

EXPERIENCE OF DOMESTIC VIOLENCE AMONG PREGNANT WOMEN IN RURAL AND URBAN AREAS OF NIGER DELTA REGION OF NIGERIA: RISK FACTORS, HELP-SEEKING RESOURCES AND COPING STRATEGIES

A.O. Tella¹, C.I. Tobin-West² and S. Babatunde^{1,2}

1. Centre for Health and Development, University of Port Harcourt, Port-Harcourt, Rivers State, Nigeria

2. Dept. of Preventive and Social Medicine, University of Port Harcourt, Port-Harcourt, Rivers State, Nigeria

Correspondence:

Dr. A.O. Tella

Centre for Health and Development,
University of Port Harcourt,
Port Harcourt

Email: adedayo_tella@yahoo.com

ABSTRACT

Background: Risk factors and coping strategies employed for domestic violence across rural and urban locales remains a topical public health concern. Geographic locations experiencing other forms of violence may contribute additional risk factors to domestic violence.

Methods: A cross-sectional study design was used to determine and compare the risk factors, help-resources and coping strategies employed by survivors of domestic violence living in rural and urban areas of the Niger-Delta region of Nigeria. Altogether 461 (225 rural, 236 urban) pregnant women participated. Statistical analysis was carried out with SPSS version 21 with $p \leq 0.05$.

Results: Predictors of violence identified were: geographical location, residing in a rural area (OR 2.052 95% C.I. 1.349 - 3.122) and alcohol intake by pregnant women (OR 1.691; 95% C.I. 1.022 - 2.798) increased the risk of domestic violence while intimate partner's occupation, being a professional was a protective factor (OR 0.513 95% C.I. 0.327 - 0.806). Less than half of the respondents in both locations (rural 44.0% versus urban 35.2%) sought for help following incidents of violence. Fewer rural (3.1%) than urban (10.7%) of them sought for formal help from the police. The main coping strategy used was 'keeping silent' by 69.4% rural compared to 46.4% urban survivors and the main reason given, was to avoid family disharmony.

Conclusion: There is urgent need for relevant stakeholders to institute measures to reduce domestic violence especially in rural areas of developing countries and establish well-linked help resource centres across both rural and urban localities.

Keywords: Rural-urban, Pregnant women, Domestic violence, Niger-Delta

INTRODUCTION

Domestic violence (DV) is a human rights issue that is increasingly attracting more public health attention. Although it has gained substantial international recognition, considerable silence still exists around the topic especially in sub-Saharan African countries^{1,2}. This may be due to certain cultural practices which limits open discussion on this global health concern¹⁻³. Over the years, domestic violence has become almost synonymous with female based violence because girls and women are often the victims while men are the major perpetrators^{4,5}. A group of women considered to be highly vulnerable to domestic violence are pregnant women and the risk factors for this group of women are often multifactorial⁶⁻¹².

The burden of domestic violence among pregnant women has been found to be high in previous African and non-African studies^{3,8,9}. In Nigeria, the prevalence of domestic violence during current pregnancy was reported as 7.4% by Iliyasu *et al* in 2013 and 17.7% by

Fawole *et al* in 2010 in urban settings of the North West and South West respectively^{8,9}. Tella *et al*, in 2018 reported on domestic violence among pregnant women in South South Nigeria. Physical domestic violence was found to be higher among rural (43.6%) compared to urban (23.7%) respondents ($p=0.001$); sexual violence was least reported, higher in rural (15.1%) than urban (9.7%) respondents ($p=0.08$). In all, rural respondents reported higher physical, psychological and sexual violence while the urban respondents reported higher verbal violence¹³.

Different risk factors predispose to diverse forms of violence including those occurring in domestic settings. The WHO Ecological Framework and Connectedness classified risk factors for domestic violence into individual, family, community and societal strata¹⁴ and this enables researchers examine specific and collective risk factors more appropriately. Common individual risk factors identified for pregnant women from

previous sub-Saharan African studies include survivors' young age at first marriage, low level of education, abuse of alcohol and having multiple sexual partners⁶⁻¹².

