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Original Paper

Experiences of Violence among Pregnant Women Attending Ante-Natal Clinics in Selected Hospitals in Abuja, Nigeria

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ABSTRACT

Anecdotal records have shown that there is increasing prevalence of gender based violence in Nigeria. Little is known about the extent and magnitude of this phenomenon as it affects pregnant women. This study described the experiences of violence among pregnant women attending ante-natal clinics in Abuja, Nigeria using a cross-sectional design. A three-stage sampling technique was used to select 300 participants from six hospitals in the three out of the six Local Government Areas in the region. Data was collected using a pretested semi-structured questionnaire and analysed using descriptive statistics and chi-square tests. Forty three percent of the respondents had experienced at least one form of violence and 15.0% were experiencing violence in their current relationships. Main forms of violence ever experienced were psychological (38.0%) and physical (36.4%). Partners/husbands (70.2%) and partner/husband relatives (29.8) were the perpetrators. Of the partner/husband's relatives, sisters-in-law (57.1%) and partners' cousins (21.5%) were the main perpetrators of the forms of violence experienced. Strategies employed to resolve violence conflict included dialogue with spouse (46.7%), ignoring the experience (30.3%), making up with sex (16.7%), providing gifts and special dishes (5.0%) and mediation by family members (1.3%). Health promotion and education intervention strategies such as counselling, male involvement in sexual and reproductive health programs, advocacy for the promotion of women's health and right as well as use of appropriate culturally sensitive conflict resolution strategies are needed to ameliorate the situation.

Keywords: **Coping strategies, Gender-based violence, Pregnant women, Prevalence**

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INTRODUCTION

Gender based violence has been recognised as an obstacle to women's reproductive and sexual health and rights by the International Conference on Population and Development (ICPD) in Cairo in 1994 and the 1995 Fourth World Conference on Women in Beijing (Patel and Khan, 2001). The World Bank estimates that rape and domestic violence account for 5 percent of the healthy years of life lost to women of reproductive age in developing countries (World Bank, 1993). Research has demonstrated that gender-based violence has implications for almost every aspect of health policy and programming, from primary care to reproductive health programs (Heise *et al*., 1999; Guedes, 2004).

Violence against women (VAW) is related to the health of women and girls. A study conducted in Colombia showed that more than half of the women investigated have had at least one unintended pregnancy during five years (1995-2000). Among the women who recently gave birth and experienced physical or sexual abuse, 63 percent of the pregnancies were unintended (Pallito and O'Campo, 2004). In forty-eight population-based surveys from around the world, 10-69 percent of women alleged being physically assaulted by an intimate partner at some point in their lives (Heise *et al*., 1999; WHO 2002). Furthermore, physical violence is almost always accompanied by psychological stress and in many cases by sexual abuse (Heise *et al*., 1999).

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Globally, one woman in every four is physically or sexually abused during pregnancy, usually by her partner (Heise *et al*., 1999). Estimates of violence during pregnancy vary widely and range from 3 percent to 11 percent among adult women and up to 38 per cent among adolescent mothers (Heise *et al.,* 1999). Violence before and during pregnancy can have serious health consequences for women and their children. Pregnant women who have experienced violence are more likely to delay seeking antenatal care, to gain insufficient weight, have a history of STIs, unwanted or mistimed pregnancies, and bleeding during pregnancy among other complications (Patel and Khan, 2001).

Violence is also known to have serious effect on pregnancy outcomes including increased risk of miscarriages, abortions, premature labour, foetal distress, low birth weight infants and even infant death (Patel and Khan, 2001).). Extreme stress and anxiety provoked by violence during pregnancy may lead to preterm delivery or reduce women's ability to obtain nutrition, rest, exercise, and medical care (Patel and Khan, 2001). A study of all maternal deaths in over four hundred villages and seven hospitals in three districts of Maharashtra revealed that 16 percent of all deaths during pregnancy were due to domestic violence (Ganatra *et al*., 1996).

In Nigeria, gender-based violence is one of the harmful practices that are prevalent but most studies have focused on the southern part of the country. Findings from a Nigerian study carried out in the southwest documented a prevalence of 47.1% among pregnant women examined with 11.7% occurring in their current state of pregnancy (Ezechi *et al*., 2004). A later study carried in the same region of the country reported a 14.2% prevalence of violence among pregnant women attending antenatal services twelve months prior to current pregnancy and 2.3% reported violence in current pregnancy (Fawole *et al*., 2008).

