Social Support, Self Efficacy and Quality of Life among Women after Miscarriage

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ABSTRACT

Background: A complicated biological and psychological experience, miscarriage is. The notions of miscarriage and intrauterine fetal death are distinct, with variations in definitions primarily resulting from advancements in medical science, increased survival rates for newborns with an extremely low birth weight, and economic factors. It is regarded as one of the crises women can experience in certain countries.. **Aim:** To evaluate the social support, self-efficacy and quality of life among women after miscarriage. **Subjects and Method:** A descriptive correlational research design was employed in this study. The El-Hayah Port-fouad Hospital and the Dar Sehat Almaraa Hospital in Port Said City were the setting of this study. A purposeful sample wrer recruited for this study to choose 148 post-miscarriage women. Three instruments were used to collect data in addition to a questionnaire on clinical and personal factors: the World Health Organization Quality of Life Scale (WHOQOL-BREF), the Generalized Self-Efficacy Scale (GSES), and the Berlin Social Support Scales (BSSS). **Results:** The women in the study were aged between 20 and 40, with a mean age ± standard deviation of 30.905 ± 5.814 years. Most of the women (75.7%) had less social support following their miscarriage, 68.2% had low self-efficacy, and only 9.0% had a very excellent quality of life. Additionally, there was a strong statistically significant positive link between quality of life and self-efficacy as well as between social support and quality of life. **Conclusion:** Between the overall quality of life score and the total social support score, there is a statistically significant positive link. Concurrently, a highly substantial and favorable statistical association was observed between the overall quality of life score and the total self-efficacy score. **Recommendations:** Peer support groups can be quite helpful because they give women a secure place to talk about their experiences, trade coping mechanisms, and offer support to one another. Peer support has been shown to dramatically increase social support, boost self-efficacy, and improve overall quality of life. To lessen stigma and misunderstandings around this subject, raise public awareness and educate the public about miscarriage.

Keywords: Miscarriage, Quality of Life, Self Efficacy, Social Support.

INTRODUCTION

Miscarriage is a complex biological and psychological experience. It is one of the crises that women can experience, defined as two or more failed clinical pregnancies before 24 weeks of gestation. It is thought to impact about 5% of women trying to conceive (Li et al., 2020). This is a major public health concern. Emotional and psychological consequences are more common than physical side effects, and can range from moderate guilt to more serious issues like depression (Gaafar, 2017). Its burden includes both the experience of loss and associated physical difficulties, such as pain, hospitalization, limitations in one's social roles, a lower sense of security, and changes in one's perceived quality of life (Palus, Mroz, & Bien, 2020).

In medicine, miscarriage is sometimes referred to as spontaneous abortion and pregnancy loss. It is also defined as the embryo's or fetus's natural death before it can survive on its own (Alqassim, Cassie Kresnye, Siek, Lee, & Wolters (2022). Oats and Abraham (2015) state that the World Health Organization (WHO, 2004) has advised that a pregnancy be deemed possibly viable if the gestation period has reached 22 weeks or longer, or if the embryo weighs at least 500 Gram/gm, due to the fact that different in the past. Nowadays, evidence- based medicine confirm tat debat.

The material and emotional resources that are given to a person through interpersonal interactions are referred to as social support. It is the sharing of resources—resources that the supplier believes will help the recipient's health between at least two people (Gaafar, 2017). In a stressful situation, being with someone else eases tension and gives one a sense of security and control. It's thought to play a big part in keeping people well, preventing illness, and making treatment work. Low self-efficacy people frequently have intense emotions, worry, or even sadness, and they may concentrate on their flaws. According to Palus, Mroz, and Bien (2020), a high degree of self-efficacy is also favorably connected with optimism, contentment with a healthy lifestyle, and an enhanced ability to deal with stress or challenges.

Self-efficacy, or people's beliefs in their ability to produce certain behavioral outcomes, is one of the factors that shape the process of coping with a difficult health-related situation. Self-efficacy is essential to human motivation, perseverance, resiliency, and adaptation (Love, Moore, & Hensing, 2011).

A person's perspective of where they are in life in regard to goals, expectations, standards, and concerns within the framework of their culture and value systems is referred to

as their quality of life (World Health Orgaization, 2004).A miscarriage is seen as a stressful life experience that may negatively impact a woman's ability to adjust psychologically and her overall quality of life in terms of her health. According to earlier studies of the literature on psychology following miscarriage, the majority of women who have miscarried before struggle with psychological adjustment, which can result in melancholy and anxiety that lasts for several months (Li, et al., 2020).

