Petros et al. BMC Women's Health (2024) 24:606
https://doi.org/10.1186/s12905-024-03450-z

BMC Women's Health

RESEARCH Open Access

Intimate partner violence against women among contraceptive users at a primary health care setting in Southern Ethiopia: a facility-based cross-sectional study

Biniam Petros[1], Agumasie Semahegn[2,3,4*], Simon Birhanu[5], Abdulmalik Abdela Bushura[6] and Merhawi Gebremedhin[7]

Abstract

Background One in three women experienced intimate partner violence (IPV) worldwide which has remained major public health challenge. Women's reproductive health service utilization has been seriously impacted by IPV. There is a paucity of evidence on the magnitude of IPV among contraceptive users in southern Ethiopia. Hence, the main aim of this study was to determine the level of IPV and its associated factors among married women who were contraceptive users in primary health care settings in Adilo Zuria district in southern Ethiopia.

Methods A facility-based cross-sectional study was conducted among systematically recruited 405 married women who were contraceptive users in a primary health care setting in Adilo Zuria district in southern Ethiopia. Data were collected through face-to-face interviews using an adapted tool from existing literature including the World Health Organization IPV survey. Collected data were entered into EpiData 4.6 and exported to SPSS version 26 for cleaning and analysis. Descriptive and logistic regression analyses were performed to determine the level of IPV and identify factors associated with IPV. An adjusted odds ratio (AOR) from multiple logistic regression at a 95% confidence interval (CI) was used to declare a significant association.

Results The prevalence of current IPV among contraceptive users was 72.6% (95% CI; 68.1-76.8%). Current psychological, physical, and sexual violence were 39.3%, 38.5%, and 31.9%, respectively. In multivariable analysis, women's being rural resident (AOR: 3.19, 95%CI: 1.69–6.02), women's formal education (AOR: 0.37, 95%CI: 0.19–0.70), partners alcohol consumption (AOR: 3.32, 95%CI: 1.89–5.84), partners Khat chewing (AOR: 7.22, 95%CI: 4.12–12.65) and poor social support (AOR: 2.47, 95%CI: 1.43–4.27) were significantly associated with current IPV against women.

Conclusions Women's experience of IPV on contraceptive users was found to be unacceptably high in the study area. Women's being rural residents, having poor social support and partners who drank alcohol and Khat chewing were predictors of women's experience of IPV. Thus, interventions in improving women's educational status,

*Correspondence:
Agumasie Semahegn
agumas04@gmail.com

Full list of author information is available at the end of the article

© The Author(s) 2024. **Open Access** This article is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License, which permits any non-commercial use, sharing, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if you modified the licensed material. You do not have permission under this licence to share adapted material derived from this article or parts of it. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by-nc-nd/4.0/.

strengthen the social support systems, and the behavior of partners who use stimulant substances are highly relevant to tackle IPV among contraceptive users in the primary healthcare setting.

Keywords Intimate partner violence, Associated factors, Contraceptive users, Ethiopia

Background

Despite efforts in progress, gender-based violence is still one of the most serious human rights violations worldwide [1, 2]. According to the United Nations (UN) Declaration on the Elimination of Violence Against Women, gender-based violence is defined as 'any act of gender-based violence that results in, or is likely to result in but not limited to physical, sexual or psychological harm or suffering to women, whether occurring in public or in private life' [3]. Globally, one in three (35%) of women experienced either physical and sexual IPV or non-partner sexual violence and 38% of all women murders were perpetrated by an intimate partner [4–6]. Any behavior within an intimate relationship causes physical, psychological and/ or sexual harms to the women [5, 7–10].

In sub-Saharan Africa, nearly one-third of ever married women experienced IPV [5, 9], and highly prevalent in Ethiopia that ranging from 20 to 78% [8, 11, 12]. The experience of IPV results in short-, medium-, and long-term consequences on the women's health [4, 5, 13], which incurred much costs for women, households, society, and the health system [14]. The common consequences related to IPV are unsafe abortion, increased risk of acquiring sexually transmitted infection including HIV [4, 5, 13, 15, 16], homicide, suicide, severe injuries, unwanted or unintended pregnancy that leads to maternal mortality [13, 16], various type of mental health conditions and substance abuse [16]. In addition, IPV caused enormous social and economic costs with negative impacts that are linked with limiting women's ability and participation on routine income generation activities, and take cares of their children [16].

Women's experience of IPV is linked with low utilization of modern contraceptives, and affected women's decision-making and negotiation power [17, 18]. Women's ability to control their contraceptive choices and ensure reproductive autonomy are crucial to improve contraceptive uptake to reduce preventable maternal death [19]. Women's experience of IPV associated with several individual-, relationship, community- and societal-level factors [20, 21], including unequal gender power [8], women's accepting attitude towards justified wife-beating [22–24], and tolerant community attitude towards inequitable gender norms [24].

Despite the international declaration of women's rights and national [Ethiopia] policy frameworks and system response, the Constitution of the Federal Democratic Republic of Ethiopia [25] provides fundamental liberties, and safeguard gender equality and women's human rights. The Criminal Code of Ethiopia under Proclamation No. 414/2004 guarantees equality before the law (Art. 4) and criminalizes any injury and suffering caused to women (Art. 561) [26], the Revised Family Code of Ethiopia specifies among other things conditions of marriage including equal rights of access to- and control-over resources (Art. 42), respect and support between partners (Art. 49), and equal rights in the management of the family (Art. 50) [27]. The government of Ethiopia launched a gender mainstreaming program in different sectors with implementation manual to enforce existing policies [28]. The Ethiopian Ministry of Health has published an implementation guideline to prevent and respond to sexual violence against women and girls in Ethiopia [29], in agreement with other gender-responsive legislation [30–32]. Nonetheless, IPV remains a serious public health challenge and systematic abuse of human rights in Ethiopia. A considerable number of studies on IPV were conducted in Ethiopia among pregnant women or antenatal care users. But there is a paucity of evidence on the extent of IPV among contraceptive users. Therefore, the main aim of this study was to determine level of IPV and its associated factors among married women who were contraceptive users in the primary health care setting in Adilo Zuria district in southern Ethiopia.