There has been poor documentation of this situation in the Northern part of Nigeria where violence against pregnant women, especially, domestic violence has been observed to be a common and serious issue. The 2008 National Demographic Health Survey concluded that the North Central zone in which Abuja is situated has the second highest prevalence of 31% of those who had ever experienced violence and the same trend was also reported among those who experienced violence twelve months preceding the survey (NPC/ICF Macro, 2009). Most importantly, Abuja, the country's administrative capital, lacks pre-existing data on gender-based violence against pregnant women. This study was therefore undertaken to evaluate the experiences of violence among pregnant women in Northern part of Nigeria by exploring the types and perpetrators of the violence and also assess the health seeking pattern and coping strategies among women who had experienced violence.

MATERIALS AND METHODS

The Setting

The study was a conducted in Abuja, the administrative capital of the Federal Republic of Nigeria. Abuja comprises six Local Government Areas (LGAs) namely Abuja Municipal Area Council (AMAC), Kuje, Kwali, Gwagwalada, Abaji and Bwari. All hospitals in the local governments have well established, accessible and well attended ante-natal centers.

Sample Size Determination and Study Population

The study populations were pregnant women attending ante-natal services in both government and privately owned health facilities in Abuja as at the time of the study. The sample size for the study was determined using the formula $n = z^2pq/d^2$, where n is sample size, d is degree of accuracy which is 0.05, z is the confidence interval (1.96) and p is the prevalence and the prevalence of 20% reported by Pro-Hope International (2005) was used. The calculated sample size was 245 and it was increased to 300 to take care of non response.

Recruitment Procedures

A three-stage sampling technique was used in selecting the 300 respondents who participated in the study. The first stage consisted of the random selection of three local government areas: AMAC, Bwari and Gwagwalada. The second stage involved the collection of a sampling frame of government and registered private hospitals within the selected LGAs, from the Federal Capital Development Authority (FCDA). Abuja Municipal Area Council (AMAC) has five government and sixty one registered private hospitals. Bwari LGA has one government and thirteen registered private hospitals while Gwagwalada LGA has two government and six registered private hospitals. A simple random sampling method was used to select a government hospital each in AMAC and

Gwagwalada LGAs and the only one in Bwari LGA was automatically co-opted. A prominent and commonly patronize private hospital with ante-natal care was selected in each of the study LGAs. The third stage involved selection of pregnant women from these hospitals. From records, an average of two hundred (200) pregnant women attend ante-natal clinics in government hospitals daily (Mondays - Fridays), while an average of fifty (50) pregnant women attend ante-natal in registered private hospitals. The pregnant women were therefore selected using the ratio 4:1 that is, for every four pregnant women in a government hospital; one pregnant woman was taken in a private hospital. Hence, eighty (80) pregnant women were selected from government hospitals in each L.G.A, while twenty (20) pregnant women were selected from private hospitals in each of the selected L.G.A. Through systematic random sampling, every fourth pregnant woman in the government hospitals and every second pregnant woman in the selected private hospitals were surveyed. Each respondent was informed about the purpose of the study that the data collected would be used for research purposes only and that participation was voluntary. All the respondents gave their verbal informed consent before being interviewed by the research assistants.

Instrument for Data Collection and Process of Data Collection

The pretested structured questionnaire used for data collection was divided into six sections namely; socio-demographic characteristics; believes and attitudes on GBV; possible risk factors for gender based violence, experiences of violence and help seeking pattern; and pregnancy outcome. Trained research assistants under authors' supervision, collected the data from the 300 pregnant women. The interviews were conducted during the waiting periods at the clinics on antenatal clinic days.

Data Analysis

Each questionnaire was scrutinized for completeness, coded and entered into the computer. The SPSS version 12 was used in analysing the data. Descriptive and chi-square statistics were used for data analysis. All statistical tests were carried out at 5% (or 0.05) level of significance.