A unique form of social connection occurs when nurses communicate with a woman who has lost a pregnancy; there is an exchange of feelings as well as tools for taking action. Acknowledging the uniqueness and complexity of a hospitalized patient benefits the patient-nurse interaction, increases the efficacy of care, and reduces the prevalence of psycho-emotional illnesses related to the patient's medical condition (Palus et al., 2020).

In the realm of healthcare services, nurses and midwives make up the largest professional group. They may also have a significant impact on the treatment of miscarriages. A nurse's or midwife's scope of practice is established by law and education, and this dictates the actions that each professional performs. The context of the practice, the competence and confidence of the nurse or midwife, the people collectively,nurses and midwives make up the largest group of professionals work ing in the healthcare industry, and they may be crucial to thThe nurse's or midwife's confidence and competence, the population's health needs, and the health service's policy requirements all have an impact on the scope of practice. In order to improve practice, streamline service delivery, and enhance women's health and reproductive autonomy, more research is required to guide the breadth of attention that nurses and midwives should devote to developing miscarriage care frameworks (Mainey, O'Mullan, Sear, Taylor, & Baird, 2020).

Quality of life is defined as as an individual perception on their position in life within the context of their culture and value systems in relation to aim, expectation, standard, and worries (World Health organization, 2004) .Miscarriage is considered a traumatic life event and could have harmful effects on the women’s psychological adjustment and health-related quality of life. Previous literature reviews on psychology after miscarriage suggested that most of women with a history of miscarriage experience difficulty in psychological adjustment leading to depression and anxiety that last for several months (Li, et al., 2020).

Significant of the study

Miscarriage is a common and dangerous clinical condition that has a significant impact on population quality in addition to the health of the woman who experiences it. The rate of miscarriage has been rising in recent years; in Egypt, it now accounts for more than 3% of pregnancies (Abd Elsalam, 2017).

The goal of modern medicine is not only to cure women, but also to enhance their quality of life and well-being. For this reason, research on the relationship between social support and the quality of life that women with various conditions experience is becoming more and more important. This is especially true for women who have lost a pregnancy, as this experience has many ramifications, including psychological, social, and occasionally even financial ones. Every woman has unique wants and ideas that influence how she views her living conditions and overall health. In order to support patients in functioning normally not only in Port Said City but also elsewhere, this study is carried out to assess the levels of social support, self-efficacy, and quality of life in women who experienced miscarriage.

Every woman has unique wants and ideas that influence how she views her living circumstances and state of health. In order to support patients in functioning regularly not only in the physical but also in the psychological and social domains, this study is carried out to assess the levels of social support, self-efficacy, and quality of life in women who experienced miscarriage in Port Said City. This research should be included into treatment plans because it advances the quality of care for certain conditions and helps to maintain improvements in those standards.

AIM OF THE STUDY

This study aims to evaluate the social support, self-efficacy and quality of life among women after miscarriage.

Objectives

The study achieved these objectives:

- Assess the level of social support in women after miscarriage.
- Determine the level of self-efficacy in women after miscarriage.
- Measure the level of perceived quality of life in women after miscarriage.

- Find out the relation between social support, self-efficacy and quality of life among women after miscarriage.

SUBJECTS AND METHOD

Study Design

A descriptive correlational research design was used to conduct the study.

Study Setting

The following hospitals in the Port Said Governorate that are associated with the Egypt Health Care Authority Hospitals conducted this study in their Obstetrics and Gynecology departments: Dar Sehet Elmaraa Hospital and El-Hayah Port-Fouad Hospital each had 18 inpatient beds when they were first opened, These hospitals receive pregnant women with abortion. El-Hayah Port-Fouad Hospital had two inpatient wards with 36 beds.

Study Subjects

A purposeful sample of 148 miscarried women who could successfully converse in the aforementioned context served as the study's subjects.
Inclusion criteria:

- Women in reproductive age between 18-40 years old.
- Pregnancy should not last more than 22 weeks.
- Agreed to participate in the study attended to the Obstetrics and Gynecology unit.

Exclusion criteria

Experience of any traumatic event in the past 6 months.