Methods

Study setting and design

A facility-based cross-sectional study was conducted from July 18, 2022 to August 17, 2022. The study was conducted in primary healthcare facilities in Adilo Zuria District, located in Kambata Tambaro Zone, Central Ethiopia Region (part of the former Southern Nation Nationality Peoples), Southern Ethiopia. It is located 267 km South-East of the capital city, Addis Ababa. Adilo Zuria district is one of the newly established district in 2019, comprising seven *kebeles* (the smallest administrative unit in the Federal Democratic Republic of Ethiopia). Adilo has a total population of 41,047, of which males and females account for 49% and 51%, respectively [33]. According to the district health office report, 794 women visit the district's family planning clinic on a monthly basis.

Participants and sampling procedure

Married and cohabitating women in reproductive age who were clients for contraceptive services attending primary healthcare facilities at Adilo Zuria district during the data collection period were included in the

study. But women who were unable to give information through interview as a result of any physical or mental health conditions were excused from the study. Sample size was determined using a single population proportion formula, considering parameters of 95% confidence level, 50% proportion to get optimum sample size and a margin of error 5%. By adding 10% non-response rate, the final sample size was 422. A systematic sampling procedure was used to recruit the four hundred and twenty-two contraceptive-user women who were included in the study. Contraceptive service performance for the previous three months was reviewed to estimate the number of women used family planning services and registered all health facilities providing the services. The sampling interval was determined using average study population who had visited family planning clinics in the previous three months (794) divided by the total sample size (422) which yields a sampling interval (K^{th}) of 2 (794/422). The first study participant was selected using lottery method, and consecutive study participants were recruited every two women attending family planning clinic. The calculated sample size was proportionally allocated to each primary healthcare facility (Fig. 1).

Data collection method

The data collection tool was adapted from existing literature including the WHO multi-country IPV survey tool [4, 34–36]. The structured questionnaire used contains socio-demographic characteristics, family related characteristics, and community and societal related characteristics. The questionnaire comprised a total of 22-item, for instance 5 items for physical, 3 items for sexual and 14 items for the psychological IPV assessment. In addition, social support was measured using the Oslo Social Support Scale (OSSS-3) [36]. Training was given to the data collectors and supervisors on the objective of the study, data collection tool and sampling techniques by the principal investigator. The questionnaire was pre-tested by taking 5% of the calculated sample size in one health center in Kedida Gamela District. The IPV assessment tool was recoded into a dichotomous variable to quantify presence and absence of women's IPV experience during the past 12 months. Data were collected by trained female midwives and nurses through face-to-face interview using local dialect. Regular supportive supervision was given during the data collection period by trained supervisors to ensure the quality of the data.

Measurement of intimate partner violence

The women's experience of current physical IPV assessed using 5-item tool such as being slapped or something thrown at them that could hurt them, pushed or shoved, hit with a fist or something else that could hurted, kicked, dragged or beaten up, choked or burnt on purpose, being threatened with, having a gun, knife or other weapon in the last 12 months. Of these, if a woman had at least one experience 'yes' out of the five items, qualified as being faced with any form of physical violence in the last 12 months. Fourteen items were used to assess the experience of psychological IPV in the last 12 months. Of these, if a woman had at least one response 'yes' that woman was qualified as experience psychological violence in the last 12 months. Sexual IPV was assessed using 3-item tool, if a woman gave at least one response 'yes' in the

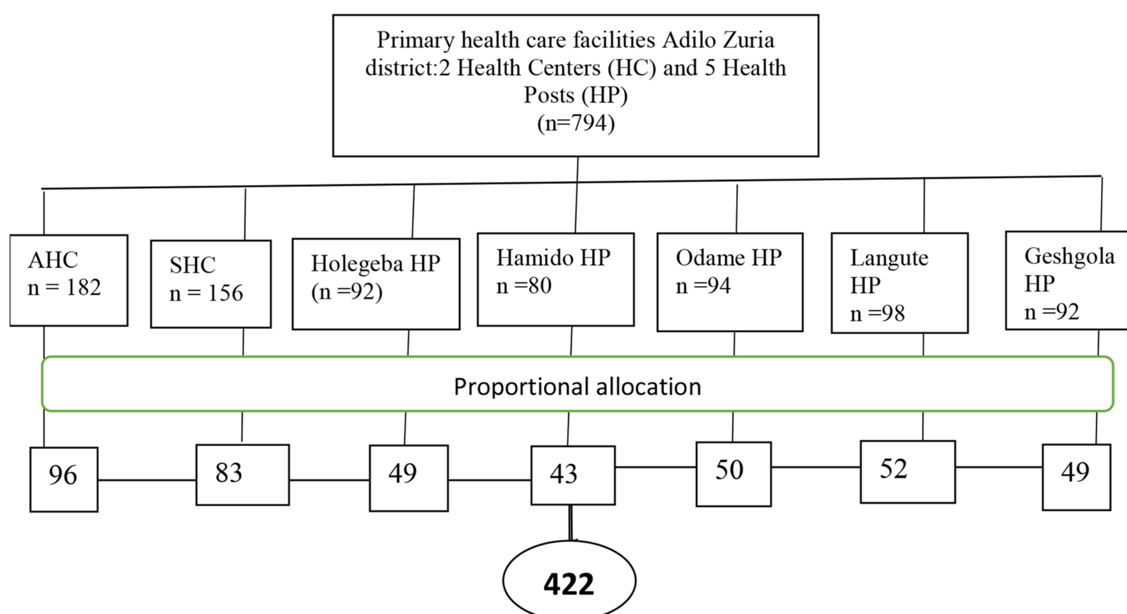

Fig. 1 Schematic presentation of sampling procedure

Table 1 Basic profile of women participated in the study in southern Ethiopia, 2022 (*n* = 405)

Variables	Categories	*n*	%
Women's age	15–24	59	14.6
	25–34	264	65.2
	35–49	82	20.2
Women's religion	Muslim	113	27.9
	Orthodox	73	18
	Protestant	193	47.7
	Catholic	26	6.2
Women's ethnicity	Kambata	290	71.6
	Halaba	62	15.3
	Hadiya	42	10.4
	Wolayita	11	2.7
Women's occupations	House wife	199	49.1
	Farmer	80	19.8
	Government employee	45	11.1
	Merchant	71	17.5
	Others	10	2.5
Women's educational status	No formal education	163	40.2
	Primary education	147	36.3
	Secondary education	53	13.1
	Higher education	42	10.4
Marital status	Married	383	94.6
	Cohabiting	22	5.4
Women's residence	Urban	101	24.9
	Rural	304	75.1
Women's income (ETB)	Do not know their income	187	46.2
	< 2500	131	32.3
	≥ 2500	87	21.5

last 12 months. Eventually, overall IPV was determined if a woman responded "yes" to at least one of the current physical, sexual or psychological IPV.

