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Original Research Article

THE DETERMINANTS AND CONSEQUENCES OF INTIMATE PARTNER VIOLENCE AMONG PREGNANT WOMEN IN TERTIARY HEALTH INSTITUTIONS IN ABIA STATE, NIGERIA

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Abstract

Background: It has been documented that pregnant women who are exposed to intimate partner violence (IPV) are prone to the risk of complications both for the mother and the baby. There is a need to identify the reasons for this abuse.

Objectives: To identify the prevalence, determinants, and consequences of Intimate Partner Violence (IPV) among pregnant women in Tertiary Health Institutions in Abia State.

Materials and Method: This was a cross-sectional Study of 214 pregnant women attending the antenatal clinic in the two Tertiary Health Institutions in Abia State using pretested questionnaires administered to attendees who consented to participate. Analysis of data was done using SPSS Version 16.

Results: The mean age of the 214 participants was 30.15 ± 5.88 years. The Prevalence of intimate partner violence among pregnant women in our study was 32.7 %(70/214). We did not establish any statistical association between age of women or that of her partner, duration of the marriage, her religion, parity or educational status of the partner and IPV ($p>0.05$). We established a statistically significant association between social habits of the partner and IPV ($p< 0.05$). About 31 %(22) of the IPV victims had sustained an emotional/ physical injury while 20 % (14) had been hospitalized. Social habits of the spouse (13%) were the highest trigger for the abuse followed by financial problems (10%). Majority of victims 68.6 %(48) did not feel the abuse should be reported.

Conclusion: This study demonstrates a high prevalence of IPV among pregnant women.

Keywords: IPV, Pregnant women, Social habit

Introduction

Violence against women is an important health and human rights issue. Intimate partner violence has been defined as a pattern of assaultive behavior and coercive behavior that may include physical injury, psychologic abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation and reproductive coercion [1]. Intimate partner violence (IPV) during

pregnancy is the most common form of violence against women which harms both the fetus and woman [2].

IPV is commonly practiced around the world, cutting across diverse ethnic, cultural, socio-economical and religious barriers impinging on the rights of women to participate fully in the society [3].More than one in three women in the United States have experienced rape, physical violence or stalking by an intimate partner in their lifetime [4].A Canadian study reported a current rate of any type of IPV of 15% while a similar study in Spain found a 32% lifetime prevalence of any type of IPV [5,6]. A study of women in Peru produced a lifetime prevalence rate of 45% [7], while a national health survey in India reported that 35% of women had experienced IPV [8]. Notwithstanding the common nature of IPV, it is still being under-reported in many places around the world, especially in developing countries. Prevalence of violence against women in developing countries is estimated to be 4-29% [9]. This could be higher if most cases of IPV were reported. A systematic review of thirteen African studies revealed that prevalence of IPV during pregnancy ranged from 2-57% while meta-analysis yielded 15.3% [10]. Studies with pregnant women in Uganda revealed an IPV prevalence of 13.5% while a similar study of IPV during pregnancy in rural Ethiopia reported a prevalence of 8% [11,12]. In Nigeria, a national IPV prevalence rate of 6% was reported but varied in different regions of the country due to differences in age, marital status, religion and socio-economic status [13].

Certain characteristics have been associated with increased risk of IPV during pregnancy. Many studies identified an increased risk of IPV among both pregnant and non-pregnant women with lower socio-economic status [14,15]. A project with 1000+ women in the United States revealed that income and educational levels were the most significant predictors of violence against pregnant women [16]. Younger women, unmarried women, and women from minority groups are also at increased risk for pregnancy IPV. Some national survey reports suggest a nearly double risk of pregnancy IPV for women under 20 while single women are at increased risk of IPV during pregnancy compared with married women [17,18].

The societal and economic effects of IPV are profound. Approximately one-quarter of a million hospital visits occur as a result of IPV annually [19]. The cost of intimate partner rape, physical assault and stalking come up to over $8.3 billion each year for direct medical and mental health care services. This also includes lost productivity from paid work and household chores [20]. Other intangible costs include women's decreased quality of life, undiagnosed depression and lowered self-esteem with loss of financial stability as a result of the destruction of the family unit [21].

Intimate partner violence against pregnant women has been significantly associated with adverse maternal health outcomes ranging from unintended pregnancies, pregnancy-related symptom distress, inadequate prenatal care, induced abortion, spontaneous abortion, gestational weight gain, hypertension, pre-eclampsia, third trimester bleeding and sexually transmitted infections. Pregnant women are also at higher risk of maternal death [22-24]. Some victims of IPV present with acute injuries to the face, breasts, abdomen, and genitalia. Others may show chronic symptoms such as sleep and appetite disturbances, chronic headaches, palpitations, chronic pelvic pain, urinary frequency, irritable bowel syndrome, sexual dysfunction and abdominal symptoms. This may lead to post-traumatic stress disorder often associated with anxiety disorders, substance abuse and suicide [25].

