found that among 83 studies (n = 144,649), the prevalence of depression was 37.12% (95% CI: 31.80–42.43%).(25).

A cross-sectional study conducted in China (2009) on the prevalence and associated factors of depressive symptoms among nurses found that out of 1,592 participants, 61.7% had depressive symptoms, with 74.9% of them experiencing mild depression.(26).

In Malaysia (2018), a study investigating depression among doctors reported a prevalence of 22.9%(27), whereas in Australia, a similar study found that 32.4% of healthcare professionals suffered from depression (28). A systematic review and meta-analysis of depression among healthcare workers in the Eastern Mediterranean Region (2021) analyzed 77 studies providing 122 prevalence measures across 7 countries and found a pooled prevalence of 33.03% (95% CI = 27.40–39.19%) (29). Meanwhile, a study in Iran (2021) reviewing 24 studies published between January 2019 and February 2021 estimated a prevalence of depression among healthcare workers at 26% (95% CI: 18–35%)(30).

In Turkey (2020), a study focusing on the mental health of healthcare workers during the COVID-19 pandemic found that 77.6% of participants exhibited symptoms of depression, indicating the severe psychological burden on frontline workers (31). Another mixed-methods study conducted in Iran (2021) found that the self-reported prevalence of depression among primary healthcare

workers was 42.6% (32). Similarly, an analytical cross-sectional study conducted in Bangladesh (2019) on junior healthcare professionals in public teaching hospitals found that 17.9% of participants suffered from major depression (33).

A cross-sectional study in China (2014) assessing depressive symptoms among nurses in public hospitals estimated that 38% of them experienced depression (34). In Nepal (2020), an online survey investigating stress, anxiety, and depression among healthcare workers during the COVID-19 pandemic reported that 13.1% of participants had mild depression, 10.9% had moderate depression, and 2.5% had severe or extremely severe depression based on the DASS-21 scale (35).

A study conducted in Vietnam (2016) on hospital health staff found that among 601 respondents, the prevalence of moderate-to-severe depression was 28.4% (36).In Egypt (2020), a study analyzing depression among health workers caring for COVID-19 patients reported that 28.1% of healthcare workers had mild-to-moderate depressive symptoms, while 64.8% exhibited severe symptoms. Furthermore, of the 152 participants who were interviewed using SCID-I, 74.3% were diagnosed with major depressive disorder (37).

In Ethiopia, a study conducted at Saint Paul's Hospital Millennium Medical College (2023) found that the overall prevalence of depressive symptoms among healthcare workers was 56.5% (95% CI: 51.8%–61.1%). The study reported that 35% of healthcare workers experienced mild depression, 13% had moderate depression, and 9% suffered from severe depression (38). Another study conducted at Jimma University (2016) on staff members found a lower prevalence of depression, approximately 22.9% (39).

2.2 ASSOCIATED FACTORS OF DEPRESSION

2.2.1 SOCIO-DEMOGRAPHIC FACTORS

Socio-demographic factors such as gender, marital status, and education level have been identified as significant predictors of depression among healthcare professionals. A study conducted in Bangladesh (2019) on junior healthcare professionals in public teaching hospitals found that female health workers had a significantly higher prevalence of depression (64.1%) compared to males. The study also found that unmarried individuals had a higher prevalence of depression (46.2%) than their married counterparts (33).

A cross-sectional study conducted in China (2009) found that a higher educational background was positively associated with depressive symptoms among nurses, suggesting that increased academic pressure and professional responsibilities may contribute to mental distress (26). An online survey conducted in Nepal (2020) during the COVID-19 pandemic found that female healthcare workers were twice as likely to experience depression compared to males (35). Similar findings were reported in a study conducted in Turkey (2020), where depression, anxiety, distress, and insomnia symptoms were significantly more prevalent among female healthcare workers (31). In Ethiopia, a study at Saint Paul's Hospital Millennium Medical College (2023) found that being single was strongly associated with an increased risk of depression compared to being divorced or married (38).

2.2.2 CLINICAL FACTORS

Clinical factors such as a family history of depression and chronic illnesses have been linked to an increased risk of depression among healthcare professionals. In Bangladesh (2019), a study found that having a family history of depression was associated with a 28.2% prevalence of depression, while having a chronic illness was linked to a 25.6% prevalence (33). Similarly, a study in China (2009) found that the presence of a chronic disease was associated with a 71.9% prevalence of depressive symptoms among nurses (26).

2.2.3 SUBSTANCE RELATED FACTORS

Substance use, particularly alcohol consumption, has been found to be a contributing factor to depression among healthcare professionals. A study in Bangladesh (2019) found that drinking alcohol was associated with a 5.1% risk of depression (33).Similarly, a study in China (2009) reported that 70.2% of alcohol consumers exhibited depressive symptoms, suggesting a strong correlation between alcohol use and mental health deterioration (26).

2.2.4 PSYCHO-SOCIAL FACTORS

Psychosocial factors such as life stressors, social support, and recent life changes play a significant role in the mental health of healthcare professionals. A study in Bangladesh (2019) found that recent life changes increased the risk of depression by 20.5% (33).Another study in China (2009) revealed that individuals with low social support had a 65.1% prevalence of depressive symptoms (26). A study in Ethiopia (2023) at Saint Paul's Hospital Millennium Medical College found that

poor social support (35.5%) and stressful life events (48.3%) significantly contributed to depression among healthcare workers (38).

2.2.5 WORK-RELATED FACTORS

Work-related factors such as job dissatisfaction, workload, and burnout have been strongly associated with depression among healthcare professionals. A study in Bangladesh (2019) found that being unsatisfied with work was associated with a 7.1% risk of depression (33). Similarly, a study in China (2009) reported that job dissatisfaction contributed to 79.9% of depressive symptoms among nurses (26). High workloads, long working hours, and a stressful work environment can contribute to burnout, which has been linked to an increased risk of depression among healthcare professionals.

Overall, the literature suggests that depression among healthcare professionals is influenced by multiple factors, including socio-demographic, clinical, psychosocial, and work-related factors. Addressing these factors through targeted interventions, workplace mental health programs, and policy changes is crucial to reducing the burden of depression in the healthcare sector.

CONCEPTUAL FRAMEWORK

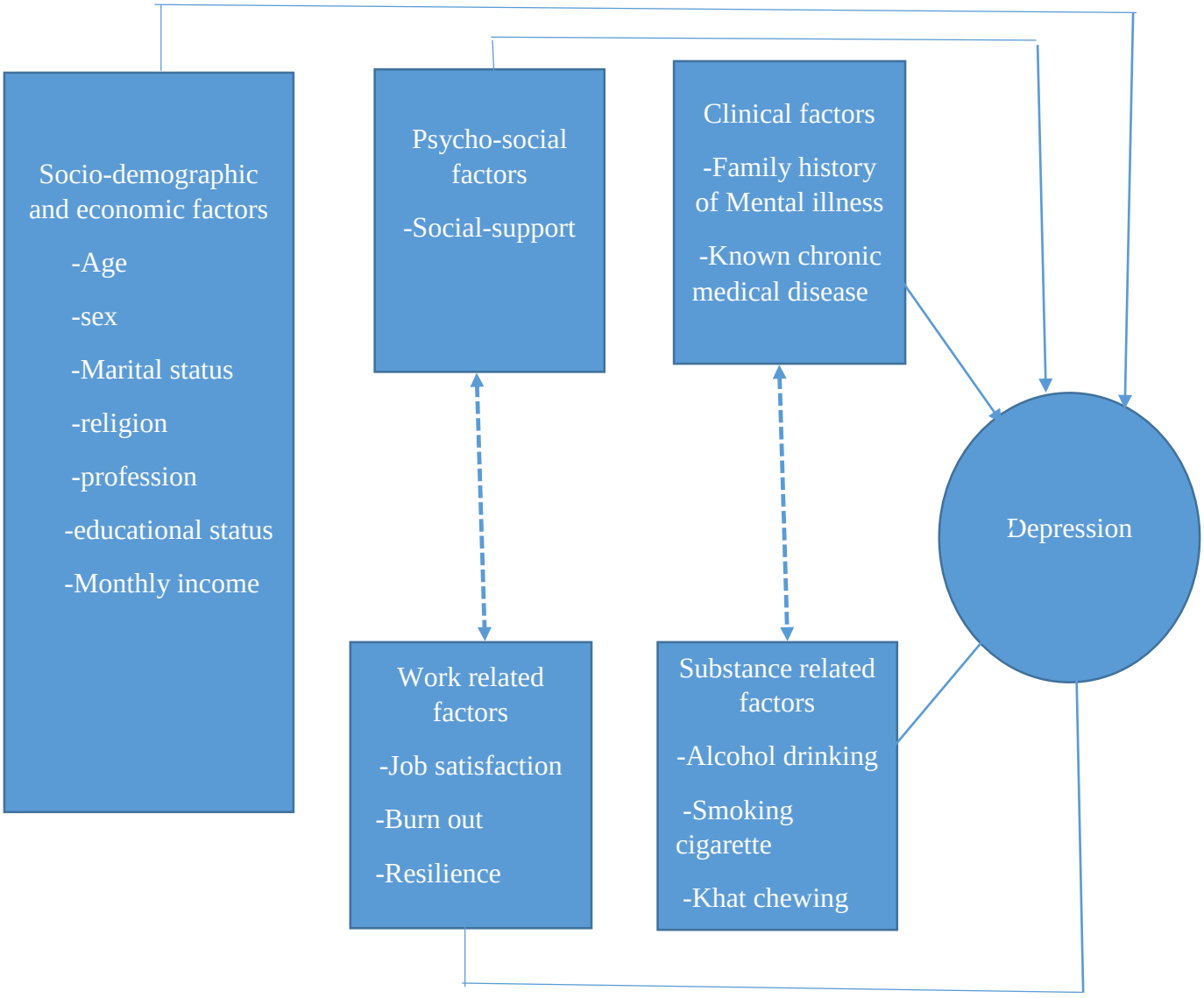


Figure 1;Conceptual framework for Prevalence and associated factors of depression among health professionals who work at tibebe gion specialized and comprehensive hospital and Felege hiwot comprehensive and specialized hospital Bahirdar, north west Ethiopia,2024 (38), (32), (26), (37).

3. OBJECTIVES

3.1 GENERAL OBJECTIVES

- To assess the prevalence, associated factors and contributing factors of depression among health professionals in governmental hospitals in Bahir dar,2024.