RESULTS

Socio-demographic Characteristics

Table 1 shows the distribution of respondents' socio-demographic characteristics. The mean age of respondents was 29.7 ± 3.9 years. The distribution of respondents based on ethnicity showed that Hausa, Ibo and Yoruba were almost equally represented. Majority 262(87.3%) of the respondents were married, 82(27.3%) were civil servants, 74(24.7%) were self employed/artisan while 68(22.7%) were housewives. Forty-six percent (46%) of the respondents' partners were civil servants. More of the respondents (47.0%) were married to men with 1 to 2 wives, followed by 103(34.3%) married to men with 3-4 wives and 56(18.7%) of them were married to men with more than 4 wives. On the respondents' parity, 41 (13.7%) were carrying their first pregnancy, 142(47.3%) respondents had between 1-2 children, 102(34.0%) had between 3-4 children, and 15(5.0%) had more than 4 children. Of the 262 respondents who were in marital union, 19 (7.3%) were in their first year of marriage, 171(65.3%) had been married for 2-5 years and 72(27.4%) had been married for 6years and above. Fourteen (4.7%) and 20(6.7%) respondents were married to partners who smoke and drink alcohol respectively.

Table 1: Socio-demographic Characteristics of Respondents (N= 300)

Socio-demographic Characteristics	No (%)
Age (in years)	
Less than 25	29 (9.7)
25 – 29	122 (40.7)
30 – 34	117 (39.0)
35 and above	32 (10.6)
Marital status	
Married	262 (87.3)
Single	17 (5.7)
Living together but not married	14 (4.7)
Divorced/separated	7 (2.3)
Ethnic group	
Igbo	85 (28.3)
Yoruba	84 (28.0)
Hausa	73 (24.4)
Others*	58 (19.3)
Partners' occupation**	
Civil servant	139 (46.3)
Professional	80 (26.7)
Self employed	55 (18.3)
Unemployed	19 (6.3)
Farmer	7 (2.3)
Partners' alcohol consumption	
Yes	20 (6.7)
No	280 (93.3)

Note * Ebira, Nupe, Igala, ** percentage not up to 100 due to rounding

Table 2: Types of Violence Reportedly Experienced by Respondents

Ever experienced violence (N=300)	No (%)
Yes	129 (43.0)
No	171 (57.0)
Types of violence reportedly experienced (N=129)	
Psychological/emotional	49 (38.0)
Physical	47 (36.4)
Sexual	17 (13.2)
Financial	16 (12.4)

Experience of Violence among Respondents

Of the 300 respondents interviewed, 129 (43.0%) had ever experienced violence. The types of violence ever experienced included psychological/emotional 49(38.0%), physical 47(36.4%), sexual 17(13.2%) and financial 16(12.4%) violence (Table 2). Of those who reported physical violence, 18(38.3%) were kicked in pregnancy. Of these episodes 7(38.9%) was directed at the stomachs, 6(33.3%) was directed at respondents' legs, 4(22.2%) was directed at other parts of the body and 1(5.6%) reported that kick was directed at her head. Physical abuse was reported to be a frequent occurrence by 44.7% of respondents. Perpetrators of various violence experienced were partners/husbands (70.2%) and partners/husbands'relations (29.8%). Partners/husbands' relations comprised sisters-in-law (57.1%), partner/husband's cousin (21.4%), mothers-in-law (7.1%) fathers-in-law (7.1%) and brothers-in-law (7.1%).

Alcohol consumption and partners' occupation were found to be the predisposing factors for GBV among partners of pregnant women who had experienced different forms of violence as it was found to be significantly associated with all forms of violence reportedly experienced (p<0.05). Nineteen (95%) out of the twenty respondents married to partners who take alcohol had ever experienced violence. Eleven (57.8%) suffered physical violence, 4(21.1%) suffered financial violence while 421.14%) had suffered sexual violence. Forty five (32.4%) of those married to civil servants, 43.8% of those married to professionals, 52.7% of those married to self-employed men, 68.4% of those married to unemployed men and all the 7 (100%) married to farmers had ever experienced violence (Table 3).

Help Seeking Pattern after Experiencing Violence and Coping Strategies

A quarter of the 47 respondents who experienced physical violence sought help after been hit. Of these, 5 (41.7%) went to the clinic for treatment, 5(41.7%) sought the help of neighbours, 1(8.3%) each was hospitalised and ran to relatives respectively. Main strategies reportedly used by respondents in resolving issues of violence were dialogue with partner/husband (46.5%), just forgot about it for the sake of keeping their marriages/relationships (30.2%). Others are shown on Table 4.

