Original Article

Prevalence and Patterns of Intimate Partner Violence among Antenatal Clinic Attendees at Federal Medical Center, Abuja

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Received: 05-Jul-2022;
Revision: 29-May-2023;
Accepted: 08-Jun-2023;
Published: 03-Aug-2023

ABSTRACT

Background: Intimate partner violence (IPV) has been a source of increasing concern to the government of nations as well as their citizens despite measures taken to reduce it. This is supported by recent data published by the World Health Organization and other development partners. In health care facilities, intimate partner violence in pregnancy has not been screened routinely. Community-based findings have been the source of most data informing policies for decisions. **Objectives:** These were to determine the prevalence and patterns of IPV among antenatal clinic attendees at the Federal Medical Center (FMC), Abuja. **Materials and Methods:** Following ethical clearance, a health facility-based cross-sectional study was conducted at the FMC, Abuja to determine the prevalence and correlates of IPV during pregnancy among attendees of antenatal clinics. It was conducted between 26th June and 17th September 2021. A total of 450 questionnaires were administered among consecutive consenting clients and 407 were returned filled giving a non-response rate of 9.6%. The questionnaire collected data on respondents' sociodemographics; experience of and types of IPV; and health problems arising from IPV. Results were presented in tables and charts and analysis was done using IBM SPSS (International Business Machines' Statistical product and service solutions) version 25 software. **Results:** The mean age was 29.37 ± standard deviation 4.43 years and the predominant ethnic group was Igbo (46.5%); 96.56% were married; 68.06% had tertiary education and 49.14% were in their third trimesters. The combined incidence of intimate partner violence among the participants was 17.69% with physical violence contributing 3.19%; the head region (40%) being the most affected body part. While 34% experienced intrauterine foetal death in the past following IPV. In Miller's landmark study, 27 of 1300 sexually active young women, one in five reported partner pregnancy non promoting behaviors, such as intimidation, threats to leave the relationship if the woman did not become pregnant or actual violence. The two most significant factors for IPV were age and marital status both at *P* values of $P = 0.0001$. **Conclusion:** Medical doctors should feel more open discussing issues around IPV with their clients during antenatal visits.

Keywords: *Abuja, antenatal, intimate partner violence, pregnancy*

Introduction

Intimate partner violence (IPV) is a global issue of public health concern. The World Health Organization (WHO) defines it as any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. It includes

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Quick Response Code:

Website: www.njcponline.com

DOI: 10.4103/njcp.njcp_446_22

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How to cite this article: Ekweani JC, Umeh YB, Ucha JN, Okoro C. Prevalence and patterns of intimate partner violence among antenatal clinic attendees at federal medical center, Abuja. Niger J Clin Pract 2023;26:889-95.

acts of physical aggression (slapping, hitting, kicking, and beating), psychological abuse (intimidation, constant belittling, and humiliation), forced intercourse and other forms of sexual coercion; various controlling behaviors (isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance).[1–4]

Intimate partner violence is a component of sexual and gender-based violence (SGBV). Domestic violence has been replaced by the term intimate partner violence.[4] Sexual and gender-based violence has occupied most conversations around the rights of women in recent years due to an upsurge in the number of cases and involvement of NGOs (non-governmental organisations) and CSOs (civil society organisations) encouraging women to report and seek help. Despite the efforts of these organizations, many women unfortunately do not speak or report IPV. The risk of a loss of economic, social, and physical status has been reported as a major reason for this low reportage.

Intimate partner violence affects millions of women worldwide cutting across cultural, socioeconomic, religious, and educational barriers; reducing the ability of women to contribute to the development of society.

Underreporting of all forms of violence is a major issue hence data are sparse or non-existent across health care facilities. However, health care centers in developed countries have adapted ways and developed protocols to identify at-risk women or those experiencing intimate partner violence.

The WHO in its recommendations for a Positive Pregnancy Experience encourages health care professionals to ask women about intimate partner violence at routine contacts such as antenatal visits. A minimum condition for health care providers to ask women about violence is that it must be safe to do so (i.e. the partner is not present) and that identification of IPV is followed by an appropriate response. In addition, providers must be trained to ask questions in the correct way and to respond appropriately to women who disclose violence.[3] In Nigeria and Africa at large, most health centers are yet to adopt this practice, hence IPV goes unnoticed.