The purpose of this study is to identify the determinants and consequences

of IPV during pregnancy in Abia State. The ultimate goal should be the prevention of IPV during pregnancy [26]. It is hoped that this study will provide useful information for public health education, researchers and policymakers to curb the menace of domestic violence against women.

Materials and Methods

This was a cross-sectional study of 214 pregnant women conducted at the Antenatal clinics of Tertiary Health Institutions in Abia State, south-east Nigeria. A minimum sample size of 210 pregnant women was statistically determined for the study using prevalence of 13.6% reported in a previous study [28], the confidence interval of 95% and standard error of 5%. However, a total of 260 responses were gotten and the 214 that were correctly filled were analyzed

Area of Study

Abia State is situated in the south-east of Nigeria. The state has two tertiary health institutions; Abia State University teaching hospital Aba and Federal Medical Centre Umuahia.

Ethics Information:

Ethical approval was obtained from the Ethical Committee of the Federal Teaching hospital, Abakaliki.

Inclusion Criteria

All pregnant women who were attending antenatal clinics during the period of the study at both tertiary health facilities were eligible to participate.

Exclusion Criteria

Pregnant women who did not consent to participate in the study, were not living with any partner were sick or accompanied by their husbands/partners were excluded from the study.

Study Instrument

Semi-structured questionnaires were consecutively administered to the antenatal attendees who met the inclusion criteria between June and August 2013. The tool was adapted by the researchers from previous studies [27,28]. The questionnaire was pretested in a facility that was not selected for the study and necessary adjustments made before administering on study participants.

Results were analyzed using SPSS version 16 (SPSS Inc, Chicago, IL, USA). Categorical variables were analyzed using the Chi-square test and *P* values less than 0.05 was taken as significant.

Results

The study included correctly filled questionnaire responses from 214 antenatal attendees at the tertiary health institutions in Abia State.

Socio-demographic characteristics of Respondents and Intimate Partner Violence (IPV) (Table1)

The mean age of respondents was 30.15 ± 5.88 years while that of their spouse Was 36.78± 8.62 years. Majority of the respondents (81) 39% were 25-29 years of age. Prevalence of IPV among the respondents was 32.7 %(70/214). The age groups most affected in this study were women ≥ 40, 56% (9/16) and ages 20-24, 37% (10/27). Majority of respondents were civil servants 62(29%). With regards to the profession, Artisans /hairdressers were the most affected, 75% (3/4) by IPV while the least affected occupation was the clergy 20% (1/5). Marriages with duration 6-10 years had the highest cases of IPV 38% (17/45) while the least was among those with duration of marriage > 10 years 16% (1/6). IPV was higher in polygamous settings 36% (4/11) than monogamous settings 32.5% (66/203). Majority of respondents had a tertiary education (128) 59.8%. Those with primary education were most affected by IPV 80% (`4/5) followed by those with no formal education 40% (2/5).

Spouses with primary education were more likely to abuse their wives 60% (6/10). A statistically significant association (P< 0.002) was found between spouse social habits and IPV.

