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RESEARCH

Pattern of intimate partner violence disclosure among pregnant women attending ante-natal clinic in Oyo East Local Government, Nigeria

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Background: Intimate partner violence (IPV) is a significant public health problem. Despite being a phenomenon that occurs globally, few studies have reviewed the issue of intimate partner violence among pregnant women as it relates to disclosure of abuse. This study sets out to determine the prevalence and pattern of disclosure of intimate partner violence among pregnant women attending antenatal clinic in Oyo East Local Government of Oyo State.
Methods: A descriptive cross-sectional study among pregnant women aged 18–49 years. A total of 350 pregnant women in the sole secondary health care facility and 3 out of the 18 primary health care facilities randomly selected by balloting were consecutively recruited. A pre-tested semi-structured questionnaire adapted from the WHO Multi-Country Study on Women's Health and Domestic Violence was used to collect data. Data were analysed with SPSS® version 16.
Results: Of 252 (72.0%) women who had been exposed to violence by their partner in pregnancy, 72 (28.6%) disclosed their IPV experience. The experience was disclosed to relatives, friends and religious leaders. Of the 72 that disclosed their IPV experience, 31 (43.1%) reported for the purpose of seeking redress through religious or local leaders, healthcare professionals and law enforcement agencies.
Conclusion: Intimate partner violence is common among pregnant women, but a culture of silence still persists, making identification of the exposed difficult. These data may encourage healthcare providers to include screening for IPV in the curriculum of the antenatal care.

Keywords: disclosure, intimate partner, pattern, pregnancy, violence

Introduction

Intimate partner violence (IPV) is a public health issue of significant importance all over the world. It has become one of the most important reproductive health as well as rights and gender issues in the last few decades. The World Health Organization (WHO), non-governmental organisations (NGOs) and other agencies have recognised this and called on countries to take proper measures to prevent violence against women through numerous conventions and conferences.[1,2] Despite this, IPV is still very common, affecting millions of women worldwide.[1] It cuts across all types of families irrespective of socio-economic, ethnic, cultural or religious background and place of residence, hampering women's right to participate fully in the society.[2,3] Unfortunately, IPV is perceived as a cultural norm or penal code and accepted as part of the rules guiding intimate partner relationship in some communities in different countries.[1,3–5]

IPV has been defined by the WHO as 'behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of aggression, sexual coercion, psychological abuse and controlling behaviours' encompassing both current and past intimate partners.[6]

There has been an established relationship between pregnancy and IPV in previous studies.[5,7] According to the Nigerian demographic health survey (NDHS) of 2013, 5.0% of women experienced violence in pregnancy and this varied by the level of education, employment status and marital status.[8] However, facility-based prevalence of IPV among pregnant women attending antenatal care in various parts of the country ranged from 7.4% in Kano to 37.4% in Abuja.[8] Yet, these figures may represent an under-estimation considering that significant proportions of women are unwilling to disclose abuse.

IPV poses an immense threat to attainment of goals of the Safe Motherhood Initiative and sustainable development goals, especially those related to good health and well-being.[1,9] It is of great concern in pregnancy because of the impact on the woman and the unborn baby; it is known to be associated with adverse pregnancy outcome such as antepartum haemorrhage, miscarriage, premature rupture of membrane, preterm delivery, low birthweight, foetal distress and perinatal death.[10–12] These consequences could be through direct or indirect mechanisms and could be prevented.

Normalisation of IPV plays out significantly in the sub-Saharan African and Nigerian context. Some recent studies suggest that over 75% of women believed that wife beating was justified when a woman does not live up to her traditional normative roles (e.g. cooking and taking care of children).[3,13,14] Ethnicity and culture on their part have a significant effect on women's attitude to IPV such that an ethnic group that is more gender restrictive is more likely to condition women to agree or consent to wife beating.[3,15]

Disclosure of abuse is a vital step in the process of finding a lasting solution and breaking the abuse chain. Therefore, screening for and eventual management of IPV may be seriously hampered unless victims are willing to disclose abuse and make use of available resources. It is noted that factors such as ethnicity, culture, gender-role definitions, kin and friendship networks may influence a woman's perception of her options and the help

she seeks, as well as the nature and scope of violence she experiences in an intimate relationship.[13,14] Societal, cultural and religious factors are not only important in determining whether women will report abuse or not, but also to whom such abuse will be reported.[13,15] In many parts of sub-Saharan Africa, marriage is considered a family and community affair rather than a private one.[16] The role of the extended family therefore includes delving into marital conflicts and finding ways to resolve them. Disclosure of abuse to institutions like law enforcement agencies or legal redress is viewed as disrespect for the family. Indeed law enforcement agencies, such as police themselves, overlook such activity as women who summon enough courage to report are usually advised to go and settle with their husbands, denying women the opportunity to press charges and ultimately reducing their interest in seeking justice.[16,17]

Though the major religions practised in Nigeria, i.e. Christianity, Islam and traditional religion, all have teachings of female submission and obedience to the man as the head, findings show that some women are willing to disclose to religious leaders.[15,17] However, there is no clear-cut difference between the categories of women who would make such reports.

