Journal of Obstetrics and Gynaecology, April 2011; 31(3): 232–236

ISSN 0144-3615 print/ISSN 1364-6893 online
DOI: 10.3109/01443615.2010.547954

informa
healthcare

OBSTETRICS

Prevalence and pattern of violence in pregnancy in Ibadan, South-west Nigeria

O. ADESINA[1], I. OYUGBO[2] & A. OLUBUKOLA[1],

Department of Obstetrics and Gynaecology, [1]*College of Medicine, University of Ibadan and* [2]*University College Hospital, Ibadan*

Summary
Violence against women is embedded in most cultures with pregnancy associated with higher rates. This study assessed the pattern of violence in pregnancy in two maternity centres in Ibadan, Nigeria. This was a cross-sectional study of antenatal clinic attendees, between 1 and 31 March, 2007 at the University College Hospital (UCH) and the Adeoyo Maternity (AMH). By systematic random sampling, 404 women were interviewed. Analysis was done by means, χ^2-test (at 5% level of significance) and logistic regression. At UCH and AMH, 156 (38.7%) and 248 (61.3%) were studied, respectively. The prevalence of abuse was 17.1% (69 women). The perpetrator was most often an intimate partner (48, 66.1%). The commonest act of violence was a threat of abuse (23, 33.3%). The most frequent reason for the abuse was demand for money. Women in polygamous unions ($p = 0.035$), attending Adeoyo hospital ($p = 0.00$) or with secondary school or less education ($p = 0.004$) had higher levels of abuse. Regression analysis revealed women attending AMH were 3.6 times more likely to be abused (95% CI for OR = 1.69–7.81). Violence is not uncommon in this population. Education and employment may reduce these acts.

Keywords: *Nigeria, pattern, pregnancy, prevalence, violence*

Introduction

The Declaration on the Elimination of Violence Against Women, adopted by the United Nations in 1992, defines 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 private life' (WHO 1997; Umeora et al. 2008). Violence against women is deeply embedded in most cultures and condoned by society as an unfortunate aspect of being a woman (Donnay 1997; Fawole et al. 2008). Although domestic violence is a neutral term, in most cases it is a gender-specific situation of men perpetrating violence against women. When women strike out against men within relationships or families, it is usually in self-defence (Ogbuji 2004; Shane and Ellsberg 2002). These acts are regardless of whether the couple is living together. Although, domestic violence by other family members can occur or occur with same-sex relationships, it is argued that male partners particularly use violence in order to maintain dominance and control over female partners (Harwin 1997; Aimakhu et al. 2004). It is one reflection of the unequal power relationship between men and women in societies (Schmuel and Sshenker 1998; Aimakhu et al. 2004).

Violence against women has been observed as resulting in negative health consequences, including significant level of morbidity, debility and mortality among women world-wide. Thus, it has become a major issue in contemporary discourse within the health and development sectors (Garcia-Moreno 2002; Adeyemi et al. 2005). Risk factors associated with violence include young age, poor education, drug and alcohol abuse and emotional instability (Fawole et al. 2003; Fawole et al. 2008). Pregnancy has been documented as being associated with higher rates of violence against women (Stark and Elicraft 1995; Gelles 1975; Fawole et al. 2008). This is of particular concern because of the risk to the mother and the developing fetus. A blow to a pregnant woman's abdomen can cause adverse outcomes such as pre-term labour and delivery, placental abruption, feto-maternal haemorrhage, fetal injury and death (Petersen et al. 1997; Cokkinides et al. 1999; Diaz-Olavarrieta et al. 2007; Ezechi et al. 2004). Aside from the physical consequences, psychological implications of domestic violence in pregnancy include stress, depression and addiction to alcohol and drugs. These are risk factors for low birth weight (Lu et al. 2003; Umeora et al. 2008; Naumann et al. 1999). The stress associated with abuse may exacerbate chronic conditions of the mother (Naumann et al. 1999). Given the association of battering and depression, it is reasonable to assume that some women diagnosed as manifesting postpartum depression may be experiencing abuse from an intimate partner (Naumann et al. 1999; Campbell et al. 1996).

