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INTIMATE PARTNER VIOLENCE IN PREGNANCY: SUSTAINABLE DEVELOPMENT GOALS IMPEDIMENT

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ABSTRACT

Background

Intimate partner violence in pregnancy is a hidden global pandemic, an increasing social injustice to women especially in developing countries. It interferes with the Sustainable Development Goals (SDG) 3 and 5, hindering the achievement of good health and well-being for all; and stagnates attaining gender equity and equality.

Aim

This study investigated the prevalence and factors contributing to intimate partner violence in pregnancy among antenatal attendees in a tertiary health facility in Anambra state.

Methods

The study was a facility-based descriptive cross-sectional study with in-depth interviews (IDI) conducted among 400 respondents at the Ante-Natal clinics of Nnamdi Azikiwe University Teaching Hospital. Twenty of the victims were purposively selected for in-depth interviews.

Results

In the study, 61% of the respondents were aged 25 to 34 years and the mean age of respondents was 30.0 years (SD ±5.3). The overall prevalence of intimate partner violence (IPV) in pregnancy was 27.3%. The prevalence of psychological, controlling behaviours, physical and sexual IPV were 17.0%, 16.0%, 5.3% and 1.0% respectively. The factors significantly associated with IPV in pregnancy were the educational status of the partner, experiencing IPV before pregnancy, witnessed IPV during childhood or adolescence, and justifying husband to beat spouse if she offends him.

In the in-depth interview, All the participants had experienced controlling behaviours especially the 'monitoring your movements'. Poverty and poor business sales were factors associated with IPV in pregnancy.

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Conclusion

The increasing economic hardship may worsen IPV. Creating awareness, screening of pregnant women for IPV, the political will and appropriate interventions will help in reducing the menace of IPV in pregnancy.

Keywords: Antenatal attendee, antenatal clinic, Anambra state, Intimate partner violence Pregnancy.

Introduction

Intimate partner violence (IPV) is an enormous public health challenge and an increasing social injustice to women both in developed and developing countries. It is one of the most important reproductive health and rights, gender, and public health issues of our time(Shamu et al., 2018; Shrestha et al., 2016). It poses an immense threat to the attainment of the goals of the Safe Motherhood Initiative (SMI)(Flaathen et al., 2022). Intimate partner violence in pregnancy affects the physical, mental and social wellbeing of the pregnant woman and impedes the achievement of the Sustainable Development Goal (SDG) 3. Intimate partner violence in pregnancy and its attributes is a type of gender-based violence, its prevention and control will promote the achievement of SDG 5 which is gender equality.

Intimate partner violence (IPV) was first publicly spoken against in the 1970s (Bonnie E. Carlson, 2013). It has other names which include domestic violence, domestic abuse, family violence or wife abuse. It is violence by a current or former spouse or partner in an intimate relationship against the other partner. The US National Institutes of Mental Health Committee on Family Violence proposed a broader description of IPV as "acts that are physically and emotionally harmful or that carry the potential to cause physical harm and may also include sexual coercion or assaults, physical intimidation, threats to kill or harm, restraint of normal activities or freedom, and denial of access to resources (Román-Gálvez et al., 2021).

Intimate partner violence is very common in the world and probably worse in the developing countries (Onoh et.al. 2013). In the first article of the Declaration on the Elimination of Violence Against Women in 1994, the United Nations defined violence against women as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (United Nations, 1994). The World Health Organization (WHO) in 2012 defined IPV as any behaviour within an intimate relationship that

causes physical, psychological or sexual harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours (WHO, 2012, 2014).

Intimate partner violence affects all spheres of women 's live such as self-esteem, productivity, autonomy, capacity to care for themselves and their children, ability to participate maximally in social activities, and can lead to death (WHO, 2012; World Health Organization, 1997). It creates a vacuum in the social and economic development of any society.

Intimate partner violence during pregnancy (IPVP) as an important public health challenge and a social problem worldwide impacts negatively on the pregnant woman, her index pregnancy, her parenting capacity as a mother, her child or children, her relationship with her neighbours and relatives; and her mental status. IPVP presents with acute and chronic consequences; and direct, and indirect adverse health consequences on the woman This exposes her child or children to poor physical, social, and mental health. The poor health and witnessing of IPV further predisposes the child or children to become future IPV perpetrators or victims of IPV(Kh et al., 2014). Therefore, a vicious circle is established that continues into the next generation(WHO, 2012). Researches have proved that IPV during pregnancy confers risks to the neonate by increasing preterm birth (PTB) as well as the infant being at risk for low birth weight (LBW)(Hughes et al., 2017; Zenebe et al., 2014).