Data analysis

The collected data were entered into Epi-Data 4.6 software and exported to SPSS version 26 for analysis. Description statistics (frequencies, proportions, means, and standard deviations) were computed to determine the frequencies of socio-demographic characteristics and the prevalence of IPV. Binary logistic regression was conducted to determine the association of each independent variable with the dependent variable. Independent variables with p-<0.25 in the binary logistic regression analysis were included in the multiple logistic regression analysis. The Hosmer-Lemeshow goodness of fit test was used to check the model's fitness. Multivariable logistic regression was carried out for adjusted model to control confounders and identify the independent predictors of IPV among contraceptive users. A p-value of less than 0.05 was considered statistically significant, and an adjusted odds ratio (AOR) with a 95% CI was calculated to determine the association.

Table 2 Socio-demographic characteristics of perpetrators in southern Ethiopia, 2022 (*n* = 405)

Variable	Categories	*n*	%
Partners age	25–34	115	28.4
	35–44	281	69.4
	≥ 45	9	2.2
Partners occupation	Farmer	176	43.4
	Government employee	70	17.3
	Merchant	91	22.5
	Daily laborer	68	16.8
Partners educational status	No formal	84	20.7
	Primary	106	26.2
	Secondary	101	24.9
	Tertiary and beyond	114	28.1
Partners income (ETB)	Do not know	88	21.7
	< 2500	257	63.5
	> 2500	60	14.8
Alcohol drinking habit	Yes	227	56.0
	No	178	44.0
Khat chewing habit	Yes	178	44.0
	No	227	56.0

Results

Study participant's socio-demographic characteristics

A total of 422 women participated in this study, yielding a response rate of 96% (405/422). The mean age of the participants was 30.1(±5.49) years. Nearly half (47.7%) of study participants were protestant Christians by religion. Almost half of the participants (49.1%) were housewives by their occupation, and three-fourths (75.1%) of the participants were rural dwellers. The majority (94.6%) of the participants were married (Table 1).

Partner's socio-demographic and behavioral characteristics

The mean age of the partners was 37.7 (±5.47) years. 43% of the partners (*n* = 176) were farmers by their occupation. One hundred fourteen (28.1%) of the partners had achieved secondary education and above, but 20.7% had not attended formal education. Approximately two-thirds (63.5%) of them had a monthly income of less than two thousand five hundred Ethiopian Birr. More than half (56%) of the partners drank alcoholic beverages at least 1 or 2 times per week, and one hundred seventy-eight (44%) of the partners chewed Khat at least 1 or 2 times per week (Table 2).

Social support

Among the study participants, two-thirds (66.4%, *n* = 269) of them had good social support. One hundred ninety-three (47.7%) of women said that they count more than five people on them if they have great personal problems. Nevertheless, 162 (40%) were uncertain about the interests and concerns people did show in what they do. More

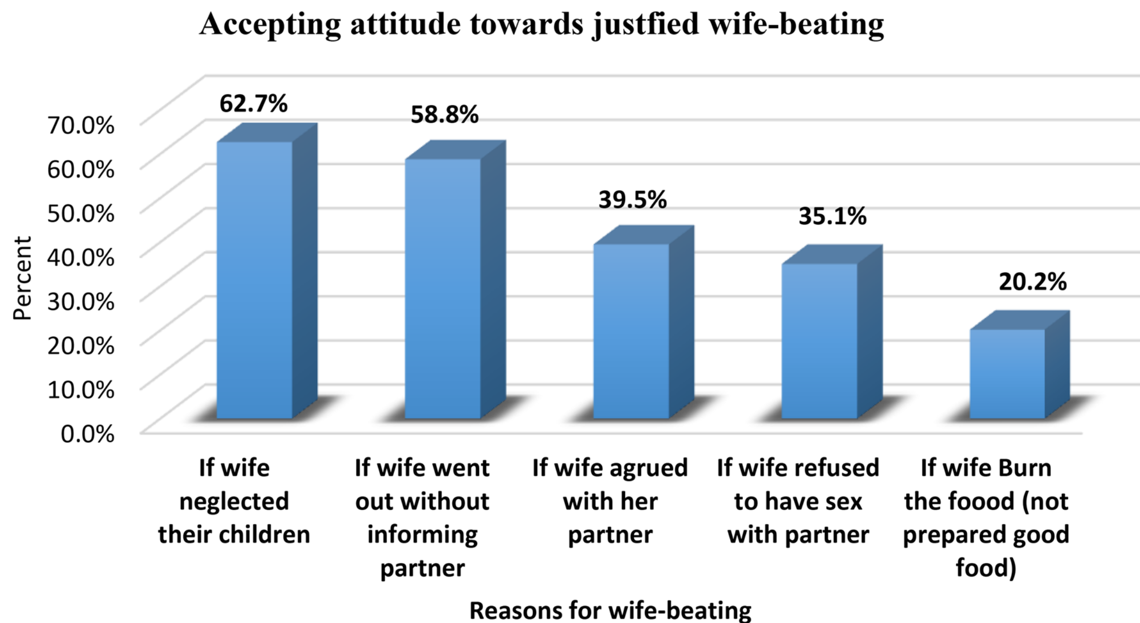

Fig. 2 Women's attitudes towards justified wife-beating in Southern Ethiopia, 2022 ($n=405$, **multiple responses were possible*)

