PATTERN AND DETERMINANT OF VIOLENCE AGAINST WOMEN ATTENDING ANTENATAL CLINIC OF UNIVERSITY TEACHING HOSPITAL, ADO-EKITI.

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ABSTRACT

Introduction: Domestic violence against women especially in pregnancy is a major social and public health problem occurring globally.

Objectives: To determine the prevalence of domestic violence against women in pregnancy, the pattern of violence, its determinant (risk) factors and the perpetrators of the violence.

Method: It was a prospective descriptive cross-sectional study and a semi-structured questionnaire was administered to pregnant women attending the antenatal clinic of the University Teaching Hospital, Ado-Ekiti.

Results: A total of three hundred and fifty women participated in the study after giving their consents and 34 women out of them had experienced domestic violence during pregnancy giving a prevalence of 9.7%. The husbands of the women were the sole perpetrators of the violence against them. Low educational attainment of the women ($p = 0.0043$) and their husbands ($p = 0.001$) and spousal alcoholic social habit ($p = 0.006$) were significantly associated with violence against women in pregnancy. Majority 29 (85.3%) of the women suffered physical abuse while 13 (30.2%) of the women suffered verbal abuse. Frequent demands for money by the unemployed women from their husbands and spousal alcoholic social habit were mostly responsible for violence against the women each accounting for 13 (38.2%) of cases. Other reasons for violence in this study include refusal of spousal sexual advances, sudden change in religious beliefs, spousal unemployment and having only female children. Only 4 women did not state the reason for violence against them from their partners. Cultural acceptability of violence against women in 13 (54.2%) women and the fear of stigmatization in 20 (80%) women were the commonest reasons why women who experienced violence did not confide in someone else and report in the hospital respectively.

Conclusion: Violence against women especially in pregnancy is common in this environment but a lot of such women keep this to themselves thus suffering in silence due to the culture and the assumption of the unfriendly health system. Health education of the populace about the danger of violence against women and the training of health workers about this public health condition are highly essential.

Keywords: Violence, Women, Pregnancy, Antenatal clinic

INTRODUCTION

Domestic Violence against women is a major social and public health problem occurring throughout history and across all society[1]. The Declaration on the elimination of violence against women, adopted by the United Nation in 1992, defines violence against women as "any act of gender based violence that results or likely to result in physical, sexual or psychological harm or suffering to women including threats of such harm, coercion or arbitrary deprivation of liberty whether occurring in public or private life[2]. Domestic Violence is not limited by ethnicity, religion, education or socioeconomic status. It is widely embedded in most cultures and condoned by society as an unfortunate aspect of being a woman[1,2]. Risk factors associated with violence include young age, poor education, drug or alcohol abuse and emotional instability. Other risk factors include divorced or separated partners, unemployment and unwanted or unintended pregnancy[3,4].

The true incidence of physical abuse in pregnancy is not known, however, incidence ranging from 0.9-26% have been reported in developed countries. Globally, at least one in every three women has been beaten, coerced into sex or otherwise abused in her lifetime[5]. Few developing countries have reliable estimates of prevalence of domestic violence. In South Africa, lifetime prevalence of experiencing physical violence from intimate partner was 24.6% while nearly one third of women surveyed in

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Pakistan had experienced physical violence at least once in their marital life[4,5].

Gender based violence is widely prevalent in Nigeria. A nationwide survey on the positive and negative traditional practices in Nigeria revealed that 19% of household heads admitted to have beaten their wives[6]. About 78.8% of women in Imo State, Nigeria were reported being battered by their male counterparts while 39.3% of women in Anambra State, Nigeria had experienced physical violence[7]. Also in Ibadan, Nigeria, 24% of young women were reported to be violated by their partners[6]. This wide variation of the reported incidence (apart from reflecting different study population, sample sizes, study designs and varying measures used) may be due to the fact that most assault victims are reluctant to report cases of violence against them[6,7].