3.2 SPECIFIC OBJECTIVES

- To assess prevalence of depression among health professionals in governmental hospitals in Bahir dar,2024.
- To determine factors associated with depression among health professionals in governmental hospitals in Bahir dar,2024.
- To explore factors contributing to depression among health Professionals in governmental Hospitals in Bahir Dar, 2024.

4. METHODS AND MATERIALS

4.1 STUDY DESIGN

An institution-based mixed-methods study design was employed. The quantitative component utilized a cross-sectional study design to assess the prevalence and associated factors of depression among health professionals. Simultaneously, the qualitative component adopted a phenomenological approach to explore and capture the contributing factors of depression among health professionals.

4.2 STUDY AREA AND PERIOD

The study was conducted from April 1 to December 30, 2024, at Tibebe gion and Felege hiwot comprehensive and specialized hospitals in Bahir Dar city, the capital of Amhara National Regional State, located 565 km from Addis Ababa. Bahir Dar has six sub-cities, three public hospitals, one military hospital, and ten public health centers. TGCSH, a specialized teaching hospital of Bahir Dar University, serves over 5 million people. It employs 719 health professionals, including 174 physicians, 312 nurses, and various other specialists, providing services in emergency, outpatient, and inpatient care across multiple departments with more than 500 beds.

FHCSH, established in 1963 and upgraded to a referral hospital in 1994, provides services in surgery, medicine, pediatrics, obstetrics, gynecology, psychiatry, dentistry, and orthopedics. It has 892 health professionals, including 156 physicians and a variety of other healthcare staff, offering both outpatient and inpatient care. (46).

4.3 POPULATION

4.3.1 SOURCE POPULATION

All health professional employees that were working in TGSCH and FHCSH.

4.3.2 STUDY POPULATION

All health professionals who were available at the time of data collection in TGSCH and FHCSH.

4.3.3 STUDY UNIT

Individual health professionals who were selected at the study in their profession working in TGSCH and FHCSH.

4.4 INCUSION AND EXCLUSION CRITERIA

4.4.1 INCLUSION CRITERIA

All health professionals who were working in TGSCH and FHCSH.

4.4.2 EXCLUSION CRITERIA

Health professionals with less than six months of work experience in TGSCH and FHCSH.

4.5 SAMPLE SIZE DETERMINATION

For the quantitative analysis the sample size was calculated by using single population formula by using proportion of depression among health professionals, from similar study at Saint Paul's Hospital Millennium Medical College, Addis Abeba, Ethiopia. (38).By using confidence level of 95%(1.96) and margin of error to be 5%, the total sample size will be calculated as follows;

$$\text{n} = \frac{\left(\frac{Za}{2}\right) 2\, p(1-p)}{d2}$$

p=56.5% (prevalence of depression among health professionals)

z=1.96(95% confidence level)

d=0.05(margin of error)

Non-response rate =10%

n= $(1.96)^2$*(0.565*0.435)/ $(0.05)^2$

n=378 after adding 10% non-response rate, the final sample size was 415.

Table 1;Assumption used to calculate Sample Size for factors associated with depression among health professional using Epi-info

No	Variables	Assumptions				Sample size	The final sample size after adding 10% non-response rate
		OR	P	Power	CI		
1	Marital status single	5.02	45.5%	80%	95%	380	418
2	History of stressful life event	2.24	47.5%	80%	95%	382	420
3	Social support	2.59	64.1%	80%	95%	353	388
4	Work load	2.55	35.4%	80%	95%	351	386
5	Job satisfaction	1.62	48.5%	80%	95%	383	421

Since sample size of the second objective (job satisfaction) is greater than the first objective so we used the final sample size of job satisfaction that is 421.

For the qualitative component, six participants were purposefully selected to ensure diverse representation of contributing factors of depression among health professionals.

4.6 SAMPLING TECHNIQUE AND PROCEDURES

The study employed a mixed-methods approach with distinct sampling techniques for the quantitative and qualitative components.

Quantitative Component

The total population of health professionals at the two hospitals—TGCSH and FHSCH—was 1,611. The distribution included various professions, such as physicians (general practitioners, specialists, and sub-specialists), nurses, midwives, pharmacists, laboratory professionals, radiographers, and others. TGCSH: 719 health professionals and FHSCH: 892 health professionals (46).

To ensure representativeness, a stratified random sampling method was used. Each profession served as a stratum, and the sample size was proportionally allocated to the size of each stratum. Within each stratum, participants were selected using a simple random sampling technique, ensuring an unbiased selection process.

Qualitative Component

For the qualitative component, maximum variation purposive sampling was used to deliberately select participants who met specific criteria relevant to the study objectives. This strategy ensured diversity in professional roles and experiences.

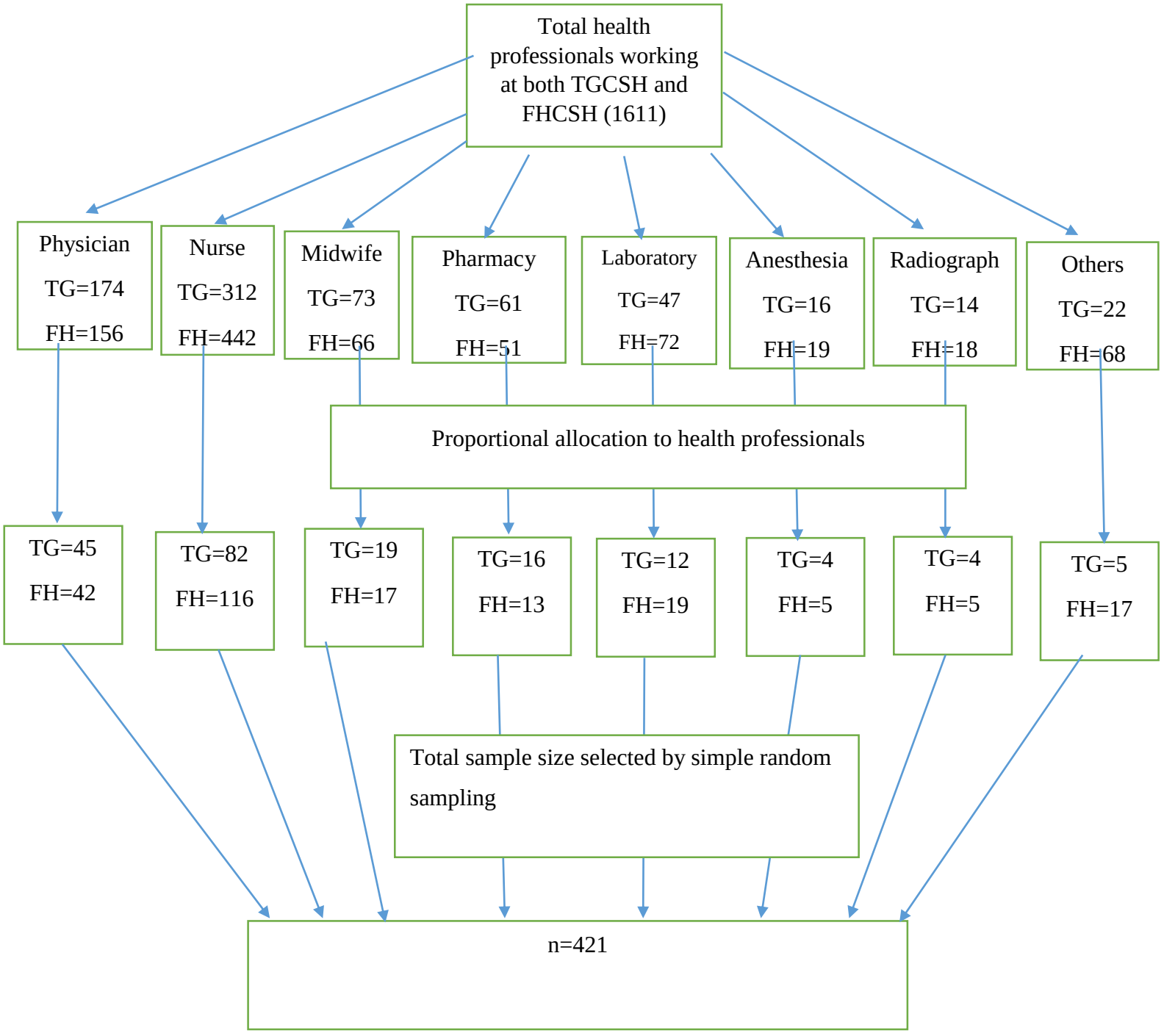


Figure 2; Schemating presentation of the sampling technique of research on prevalence and associated factors of depression among health professionals at TGSCH and FHCSH

Table 2;Presentation of sampling technique of research on prevalence and associated factors of depression among health professionals at TGSCH and FHCSH,2024 n= 404

Comprehensive specialized hospitals (1611)		TGSCH (719)	FHCSH(892)
Physicians	Sub-specialists	19(5)	1(1)
	Specialists	134(35)	49(13)
	General Practitioner	21(5)	106(28)
Nurse		312(82)	442(116)
Midwife		73(19)	66(17)
Laboratory professional		47(12)	72(19)
Pharmacy professional		61(16)	51(13)
Radiology professional		14(4)	18(5)
Anesthesia professional		16(4)	19(5)
Others		22(5)	68(17)

Others profession; (dentists, psychiatry professionals, Optometrist).

4.7 STUDY VARIABLES

4.7.1 DEPENDENT VARIABLES

Depression

4.7.2 INDEPENDENT VARIABLES

Socio-demographic and economic factors; Age, sex, Marital status, religion, profession, educational status, Monthly income

Psycho-social factors; social support

Substance related factors; Alcohol, Tobacco and Khat Use

Clinical factors; Family history of Mental illness, known chronic medical disease

Work related factors; Job satisfaction, burn out and resilience

4.8 OPERATIONAL DEFINITIONS

Depression: using the DASS-21 screening tool Participants who had a score of 1-13 no depression and a score of >= 14 have depression. (40)

Monthly income: Based on the World Bank poverty line cut point, those who have an average monthly family income of < 1.9 dollars per day (< 2394 Ethiopian Birr per month) are below the poverty line, and those who have an income of ≥1.9 dollars per day (>2394 Ethiopian Birr per month) are above the poverty line (41).

Social support: A score of 3-8 on the Oslo 3-item social support scale is considered poor social support, a score of 9-11 as intermediate social support, and a score of 12-14 as strong social support (42).

Burnout: Total 17 or less: Low-level burnout Total between 18 and 29 inclusive: Moderate burnout, Total over 30: High-level burnout (43).