In Nigeria, six percent of ever pregnant women have experienced physical violence during pregnancy; The percentage was highest in the North East (12%) and lowest in the North West (1%). It is 5.7% in North Central, 3.6% in South West, 8.0% in South-South, and 9.5% in South East. Divorced, separated, or widowed women (15%) are more likely than currently married women (5%) and never-married women (9%) to have experienced violence during pregnancy(Benebo et al., 2018; National Population Commission (NPC) [Nigeria] & ICF, 2019). These variations are due to the level of education, employment status and marital status of the women and their partners

In 2015, Nigeria passed the comprehensive Violence Against Persons Prohibition Act 2015, which incorporates the right to aid for victims of violence and aims to eradicate all types of violence in both the public and private domains (Federal Ministry of Women Affairs and Social Development 2015). The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is another treaty Nigeria has ratified. However, despite legislation and ongoing

initiatives to safeguard women and vulnerable groups from violence, domestic violence against women still persist (United Nations Childrens Fund (UNICEF), 2000).

Despite all the above measures to curb IPV and IPV in pregnancy, the prevalence of all forms of violence was higher in 2018 than in 2008 and 2013 indicating increasing trend in the prevalence of IPV in Nigeria (National Population Commission (NPC) [Nigeria] & ICF, 2019).

This study determined the prevalence and forms of IPV, and the risk factors for IPV among antenatal care attendees of a tertiary hospital in Anambra state, Nigeria.

This study elucidated peculiarities in the variables associated with IPV in pregnancy within the context of the economic and socio-cultural setting in Anambra state, Nigeria. The data from this study is expected to help the government, policy makers, the health sector, social welfare, the justice system and other stakeholders in modifying, and improving on existing policies; enhance and adopt effective measures that will significantly reduce IPVP and its consequences

Methodology

The study was carried out in Anambra state. Anambra state is in the southeaster part of Nigeria with Awka as the capital. The study site was the Nnamdi Azikiwe University Teaching Hospital (NAUTH), a Federal Teaching institution in Anambra state of Nigeria. It runs routine Antenatal Care clinic (ANC) from Mondays to Fridays every week.

The research was a descriptive cross-sectional study. Data collection was a mixed method which employed a quantitative method using questionnaire adopted from WHO Multi-Country Study on Women's Health and Domestic Violence and in-depth interview of 20 of the respondents that experienced IPV.

Study Population: All pregnant women attending antenatal care (ANC) clinic in five sites of Nnamdi Azikiwe University Teaching Hospital (NAUTH) during the study period.
Inclusion Criteria: All pregnant women attending ANC clinic at Nnamdi Azikiwe University Teaching Hospital (NAUTH) irrespective of their gestational age

*Sample size determination***:** Sample size was calculated using the Taro Yamane method for sample size calculation as the total population is less than 10,000. The sample size for the quantitative study was 400 participants. And 20 respondents that experienced IPV were purposively selected for the in-depth interviews.

Sampling technique: A simple random sampling technique was employed in this study. All pregnant women registered or booked for ANC in the five study sites of Nnamdi Azikiwe

University Teaching Hospital (NAUTH) during the study period make up the sample frame using the ANC booking register. The sample size was proportionately distributed among the 5 study sites. Data were collected using a semi-structured interviewer-administered questionnaire by five trained female data collectors who are fluent in the local language. Data analysis was done using SPSS version 25.0.

Ethical considerations: Ethical clearance was obtained from the ethics research committee of Nnamdi Azikiwe University Teaching Hospital (NAUTH). Written informed consent and signed consent was obtained from each participant after clearly addressing and informing them about the purpose, risk, and benefit of the study.

Results

A 100% response rate was achieved in the course of data collection as interviewer administered method of data collection was applied.

