Original Article

Violence against women: A comparative study of the pattern and experience before and during pregnancy among antenatal clinic attendees at University of Ilorin Teaching Hospital, Nigeria

Enang E. Eno[1], Kikelomo T. Adesina[2], Abiodun S. Adeniran[2], Adebunmi O.Olarinoye[2], Adegboyega A. Fawole[2], Abiodun P. Aboyeji[2]

[1]Obstetrics & Gynaecology Department, Federal Medical Centre, PMB 004, Keffi, Nigeria.
[2]Obstetrics & Gynaecology Department, University of Ilorin / University of Ilorin Teaching Hospital, Ilorin, Nigeria.

ABSTRACT

Background: While violence against women is increasing globally, its prevention and evaluation in pregnancy has not receiving adequate attention.

Aim: To evaluate the occurrence and pattern of violence against women before and during index pregnancy.

Methods: A prospective, comparative study comprising 200 antenatal clinic attendees categorized into two groups of 100 each was conducted at the University of Ilorin Teaching Hospital, Ilorin, Nigeria. Group I consisted of women who had suffered violence previously while those in group II did not have such experience. Participants were recruited at the antenatal clinic and informed consent obtained. Participants were screened using a modified version of Abuse Assessment Screen from Centre for Disease Control; the data was analyzed using SPSS version 20.0 and $p<0.05$ was significant.

Result: There was similarity in the age (p0.688), marital status (p0.605), level of education (p0.914) and gestational age at booking (p0.490) among the two groups. Alcohol consumption was significantly higher (21 vs. 10; p0.045) among partners of victims of violence (group I). Physical violence decreased from 47% before to 22% during index pregnancy while sexual violence reduced from 53% vs. 50%. A total of 68 cases of psychological violence (68%) occurred during pregnancy. The partner was responsible in 78.7% of physical and 84.7% of sexual violence cases before pregnancy as well as 91.0% of physical, 100.0% of sexual and 78.0% of psychological violence which occurred during index pregnancy.

Conclusion: Violence against women (especially psychological violence) is heightened during pregnancy. Routine screening for violence during pregnancy is justified because it is associated with poor maternal/fetal outcomes while its prevalence is higher than other conditions routinely screened for in pregnancy.

INTRODUCTION

Violence against women is a form of women-targeted gender-based violence; it is reported to be on the increase globally and occurs within the context of the home setting and beyond. It is an important public health and humanitarian problem with potential fatal outcomes.[1] Domestic violence is a pattern of abusive behaviour used by one partner to gain or maintain power and control over another

Corresponding Author:
Enang Eno
Federal Medical Centre, PMB 004, Keffi, Nassarawa State, Nigeria.
E-mail: enolaseng@yahoo.com; Tel: +234 8035 973 014

Keywords: Domestic violence, Gender based violence, Violence against women.

intimate partner;[2] however, the victims are predominantly females in 90% to 95% of cases.[2,3] Violence against women cut across race, age, religion, socioeconomic status or educational level. It may be physical violence (hitting, kicking, biting, shoving, restraining, slapping) or threat thereof; sexual or psychological violence (stalking, controlling, intimidation, passive/covert abuse or economic deprivation).[2] Pregnancy represents a time of heightened risk for violence, while some women may experience it for the first time during pregnancy.[4] Identified risk factors for violence in pregnancy include adolescence, unmarried, separated or divorced women, low educational status, poverty as well as substance and drug abuse.[5,6] Violence against women represents a violation of women's right as human beings and its estimated prevalence range from 4% to 41%.[5,6] Although violence against women is estimated to be rampant in Nigeria,[5] the data to support this claim remains scanty due to under-reporting. This is attributable to feelings of shame and guilt by the victims, fear of social ridicule, reprisal attack from the perpetrator and poor response from law enforcement officials.

Antenatal care services provide opportunities for screening pregnant women, individualised counselling and in-depth discussions with the health care provider.[7] Thus, it can be explored to screen, prevent and offer support for victims of violence although this has not been introduced into the policy possible due to limited evidence. This study aimed to describe the pattern and experience of pregnant women who suffered violence before and during the index pregnancy.

METHODS

This study was carried out at the department of Obstetrics and Gynaecology of the University of Ilorin Teaching Hospital (UITH), Ilorin, Nigeria over a period of six months. Participants were antenatal clinic attendees at the study site; they were informed about the study and an informed consent was obtained. Thereafter, screening was conducted using a modified version of Abuse Assessment Screen adopted from Centre for Disease Control.[8] Pregnant women were asked to affirm to whether they have suffered physical, sexual, emotional or psychological violence prior to or during index pregnancy.

