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Midwifery Care Management for Threatened Abortion in Early Pregnancy: A Qualitative Descriptive Study and Document Review at Medan Haji Hospital

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Abstract: Threatened abortion (abortus imminens) is a common early-pregnancy condition characterized by first-trimester vaginal bleeding with a closed cervix and an ongoing intrauterine pregnancy. Besides clinical risk, it frequently produces psychological distress and is influenced by socioeconomic barriers, health literacy, and the coordination of care across providers and families. **Objective:** This study aimed to describe and analyze midwifery care management for women with threatened abortion at approximately 8 weeks' gestation at Medan Haji Hospital, using an SDG-oriented lens on access (SDG 1), education/health literacy (SDG 4), and partnerships (SDG 17). **Methods:** A qualitative descriptive approach was combined with a desk-based document review. Primary information was collected through semi-structured interviews with women receiving care for threatened abortion in the Jabal Uhud UPTD Room. Secondary information was obtained from peer-reviewed literature, midwifery textbooks, and official reports/guidelines. Data were analyzed through thematic categorization and integrated by triangulation to synthesize patterns across access, education, and partnership domains. **Findings:** Three major patterns emerged. First, economic and transportation/coverage constraints were consistently linked to delayed or fragmented antenatal care and follow-up, weakening early detection and safety-netting. Second, limited health literacy and inconsistent counseling contributed to delayed care-seeking and suboptimal adherence to follow-up recommendations. Third, stronger partnerships interprofessional coordination, facility-to-system linkages, and family (including husband) support were associated with clearer referral pathways, improved continuity of care, and better emotional support for women experiencing early pregnancy bleeding. **Implications:** A continuity-oriented midwifery care bundle is recommended, integrating standardized counseling and return precautions, structured follow-up planning, and partnership mechanisms involving interprofessional coordination and family engagement to improve early pregnancy care quality and maternal well-being. **Originality/Value:** This study offers an integrated, SDG-linked interpretation of threatened-abortion midwifery care management by connecting clinical processes with structural access barriers, maternal health literacy, and partnership mechanisms, providing a practical framework for service improvement.

Keywords: Threatened Abortion; Midwifery Care Management; Antenatal Care; Health Literacy; Partnerships.

INTRODUCTION

Bleeding in early pregnancy is one of the most common reasons women seek urgent obstetric evaluation and is often experienced as a frightening event for the woman and her family. Clinically, threatened abortion (threatened miscarriage/abortus imminens) is defined as vaginal bleeding in the first trimester with a closed cervix and a continuing intrauterine pregnancy, and it is reported to occur in around one-fifth of clinically recognized pregnancies (Sotiriadis et al., 2004). Importantly, the clinical significance is not uniform: cohort evidence shows that heavier bleeding especially when accompanied by pain is associated with a higher risk of miscarriage, reinforcing the need for timely assessment and close follow-up (Hasan et al., 2009).

Beyond the biomedical risk, threatened abortion frequently brings a substantial psychosocial burden. Uncertainty about pregnancy viability can trigger anxiety, fear, and distress that may disrupt daily functioning and influence how women interpret symptoms, communicate concerns, and adhere to recommended follow-up. Research on early pregnancy loss and complications consistently indicates elevated psychological morbidity (including anxiety and depressive symptoms) around these events, underlining that early pregnancy care must address both physical safety and maternal well-being (Farren et al., 2016; San Lázaro Campillo et al., 2017; Ip et al., 2023). This is particularly relevant in real-world settings where women may face barriers to timely care and consistent information, making supportive communication and continuity central to patient-centered management (World Health Organization, 2016; Tunçalp et al., 2017).

Clinical assessment and management pathways. International guidance emphasizes that early pregnancy bleeding and pain require structured diagnostic pathways and consistent initial management, including appropriate evaluation to distinguish threatened miscarriage from other urgent conditions and to improve the quality of support provided to women (National Institute for Health and Care Excellence, 2019). Professional guidance also details evidence-based options for early pregnancy loss management and highlights the need for clear counseling and follow-up planning elements that shape patient understanding and safety-netting even when pregnancy remains viable (American College of Obstetricians and Gynecologists, 2018). However, practice variation remains common across facilities, and documentation of how comprehensive care is delivered (monitoring, counseling, return precautions, and referral) is often inconsistent, limiting service improvement.