There is an increasing interest in the understanding of the relationship between violence and pregnancy outcomes because of the recognition of the increased prevalence of domestic violence worldwide. Violence against pregnant women is particularly significant because of the risks to both the mother and the developing foetus. Numerous studies have identified a link between domestic violence and unfavourable sexual and reproductive health outcomes including gynaecological morbidities. Such violence occurring during pregnancy may result in an adverse obstetric outcome including low birth weight, preterm labour and delivery, placental abruption, fetomaternal haemorrhage and maternal and foetal demise. They are also likely to suffer from depression and suicide as well as engage in tobacco, alcohol and drug use during pregnancy[7].

Domestic violence is not routinely screened for even though this has been advocated[3] and this may account for the gross underreporting of cases. The true incidence is higher than the reported rates; hence violence against women is of public health significance in developing countries like Nigeria requiring the institution of effective strategies for its management and prevention. The formulation of effective strategies to address violence against women requires an understanding of all dimensions of the problem. Pregnancy often serves as entry point for many women into health care services in developing countries. Antenatal care in these settings may be strategic to interventions aimed at identifying women at risk of domestic violence by providing a unique opportunity to screen for domestic violence. This is because women tend to trust and confide in their doctors and midwives and easily divulge information when ordinarily they will not[8].

This study was carried out among the women attending the antenatal clinic of the University Teaching Hospital, Ado-Ekiti to determine the pattern and determinants of domestic violence against pregnant women and findings from the study would add to the already existing data so that the enormosity and the burden of this problem would be appreciated to allow formulation of appropriate policy for routine screening of domestic violence among the pregnant women. This would ensure that appropriate strategies for management and prevention would be put in place in our health care settings.

MATERIALS AND METHODS

The study was a cross-sectional descriptive study of pregnant women attending the antenatal clinic of the University Teaching Hospital, Ado-Ekiti. The hospital is an emerging hospital that was established about three years ago. About four thousand women booked annually for antenatal care at the University Teaching Hospital with about 100 attendees at each of the 2 consultant clinic days of the week. The annual delivery rate is about 1500. Pregnant women who were between 37-42 weeks of gestation, had attended the clinic on at least two visits and gave their consent to participate in the study were included while those who did not meet these criteria were excluded.

A simple random technique was used in selecting respondents among those consented to participate in the study. The selected women filled a structured questionnaire with the assistance of house-officers and medical-officers who were instructed on how to fill the questionnaires. The questionnaire was made anonymous to ensure the confidentiality of the information supplied by the respondents. The questionnaire was in two parts. The first part contained information about the sociodemographic data of the women including the age, parity, religion, educational status of the women, occupation of the husband, marital status, marriage setting(monogamy, polygamy) etc. The second part contained information about previous experience of domestic violence, pattern of violence, risk factors that led to such violence and the perpetrator of such violence. It also found out how such cases of domestic violence were handled. The social class of

each woman was determined by adding the scores from the husband's occupation and woman's level of education as described by Olusanya et al[9]

The data collected was analyzed using computer software Statistical Package for Social Sciences (SPSS) version 15. Frequency tables were made and X^2 test was used for categorical variables with level of significance set at 0.05. Association between risk factors and violence would be assessed using Odd ratio (OR) within 95% confidence interval (CI).

RESULTS

A total of three hundred and fifty pregnant women were interviewed.

Majority, 256 (73.1%) of the women were between 20-39years, 23 (6.6%) were 40 years and above while 71 (20.3%) of the respondents were 19 years and below. 210 (60%) of the respondents were Christians and 140 (40%) of them were Muslims. Majority, 209 (59.7%) of the respondents were multipara, 67 (19.2%) were grandmultipara and 74 (21.1%) of the women were nullipara. 187 (53.4%) of the women were Yorubas, 106 (30.3%) were Igbos and 57 (16.3%) of them were Hausas. 60 (17.1%) of the women had no formal education, 119 (34%) had primary school education while 171 (48.3%) of them had post-primary school education. 205 (58.6%) of the women were self employed, 104 (29.7%) of them were engaged in white collar jobs such as banking, civil service and 41 (11.7%) were unemployed. 195 (55.7%) of the respondents were in the low social class, 64 (18.3%) were in the middle social class while 91 (26.0%) of them were in the upper social class. 313 (89.4%) of the pregnant women were in a marital relationship while 37 (10.6%) of them were single. 246 (78.6%) of the 313 pregnant women in marital relationship were in a monogamous family setting while 67 (21.4%) were in a polygamous family setting. Of the 67 women in polygamous family setting, 37 (55.2%) of them were the first wives, 21 (31.3%) were the second wives and 9 (13.4%) were the third wives of their husbands. Majority 172 (55.0%) of the married respondents have been married for between 6-10years, 70 (22.4%) for 1-5 years while 81 (23.1%) of the respondents have been married for more than 10years.