Resilience: 0 – 37 score a developing level of resilience, 38 - 43 score an established level of resilience, 44- 48 score a strong level of resilience, 49 -60 score an exceptional level of resilience. (44).

Job satisfaction: Respondents who score 11-25 very low satisfaction, 26-35 low satisfaction, 36-45 moderate satisfaction and 46-55 high satisfaction. (22)

WHO ASSIST: 0 – 3 score Lower risk level, 4 – 26 score Moderate risk level and 27+ score High risk level for all other substances, for Alcohol 0-10 lower risk,11-26 moderate risk,27+ High risk. (45).

4.9 DATA COLLECTION TOOLS AND PROCEDURES

Quantitative Data Collection

Data for the quantitative component was collected using an interview-guided questionnaire administered by four BSc psychiatric nurses, supervised by two MSc psychiatry professionals. The questionnaire consisted of six sections: Socio-demographic factors, Clinical factors, Substance related factors, Psychosocial factors, Depression, Work-related factors

Key tools used for data collection included:

DASS-21: The DASS-21 (Depression, Anxiety, and Stress Scale-21) is a widely used tool to assess depression, anxiety, and stress, consisting of 21 items in three subscales. In Ethiopia, it has been validated with strong psychometric properties, including good internal consistency (Cronbach's alpha > 0.7) and adequate construct validity through confirmatory factor analysis (CFA). Reliability studies also confirm high test-retest stability, making it a reliable instrument for assessing mental health among Ethiopian populations (40).

WHO's ASSIST: The WHO's Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) detects and manages substance use. It has been validated in Ethiopia, demonstrating strong reliability and validity, with good internal consistency and test-retest reliability. It is widely used for identifying substance-related issues in clinical and community settings, facilitating early intervention in the Ethiopian context (45).

Oslo Social Support Scale (OSS-3): The OSS-3 assesses social support by evaluating close confidants, concern from others, and practical help from neighbors. In Ethiopia, it has shown utility, with a Cronbach's alpha of 0.68, indicating acceptable internal consistency. Though not formally validated, it is a reliable tool for understanding social support's impact on mental health in Ethiopia (42).

Maslach Burnout Inventory (MBI): The MBI measures burnout across emotional exhaustion, depersonalization, and reduced personal accomplishment. In Ethiopia, it has been used to assess burnout in healthcare and high-stress professions. Although specific validation studies are limited, general research shows strong reliability and internal consistency across various professional groups (43).

Job Satisfaction Survey Questions: The Job Satisfaction Survey (JSS) measures employee satisfaction across dimensions like pay, promotion, and work conditions. In Ethiopia, it has been used to evaluate job satisfaction, particularly among health professionals. Despite limited validation studies, the JSS is considered reliable and valid, with strong internal consistency and relevance in identifying factors influencing employee well-being (22).

Nicholson McBride Resilience Questionnaire (NMRQ): The Nicholson McBride Resilience Questionnaire (NMRQ) is a 12-item self-report tool designed to assess individual resilience levels. It employs a five-point Likert scale, with total scores ranging from 0 to 37, where higher scores indicate greater resilience. The NMRQ has demonstrated strong internal consistency and reliability in various populations. For instance, a study in Greece reported a Cronbach's alpha of 0.80, indicating good internal consistency (44).

Qualitative Data Collection

For the qualitative component, data was collected through semi-structured interviews designed to explore participants' lived experiences. The interview guide included the following sections:

Demographic information, Experience in conflict areas, Mental health and depression, contributing factors, Coping mechanisms, Recommendations for support

Interview Process: Format: Face-to-face interviews, Duration: 30-40 minutes per session

Recording: With consent, interviews were audio-recorded to ensure accurate transcription and analysis.

Data Collection Procedures

Preparation: Finalized the semi-structured interview guide to ensure all key topics were covered.

Recruitment of Participants: Utilized purposive sampling to select health professionals with relevant experience in conflict areas. Provided participants with detailed study information and obtained informed consent.

Conducting Interviews: Scheduled interviews at convenient times and locations for participants. Ensured a comfortable environment and began interviews with a brief introduction to the study and confidentiality assurance. Recorded interviews with participant consent and took notes on non-verbal cues and key points.

4.10 DATA QUALITY CONTROL

To ensure data quality, the questionnaire was translated into Amharic and back-translated into English to maintain consistency. Four BSc psychiatric nurses received two days of training on the study tools, ethical conduct, and data collection techniques. A pre-test was conducted with 5% (21 participants) at Addis Alem Primary Hospital, demonstrating good reliability and leading to minor revisions for clarity. Data collection was closely monitored by the supervisor and principal investigator to ensure accuracy and completeness. Additionally, data was reviewed daily, and incomplete responses were excluded.

The internal validity and reliability of the Depression, Anxiety, and Stress Scale (DASS) were confirmed through exploratory factor analysis (EFA) and Cronbach's Alpha. The EFA with Principal Axis Factoring and Varimax rotation revealed a clear three-factor structure corresponding to Depression, Anxiety, and Stress, with minimal cross-loadings. Depression-related items loaded strongly on Factor 1 (e.g., "I felt down-hearted and blue," loading = 0.728), anxiety-related items on Factor 3 (e.g., "I was worried about situations in which I might panic," loading = 0.702), and stress-related items on Factor 2 (e.g., "I found myself getting agitated," loading = 0.766). Reliability testing showed excellent internal consistency across all subscales, with Cronbach's Alpha values of 0.873 for Depression, 0.824 for Anxiety, and 0.858 for Stress. These results indicate that the DASS is a valid and reliable tool for assessing Depression, with strong discriminant validity and internal consistency.

For the qualitative component, interviewers were trained to facilitate effective discussions, and the semi-structured interview guide was pre-tested to ensure clarity and appropriateness. Sampling continued until data saturation was achieved, ensuring comprehensive coverage of key themes.

Trustworthiness in qualitative research was ensured through several strategies. Credibility was addressed by member checking, allowing participants to review findings, and triangulating data from multiple sources. Transferability was enhanced through thick descriptions of the context and diverse sampling to capture a broad range of experiences. Dependability was ensured by maintaining an audit trail documenting the research process and engaging experts in peer review to provide feedback. Confirmability was strengthened through reflexivity, where researchers reflected on potential biases, and triangulation of perspectives to ensure balanced interpretations.

4.11 DATA PROCESSING AND ANALYSIS

For the quantitative data, the collected information was manually checked for completeness and consistency before being coded and entered into Epicollect5. It was then exported to SPSS version 25 for further analysis. Binary logistic regression was used to examine the relationship between the dependent variable (depression status) and independent variables. Multicollinearity was evaluated using the Variance Inflation Factor (VIF), and highly correlated predictors were excluded. The model's goodness-of-fit was assessed using deviance and Pearson chi-square tests. Adjusted odds ratios (AOR) with 95% confidence intervals (CI) were computed, and predictors with $P < 0.05$ were considered significant. The final model included predictors significant at the 25% level in bivariate analysis.

For the qualitative data, audio recordings of interviews were transcribed verbatim within a week, with identifying information removed for confidentiality. The transcripts were thoroughly reviewed for familiarization, and thematic analysis was performed using Atlas.ti 9.1. Initial coding identified key ideas, followed by focused coding to group similar themes. These themes were refined and interpreted in relation to the research questions and existing literature. Member checking was conducted to ensure validity, allowing participants to confirm the accuracy of their responses. Peer debriefing with qualitative research experts strengthened the credibility of the analysis. All data were securely stored, and findings were presented thematically with structured headings for clarity.

4. 12 ETHICAL CONSIDERATION

Ethical clearance was obtained from the Institutional review board of Bahir Dar University, College of Medicine and Health Science. Following the approval official letter of cooperation was written to concerned bodies by the College of Medicine and Health Science. The data collectors were clearly explaining the aims of the study for study participants and The right were given to the study participants to refuse or discontinue participation at any time they want and the chance to ask anything about the study. All personnel information was kept entirely anonymously and confidentiality was assured throughout the study period. Participants identified at risk of Depression was referred for psychiatric evaluation.

5. RESULTS

5.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

A total of 404 health professionals participated in the study, yielding a response rate of 95.9%. The majority of participants (55.7%) were aged 25–34 years, and 59.2% were male. More than half (55.0%) were married, and 69.1% identified as Orthodox Christians. Nurses comprised 45.0% of the study population, and 58.7% held a BSc degree. Nearly half (49.3%) of the participants reported a monthly income between 5000 and 8000 ETB.

Table 3;Socio-demographic data of health professionals who work in Tibebe Ghion and Felege Hiwot Comprehensive Specialized Hospital in, Ethiopia,2024 n=404.

Variables	Category	Frequency	In Percent (%)
Age	25-34	225	55.7
	35-44	132	32.7
	45-54	47	11.6
Sex	female	165	40.8
	male	239	59.2
Marital Status	married	222	55.0
	single	128	31.7
	divorced	48	11.9
	widowed	6	1.5
Religion	orthodox	279	69.1
	protestant	68	16.8
	Muslim	46	11.4
	other	11	2.7
Profession	nurse	182	45.0
	midwife	36	8.9
	physician	88	21.8
	pharmacist	29	7.2

	laboratory professionals	27	6.7
	anesthesia professionals	10	2.5
	radiology professionals	10	2.5
	others	22	5.4
Educational Status	BSc degree	237	58.7
	MSc degree	79	19.6
	MD	37	9.2
	Speciality	45	11.1
	Sub-speciality	6	1.5
Monthly Income	5000-8000	199	49.3
	8001-11000	127	31.4
	11001-15000	78	19.3

Others profession; (dentists, psychiatry professionals, Optometrist).

5. 2 PSYCHO-SOCIAL FACTORS OF THE PARTICIPANTS

The study found that 46.5% had intermediate support, 44.1% reported poor social support, and 9.4% had strong social support.

Table 4; Psycho-social factors data of health professionals who work in Tibebe Ghion and Felege Hiwot Comprehensive Specialized Hospital in, Ethiopia,2024 n=404

Variables	Category	Frequency	In Percent(%)
Level of social support	poor social support	178	44.1
	intermediate social support	188	46.5
	strong social support	38	9.4

5.3 CLINICAL FACTORS OF THE PARTICIPANTS

A family history of diagnosed mental illness was reported by 8.6% of participants. Similarly, 13.6% had at least one diagnosed chronic medical condition. Hypertension was the most common chronic illness (6.2%), followed by diabetes (3.0%), heart disease (2.0%), and HIV/AIDS (1.7%), while 1.7% reported other unspecified conditions.

