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Lived experiences of intimate partner violence survivors during pregnancy and who had spontaneous abortions: A phenomenological study to inform survivor-centered strategies

Zenawi Hagos Gufue[1], Helen Teweldebrhan Hailu[1], Abadi Hailay Atsbaha[1], Berhe Mengesha Kiros[2], Etsay Weldekidan Tsegay[3] and Meresa Berwo Mengesha[4]

Abstract

Background: Previous studies quantified that women who experienced intimate partner violence (IPV) had a higher risk of spontaneous abortion than women who did not experience IPV. However, there is limited evidence documenting the experiences of women in Northern Ethiopia who have been subjected to partner violence and who had spontaneous abortions. This evidence is critical for policymakers looking to improve women's access to maternity care.

Objectives: This study aimed to explore the lived experiences of IPV survivors during pregnancy who had spontaneous abortions in Northern Ethiopia.

Design: A phenomenological qualitative study design was used to explore the lived experiences of survivors of IPV who had spontaneous abortions.

Methods: A total of 16 interviews were conducted between April 23 and June 5, 2020. Eight in-depth interviews and eight key informant interviews were conducted with eligible mothers who received the required service, Adigrat General Hospital service providers, zonal women's affairs experts, and legal professionals. The purposive sampling technique was used to select study participants, and the sample size was determined using the information saturation principle. The data were analyzed through open coding and thematic content analysis.

Result: The themes that emerged in this study included opinions toward IPV, mothers' and experts' experiences of partner support during pregnancy, attitudes toward IPV, and understanding of spontaneous abortion. Physical, emotional, sexual, and economic pressure were identified as the most common forms of IPV. Participants in the study believed that physical violence and stress were associated with spontaneous abortion. They also mentioned various strategies for preventing IPV, such as providing job opportunities for women, punishing perpetrators, and encouraging mutual tolerance.

Conclusion: This study found that spontaneous abortion is linked to any type of IPV, including physical IPV during pregnancy. IPV is a community-supported event that necessitates strategies and legal frameworks to prevent and mitigate its effects.

[1]Department of Public Health, College of Medicine and Health Science, Adigrat University, Adigrat, Ethiopia
[2]Department of Nursing, Dr. Tewelde Legesse Health Sciences College, Mekelle, Ethiopia
[3]Department of Pharmacy, College of Medicine and Health Science, Adigrat University, Adigrat, Ethiopia
[4]Department of Midwifery, College of Medicine and Health Science, Adigrat University, Adigrat, Ethiopia

Corresponding author:
Zenawi Hagos Gufue, Department of Public Health, College of Medicine and Health Sciences, Adigrat University, Kebelle 04, Adigrat, Tigray 50, Ethiopia.
Email: Zenawi.2009@gmail.com

Plain language summary

Ethiopia has made significant strides in recent decades towards protecting women from IPV through the implementation of gender-sensitive legislation. Despite these efforts, IPV continues to result in a range of health problems and complications during pregnancy. There is limited evidence documenting the experiences of women in Northern Ethiopia who have been subjected to partner violence and who had spontaneous abortions. This evidence is critical for policymakers looking to improve women's access to maternity care. This study aimed to explore the lived experiences of intimate partner violence survivors during pregnancy and those who had spontaneous abortions using a phenomenological qualitative study design. Intimate partner violence is a community-supported event that necessitates strategies and legal frameworks to prevent and mitigate its effects.

Keywords

intimate partner violence, lived experience, partner support, phenomenological study, spontaneous abortion, northern Ethiopia

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Introduction

The World Health Organization (WHO) defines spontaneous abortion as fetal death that occurs spontaneously before the 28th week of gestation.[1,2] It has been documented that spontaneous abortion is the most common pregnancy complication that occurs in about 10–15% of all confirmed and suspected pregnancies globally.[3] The majority of miscarriages occur in low- and middle-income countries (LMICs) and the sub-Saharan African (SSA) region. Studies also indicate that the risk of pregnancy termination is higher among adolescent girls and young women in comparison to older women.[4] Unsafe abortions are the primary cause of maternal morbidity and mortality, but spontaneous abortion also plays a significant role in these issues. Complications such as hemorrhage, sepsis, organ damage, ectopic pregnancy, and secondary infertility can arise from spontaneous abortion.[5]