Psychological impact and supportive care needs. A growing body of evidence shows that threatened miscarriage and related early pregnancy complications are associated with meaningful psychological distress. Cross-sectional findings in women experiencing threatened miscarriage demonstrate psychological morbidity and highlight the need to identify women at risk and provide early supportive interventions (Ip et al., 2023). Recent case-control evidence similarly reports depressive and anxiety symptoms among women with threatened abortion, strengthening the rationale for integrating emotional support and reassurance into standard care rather than treating bleeding as solely a biomedical event (Mirtabar et al., 2024). More broadly, emotional sequelae after early pregnancy loss including anxiety, depression, and post-traumatic stress symptoms are well-documented, suggesting that supportive, empathetic care and clear communication can be clinically meaningful components of care quality (Farren et al., 2016; San Lázaro Campillo et al., 2017).

Social determinants, education, and access/continuity of maternal care. Systematic review evidence shows that antenatal care utilization is repeatedly shaped by socioeconomic status, education, transportation, and financial barriers, which can delay early assessment and fragment follow-up in pregnancy complications (Alibhai et al., 2022). At the health-system level, WHO's antenatal care model emphasizes person-centered care and a "positive pregnancy experience," encouraging timely first contact and quality interactions, including information, counseling, and respectful care (WHO, 2016; Tunçalp et al., 2017). In parallel, evidence on midwife-led continuity models indicates benefits in women's care experience and outcomes, supporting continuity and relationship-based care as a relevant service strategy where monitoring, counseling, and follow-up are essential. These determinants and service features also align with the broader 2030 Agenda's emphasis on reducing inequities and strengthening partnerships for sustainable health improvements (United Nations General Assembly, 2015).

Based on these gaps, this study aims to describe and analyze midwifery care management for pregnant women with threatened abortion at approximately 8 weeks' gestation at Medan Haji Hospital. The focus is on the practical components of comprehensive midwifery care clinical monitoring, health education on danger signs and return precautions, emotional support, continuity/follow-up planning, and collaboration/referral pathways in order to generate actionable evidence for strengthening early pregnancy care quality and patient experience (NICE, 2019; WHO, 2016).

We argue that structured and continuous midwifery care management integrating timely assessment, individualized counseling and education, and consistent emotional support supported by clear collaboration and referral pathways will be associated with better maternal engagement and coping during threatened abortion (e.g., improved understanding of warning signs, stronger adherence to follow-up recommendations, and reduced psychological distress). This argument is supported by converging evidence that standardized early-pregnancy pathways improve support and safety-netting (NICE, 2019), and that psychological morbidity in threatened miscarriage highlights the need for early supportive interventions embedded within routine care (Ip et al., 2023; Mirtabar et al., 2024).

RESEARCH METHOD

This study focused on midwifery care management provided to pregnant women diagnosed with threatened abortion (abortus imminens) in the Jabal Uhud UPTD Room, Medan Haji Hospital. The inquiry examined how care was implemented in routine clinical practice covering assessment and monitoring, counseling and health education, emotional support, follow-up planning, and referral or collaboration pathways and how women perceived and experienced these components while receiving treatment. In addition, the study explored how the documented care processes relate to broader determinants emphasized in the SDG framework, particularly economic constraints affecting access to care (SDG 1), maternal health literacy and education (SDG 4), and partnerships or interprofessional collaboration in service delivery (SDG 17).

A qualitative descriptive design was selected because the study aimed to produce a clear, practice-oriented description of care processes and patient experiences rather than to test a causal effect statistically. This design is appropriate for capturing “what happens” in real clinical settings and for summarizing clinical experiences in a way that can inform service improvement. To strengthen interpretation and ensure the findings were grounded in existing evidence and policy context, the study incorporated a desk-based document review of national and international sources discussing threatened abortion management, maternal health education, and related SDG dimensions.