The World Health Organization recognises that violence against women constitutes a serious health risk to women, their families and their communities (WHO 1996). Routine screening of all women during pregnancy for any form of domestic violence has been advocated (Ameh and Abdul 2004; Diaz-Olavarrieta et al. 2007). The objectives of this study were to assess the pattern and prevalence of violence against pregnant

Correspondence: O. A. Adesina, Department of Obstetrics and Gynaecology, College of Medicine, University of Ibadan, Ibadan, Nigeria.
E-mail: bukiadewole@yahoo.com

women presenting for antenatal services in two urban maternity centres in Ibadan.

Methods

This was a hospital based cross-sectional study of antenatal clinic attendees. The study took place between 1 and 31 March, 2007 at the antenatal clinics of the University College Hospital and the Adeoyo Maternity, both in Ibadan, south-western Nigeria. The antenatal clinic of the University College Hospital manages about 60–80 patients per clinic day while Adeoyo Maternity manages about 90–120 patients per clinic day. The pregnant women who attended these antenatal clinics during the study period and who consented to participating in the study formed the study population.

The calculated sample size of 328 was approximated to 400 and split in a ratio of 3:2 in favour of Adeoyo Maternity. This gave a sampling size of 156 for the University College Hospital and 248 for the Adeoyo Maternity. A systematic random sampling was carried out. The data collection was done using interviewer administered semi-structured questionnaire.

The questionnaires were checked for data entry errors. Entry was done into the SPPSS software version 12. Mean, standard deviations and proportions were used to summarise variables. The relationship between abuse and the bio-data of the subjects were tested using the χ^2-test at 5% level of significance. Logistic regression analysis was also performed.

Ethical clearance and approval was sought from the joint UI/UCH Institutional Review Board. Informed consent was obtained from the pregnant women after giving them information about the study and ascertaining that they fully understood it.

Results

A total of 404 pregnant women were studied. A total of 156 (38.7%) of the women were studied at the University College Hospital, while the remainder (61.3%) were at the Adeoyo Maternity. The mean age of the women was 28.7 years ($\pm$5.0). Table I shows the sociodemographic characteristics of the women studied. About two-thirds of the women were between 25 and 34 years of age. The majority of the women were married. Almost half of the women were in their first pregnancy. Women in monogamous unions accounted for 90.8% (367) of the marriage types. Most of the women had had some form of formal education. Christians constituted over half of the respondents. Most respondents were Yoruba, reflecting the geographic region in which the study was done.

The prevalence of abuse was 17.1% (found in 69 women). Table II shows the perpetrator, type of abuse experienced and the reasons for the acts of abuse. The perpetrator was most often an intimate partner, i.e. husband or boyfriend. The commonest act of violence experienced was a threat of abuse. The most frequent reason given for the abuse was demand for money by the woman. Table III shows the bivariate associations between abuse and sociodemographic characteristics. Higher proportions of abuse were noted among women who were $\leq$24 years of age. These differences were however not statistically significant. Similar proportions of women reported violence among the primigravidae (36, 18.6%) and the multipara (34, 16.2%). Women in polygamous unions or attending Adeoyo hospital also had higher proportions of abuse. The difference was statistically significant, $p = 0.035$ and $p = 0.00$, respectively. More women who had secondary school or less education also had higher levels of abuse. The difference was significantly higher, $p = 0.004$. Being Yoruba was associated with higher abuse prevalence but the result was not statistically significant. Regression of abuse on the variables significant at 10% (Table IV) revealed that women attending Adeoyo Maternity were 3.6 times more likely than those at the University College Hospital to be abused (95% CI for OR = 1.69–7.81). The other variables were not significant.

Table I. Sociodemographic characteristics of the participants.