According to a report by the WHO from 2017, globally, approximately 7% of maternal mortality and 8.9% of years of life lost are attributed to abortion. In SSA, abortion accounts for 9.6% of maternal mortality.[6] A systematic review conducted in Ethiopia in 2016 found that abortion was the fourth leading cause of maternal mortality from 1990 to 2016.[7] It is estimated that globally, approximately 8.9% of hospital admissions due to nearly missed morbidity are caused by abortion-related complications.[6] A study conducted in Addis Ababa, Ethiopia, also showed that 4% of maternal near-miss cases were due to abortion.[8] One of the well-established and significant risk factors for pregnancy loss is intimate partner violence (IPV).[9]

Violence inflicted by a partner may be described as IPV, defined by the WHO as "IPV encompasses actions within an intimate relationship that lead to physical, sexual, or psychological harm, such as physical aggression, sexual coercion, psychological abuse, and controlling behaviors."[10] IPV has been linked to numerous adverse outcomes for women, including spontaneous abortion, induced abortion, and stillbirth.[3,11,12] Women who experience IPV may have their pregnancy terminated due to direct trauma, stress, and emotional distress resulting from physical, emotional, and sexual abuse.[3]

Furthermore, some women may undergo induced abortion as a result of high levels of depression, posttraumatic stress disorder, psychological distress, and suicidal thoughts.[13] However, it is important to note that women exposed to IPV have low utilization of health services.[3] According to global studies, 26% of women have experienced physical and/or sexual violence from a current or former male intimate partner at least once in their lifetime.[14] It is estimated that between 4 and 29% of violence against women during pregnancy occurs in LMICs, including SSA.[15]

Based on data from the Ethiopia Demographic and Health Survey (EDHS), over one-third of ever-married women in the country have experienced IPV. The Oromia region has the highest incidence of IPV during pregnancy, accounting for 38% of the reported incidents.[16] Due to the negative consequences of IPV on maternal and child health, in recent decades, both globally and nationally, efforts have been made to prevent violence against women, which also includes IPV. Various policies and programs have been developed to address this issue, such as the Convention on the Elimination of All Forms of Discrimination Against Women adopted in 1979, the Declaration to Eliminate Violence Against Women in 1993, the start of WHO's work on gender-based violence in 1996, and the development of WHO's prevention of intimate partner and sexual violence against women in 2010.[3,17]

The current Sustainable Development Goal target 5.2 also aims to eliminate all forms of violence against all women and girls.[18] Ethiopia has made significant strides in recent decades toward protecting women from IPV through the implementation of gender-sensitive legislation. For instance, the 2005 revised criminal code Article 564–565, 587, 620, and 648 and the 2003 revised family law both

prohibit violence against a marriage partner or a person cohabiting in an irregular union. The legislation explicitly prohibits domestic violence, female circumcision, rape outside of marriage, abduction of women for marriage, and marriage with a minor, and outlines the penalties associated with each crime.[19,20]

While such initiatives are considered to be in a position to mitigate this alarming problem, IPV continues to result in a range of health problems and complications during pregnancy. Lack of provision of education for raising awareness, traditional norms and beliefs within the community, lack of provision of professional help, outdated laws that should have been revised, and failure to enforce new laws according to the needs and experiences of the women were some of the reasons for the escalations of this incident.

Despite this, there are limited studies on women's experiences of living with violence during pregnancy and there is a paucity of data on healthcare providers' and experts' perceptions and responses toward women who are exposed to IPV during pregnancy. The WHO emphasizes the need to understand the prevailing culture of violence to eliminate gender discrimination and all forms of violence against women. This study explores different options for improving the circumstances of women who have undergone a spontaneous abortion and are experiencing IPV.