Sample Size

The sample size was calculated using the following equation with a confidence level of 99% (Daniel, 1999).

Total number of women in Dar Sehet Elmaraa hospital was 102 women, total number of women in El-Hayah port-fouad hospital was 46 women. Total number of targeted population was148 women (Daniel, 1999)..

$$n = \frac{N \times P(1-P)}{N-1 \times (d^2 \div z^2) + P(1-P)}$$

$$n = \frac{321 \times 0.5\,(1-0.5)}{321-1 \times (0.05^2 \div 1.96^2) + 0.5\,(1-0.5)} = 148$$

Where:

Z: Class standard corresponding to the level of significance equal to 0.95 and 1.96.

D: the error rate is equal to 0.05.

P: Ratio provides a neutral property = 0.50.

Accordingly, the estimated sample size is 148 subjects per group and adding to them the 10 % to avoid dropped incomplete responses or withdrawal, the final number for sample size will be 163.

Tools of Data Collection

Data from this study was collected by using three different tools they were:

Tool I: The Berlin Social Support Scale (BSSS)

These are a series of self-report questions that were created in English by DiMillo, Hall, Ezer, Schwarzer, and Körner (2019) then translated into Arabic by the researcher in order to gauge social support. The six subscales that make up the BSSSs use a multidimensional approach to assess the level of illness support by measuring the following: Actually received support (14 items), need for support (4 items), perceived available support (8 items), and support seeking (5 items).

Scoring system

Every item was evaluated using a four-point Likert scale, where one represents total disagreement and four represents total agreement with the statement. Additional social support is indicated by higher ratings (DiMillo et al., 2019).

Tool II: The Generalized Self-Efficacy Scale (GSES)

In the English language, Gardner and Pierce (1998) adopt it. Ten items are intended to use this concept. All of the items allude to effective coping and suggest an internally consistent interpretation of achievement. With the intention of predicting both coping with day-to-day difficulties and adapting following a variety of stressful life events, it was designed to evaluate a general feeling of perceived self-efficacy.

Scoring system

A four-point likert scale is used for responses. The ultimate composite score, which ranges from 10 to 40, is calculated by adding the answers to each of the ten items. Three is slightly agree, four is somewhat disagree, and one is disagree. The entire level of self-efficacy is reflected in the total score when transformed into standardized units. Scores of 24 or fewer points indicate low self-efficacy, 25 to 29 points suggest moderate self-efficacy, and 30 points or more show strong self-efficacy.

Tool III: World Health Organization Quality Of Life Scale (WHOQOL-BREF)

It was first created in English by the World Health Organization (2004) as a tool to gauge people's perceived quality of life. The text was translated into Arabic and modified to align with Egyptian customs and the distinct facets of postnatal quality of life. It included 26 elements spanning five primary domains. In particular: overall impression of health (2 things), social relationships (3 items), psychological health (6 items), physical health (6 items), and environmental health (9 items).

Scoring system

A five-point Likert scale was used to score each item, with one representing an extremely low quality of life and five representing an extremely high quality of life. The overall score was between 26 and 130. According to the total score, each subject's perceived quality of life was rated as follows: poor QOL <58, fair QOL <59-65, good QOL <66-97, and very good QOL >97.

Apart from individual traits, medical background, and pregnancy history, the researcher created it in Arabic. Personal details including age, income, employment position, and educational attainment are gathered on the sheet. Along with clinical features and obstetric history, the questions covered gravida, gestational age, number of abortions, reasons for abortions, prenatal care, pregnancy methods, number of live children, and number of

abortions. medical history, including conditions like ischemic illness, hypertension, and diabetes mellitus.

Tools validity

A jury made up of seven experts in academic obstetrics and gynecological nursing determined it. They were asked to share their thoughts and feedback regarding the translated tool. They checked the tools for comprehensiveness, relevancy, and clarity. The tools were altered based on the jury's recommendations, changing the translation of a few terms, for example. Following a translation and back translation process by bilingual specialists in both Arabic and English, the validity of the research instruments was maintained.

Pilot Study

The pilot study was conducted on 10% of the total sample (15 women) for about a month before the actual data collection started. Its goals were to assess the study tools' applicability, clarity, and feasibility as well as to determine how long it would take to fill out the tools and conduct the interview. The modifications were made in accordance with the pilot study's findings.