Although relationship in the domestic sense includes intimate partners, parents and siblings, majority of the perpetrators of domestic violence among pregnant women are their intimate partners⁸⁻¹⁰. Over 50% of perpetrators were intimate partners in indigenous studies by Iliyasu *et al* (58.6%) and Fawole *et al* (65.8%)^{8,9}. Documented risk factors among perpetrators include alcohol use, substance abuse and exhibition of controlling behaviour by denying victims access to family, friends and health care services^{8-10,15-19}. Cultural influences especially those that encourage victims to keep silent remain persistent community risk factors for domestic violence in many sub-Saharan African countries^{1,2,18}.

Survivors of violence often seek ways to avoid repeated violence by mitigating against risk factors they have identified. Such ways and means of preventing recurrence of domestic violence has been classified as internal and external coping strategies; and use of formal and informal help-seeking resources^{2,18}. Internal coping strategies includes keeping silent and avoiding perpetrators of violence. Studies from sub-Saharan African region have reported that a considerable number of survivors employ the keeping silent strategy to avoid recurrence of violent scenes especially in the presence of their children and to keep themselves safe from avoidable harm^{2,18}. In recent times, women are encouraged to speak out, however, certain factors such as socio-cultural and geographical location factors still hinders survivors from reporting or making use of formal help-seeking resources. Rural areas for instance are often isolated and the few available help-resources are usually at a far distance from one another, thus survivors are often at a disadvantage²⁰⁻²³. The burden of domestic violence is often more when the rural area is located in an environment prevalent with other forms of violence such as communal clashes and intertribal war^{18,19}. Poverty, anger and transferred aggression prevailing in such areas further heightens the burden of domestic violence^{18,19}. For these reasons, many survivors in rural areas employ 'keeping silent', 'avoiding the perpetrators' and 'reporting to family members' as their other forms of coping strategy^{2,18}. Survivors of violence in the urban areas on the other hand tend to have more help-resource options from the formal sector, such as reporting to police, lawyers and work colleagues^{2,24}. However, studies in certain developing countries have shown that many survivors of domestic violence living in urban areas may have low confidence in formal help as a result of delay in execution of justice and diverse forms of

exploitations^{2,24}. As such, other coping methods and informal help resources are also employed by urban survivors of domestic violence.

Two pertinent theories explaining internal coping mechanisms among vulnerable groups are cognitive dissonance and change in gender-role theories¹⁷. Cognitive dissonance theory, explained by Festinger identifies the 'principle of cognitive consistency as an important factor which makes people express an inner but powerful drive that holds all their attitudes and beliefs in harmony just to avoid disharmony'²⁵. In cases of domestic violence, survivors, often women, exhibit this theory although their actions or inactions may not be considered as rational^{25,26}. Change in gender role theory explains that males and females occupy different recognized social roles within the community where they live and they are often judged, whenever they exhibit 'deviant' conducts²⁷. This can be seen especially in rural areas of the sub-Saharan African region where women are expected to be tolerant and enduring while men can take up stipulated masculine social roles that may enhance perpetuation of domestic violence.^{17,27}

Although studies on risk factors, help-seeking resources and coping strategies for domestic violence among pregnant women have been carried out globally and locally, majority of these studies have been carried out in urban areas with limited findings from rural areas. Also fewer studies have examined risk factors of domestic violence in areas with other forms of violence and instability. Knowledge of the burden, risk factors, help-resources and coping strategies of domestic violence in these peculiar settings is necessary for policy makers and other stakeholders to enable them develop appropriate intervention programmes that will reduce the burden of domestic violence. In view of these, the authors examined the risk factors, help-resources and coping strategies among rural and urban pregnant women residing in a violence prone region of a developing country.

METHODOLOGY

The study was conducted in Rivers State, in the Niger-Delta region of Nigeria, an oil-rich state, and one of the six states making up the South-south geopolitical region of the nation²⁸. The state has a population of about 6,000,000 people²⁹ about three-fifths of whom live in rural areas. The rural dwellers are mainly into farming and fishing activities. The urban residents are mostly civil servants and workers of oil and oil-servicing companies. Oil production activities has had both negative and positive effects on the region^{18,19}. Economic gains and infrastructural development are some positive effects while negative effects include ecological disruption, gender inequality, workplace

stress and transferred aggression^{18,19}. These negative effects are common phenomenon in geographical areas with oil blocks or other natural resources, especially those of low and middle income settings³⁰. Likewise, the Niger-Delta has been reported to have a high level of violence due to poverty, youth restiveness, communal clashes and militancy activities in the past but also in recent times^{13,18,19}.