It is crucial to acquire more knowledge about the experiences, needs, and challenges of women who have suffered a spontaneous abortion as a result of IPV so that we can develop survivor-centered approaches and strategies. This will have a favorable impact on providing appropriate assistance and support to these women. Furthermore, we include healthcare workers' insights, responses, and expert views on IPV during pregnancy to have clear strategies and policy options to prevent the problem. This study aimed to explore the lived experiences of IPV survivors who had spontaneous abortions in northern Ethiopia.

Research question

What are the lived experiences of IPV survivors during pregnancy who had spontaneous abortions in northern Ethiopia that can be useful for policymakers?

Methods

Study setting and study period

The study was conducted at Adigrat General Hospital from April 23 to June 5, 2020. Adigrat General Hospital is located in Adigrat town administration, in the eastern zone of Tigray, northern Ethiopia, 903 kms to the north of Addis Ababa, the capital city of Ethiopia, and 120 kms away from the regional capital city of Mekelle. Adigrat General Hospital is a government-owned facility that functions as a general hospital and teaching center for Adigrat University. It also serves as a referral hospital for the surrounding areas in the eastern zone of the Tigray region, with an average of 142,765 patient visits per year.

Mothers who had spontaneous abortions were initially assessed at the emergency department of the hospital, and cases of incomplete and inevitable abortions were admitted to the abortion unit of the Maternal and Child Health (MCH) wards. According to the 2019 Adigrat Hospital report, there were 1009 abortion cases, out of which 616 were spontaneous abortions. The qualitative data presented in this article were derived from a larger mixed-methods study aimed at identifying the determinants of spontaneous abortion among women survivors of IPV during pregnancy and exploring their lived experiences.[21] Qualitative data on the lived experiences of IPV survivors during pregnancy and who had spontaneous abortions were presented in this paper.

Study design

A phenomenological qualitative research design was used to explore the lived experiences of mothers who had experienced IPV and who had spontaneous abortions. Phenomenological study design is an approach focused on exploring and understanding the lived experiences of individuals based on subjective experiences and perceptions to describe and interpret the meaning that the individuals ascribe to their experiences, often capturing the essence of a particular phenomenon. We applied this approach to explore the experiences and perceptions of IPV survivor mothers who had spontaneous abortions. In-depth interviews (IDIs) were conducted to gather relevant information from the survivors, and key informant interviews (KIIs) were conducted for service providers, experts, and legal officers.

Participants and recruitment

The study participants comprised eight women who had received treatment for spontaneous abortion, four healthcare providers working in Adigrat General Hospital's maternity ward, two police officers, and two key informants from the Eastern Zone of the Tigray Region's Bureau of Women Affairs. Mothers who had undergone spontaneous abortions were asked about their experience of IPV. Purposive sampling was used to recruit participants from these mothers. Hence, women who had experienced IPV and who had spontaneous abortions were chosen purposefully.

Healthcare providers were required to have at least 6 months of work experience in the Maternal and Child Health Department. At the same time, the KIIs included two policemen and two gender office experts selected purposefully. Taking into account the necessity to preserve the interviews' scientific rigor, reliability, and trustworthiness,

the sample size for the interviews was determined or guided using the information saturation principle.[22]

Data collection instrument

The interview guide was initially developed in English and then translated into Tigrigna by an independent professional translator. It was an open-ended questionnaire that was pilot-tested across health services, and iteratively refined based on the emerging data to gather and get better information from the participants' experiences, opinions, and perceptions. Separate interview guides were prepared for mothers, healthcare providers, police officers, and the experts of the gender office zonal department. During the interviews, probes such as "please explain," "list," or "can you elaborate on the idea" were used as required (see Supplemental File 1). The audio-recorded data was transcribed word for word, and then translated from Tigrigna to English.

Data collection process

In this research, two different data collection methods were employed. First, IDIs were conducted with mothers who had sought abortion care services. Second, KIIs were held with healthcare providers, zonal gender office experts, and police officers. The first and last authors conducted the IDIs and KIIs using an open-ended study guide and recorded them using audio recorders, respectively. The length of each interview was determined by the point of information saturation during the data collection period.