SOCIO-DEMOGRAPHICS CHARACTERISTICS OF THE RESPONDENTS' SPOUSES

234 (74.8%) of the husbands of the respondents were between 20-39years, 69 (20.1%) were 40 years and above while 16 (5.1%) of their husbands were 19years and below. 16 (5.1%) of the husbands of the respondents had no formal education, 79 (25.2%) had primary school education while 229 (65.4%) had post-primary education. Majority, 226 (72.2%) of the husbands of the respondents were artisans workers while 96 (27.8%) of their husbands were in one form of paid employment or the other such as civil servants, bankers etc. 161 (51.4%) of the husbands of the respondents had no form of social habits, 87 (27.8%) of them are smokers and 65 (20.8%) of them drink alcohol.

PATTERN OF VIOLENCE EXPERIENCED BY THE RESPONDENTS

Twenty-nine (85.3%) of the women who experienced violence suffered physical abuse, thirteen (38.2%) suffered verbal abuse and eight (23.5%) women had forced sex. Nine (26.5%) of the women with the history of violence reported in the hospital for treatment while twenty five (73.5%) of them did not report in the hospital. Of the nine women that reported in the hospital, seven (77.8%) of them had outpatient treatment while two (22.2%) received inpatient treatment. Four (44.4%) of those women treated were satisfied with the treatment given while 5 (55.6%) of them were not satisfied with the treatment received. The twenty five women who did not report in the hospital had various reasons for not doing so: twenty (80%) were afraid of stigmatization, eighteen (72%) because of fear of not getting appropriate treatment, ten (40%) for fear of provoking further violence from their spouse and ten (40%) for fear of being sent away from their marital home.

Ten (29.4%) of the women who experienced violence confided in at least someone else while twenty four (70.6%) did not confide in anybody. Of the ten who confided in someone else, four (40.0%) of the women received satisfactory response. Thirteen (54.2%) of the 24 women who did not confide in someone else thought that spousal violence was culturally acceptable, ten (41.7%) were afraid of stigmatization, ten (41.7%) forgave their spouse based on religious beliefs and another ten (41.7%) of the women felt it may lead to divorce. (Note: some women have more than one reason for not reporting the cases of violence against them either to someone else or in the hospital).

Majority of the women with history of violence experienced this during pregnancy and this was

statistically significant (p = 0.0001).

REASONS FOR SPOUSAL VIOLENCE

In thirteen (38.2%) of the 34 women with history of violence, violence was related to frequent demand for funds by the women (who were unemployed) from their spouses and in another 13 (38.2%), alcohol abuse by the spouse. Other reasons for spousal violence against the women include refusal of spousal sexual advances in 8 (23.5%), sudden change in religious beliefs especially change of church by the women in 5 (14.7%), spousal unemployment in 5 (14.7%) and having only female children in 3 (8.8%) of the women. Four women did

TABLE 1: SOCIODEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS.

Characteristics	Frequency	Percentage (%)
Age group (years)		
19 or less	71	20.3
[illegible]	157	44.9
30 – 39	99	28.2
40 & above	23	6.6
Total	350	100.0
Religion		
Christianity	210	60.0
Muslim	140	40.0
Total	350	100.0
Occupation of the women		
Unemployed	41	11.7
Petty Trader	91	26.0
Artisans	57	16.3
Civil servant	86	24.6
Total	350	100.0
Educational Status		
None	60	17.1
Primary	119	34.0
Secondary	98	28.0
Tertiary	73	23.7
Total	350	100.0
Ethnicity		
Yoruba	187	53.7
Igbo	106	30.3
Hausa	57	16.3
Total	350	100.0
Social Status		
Class I & II	91	26.0
Class III	64	18.3
Class IV & V	195	55.7
Total	350	100.0

TABLE 2: MARITAL BACKGROUND OF THE RESPONDENTS.