Data were obtained from two complementary sources. Primary information was collected through direct interviews with pregnant women who presented with threatened abortion and received care in the unit. Secondary information was gathered through

document review of peer-reviewed journals, accredited midwifery textbooks, and official reports or guidelines from recognized health organizations relevant to early pregnancy bleeding, supportive care, and referral/collaboration practices. Using both sources enabled triangulation between lived clinical experiences and established recommendations, increasing the interpretive robustness of the study.

Primary data collection used semi-structured interviews guided by a set of domains derived from the study objectives and the literature, including symptom experience (bleeding and pain), understanding of diagnosis and danger signs, clarity and usefulness of counseling, emotional support received, perceived barriers to accessing and continuing care (cost, transportation, family support), and comprehension of follow-up or referral instructions. Interviews were conducted in a private setting after clinical stabilization to minimize burden and protect confidentiality. Participation was voluntary, identities were anonymized, and informed consent was obtained; interview materials were handled securely to maintain privacy. For the desk review, relevant documents were identified and screened for relevance to threatened abortion, comprehensive midwifery care, patient education, access barriers, and partnership mechanisms, and key information was extracted using a simple data-extraction matrix to keep the synthesis consistent across sources.

Data analysis followed a qualitative descriptive approach using thematic categorization. Interview data were repeatedly read for familiarization, then coded into meaningful units reflecting care components and patient needs. Codes were grouped into broader categories (e.g., monitoring and safety-netting, education and danger-sign recognition, emotional reassurance, barriers to continuity, and collaboration/referral). In parallel, evidence from the document review was categorized using the same framework and mapped to SDG-related dimensions (economic barriers, education/health literacy, and partnerships). Finally, interview-derived themes and document-derived categories were integrated through triangulation to generate a synthesized account of midwifery care management for threatened abortion in this setting and to highlight practical implications for strengthening continuity, patient education, and collaborative care pathways.

RESULT AND DISCUSSION

Socioeconomic pattern and access to ANC (SDG 1)

The document review consistently indicates that threatened abortion is more frequently reported among women with lower educational attainment, middle-to-lower

socioeconomic status, and limited access to routine antenatal care (ANC). Economic constraints were repeatedly described not only as direct service costs but also as indirect burdens (transportation, time off work, waiting time, and gaps in financial coverage), which collectively reduce timely ANC contact and continuity of follow-up (Alibhai et al., 2022; World Health Organization, 2016). Across the reviewed sources, delayed ANC and fragmented follow-up were linked with late recognition of worsening symptoms and weaker "safety-netting" (clear return precautions), increasing the likelihood of preventable adverse maternal–fetal outcomes.

Table 1. Summary of desk-review evidence: SDG 1 (economic barriers, access, and clinical implications)

Evidence aspect	Recurrent finding in the reviewed sources	Practical implication for threatened abortion care	Key sources
Economic barriers	Direct and indirect costs limit service use	Delayed assessment of bleeding/pain and missed follow-up	Alibhai et al., 2022; WHO, 2016
Transportation/access	Distance and transport difficulties reduce routine visits	Reduced early detection and continuity of monitoring	Alibhai et al., 2022
Insurance/coverage gaps	Inadequate coverage contributes to postponed care	Late presentation and weak safety-netting	WHO, 2016
Uneven service quality	Variation in counseling and follow-up instructions	Inconsistent adherence and return-to-care decisions	WHO, 2016

Overall, this pattern reinforces the SDG 1 perspective that improving threatened-abortion management requires service strategies that reduce economic and access barriers so that early evaluation and follow-up can occur on time and more equitably.