Before data collection, the study participants were informed about the study's purpose and data collection procedures. To maintain rapport and trust and get better data, the data collection using IDI for mothers was conducted in Adigrat General Hospital's separate room, where the privacy and confidentiality of participants were not exposed. KIIs for the healthcare providers were conducted in a separate room, and those for the police officers and zonal gender office focal person were held at their offices.

Data processing and analysis

First, the audio-recorded data and field notes were listened to and read repeatedly until they were fully understood and familiar with them. Verbatim transcription was conducted during the interviews and the transcribed text was translated from Tigrigna into English. Each transcription and its respective notes were read and reread simultaneously by investigators to become familiar with them, checking for errors and cross-checking the transcribed verbatim and audio-recording voices. The English version was exported to Open Code software version 4.02, and the software was used for coding and categorization.

Thematic content analysis was used to generate codes, categories, and themes from interviews. The authors independently coded the interviews line-by-line and discussed them with the research team. Data and codes were constantly compared to resolve occasional discrepancies and increase confidence in the analysis. The codes gradually collapsed to form categories that further collapsed to form a recurring theme. Data collection and analysis were carried out concurrently until there was no new emerging data and the research teams were satisfied with the data saturation level.

Data quality assurance

Careful sampling and participant selection were then performed to provide sufficient information about the research context and to assure the transferability of the findings. Triangulation of participants and researchers, prolonged engagement, persistent observation with participants, member checking, peer reviewing, and debriefing by other researchers were done to ensure the credibility of the study. Member checking was done by presenting the findings and interpretations of the study to the participants to express their views.

There was extensive engagement with the study participants, triangulation, member checking, and searching for negative cases. Audio records of participants' interviews, notes taken during the interview, and transcriptions were saved for cross-checking the process and to sustain the consistency of the interpretation. This study included an audit of transcripts, field notes, coding and analysis, interpretation, and other documents. To reduce bias during data analysis and interpretation of the results, the respondents' expressions were recorded. We followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines while writing this paper.[23]

Results

A total of 16 interviews were conducted, eight of which were IDIs with mothers about their spontaneous abortion experiences. The KIIs also included four healthcare professionals working in maternal and child health clinics, two police officers, and two focal persons from the gender office. All eight interviewed mothers had experienced IPV and spontaneous abortion.

Theme 1: Perceptions toward IPV

Meaning of IPV

In our study, the majority of the study participants opposed violence against intimate partners. They believe that a husband should never physically abuse his wife, preferring to talk to her and make her realize her mistakes. The majority

of respondents identified IPV as a husband hitting, belittling, or degrading his spouse. Some participants define it as a spouse beating, raping, threatening, or isolating his wife from decision-making.

> . . .. I considered a physical assault an easy assault. But a serious assault is when one is sexually assaulted, raped, or even put under unnecessary pressure from family. For example, when the husband doesn't include her in making decisions or doesn't even consider her as his partner and beats her. (ID 03, F).

Types of IPV

According to our research, almost all mothers categorize IPV into four types: physical abuse, emotional abuse, sexual abuse, and controlling behavior. Health professionals identify four types of IPV: economic, sexual, emotional, and physical pressure. Our findings indicate that participants in our study classified their intimate partner's behavior as emotional abuse, physical abuse, controlling behavior, or sexual abuse.

Causes of IPV

Though all participants opposed IPV, it remains prevalent on the ground, and some societies view it as a normal phenomenon, with certain sayings encouraging IPV. IPV is one common source of suffering for mothers in their lives. This societal and cultural approval for the normalization of IPV was one of the main causes of IPV. Some of those sayings are:

> . . .. . . A wife and a donkey have to be hit to do the right thing. (ID 01, F).

> . . .. Women should get used to their husband's behavior, whatever that is . . . (ID 06, F)

According to study participants, factors that contribute to IPV include alcohol consumption, inequality, societal perspectives on IPV, substance use, a lack of education, financial problems, unemployment, jealousy, traditional attitudes, dependence, dishonesty, partner habitual abusive behavior, a lack of family support, misunderstandings, and disrespect for one's partner.

> . . .. . . The community considers the abuse of a wife by her husband as normal but forbids her to do anything wrong to her husband. Even your family will not support you when you want to take action or divorce them . . .. . . (KI 06, M).