Characteristics	Frequency	Percentage (%)
Marital Status		
Married	313	89.4
Single	37	10.6
Total	350	100.0
Family Setting		
Monogamous	246	78.6
Polygamous	67	21.4
Total	313	100.0
Duration of Marriage (years)		
1 – 5	70	22.4
6 – 10	172	55.0
11 & above	71	22.6
Total	313	100.0

TABLE 3: SOCIODEMOGRAPHIC CHARACTERISTICS OF THE 313 HUSBANDS OF THE RESPONDENTS.

Characteristics	Frequency	Percentage (%)
Age (years)		
19 & below	16	5.1
20 – 29	83	26.5
30 – 39	151	48.3
40 & above	63	20.1
Total	313	100.0
Educational status		
None	16	5.1
Primary	79	25.2
Secondary	135	43.1
Tertiary	83	26.6
Total	313	100.0
Occupation		
Farmer	11	3.5
Artisans	215	68.7
Bankers	13	4.2
Civil servants	74	23.6
Total	313	100.0
Social Habits		
None	161	51.4
Smoking	87	27.8
Alcohol	65	20.8
Total	313	100.0

TABLE 4: CHARACTERISTICS OF THE RESPONDENTS EXPOSED TO DOMESTIC VIOLENCE.

Characteristics	Yes		No		X^2 f P value
	n = 34	%	n= 316	%	
Age of women (years)					
<19 – 29	17	7.5	211	92.5	3.803 1 0.510
30 – 40 & above	17	13.9	105	86.1	
Parity					
Nullipara & Grandmultipara	16	11.3	125	88.7	0.718 1 0.397
Multipara	18	8.6	191	91.4	
Marital Status					
Married	30	9.6	283	90.4	0.057 1 0.812
Single	4	10.8	33	89.2	
Family Setting					
Monogamous	20	7.1	263	92.9	2.369 1 0.124
Polygamous	14	20.9	53	79.1	
Educational status of the women					4.105 1 0.043*
Up to primary	23	12.8	156	87.2	
Post-primary	11	6.4	160	93.6	
Educational status of their husband					
Up to primary	24	19.8	97	80.2	21.59 1 0.001*
Post-primary	10	4.4	219	95.6	
Social status of the women					
Class I-III	7	4.5	148	95.5	8.571 1 0.003*
Class IV-V	27	13.8	168	86.2	
Duration of marriage					
Less than 10yrs	23	8.6	246	91.4	
Above 10yrs	11	13.6	70	86.4	1.796 1 0.180
Social habits of the husband					
None	10	5.6	168	94.4	

*Statistically significant.

Of the 350 pregnant women, 34 (9.7%) reported history of physical abuse while 316 (90.3%) reported no history of physical abuse.

The husbands of the women were the perpetrators of the violence in all the 34 (100%) women with the history of violence.

TABLE 5: MULTIVARIATE LOGISTIC REGRESSION ANALYSIS WITH EXPERIENCE OF VIOLENCE AS DEPENDENT VARIABLE.

Variable	p value	Odd ratio	95% CI for odd ratios Lower	Upper
Education of women				
Up to primary		1.370	1.059	1.773
Post-primary	0.860	0.639	0.388	1.051
Education of husband				
Up to primary		2.300	1.750	3.021
Post-primary	0.003*	0.424	0.254	0.718
Social status				
Class I-III		0.440	0.225	0.860
Class IV-V	0.002*	1.494	1.223	1.824

Odd ratio between women who had the variable being analyzed versus those who do not have it.

C.I: Confidence interval. *Statistically significant.