Furthermore, protocol for care for cases of IPV are either non-existent or loosely followed where available when health professionals identify these violent patterns of behavior by spouses of patients. The WHO multicountry study on domestic violence has challenged the dictum that home is a haven for women hence the need for screening for domestic violence cannot be overlooked.[4]

The WHO recommends that reproductive health providers should be sensitized and trained to recognize and respond to violence, particularly during and after pregnancy. Recognizing that identification is not enough, protocols and referral systems need to be put in place to ensure that appropriate care, follow-up, and support services are available. In settings where resources are limited and referral is not possible, health staff should at least be aware of the problem and should provide information about legal and counselling options, as well as supportive messages that emphasize that such violence is wrong, and that it is a widespread problem. Ensuring confidentiality and women's safety should be paramount. In places where antenatal services involve male partners in parenting classes and similar activities, adding an anti-violence component to such activities may be an avenue for attempting to change male attitudes and prevent violence.[3,4]

Intimate partner violence in pregnancy has also been demonstrated to exceed feared complications of pregnancies such as preeclampsia, diabetes mellitus complicating pregnancies as almost 72 percent of women screened reported this in a study in Lagos, south western Nigeria, and therefore, threatens the goals of safe motherhood due to increased perinatal and maternal complications such as miscarriages, antepartum hemorrhage, premature rupture of membranes, intrauterine growth restriction, preterm births, perinatal deaths, and suicide.[2,5]

Patterns of sexual violence experienced by women cut across a wide range of abuse forms from commonly cited emotional, physical, financial abuse, and controlling patterns of behavior to reproductive coercion. Reproductive coercion can be defined as attempts by men to control their female partners' pregnancies and pregnancy outcomes. In Miller's landmark study, 27 of 1300 sexually active young women, one in five reported partner pregnancy-promoting behaviors, such as intimidation, threats to leave the relationship if the woman did not become pregnant or actual violence, and one in seven experienced interferences with contraception by intimate partners. Additionally, most of these women reported a history of domestic violence.[2]

Risk factors and indicators

Some of the most consistent risk factors associated with IPV in available literatures are youthful age, male dominance in the family, man having multiple partners, personality disorder, history of abusing partner, poverty, and low self-esteem. There is dearth of knowledge on perpetrators' characteristics that may be associated with violence.[6] The following symptoms or conditions are indicators of possible domestic

violence or abuse: symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders, suicidal tendencies or self-harming, alcohol or other substance misuse, unexplained chronic gastrointestinal symptoms, unexplained gynecological symptoms, including pelvic pain and sexual dysfunction, adverse reproductive outcomes, including multiple unintended pregnancies or terminations, delayed pregnancy care, miscarriage, premature labor and stillbirth, genitourinary symptoms, including frequent bladder or kidney infections, vaginal bleeding or sexually transmitted infections, chronic unexplained pain, traumatic injury, particularly if repeated and with vague or implausible explanation, problems with the central nervous system—headaches, cognitive problems, hearing loss, repeated health consultations with no clear diagnosis.[7]

Predictors of IPV

Independent predictors of IPV experience before and during pregnancy were younger-aged partners (<40 years). Adjusted Odds Ratio (<40 years). [Adjusted Odds Ratio AOR 1.72; 95% confidence interval (CI) = 1.17, 2.53], partner having controlling behavior AOR 2.24; 95% C. I = 1.51–3.32) and partner's frequent involvement in physical fights (AOR 2.29; 95% C.I = 1.43–3.66).[8]

Materials and Methods

The study was conducted in Abuja, Federal Capital Territory capital of Nigeria. Economically, the area is urban with a sizable proportion of young and middle-aged working population. Federal Medical Centre (FMC), Abuja is one of four tertiary health institutions in the Federal Capital catering for a combined population of about 3.4 million. The ethical approval for this study with registration number NHREC/10/12/2020 and protocol number FMCABJ/HREC/2021/031 was obtained from the institutional ethics review board of this hospital. A written informed consent was also obtained from each participant before recruitment into the study. We conducted a health facility-based cross-sectional study to determine the prevalence and correlates of IPV before and during pregnancy among attendees of antenatal clinics. The study population was booked pregnant women attending for care at the Department of Obstetrics and Gynecology at FMC, Abuja. The sample size was determined using the formula for calculating sample size of a cross-sectional survey assuming a prevalence of IPV against women during pregnancy in Enugu state of 37.2 percent.

Sample size was calculated using the formula

$n = z^2pq/d^2$ where:

n = minimum sample size; z = the standard normal deviation, usually set at 1.96; P = Prevalence of IPV; q = 1-p; d = degree of accuracy desired, usually set at 0.05.