The methodology used for this study has been described in detail in the earlier mentioned paper by the authors¹³. The study utilized a cross-sectional study design and sample size formula for comparison of two proportions for calculating the minimum sample size³¹. The prevalence of physical violence of 14% found among urban women from a similar study in the South West of Nigeria¹⁰ was used as P_1 while the prevalence of physical violence in rural setting P_2 was 28%. The second proportion was estimated based on evidence from literature showing that domestic violence tends to be more prevalent in rural than in urban communities^{10,32-38}. Using a power of 80%, alpha level of 0.05 and assuming a non-response rate of 10%, minimum sample size calculated for this study was 440 pregnant women. A multistage sampling technique was used to select 461 (236 in the urban and 225 in the rural strata) pregnant eligible women attending PHCs that consented and participated in this study. First, two (a rural and an urban) LGAs in Rivers were purposively selected, then a simple random sampling technique was used to select six PHCs (4 rural and 2 urban) and finally consecutive sampling technique was used in selecting the pregnant women. Only pregnant women with mental and severe systemic medical conditions were excluded from taking part in the study. Ethical permission to conduct this study was obtained from the University of Port Harcourt Teaching Hospital while administrative approval was gotten from the Rivers State Primary Health Care Board. Those that needed professional psychological care such as those that had weeping spells and those that were withdrawn or anxious while responding to the questions were referred to a volunteer psychologist who provided mental care at the interview sites.

Data Collection

A structured questionnaire adapted from the 2013 National Demographic and Health Survey questionnaire on domestic violence was used for data collection³⁹. The instrument was pretested among 20 pregnant women (10 women each from a rural and an urban PHC) in a different but similar rural and urban community of Rivers state. Findings from the pre-test were used in reviewing the study instrument, removing any form of ambiguity and ensuring validity. Information was obtained on socio-demographic

characteristics; risk factors for domestic violence for respondents and their intimate partners; as well as help-resources and coping strategies employed by survivors of domestic violence.

A two-day training facilitated by a psychologist and a reproductive/sexual health researcher was conducted for three female research assistants that collected data. On the first day, lectures on types of domestic violence, risk factors, help-resources and coping strategies were covered. The second day was used to build research assistants capacity on interviewing, counseling and referral skills. They were also trained on handling cases of domestic violence disclosure with empathy. The volunteer psychologist was available in the course of the study to attend to respondents with mental disturbances and breakdown. Questionnaires were administered to the pregnant women in reserved areas of the PHC and each completed within an average time of 20 minutes.

Data Management

Outcome variable

The outcome variable was experience of domestic violence

Independent variables

Independent variables included socio-demographic characteristics such as respondents' age, age at first marriage, level of education; intimate partner's age, level of education, and employment status. Selected risk factors assessed included experiences of controlling behavior to friends and family, alcohol use and substance abuse for the respondents and their intimate partners, history of forced sexual act, age at first forced sexual act and perpetrator of first forced sexual act.

Data was analyzed using SPSS version 21.0. Descriptive statistics was carried out using mean, standard deviations, frequencies and proportions. Inferential statistics were done using independent t-test and chi-square test. Independent factors associated with domestic violence were assessed using multivariate analysis. Level of statistical significance was set at $p \leq 0.05$ for all tests.

RESULTS

Of the 480 questionnaires, 461 (rural 225 and urban 236) were completed, giving a response rate of 96%.