The impacts of IPV

The study participants mentioned several commonly reported IPV consequences. These outcomes include disability, depression, divorce, and miscarriage. Some participants also mentioned insecurity, low self-esteem, HIV, financial difficulties, unwanted pregnancy, stress, premature labor, preeclampsia, pregnancy bleeding, and even death as potential outcomes of IPV. Children may also suffer negative effects on their mental and physical health as a result of IPV.

> . . .. . . Those women who faced IPV suffered from economic, psychological, and health problems. When I say psychological, she may suffer from depression and less self-confidence. They also suffer from unwanted pregnancy because she is dependent on her husband; she may not use contraceptives if her husband doesn't allow her. (KI 03, M).

Strategy, programs, and preventions for IPV

Many participants believe that increasing awareness and communication can help prevent IPV. Some argue that providing job opportunities for women could alleviate the financial issues that are frequently the root cause of IPV. Others propose punishing perpetrators of IPV, promoting IPV-related media programs, and refusing to accept abusive behavior. Some argue that women should protect themselves from abuse by avoiding confrontation with their drunk partner and reporting the abuse to the police.

> . . .. . . She either has to go to the police or communicate if he is kind enough to listen and change . . .. . . Society will not help her unless she is very hurt, like bleeding or worse so she has to fight herself. The government should give job opportunities to jobless women. (KI 02, F).

During the prevention of IPV, the zonal gender office has faced many challenges. Some of those challenges mentioned by the focal person are women not pursuing litigation until the end, pride, and being afraid to talk about their abuse.

> . . .. They hide their pain by fearing gossip. They don't pursue it till the end. They usually associate it with pride. But the main problem is that after every abuse, these women make peace with their husbands in fear of social judgment. (KI 08, F).

Management of IPV

Healthcare management of IPV. Most healthcare providers treat IPV that results in a spontaneous abortion by admitting the victim, administering antibiotics, performing a manual vacuum aspiration, and providing medical care. Data indicate that the majority of the health professionals in our study lacked training or understanding of how to deal with IPV. Only one participant helps victims of IPV who have had a spontaneous abortion by connecting them with social workers and women's services.

> There was this woman who came from Gulomekeda woreda. She said that her life was in danger and she wouldn't go back to her house. By collaborating with the social committee, we linked her up with women's affairs. (KI 03, M).

Society management of IPV. The majority of participants believe that in society, when women complain about IPV, it is usually resolved through negotiation, reconciliation, and advice to be women, or it can end up in divorce. Negotiation occurs when society provides advice, resolves a problem through interaction with both parties and counsels them. However, some of them may sue their partners in court, which is uncommon.

> Most of the time, the solution is divorce. Some of the educated women think suing is better but some of society tells you to be patient. Women should get used to their husband's behavior, whatever that is (ID 06, F).

Legal management of IPV. When a woman approached a police officer, she complained that her husband had beaten her. They handle it by gathering information about the cause of IPV, developing a solution in collaboration with elders, and transferring the case to court if the problem is not resolved. Furthermore, most husbands and wives argue at night, so until the issue is resolved in the morning, the husband will temporarily sleep in the home of a friend or family member.

> . . .. We will try to get the husband out of the house by negotiation. However, we can't force him to get out of the house. But if he abuses her severally (that means physically injuring her severally), we will oblige to arrest him overnight in the station. (KI 05, M).

Theme 2: Understanding the prevention of spontaneous abortion

The participants in the study had varying interpretations of the term "spontaneous abortion." According to their responses, spontaneous abortion refers to the natural occurrence of losing a pregnancy, characterized by the loss of blood and the death of the fetus in the mother's womb, resulting in an unwilling termination of the pregnancy.

> . . .. Spontaneous abortion for me is when the fetus dies in the mother's womb. (ID 05, F).

According to the participants, the most common causes of spontaneous abortion were carrying heavy objects, experiencing stress, natural causes, anger, physical abuse, and using traditional medicine. Some participants also mentioned drinking alcohol, having other health problems such as high blood pressure, having unmatched blood types between couples, not getting regular medical check-ups, and using traditional medicine as a cause of spontaneous abortion.