Table 1: IPV and Socio-demographic characteristics of respondents

Variable	Frequency (%)	Abused	Not abused	χ^2	P value
Age of Respondent (years)					
< 20	4 (1.9)	1 (1.4)	3 (2.1)	8.948	0.110
20 – 24	27 (12.5)	10 (14.3)	17 (11.8)		
25 – 29	81 (37.9)	28 (40.0)	53 (36.8)		
30 -34	53 (24.8)	11 (15.7)	42 (29.2)		
35 – 39	34 (15.9)	11 (15.7)	23 (16.0)		
≥ 40	15 (7.0)	9 (12.9)	6 (4.2)		
Occupation					
Housewife	25 (11.6)	7 (10.0)	18 (12.5)	14.905	0.136
Trading	21 (9.8)	7 (10.0)	14 (9.7)		
Seamstress	8 (3.7)	2 (2.9)	6 (4.2)		
Artisan/hair dressing	4 (1.9)	3 (4.3)	1 (0.7)		
Civil servant	70 (32.7)	24 (35.7)	45 (31.3)		
Professional	18 (8.4)	6 (8.6)	12 (8.3)		
Business	38 (17.8)	9 (12.9)	29 (20.1)		
Clergy	5 (2.3)	1 (1.4)	4 (2.8)		
Student	25 (11.7)	10 (14.3)	15 (10.4)		
Duration of marriage (years)					
≤ 5	163 (76.2)	52 (74.3)	111 (77.1)	1.275	0.529
6 – 10	45 (21.0)	17 (24.3)	28 (19.4)		
>10	6 (2.8)	1 (1.4)	5 (3.5)		
Family setting					
Monogamous	203 (94.9)	66 (94.3)	137 (95.1)	0.070	0.791
Polygamous	11 (5.1)	4 (5.7)	7 (4.9)		
Educational status					
None formal	5 (2.3)	2 (2.9)	3 (2.1)	6.137	0.105
Primary	5 (2.3)	4 (5.7)	1 (0.7)		
Secondary	76 (35.5)	21 (30.0)	55 (38.2)		
Tertiary	128 (59.8)	43(61.4)	85(59.0)		
Educational status of Husband					
None formal	6 (2.8)	2 (2.9)	4 (2.8)	4.027	0.259
Primary	10 (4.7)	6 (8.6)	4 (2.8)		
Secondary	95 (44.4)	32 (45.7)	63 (43.8)		
Tertiary	103 (48.1)	30 (42.9)	73 (50.7)		
Social habit of husband					
Smoking	3 (1.4)	2 (2.9)	1 (0.7)		
Drinking of alcohol	20 (9.3)	14 (20.0)	6 (4.2)		
Staying late outside	11 (5.1)	4 (5.7)	7 (4.9)		
Eats outside often	9 (4.2	3 (4.3)	6 (4.2)	18.526	*0.002
Has a woman/girlfriend	3 (1.4)	2 (2.9)	1 (0.7)		
None applicable	168 (78.5)	45 (64.3)	123 (85.4)		

Reasons for IPV Figure: 1

Majority of the respondents (24.3%) reported social habit of their spouse as the reason for misunderstanding resulting in IPV. Other factors were a financial problem (17.1%), domestic issues (14.3%) and extramarital affairs (11.4%). Several respondents (15.7%) could not identify any reason for the IPV.

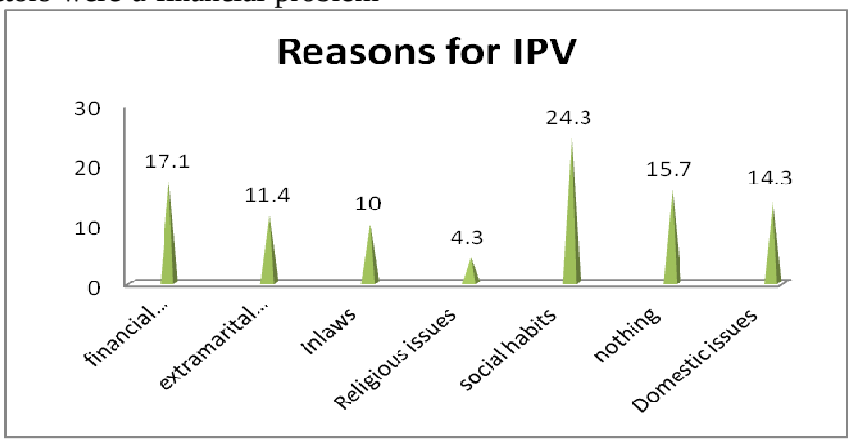

Figure 1: Reasons for IPV

Type of IPV experienced by the Respondents (Table 3)

The commonest form of IPV reported in this study was "Shouting" 41.4 %, physical beating, 21.2 % and verbal abuse/threats15.5%.Others included forced sex, financial denial, "sent out of the home"

Table 2: Type of IPV experienced by the Respondents

Type of IPV	Frequency	% (100)
Shouting	29	41.4
Physical beating	17	24.3
Verbal abuse/threats	13	18.6
Extramarital affairs	3	4.3
Forced sex	2	2.9
Financial denial	3	4.3
sent out of the home	3	4.3

Consequences of IPV (table 3)

The respondents reported challenges they had experienced following IPV. Thirty-one percent (31%) 22/70 of the pregnant women had suffered emotional/ physical injuries following IPV while 20% (14/70) had been hospitalized following intimate partner violence. On willingness to report cases of IPV, 69% (48/70) felt it should not be reported. 80% of the perpetrators apologized to the respondents following the incidence while 20% did not.

Table 3: Consequences of Intimate Partner Violence

Variable	**Frequency**	**% (100)**
Emotional/physical Injuries		
Yes	22	31
No	48	69
Hospitalization		

Yes	14	20
No	56	80
Willingness to Report IPV		
Yes	22	31
No	48	69
Apology by spouse		
Yes	56	80
No	14	20

Response to IPV

Less than 1% of affected respondents had reported the matter to the police. Majority; 24 (34.3%) responded by crying while for 17 (24.3 %) response was praying. Others reported to parents, friends, or fought back.