Tools Reliability

The results of the Cronbach's alpha test, which assessed reliability, showed comparatively uniform instruments. The WHOQOL-BREF scored 0.863, the generalized self-efficacy scale scored 0.820, and the BSSS scored 0.874 in terms of internal consistency.

Field Work

Prior to starting the data collection process, the heads of the hospitals (El-Hayah Port-Fouad and Dar Sehet Elmaraa Hospitals) as well as unit managers (supervisor physician and head nurse) gave their consent. This process took place in the first week of July 2021. After explaining the study's objectives to the director of the chosen hospital, their signed agreement was obtained to carry it out. The researcher used the created tools to gather data from the choosing setting. After obtaining the oral agreement of 148 patients, the study was carried out on them. The researcher completed the sheet.

Before any data was collected, the lady who consented to participate in the study was given a brief explanation of its purpose. The fieldwork was conducted from the beginning of

July 2021 to the end of July 2022, with a tewelve-month timeframe for data collection and completion.

According to the available woman, the researcher was available for the morning shift two days a week. 148 study participants received the questionnaire, which they completed in just two weeks at the start of the study. All 148 study participants completed the checklist, which they did in less than 48 weeks. Data was gathered daily from one to two women. After the researcher had categorized, reviewed, and edited the data, statistical analysis was performed.

The current study took almost 18 months to complete, including two month for the pilot study, official approval, and tool clarity and viability tests. The next one year was spent gathering data, followed by a month-long data input process and four months of statistical analysis.

Administrative Design

An official letter from the vice dean for graduate studies and dean of the faculty of nursing was sent to the director of the chosen study area before any action in the study was taken. In order to get permission to include the women in the current study, the director of the previously stated setting was approached.

Ethical Considerations

The Port Said University faculty of nursing's research ethics committee granted ethical approval, using code number ERN: (73) (1/5/2024). Women gave their informed agreement to take part in the study. Anonymity and confidentiality were ensured for the data gathered. The women who were being investigated were made aware that their involvement in the study was entirely voluntary and that they might leave at any time. The results were utilized as part of the required research, and the study sample's privacy was guaranteed. further for upcoming books and instruction.

Statistical Analysis

IBM Corp., Armonk, New York, published SPSS (Statistical for Social Sciences) version 21.0, which was used to analyze the data that had been gathered. Frequencies and percentages were used to characterize the qualitative data. Standard deviations and means were among the descriptive statistics used to present quantitative data. The correlation

between the variables was examined using Pearson's correlation coefficient. A statistically significant P value was defined as 0.05 or less, and a very statistically significant P value was defined as 0.01 or less.

RESULTS

Table 1 displays the distribution of the women under study based on their individual traits. Based on this table, the wife under study was between the ages of 20 and 40 years, with a mean ± standard deviation of 30.905 ± 5.814. Furthermore, the data indicated that 37.8% of the investigated wives were between the ages of 35 and 40. Conversely, the husbands' ages varied from 22 to 46 years old, with a mean ± standard deviation of 35.02 to 7.120. Additionally, 39.2% of the husbands in the study had ages ranging from 40 to above.

In terms of their wives' working status, fewer than two thirds of them (64.9%) did not have a work, compared to just 4.7% of their husbands. In terms of educational level, it was found that 37.3% of the husband and 47.3% of the wife had a university degree. Over half of the women in the study (58.8%) had been married for more than five years, making up the bulk of the sample (95.3%).

The distribution of the women under study based on their obstetric history is shown in **Table 2.** In relation to gravida, it was found that 81.0% of them had previously given birth one to three times. Parity showed that 43.2% of them had already become mothers (1-3 p). 6.6% of the women in the study had two or three living children. Eventually, it was discovered that every single one of them had a follow-up throughout the first trimester.

The distribution of the women under study based on their current abortion status is shown in **Table 3.** Based on the data presented in this table, the women under study had abortions at intervals of 3 to 22 weeks, with a mean ± standard deviation of 9.202 ± 4.929. Approximately 50% of the women under study underwent an abortion prior to eight weeks, and over two thirds (69.5%) underwent an abortion using an instrument. According to reports, 83.1% of them intended to become pregnant, 16.9% of them used contraception while pregnant, and 60.0% used hormonal contraception.