Table 5; Clinical factors data of health professionals who work in Tibebe Ghion and Felege Hiwot Comprehensive Specialized Hospital in, Ethiopia,2024 n=404

Variables	Category	Frequency	In Percent(%)
family history of diagnosed known mental illness	yes	35	8.6
	no	369	86.4
known diagnosed chronic medical condition	yes	55	13.6
	no	349	86.4
which known medical condition have you diagnosed	diabetes mellitus	12	3.0
	hypertension	25	6.2
	hiv/aids	7	1.7
	heart disease	8	2.0
	others	7	1.7

5.4 SUBSTANCE RELATED FACTORS OF THE PARTICIPANTS

Tobacco product use was reported by 1.2% of participants, while 3.0% had used Khat, and 19.1% had consumed alcohol at some point in their lives. In the past three months, 0.5% reported occasional tobacco use, 2.5% had used Khat, and 4.7% consumed alcohol once or twice.

Table 6; Substance related factors, ever use of a substance data of health professionals who work in Tibebe Ghion and Felege Hiwot Comprehensive Specialized Hospital in, Ethiopia,2024 n=404

Variables	Category	Frequency	In Percent(%)
In your life, have you ever used Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	yes	5	1.2
	no	399	98.8
In your life, have you ever used Khat	yes	12	3.0
	no	392	97.0
In your life, have you ever used Alcoholic beverages (beer, wine, spirits, etc.)	yes	77	19.1
	no	327	80.9

5.5 WORK RELATED FACTORS OF THE PARTICIPANTS

The data reveals that most respondents show established (37.6%) or strong (37.9%) resilience, with a smaller percentage (22.5%) at a developing level. Burnout levels are generally low, with 71.8% experiencing low burnout, and job satisfaction is also low, with 82.6% reporting either low or moderate satisfaction.

Table 7; Work related factors data of health professionals who work in Tibebe Ghion and Felege Hiwot Comprehensive Specialized Hospital in, Ethiopia,2024 n=404

Variables	Category	Frequency	In Percent(%)
Level of Resilience	developing level of resilience	91	22.5
	established level of resilience	152	37.6
	strong level of resilience	153	37.9
	exceptional level of resilience	8	2.0
Level of Burnout	Low-level burnout	290	71.8
	Moderate burnout	80	19.8
	High-level burnout	34	8.4
Level of Job satisfaction	very low satisfaction	64	15.8
	low satisfaction	167	41.3
	moderate satisfaction	167	41.3
	high satisfaction	5	1.2

5.6 PREVALENCE OF DEPRESSION AMONG HEALTH PROFESSIONALS

The overall prevalence of depression among health professionals in Tibebe gion and Felege hiwot comprehensive and specialized hospitals in Bahir Dar was found to be 37.6%.

5.7 FACTORS ASSOCIATED WITH DEPRESSION AMONG HEALTH PROFESSIONALS

In the multivariable logistic regression analysis, female health professionals had significantly higher odds of depression compared to males (AOR = 3.09, 95% CI: 1.84–5.19, p = 0.001). Single individuals were also more likely to experience depression compared to married participants (AOR = 1.82, 95% CI: 1.09–3.04, p = 0.032). Having a family history of mental illness was significantly associated with depression (AOR = 1.83, 95% CI: 1.21–3.18, p = 0.02). Poor social support was a

strong predictor of depression (AOR = 2.07, 95% CI: 1.35–3.28, p = 0.04), while individuals aged 35-44 had increased odds compared to those aged 45-54 (AOR = 2.06, 95% CI: 1.23–4.90, p = 0.02). Participants with low burnout levels had lower odds of depression compared to those with high burnout (AOR = 0.54, 95% CI: 0.13–0.74, p = 0.03).

Table 8; Factors associated with depression among health Professionals in multivariable logistic regression in Tibebe Ghion and Felege Hiwot Comprehensive and Specialized Hospitals in, Ethiopia,2024 n=404

Variables	Characteristics	depression		COR(95%CI)	AOR(95%CI)	P-Values
		Yes	No			
Sex	1. Female	82	83	2.08 (1.38 - 3.13)	**3.09 (1.84-5.19)**	**.001 ** **
	2. Male	77	162	1	1	
Marital Status	1. Married	78	144	0.67 (0.37 - 1.23)	2.54(.14,4.12)	.52
	2. Single	57	71	1.03(1.01 - 1.90)	**1.82 (1.09 - 3.04)**	**.032 ** **
	3.Divorced/ Widowed	24	30	1	1	
Religion	1.Orthodox	102	177	.79(.07,1.49)	.24(.06,.88)	.221
	2. Protestant	33	35	1.29(.06,1.92)	.32(.06,1.72)	.18
	3. Muslim/ Other	24	33	1	1	
Educational Status	1. BSc degree	91	146	2.02(1.01 - 4.00)	2.55(.24,6.35)	.43
	2. MSc degree	42	37	3.68(1.69 - 8.14)	1.56(.13,8.32)	.72
	3. MD	14	23	1.97 (0.79 - 4.89)	3.12(.30,3.3)	.34
	4. Speciality/ Sub-Speciality	12	39	1	1	

Family History of Mental Illness	1.Yes	17	18	1.51(0.74 - 3.02)	**1.83(1.21,3.18)**	**0.02***
	2. No	142	227	1	1	
Social Support	1.Poor	84	94	1.93(0.92 - 4.03)	**2.07(1.35,3.28)**	**.04***
	2.Intermediate	63	125	1.09(0.51 - 2.41)	.93(.30,2.83)	.90
	3. Strong	12	26	1	1	
Age	1.25-34	95	130	2.39(1.16 - 4.82)	.65(.13,3.24)	.60
	2. 35-44	53	79	2.19(1.02 - 4.61)	**2.06(1.23,4.90)**	**.02***
	3. 45-54	11	36	1	1	
Level of Burnout	1. Low-level	85	205	0.22(0.11 - 0.48)	**.54(.13,.74)**	**.03***
	2. Moderate-level	52	28	1.01(0.42 - 2.46)	3.89(.06,4.22)	.38
	3. High-level	22	12	1	1	

NB: *=significant at 0.05, **=significant at 0.01 COR=Crude odd ratio AOR=Adjusted odd ratio CI= Confidence interval, 1=reference category

5.8 QUALITATIVE STUDY RESULTS

5.8.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF QUALITATIVE STUDY PARTICIPANTS

The study included six participants with diverse professional backgrounds, including a 35-year-old male orthopedic surgeon, a 30-year-old female psychiatry professional, a 39-year-old male internal medicine specialist, a 32-year-old female nurse, a 30-year-old male laboratory

professional, and a 28-year-old male anesthesia professional. Their professional experience ranged from 2 to 6 years, and their educational qualifications varied from BSc to MSc degrees.

Table 9; Socio-demographic data of In-depth interview health professionals who work in Tibebe Ghion and Felege Hiwot Comprehensive Specialized Hospital in, Ethiopia,2024 n=404

Participant	Age	Sex	Educational Status	Profession	Years of experience
P001	35	Male	Speciality	Orthopedic Surgery	2 years
P002	30	Female	BSc degree	Psychiatry Professional	6 years
P003	39	Male	Speciality	Internal Medicine	5 years
P004	32	Female	BSc degree	Nursing	4 years
P005	30	Male	MSc degree	Laboratory professional	2 years
P006	28	Male	BSc degree	Anesthesia Professional	3 years

5.8.2 EMERGED THEMES

The study identified five key themes based on participants' experiences. These include Experiences in Conflict Areas, which highlights the challenges of working in high-stress environments, and Mental Health and Depression, addressing the impact of mental health issues on both personal and professional lives. The study also explored Factors Contributing to Depression, Coping Mechanisms, and Recommendations for Support, offering insights into stressors, coping strategies, and potential interventions to improve mental health resources and support systems.

Table 10; Emerged themes of In-depth interview health professionals who work in Tibebe Ghion and Felege Hiwot Comprehensive Specialized Hospital in, Ethiopia,2024 n=404

Number	Theme	Sub-theme
1	Experiences in Conflict Areas	Emotional and Psychological Impact
		Professional Challenges
2	Mental Health and Depression	Psychological Challenges
		Depression Symptoms
3	Factors Contributing to Depression	Exposure to Trauma
		Work-Related Stress
4	Coping Mechanisms	Professional Help
		Family and Social Support
5	Recommendations for Support	Training and Education
		Access to Mental Health Resources

Experiences in Conflict Areas

Healthcare professionals working in conflict zones face extreme challenges, including exposure to violence, inadequate medical resources, and constant threats to their safety. These conditions take a significant emotional and psychological toll, often leading to stress, anxiety, and burnout.

Emotional and Psychological Impact

Participants described the immense emotional burden of witnessing suffering, mass casualties, and severe injuries. Many reported experiencing anxiety, depression, and PTSD due to their work environment.

"In conflict zones, the emotional impact is immense. I encounter profound trauma daily—orphans, survivors of violence, and individuals with severe PTSD. The constant demand, coupled with limited resources, makes it emotionally exhausting, and at times, I feel powerless. The stories of

suffering stay with me, affecting my own mental well-being." (P002, Psychiatry Professional, 30 years)

Professional Challenges

Professionals highlighted the difficulties of working with limited resources, treating high volumes of critically ill patients, and making life-and-death decisions under extreme conditions.

"One of the most difficult challenges I face is the constant shortage of medical supplies and equipment. The demand is so high, but we often don't have what we need to treat patients properly. We also deal with emotional exhaustion, as it's hard to witness so much suffering, knowing there's little we can do to prevent it." (P004, Nurse, 32 years)

Mental Health and Depression

Health professionals in conflict areas reported high levels of stress, burnout, and depression due to ongoing exposure to traumatic events. The emotional strain was often intensified by isolation from their families and a lack of mental health support.

Psychological Challenges

Participants frequently reported experiencing burnout, anxiety, and emotional exhaustion, affecting both their professional performance and personal lives.

"In conflict areas, we face immense psychological challenges, including burnout, anxiety, and trauma, as we work in high-stress environments with limited resources and constant exposure to violence and suffering." (P006, Anesthesia Professional, 28 years)

Depression Symptoms

Symptoms of depression, such as fatigue, irritability, emotional numbness, and hopelessness, were commonly reported.