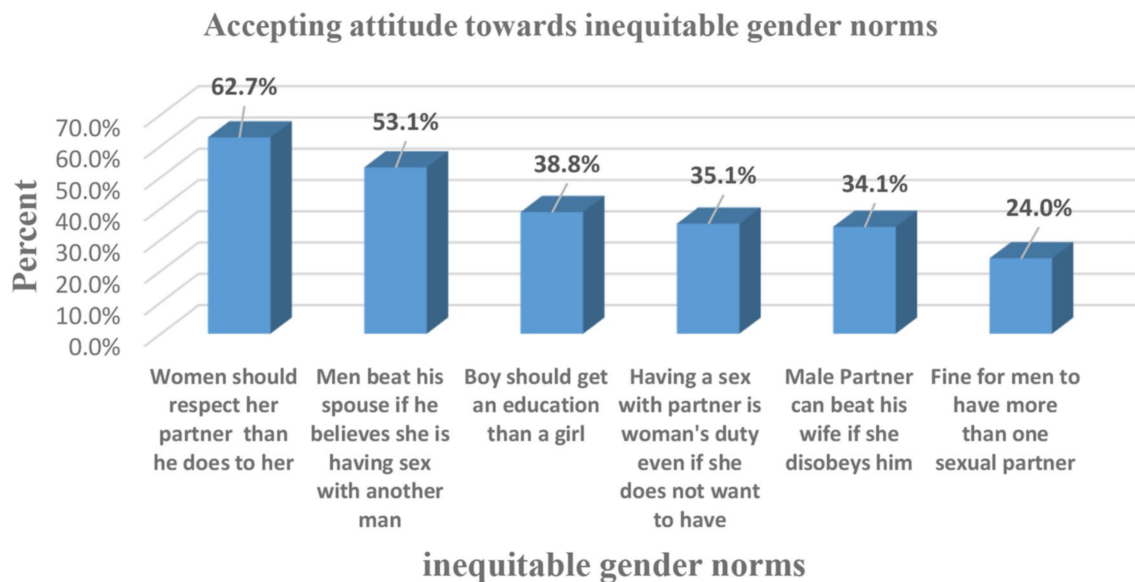

Fig. 3 Community attitude towards gender norms in southern Ethiopia 2022 ($n=405$, **multiple responses were possible*)

than one third (34.3%) of the study participants reported difficulty to get practical help from neighbours if they need help.

Women's attitudes towards justified wife-beating

Out of the total participants, more than one-third (35.1%, $n=142$) of women who were using contraceptives had accepting attitudes towards justified wife-beating (Fig. 2).

Community's attitudes towards gender-norms

Two hundred fifty-four (62.7%) of the study participants said that the wife should respect her partner more than her partner should respect her; 53.1% of the participants responded that a partner or husband beat his spouse or wife if he believes that his wife or spouse is having sex with another man (Fig. 3). Furthermore, almost seven-in-ten (70.4%, $n=285$) of women lived in husbands headed households. Two-thirds (66.7%, $n=270$) of the women made decisions about contraceptive use without influence from male partners. Almost half (49.4%, $n=200$) of women who used contraceptive made decisions about other healthcare services. Nevertheless, more than half (55.8%, $n=226$) of them reported that husbands were the

decision-makers for the women to attend workshops and other conferences.

Prevalence of intimate partner violence among contraceptive users

Among the total contraceptive user women included in the study, nearly three-fourths (72.6%, $n=294$) of women experienced at least one form of IPV in the last 12 months. Regarding the forms of current IPV among the victims, physical IPV among contraceptive-user women was 38.5% ($n=156$). Among these women, 28.6% reported being slapped, kicked, dragged, or beaten by their partner. Women's experience of current psychological IPV was 39.3% ($n=159$). Among these, frightening their partner by look at them aggressively (15.6%, $n=63$), and insisted by their partner know where they are at all time (15.1%, $n=61$). In addition, women's experience of current sexual IPV was 31.9% ($n=129$). Among this, 31.1% ($n=126$) were physically forced to have sex with their husband against their interest, and 10.1% ($n=41$) of them had been physically forced by their husband to have sex because they were frightened by what the partner might do if they refuse (Table 3).

Table 3 Women's experience of different types of IPV in Southern Ethiopia, 2022 ($n=405$, **Multiple responses were possible*)

Intimate partner violence item in the last 12 months	n	%
Physical IPV		
• Being pushed/shake/thrown something	71	17.5
• Being slapped, kicked, dragged or beaten	116	28.6
• Being punched, hit with fist, or twist arm	35	8.6
• Tried to intentionally choke or burn you	13	3.2
• Being threatened /attacked with a knife, gun, or any other weapon	29	7.2
Overall physical IPV	*156*	*38.5*
Sexual IPV		
• Physically forced to have sex without will/interest	126	31.1
• Physically forced with threats you to perform any other sexual acts you did not want to	41	10.1
• Forced to do something sexual that was degrading or humiliating	25	6.2
Overall sexual IPV	*129*	*31.9*
Psychological/emotional IPV		
• Partner feels jealous/angry if you (talk/talked) to other men	41	10.1
• Partner (insists/insisted) on knowing where you (are/were)	61	15.1
• Insulted by partner using abusive language that made feel bad	52	12.8
• Threatened by partner using stick, belt, knife, gun, or other type of weapon, etc.	19	4.7
• Created financial hardship/not trust by partner	49	12.1
• Frightened partner by looking at you angrily	63	15.6
• Expressed suspicion/accused for unfaithful	18	4.4
• Ignored or shown indifference by partner	20	4.9
• Deprived from privileges in the family partner	14	3.5
• Denied by partner on your basic personal needs	14	3.5
• Intentionally not involved in decision-making in the family	13	3.2
• Belittled or humiliated you in front of other people	16	4.0
• Done things purposively to scare or intimidate	7	1.7
• Restricted by partner from going to parent/friends	32	7.9
Overall psychological violence	*160*	*39.3*
Overall prevalence of IPV among contraceptive users	*294*	*72.6*

Concurrent intimate partner violence

7% of women who used contraceptives experienced concurrent forms of IPV (psychological, physical and sexual) by their intimate partner. The occurrence of concurrent physical and sexual IPV was the most common (9.6%, $n=28$) (Fig. 4).