Health literacy, education, and care-seeking behavior (SDG 4)

A second consistent finding is that low health literacy and limited education are associated with insufficient understanding of pregnancy danger signs and the purpose of regular ANC visits. In the reviewed literature, limited knowledge about early warning signs such as vaginal bleeding and abdominal pain contributes to underestimation of symptom severity and delayed care-seeking. WHO's ANC framework emphasizes that quality ANC includes effective communication, counseling, and information that enable women to make timely decisions and follow care recommendations (WHO, 2016; Tunçalp et al., 2017). In threatened abortion, these educational components are central because the clinical pathway

often depends on prompt reassessment, adherence to follow-up, and correct interpretation of "return immediately" symptoms.

Table 2. Desk-review synthesis: health literacy and its pathway to continuity of care (SDG 4)

Component	Recurrent evidence statement	Typical downstream effect in practice	Key sources
Low health literacy/education	Limited recognition of danger signs and follow-up importance	Delayed care-seeking and missed control visits	Alibhai et al., 2022; WHO, 2016
Counseling during ANC	Clear counseling improves knowledge and preparedness	Better adherence to follow-up and safety-netting	WHO, 2016
Communication quality	Respectful, understandable communication reduces uncertainty	Improved coping and more appropriate decision-making	Tunçalp et al., 2017
Community-based health promotion	Health education beyond facilities strengthens awareness	Earlier presentation for symptoms and prevention behaviors	WHO, 2016; United Nations General Assembly, 2015

In plain terms, the reviewed evidence suggests that strengthening maternal health education functions as a protective lever improving knowledge, reinforcing follow-up adherence, and reducing delays thereby aligning threatened-abortion care improvement with SDG 4 (United Nations General Assembly, 2015; WHO, 2016).

Partnerships, family (husband) support, and care coordination (SDG 17)

The third pattern highlights that threatened-abortion prevention and management depend on multi-level partnerships, spanning clinical teamwork, facility-to-system coordination, and family support. Clinical guidance emphasizes the importance of clear pathways for assessing early pregnancy bleeding, planning follow-up, and arranging referral when needed processes that require coordination among midwives, physicians, nurses, and referral systems (National Institute for Health and Care Excellence, 2019). In addition, family support especially the husband's role emerged as a relevant factor influencing emotional stability, adherence to ANC recommendations, and timely care-seeking. Evidence from (Sinaga et al.,2022) indicates that husband-focused educational approaches can improve knowledge, attitudes, and practices related to prenatal care, while also implying that programs emphasizing the husband's role are not yet consistently implemented.

Table 3. Desk-review mapping: partnership levels and expected contributions (SDG 17)

Partnership level	Form of partnership/support	Expected contribution to threatened-abortion care	Key sources
Interprofessional team	Shared assessment, counseling, follow-up plan, referral decision	Greater consistency, patient safety, clearer pathways	NICE, 2019
Facility–local government/system	Policy support, financing schemes, outreach for underserved areas	Improved access and continuity of ANC and follow-up	United Nations General Assembly, 2015; WHO, 2016
Educational institutions–community	Integration of reproductive health education and community reinforcement	Improved literacy, earlier symptom recognition, supportive norms	WHO, 2016
Family (husband) support	Emotional support, practical help, decision support for seeking care	Better coping and adherence to prenatal care recommendations	Sinaga et al., 2022

Taken together, these findings suggest that stronger partnerships within services and at the household/community level support more consistent communication, safer follow-up, and improved continuity, which is central to SDG 17's partnership emphasis (United Nations General Assembly, 2015; NICE, 2019; Sinaga et al., 2022).

Before presenting the clinical-visual summary, it is important to note that the reviewed documents converge on a shared clinical message: threatened abortion is typically characterized by early pregnancy bleeding with a closed cervix, and care quality is strongly influenced by the clarity of warning signs and return precautions communicated to the patient (NICE, 2019). The figure below is positioned as a practice-oriented visual aid to support consistent counseling and safety-netting.