"We often experience depression symptoms such as persistent fatigue, irritability, and feelings of hopelessness. The constant stress and trauma exposure can lead to difficulty concentrating, emotional numbness, and a loss of interest in activities, making it hard to maintain both personal and professional well-being." (P004, Nurse, 32 years)

Factors Contributing to Depression

Several factors were identified as contributors to depression among healthcare professionals in conflict zones. These included chronic exposure to trauma, overwhelming workloads, and high-stress environments.

Exposure to Trauma

The repeated exposure to injuries, death, and suffering led many participants to experience vicarious trauma and emotional distress.

"We are constantly exposed to trauma, witnessing severe injuries, death, and immense suffering. The emotional toll of caring for victims of violence, coupled with the lack of resources, creates immense psychological strain." (P001, Orthopedic Surgeon, 35 years)

Work-Related Stress

Heavy workloads, long hours, and lack of support systems were major stressors, increasing the risk of burnout and mental health deterioration.

"Work-related stress is a constant challenge. We often deal with high patient volumes, inadequate resources, and long hours, all while being exposed to the constant threat of violence. The emotional burden of caring for severely injured patients in such dire conditions can be overwhelming." (P005, Laboratory Professional, 30 years)

Coping Mechanisms

Despite the challenges, participants employed various coping strategies to manage stress, including seeking professional help and relying on social and family support.

Professional Help

Accessing mental health resources, therapy, and counseling was considered essential for maintaining emotional resilience.

"Accessing professional help is crucial for managing the emotional and psychological challenges we face. Counseling and therapy provide a safe space to process the trauma and stress we experience, helping us develop coping strategies." (P002, Psychiatry Professional, 30 years)

Family and Social Support

Maintaining contact with family and engaging with social support systems were identified as key factors in coping with workplace stress.

"Family and social support are essential for maintaining our emotional well-being. Regular communication with loved ones helps alleviate feelings of isolation and provides a sense of stability during challenging times." (P004, Nurse, 32 years)

Recommendations for Support

Participants emphasized the need for structural interventions to support healthcare professionals working in conflict areas, including specialized training, mental health support, and resource allocation.

Training and Education

Providing targeted training in trauma care, emergency response, and mental health support was suggested to better equip professionals for the challenges they face.

"We need targeted training in trauma care, emergency response, and mental health support, alongside skills in security and resource management. Accessible education through online modules, hands-on simulations, and mentorship can empower us to deliver effective care in the most challenging conditions." (P003, Internal Medicine Specialist, 39 years)

Access to Mental Health Resources

Ensuring access to counseling services, peer support programs, and workplace mental health initiatives was highlighted as a critical need.

"Access to mental health resources is vital. Confidential counseling, peer support, and tools for managing stress help us cope with the emotional challenges we face daily, enabling us to stay resilient and continue providing care to those in need." (P002, Psychiatry Professional, 30 years)

6. DISCUSSION

The overall prevalence of depression among health professionals in Tibebe Gion and Felege Hiwot Comprehensive and Specialized Hospitals was found to be 37.6%, which is a significant finding indicating the mental health challenges faced by healthcare workers in these settings. This prevalence rate is in line with global and regional studies that have identified high levels of depression among healthcare workers. For example, a meta-analysis conducted in the Eastern Mediterranean Region reported a pooled prevalence of 33.03% among healthcare professionals (29), while in Bangladesh, the prevalence of depression among healthcare workers was found to be 37.12% (25). These figures suggest that the prevalence of depression in our study is within the expected range and reflects the mental health burden on healthcare professionals, particularly in challenging environments such as conflict zones or high-stress healthcare settings. The relatively high prevalence rate also draws attention to the need for better mental health support systems for these professionals, as they are a vulnerable group due to the emotional and physical demands of their work.

Our study revealed several socio-demographic and clinical factors that are significantly associated with depression. Specifically, female health professionals were found to have significantly higher odds of depression compared to their male counterparts (AOR = 3.09, 95% CI: 1.84–5.19, p = 0.001). This finding aligns with other studies, such as those in Nepal and Bangladesh, where females were found to be at higher risk for depression due to factors like work-related stress, family responsibilities, and societal expectations (35),(33). Additionally, single individuals were more likely to experience depression compared to married individuals (AOR = 1.82, 95% CI: 1.09–3.04, p = 0.032). This is consistent with research that shows single individuals are at a higher risk of

depression due to the lack of marital support and social connections, which may help buffer against the emotional strains of healthcare work (38).

Moreover, having a family history of mental illness was also significantly associated with depression (AOR = 1.83, 95% CI: 1.21–3.18, p = 0.02), further supporting the growing body of literature that emphasizes the role of genetic and familial factors in the development of mental health issues(26). Poor social support emerged as a strong predictor of depression (AOR = 2.07, 95% CI: 1.35–3.28, p = 0.04), which is consistent with the findings of other studies showing that low social support significantly increases the risk of depression (26),(38). The role of social support in mental health is critical, as healthcare workers who lack emotional support from family, friends, or colleagues may struggle to cope with the stressors inherent in their work.

An interesting finding in our study was that individuals aged 35-44 had higher odds of depression compared to those aged 45-54 (AOR = 2.06, 95% CI: 1.23–4.90, p = 0.02). This may reflect the heightened stress levels faced by mid-career professionals who may experience burnout or feel overwhelmed by career expectations, personal responsibilities, and the demands of their roles. Additionally, the study showed that participants with low burnout levels had lower odds of depression compared to those with high burnout (AOR = 0.54, 95% CI: 0.13–0.74, p = 0.03). Burnout has long been associated with depression, and our study corroborates the idea that high levels of work-related stress and exhaustion contribute to the onset of depressive symptoms among healthcare workers (33),(34).

The qualitative findings from the in-depth interviews provide a deeper understanding of the experiences of healthcare professionals in conflict zones. One of the key themes that emerged from the interviews was the Emotional and Psychological Impact of working in conflict areas. Participants frequently described the intense emotional burden of witnessing trauma, death, and suffering, which led to feelings of anxiety, depression, and emotional numbness. This aligns with previous research highlighting the psychological toll of working in high-stress and conflict environments, where healthcare workers are exposed to traumatic events on a daily basis(29), (32). In conflict zones, healthcare professionals often face overwhelming workloads and have to make life-and-death decisions with limited resources, adding further to their emotional distress (31).

The theme of Factors Contributing to Depression revealed that exposure to trauma and work-related stress were major contributors to the development of depressive symptoms. Healthcare workers working in these high-pressure environments reported that the constant exposure to suffering, death, and violence was emotionally exhausting and led to significant mental health challenges. This is consistent with global studies that identify work-related stress, trauma exposure, and heavy workloads as major risk factors for depression (26),(33),(38).

The study also revealed important Coping Mechanisms employed by healthcare professionals in conflict areas. These included seeking professional help, such as counseling or therapy, and relying on family and social support systems. This theme highlights the importance of mental health resources and supportive networks in helping healthcare workers manage the psychological strain of their roles. Studies have shown that professional counseling, peer support, and regular communication with family members are critical in helping healthcare workers cope with the emotional challenges they face (35),(24). Additionally, participants emphasized the need for Training and Education in trauma care and mental health support, as well as better access to mental health resources, which are essential for equipping healthcare workers to cope with the psychological demands of their jobs.

Participants also provided Recommendations for Support, including the need for improved mental health resources, training programs, and structural interventions to address the specific challenges faced by healthcare professionals in conflict zones. These recommendations align with the growing call for more comprehensive mental health support in healthcare settings, particularly in high-stress environments like conflict zones(23),(24),(31). Providing access to counseling services, peer support programs, and mental health initiatives within healthcare institutions would likely alleviate some of the mental health burdens faced by healthcare workers.

7. STRENGTH AND LIMITATION

7. 1 STRENGTH

Studying the prevalence, associated factors, and contributing factors of depression among health professionals using a mixed-methods design offers several strengths. This approach provides a comprehensive understanding by combining quantitative data on prevalence and risk factors with qualitative insights into lived experiences and underlying causes. The integration of both methods

enhances the validity and reliability of findings, as statistical associations identified in the quantitative analysis are further explained and contextualized through qualitative data. Additionally, the study helps uncover workplace stressors and psychosocial challenges that may not be fully captured through surveys alone, allowing for a deeper exploration of the factors contributing to depression.

By identifying both measurable risk factors and personal experiences, the study can inform targeted interventions that address mental health challenges among healthcare professionals more effectively. Furthermore, the context-specific nature of the research ensures that findings are relevant to Ethiopia's healthcare system, shedding light on unique stressors such as high patient loads, resource constraints, and exposure to trauma. The triangulation of data strengthens the credibility of the study, while its mixed-methods approach lays a foundation for future research and long-term mental health strategies in the healthcare sector.

7. 2 LIMITATION

The study also has limitations. One notable limitation is the generalizability of the results, as the study focuses on health professionals at two specific hospitals in a single region, which may not be representative of the broader healthcare workforce in Ethiopia or other countries. The use of self-reported data also presents a potential bias, as respondents may underreport their symptoms, which could affect the accuracy of the findings. Additionally, the study is cross-sectional and it provides only a snapshot of the prevalence and associated factors at a single point in time, limiting the ability to draw conclusions about causal relationships. Longitudinal studies would provide more insight into how depression develops over time and its causes.

8. CONCLUSIONS

This study found that the prevalence of depression among health professionals at Tibebe Ghion and Felege Hiwot Comprehensive and Specialized Hospitals was 37.6%. Several factors were significantly associated with depression, including being female, single marital status, family history of mental illness, poor social support, and high levels of burnout. Additionally, health professionals working in high-stress environments, particularly in conflict-affected areas, reported severe emotional and psychological challenges. Exposure to trauma, heavy workloads, and limited resources contributed to increased stress, anxiety, and depression. These findings highlight the

substantial mental health burden faced by healthcare workers, which can negatively impact both their well-being and the quality of patient care.

Despite these challenges, some coping mechanisms were identified, including seeking professional help and relying on social and family support. However, the study emphasizes the need for stronger institutional support systems, including workplace mental health programs, structured training on stress management, and improved access to psychological services. Addressing these issues through policy interventions and targeted mental health strategies is essential to reducing the prevalence of depression among health professionals. Strengthening support networks and providing adequate resources can help mitigate work-related stress and improve the overall mental health of healthcare workers, ultimately ensuring better healthcare service delivery.