Table 1: Socio-demographic Characteristics of the Pregnant Women

Variable (N = 400)	**Experience of IPV in index Pregnancy**			**P-Value**
	Yes (N= 109)	No (N = 291)	Total	
	Frequency (%)			
Age (years)				0.751
< 20	0(0.0)	2(100)	2(0.5)	
20 to 24	16(22.9)	54(77.1)	70(17.5)	
25 to 29	34(28.3)	86(71.7)	120(30.0)	
30 to 34	37(29.1)	90(70.9)	127(31.8)	
35 to 39	18(30.0)	42(70.0)	60(15.3)	
≥ 40	4(19.1)	17(80.9)	21(5.3)	
Religion				0.540
Christianity	109(27.3)	290(72.3)	398(99.5)	
Islam	0(0.0)	2(100)	2(0.5)	
Ethnicity				0.341
Igbo	106(27.2)	286(73.3)	390(97.5)	
Efik	0(0.0)	3(100)	3(0.8)	
Tiv	2(66.7)	1(33.3)	3(0.7)	
Yoruba	1(50.0)	I(50.0)	2(0.5)	
Edo	50(50.0)	50(50.0)	2(0.5)	

Marital status				0.736
Single	0(0.0)	(100)	1(0.3)	
Married	108(27.3)	288(72.7)	396(99.0)	
Divorced or separated	1(50.0)	1(50.0)	2(0.5)	
Cohabiting	0(0.0)	1(100)	1(0.3)	
Educational status				0.108
No formal education	2(100.0)	0(100)	2(0.5)	
Primary education	3(21.4)	11(78.6)	14(3.5)	
Secondary education	50(25.5)	146(74.5)	196(49.0)	
Tertiary and above	54(28.7)	134(71.3)	188(47.0)	
Place of residence				0.570
Rural	30(29.4)	72(70.6)	102(25.5)	
Urban	79(26.5)	219(73.5)	298(74.5)	
Living arrangement				0.542
With only partner	89(26.6)	245(73.4)	334(83.5)	
With partner and his extended family	20(30.3)	48(69.7)	66(16.5)	
Occupation				0.263
Office worker	16(34.8)	30(65.5)	46(11.5)	
Professional	14(29.2)	34(70.8)	48(12.0)	
Skilled/ Semi-skilled worker	23(34.8)	43(65.2)	66(16.5)	
Trading	37(23.9)	118(76.1)	155(38.8)	
Unemployed (house Wife and student)	19(22.4)	66(77.6)	85(21.2)	
Smoking				0.021
Yes	2(100.0)	0(0.0)	2(0.5)	
No	107(26.9)	291(73.1)	398(99.5)	
Alcohol use				0.278
Yes	30(31.6)	65(68.4)	95(23.8)	
No	79(25.9)	226(74.1)	305(76.3)	

Table 1. shows that among the 400 participants interviewed, 27.3% (109) had experienced at least one form of intimate partner violence (IPV) in the index pregnancy.

Most of the pregnant women (127 ;31.8%) were aged 30 to 34 years followed by 120 (30.0%) pregnant women who were aged between 25 to 29 years.

The mean age of the respondents was 30.0 years (SD ±5.3), the minimum and maximum ages were 18 and 43 years respectively. Among the respondents 99% (396) were married, 0.5% (2) were divorced or separated and 1(0.3%) respondent was cohabiting.

Most of the respondents (49.0%;196) had secondary education, 47.0% (188) had tertiary and above level of education, 3.5% (14) had primary Education and 0.5% (2) did not have any formal education. Respondents who had no formal education experienced IPV the most (100%)