> . . .. If another pregnant woman passes near the other pregnant women (which means a pregnant woman who has tied traditional medicine to protect her baby can harm the other and lead to miscarriage). (ID 01, F).

The impacts of spontaneous abortion

Most participants report the physical and emotional consequences of spontaneous abortion, including bleeding, pain, depression, anemia, guilt, discomfort, infection, and potential abuse.

> . . .. . . Women may be further abused by their husband because he thinks it is the woman's fault that the baby died. They may also suffer from infections. (KI 07, M).

Relationship between spontaneous abortion and IPV

In our study, two mothers did not believe that there was a connection between IPV and spontaneous abortion. However, the majority of the mothers in our study acknowledged that physical beatings, stress, and sadness caused by IPV could lead to spontaneous abortion.

> . . .. In my opinion, spontaneous abortion and intimate partner violence have a relationship. For example, if her husband beats her severely, she may lose the baby. (KI 04, F).

Prevention of spontaneous abortion

According to most of the participants, spontaneous abortion can be prevented by taking certain measures. These include avoiding heavy lifting, seeking prenatal advice, regularly undergoing check-ups, maintaining a balanced diet, refraining from using traditional medicine, and controlling anger. However, some participants hold the opinion that spontaneous abortion cannot be prevented.

> . . .. I do not believe that using traditional medicine to protect yourself is the right thing to do because it implies killing someone else's child to protect yourself. This does not make sense to me. The solution is to stop using traditional medicine like our mothers used to. (ID 02, F).

Theme 3: Perception of mothers toward partner support during pregnancy

Type of partner supports

In our study, we found that most mothers perceived that husbands should support their wives during pregnancy by helping with household chores, fulfilling their needs (such as buying fruits and vitamins and satisfying their cravings), listening to their opinions, accompanying them to

ANC follow-up appointments, and helping them carry heavy objects.

> . . .. He must help her by fulfilling her medical and nutritional needs. He also needs to understand her pregnancy emotions, such as cravings, loss of appetite, and nausea. He also should support her on house chores. (ID 03, F).

KII findings indicated that the husband should help in providing pregnancy-related pieces of information that are vital to the health of the mother and baby.

> . . .. A husband should play a vital role in the provision of pregnancy-related pieces of information even by searching and asking health professionals to help his wife and create a supportive and positive environment for better health of pregnant mother and baby. (KI 04, F).

Impact of partner supports

Participants mentioned that if there is low or no partner support, it can have a substantial impact on the mother. These include early pregnancy loss, less tolerance to pregnancy-induced body changes, stress, anxiety, depression, being a victim of violence during pregnancy during pregnancy, and for the baby; low birth weight, premature birth, and developmental delay.

> . . .. . . if a pregnant mother doesn't get support from her partner, it impacts the overall mother and baby's health. Let me tell you what I encountered when I was pregnant with my lost baby. My husband didn't support me in reverse he was insulting, heating, and committing other sorts of violence and I was anxious, depressed, stressed, angry, and sad then in the end my baby was lost. (IDI 02, F).

However, if there is strong support from a partner and a romantic relationship between husband and wife, it significantly enhances the overall pregnancy experience and will have or contribute to better outcomes for both the mother and baby.

> . . .. . . When the husband helps his wife in a diverse dimension of life not only the wife but also the whole family become thrilled and have a common understanding then the mother and her baby's health is well maintained. (KI 07, M).

Discussions

This study tried to explore the lived experiences of IPV survivors who had spontaneous abortions by collecting relevant information from themselves, healthcare or service providers of MCH, policemen, and zonal gender office affairs experts to have diverse and better opinions, feelings and evidence of the influence of IPV on spontaneous abortion in Northern Ethiopia. According to the qualitative analysis, three recurrent themes have emerged: opinions toward IPV, perceptions of partner support during pregnancy, and understanding of spontaneous abortion.