9. RECOMMENDATIONS

For the Ministry of Health:

- **Establish and expand mental health services**: Focus on creating mental health departments in hospitals that lack them, and ensure the services are affordable, especially targeting areas with female and low-income populations.
- **Strengthen community-based mental health programs**: Address social isolation, stigma, and provide targeted outreach programs for high-risk groups, including women, single individuals, and those with poor social support.
- **Provide economic relief programs**: Offer financial aid or income support to lower-income groups to reduce economic stress that could contribute to depression.

For Tibebe Gion & Felege Hiwot Comprehensive and Specialized Hospitals:

- **Implement routine mental health screenings**: Focus on at-risk groups, such as females, single individuals, and those with poor social support, to identify early signs of depression and provide timely intervention.
- **Provide gender- and age-sensitive care**: Tailor mental health services to consider gender and age ensuring these groups receive appropriate, personalized care.

- **Enhance staff training**: Train healthcare providers on managing depression, emphasizing the significance of socio-economic factors, and set up multidisciplinary teams to handle severe depression cases.
- **Community collaboration for ongoing support**: Establish partnerships with community organizations to offer continuous support for patient's post-treatment, particularly for those with lower social support.

For Health Professionals:

- Actively seek mental health support when experiencing symptoms of depression or burnout, utilizing available counseling and psychological services.
- Engage in self-care practices such as regular exercise, healthy eating, mindfulness techniques, and work-life balance strategies to manage stress.
- Build strong professional and social support networks to share experiences, reduce isolation, and enhance emotional well-being.
- Participate in stress management and resilience training programs to improve coping mechanisms in high-pressure work environments.
- Advocate for better mental health policies and workplace conditions by engaging in professional organizations and discussions with hospital administrators.

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11. APPENDIX

I. Participant consent and information sheet (English version)

A. Participant information sheet

Hello. My name is----------. I am here to a data collector for a study which entitled with Prevalence and associated factors of depression among Health professionals. The study is conducted by Bereket Mulu MSc student in ICCMH at Bahir Dar University, college of medicine and health science.

The research is intended to benefit the health professional including the patients that will be participating in this research and will not introduce risk to the participant. Your participation is entirely voluntarily, and you can quit from the study any time you want. You will have no penalty if you fail to show desire to participate. I, however, do hope that you will participate in the study since the data that will come from you will be important for us. Your name and other personal identity will not be used, and hence the information we will collect from you will completely be kept confidential and will not be disclosed to any third person other than the people participating in this study.

B. Informed consent sheet

I have been briefly informed about the study and I clearly understood the objective. Since it doesn‘t affects me, I agreed to take part in the study. Consequently, I here approve my consent to take part in the study as an interviewee/ to participate in the study with my signature.

Agreed to participate ……sign and proceed to interview

Not agreed to participate……. thank the respondent and end the interview

Name of the interviewer_____ Sign. _____ Date _____

Name of the supervisor _____. Sign. _____ Date_____

Thank you for your willingness to participate

Persons to contact: If you have any question you can contact the investigator at the following address and you may ask at any time you want.

Name: Bereket Mulu, Mobile number; 0945300560

email address; bereketmulutesfu@gmail.com

II. Questionnaire (English version). Code No._____

Questionnaire on: Prevalence and associated factors of depression among health professionals who work at TGSCH and FHCSH, Northwest, Ethiopia, 2024

Section 1: Socio-demographic information This Part of the Study is concerned with your background information.

No	Questions	Answer
101	Age in years	1. 25- 34 2. 35-44 3. 45-54
102	What is your sex?	1. Female 2. Male
103	What is your religion?	1. Orthodox 2. Protestant 3. Muslim 4.other
104	What is your marital status?	1. Married 2. Single 3. Divorced 4.Widowed
105	Profession	1.Nurse 2. Midwife 3. Physician 4. Pharmacist 5. Laboratory Professional 6. Anesthesia Professional 7. Radiology Professional 8. Others
106	Educational status	1.Bsc degree 2.Msc degree 3.MD 4.Speciality 5.Sub-speciality
107	Monthly income	1. 5000-8000 2. 8001-11000 3. 11001-15000

Section 2; Clinical Factors

No	items	Response	
		1.Yes	2.No
201	Do you have known family history of diagnosed known mental illness?		
202	Do you have any known diagnosed chronic medical condition?		
203	If yes, which known medical condition have you diagnosed? A. Diabetes Mellitus B. Hypertension C. HIV-Aids D. Heart Disease E. Others, Specify		

Section 3: Depression, Anxiety and Stress scale (DASS-21)

0: NEVER ,1: SOMETIMES ,2: OFTEN ,3: ALMOST ALWAYS

		0	1	2	3
301	I found it hard to wind down	0	1	2	3
302	I was aware of dryness of my mouth	0	1	2	3
303	I couldn't seem to experience any positive feeling at all	0	1	2	3
304	I experienced breathing difficulty (e.g. excessively rapid breathing breathlessness in the absence of physical exertion)	0	1	2	3
305	I found it difficult to work up the initiative to do things	0	1	2	3
306	I tended to over-react to situations	0	1	2	3
307	I experienced trembling (e.g. in the hands)	0	1	2	3
308	I felt that I was using a lot of nervous energy	0	1	2	3
309	I was worried about situations in which I might panic and make a f of myself	0	1	2	3
310	I felt that I had nothing to look forward to	0	1	2	3
311	I found myself getting agitated	0	1	2	3
312	I found it difficult to relax	0	1	2	3
313	I felt down-hearted and blue	0	1	2	3
314	I was intolerant of anything that kept me from getting on with what was doing	0	1	2	3
315	I felt I was close to panic	0	1	2	3
316	I was unable to become enthusiastic about anything	0	1	2	3
317	I felt I wasn't worth much as a person	0	1	2	3
318	I felt that I was rather touchy	0	1	2	3
319	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
320	I felt scared without any good reason	0	1	2	3
321	I felt that life was meaningless	0	1	2	3

Section 4: Psychosocial Factors

Social Support

OSLO-3 social support scale(OSS-3)		
401	**How many people are to close to you that you can count on them if you have serious problems**	
	None	1
	1 or 2	2
	3 to 5	3
	6 or more	4
402	**How much concern do people show in what you are doing?**	
	A lot of concern and interest	5
	Some concern and interest	4
	Uncertain	3
	Little concern and interest	2
	No concern and interest	1
403	**How easy can you get practical help from neighbors if you should need it?**	
	Very easy	5
	Easy	4
	Possible	3
	Difficult	2
	Very difficult	1

Section 5: Substance related factors (Who ASSIST)

In your life, which of the following substances have you ever used? (NON-MEDICAL USE ONLY)		Yes	No
501	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)		
502	Alcoholic beverages (beer, wine, spirits, etc.)		
503	Khat		

Probe if all answers are negative: “Not even when you were in school?” If "No" to all items, stop interview. If "Yes" to any of these items, ask Question 2 for each substance ever used

In the past three months, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?		No	Yes	If Yes			
				Once or twice	Monthly	Weekly	Daily /Almost daily
511	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	1	2	3	4	5
512	Alcoholic beverages (beer, wine, spirits, etc.)	0	1	2	3	4	5
513	Khat	0	1	2	3	4	5

Section 6: Work related factors

Resilience Questionnaire

This is an abbreviated version of the Nicholson McBride Resilience Questionnaire (NMRQ). For each question, score yourself between 1 and 5, where 1 = strongly disagree,2= disagree, 3= Neither, 4= Agree and 5 = strongly agree.

Questions	Score
601. In a difficult spot, I turn at once to what can be done to put things right.	
602. I influence where I can, rather than worrying about what I can't influence.	
603. I don't take criticism personally.	
604. I generally manage to keep things in perspective.	
605. I am calm in a crisis.	
606. I'm good at finding solutions to problems.	
607. I wouldn't describe myself as an anxious person.	
608. I don't tend to avoid conflict.	
609. I try to control events rather than being a victim of circumstances.	
610. I trust my intuition.	
611. I manage my stress levels well.	
612. I feel confident and secure in my position.	

Burnout Self-Test Maslach Burnout Inventory (MBI)

Questions	Never	A Few Times per Year	Once a Month	A Few Times per Month	Once a Week	A Few Times per Week	Every Day
	0	1	2	3	4	5	6
701. I feel emotionally drained by my work							
702. Working with people all day long requires a great deal of effort.							
703. I feel like my work is breaking me down.							
704. I feel frustrated by my work.							
705. I feel I work too hard at my job.							
706. It stresses me too much to work in direct contact with people.							
707. I feel like I'm at the end of my rope.							

Job satisfaction

Job satisfaction questions: - Please put circle that applies your current satisfaction level in front of each question as 1 = Very dissatisfied, 2 = Dissatisfied, 3= Uncertain, 4 = Satisfied, 5 = Very Satisfied.

No	Sub-components and items	Very dissatisfied	Dis-satisfied	Uncertain	Satisfied	Very Satisfied
	1.Remuneration/Payment					
801	Does your income is a reflection of the work you are doing?	1	2	3	4	5
802	With your job do you get advantages that you expected from your education in terms of income?	1	2	3	4	5
	2. Promotion opportunity					
803	Do you have Sufficient opportunity for professional growth	1	2	3	4	5
804	Having Support for Personal growth and development through education and training	1	2	3	4	5
	3.Recognition (from leaders or managers)					
805	Adequate Consideration given to your opinion and suggestion for change in the work setting	1	2	3	4	5

806	Do you get recognition for tasks that you well done	1	2	3	4	5
	4. Professional training					
807	Training opportunities availability	1	2	3	4	5
808	Your organization gives training and orientation to new staffs	1	2	3	4	5
	5. Staff Interaction and working environment					
809	having good working relationship with your colleagues	1	2	3	4	5
810	Good atmosphere of co-operation between staff & managers	1	2	3	4	5
811	Working environment encourage you to make adjustment in your professional practice to meet patient needs	1	2	3	4	5

Qualitative questions

Instructions: Please answer the following questions in as much detail as you feel comfortable. Your responses will be kept confidential, and your identity will not be disclosed. Feel free to elaborate on your answers.

Demographic Information

1.Age:

2.Sex:

3.Profession:

4. Years of Experience:

5.Can you describe your overall experience working in a conflict zone?

6.What specific challenges have you faced while providing care in these environments?

7.How did these experiences affect your daily work and interactions with patients and colleagues?

8.How would you describe your mental health during your time working in conflict areas?

9.Have you experienced symptoms of depression? If so, can you elaborate on these experiences?

10.What factors do you believe have contributed to your mental health challenges while working in conflict zones?

11.Can you describe any specific incidents that have significantly impacted your mental health?