The distribution of the women under study in relation to their levels of social support was covered in Table 4. 75.7% of the women in the study reported low or no social support, whereas 24.3% had high social support.

Figure 1 shows that, among the women in the study, 68.2% had low levels of self-efficacy and 16.9% had high levels. At last, a mere 14.9% exhibited a moderate degree of self-efficacy.

Figure 2 showed that 58.0% of the women in the study had a poor quality of life, 23.0% had a fair quality of life, and 10.0% had good quality of life. Lastly, just 9.0% of people reported having a very good quality of life.

The correlation matrix between the women under study's self-efficacy, social support, and quality of life is shown in Table 5. Between the overall quality of life score and the total social support score, there was a significant statistical correlation at p value (<0.01**). Additionally, at p value (<0.008**), there was a significant statistical correlation between the total quality of life score and the total self-efficacy score.

Table 1: Distribution of the studied women according to their personal characteristics (n=148).

Personal characteristics items	No	%
Women age (years)		
<25	27	18.2
25-<30	19	12.8
30-<35	46	31.1
35+	56	37.8
Mean ± SD	**30.858 ± 5.875**	
Min.- Max	**20 - 40**	
Husband age (years)		
<25	11	7.4
25-<30	28	18.9
30-<35	27	18.2
35-<40	24	16.2
40+	58	39.2
Mean ± SD	**35.02 ± 7.120**	
Min.- Max	**22 - 46**	
Wife working status		
Working	52	35.1
Not working	96	64.9
Husband working status		
Working	141	95.3
Not working	7	4.7
Wife educational level		
Don't read and write	6	4.1
Read and write	21	14.2
Basic education	20	13.5
Secondary education	26	17.6
University education	70	47.3
Postgraduate education	5	3.4
Husband educational level		
Don't read and write	0	0
Read and write	15	10.1
Basic education	13	8.8
Secondary education	65	43.9
University education	50	33.8
Postgraduate education	5	3.4
Marital status		
Married	141	95.3
Divorced	7	4.7
Marriage duration/Years		
<1	12	8.1
1- 5 years	48	32.4
5-10 years	38	25.7
>10 years	50	33.8

Table 2: Distribution of the studied women according to their obstetric history (n=148).		
Obstetric history items	**No**	**%**
Gravida/times		
1-3	120	81.0
>3	28	19.0
Parity		
Nullipara	65	44.0
1-3 p	64	43.2
>3 times	19	12.8
Number of living child (n=83)		
1	17	20.5
2-3	47	56.6
>3	19	22.9
Time of starting ante natal care(n=114) First trimester (by months ... 1st month, 2nd month, 3th month)	114	100

Table 3: Distribution of the studied women according to their current abortion (n=148).		
Current abortion items	**No**	**%**
Weeks at abortion		
<8	73	49.3
8-<16	55	37.2
16-<24	20	13.5
≥24	0	0
Mean ± SD	**9.202 ± 4.929**	
Min. –Max.	**3-22**	
Types of evacuation		
Spontaneous	45	30.4
Instrumental **(n=103)**	**103**	**69.6**
Medical	47	45.6
Surgical	56	54.4
Planned pregnancy		
Yes	123	83.1
No	25	16.9
Pregnancy with contraception		
Yes	25	16.9
No	123	83.1

Table 4: Distribution of studied women related to their social support levels (n=148)		
Levels of social support	**No**	**%**
Higher social support	75	24.3
Lower social support	112	75.7
Mean ± SD **Min.- Max.**	80.1081± 16.903 40-118	
Types of contraception (n=25) IUD Hormonal Male condom	 8 15 2	 32.0 60.0 8.0