Factors associated with women's experience of IPV

Women who live in rural areas women had a formal education, partners alcohol drinking habits, partners Khat chewing behavior, and poor social sport were significantly associated with IPV among contraceptive-user women. Women who lived in rural area were 3.19 times more likely to experience IPV compared to women who lived in urban area (AOR=3.19, 95% CI: 1.69–6.02). Women whose partners used alcohol were 3.3 times more likely to experience IPV than women whose partners never used alcohol (AOR=3.32, 95% CI: 1.89–5.84). Women whose partners chewed Khat were seven times more likely to experience IPV compared to those women whose partners have never chewed Khat (AOR: 7.22, 95% CI: 4.12–12.65). Women who had poor social support were 2.5 times more likely to experience IPV as compared with those women who had good social support (AOR=2.47, 95% CI: 1.43–4.27). But the odds of women experience of IPV were 63% less among women with formal education as compared with women who had no formal education (AOR=0.37, 95% CI: 0.19–0.70) (Table 4).

Discussion

This study determined the prevalence of IPV among women who visited the primary healthcare facilities at Adilo Zuria District for contraceptive use. Overall, current prevalence of IPV was 72.6% (95%CI: 68.1–76.8%). The present study has also identified the factors associated with IPV among contraceptive users in the study area. Women who have poor social support, live in rural settings and partner's substance use behavior predict their experience of IPV. The present finding is similar to the finding from studies conducted in Southwestern Ethiopia which shows the prevalence of IPV was 72.5% [12] and 73.2% in Tanzania [18].

Contrary to this, the finding was lower than a study conducted in Conakry, Guinea among family planning

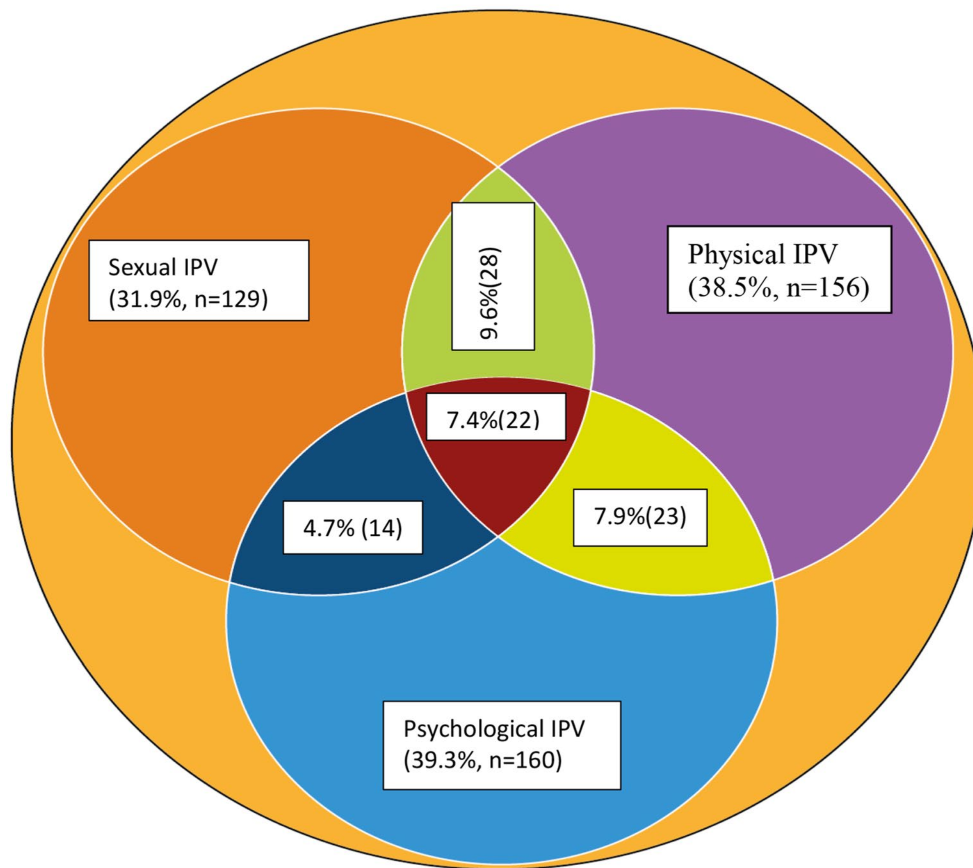

Fig. 4 Venn diagram illustrating concurrent experiences of IPV among contraceptive user women in Adilo Zuria District Southern Ethiopia 2022

Table 4 Factors associated with IPV among contraceptive users in Southern Ethiopia 2022 (*n* = 405)

Variables	Categories	IPV experience		COR (95%CI)	AOR (95%CI)
		Yes (%)	No (%)		
Women residence	Urban	95(23.5)	24(5.9)	1	1
	Rural	199(49.1)	87(21.5)	1.73(1.04–2.89)	3.19(1.69–6.02)*
Head of household	Husband	215(53)	70(17.2)	1	1
	Wife	79(19.5)	41(10.1)	1.59(1.01–2.53)	1.44(0.81–2.54)
Marital status	Unmarried	21(5.2)	1(0.25)	1	1
	Married	273(67.4)	110(27.1)	8.46(1.12–63.68)	5.84(0.66–51.5)
Women educational status	No Formal	168(41.5)	85(20.1)	1	1
	Formal	126(31.1)	26(6.41)	0.41(0.25–0.67)	0.369(0.19–0.70)*
Partners educational status	No formal education	56(13.8)	28(6.9)	1.52(0.81–2.85)	1.58(0.73–3.45)
	Primary education	74(18.3)	32(7.9)	1.71(0.92–3.17)	2.42(1.10–5.20)
	Secondary education	73(18)	28(6.9)	1.98(1.04–3.77)	1.60(0.69–3.20)
	Above secondary	91(22.5)	23(5.7)	1	1
Alcohol consumption	No	151(37.2)	27(6.7)	1	1
	Yes	143(35.3)	84(20.7)	3.29(2.01–5.36)	3.32(1.89–5.84)*
Khat chewing	No	199(49.1)	28(6.9)	1	1
	Yes	95(23.4)	83(20.5)	6.21(3.79–10.16)	7.22(4.12–12.65)*
Discuss about family planning	No	139	69	1	1
	Yes	155	42	0.55(0.35–0.85)	0.73(0.42–1.26)
Social support	Strong	199	56	1	1
	Poor	95	55	2.06(1.04–2.89)	2.47(1.43–4.27)*