Pregnancy seems to provide a unique opportunity to screen for domestic violence because women tend to trust and confide in health workers when ordinarily they may not. This was one of the reasons why pregnant women were chosen for this study. This study will add to the few available studies especially within the Nigerian and African context on the willingness of the victimised pregnant women to disclose abuse, to whom such disclosure would be made and reasons for disclosure.

Methods

This cross-sectional study was conducted in Oyo East Local Government Area (OELGA) during the three-month period of data collection from July to September 2010. OELGA is one of the 33 local government areas in Oyo State with a population that is predominantly of Yoruba ethnicity. It has many social groups based on religious, political and ethnic inclinations. It has 18 primary health centres and one secondary health centre.

The participants were pregnant women between the ages of 18 and 49 who attended for antenatal visits, excluding all those who were too ill to participate. A total sample of all 350 consenting pregnant women who attended antenatal care in the sole secondary health centre facility and 3 of the 18 primary health care centre facilities, randomly selected by balloting, were sequentially recruited. The primary health centres selected were Apaara health centre, Durbar health centre, and Jabata health centre, while the sole secondary health centre was the State General Hospital, Oyo.

A minimum sample size was statistically determined for the study using a prevalence of 28% as reported by Ameh *et al.*,[5] with a confidence interval of 95% and standard error of 5% as 310. This was increased to 340 to compensate for 10% non-response to certain questions; in all, 350 pregnant women were recruited to participate in the study.

A pre-tested semi-structured interviewer-assisted questionnaire adapted from the WHO Multi-Country Study on Women's Health and Domestic Violence was used to collect data for this study. Data were obtained on socio-demographic characteristics of respondents, type of IPV perpetrated by their partner and coping strategies and services utilised. During the booking or routine antenatal visit, the author had the opportunity to address all the pregnant women. This opportunity was used to introduce the study to them, and to explain the rationale for the study and its benefits. They were given the opportunity to ask questions, and these were clarified. It was also stressed to them that all information obtained would be treated with confidentiality and that participation in the study was voluntary. Data gathered were entered into and analysed with SPSS 16.0® software (SPSS Inc, Chicago, IL, USA). Frequency tables were generated.

Outcome measures

Women whose partners exhibited any of the behaviours below were considered to have experienced *psychological IPV*:

(a) Tries to restrict her from seeing her friends.

(b) Tries to restrict contact with her family of birth.

(c) Monitors her movement.

(d) Ignores her and treats her indifferently.

(e) Gets angry if she speaks with another man.

(f) Often suspicious that she is unfaithful.

(g) Expects her to ask for permission to seek healthcare.

(h) Very jealous or controls her life.

A woman was considered to have experienced *emotional IPV* if she said 'yes' to any of the following. Her partner:

(a) Insulted her or made her feel bad about herself.

(b) Belittled or humiliated her in front of others.

(c) Scared or intimidated her on purpose.

(d) Threatened to hurt her/someone she cared about.

(e) If she is afraid of her partner.

Sexual violence was considered to have occurred if the woman reported any of the following:

(a) Was physically forced to have sexual intercourse when she did not want to.

(b) Was forced to do something sexual that she found degrading or humiliating.

(c) Had sexual intercourse she did not want for fear of her partner.

Women whose partner exhibited any of the behaviour below were considered to have experienced *physical IPV*:

(a) Slapped or threw objects that could hurt her.

(b) Pushed, shoved or pulled her hair.

(c) Hit her with fist or objects that could hurt her.

(d) Kicked, dragged or beat her up.

(e) Choked or burnt her on purpose.

(f) Threatened to use or actually used a gun, knife or other weapon against her.

A woman was considered to have experienced *intimate partner violence* if she said 'yes' when asked if a current or past partner ever abused her in any of the ways listed as psychological, emotional, sexual and physical IPV.

Verbal and written consent were obtained before administration of the questionnaire. Respondents were interviewed in a private room within the clinic to ensure confidentiality. Ethical approval to conduct the study was obtained from the Oyo State Ministry of Health Ethical Review Committee.

Results

A total of 395 pregnant women were approached to participate in the study with 350 consenting to do so. The mean age of respondents was 29.5 ± 5.9 years with a range of between 18 and 44 years. The mean age of partners was 33.9 ± 7.3 with a range between 18 and 58 years. The mean duration of relationship was 6.5 ± 3.9 years with a range between 8 months and 24 years. Table 1 gives socio-demographic characteristics. The most frequent age group among the respondents was 25–34 years. Most of the women, 318 (90.9%), were married, mostly in a monogamous setting. The respondents' educational attainment was generally high; 137 (39.1%) had tertiary education, 118 (33.7%) had secondary education. The majority 312 (89.1%) of the respondents had been in their relationships for less than 10 years.