Figure 1. Clinical Manifestations of Threatened Abortion (Abortus Imminens) and Return Precautions

After the figure, the synthesis can be summarized as follows: across the evidence base, effective threatened-abortion care is not limited to clinical assessment, but also depends on

timely access (economic/transport), health literacy and counseling, and coordinated partnerships that secure follow-up and referral where needed. This integrated view supports the study's SDG framing by showing how poverty-related barriers (SDG 1), education/health literacy (SDG 4), and partnerships (SDG 17) operate together to shape both clinical safety and maternal experience (United Nations General Assembly, 2015; WHO, 2016; Tunçalp et al., 2017).

DISCUSSION

This study synthesized evidence from a desk-based document review (and field-context interviews as designed) to describe how threatened abortion is shaped by three interlinked domains: (1) socioeconomic barriers and access to antenatal care, (2) maternal health literacy and the quality of counseling/education, and (3) partnership-based care coordination involving the health system and family support. Across the reviewed sources, threatened abortion is repeatedly positioned as both a clinical risk state and a patient-experience event that requires timely assessment, continuity of follow-up, and supportive communication to reduce escalation and psychological burden (NICE, 2019; World Health Organization, 2016; Sotiriadis et al., 2004). These findings also align naturally with an SDG lens SDG 1 (poverty-related access), SDG 4 (education/health literacy), and SDG 17 (partnerships) because the mechanisms that influence early-pregnancy outcomes extend beyond the clinical encounter into affordability, knowledge, and coordination capacity

The observed pattern is plausible for several reasons. First, threatened abortion commonly presents with bleeding (often with pain/cramping), and evidence indicates that symptom severity especially heavier bleeding with pain can be associated with a higher likelihood of subsequent miscarriage, making timely assessment and repeat evaluation clinically meaningful (Hasan et al., 2009). When women face economic and logistical barriers, the pathway from symptom onset to assessment and follow-up becomes delayed or fragmented. This reduces opportunities for confirmation of viability, reinforcement of warning signs ("return immediately" precautions), and continuity plans elements repeatedly emphasized in early pregnancy care guidance (NICE, 2019; ACOG, 2018). In other words, the SDG 1-related barriers operate as upstream constraints that shape whether guideline-consistent care can occur in real time (United Nations General Assembly, 2015; Alibhai et al., 2022).

Second, the relationship between health literacy and care-seeking is also expected. Threatened abortion is a condition in which management often depends on the woman's ability to recognize symptoms, interpret advice, and adhere to follow-up schedules. WHO's antenatal care model stresses that quality ANC includes communication and counseling that enable informed decision-making, not merely service contact counts (WHO, 2016; Tunçalp et al., 2017). When maternal knowledge is limited, symptoms may be underestimated, anxiety may increase, and follow-up may be inconsistent. This is clinically relevant because uncertainty and distress are not just "side effects"; psychological morbidity around threatened miscarriage and early pregnancy complications is frequently documented, strengthening the rationale for integrating reassurance, empathic counseling, and continuity into routine care (Ip et al., 2023; Mirtabar et al., 2024; Farren et al., 2016).

When compared with prior studies, the study's synthesis is broadly consistent with earlier evidence while offering a practical integration that is often missing in single-focus research streams. Socioeconomic and access determinants identified in systematic evidence align with this study's first result (Alibhai et al., 2022), while the need for high-quality counseling and person-centered ANC echoes WHO's recommendations (WHO, 2016; Tunçalp et al., 2017). Similarly, the psychological burden described in studies of threatened miscarriage and early pregnancy loss supports the second result and highlights why supportive care needs to be embedded in clinical pathways (Ip et al., 2023; Mirtabar et al., 2024; San Lázaro Campillo et al., 2017). What this study adds (novelty) is an SDG-linked interpretation that connects the three domains into a coherent service logic: access enables timely care, education improves interpretation and adherence, and partnerships stabilize continuity a framing that can be directly translated into quality-improvement actions in hospital and community settings.