*Significant at p value of ≤ 0.05, COR: crude odds ratio, AOR: adjusted odds ratio

clients which shows the prevalence of IPV was 92% [37]. In addition to the sociocultural variations across settings, the study in Conakry, Guinea used women's experience of IPV in their lifetime which increased the prevalence. On the other hand, the finding of this study was higher than findings from previous studies in Ethiopia which ranged from 20 to 58% [11, 20, 38–40], 56% in Nigeria [41], 35.9% in Malaysia [42], 46.1% in Tanzania [43], 55.89% in Afghanistan [44]. The study in southeast Nigeria [41] focused on severe form of physical and sexual violence assessment including marital rape that may hide of information due to family secrecy which may underestimate the level of IPV. In addition, the existing gender norms, cultural variations and some studies used multisite data caused the discrepancy across studies.

In this study, women being rural resident were 3.19 times more likely to experience IPV compared to women who live in urban settings. The finding is consistent with findings from studies conducted in Ethiopia [39, 45–48]. The current study also found that women's educational status was significantly associated with IPV. The odds of women's experience to IPV reduced by 63% among women with formal education as compared with women who had no formal education. The findings are consistent with those of studies conducted in different parts of Ethiopia [45, 49], a study in Bangladesh [17], and findings from a WHO multi-country study [23].

Women whose partners used alcohol were 3.3 times more likely to experience IPV than women whose partners never used alcohol. The finding is consistent with those of studies conducted in Ethiopia [2, 11, 38, 49–53] and the nine countries of the WHO multi-country study, including Ethiopia [8]. The fact that alcohol consumption disturbs the consumers' cognitive/thinking and physical functions. These disturbances in thinking ability may lead the users to become aggressive, to misunderstand verbal or non-verbal communication in the relationship, altered mental judgment, increase the sense of power and control leading to exercise power and control on intimate partners.

Moreover, women whose partners chew Khat were seven times more likely to experience IPV compared to those women whose partners never chew Khat. This finding is consistent with studies conducted in Ethiopia [20, 50, 54]. This may be due to Khat chewing enhance sexual desire of men that women may not want to have, and Khat chewing increased money spent and consume time cause intra-marital conflict [55]. Finally, the contraceptive user women who had poor social support were 2.5 times more likely to experience IPV as compared with those women who had good social support. This finding is consistent with a study conducted in Ethiopia [56], Tanzania [57], and a study in six European countries [58]. The main reason may be getting social support from neighbour, friends and family members is associated with less victimization of women. Not having social support increases the probability of IPV among contraceptive users.

Implication of the study

In spite of the fact that the Ethiopian government has put policy and programmatic actions to combat gender-based violence and ensure gender equality, Ethiopia is one of the countries with a high burden of violence against women and patriarchal norms that affects women's reproductive health service-seeking behavior and uptake of services. This finding on the extent of intimate partner violence against women among contraceptive users helps the program planners and healthcare service providers to consider the influence of partners, social support and partner substance use behaviors. It uncovers the extent of the problem in the study area that may inform the intervention to be designed to transform patriarchal norm, enhance social support and partner involvement in supporting women to use reproductive health service. This finding may also stimulate researchers to conduct further studies in large scale and design interventions to tackle violence against women in the setting.

Strengths and limitation of the study

The strength of this study is that the sample is adequate and from a well-defined catchment area and uses standard instruments of the WHO multicounty study on violence against women. However, as this study uses a cross-sectional design, it will be prone to recall bias. Women may hide the information as a result of the issue of being family secrecy and social desirability bias. The study design also cannot test cause- and- effect relationship between outcome variables and explanatory variables. Another limitation may be as this study is a facility-based study, it may miss women who do not come for family planning services during the data collection period.

Conclusions

The intimate partner violence against women among contraceptive users in the study is unacceptable high. It was found to be approximately three-fourths of women who were using contraceptives in Adilo District. Women live in rural settings, poor social support and live with partners who have substance (alcohol and Khat) use behavior are the common predictors of women's experience of IPV. Although women education has reverse causality on women's experience, women's education remains a protective factor that should be strengthened. We suggested that programs that support gender-norm transformative intervention to men and women, strengthen women education, improve social support to women by their male

partners to engage in community conversation to transform old-fashioned behaviors are crucial to prevent and control IPV in the southern Ethiopia.

Abbreviations

AOR Adjusted Odds Ratio
CI Confidence Interval
IPV Intimate partner violence
WHO World Health Organization.

Acknowledgements

We would like to acknowledge Haramaya University for financial support and the study participants, data collectors, supervisors, health facility administrators, and staff for their willingness to give their time and information for this study.

Author contributions

BP, AS, and MG had involved since conception, study design, acquisition of data, analysis and interpretation. AS, SM, and BP drafted the manuscript. All authors revised the manuscript critically for important intellectual contents. All authors reviewed and approved the final manuscript.

Funding

This study was financially supported by Haramaya University.

Data availability

All related data are presented fully within the paper, and available upon reasonable request to the lead author and the corresponding author.