Table 1: Socio-demographic characteristics of respondents

Variables	*n* = 350 (%)
Age group (years)	
Less than 25	106 (30.3)
25–34	182 (52.0)
35–44	62 (17.7)
Religion	
Christianity	142 (40.6)
Islam	196 (56.0)
Traditional	12 (3.4)
Educational attainment	
No formal education	29 (8.3)
Primary education	66 (18.9)
Secondary education	118 (33.7)
Tertiary education	137 (39.1)
Occupation	
Skilled	280 (80.0)
Unskilled	70 (20.0)
Marital status	
Single	11 (3.1)
Married	318 (90.9)
Co-habiting	21 (6.0)
Family structure	
Monogamous	267 (76.3)
Polygamous	83 (23.7)
Length of relationship	
Less than 10 years	312 (89.1)
More than 10 years	38 (10.9)
Parity	
Less than 2	162 (46.3)
2 or more	188 (53.7)
Current pregnancy unplanned	
Yes	71 (20.3)
No	279 (79.7)
Gestational age of pregnancy	
Second trimester	46 (13.1)
Third trimester	304 (86.9)

Table 2: Respondents' experience of IPV (*n* = 350)

Variable	Frequency
Lifetime	252 (72.0)
Current pregnancy	61 (17.4)

Table 3: Distribution of respondents with regard to forms of IPV*

Variables	Frequency (%)
Psychological IPV	211 (60.3)
Emotional IPV	176 (50.3)
Physical IPV	75 (21.4)
Sexual IPV	83 (23.7)

*Multiple entries allowed, IPV = intimate partner violence.

As depicted in Table 2, the prevalence of lifetime experience of IPV among respondents was 72%, while 17.4% had experienced IPV in index (current) pregnancy.

Table 3 shows that the most common form of IPV experienced was psychological (211; 60.3%).

Table 4 shows that 72 (28.6%) of the respondents disclosed their IPV experience. Twenty-three (31.9%) informed their own family members. Others informed religious leaders, friends, in-laws, or neighbours.

Of the 72 respondents who disclosed their IPV experience, 31 (12.3%) did so with the intent of getting help, as shown in Table 5.

Table 6 shows that frequent sources of help among respondents with physical IPV experience were the hospital and religious leaders, nine (39.1%) and eight (34.8%) respectively. Others were the police, court and local leaders.

As shown in Table 7, respondents who sought help did so when they could not endure the violence any more (29.0%). Other frequent reasons for seeking help include encouragement by friends (25.8%), and being badly injured (22.6%).

Table 4: Distribution of respondents who told someone of their IPV experience (*n* = 252)*

Variables	Frequency (%)
Told someone of any IPV experience	72 (28.6)
Person to whom they disclosed	
Own family	46 (18.3)
Religious leader	16 (6.3)
Friends	11 (4.3)
In-laws	6 (2.4)
Neighbours	2 (0.8)

*Multiple entries allowed.

Table 5: Distribution of respondents who sought help

Variables	Sought help, *n* (%)	Told someone, *n* (%)	Never told someone, *n* (%)	Total, *n* (%)
Respondents who ever experienced IPV	31 (12.3)	41 (16.3)	180 (71.4)	252 (100.0)
Experienced any IPV in current pregnancy	15 (24.6)	1 (1.6)	45 (73.8)	61 (100.0)

Table 6: Respondents' sources of help

Variables	Types of violence	
	Physical IPV	Sexual IPV
Police	3 (13.0)	5 (26.3)
Court	1 (4.3)	1 (5.3)
Hospital	9 (39.1)	7 (36.8)
Local leader	2 (8.7)	2 (10.5)
Religious leader	8 (34.8)	4 (21.1)

Table 7: Respondents' reasons for seeking help ($n = 31$)

Reasons	Frequency (%)
Encouraged by family/ friends	8 (25.8)
Could not endure more	9 (29.0)
Badly injured	7 (22.6)
Threatened or tried to kill her	2 (6.5)
Threatened or hit her children	2 (6.5)
Saw that children were suffering	3 (9.7)

Discussion

Slightly above half, 52.0% of the respondents, were aged 25–34 years, which is comparable to a study conducted among pregnant women in different parts of Nigeria[5,18] and Ghana.[19] This is the most fertile age period for women and so they are more likely to be victims of IPV in pregnancy. Almost all the respondents had had formal education, which is to be expected as the study area was located in the south-western zone of Nigeria characterised by a better level of female empowerment through education.[8] This may also account for the reason why the majority of the respondents were engaged in skilled labour.