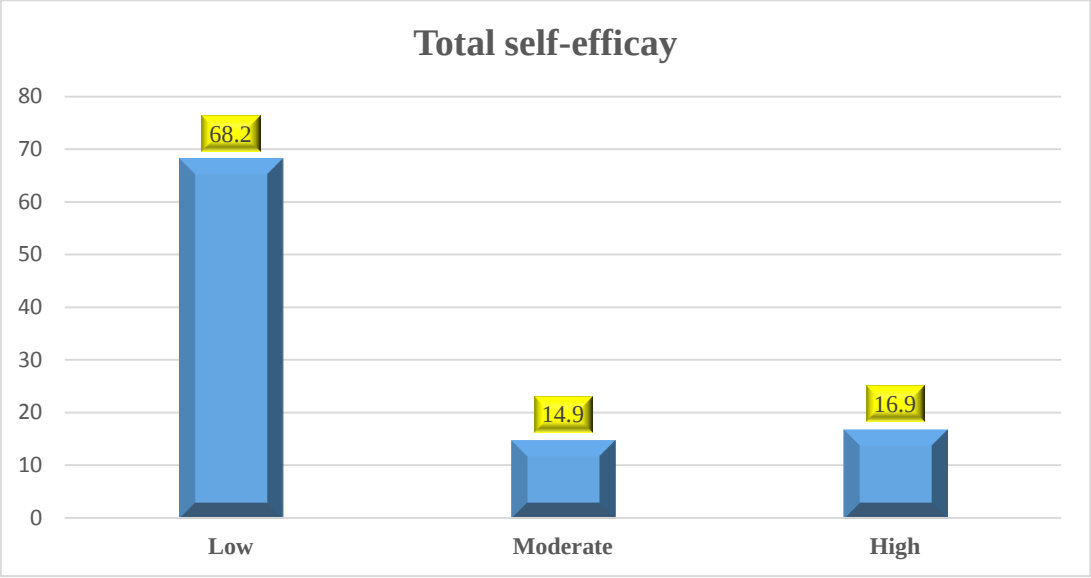

Figure 1: Distribution of studied women related to their self-efficacy levels (n=148)

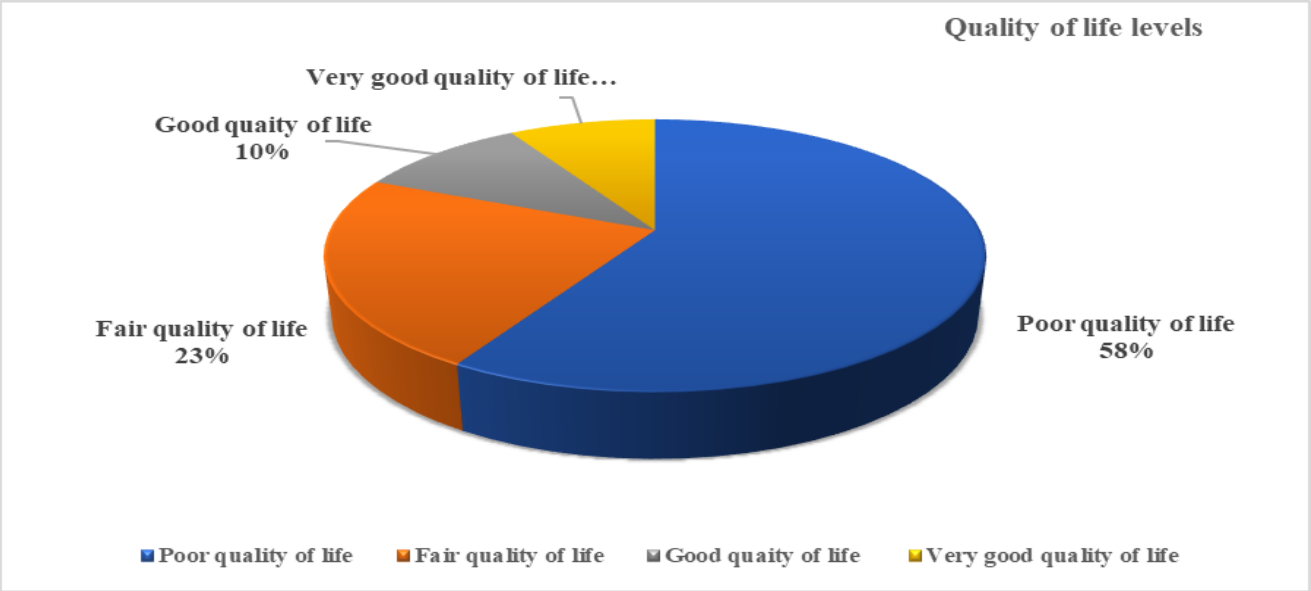

Figure 2: Distribution of studied women related to their quality-of-life levels (n=148)

Table 5: Correlation matrix between self-efficacy, social support and quality of life of the studied women (n=148)

Variables		Total self-efficacy score	Total quality of life score
Total berlin social support score	**r**	0.020	.263**
	p	0.810	.001*
Total quality of life score	**r**	0.218**	
	p	0.008*	