12.What strategies or coping mechanisms have you developed to manage stress and depression?

13.Are there any resources or support systems that you found particularly helpful?

14.What changes or resources do you think would help health professionals in conflict areas cope better with mental health challenges?

15.How can organizations better support health workers facing these issues?

16.Is there anything else you would like to share about your experiences or insights regarding mental health in conflict areas?

Thank you for your time and insights! Your contributions are invaluable to this research

I. የተሳታፊ ስምምነት እና የመረጃ ወረቀት (የአማርኛ ቅጂ)

ሀ. የተሳታፊ መረጃ ወረቀት

ሰላም የኔ ስም----------። እኔ እዚህ ያለሁት በጤና ባለሙያዎች ውስጥ ያለውን የድብርት መስፋፋት እና ተያያዥ ምክንያቶች በሚለው ጥናት ላይ መረጃ ሰብሳቢ ነኝ። ጥናቱ የሚካሄደው በበረከት ሙሉ ሲሆን በባህር ዳር ዩኒቨርሲቲ በህክምና እና ጤና ሳይንስ ኮሌጅ በአእምሮ ህክምና ክፍል ኤምኤስሲ ተማሪ ነው።

ጥናቱ በዚህ ጥናት ውስጥ የሚሳተፉትን ታማሚዎችን ጨምሮ የጤና ባለሙያውን ተጠቃሚ ለማድረግ የታሰበ ሲሆን ለተሳታፊው ስጋት የማይፈጥር ነው። የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ነው, እና በማንኛውም ጊዜ ከጥናቱ ማቆም ይችላሉ. ለመሳተፍ ፍላጎት ካላሳየህ ምንም ቅጣት አይኖርብህም። እኔ ግን ከእርስዎ የሚመጣው መረጃ ለእኛ ጠቃሚ ስለሚሆን በጥናቱ ላይ እንደሚሳተፉ ተስፋ አደርጋለሁ። ስም እና ሌላ የግል ማንነትህ ጥቅም ላይ አይውልም ስለዚህ ከእርስዎ የምንሰበስበው መረጃ ሙሉ በሙሉ ሚስጥራዊ ይሆናል እናም በዚህ ጥናት ውስጥ ከተሳተፉት ሰዎች በስተቀር ለሌላ ሶስተኛ ሰው አይገለጽም.

ለ. በመረጃ የተደገፈ የስምምነት ወረቀት

ስለ ጥናቱ በአጭሩ ተነግሮኛል እና አላማውን በግልፅ ተረድቻለሁ። ስለሆነም፣ እኔ በጥናቱ ለመሳተፍ ፈቃዴን አፀድቄያለሁ።

ለመሳተፍ ተስማምተናል ..... መፈረም እና ወደ ቃለ መጠይቁ ይቀጥሉ

ለመሳተፍ አልተስማማም ..... ምላሽ ሰጪውን አመሰግናለሁ እና ቃለ ምልልሱን ጨርስ

የቃለ-መጠይቁ ጠያቂው ስም_____ ይፈርሙ። _____ ቀን _____

የተቆጣጣሪው ስም _____. ይፈርሙ። _____ ቀን_____

ለመሳተፍ ፈቃደኛ ስለሆናችሁ እናመሰግናለን

የሚያገኟቸው ሰዎች፡ ማንኛውም አይነት ጥያቄ ካሎት መርማሪውን በሚከተለው አድራሻ ማነጋገር እና በፈለጉት ጊዜ መጠየቅ ይችላሉ።

ስም፡ በረከት ሙሉ የሞባይል ቁጥር; 0945300560

የኢሜል አድራሻ; bereketmulutesfu@gmail.com

II. መጠይቅ (የአማርኛ ቅጂ). ኮድ ቁጥር _____

መጠይቅ፡ በጥበበ ጊዮን እና ፈለገ ሂወት ሆስፒታል በሚሰሩ የጤና ባለሙያዎች መካከል የድብርት ስርጭት እና ተያያዥ ምክንያቶች ለማጥናት የሚደረግ መጠይቅ

ክፍል 1፡ የሶሺዮ-ዲሞግራፊ መረጃ

ቁጥር	ጥያቄዎች	መልስ
101	እድሜ	1.25-34 2.35-44 3.45-54
102	የእርስዎ ጾታ ምንድን ነው?	1. ሴት 2. ወንድ
103	ሃይማኖትህ/ሽ ምንድን ነው?	1. ኦርቶዶክስ 2. ፕሮቴስታንት 3. ሙስሊም 4.ሌላ
104	የጋብቻ ሁኔታ?	1. ያገባ 2. ያላገባ 3. የተፋታ 4. ባል የሞተባት
105	ሙያ	1.ነርስ 2.አዋላጅ 3.ሀኪም 4. ፋርማሲስት 5.የላብራቶሪ ፕሮፌሽናል 6.የማደንዘዣ ባለሙያ 7.ራዲዮሎጂ ባለሙያ 8. ሌሎች
106	የትምህርት ደረጃ	1.ቢኤስሲ ዲግሪ 2.ኤም.ኤስሲ. 3.ኤምዲ 4. ስፔሻሊቲ 5.ሰብ-ስፔሻሊቲ
107	ወርሃዊ ገቢ	1.5000-8000 2.8001-11000 3.11001-15000

ክፍል 2; ክሊኒካዊ ምክንያቶች

	ጥያቄዎች		
		1. አዎ	
201	የታወቀ የአእምሮ ሕመም የቤተሰብ ታሪክ ያውቃሉ?		አይደለም
202	በምርመራ የተረጋገጠ ሥር የሰደደ የጤና ችግር አለህ?		
203	አዎ ከሆነ፣ የትኛውን የታወቀ የጤና ሁኔታ መርምረሃል? ሀ. የስኳር በሽታ ለ. የደም ግፊት ሐ. ኤችአይቪ-ኤድስ መ ካንሰር ሰ. የልብ ሕመም ረ. ሌሎች, ይግለጹ		

ክፍል፡3

ከዚህ በታች የተዘረዘሩትን እያንዳንዱ ጥያቄዎች ካነበቡ በኋላ በእርስዎ ሊይ ባለፈው አንድ ሳምንት ውሰጥ የእርስዎን ስነ ልቦናዊ ሁኔታ በይበልጥ ይገልፃል የሚሉትን ከተዘረዘሩት አራት አማራጮች አንዱን በማክበብ ይመልሱ።

0). ፈፅሞ የእኔን ሁኔታ አይገልፅም (አልቀበለውም) 1). አንዳንድ ጊዜ (አልፎ አልፎ) 2). ብዙ ጊዜ(በተደጋጋሚ) 3). እጅግ ብዙ ጊዜ (ሁልጊዜ)

		0	1	2	3
301	መጨነቅ በማቆም ዘና ለማለት ይከብደኝ ነብር	0	1	2	3
302	አፌ ሲድርቅ ይታወቀኝ ነበር	0	1	2	3
303	ምንም አይነት ጥሩ ስሜት እየተሰማኝ አልነበረም	0	1	2	3
304	ለመትንፈስ እቸገር ነበር(ለምሳሌ- ከልክ ያለፈ ቶል ቶል መተንፈስ፣ያለ ምንም አካለዊ እንቅስቃሴ ትንፋሽ ማጣት)	0	1	2	3
305	ማንኛወንም ነገር ለማከናወን ተነሳሽነት አጣለሁ	0	1	2	3
306	አንዳንድ ነገሮች ከተገቢው በላይ አጋንናለሁ	0	1	2	3
307	መንቀጥቀጥ አጋጥሞኛል (ለምሳሌ- እጆቸ ላይ)	0	1	2	3
308	ብዙ የነርቨ(ስሜታዊ ጉሌብት) እንደተጠቀምኩ ይሰማኛል	0	1	2	3
309	አንዳንድ አጋጣሚዎች ላይ ተጨንቄ እራሴን እንዳላዋርድ እሰጋ ነበር	0	1	2	3
310	ምንም ወደፊት የሚያጓጓ ነገር እንደለለኝ ይሰማኛል	0	1	2	3
311	የመንፈስ መረበሽ ውስጥ እራሴን አገኘዋለሁ	0	1	2	3
312	የመዝናናት መንፈስ ውስጥ መግባት ይከብደኛል	0	1	2	3
313	የሃዘን ስሜት ይሰማኝ ነበር	0	1	2	3
314	ማንኛውም እያደረኩት ከነበረው ነገር የሚያስቆመኝ ነገር መታገስ አልችልም	0	1	2	3
315	ልረበሽ ትንሽ የቀረኝ እንደሆነ ይሰማኛል	0	1	2	3
316	ማንኛውም ነገር በጥሩ ስሜት ማየት አቅቶኝ ነበር	0	1	2	3
317	እንደ ሰው ምንም የማልረባ መስሎ ይሰማኝ ነበር	0	1	2	3
318	ትንሽ የሚበቃው እንደሆንኩ ይሰማኛል	0	1	2	3
319	የአካል እንቅስቃሴ በሌለበት የልቤን ድርጊት አስተውል ነበር (ለምሳሌ- የልብ ምት መጠን መጨመር፣ የልብ ምት መዝለል)	0	1	2	3
320	ያለ ምንም ምክንያት ፍርሃት ይሰማኛል	0	1	2	3
321	ህይዎት ትርጉም እንደሌለው ይሰማኛል	0	1	2	3

ክፍል 4: ሳይኮሶሻል ምክንያቶች

ማህበራዊ ድጋፍ

የማህበራዊ ድጋፍ ልኬት

ከዚህ በመቀጠል የሚመጡት ሦስት ጥያቄዎች የእርስዎን ማህበራዊ ግኑኝነት አና የግል ተሞክሮዎን ይመለከታሉ;; እባክዎትን የእርስዎን የግል ተሞክሮ የሚመለከተውን ምርጫ ብቻ በማክበብ ይተባበሩን።

ማህበራዊ ግንኙነት መጠይቅ		
1	አደጋ (ችግር) በሚያጋጥሞት ጊዜ ምን ያህል ሠው በቅርብ የችግርዎ ተካፋይ ሊሆኑልዎት ይችላሉ?	
	ምንም	1
	1 ወይም 2	2
	ከ3-5	3
	6 እና ከዚያ በላይ	4
2	ምን ያህል ሠው ስለእርስዎ ግድ ይለዋል?	
	ብዙ	5
	ጥቂት	4
	እርግጠኛ አይደለሁም	3
	በጣም ትንሽ	2
	ምንም	1
3	ከ ጎደኞችዎ ወይንም አበረው የጋራ መኝታቤት ክሚጋሮአቸው ሠዎች ተጨባጭ እርዳታ የማግኘት እድልዎ ምን ያህል ነው? (አንድ ምርጫ ብቻ ያክብቡ)	
	በጣም ቀላል	5
	ቀላል	4
	መጠነኛ	3
	አስቸጋሪ ከባድ	2
	በጣም ከባድ	1