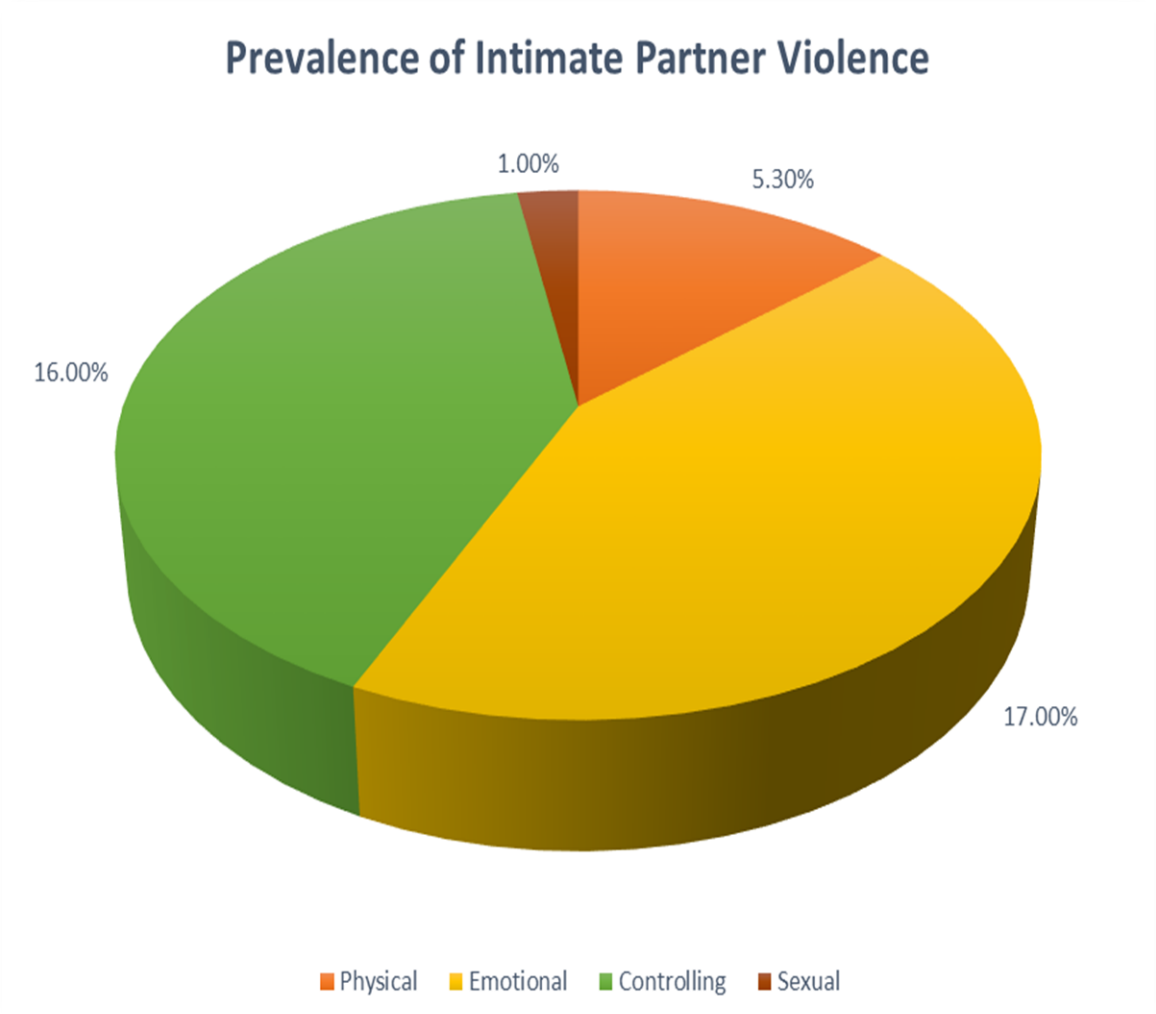


Figure 1: Prevalence of Intimate Partner Violence in Pregnancy

The overall prevalence of IPV in this study was 27.3%. The prevalence of emotional, controlling behaviour, physical and sexual IPV were 17.0%, 16.0%,5.3% and 1.0% respectively.

Table 2: Risk Factors Associated with IPV In Pregnancy

Logistic regression of experience of IPV in pregnancy and associated risk factors

Risk factor	Experienced IPV		χ^2	P value	OR	95% CI
	Yes (n = 109)	No (n = 291)				
Age (years)			2.158	0.707		
< 20 to 24 (Ref.)	16 (14.7)	56 (19.2)			1	
25 to 29	34 (31.2)	86 (29.6)			1.384	0.699 - 2.739
30 to 34	37 (33.9)	90 (30.9)			1.439	0.733 - 2.825
35 to 39	18 (16.5)	42 (14.4)			1.500	0.685 - 3.283
≥ 40	4 (3.7)	17 (5.8)			0.824	0.242 - 2.797
Age of partner (years)			1.538	0.820		
20 to 24 (Ref.)	2 (1.8)	4 (1.4)			1	
25 to 29	4 (3.7)	18 (6.2)			0.444	0.059 - 3.329
30 to 34	28 (25.7)	73 (25.1)			0.767	0.133 - 4.425
35 to 39	34 (31.2)	98 (33.7)			0.694	0.122 - 3.960
≥ 40	41 (37.6)	98 (33.7)			0.837	0.147 - 4.749
Educational status			6.084	0.108		
No formal education	2 (1.8)	0 (0.0)			40087709 61.165	0.000
Primary	3 (2.8)	11 (3.8)			0.677	0.182 - 2.521
Secondary	50 (45.9)	146 (50.2)			0.850	0.542 - 1.333
Tertiary (Ref.)	54 (49.5)	134 (46.0)			1	
Educational status of partner			11.569	0.009		