***Significance at P ≤ 0.05** **Highly significant at P ≤ 0.01**

DISCUSSION

It is generally recognized that losing an embryo is an extremely traumatic life experience that frequently results in complex grieving processes that have a detrimental impact on both physical and mental health. Pregnancy loss increases in correlation with prior miscarriages; and unexpected pregnancy loss following one might be a catastrophic event resulting in discernible psychological morbidity for certain women (Abbaspoor, Razmju, & Hekmat, 2016). The experience of loss and associated physical problems, which are linked to discomfort, hospital stays, restrictions on one's social roles, a diminished sense of security, and adjustments in one's perceived quality of life, are both significant components of its burden (Li et al., 2020). The purpose of this study was to assess women's quality of life, self-efficacy, and social support following miscarriage.

The experience of loss and associated physical problems, which are linked to discomfort, hospital stays, restrictions on one's social roles, a diminished sense of security, and adjustments in one's perceived quality of life, are both significant components of its burden (Li et al., 2020). The purpose of this study was to assess women's quality of life, self-efficacy, and social support following miscarriage.

Based on the current research findings, it can be deduced that around 50% of the women surveyed were already mothers with two or three children, had undergone at least one abortion, and most of them were unaware of the reason behind their most recent abortion. This conclusion contrasted with that of Grauerholz, Berry, Capuano, and Early (2021), who reported that a smaller percentage of the women in their study reported having lost more than one pregnancy.

The results of the current study clarified that most of the women under study had support; however, less than one-third of them got it from their mothers, a smaller percentage from their sisters, and over one-third from their husbands, who provided roughly three quarters of this support.

In keeping with the earlier conclusions of this study by Gergett and Gillen (2014) found that social support is essential to the emotional and psychological recovery process following a miscarriage in their investigation of "Early pregnancy loss; perceptions of healthcare professionals." It can give women the certainty, comprehension, empathy, and

affirmation they need during this trying time. Feelings of loneliness and sorrow can be lessened by having someone to talk to, share feelings with, and find solace from.

As the current study reports, the results emphasize how critical it is to give those who have lost a pregnancy enough social support. Having a solid support network helps enhance general wellbeing and healing while easing some of the psychological discomfort brought on by such traumatic experiences.

As to the findings of Kolte, Olsen, and Mikkelsen (2015), losing a pregnancy can be an upsetting event that may lead to psychological instability. Many elements, such as one's degree of confidence and self-belief, affect how people respond to difficult health conditions (Schwarzer & Jerusalem, 2012).

According to Gergett and Gillen's (2014) research on "Early pregnancy loss; perceptions of healthcare professionals," social support plays a crucial role in the emotional and psychological healing process after miscarriage. These findings are consistent with the findings of this study. It can offer women the support, comprehension, understanding, and assurance they need at this trying time. Having a network of support and someone with whom to share sentiments could lessen feelings of grief and loneliness.

The results of the current study showed that the lowest percentage of the women investigated had high levels of self-efficacy, and fewer than three quarters had poor levels. Reardon (2018) found similar results in his study, "The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities." However, personality factors such as low self-esteem and low perceived control over one's life after abortion were present in more than half of the women in the study.

According to the current study's findings, there was a highly favorable statistically significant association between social support and quality of life for the women under study, as well as between social support and self-efficacy. Furthermore, the current study showed a favorable association between self-efficacy and quality of life that is highly statistically significant.

Palus et al., (2021) found that the physical, social, and psychological domains of quality of life were positively correlated with emotional perceived social support and

self-efficacy. These findings were supported by their study on "Quality of life, environmental, social support, and self-efficacy in women after a miscarriage."

Further supporting this finding is a study by Charlton, McQuaid, and Wallace (2023) titled "Social support and links to quality of life among middle-aged and older autistic adults" which found a relationship between all aspects of quality of life (physical, psychological, social, environmental, and autism specific) and anxiety, self-reported depression, instrumental, subjective, and interaction social support.

CONCLUSION

Nonetheless, there was a statistically significant positive association found between the overall quality of life score and the total social support score. Concurrently, a highly substantial and favorable statistical association was observed between the overall quality of life score and the total self-efficacy score.