There was no significant statistical difference between the ages of the women (p = 0.510), their parity (p = 0.397), type of religion (p = 0.105), marital status (p = 0.812), family setting (p = 0.124) and duration of marriage (p = 0.180) and the prevalence of domestic violence among them. Women who had no formal education or had primary school education and those whose husbands had no formal education or had primary school education were more at risk of violence and the risk decreases as the education level increases. This was statistically significant (p = 0.043 and 0.001 respectively). Women whose husbands had one form of social habit or the other suffered more violence during pregnancy compared to other women whose husbands had no form of social habits. This was statistically significant (p = 0.006). Multivariate regression analysis showed that the educational level of the husbands of the women, their social habit and social status of the women were associated with increased risk of experiencing violence.

TABLE 6: PATTERN OF VIOLENCE EXPERINCED BY THE WOMEN.

Pattern of violence	Frequency (n= 34)	Percentage (%)
Physical abuse	29	85.3
Verbal abuse	13	38.2
Forced sex	8	23.5

TABLE 7: TIMING OF THE VIOLENCE.

Time of violence	Frequency n= 34	Percentage (%)	X^2	df	p value
Before pregnancy	5	14.7	350	2	0.0001
During pregnancy	18	52.9			
Before & during pregnancy	11	32.4			

TABLE 8: REASONS FOR SPOUSAL VIOLENCE

Reasons	Frequency (n= 34)	Percentage (%)
Finances	13	38.2
Alcoholic social habit	13	38.2
Refused sexual advances	8	23.5
Spousal unemployment	5	14.7
Change of church (new belief)	5	14.7
Having only female children	3	8.8
No reason	4	11.8

Note: Some women have more than one reason for violence against them.

DISCUSSION

Domestic violence against women has remained a major social and public health problem occurring globally.[1] However, it has remained neglected in Nigeria despite the fact that it exposes the pregnant woman to a variety of health, obstetric and psychological complications.[7] The prevalence of domestic violence against pregnant women of 9.7% found in this study compares with 13.6% and 11% recorded in previous studies by Umeora et al[7] and Ezegwui et al [10] but higher than that reported by Diaz-Olavarrieta et al[3] (Mexico-City), Fawole et al[6] (Nigeria) and lower than that of Ezechi et al[8]. The prevalence of violence reported in this study also showed clearly the underreporting of cases of domestic violence against women and especially during pregnancy which was clearly shown in this study that more women suffered physical abuse during pregnancy than at any other times. This is in agreement with the reports of Fawole et al[6] and Singh et al[11] The low incidence may due to the unwillingness of our women to divulge their experience of violence in their marriage because of fear of more violence and stigmatization or a cultural perception of maintaining silence due to the fact that violence is a family issue[6].

Adolescents and older mothers (40years and above), nulliparous and grandmultiparous women, single women and women in polygamous family setting were prone to intimate partner violence in pregnancy but they were not statistically significant in this study. This is similar to the findings of Umeora et al[7], Ezechi et al[8] and Singh et al[11]. The husbands of the respondents were the sole perpetrators of the violence against them in this study. This is consistent with the previous reports from Obi et al[4], Umeora et al[7] and Ezechi et al[8]. This may be due to the fact that the age difference characteristic of many African relationships with the male being much older than the female counterpact helps in maintaining male dominance[12]. With increasing age differences between couples, there are divergent views on various social issues and this predisposes to domestic violence. The older man exercises his authority on all family issues including decision making in sexual and reproductive health matters as they affect the woman. The adolescent mothers are particularly disadvantaged in such circumstances while the older pregnant patients and the grandmultiparous women become victims of neglect and intimate partner violence often arising from marital infidelity and other social habit of the husbands such as alcoholism which ranked high in this study as a reason for violence against women[5,6].

Low educational attainment of the women was found to be more associated with domestic violence against them compared to those with high educational attainment in this study even though it was not significant as an independent predictor of violence against the women. Also low educational attainment of the husbands of women who experienced violence and low social status of the women[9], were more associated with domestic violence in pregnancy compared with those with high educational and social status and both were statistically significant as independent predictors of domestic violence. This is because woman empowerment and economic power are linked to a woman's educational attainment and these lessen her dependence on the man[9].