Declarations

Ethics approval and consent to participate

Ethical clearance to conduct the study was obtained from Haramaya University, College of Health and Medical Sciences Institutional Health Research Ethics Review Committee with reference number (IHRERC/2866/14). The study was conducted in accordance with the declaration of Helsinki. Informed verbal and written consent were obtained from each study participant on voluntary basis to be included in the study. Informed consent from participant/legal guardian and assent from them were obtained from study participants who age younger than 18 years old, and not attended formal education. The collected data had kept confidential anonymously through de-identification of names and other personal identifiers from record/sheet. Parents/guardians in case of minor study participants and legally authorized representatives in case of illiterate participants.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Author details

[1]Adilo Zuria District Health Office, Kambata Tambaro Zone, Durame, Southern, Ethiopia
[2]College of Health and Medical Sciences, Haramaya University, Harar, Ethiopia
[3]Center for Innovative Drug Development and Therapeutic Trials for Africa (CDT-Africa), College of Health Sciences, Addis Ababa University, Addis Ababa, Ethiopia
[4]Department of Population, Family and Reproductive Health, School of Public Health, University of Ghana, Accra, Ghana
[5]College of Health Sciences, Debark University, Debark, Ethiopia
[6]East Hararghe Zonal Health Department, Oromia Regional State, Harar, Ethiopia
[7]School of Public Health College of Health and Medical Sciences, Haramaya University, Harar, Ethiopia

Received: 18 June 2023 / Accepted: 7 November 2024
Published online: 15 November 2024

References

1. Paul P, Mondal D. Investigating the relationship between women's experience of intimate partner violence and utilization of maternal healthcare services in India. Sci Rep. 2021;11(1):11172.
2. Semahegn A, Belachew T, Abdulahi M. Domestic violence and its predictors among married women in reproductive age in Fagitalekoma Woreda, Awi Zone, Amhara regional state, North Western Ethiopia. Reproductive Health. 2013;10(1):1–9.
3. Assembly UG. Declaration on the elimination of violence against women. UN General Assembly; 1993.
4. WHO. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organization; 2013.
5. WHO. Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. World Health Organization; 2021.
6. WHO. Violence against women: intimate partner and sexual violence against women: intimate partner and sexual violence have serious short- and long-term physical, mental and sexual and reproductive health problems for survivors: fact sheet. Geneva: World Health Organization; 2014. Report No.: Contract No.: WHO/RHR/14.11.
7. Yohannes K, Abebe L, Kisi T, Demeke W, Yimer S, Feyiso M, et al. The prevalence and predictors of domestic violence among pregnant women in Southeast Oromia, Ethiopia. Reproductive Health. 2019;16(1):37.
8. World Health O. WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses/authors: Claudia Garcia-Moreno … et al]. Geneva: World Health Organization; 2005.
9. Ebrahim NB, Atteraya MS. Women's household decision-making and intimate partner violence in Ethiopia. Acad J Interdisciplinary Stud. 2019;8(2):284.
10. Muluneh MD, Alemu YW, Meazaw MW. Geographic variation and determinants of help seeking behaviour among married women subjected to intimate partner violence: evidence from national population survey. Int J Equity Health. 2021;20(1):1–14.
11. CSA I. Central statistical agency (CSA)[Ethiopia] and ICF. Ethiopia demographic and health survey, Addis Ababa, Ethiopia and Calverton, Maryland, USA. 2016.
12. Abeya SG, Afework MF, Yalew AW. Intimate partner violence against women in western Ethiopia: prevalence, patterns, and associated factors. BMC Public Health. 2011;11(1):1–18.
13. Organization WH. Understanding and addressing violence against women: intimate partner violence. World Health Organization; 2012.
14. UN. Economic Costs of Intimate Partner Violence against Women in Ethiopia: Summary Report. 2022.
15. García-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts C. WHO multi-country study on women's health and domestic violence against women. World Health Organization; 2005.
16. WHO. Violence against women key facts. 2021. https://www.who.int/news-room/fact-sheets/detail/violence-against-women#:~:text=Estimates%20published%20by%20WHO%20indicate,violence%20is%20intimate%20partner%20violence.
17. Dalal K, Andrews J, Dawad S. Contraception use and associations with intimate partner violence among women in Bangladesh. J Biosoc Sci. 2012;44(1):83–94.
18. Baritwa MS. Influence of intimate partner violence on modern family planning use among married women in Mara region. Tanzania: The University of Dodoma; 2020.
19. Silverman JG, Challa S, Boyce SC, Averbach S, Raj A. Associations of reproductive coercion and intimate partner violence with overt and covert family planning use among married adolescent girls in Niger. EClinicalMedicine. 2020;22:100359.
20. Semahegn A, Mengistie B. Domestic violence against women and associated factors in Ethiopia; systematic review. Reproductive Health. 2015;12(1):78.
21. Tiruye TY, Chojenta C, Harris ML, Holliday E, Loxton D. Intimate partner violence against women and its association with pregnancy loss in Ethiopia: evidence from a national survey. BMC Womens Health. 2020;20(1):1–11.
22. Uthman OA, Lawoko S, Moradi T. Factors associated with attitudes towards intimate partner violence against women: a comparative analysis of 17 sub-saharan countries. BMC Int Health Hum Rights. 2009;9(1):14.
23. Abramsky T, Watts CH, Garcia-Moreno C, Devries K, Kiss L, Ellsberg M, et al. What factors are associated with recent intimate partner violence? Findings