In our study, we found that nearly all mothers categorize IPV into four types: beating, insulting, rape, and controlling. Health professionals also classify IPV into four categories: physical, emotional, sexual, and economic pressure. Although the terms used to describe the various types of IPV are similar, they are not interchangeable. So, our findings suggest that the participants in our study classified their intimate partner's behavior as emotional, physical, controlling, and sexual IPV. The findings of this study go with the study done in Ofla district, Southern Tigray[24] and the EDHS 2016 report, which classified IPV as physical spouse violence (beating), sexual spouse violence (raping), and emotional spouse violence (insulting and controlling).[25]

Even though all participants did not support IPV, the societies support and consider IPV as a normal phenomenon in a relationship. Similar studies show that there is a normalization and acceptability of IPV in communities or societies.[26–28] It is also similar to the EDHS 2016 report that beating a wife is more acceptable in societies, especially in the rural areas of Ethiopia.[25]

This suggests that existing social norms, which regard men as more powerful and women as less contributing, do not treat women equally across cultures and beliefs. In our study, we explored the risk factors for IPV: drinking alcohol, inequality, social perspectives of IPV, smoking, lack of education, financial problems, unemployment, jealousy, backwardness, dependence, dishonesty, habitual behavior of beating a wife, lack of family support, misunderstandings, and talking back to one's spouse.

This study is in line with the study conducted in Southern Tigray, Northern Ethiopia, that shows having an alcohol consumer partner, acceptance of violence, and low decision-making power[24] and multilevel analysis of the 2011 EDHS arguing with husband and accepting the violence as nothing were predisposing to IPV.[28] This implies that deep-rooted cultural beliefs are facilitators of accepting problems as normal events. The study showed that most mothers in our study acknowledged that physical beatings, stress, and sadness caused by IPV could lead to spontaneous abortion.

Physical violence by an intimate partner during pregnancy can increase the risk of spontaneous abortion by causing trauma to the abdomen. Many people believe that if a pregnant woman is physically abused by her partner and is under a lot of stress, she is more likely to have a spontaneous abortion. This lends support to the theory that IPV can cause spontaneous abortion through both stress and direct physical trauma. This finding is supported by different studies done in Ethiopia[12,21] and Malawi[29] that reveal IPV, mainly physical violence, is highly related to pregnancy loss or adverse pregnancy outcomes, including spontaneous abortions.

The possible reason could be due to direct mechanical trauma to the womb of the mother and stress following IPV. The study participants mentioned several common consequences of IPV, including disability, depression, divorce, miscarriage, insecurity, poor self-esteem, HIV, economic problems, unwanted pregnancy, stress, premature labor, preeclampsia, bleeding during pregnancy, and even death as potential outcomes of IPV. Children can also experience negative effects on their mental and physical health as a result of IPV. These reports agree with other studies indicating that IPV generally causes physical, psychosocial, and economic problems.[30,31]

Many participants believe that raising awareness and improving communication can help prevent IPV. Some suggest that creating job opportunities for women could solve the financial problems that are often the root cause of IPV. Others propose punishment for those who commit IPV, watch media programs related to IPV, and accept each other's behavior or show tolerance. Some argue that women themselves should protect against abuse by not talking back or being around their husband when he is drunk and by reporting the abuse to the police.

The results contribute to the design of strong and applicable maternal health programs or strategies in Ethiopia to minimize IPV by advocating, extending, and strengthening the existing maternal health services. This includes different sectors, not only health institutions. The participants in our study have mentioned that stress can pose a risk for spontaneous abortion, although the mechanism behind it is indirect. A similar phenomenological study was conducted in southern Ethiopia to explore the lived experience of IPV survivors. The study found that women were beaten with sticks, had material thrown at their faces, and had their hands and teeth broken.[32]

Similarly, a mixed cross-sectional study conducted in northern Ethiopia indicated that pregnant women whose intimate partners consumed alcohol were more likely to encounter physical violence and face an abortion.[33] Most healthcare professionals who participated in the study stated that spontaneous abortions related to IPV can be clinically managed. However, the mothers who were victims of IPV did not receive mental and social support, which could have aided in their treatment.