No formal education	1 (0.9)	1 (0.3)			2.818	0.173 - 46.024
Primary	11 (10.1)	7 (2.4)			4.429	1.616 - 12.136
Secondary	53 (48.6)	159 (54.6)			0.939	0.591 - 1.493
Tertiary (Ref.)	44 (40.4)	124 (42.6)			1	
Alcohol use by partner			0.078	0.781		
No (Ref.)	47 (43.1)	130 (44.7)			1	
Yes	62 (56.9)	161 (55.3)			1.065	0.683 - 1.660
Duration of the relationship			1.764	0.184		
Less than 5 years (Ref.)	61 (56.0)	184 (63.2)			1	
5 years and above	48 (44.0)	107 (36.8)			1.353	0.865 - 2.116
Experience of IPV before index pregnancy			54.822	<0.0001		
No (Ref.)	84 (77.1)	287 (98.6)			1	
Yes	25 (22.9)	4 (1.4)			21.354	7.229 - 63.077
Marital conflict			9.225	0.002		
No (Ref.)	38 (34.9)	151 (51.9)			1	
Yes	71 (65.1)	140 (48.1)			2.015	1.277 - 3.180
Justification of husband beating wife			11.390	0.001		
No (Ref.)	97 (89.0)	283 (97.3)			1	
Yes	12 (11.0)	8 (2.7)			4.376	1.737 - 11.024
Witnessed IPV during childhood or adolescence			12.332	<0.001		
No (Ref.)	66 (60.6)	227 (78.0)			1	
Yes	43 (39.4)	64 (22.0)			2.311	1.439 - 3.711

Table 2 shows the logistic regression of intimate partner experience in pregnancy and the risk factors. The risk factors of IPV in pregnancy that were statistically significant in the study include: The educational status of partner, experience IPV before pregnancy, witnessed IPV during childhood or adolescence, and justifying husband to beat spouse if she offends him

In the in-depth interviews, 20 of the respondents who experienced IPV were selected for the interviews. They have experienced at least one form of intimate partner violence. The type of IPV experienced at each point in time also varies with the cause of the violence. Poverty and lack of job were consistently identified as important risk factors for intimate partner violence.

Discussion

The prevalence and forms of intimate partner violence varies across cultures, societies, states, nations, regions in the world for reasons related to cultural, socioeconomic, and religious factors. A study in Uganda showed similar overall prevalence of 27.8%(Joshua Epuitai, Samson Udho, Anna Grace Auma, 2019). Several studies showed lower overall prevalence, a systematic review in North Central Jos, Nigeria showed 14.8%, in Oyo East Local Government Area of Nigeria the overall prevalence was 17.4%, in Ethiopia it was 26.1%, and a study in South Africa 15.0% was gotten (A.O Ayodapoa, 2017; Alebel A, Kibret GD, Wagnew F, 2018; Anzaku et al., 2017; Field et al., 2018). The differences in prevalence rate in various studies may be due to differences in the wiliness to disclose information regarding the experience of IPV, the awareness level of what intimate partner violence encompasses, cultural and religious belief, comfortable privacy, assurance of confidentiality, and confidence in the system for help or assistance. More important is the type of screening tool for IPV used, and the methodology of the study.

In this study, the most common type of IPV experienced by the respondents were emotional IPV (17.0%) and controlling behaviours (16.0%). The 'very jealous' or 'control your life' component of controlling behaviour and the 'insults you and made you fill bad' components of the emotional IPV were the commonest and this is because the perpetrators of IPV adopted this method which impact was easier to conceal from public compared to physical violence, to avoid been blamed for physically assaulting a woman that is pregnant; and to avoid inflicting harm to the unborn baby.