Then $n = 1.96 \times 1.96 \times 0.372 \times 0.628/0.05 \times 0.05 = 358.9$

Given an attrition rate of 10%, the calculated sample size will be 394.8 which was rounded up to 400. Therefore, a total of 400 pregnant women were recruited for this study. However, a total of 450 questionnaires were administered and 407 were returned filled giving a non-response rate of 9.56%. Consecutive sampling technique was employed.

Data collection and analysis

We used pre-tested questionnaire for data collection. A semi-structured questionnaire was used to collect quantitative data. Two[2] trained research assistants and the investigators were responsible for collecting the data. The questionnaire collected data on respondents' socio-demographic characteristics, respondents' experience of IPV, types of IPV experienced, health problems arising from IPV, and potential risk factors associated with IPV before and during pregnancy. Those antenatal clients with clinical evidence of depression were co-managed with the psychiatrists and those with physical injuries were co-managed as well with the surgical team. Qualitative data were collected by the principal investigator and research assistants using a key informant guide.

A simple and easy-to-understand questionnaire[9] was used to assess the incidence of physical abuse, verbal abuse/emotional abuse, harassment, sexual abuse, and combined abuse.

Results were presented in tables, bar charts, graphs, and bar charts. Data were analyzed using IBM SPSS v 25 software. Ethical clearance was obtained from the Research and Ethics committee of Federal Medical Centre, Abuja.

Results

The age of participants ranged from 16 to 42 years,

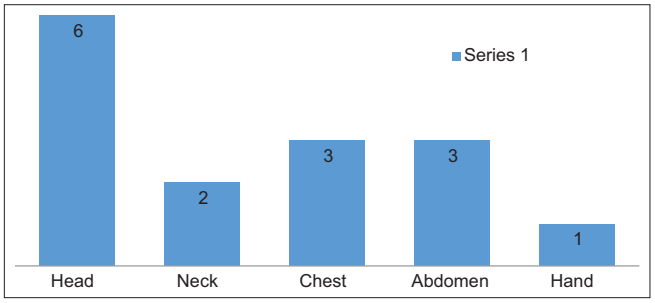

Figure 1: Body Parts affected by physical trauma during index pregnancy

Table 1: Sociodemographics

Socio-demographic characteristics	Frequency	Cumulative Frequency	Percentage (%)
Age (years)			
15–19	4	4	0.98
20–24	41	45	10.07
25–29	175	220	43.00
30–34	136	356	33.42
35–39	42	398	10.31
40–44	9	407	2.21
Ethnicity			
-Hausa	39	39	9.40
-Fulani	17	56	4.10
-Igbo	194	250	46.50
-Yoruba	78	328	18.70
-Others	79	407	19.41
Religion			
-Islam	49	49	12.04
-Christianity	352	401	86.49
-Others	6	407	1.47
Occupation			
-Government worker	79	79	19.41
-Self-employed	228	307	56.02
-Private firm	61	368	14.99
-Unemployed	39	407	9.58
Marital Status			
Married	393	393	95.56
Single	12	404	2.95
Widowed	3	407	0.74
Highest level of education			
Primary	21	21	5.16
Secondary	93	114	22.85
Tertiary	277	391	68.06
Quranic	6	397	1.47
None	10	407	2.46
Trimester at which candidate was seen			
First Trimester	44	44	10.81
Second Trimester	163	207	40.05
Third Trimester	200	407	49.14
Total	407	407	100.00

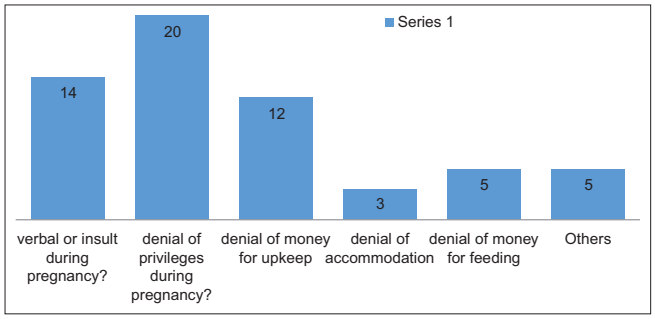

Figure 2: Other non-physical forms of violence meted by partners

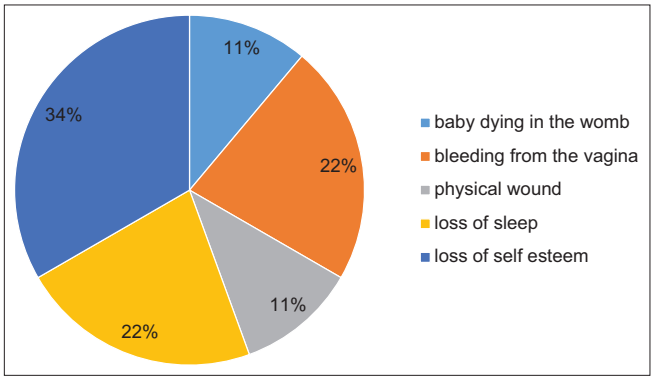

Figure 3: Outcomes of IPV

with mean 29.37 ± SD 4.43. Modal age was 30 years. Thirteen (13) of the participants alluded that they have experienced at least a form of physical violence from their partners giving an incidence of 3.19% and the body parts distributed as follows:

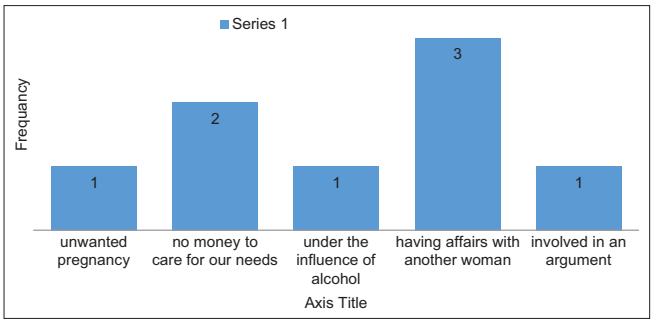

Figure 4: Perceived reasons for intimate partner violence

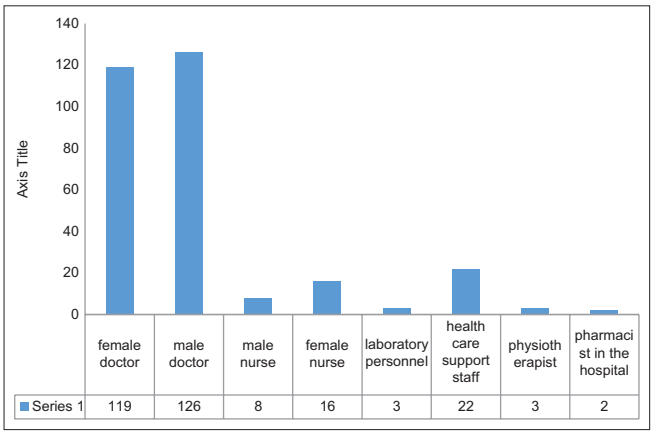

Figure 5: Categories of health workers that participants are willing to report incidence of IPV to

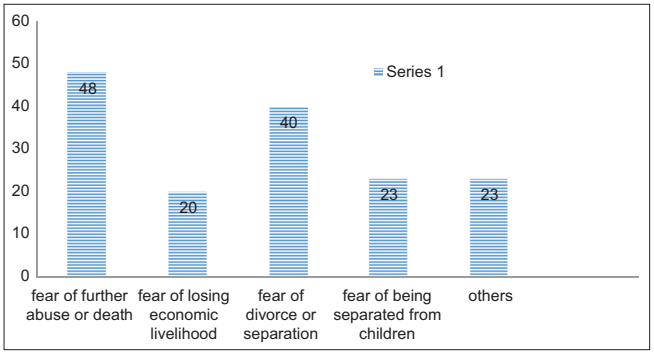

Figure 6: Why people are afraid of reporting abuse

Other forms of intimate partner violence experienced are distributed as follows:

Outcomes of IPV were as follows:

Among the participants of the survey, 45.5% kept the incidence of IPV to themselves, 18.2% of those affected confided in a friend; 27.3% confided in family members, while 9.1% confided in a cleric.

Forty-two (10.3%) of the respondents were aware of the existence of social support services for women who were victims of IPV. One hundred and forty-nine (149) of the participants of the survey (36.6%) expressed willingness to share abused cases with health workers. Three hundred of the participants which represent 73.71% believed asking for abuse routinely during antenatal clinics should be introduced. The most significant factors that affected the likelihood of experiencing physical violence during pregnancy were age (P = 0.0001) and marital status (P = 0.0001). Others such as ethnicity, occupation, educational level, and gestational age at interview had no significant impact (P values 0.091, 0.187, 0.352, and 0.162 respectively). Figure 1 illustrates the different body parts affected; Table 1 illustrates the descriptions of the participants' sociodemographic characteristics; Figure 2 showed the other forms of non-physical violence; Figure 3 illustrates the outcomes of intimate partner violence; Figure 4 showed the perceived reasons behind intimate partner violence; Figure 5 illustrates the categories of persons/health workers that the victims of intimate partner violence are willing to open up to and Figure 6 showed the reasons for non-disclosure.