ክፍል 5፡ የባህሪ ሁኔታዎች

ጥያቄ 1

በህይወትዎ ውስጥ ከሚከተሉት ንጥረ ነገሮች ውስጥ የትኛውን ተጠቅመው ያውቃሉ?		አዎ	አይደለም
501	የትምባሆ ምርቶች (ሲጋራዎች፣ ትንባሆ የሚያኝኩ፣ ሲጋራዎች፣ ወዘተ.)		
502	የአልኮል መጠጦች (ቢራ፣ ወይን፣ ወዘተ.)		
503	ጫት		

ሁሉም መልሶች አሉታዊ ከሆኑ ይመርምሩ፡ ለሁሉም ጥያቄዎች "አይደለም" ከሆነ, ቃለ መጠይቁን ያቁሙ. ከእነዚህ ጥያቄዎች ውስጥ ለአንዱ "አዎ" ከሆነ፣ እስካሁን ጥቅም ላይ ለዋለ እያንዳንዱ ንጥረ ነገር ጥያቄ 2ን ይጠይቁ

ባለፉት ሶስት ወራት ውስጥ ምን ያህል ጊዜ ተጠቅመዋል የጠቀስካቸው ንጥረ ነገሮች (የመጀመሪያው መድሃኒት፣ ሁለተኛ መድሃኒት፣ ወዘተ)?		አይ	አዎ	አዎ ከሆነ			
				አንድ ወይም ሁለት	በየወሩ	በየሳምንቱ	በየቀኑ / በየቀኑ ማለት ይቻላል
511	የትምባሆ ምርቶች (ሲጋራዎች፣ ትምባሆ ማኘክ፣ ሲጋራዎች፣ ወዘተ.)	0	1	2	3	4	5
512	የአልኮል መጠጦች (ቢራ፣ ወይን፣ መናፍስት፣ ወዘተ)	0	1	2	3	4	5
513	ጫት	0	1	2	3	4	5

ክፍል 6፡ ከስራ ጋር የተያያዙ ምክንያቶች

የመቋቋም መጠይቅ

ለእያንዳንዱ ጥያቄ እራስዎን በ 1 እና 5 መካከል ያስመዝግቡ፣ 1 = በጽኑ የማይስማሙበት እና 5 = በጥብቅ ይስማሙ።

ጥያቄዎች	ነጥብ
601. በአስቸጋሪ ቦታ, ነገሮችን ለማስተካከል ምን ማድረግ እንደሚቻል ወዲያውኑ እመልሳለሁ.	
602. ተጽዕኖ ማድረግ የማልችለውን ነገር ከመጨነቅ ይልቅ በምችለው ቦታ ላይ ተጽእኖ አደርጋለሁ.	
603.በግሌ ትችትን አልወስድም	
604.በአጠቃላይ ነገሮችን በእይታ እጠብቃለሁ።	
605.በችግር ውስጥ እረጋጋለሁ።	
606.ለችግሮች መፍትሄ ለማግኘት ጥሩ ነኝ.	
607.እራሴን እንደ ጭንቀት እንዳለበት ሰው አልገልጽም.	
608.ግጭትን የማስወገድ ዝንባሌ የለኝም።	
609.የሁኔታዎች ተጠቂ ከመሆን ይልቅ ክስተቶችን ለመቆጣጠር እሞክራለሁ።	
610.ውስጤን አምናለሁ።	
611.የጭንቀት ደረጃዎችን በደንብ እቆጣጠራለሁ.	
612.በራስ የመተማመን ስሜት ይሰማኛል	

Maslach Burnout Inventory (MBI)

ጥያቄዎች	የለም	በዓመት ጥቂት ጊዜ	በወር አንድ ጊዜ	በወር ጥቂት ጊዜ	በሳምንት አንድ ጊዜ	በሳምንት ጥቂት ጊዜያት	በየቀኑ
	0	1	2	3	4	5	6
701.በስራዬ ላይ ያለኝ ስሜት እንደተሟጠጠ ይሰማኛል።							
702.ቀኑን ሙሉ ከሰዎች ጋር መስራት ብዙ ጥረት ይጠይቀኛል።							
703.ስራዬ እያፈረሰኝ እንደሆነ ይሰማኛል።							
704.በስራዬ ብስጭት ይሰማኛል።							
705.በስራዬ በጣም ጠንክሬ እንደምሰራ ይሰማኛል.							
706.ከሰዎች ጋር በቀጥታ ግንኙነት ለመስራት በጣም ያስጨንቀኛል.							
707.በገመድ መጨረሻ ላይ እንዳለሁ ይሰማኛል.							

የሥራ እርካታ

ቁጥር	ንዑስ ክፍሎች	በጣም እርካታ የለኝም	እርካታ የለኝም	እርግጠኛ ያልሆነ	እርካታ	በጣም እርካታ
	1. ክፍያ					
801	ገቢህ የሥራው ነጸብራቅ ነው?	1	2	3	4	5
802	ከትምህርትዎ አንፃር በስራዎ እርስዎ የሚያገኙት ጥቅም የሚጠበቀውን ገቢ ያክል ያገኛሉ?	1	2	3	4	5
	2.የማስተዋወቅ እድል					
803	ለሙያዊ እድገት በቂ እድል አለወት	1	2	3	4	5
804	በትምህርት እና በስልጠና ለግል እድገት ድጋፍ ማግኘት	1	2	3	4	5
	3. እውቅና (ከአመራሮች ወይም አስተዳዳሪዎች)					

805	ለእርስዎ አስተያየት በቂ ግምት ተሰጥቷል እና በስራ ቦታ ላይ ለውጥን በተመለከተ አስተያየት	1	2	3	4	5
806	በደንብ ላደልረጉት ተግባራት እውቅና ታገኛለህ?	1	2	3	4	5
	4. ሙያዊ ስልጠና					
807	የስልጠና እድሎች ማግኘት	1	2	3	4	5
808	የእርስዎ ድርጅት ስልጠና ይሰጣል እና ለአዳዲስ ሰራተኞች አቅጣጫ	1	2	3	4	5
	5. የሰራተኞች መስተጋብር እና ሥራ አካባቢ					
809	ከስራ ባልደረቦች ጋር ጥሩ ግንኙነት አለዉት	1	2	3	4	5

810	ሰራተኞች እና አስተዳዳሪዎች መካከል ጥሩ የትብብር ድባብ አለ	1	2	3	4	5
811	በሙያዊ ልምምድዎ ውስጥ ማስተካከል የታካሚ ፍላጎቶችን ማሟላት የሥራ አካባቢዎ እንዲያደርጉ ያበረታታል	1	2	3	4	5

መጠይቅ

ርዕስ፡ ግጭት በሚፈጠርባቸው አካባቢዎች የጤና ባለሙያዎችን የሕይወት ተሞክሮ መመርመር፡ ለድብርት አስተዋጽኦ የሚያደርጉ ምክንያቶች

መመሪያ፡ እባክህ የሚከተሉትን ጥያቄዎች በተመችህ መጠን በዝርዝር መልሱ። ምላሾችዎ በሚስጥር ይያዛሉ፣ እና ማንነትዎ አይገለጽም። በመልሶችዎ ላይ ለማብራራት ነፃነት ይሰማዎ።

የስነ ሕዝብ አወቃቀር መረጃ

1.ዕድሜ፡-

2.ጾታ፡

3.ሙያዊ ሚና፡

4.የዓመታት ልምድ፡-

5. በግጭት ቀጠና ውስጥ የመሥራት አጠቃላይ ልምድዎን መግለጽ ይችላሉ?

6. በእነዚህ አካባቢዎች እንክብካቤ ሲሰጡ ምን ልዩ ተግዳሮቶች አጋጥመውዎታል?

7. እነዚህ ልምዶች በዕለት ተዕለት ሥራዎ እና ከሕመምተኞች እና ከሥራ ባልደረቦችዎ ጋር ባለዎት ግንኙነት ላይ ምን ተጽዕኖ አሳድረዋል?

8. በግጭት አካባቢዎች በሚሰሩበት ጊዜ የአእምሮ ጤናዎን እንዴት ይገልፁታል?

9. የመንፈስ ጭንቀት ምልክቶች አጋጥመውዎታል? ከሆነ፣ ስለእነዚህ ልምዶች ማብራራት ትችላለህ?

10. በግጭት ቀጠናዎች ውስጥ በሚሰሩበት ጊዜ ለአእምሮ ጤና ችግሮችዎ ምን ምን ነገሮች አስተዋፅዖ አድርገዋል ብለው ያምናሉ?

11. በአእምሮ ጤናዎ ላይ ከፍተኛ ተጽዕኖ ያደረጉ ማንኛቸውም ልዩ ክስተቶችን መግለጽ ይችላሉ?

12. ጭንቀትን እና ድብርትን ለመቆጣጠር ምን አይነት ስልቶችን ወይም የመቋቋሚያ ዘዴዎችን አዳብረዋል?

13. በተለይ አጋዥ ሆነው ያገኟቸው ግብዓቶች ወይም የድጋፍ ሥርዓቶች አሉ?

14. በግጭት አካባቢዎች ያሉ የጤና ባለሙያዎች የአእምሮ ጤና ተግዳሮቶችን በተሻለ ሁኔታ እንዲቋቋሙ የሚረዱት ምን አይነት ለውጦች ወይም ግብአቶች ናቸው ብለው ያስባሉ?

15. እነዚህን ጉዳዮች የሚያጋጥሟቸውን የጤና ባለሙያዎች እንዴት ድርጅቶች በተሻለ ሁኔታ መደገፍ ይችላሉ?

16. በግጭት አካባቢዎች የአእምሮ ጤናን በሚመለከት ስላጋጠሙዎት ወይም ግንዛቤዎ ለማካፈል የሚፈልጉት ሌላ ነገር አለ?

ስለ ጊዜዎ እና ግንዛቤዎችዎ እናመሰግናለን! ለዚህ ጥናት ያበረከቱት አስተዋጽዖ በዋጋ ሊተመን የማይችል ነው።