For this study, physical violence considered included beating, slapping, kicking, punching, or using objects with intent to hurt or induce pain or instil fear. Sexual violence included unwanted touching or fondling with the intent to have sexual intercourse not desired by the victim or forced sex. Psychological violence included stalking, frequent criticism, verbal abuse, humiliation and isolating the victim from family and friends. Socio-demographic information included age, educational qualification (woman and partner), occupation (woman and partner), marital status as well as social practices including the use of alcohol by the woman and the partner. Women who had suffered violence before or during index pregnancy were categorized into group I while group II consisted of pregnant women with no history of violence prior to or during index pregnancy. The sample size was determined by the formula for comparison of groups[9] while selection of the study population was by simple random sampling with inclusion of all consenting eligible women until the desired sample size was obtained.

Ethical approval was obtained from the ethics and research committee of the UITH before the commencement of the study and data analysis was performed using the Statistical Package for Social Sciences (SPSS-version 20.0) and p-value <0.05 was significant.

RESULTS

A total of 200 pregnant women were recruited for the study; these were categorized into equal number (100) each of those who had suffered violence before or during index pregnancy (group I) and those without such experience (group II).

Table 1 shows that there was no statistical significance in the age (p0.688), level of education

(p0.914) and type of marriage (p0.298) among the study groups. However, alcohol use by the male partner was significantly higher in group I (victims of violence) (21 vs. 10; p0.045); woman's use of alcohol was also higher among women who suffered violence (group I) but not statistically significant (4 vs. 2; p0.341) compared to group II participants.

Table 1: Sociodemographic characteristics of participants

Parameter	Group I Freq (%)	Group II Freq (%)	χ^2	P-Value
Maternal age				
< 20	1 (1.0)	0		
20 – 24	9 (9.0)	12 (12.0)	3.081	0.688
25 – 29	39 (39.0)	30 (30.0)		
30 – 34	31 (31.0)	36 (36.0)		
35 – 39	18 (18.0)	20 (20.0)		
= 40	2 (2.0)	2 (2.0)		
Marital Status				
Single	3 (3.0)	3 (3.0)	1.005	0.605
Married	96 (96.0)	97 (97.0)		
Separated	1 (1.0)	0		
Level of Education				
Uneducated	1 (1.0)	1 (1.0)	0.523	0.914
Primary	6 (6.0)	8 (8.0)		
Secondary	21 (21.0)	18 (18.0)		
Tertiary	72 (72.0)	73 (73.0)		
Woman's occupation	7 (7.0)	9 (9.0)	9.162	0.103
Artisan				
Civil Servant	35 (35.0)	46 (46.0)		
Private	1 (1.0)	6 (6.0)		
Petty Trader	10 (10.0)	6 (6.0)		
Trading	18 (18.0)	15 (15.0)		
Unemployed	29 (29.0)	18 (18.0)		
Type of marriage				
Monogamy	82(82.0)	89(89.0)	2.417	0.298
Polygamy	15(15.0)	8(8.0)		
Consensual living	3(3.0)	3(3.0)		
EGA at booking				
< 14	16 (16.0)	12 (12.0)	1.427	0.490
14 – 26	47 (47.0)	55 (55.0)		
27 – 40	37 (37.0)	33 (33.0)		
Parity Group				
Para 1	25 (25.0)	28 (28.0)	1.629	0.443
Para 2-4	59 (59.0)	62 (62.0)		
Para =5	16 (16.0)	10 (10.0)		
Woman use alcohol				
Yes	4 (4.0)	2 (2.0)	0.690	0.341
No	96 (96.0)	98 (98.0)		
Partner use alcohol				
Yes	21 (21.0)	10 (10.0)	5.760	0.045
No	79 (79.0)	90 (90.0)		

EGA- Estimated Gestational Age

Table 2 shows that the commonest form of violence before pregnancy was sexual violence (53.0%) while psychological violence was the commonest during index pregnancy (68.0%). Physical violence decreased from 47% before to 22% during pregnancy, sexual violence decreased from 53% to 50% while psychological abuse occurred only during index pregnancy (68%). The commonest form of physical violence before pregnancy was to be beaten (31%) while to be slapped (11%) was commonest during pregnancy. The pattern of psychological violence shows that verbal abuse was commonest (44%), followed by embarrassment (34%), restriction of movement (31%) and frequent criticism (31%).