Discussion

The bulk of the participants (76%) were in the 25–34 year age group, which represents mid reproductive age group. Also, most were of southern Nigerian extraction and of post-secondary education and self-employed which mirrors the metropolitan nature of the federal capital territory where many people from outside come to settle and engage in different businesses and assume civil service employments. Majority were also married and hence were in a stable family relationship. Statistical analysis showed that the incidence of intimate partner violence was commoner among younger women and married people possibly because they have been recently married and hence are undergoing the initial stages of marital adjustments as the couple were getting accustomed to each other. This is the period they may be newly moving to a metropolitan city from other parts of the country, trying to adjust to the new and harsh economic realities. Some may have just graduated from higher institutions and moved to the FCT in search of greener pastures. Combining all these with a new marriage and pregnancy adjustments may significantly strain relationships and cause conflicts that can result in physical or verbal insults and assaults.

The incidence of physical IPV from this study was 3.19% which is significantly low when compared with community-based assessments as seen from the review by Benebo *et al*.[10] This also contrasts significantly when compared with a study by Bilal Sulaiman *et al*.[11] in a hospital-based study in a neighboring hospital in a study conducted at that location that found an incidence of 56.3%. The difference might be alluded to the fact

that our study was a hospital-centered study when compared to the former study and that their study included other non-physical forms of violence which our study also examined. Perhaps, a difference in population characteristics especially so as our location was more central. This is against the backdrop that antenatal care services are grossly underutilized in our environment as seen from a publication by Adewuyi *et al*.[12]

Most of them were encountered during the third trimester suggesting that many of them may have booked their antenatal care late and would have lost the opportunity to gain help from antenatal clinic educators and support from fellow pregnant women.

Forty percent of the women who experienced physical trauma had it on their head region and followed by the abdomen. The head region is the most visible and accessible part of the body and hence this may explain this. The abdomen closely followed this as most of our clients presented in their second and third trimesters, their abdomen became very prominent and equally accessible to physical traumas. Violence of any nature may have followed verbal exchanges and may have come in the form of slaps and blows across the face. Abdominal traumas may have come in the form of kicks or falls on the abdomen and may herald imminent complications which some of them may experience. Thirty-four percent have experienced intrauterine foetal death because of intimate partner violence, and this is a recognized consequence as seen in a study by Gottlieb *et al*. and by Oluwole.[1,2]

Worthy of note is also the incidence of other non-physical forms of IPV which include verbal assaults and denial of certain privileges which may range from emotional support, financial support, accommodation, and even sexual intimacy. Trigger factors for violence majorly are suspicions and talks around marital infidelities and may suggest that male partners are not comfortable discussing such issues with their female partners and a neutral third party may be needed to resolve such issues and in this study, they indicated that they are more comfortable discussing with their doctors whether male or female. Male doctors were slightly more preferred than their female counterparts and this may be because they find male doctors more able to challenge unhealthy behaviors from their fellow males. This point further buttresses the role of the male figure in our environment in confronting social issues of this nature.[10] Discussions around finance come second further emphasizing the importance of their geographical location and the economic pressures that follow.

It was further observed that fear of repeated abuse was the main reason behind delayed or non-reporting of the cases of abuse. That may also explain the reason many women prefer to keep enduring abusive relationships especially in a marriage setting where the African culture and our different religious faiths value the marriage institution and the male dominance in relationships.

Age of the female partner was the most important risk factor for IPV from this and this corroborated from the study by Ford-Gilboe *et al*.[9] where age less than 40 years was stated as an important risk for IPV. In this study, 76% were in the 25–34 year age group. Young age goes together with inexperience and immaturity and handling issues of life and more so with complicated relationships such as with marriage and suspected extra-marital affairs. Couples who were also not in stable different-sex relationships were also more prone to IPV. A study by Madzou *et al*.[13] in a retrospective case-control study examined the effect of clitoral reconstruction in pregnant women who delivered via vaginal delivery and discovered a significant decline in the need for episiotomies compared to those who did not. This aspect may be examined in subsequent studies in our environment as this has become a problem of public health importance.[14]

Conclusion

Intimate partner violence is a problem in our environment and demands the needed attention and keen sense of suspicion. Antenatal clinics should look out more for this and develop programs to aid in the identification and support of couples with this problem.

Limitations

It was a hospital-based study and fraught with all the problems that come with such and as such may not be representative of the true situation in our environment especially as it is a single-center study. Also, because it was an interviewer questionnaire-based study, which may further accentuate the fear of reporting on the part of the participants.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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