This finding is parallel with the EDHS 2016 report that the majority of women who faced IPV did not need support and told others to share their pain. The supports are clinical, social, mental, and legal. In the Tigray region, above three-quarters of the women who faced IPV did not seek support and told others.[25] This might be due to the fear of gossip and social pressure from societies that expose IPV to concerned bodies, neighbors, and peers to get support.

Participants forwarded ideas that husbands should support their pregnant wives in doing household chores and providing relevant pregnancy-related information that brings better outcomes for the mother and baby's health. This finding aligns with the study conducted in the Netherlands in which partners should help their pregnant wives instrumentally in cooking, and grocery shopping, making them refrain from eating unsafe food during pregnancy, ensuring the intaking of adequate fluids, preparing food, tea, and fruits, and carrying heavy materials. Besides, the informational support is to differentiate foods that are safe for pregnant mother and not through reading and checking their labels.[34]

Partner support substantially impacts the health of the mother and baby. It affects the health status of the pregnant mother and baby both positively when there is a strong partner and negatively when there is low or no partner support. This finding goes with other studies done and noticed that strong partner support is highly related to lower depression, psychological stress, IPV victimization, pregnancy loss, and other unwanted health outcomes and vice versa.[35–37] However, a study conducted in Boston indicated that birth weight, gestational age, and fetal growth and development have no significant association with partner support.[35] The possible reason for this difference might be the sociocultural variation, different insights on the value of partner support, and economic status differences.

Limitations

This study was not without limitations; due to the sensitivity of the topic, responses to IPV during pregnancy may remain underreported. Furthermore, induced abortions may be misdiagnosed as spontaneous abortions, leading to missed and underreported cases and potentially overestimating the results. The limited sample size is another limitation of the study. As a result, the study's findings should be interpreted in light of these potential limitations.

Conclusions

IPV is a common phenomenon and the least community-concerned issue in society. This affects maternal health directly and indirectly. The study participants, pregnant mothers, had experienced IPV and spontaneous abortion. To prevent and mitigate the negative consequences of IPV, effective strategies and legal frameworks are needed. Healthcare providers should receive training on how to deal with IPV in cases of spontaneous abortion. Similarly, policymakers work to strengthen the legal framework while also raising community awareness about IPV.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the Research and Ethics Committee (REC) of the School of Public Health, College of Health Sciences, Addis Ababa University (Ref: SPH/033/2020).

Before beginning the study, all participants were asked to provide written informed consent. The data obtained from the patients were strictly protected, which were accomplished by not writing the identification of the participant's name. There was no remuneration or incentive given to study participants without their consent. All participant data were kept anonymous following the 1964 Declaration of Helsinki.

Consent for publication

Not applicable.

Author contribution(s)

Zenawi Hagos Gufue: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Supervision; Writing – original draft; Writing – review & editing.
Helen Teweldebrhan Hailu: Conceptualization; Formal analysis; Investigation; Methodology; Software; Supervision; Validation; Writing – original draft.
Abadi Hailay Atsbaha: Conceptualization; Data curation; Formal analysis; Software; Supervision; Writing – original draft; Writing – review & editing.
Berhe Mengesha Kiros: Investigation; Methodology; Project administration; Resources; Supervision; Validation; Writing – original draft; Writing – review & editing.
Etsay Weldekidan Tsegay: Formal analysis; Investigation; Project administration; Supervision; Writing – original draft; Writing – review & editing.
Meresa Berwo Mengesha: Conceptualization; Investigation; Methodology; Project administration; Supervision; Validation; Writing – original draft; Writing – review & editing.

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Competing interests

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Availability of data and materials

The datasets generated and analyzed during the current study are available from the corresponding author at a reasonable request.

ORCID iDs

Zenawi Hagos Gufue https://orcid.org/0000-0002-2236-5524
Abadi Hailay Atsbaha https://orcid.org/0000-0002-4382-2886
Berhe Mengesha Kiros https://orcid.org/0000-0002-2341-6530
Etsay Weldekidan Tsegay https://orcid.org/0000-0001-8635-304X
Meresa Berwo Mengesha https://orcid.org/0000-0003-3645-6600

Supplemental material

Supplemental material for this article is available online.

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