Table 2: Types and pattern of violence before and during index pregnancy among victims of violence

Parameter	Prior to pregnancy	Index pregnancy
Type of violence		
Physical	47 (47.0)	22(22.0)
Sexual	53 (53.0)	50(50.0)
Emotional/ Psychological	0	68(68.0)
Pattern of physical violence*		
Hit	0	2(2.0)
Punched	1(1.0)	0
Pushed	4(4.0)	5(5.0)
Kicked	5(5.0)	2(2.0)
Slapped	22(22.0)	11(11.0)
Beaten	31(31.0)	9(9.0)
Pattern of Psychological violence*	NA	17(17.0)
Fear	NA	26(26.0)
Determines visit to family/ relatives	NA	27(27.0)
Determines friends to keep	NA	31(31.0)
Frequent criticism	NA	31(31.0)
Restriction of movement	NA	34(34.0)
Embarrassment	NA	44(44.0)
Verbal abuse		

*Some victims suffered multiple type of violence

From table 3, the women's partners/ husbands were the major perpetrators of violence before and during index pregnancy for all types of violence. Husbands were responsible for 78.7% of pre-pregnancy physical and 84.9% of sexual violence. During

pregnancy, husbands were responsible for 91.0% of physical, 100.0% of sexual and 78.0% of psychological violence among participants.

Table 3: Comparison of perpetrators of violence against women during and before index pregnancy

Variable	Prior to pregnancy		Index pregnancy		
	Physical n=47 (%)	Sexual n=53 (%)	Physical n=22 (%)	Sexual (%) n=50 (%)	Psychological n=68 (%)
Husband	37 (78.7)	45 (84.9)	20 (91.0)	50 (100.0)	53(78.0)
Ex-husband	3 (6.4)	1 (1.9)	0	0	1(1.5)
Boy Friend	0	1 (1.9)	0	0	2(2.9)
Ex-boyfriend	1 (2.1)	3 (5.6)	0	0	2(2.9)
Stranger	3 (6.4)	2 (3.8)	1 (4.5)	0	3(4.4)
Relation	3 (6.4)	1 (1.9)	1 (4.5)	0	7(10.3)
Total	**47 (100.0)**	**53 (100.0)**	**22 (100.0)**	**50 (100.0)**	**68(100.0)**

DISCUSSION

This study showed that violence against women is common in our population with increased frequency of psychological violence during pregnancy. Psychological violence specifically emerged during pregnancy as the commonest form of violence ahead of sexual and physical forms. Alcohol consumption by the husband/ partner was a significant factor while woman's age, marital status, level of formal education, gestational age at booking and partner's education were not significantly associated with violence. The male partner was the major perpetrator of all forms of violence against women before and during the index pregnancy.

The prevalence of violence against women ranges from 23.5% to 43.8% from reports across continents;[10-14] however, a systematic review of the prevalence across 19 countries reported a prevalence of 2.0% to 13.5%.[15] A multi-national review suggested that although it is common in all cultures,[16] violence against women was higher in Africa and Latin America.[15] This may be explained by the patriarchal culture especially in Africa in which the male partner is the determinant of what happens to the wife/ female partner and the whole family. In addition, although pregnant women have a privileged public position, the violence targeted against them shows a disconnect between their perception in the public and private spheres.[16] Pregnancy has been reported to be a period of increased violence to women; while violence may be experienced for the first time, it may be heightened during the period.[4,16] In a study among Ugandan women, a third of the pregnant women reported worsening of the violence during pregnancy[13] while another study reported that the violence can extend into the postnatal period.[17] The increased violence can be associated to the pregnancy-induced physiological changes in the woman resulting in reduced desire for sex, delay in promptness to domestic duties, changes in the body shape, as well as perceived jealousy or anger directed towards the unborn baby by the male partner.[4] The repetitiveness of violence against women depicts the typical cycle of abuse that usually starts with a tension phase, progresses to a violent phase and ends with the honey moon phase during which the husbands feel sober, apologizes and shows love until another cycle starts.[2]