Respondents Suggestions on the solution to Domestic Violence

Thirty-three 33 respondents, 15.4% (33/214) suggested cases of IPV should be reported to the church while 15% (32/214) felt public enlightenment programmes could help in addressing IPV and 11% (24/214) opined that cases of IPV be reported to the police.

Discussion

Many people all over the world are daily faced with violence in various forms. For many victims, exposure to violence outside is not as worrisome as the violence behind closed doors in a seemingly "trusted" relationship. The prevalence of pregnancy IPV in this study is 33%. The finding differs from another study carried out in Ebonyi State, Nigeria which reported a pregnancy IPV prevalence of 44.6% [27]. This is relatively high but falls within the range of 2-57% reported in a systematic review of thirteen African studies [10]. This is also higher than what was reported by Fawole, et al in Abeokuta (2.3%),17.6% by Umeora, et al in Abakaliki and 7.4% by Iliyasu, et al in Kano [26,28,29]. The prevalence may actually be higher than was reported in this environment because of fear of more violence, stigmatization and cultural perceptions of accepting IPV as a means of correcting an erring wife [30,31].

Majority of the pregnant women in this study were in monogamous marriages, had attained tertiary education and were civil servants who have been married for less than 5 years. This finding differed from the findings in a similar study in Abakaliki which reported most of their respondents with no formal education, in polygamous setting, married for a longer duration (>6 years) and were unemployed [27]. These differences could be because Abia State has several tertiary institutions located in different cities in the state and the people take advantage of such educational opportunities. Most of the pregnant women interviewed in this study were within 25-29 years age group however, IPV was greater in women ≥40. This is in consonance with some other studies where IPV is commoner in women > 36 years.[30]

Social habit of the husband including drinking of alcohol was noted to have statistically influenced IPV in this study. The most common reason for IPV in this study was social habits of the husband. Other important reasons given by the women in this study were "no particular reason", domestic issues, financial problems, extramarital affairs and interference by in-laws. This is in consonance with a systematic review which demonstrated strong evidence of IPV in pregnancy and alcohol abuse by the partner as well as risky sexual behaviors [10]. Fawole, et al also corroborated the significant association between alcohol

abuse and wife-beating, in addition to growing up in an environment where the parents fight publicly. [30] Financial and domestic issues were the major triggers of domestic violence as reported by another study in northern Nigeria [29].

The commonest types of IPV received by the victims in this study was shouting at, verbal abuse and beating up. This is similar to the findings in Abakaliki except for beating up the victim [27,28]. Many other African studies found beating up, forced sexual intercourse and throwing of objects as the common types of IPV [32,33,34]. Majority of the respondents in this study did not feel that IPV should be reported. Onoh, et al also found a similar response in their study [27]. Non-reporting of IPV could be as a result of fear of stigmatization, cultural norms or religious beliefs [32,34]. Other reasons were given by Fawole, et al in Ibadan for remaining in abusive relationships include; "not wanting the children to suffer" and "hoping that partner will change"[30]. In this study, Personal decision, the victim being advised against reporting and religious beliefs were major reasons given by respondents for not reporting IPV.

Most of the women responded to IPV in this study by crying, praying and begging. This was also the finding by Onoh, et al at Abakaliki and Fawole, et al in Ibadan [27,30]. Fourteen (20%) were hospitalized following the effects of IPV while 22 (31%) sustained emotional and physical injury as a result of the violence. The study at Abakaliki on IPV during pregnancy also got similar findings with 7.7% hospitalized and 21% sustaining emotional and physical injury [27]. The study to assess the consequences of domestic violence on women's mental health in Bosnia and Herzegovina revealed that victims of domestic violence had a significantly higher rate of general neuroticism, depression, somatization, sensitivity, obsessive-compulsive symptoms, anxiety, and paranoia than women who were not abused [35]. WHO has also reported that women who have been physically or sexually abused by their partners are more than twice as likely to have an abortion, almost twice as likely to experience depression and in some regions, 1.5 times more likely to acquire HIV, as compared to women who have not been abused [36].

Suggestions on solutions to IPV by pregnant women in this study showed that public health enlightenment and reporting to the church were more common suggestions of curbing IPV. Reporting to family members was also advocated by victims since in our setting, domestic violence is most likely settled within the family than reporting to lawful authorities. In all, public enlightenment and legislation are being advocated globally as the most appropriate measure to effectively prevent violence against women [36].

This study demonstrated a high prevalence of IPV among the study population. Routine screening for IPV by health workers is therefore advocated among pregnant women to forestall the harmful consequences. Public enlightenment programmes should be designed to address this abuse as most victims are unwilling to report incidences

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