The meaning of these findings is that threatened abortion should be understood as a condition where clinical safety and patient experience are inseparable. Clinically, standardized pathways and safety-netting reduce preventable escalation and ensure appropriate reassessment. Socially, affordability and transport barriers shape who receives timely assessment and who does not, potentially widening inequities in early pregnancy outcomes (Alibhai et al., 2022; United Nations General Assembly, 2015). Ideologically, the results reinforce a shift from "episode-based" management toward continuity and respectful, person-centered care, which is central to WHO's positive pregnancy experience framework (WHO, 2016; Tunçalp et al., 2017). In addition, recognizing the role of family

particularly the husband as a support actor is consistent with evidence that husband-focused educational strategies can improve prenatal care-related knowledge and practices, although such programs are not consistently implemented (Sinaga et al., 2022).

Reflecting on function and dysfunction, the integrated approach has clear benefits: improved access and counseling can increase timely presentation, strengthen follow-up adherence, and potentially reduce psychological distress, which is commonly reported after early pregnancy complications (Farren et al., 2016; Ip et al., 2023). However, there are also potential downsides if implementation is weak. Emphasizing partnerships without clear role definitions can create coordination gaps; intensive counseling without standardized scripts can lead to inconsistent messaging; and focusing on patient responsibility without addressing structural barriers risks "blaming" women for late presentation. These dysfunctions highlight why structured pathways, clear communication tools, and system-level support are necessary complements to individual counseling.

Based on these findings, several action-oriented implications can be proposed. At the facility level, Medan Haji Hospital can implement a simple threatened-abortion counseling and follow-up bundle: standardized assessment documentation, a one-page return-precautions checklist, and scheduled follow-up instructions delivered consistently by midwives and reinforced by physicians when needed . At the community and primary-care level, targeted health education during ANC and community outreach should prioritize danger-sign recognition and practical planning for rapid access (WHO, 2016). To address SDG 1-related barriers, coordination with local health authorities and referral networks can focus on transport facilitation, clearer coverage pathways, and outreach for underserved areas. Finally, to operationalize SDG 17, hospitals and educational institutions can co-develop husband/family engagement modules, leveraging culturally sensitive materials shown to improve husbands' prenatal care support behaviors (Sinaga et al., 2022).

CONCLUSION

This study highlights that threatened abortion in early pregnancy should be understood and managed not only as a clinical condition, but also as a care-continuity challenge shaped by social determinants and coordination capacity. The most important lesson from the findings is that three interconnected domains consistently influence the quality and timeliness of care: (1) socioeconomic and access barriers that delay or fragment antenatal care and follow-up (SDG 1), (2) maternal health literacy and the consistency of counseling

that determine whether danger signs are recognized and recommendations are followed (SDG 4), and (3) partnership-based coordination across providers, institutions, and families that stabilizes referral pathways and sustained support (SDG 17). Together, these domains suggest that comprehensive midwifery care combining monitoring, clear safety-netting, emotional support, and planned follow-up represents a practical pathway to strengthen early pregnancy services and maternal well-being.

Scientifically, this study contributes by offering an integrated SDG-linked framework for interpreting threatened-abortion care management that connects clinical guidance with real-world determinants of access, education, and partnerships. Rather than treating these factors separately, the study synthesizes them into a coherent service logic access enables timely assessment, education improves interpretation and adherence, and partnerships secure continuity thereby providing a structured perspective that can inform quality-improvement initiatives in hospital and community maternal health services. This contribution is particularly relevant for strengthening the role of midwives in early pregnancy bleeding management through standardized counseling and continuity-oriented care pathways.

This study also has limitations. The findings are primarily based on a document review synthesis (and qualitative insights as designed) and therefore cannot quantify effect sizes or establish causal relationships between care components and pregnancy outcomes. In addition, the evidence is context-dependent and may not fully represent all local variations in service delivery. Future research should include clearly defined participant samples and rigorous qualitative procedures (e.g., thematic analysis with trustworthiness strategies) and/or prospective designs that measure clinical and psychosocial outcomes (e.g., follow-up adherence, anxiety reduction, and pregnancy continuation) to evaluate the effectiveness of structured midwifery care management and partnership interventions in threatened abortion cases.

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