From the present study, most pregnant women, 72.0%, have lifetime IPV while 17.4% experience IPV in index pregnancy. This is quite high but is within the range of 11.5–79% seen in different parts of Nigeria.[3–5,20–23] The high prevalence rate observed in this study may be because the respondents were willing to disclose information regarding their experience of IPV. This is most likely due to the fact that the respondents were assured of confidentiality, and were taken into a separate apartment to complete the questionnaires. Thus they had no fear of stigmatisation, and did not feel that they were exposing their family affairs to the public.

Psychological and emotional abuse occurred most commonly, which was similar to what was reported by other studies[16,22,24,25] These forms of abuse are usually adopted by the perpetrator rather than physical abuse, so as not to inflict harm to the baby in utero. Another reason for this could be the changing socio-cultural environment and the decreasing gap between the age of the husband and his wife, which in the past was wide, in which case the husband was then also looked upon as a father figure. These factors may have increased the sensitivity of the woman towards verbal reprimand by the husband. In Jos, sexual violence was the commonest form of domestic violence, occurring in almost two-thirds of the cases.[26] Although physical violence was least reported in this study, there is a possibility that this might have been underreported, which is a common phenomenon with issues of domestic violence as has been documented.[3–5]

The majority in this study chose not to disclose violence, which contrasts with what has been observed by other researchers.[14,27] Among women who disclosed abuse, many opted for disclosure to close relatives rather than to institutions. These findings are in agreement with other research conducted within the African context.[13,19,21–23] IPV historically has been viewed as a private family matter that need not involve the law enforcement agencies or criminal justice. Of all the victims of IPV in this study, only about a tenth of those who were physically abused and a fourth of those who were sexually abused sought help from law enforcement agencies. Most women, as reported in this study, would not tell anyone about their experience, let alone seek help. This is done to protect their marriage and to prevent their children from suffering from neglect and abuse.[1,3,28] Among the few that told someone of their experience, only a few did for the purpose of intervention to prevent recurrence. When IPV is reported, it is usually to family members such as parents, siblings, or close friends and religious leaders. This is because marriage in the Nigerian setting is seen as a family affair rather than a public or private affair. This was further buttressed by the fact that only about a tenth of physically abused respondents reported to law enforcement agents with only one of these cases leading to prosecution.

These results further substantiate the role of the extended family in arbitrating marital conflicts, including violence, and suggest a divergence from capitalising on established institutions purported to protect women from abuse. On the other hand, it is not unusual to see parents send their daughters back to an abusive husband, encouraging them to 'settle their differences amicably', perhaps because a bride price has been paid.[13] The society also frowns on divorce and would prefer that a couple continue their relationship in spite of their differences rather than formally separate or divorce.[13] Thus, resolving marital disputes is considered a responsibility of the extended family and not of government institutions such as law enforcement agents.

On the other hand, women refraining from disclosing IPV to the relevant institutions could also have been an indication that they lack trust in such institutions or that such institutions lack interest in domestic problems.[14,15,29,30] Further research is warranted to investigate institutional readiness to assist abused women in Nigeria. Institutional readiness to assist abused women may vary depending on religious and ethnic affiliations.

This study showed that reporting to family members and religious leaders are the most common means of abuse disclosure. This is mainly because of the pedigree of the institution of marriage in this part of the country. There is a strong religious and/or cultural tie in family settings in Nigeria. In practice, the implications of the findings for intervention or

prevention programmes are enormous. The extended family remains a respected authority in resolving marital issues in the Nigerian culture. Prevention programmes can capitalise on this through empowering the family unit by providing IPV-related educational workshops, and improving their access to IPV prevention information, including information related to gender-role issues. The importance of involving the family in IPV prevention cannot be overemphasised. It is indeed suggested that lack of family support could be a barrier to victims of IPV, preventing them from taking steps towards ending their ordeal.[17] Lack of willingness of women to disclose IPV to the relevant institutions also has important implications for the training of law enforcement officers as well as religious leaders to become more proactive in handling and dealing with reports of IPV.

Conclusion

IPV violates basic human rights and it affects women physically, emotionally, sexually and psychologically. Most respondents neither sought help nor reported the incidents, while the few that did, sought help majorly from health workers and religious leaders.

It is recommended that screening for IPV should be included in the curriculum of the various health worker cadres with a particular emphasis during the antenatal care period. This will help in identifying, evaluating, counselling and offering immediate solutions to victims. Support group formation will also help in follow-up and reporting of intractable cases to the appropriate authorities.

Area for further research

More research is warranted to further determine the underlying factors determining women's choice of disclosing IPV and to whom the disclosure is made.

Limitation

This study was conducted in a hospital setting, which limits the generalisability of the findings. Larger studies are needed to assess determinants of the IPV disclosure pattern and behaviour among women in Nigeria.

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