Although pregnancy is a heightened period for violence against women, the pattern before and during pregnancy varies. In this study, physical violence reduced during pregnancy while psychological violence emerged and became the commonest form of violence. This corroborates reports from Nigeria,[10] Kenya,[18] Uganda,[14] and Mexico[12] in which psychological violence was the commonest form of violence in pregnancy. In Mexico,[12] 72.9% of participants experienced psychological violence while 55.8% was reported from Kenya.[18]

A possible explanation is that psychological violence almost always precedes physical abuse but it may not progress to physical abuse in a number of instaces.[19] In addition, some men may be afraid of the possible harm to the fetus thereby preferring the non-physical option of psychological violence. Also, psychological violence does not result in physical marks as evidence; thus, it can easily go unnoticed or be denied by the male partner. However, sexual violence remains important in pregnancy with only a slight reduction from 53% before to 50% during pregnancy in this study. This

supports another study from Papua New Guinea[20] where half of the women admitted to being forced by their husbands to have sex; in another report, many of the pregnant women gave in to the sexual violence out of fear of the possible consequences of refusal[21] which might include beating as well as denial of financial allowance to the family. In a study on the role of men during pregnancy and delivery, 80.85% of pregnant women advocated for education for their spouses during the antenatal period while 25.2% opined that sex during pregnancy should be discussed.[22]

The socio-demography of the victims of violence against women in pregnancy varies; some reports indicate association with unemployment, being single/ divorced / widowed, unwanted pregnancy, violence before pregnancy, marital conflict, low socio-economic class and higher level of education in the woman than the man.[2,7,10,23] However, other studies established no association between violence in pregnancy and socio-demographic characteristics when compared to control group[24] which is similar to this study.

The male partner/ husband has remained the major perpetrator of violence against women during pregnancy[10,11-14,21] similar to this study. In addition, the use of alcohol by the male partner as a risk factor for violence as reported in this study compares to previous reports with a significant increase in the odds for violence in men with alcohol dependence.[13,18]

Previous reports have shown that violence against women during pregnancy is commoner with resultant maternal, foetal and neonatal side effects compared to many other health conditions which are routinely screened for during pregnancy.[2,3,6,10-12] Therefore, it is logical to consider a policy on routine screening for violence among pregnant women. In addition, screening for violence is cost effective; it involves the use of abuse screening questionnaires by trained healthcare workers unlike other health conditions which require additional cost for laboratory investigations. A report from Nigeria reported the prevalence of 9.11% for Rhesus Negative, 0.15% for genotype SS, 27.85% for anaemia in pregnancy, 4.83% for HIV, 0.53% for syphilis and 3.14% for hepatitis B Virus infection[25] among pregnant women; these are much lower than the prevalence of violence in pregnancy. In addition, health care providers should be sensitized to lookout for effects of violence including injuries, recurrent sexually transmitted diseases, history of unintended pregnancy and pain disorders, anxiety, depression as well as suicidal ideation.[3]

This study concludes that violence against women is heightened during pregnancy with a shift towards psychological violence while other forms of abuse still continue. The male partner/ husband remain the major perpetrator especially those who ingest alcohol. The prevalence of violence against pregnant women exceeds the prevalence of most medical conditions routinely screened for in pregnancy; therefore, its routine screening is recommended during pregnancy because it is cost effective and helps to prevent adverse maternal, fetal and neonatal outcomes.

Sources of support: Nil

Conflict of interest: The authors declare no conflict of interest.

REFERENCES

1. WHO. Intimate partner violence during pregnancy. WHO information sheet 2011. WHO/RHR/11.35. Available at: apps.who.int>iris>bitstream>handle>WHO_RHR_11.35_eng.pdf
2. Michael CL, Jessica S L, Vivian PH. Domestic Violence and Sexual Assault. In: DeCherneyA. H, Lauren N, Goodwin TM, LauferN. (eds). Current Obstetrics and Gynaecology Diagnosis and Treatment. McGrawHill Companies. 2007:1025-1030. 2
3. Chisholm CA, Bullock L, Ferguson II JE. Intimate partner violence and pregnancy: epidemiology and impact. AJOG 2017;217(2):141-144.