An economically underpowered woman is bound to depend solely on her spouse for food, shelter, welfare and sundry while her financial independence, on the contrary, earns her respect from the male spouse and assures her of some decision making power[12]. This explained the reason why frequent financial demands from their husbands by the unemployed women were one of the commonest reasons for spousal violence in this study. Low educational attainment of the husbands may be linked with unemployment with consequent engagement in alcoholism in them and frequent unmet demand for money by the husbands from the women to meet their social habits would then lead to one form of physical violence or the other against the women. This association was also noted in earlier studies by Fawole et al[6] and Umeora et al[7]. Malcoe et al[12] reported that low socioeconomic status was the single most strongly associated risk factor for partner violence however, this was not in agreement with the finding of Ezechi et al[8] and Obi et al[5] who reported no significant association between the socioeconomic status of a woman and violence against her.

Physical and verbal abuses which humiliate the women were the commonest form of violence against the respondents in this study and this is similar to findings by Umeora[7] and Ezechi et al[8]. The high prevalence of physical and verbal abuses may be attributable to the ease of perpetration and cultural acceptability where it is not perceived as a form of violence[10]. However forced sex, punching and slapping also ranked high as forms of violence experienced in this study. In many African societies, women are viewed as their husbands' property and are therefore expected to be submissive to them even

without protest to his sexual demands. This is further supported by religious beliefs and inclination that women are expected also to respect and submit to their husbands and learn in silence. This is corroborated in this study where majority of the women that experienced violence did not report to someone else because of the culture and the religious settings in which they found themselves but rather would keep silence on the issue or forgave on religious ground. Decision making on sex and contraception issues ultimately rest with the man and this dominance manifests in a considerable number of forced sex by the male spouse, resulting in a number of unplanned and unwanted pregnancies. Sometimes refusal of spousal sexual advances by the women engenders intimate partner violence[3,4]. Domestic violence is reportedly predictably cyclical and consists of tension building, the battering and the honeymoon phases[3].

Diaz-Olavarrate et al[4] reported the main predictor of violence during pregnancy was violence prior to pregnancy. In this study, 52.9% of the women with experience of violence suffered this first in the index pregnancy and this was significant while 47.1% of the women suffered violence both before and during pregnancy. Therefore, pregnancy is thus a risk factor for domestic violence against women. This was earlier reported by Stark et al[4] who documented a higher risk of domestic violence against pregnant women.

A conspiracy of violence surrounds the gender based violence against women. Cases of violence against women are usually not reported. This is supported by this study in which only 26.5% and 29.4% of the victims reported their experience of violence in the hospital for treatment and to someone else respectively. Majority of the victims who reported to somebody reported the experience to their pastors and parents. None of the women reported to the police because abused women are intimidated and are afraid to report to police or face further abuse. This is similar to findings reported by Ezechi et al[8] and Multhal-Rathore et al[13]. This is supported by this study where majority of the women who reported in the hospital (55.6%) and to someone else (60%) were not satisfied with response they received.

RECOMMENDATION

There should be routine screening for violence during antenatal clinic using standard screening questions as for other medical conditions to enable early identification and management thereby protecting the health of both the mother and the child. Health care providers should be on the alert for the clues for domestic violence in pregnancy in order to protect the mother for further violence. There should be institution of effective intervention strategies with multidisciplinary and multiagency input involving health professionals, medical social workers, voluntary agents and action support services.

There should be legislation and institution of criminal justice system for perpetrators of violence to reduce the prevalence of abuse. There should be intervention programs for perpetrators of domestic violence as a crucial step towards controlling abuse and its recurrence. There should be improvement of the socioeconomic status of families and families should be encouraged to allow for dialogue among them. Women especially pregnant women should be encouraged to seek safety from abuse which would help to improve pregnancy outcomes and promote maternal welfare. There is a need to educate our men on harmful effects of domestic violence and the need for mutual respect irrespective of gender. There is a need to transform all cultural harmful practices that condones abusive behaviour against women.

CONCLUSION

Demographic, cultural and economic inequalities between African man and his spouse engender intimate partner violence among women attending antenatal clinics in Ado-Ekiti. Physical and verbal abuses are the commonest form of violence resulting from financial issues and social habits of the husbands. Consideration should be given for routine screening of domestic violence in pregnancy in order to institute effective intervention strategies.

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