Socio-demographic Characteristics of Respondents

The mean age of pregnant women in the rural (25.8 ± 7.1 years) was significantly lower than that of the urban group (29.2 ± 4.7 years) $p < 0.001$. Proportion of married women was higher in the urban than rural

Table 1: Socio-demographic characteristics of respondents and perpetrators of violence

Variables	Rural n (%) N = 225	Urban n (%) N = 236	χ^2 Test Statistic	P value
Age group (years)				
15 – 19	20 (9.2)	7 (3.0)		
20 – 24	76 (35.2)	31 (13.1)		
25 – 29	64 (29.6)	92 (39.0)		
30 – 34	46 (21.3)	72 (30.5)		
35 – 39	8 (3.7)	30 (12.7)		
40 – 44	1 (0.5)	4 (1.7)		
≥45	1 (0.5)	0 (0)		
Mean Age \pm S.D years	25.8 \pm 7.1	29.2 \pm 4.7	-6.1#	< 0.001
Marital status				
Currently Married	152 (67.6)	213 (90.3)		
Single and Co-habiting	63 (28.0)	21 (8.9)		
Single Not Co-habiting	10 (4.4)	2 (0.8)	-	<0.001*
Family structure				
Monogamous	143 (94.1)	212 (99.5)		
Polygamous	9 (5.9)	1 (0.5)	-	0.002*
Ethnic group				
Indigenous	216 (96.0)	76 (32.2)		
Non-indigenous	9 (4.0)	160 (67.8)	201.9	<0.001
Level of education completed				
No formal education	10 (4.4)	2 (0.9)		
Primary	43 (19.1)	7 (3.0)		
Junior Secondary	33 (14.7)	10 (4.2)		
Senior Secondary	112 (49.8)	95 (40.2)		
Tertiary	27 (12.0)	122 (51.7)	-	<0.001*
Occupation				
Professional	7 (3.1)	17 (7.2)		
Non-manual skilled	39 (17.4)	80 (33.9)		
Manual skilled	124 (55.1)	111 (47.0)		
Semi-skilled	5 (2.2)	2 (0.9)		
Unskilled	50 (22.2)	26 (11.0)	-	<0.001*
Burden of physical violence				
	98(43.6)	56(23.7)	20.353	<0.001
Perpetrators of violence				
Intimate partner	58(59.1)	27(48.2)		
Parents and male siblings	15(15.3)	6(10.7)		
In-laws	13(13.3)	6(10.7)		
Authority figure (teachers)	5(5.1)	0(0.0)		
Other household members	7(7.2)	17(30.4)		

group (90.3% versus 67.6%, $p < 0.001$) and proportion of women in monogamous union was higher in the urban compared to rural group (99.5% versus 94.1% $p < 0.001$) (Table 1)

Perpetrators of Domestic Violence

The highest proportion of perpetrators for both groups was 'intimate partner' category: 59.0% in rural and 48.7% in urban group. For the rural group, this was followed by family members made up of parents and male siblings (15.4%) and in-laws (12.8%). The least proportion for the rural group was in the 'authority figure' category, all of whom were teachers

(5.10%). For the urban group, 'other household members' including landlords/landladies and male domestic staff (29.7%) followed the intimate partner category. The least proportion of perpetrators for the urban group was in the 'family member' (10.8%) and 'in-law' (10.8%) categories (Table 1).

Risk Factors Associated with Domestic Violence in Pregnant Women

Table 2 shows the following bivariate analysis findings: *Geographic location:* The prevalence of physical domestic violence was 43.6% in the rural compared to 23.7% in

the urban group and the difference was statistically significant ($p < 0.001$).

Marital status: Altogether, higher proportions of 'not currently married' women reported experiences of domestic violence compared to those 'currently married' ($p = 0.0003$). The difference among the 'currently married', in rural (53.4%) versus urban (34.8%) survivors was statistically significant ($p = 0.0008$). Among the 'not currently married' the

partners were non-professionals. Survivors, whose intimate partners were professionals, were more in the rural (28.1%) than urban (19.5%) group; survivors whose intimate partners were non-professionals were also more among the rural (49.7%) than urban (28.0%) group. The difference in the proportions was statistically significant ($p = 0.004$).