This result was similar to the studies by Ayodapo *et al* in Oyo East Local Government of Nigeria, and Simukai et al in Zimbabwe (Ayodapo et al., 2017; Shamu et al., 2013) but in contrast to a studies by Lencha et. al. in southeast Ethiopia and Ashenafi et al. in eastern Ethiopia where Sexual IPV is higher than in our study(A. Semahegn and B. Mengistie, 2015; Ashenafi W, Mengistie B,

Egata G, 2020; Lencha B, Ameya G, Baresa G, Minda Z, 2019). It was observed that in the studies, most of the women do not have any formal education or had low educational status and were predominantly Muslims. Low education status could mean having a spouse with low educational status who tend to perpetrate violence via the cultural ideology that he possesses the woman and can take advantage of her any time. Another possible reason for the high sexual violence is that in the Muslim religion under aged female children are given out for marriage. These children do not understand how to handle marriage and cannot negotiate sex; and they are been forced and raped by their spouse without their approval.

The risk factors that were statistically significant for IPV in pregnancy in our study include the educational status of the partner (P-value = 0.009; 95% CL:1.616-12.136) , experiencing IPV before pregnancy(P <0.0001, 95% CI: 7.329-63.077) , witnessed IPV during childhood or adolescence (P< 0.001; 95% CI :1.439-3.711), justifying husband to beat spouse if she offends him(P=0.001; 95% CI:1.737-11.024) and marital conflict (P= 0.002; 95% CI :1.277-3.180) respectively. The educational status of the husband was significant in this study and the studies by world Health Organization (WHO. 2012) and Owaka et. al. 2017 in a Kenyan health facility. which explained that the lower the educational status of the husband the more the likely chance that the spouse will experience violence. Low level of education is associated to low income or no employment which causes frustration and tendency for conflict at home and violence. In this study, intimate partner violence before pregnancy was associated with intimate partner violence during pregnancy, which was consistent with findings from Epuitai et.al. study done an hospital facility in Uganda This suggests that violence during pregnancy may simply be a continuation of abuse before pregnancy.

Marital conflict was independently associated with IPV in this study. Fights or disagreement may predispose to the experience of intimate partner violence during pregnancy. Marital conflicts arise from patriarchal dominance and disagreements regarding the use of family resources, and the consequent intimate partner violence may be a way of resolving the conflicts or disagreements in the family. This was similar to the findings by the study done by Epuitai et.al. in 2019.

The experience of IPV before pregnancy and marital conflict are factors found significant in a study done in Uganda (Joshua Epuitai, Samson Udho, Anna Grace Auma, 2019). Level of education of the partner was a significant risk factor for IPV in as study carried out in Kenya (Owaka et al., 2017; WHO, 2012). This study showed that women who justify spouse beating their

wife if she was insulting, committed adultery, stubborn, or did not do house chores are more likely to experience IPV than those against spouse beating.

Limitation of the study and suggestion for further research:

This study was limited by the fact that it was hospital-based research and so generalization of the findings to the general population should be done with caution. The cross-sectional nature of the quantitative data limits an investigation into the progression of violence before, during the pregnancy and after birth. This study cannot claim generalization because it is limited to participants attending an antenatal clinic in a government-established hospital. Therefore, further research using longitudinal and community-based studies advocated for comprehensive understanding of IPV in pregnancy.

Conclusion: The prevalence of intimate partner violence in pregnancy (IPV) was high (27.3%) in Anambra state. In the study, controlling and emotional violence was the most common forms of intimate partner violence experienced but most of the women were not aware that the items for the screening of controlling behaviours and emotional IPV were abuse. In addition to the other risk factors of IPV, economic hardship, lack of money and poverty are very important risk factor for IPV in pregnancy. Without addressing poverty in society, IPV cannot be reduced to a significant level.

Recommendations: The education of the girl child is key; the education of the male child is equally very important. When our children are educated, domestic violence programme is included in the school curriculum. Domestic violence will be significantly reduced. Strategies to alleviate economic hardship, provision of conducive environment and policies that encourages employment for both men and women by government and stakeholder can not be overemphasized.

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