4. Cottrell S. Domestic violence in pregnancy. In: Squire C (ed.). The social context of birth. Abingdon: Routledge; 2017:129-142.
5. Simukai S, Naeemah A, Marleen T, Alfred M, Christian ZA. Systematic Review of African studies on IPV against pregnant women: Prevalence and risk factors. Plos One 2011; 6 (3)e 17591. 5
6. Taillieu TL, Brownridge DA. Violence against pregnant women: Prevalence, Patterns, Risk factors, Theories and Directions for future research. Aggression and Violent Behaviour 2010, 15:14. 6
7. Saltzman LE. Battering during pregnancy: A role for physicians. Atlanta Med. 1990; 64(3): 45-48. 7
8. Kathleen CB, Marci FH, Sudie EB. Intimate Partner Violence and Sexual Violence Victimization Assessment for use in Healthcare Settings. Version 1.0. Centre for Disease and Control. 2007:11-111. 8
9. Semple D, Smyth R. Depressive illness, Bipolar illness, Anxiety and Stress-related disorders. Oxford Handbook of Psychiatry. 2nd edition. London; Oxford University Press; 2009: 223-355. 9
10. Efetie ER, Salami AH. Domestic violence amongst pregnant women in Abuja. J Obstet Gynaecol 2007; 27(4): 379-382. 10
11. Almeida FSJ, Coutinho EC, Duarte JC, Chaves CMB, Nelas PAB, Amaral OP, et al. Domestic violence in pregnancy: prevalence and characteristics of the pregnant women. J Clin Nursing 2017;26(15-16):2417-2425.
12. Romero-Gutierrez G, Cruz-Arvidu VC, Regalado-Cedillo CA, Ponce-Ponce de Leon AL. Prevalence of violence against pregnant women and associated maternal and neonatal complications in Leon, Mexico. Midwifery 2010;27(5):750-753.
13. Clarke S, Richmond R, Black E, Fry H, Obol JH, Worth H. Intimate partner violence in pregnancy: a cross-sectional study from post-conflict northern Uganda. BMJ Open 2019;9:e027541.doi: 10.1136/bmjopen-2018-027541
14. Eputai J, Udho S, Auma AG, Nabirye RC. Intimate partner violence among pregnant women in Uganda. Afr J Midwifery Women's Health 2018;0027.
15. Devris KM, Kishor S, Johnson H, Stockl H, Bacchus LJ, Garcia-Moreno C, et al. intimate partner violence during pregnancy: analysis of prevalence data from 19countries. Reprod Health Matters 2010;18(36):158-170.
16. Cook J, Bewley S. Acknowledging a persistent truth: domestic violence in pregnancy. J Royal Soc Med 2008;101:358-363.
17. Martin-de-la-Heras S, Velasco C, Luna-del-Castillo JdD, Khan KS. Maternal outcomes associated to psychological and physical intimate partner violence during pregnancy: A cohort study and multivariate analysis. PLoS ONE 2019;14(6):e0218255. https//doi.org/10.1371/journal.pone.0218255.
18. Owaka IO, Nyanchoka MK, Atieli HE. Intimate partner violence in pregnancy among antenatal attendees at health facilities in West Pokot country, Kenya. Pan Afr Med J 2017;28:229 doi:10.11604/pamj.2017.28.229.8840
19. O'Leary KD. Psychological Abuse: A variable deserving critical attention in domestic violence. Violence and Victims 1999; 14(1): 3-23. 19
20. Adebanjo BA, Omolola OI, Benedicta YO, Femi OF, Adesegun OF. Detection of indices of Violence Against Women by Health professionals in a Nigeria Teaching Hospital. Trop J Obstet Gynaecol 2005; 22(1): 27-32. 20
21. Population Report. Ending Violence Against Women. XXVII Number 4(series L, number 11) Dec. 1999: 1-10. 21
22. Adeniran AS, Aboyeji AP, Fawole AA, Balogun OR, Adesina KT, Adeniran PI. Male partner's role during pregnancy, labour and delivery: Expectations of pregnant women in Nigeria. Int J Health Sci (Qassim) 2015;9(3):305-313.
23. Antoniou E, Iatrakis G. Domestic violence during pregnancy in Greece. Int J Environment

Res Public Health 2019; 16:4222. Doi: 10.3390/ijerph16214222.

24. Ezechi OC, Kalu BK, Ezechi LO, Nwokoro CA, Ndububa VI, Okeke GCE. Prevalence and pattern of domestic violence against pregnant Nigerian women. J Obstet Gynaecol 2004; 24(6): 652-656.

25. Okafor II, Odugu BU, Ndibuagu EO. Patterns of routine antenatal laboratory test results at booking in Enugu State University Teaching Hospital, Enugu, Southeast Nigeria. IOSR J Pharmacy 2017;7(1):41-48.