Substance Abuse among Intimate Partners: More rural (30.6%) compared to urban (19.6%) survivors stated

Table 2: Risk factors for physical violence among rural and urban respondents

Variables	Rural victims n(%) N = 98	Urban victims n(%) N = 56	Test Statistics	P value
Current age* (years)				
<18 years	6(46.2)	0(0.0)	-	0.584
≥18 years	88(43.3)	56(23.7)		
Age at first marriage				
<18 years	51(39.2)	47(22.5)	11.645	0.001
≥18 years	47(49.5)	9(33.5)		
Marital Status				
Married	59(38.8)	48 (22.5)	13.184	<0.001
Not married	39(54.8)	8(34.8)		
Educational level				
≤ Junior secondary	41(47.7)	6(31.6)	7.882	0.007
>Junior secondary	57(41.0)	50(23.0)		
Employment Status				
Currently employed	66(42.9)	37(23.4)	0.067	0.833
Not currently employed	32(45.1)	19(24.4)		
Alcohol use				
Yes	32(54.2)	9(34.6)	10.302	0.002
No	66(39.8)	47(22.4)		
Intimate partner profession				
Professional	18(28.1)	23(19.5)	8.662	0.004
Non-professional	80(49.7)	33(28.0)		
Intimate partner exhibiting controlling behavior				
Present	14(66.7)	6(37.5)	1.3889	0.141
Absent	84(41.2)	50(22.7)		
Substance abuse among intimate partner				
Yes	30(56.6)	11(25.6)	1.8048	0.527
No	68(39.5)	45(23.3)		

difference between rural (38.8%) and urban (22.5%) survivors was not statistically significant ($p = 0.123$).

Alcohol use: More rural (26.2%) than urban (11.3%) respondents frequently ingested alcohol ($p < 0.0001$). Among the survivors, 54.2% rural compared to 34.6% urban women ingested alcohol. The difference in the proportions was not statistically significant ($p = 0.129$).

Risk Factors among Intimate Partners'

Occupation class: In both groups, domestic violence was reported more among respondents whose intimate

partners engaged in substance abuse. The difference was not statistically significant ($p = 0.527$).

Controlling Behaviour by Preventing Access to Family: More rural (14.3%) than urban (10.7%) survivors experienced controlling behavior. The difference in the proportions was not statistically significant ($p = 0.141$).

As in Table 3, multivariate analysis revealed that pregnant women living in rural area had a two-fold increased risk of experiencing physical violence compared to those living in urban areas (OR 2.052,

Table 3: Multivariate analysis for physical violence risk factors among rural and urban respondents

Variable	Adjusted Odds	95% Confidence Interval	p-value
Location			
Rural	2.052	1.349 – 3.122	0.005
Urban	1		
Alcohol use			
Yes	1.691	1.022 – 2.798	0.041
No	1		
Intimate Partners Occupation			
Professional	0.513	0.327 – 0.806	0.004
Non-professional	1		

95% CI:1.349-3.122). Generally, pregnant women who consumed alcohol were more likely to experience violence than women who did not consume alcohol (OR = 1.691, 95% CI:1.022 - 2.798). Intimate partners that were professionals were less likely to be perpetrators of violence (OR = 0.513, 95% CI: 0.327-0.806) than the non-professionals.

Help-seeking Resources and Coping Strategies Employed by Victims of Domestic Violence

Many of the survivors had multiple experiences of domestic violence. Formal help by reporting to police, lawyers and social welfare officers was seldom used in both locations. Only 3.1% rural and 10.7% urban survivors used the formal help-seeking resources by reporting to the police. Fewer survivors among the rural (25.5%) compared to urban (71.4%) group employed the informal help-seeking method by reporting to family, friends and co-workers. The difference in the proportions on use of formal and informal help-seeking resources in the two groups was not statistically significant ($p=0.766$).

Coping strategy employed revealed that more rural (69.4%) than urban (46.4%) survivors used the 'keeping silent' strategy. The difference was statistically significant ($p=0.006$). Fewer women used the 'stayed away from perpetrators' strategy; 3.1% of rural compared to 3.6% urban survivors. The difference was not statistically significant ($p=0.863$). Many women in both groups admitted to consumption of alcohol especially local gin (*kaikai*) in the rural group. Only 1.3% of the rural survivors admitted to use of alcohol as a coping strategy while none of the urban survivors used alcohol as a coping strategy.

DISCUSSION

When domestic violence occurs in geographic areas already experiencing other forms of violence such as the study area in this research, it is imperative to take a closer look at the risk factors. The rural much more than the urban area in this study is an oil-rich

environment prevalent with different forms of violence including domestic violence, gangism, drug and alcohol abuse^{18,19}. Domestic violence was reported more in the rural than urban area, and this finding aligns with those of other studies that have shown that areas with oil blocks and other natural resources tend to report diverse forms of violence^{18,19,30}.