RECOMMENDATIONS

The study's findings led to the following recommendations being made:

- Medical professionals should create extensive support systems specifically designed to meet the needs of miscarried women. To help women cope, these programs should provide counseling services, instructional materials, and emotional support.
- Peer support groups are incredibly helpful because they give women a secure place to talk about their experiences, trade coping mechanisms, and offer support to one another. Peer support has been shown to dramatically increase social support, boost self-efficacy, and improve overall quality of life.
- Raise public knowledge and education about miscarriage in order to dispel stigma and false beliefs about the subject.
- By educating medical personnel about the psychological effects of miscarriage, patients may receive more sympathetic and encouraging treatment.
- Promote the use of self-care activities by women, such as physical exercise, mindfulness, and relaxation techniques, to improve their emotional resilience and well being after miscarriage.

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الدعم الاجتماعى والكفاءة الذاتية و جودة الحياة لدى النساء بعد الإجهاض

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الخـــلاصـــــــــــــة

الإجهاض تجربة بيولوجية ونفسية معقدة. تختلف مفاهيم الإجهاض وموت الجنين داخل الرحم، مع اختلافات في التعريفات الناتجة في المقام الأول عن التقدم في العلوم الطبية، وزيادة معدلات البقاء على قيد الحياة للمواليد الجدد ذوي الوزن المنخفض للغاية عند الولادة، والعوامل الاقتصادية .يُنظر إليه على أنه إحدى الأزمات التي قد تمر بها النساء في بعض المناطق.. هدف البحث: تهدف هذه الدراسة الى تقييم الدعم الاجتماعي، والفعالية الذاتية ونوعية الحياة لدى النساء بعد الإجهاض. طرق وادوات البحث: واستخدمت الدراسة الحالية التصميم الوصفي الترابطى. وقد أُجريت هذه الدراسة في مستشفى الحياه بورفؤاد ومستشفى دار صحة المرأة في مدينة بورسعيد. وتم أخذ عينة هادفة لاختيار 148 امرأة بعد الإجهاض. وإلى جانب استبيان عن العوامل الشخصية والإكلينيكية، تم استخدام ثلاث أدوات لجمع البيانات بالإضافة إلى استبيان عن العوامل السريرية والشخصية: مقياس منظمة الصحة العالمية لجودة الحياة (WHOQOL-BREF)، ومقياس الكفاءة الذاتية المعممة (GSES) ، ومقاييس برلين للدعم الاجتماعي(BSSS) . النتائج: تراوحت أعمار النساء اللاتي شملتهن الدراسة بين 20 و 40 سنة بمتوسط عمر ± انحراف معياري 30.905 ± 5.814 ، وتتلقى غالبية النساء اللاتي شملتهن الدراسة (75.7 %) دعما اجتماعيا أقل بعد الإجهاض، و68.2 % من النساء اللاتي شملتهن الدراسة يعانين من ضعف الكفاءة الذاتية، و9 % منهن يتمتعن بنوعية حياة جيدة جدا. كما أن هناك أيضاً ارتباطاً كبيراً من الناحية الإحصائية بين الدعم الاجتماعي ونوعية الحياة، كما أن هناك ترابطاً إيجابياً كبيراً من الناحية الإحصائية بين نوعية الحياة والفعالية الذاتية. الاستنتاجات: توجد إحصائياً علاقة إيجابية وهامة بين مجموع درجات الدعم الاجتماعي و مجموع درجات جودة الحياة. وفي الوقت نفسه، كان هناك في الإحصاءات ارتباط إيجابي كبير وهام بين مجموع درجات نوعية الحياة و مجموع درجات الكفاءة الذاتية. التوصيات: ويمكن أن يكون إنشاء مجموعات دعم الأقران مفيداً للغاية، إذ يوفر للنساء حيزاً آمناً لتبادل الخبرات وتبادل استراتيجيات التكيف وتقديم الدعم المتبادل. ويمكن للدعم الذي يقدمه الأقران أن يعزز إلى حد كبير الدعم الاجتماعي ويسهم في تحسين كفاءة الذات ونوعية الحياة. زيادة وعي الجمهور وتثقيفه بشأن الإجهاض للحد من الوصم والتصورات الخاطئة المحيطة بهذا الموضوع.

الكلمات المرشدة: الأجهاض، جودة الحياة، الكفاءة الذاتية، الدعم الاجتماعي.