from the WHO multi-country study on women's health and domestic violence. BMC Public Health. 2011;11(1):109.
24. Gashaw BT, Schei B, Magnus JH. Social ecological factors and intimate partner violence in pregnancy. PLoS ONE. 2018;13(3):e0194681.
25. FDRE. FDRE. Constitution of The Federal Democratic Republic of Ethiopia Constitution of The Federal Democratic Republic of Ethiopia. Addis Ababa, Ethiopia; 1994.
26. FDRE. The Criminal Code of the Federal Democratic Republic of Ethiopia. 2004. Proclamation No.414/2004. Addis Ababa, Ethiopia: Federal Democratic Republic of Ethiopia; 2005. (2004).
27. FDRE. FDRE. The Revised Family Code Proclamation No.213/2000. Addis Ababa, Ethiopia. 2000. p. 96.
28. FMOH. Health sector gender mainstreaming Manual. Federal Democratic Republic of Ethiopia Ministry of Health. Addis Ababa, Ethiopia; 2013.
29. FMoH. Ministry of Health of Ethiopia standard operating procedures to respond to and prevent sexual violence against women and girls. 2016.
30. Assembly UG. Convention on the elimination of all forms of discrimination against women. Retrieved April. 1979;20:2006.
31. Women A. Rotocol To The African Charter on Human And Peoples' Rights on the Rights of Women In Africa. 1995.
32. WHO. WHO. (2016). WHO recommendations on antenatal care for a positive pregnancy experience. World Health Organization, Switzerland, Geneva. https://www.who.int/publications/i/item/9789241549912 2016.
33. Department KTZH. Zonal health department poplation profile 2022.
34. WHO. WHO Multi-country Study on Women's Health and Domestic Violence against Women Initial results on prevalence, health outcomes and women's responses. Geneva, World Health Organization. 2005. Accessed date 2-21-2022 http://www.who.int/reproductivehealth/publications/violence/en/index.html.
35. Semahegn A, Torpey K, Manu A, Assefa N, Ankomah A. Adapted tool for the assessment of domestic violence against women in a low-income country setting: a reliability analysis. Int J Women's Health. 2019a;11:65.
36. Rüya-Daniela Kocalevent RK, Ber L, Manfred E, Beutel ME, Hinz A, Zenger M, Härter M, Nater U, Brähler E. Social support in the general population: standardization of the Oslo social support scale (OSSS-3). BMC Psychol. 2018;6(31). https://doi.org/10.1186/s40359-018-0249-937.
37. Delamou A, Samandari G, Camara BS, Traore P, Diallo FG, Millimono S, et al. Prevalence and correlates of intimate partner violence among family planning clients in Conakry, Guinea. BMC Res Notes. 2015;8:814.
38. Fekadu E, Yigzaw G, Gelaye KA, Ayele TA, Minwuye T, Geneta T, et al. Prevalence of domestic violence and associated factors among pregnant women attending antenatal care service at University of Gondar Referral Hospital, Northwest Ethiopia. BMC Womens Health. 2018;18(1):1–8.
39. Azene ZN, Yeshita HY, Mekonnen FA. Intimate partner violence and associated factors among pregnant women attending antenatal care service in Debre Markos town health facilities, Northwest Ethiopia. PLoS ONE. 2019;14(7):e0218722.
40. Andarge E, Shiferaw Y. Disparities in intimate Partner violence among currently married women from Food Secure and Insecure Urban households in South Ethiopia: A Community based comparative cross-sectional study. Biomed Res Int. 2018;:4738527.
41. Anolue F, Uzoma O. Intimate partner violence: prevalence, contributing factors and spectrum among married couples in Southeast Nigeria. Int J Reprod Contracept Obstet Gynecol. 2017;6(9):3748–54.
42. Kadir Shahar H, Jafri F, Mohd Zulkefli NA, Ahmad N. Prevalence of intimate partner violence in Malaysia and its associated factors: a systematic review. BMC Public Health. 2020;20(1):1550.
43. Kazaura, Ezekiel C. Magnitude and factors associated with intimate partner violence in mainland Tanzania. BMC Public Health. 2016;16(1):494.
44. Dadras O, Nakayama T, Kihara M, Ono-Kihara M, Dadras F. Intimate partner violence and unmet need for family planning in Afghan women: the implication for policy and practice. Reproductive Health. 2022;19(1):52.
45. Gebrezgi BH, Badi MB, Cherkose EA, Weldehaweria NB. Factors associated with intimate partner physical violence among women attending antenatal care in Shire Endaselassie town, Tigray, northern Ethiopia: a cross-sectional study, July 2015. Reproductive Health. 2017;14(1):1–10.
46. Yitbarek K, Woldie M, Abraham G. Time for action: intimate partner violence troubles one third of Ethiopian women. PLoS ONE. 2019;14(5):e0216962.
47. Chernet AG, Cherie KT. Prevalence of intimate partner violence against women and associated factors in Ethiopia. BMC Womens Health. 2020;20(1):22.
48. Semahegn A, Torpey K, Manu A, Assefa N, Tesfaye G, Ankomah A. Are interventions focused on gender-norms effective in preventing domestic violence against women in low and lower-middle income countries? A systematic review and meta-analysis. Reproductive Health. 2019;16(1):93.
49. Alebel A, Kibret GD, Wagnew F, Tesema C, Ferede A, Petrucka P, et al. Intimate partner violence and associated factors among pregnant women in Ethiopia: a systematic review and meta-analysis. Reproductive Health. 2018;15(1):196.
50. Lencha B, Ameya G, Baresa G, Minda Z, Ganfure G. Intimate partner violence and its associated factors among pregnant women in Bale Zone, Southeast Ethiopia: a cross-sectional study. PLoS ONE. 2019;14(5):e0214962.
51. Adhena G, Oljira L, Dessie Y, Hidru HD. Magnitude of Intimate Partner Violence and Associated Factors among pregnant women in Ethiopia. Adv Public Health. 2020;2020:1682847.
52. Temesgen T, Teji K, Dheresa M, Asegid A. Intimate Partner Violence and Associated Factors among Married Women live in Hosanna Town, Southern Ethiopia. 2019.
53. Tesfa A, Dida N, Girma T, Aboma M. Intimate Partner Violence, its sociocultural practice, and its Associated factors among women in Central Ethiopia. Risk Manage Healthc Policy. 2020;13:2251–9.
54. Gadisa TB, Kitaba KA, Negesa MG. Prevalence and factors associated with domestic violence against married women in Mana District, Jimma Zone, Southwest Ethiopia: a community-based cross-sectional study. Int J Afr Nurs Sci. 2022;17:100480.
55. Sharma V, Papaefstathiou S, Tewolde S, Amobi A, Deyessa N, Relyea B, et al. Khat use and intimate partner violence in a refugee population: a qualitative study in Dollo Ado, Ethiopia. BMC Public Health. 2020;20(1):670.
56. Getinet W, Azale T, Getie E, Salelaw E, Amare T, Demilew D, et al. Intimate partner violence among reproductive-age women in central Gondar zone, Northwest, Ethiopia: a population-based study. BMC Womens Health. 2022;22(1):109.
57. Sigalla GN, Rasch V, Gammeltoft T, Meyrowitsch DW, Rogathi J, Manongi R, et al. Social support and intimate partner violence during pregnancy among women attending antenatal care in Moshi Municipality, Northern Tanzania. BMC Public Health. 2017;17(1):240.
58. Dias NG, Costa D, Soares J, Hatzidimitriadou E, Ioannidi-Kapolou E, Lindert J, et al. Social support and the intimate partner violence victimization among adults from six European countries. Fam Pract. 2018;36(2):117–24.

Publisher's note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.