More cases of physical violence was reported among single women, in both rural and urban areas compared in this study. Similar findings of higher proportions of domestic violence among single women was reported by Fawole *et al*³² in Ibadan, Nigeria and Perales *et al*³³ in Peru. Marriage especially monogamous marriage has been found to provide stable, respectable and more conducive environments for spouses than many single relationships. The difference between those currently married and not currently married in the rural and urban groups revealed some differences, especially among the married group. It may be necessary to further investigate the association between types of marriage for example traditional versus court marriage; and experiences of domestic violence.

Generally, higher occurrences of physical violence was reported among pregnant women whose intimate partners were engaged in substance abuse, the proportion was however higher among rural compared to urban survivors of physical abuse. Intimate partners' abuse of substances, illicit trading of drugs and alcohol use have been reported in local and foreign studies as risky behaviours that influence the occurrence of domestic violence among pregnant women¹⁹. Controlling behaviour by limiting access of pregnant women to their families was experienced more among the rural than urban survivors. This finding was different from information available and compared between an urban study by Envuladu *et al*³⁴ and a rural study by Umeora *et al*³⁸ where controlling behaviour was reported more among the urban than among the rural respondents. Professional occupations are often made up of individuals with higher levels of education.

Having well educated intimate partners has been reported as a protective factor in previous studies^{8-10,40}. Less educated partners have been associated with higher frequencies of physical fights and exhibiting controlling behaviours¹⁰.

Similarly in this study, domestic violence was more prevalent in both groups of women whose intimate partners were non-professionals, with the rural group having a higher proportion of non-professional partners. Level of education is related to professions and education has been noted to confer some sense of responsibility in tolerating individual differences which helps to promote harmony among spouses⁸⁻¹⁰.

Utilization of formal help-resources was low in both groups, but the proportion was much lower among the rural group, despite the higher prevalence of physical violence reported in this group. Generally, survivors in both groups resorted more to informal help-resources. This is a huge public health concern in view of curbing domestic violence. In terms of coping strategies, majority of the survivors in both groups employed the 'keeping quiet' internal coping strategy as a means of avoiding physical fights. However, more rural than urban survivors, employed this strategy despite more experiences of controlling behaviour in the rural group. This raises the concern of gender inequality related to traditional harmful practices which is more predominant in rural settings^{20,22,23}. Similar findings have also been documented in other areas of the country^{2,8,10,32}. Ideally all these should be reasons for availability of formal help such as the police and other law enforcement agencies in rural areas but confidence in the armed security agents was found to be low among the respondents including rural dwellers. Ashimolowo and Otufale² had earlier reported low confidence in formal help-resources among the respondents of their study while Owoaje and Olaolorun²¹ laid emphasis on rural areas being 'isolated' with 'far in-between' formal help centres. Furthermore, poor linkages between rural and urban help-resources was also found to be lacking in this study. These challenges are of great concern for pregnant women experiencing domestic violence in rural environments especially in those located in areas with other forms of violence.

CONCLUSION AND RECOMMENDATION

Domestic violence among vulnerable groups such as pregnant women living in isolated rural areas has huge public health effect and the outcomes of such can lead to intergenerational violence if effective measures are not taken to stop perpetuation of the act. Health promotions to establish positive cultural values and deface negative ones need to be enhanced in all locales

but especially in rural communities. The capacity of community leaders needs to be built to understand the important role they can play in curbing domestic violence. In addition, they should be trained to view domestic violence with a pragmatic lens and institute culturally acceptable informal help-seeking resources for victims and proper linkages with formal help-seeking resources, when required. There is need to educate pregnant women during antenatal care visits on ways to avoid violence and encourage them to use help-centres when necessary. The State ministries of Women Affairs/Youth and Social Welfare needs to collaborate to institute and promote multiple interventions aimed at reducing domestic violence especially in rural and hard-to-reach areas of the Niger-Delta oil rich region. They should set up well-linked help centres between rural and urban communities manned by well trained social and health workers.

STUDY LIMITATIONS

The study design was cross sectional in design; follow-up and qualitative studies may be required to fully understand the risk factors of domestic violence especially in rural environments of the Niger-Delta region of Nigeria.