Table 3 – Respondents' Reported Experience of Violence Based on Selected Possible Risk factors

Partner's variables	Ever experienced violence		X^2	*P*-values
	Yes	No		
Years of Marriage				
0 – 1 year	7 (36.8)	12 (63.2)		
2 – 5 years	74 (43.3)	97 (56.7)	3.289	p>0.001
6 years and above	39 (54.2)	33 (45.8)		
Partners' occupation				
Civil servant	45 (32.3)	94 (67.7)		
Professional	35 (43.8)	45 (56.2)	22.834	p<0.001
Self employed	29 (52.7)	26 (47.3)		
Unemployed	13 (68.4)	6 (31.6)		
Farmer	7 (100.0)	0 (0.0)		
Alcohol consumption by partners				
Yes	19 (95.0)	1 (5.0)	21.422	p<0.001
No	110 (39.3)	170 (60.7)		

Table 4: Coping Strategies Reportedly used by Respondents who Experienced Violence

Coping strategies employed (N = 129)	Number	%
Dialogue with partner	60	46.5
Just forgot about it	39	30.2
Made up with sex	22	16.7
Provided gifts for partner	6	4.7
Held family meeting	2	1.5

DISCUSSION

Our results show a violence prevalence of 43.0% among respondents. This result is in line with the results documented by Ezechi *et al*. (2004) who found a prevalence of 47.1% among pregnant women studied. The result of 38.9% of respondents who were kicked in the stomach during pregnancy was higher than the 20.0% reported by Pro-Hope International (2005) in Mexico and lower than the 49.0% reported in Costa Rica. This highlights the universal nature of violence experienced by women. Probable reasons for the high prevalence recorded in this study are culturally embedded. In the part of the country where the study was conducted, there is an obvious power imbalance between men and women. Also, refusal of sex by woman has been known to be a major cause of violence among partners (Jejeebhoy 1998, Visaria, 1999).

The main perpetrators of violence experienced by the respondents were husbands/partners and husband's relatives. This is in line with an earlier study which documented that 89.1% of their respondents suffered violence perpetrated by their male partners (Heise *et al*., 1994). Another dimension is the magnitude of sisters – in – law who perpetrate the act of violence against women. This may be attributed to rivalry that usually exist between sisters – in – law and their brothers' partners in a typical Nigerian setting where the wife is seen as an intruder into the family and she is treated as such. This has implications for intervention programmes. If women are perpetrators of violence against women then, it becomes a much more onerous task.

The data generated in this study also corroborated an earlier study (Heise *et al*., 1994) where it was documented that physical violence is almost always accompanied by psychological abuse. This is evident in the prevalence of these two types of violence (38.0% psychological violence and 36.4% physical; violence) recorded by this study. Even though the exact relationship between alcohol and violence remains unclear, researches have consistently found drinking patterns to be related to intimate partner and sexual violence. Fawole *et al*. (2008) reported that low level of education in both woman and partner and consumption of alcohol by partners were significant risk factors for violence. This was confirmed by this study as 95% of respondents married to partners who take alcohol had ever experienced a form of violence or the other.

The coping strategies used in resolving cases of violence are worth noting. It brought to the fore the attitudinal disposition to violence. A higher proportion would still opt for dialogue. This is not unexpected as in African setting where the extended family system still exist with respect for the gate keepers' opinions on such issues. The high proportion (30.3%) who would remain silent typified the average Nigerian woman who would endure such violence for the sake of their children and losing their marriage. This affirms the low reporting of violence in Nigeria as documented by Illka *et al*. (2002). From cultural perspective, other strategies that were used are also closely linked with the woman's perception of keeping her home at whatever cost. The implication of this perception is that such violence as reported by this study would continue unabated with increased morbidity and mortality among women especially the pregnant women.

CONCLUSION

High prevalence of gender based violence against pregnant women has been reported by this study. Both men and women have been documented to be perpetrators of this act against the group of women studied. This has great implications for the health of pregnant women, pregnancy outcomes and general well being as it affects all spheres of their lives. Also, the coping strategies as observed are not effective and this could drive the act. Our findings also highlighted that there is an unmet need among women of reproductive age especially pregnant women. Health promotion and education intervention strategies such as male involvement in women's health, engaging in advocacy for the promotion of women's health especially among older women to desensitize them against the perception of seeing the wife as an intruder and adopting a culturally sensitive conflict resolution strategies to ameliorate the situation.

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