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REFERENCES

1. **Garcia-Moreno C**, Watts C. Violence against Women: An Urgent Public Health Priority. Bull World Health Organization 2011;89(1):2.
2. **Ashimolowo O.**, Otufale G. Assessment of Domestic Violence among Women in Ogun State, Nigeria. Greener Journal of Social Studies 2012;2(3):102-14.
3. **Ellsberg M**, Jansen H, Heise L, *et al*. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and Domestic Violence: an observational study. Lancet 2008; 371(9619): 1165–1172.
4. **Fernandez M**. Violence and Exploitation against Women and Girls. Ann N Y Acad Sci 2006; 1087:250–260.
5. **Oladepo O**, Yusuf O, Arulogun O. Factors influencing gender based violence among men and women in selected states in Nigeria. Afr J Reprod Health 2011;15(4):78-86.

6. **Makayoto L**, Omolo J, Kamweya A, *et al.* Prevalence and Associated Factors of Intimate Partner Violence among Pregnant Women Attending Kisumu District Hospital, Kenya. *Matern Child Health J* 2013;17(3):441-447.
7. **Gyuse A**, Ushie A. Pattern of Domestic Violence among pregnant women in Jos, Nigeria. *SA Fam Pract* 2009;51(4):343-345.
8. **Iliyasu Z**, Abubakar I, Galadanci H, *et al.* Prevalence and Risk Factors for Domestic Violence Among Pregnant Women in Northern Nigeria. *J Interpers Violence* 2013; 28(4):868-883.
9. **Fawole A**, Hunyinbo K, Fawole O. Prevalence of violence against pregnant women in Abeokuta, Nigeria. *Aust N Z J Obstet Gynaecol* 2008; 48 (4) :405-414.
10. **Balogun M**, Owoaje E, Fawole O. Intimate Partner Violence in South-western Nigeria: Are There Rural Urban Differences? *Women Health* 2012;52(7):627-645.
11. **Ameh N**, Shittu S, Abdul M. Risk scoring for Domestic Violence in pregnancy. *Niger J Clin Pract* 2008;11(1):18-21.
12. **Abasiubong F**, Abasiattai A, Bassey E, Ogunsemi O. Demographic Risk Factors in Domestic Violence among Pregnant Women in Uyo, a community in the Niger Delta Region, Nigeria. *Health Care Women International* 2010; 31(10):891-901.
13. **Tella A**, Tobin-West C, Babatunde S. Pattern, consequences and medical cost of domestic violence among pregnant women in rural and urban areas of Rivers State, Nigeria. *The Nigerian Journal of Public Health* 2018; 2(2):151-161.
14. World Health Organization. World Health Report on Violence and Health. Ecological framework for Gender Based Violence. Available from http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf accessed on November 3, 2012.
15. The Istanbul Convention and the CEDAW framework. A comparison of measures to prevent and combat violence against women. Available from http://www.coe.int/t/dghl/standardsetting/equality/02_GenderEqualityProgramme/GEC/GEC_3/Documents/IC_comparison_table.pdf accessed on October 25, 2013.
16. **Shamu S**, Abrahams N, Zarowsky C, *et al.* Intimate partner violence during pregnancy in Zimbabwe: a cross-sectional study of prevalence, predictors and associations with HIV. *Trop Med Int Health*, 2013; 18(6):696-711.
17. **Eno E**, Fawole A, Aboyeji A, *et al.* Domestic Violence and Obstetric Outcome among Pregnant Women in Ilorin, North Central Nigeria. *Int J Gynaecol Obstet* 2014; 125(2):170-1.
18. **Antai D**, Antai J. Collective violence and attitudes of women toward intimate partner violence: Evidence from the Niger Delta. *BMC Int Health Hum Rights*. 2009; 9:12.
19. **Brisibe S**, Ordinioha B, Dienye P. Intersection Between Alcohol Abuse and Intimate Partner's Violence in a Rural Ijaw Community in Bayelsa State, South-South Nigeria. *J Interpers violence* 2012; 27(3):513-522.
20. **Ezeah P**. Socioeconomic and cultural processes associated with Domestic Violence in Rural Nigeria: A study of Uzo Uwani Local Government Area of Enugu State. *Bangladesh e-Journal of Sociology* 2013; 10(1):92-100
21. **Owoaje E**, OlaOlorun F. Women at risk of physical intimate partner violence: a cross-sectional analysis of a low income community in South West Nigeria. *Afr J Reprod Health* 2012;16(1):43-53.
22. **Peek-Asa C**, Wallis A, Harland K, *et al.* Rural disparity in domestic violence, prevalence and access to resources. *J Women's Health (Lachmt)* 2011; 20(11):1743-1749.
23. **Hatcher A**, Romito P, Odenro M, *et al.* Social context and drivers of intimate partner violence in rural Kenya: implications for the health of pregnant women. *Cult Health Sex* 2013;15(4):404-419.
24. **Shannon L**, Logan T, Cole J, Karen M. Help-seeking and coping strategies for intimate partner violence in rural and urban women. *Violence and Vict* 2006;21(2):167-181.
25. **Festinger L**. A Theory of Cognitive Dissonance. Evanston IL: Row, Peterson. 1962.
26. **Whiting J**, Oka M, File S. Appraisal, distortions and intimate partner violence: gender, power, and interaction. *J Marital Fam Ther* 2012;38(Suppl 1):133-149.
27. **Gera W**, Edavard A, Matthews C, *et al.* Associates between attitudes toward violence and intimate partner violence in South Africa and Tanzania. *Violence and Victims* 2013; 28(2):324-440.
28. Rivers State Government Official website. Available from: <http://www.riverstate.gov.ng> accessed on March 1, 2015.
29. Nigeria Census 2006 Available from <http://www.population.gov.ng/files/nationalfinal.pdf> accessed on March 1, 2015.
30. **Jayasundara D**, Legerski E, Danis F, Ruddell R. Oil Development and Intimate Partner Violence: Implementation of Section 8 Housing Policies in the Bakken Region of North Dakota and Montana. *J Interpers violence* 2018;33(21):3388-3416.
31. **Kirkwood B**, Sterne J. Essential Medical Statistics. 2nd ed. Massachusetts, USA: Blackwell Science Limited. 2006; 420.

32. **Fawole O.**, Abass L., and Fawole A. (2010). Prevalence of violence against pregnant women in Ibadan, Nigeria. *Afr J Med Med Sci*, 39(4):293-303.
33. **Perales M**, Cripe S, Lam N, *et al.* Prevalence, Types, and Pattern of Intimate Partner Violence among Pregnant Women in Lima, Peru. *Violence against Women* 2009;15(2):224-250.
34. **Envuladu E.**, Chia L., Banwat M., *et al.* Domestic Violence among pregnant women attending antenatal clinic in a PHC facility in Jos north LGA, Plateau State, Nigeria. *E3 Journal of Medical Research* 2012;1(5):63-68.
35. **Zacarias A**, Macassa G, Svanstrom L, *et al.* Intimate Partner Violence in Maputo City, Mozambique. *BMC Int Health Hum Rights* 2012; 12:35.
36. **Nguyen D**, Ostergren P, Krantz G. Intimate partner violence against women in rural Vietnam different socio-demographic factors are associated with different forms of violence: Need for new intervention guidelines? *BMC Public Health*. 2008; 8:55.
37. **Hoque M**, Hoque M, Kader S. Prevalence and experience of Domestic Violence among rural pregnant women in Kwa Zulu-Natal, South Africa. *The Southern Africa Journal of Epidemiology and Infection* 2009 ;24(4):34-37
38. **Umeora O**, Dimejesi B, Ejikeme B, Egwuatu V. Pattern and determinants of Domestic Violence among prenatal clinic attendees in a referral centre, South-east Nigeria. *J Obstet Gynaecol* 2008;28 (8): 769–774.
39. National Population Commission. (NPC). (2009). *Nigeria Demographic and Health Survey 2008*. Calverton, MD: National Population Commission and ORC Macro Inc. Available from <http://www.measuredhs.com/what-we-do/survey/surveydisplay-302.cfm> accessed on March 1, 2013.
40. **Farre L**. The Role of Men in the Economic and Social Development of Women: Implications for Gender Equality. *World Bank Res Obs*, 2013;28 (1):22-51.