	Frequency	(%)
Age (years)		
≤24	80	19.8
25–29	141	34.9
30–34	129	31.9
≥35	54	13.4
Marital status		
Married	396	98.0
Single	8	2.0
Parity		
Primigravidae	194	48.0
Multipara	210	52.0
Educational status		
None	10	2.5
Primary	48	11.9
Secondary	127	31.4
Tertiary	219	54.2
Religion		
Christianity	236	58.4
Islam	168	41.6
Tribe		
Yoruba	365	90.5
Ibo	12	3.0
Hausa	14	3.4
Others	13	3.1

Table II. Perpetrator, type of abuse and reasons for abuse.

	Frequency	(%)
Perpetrator of abuse		
Husband	45	63.2%
Boyfriend	3	2.9%
In-laws	5	5.9%
Neighbours	7	8.8%
Strangers	2	1.5%
Others	7	8.8%
Type		
Threats of abuse	23	33.3%
Financial deprivation	17	24.6%
Husband communicating less	17	24.6%
Husband refusing to eat	12	17.4%
Forced physical activities	11	15.9%
Beating/slapping	6	8.7%
Forced sex/sexual harassment	4	5.8%
Denying sexual relationship	4	5.8%
Others	3	4.3%
Reasons for abuse		
Demand for money	11	15.9%
Not satisfying husband sexually	7	10.1%
Unplanned pregnancy	4	5.8%
Woman is unemployed	3	4.4%
Living alone	3	4.4%
Woman has only female children	1	1.5%

Table III. Bivariate association between abuse and sociodemographic characteristics.

	Abuse					
	Yes		No			
Variable	*n*	(%)	*n*	(%)	χ^2	*p* value
Age (years)						
≤24 (*n* = 84)	19	21.4	65	78.6	3.688	0.297
25–29 (*n* = 138)	18	13.0	120	87.0		
30–34 (*n* = 126)	24	19.1	102	80.9		
≥35 (*n* = 56)	8	14.3	48	85.7		
Marriage type						
Monogamous (*n* = 371)	59	15.9	312	84.1	4.435	0.035
Polygamous (*n* = 33)	10	30.3	23	69.7		
Educational status						
Primary or less (*n* = 57)	17	29.8	40	70.2	10.886	0.004
Secondary (*n* = 128)	26	20.3	102	79.7		
Tertiary (*n* = 219)	26	11.9	193	88.1		
Tribe						
Yoruba (*n* = 367)	65	17.7	302	82.3	1.032 3	0.310
Others (*n* = 37)	4	10.8	33	89.2		
Facility type						
UCH (*n* = 157)	12	7.6	145	92.4	15.948	0.000
Adeoyo (*n* = 247)	57	23.1	190	76.9		

Table IV. Multivariate logistic regression analysis of abuse on variable.

Variable	B	Odds ratios	95% CI for odds ratios	*p* value
Facility type				
Adeoyo vs UCH	1.292	3.683	1.69–7.81	0.001
Education: ≤2° vs 3°	0.193	1.213	0.65–2.27	0.544
Monogamy vs polygamy	−0.585	0.557	0.23–1.33	0.189

B = regression estimate. The B exponential gives the odds ratio. ° = educational level; 2° = secondary school; 3° = tertiary level of education.

About 36 (52%) of the women had been abused outside pregnancy. The proportion reporting that the frequency of the abuse had increased, decreased and remained same in that pregnancy were roughly the same, i.e. 29.1%, 32.7% and 38.2%, respectively. About two-fifths of the women (29, 42.0%) had been abused only once, 23 (33.3%) twice, seven (10.1%) had been abused three times, while 11 (15.9%) had been abused more than three times in this pregnancy. Twenty-six (36.7%) of the women had reported the abuse to someone. Report was to the woman's family in 21.7% of cases, in-laws in 14.5%, priest in 4.3%, close friends in 4.3%, other people 4.3% of cases. Those who did not report felt it would not make any difference.

Discussion

The prevalence value of abuse in pregnancy of 17.1% reported in this study is lower than the values of 28% and 37.4% reported from Abuja and Zaria (Efetie and Salami 2007; Ameh and Abdul 2004), respectively, both in northern Nigeria. From south-eastern Nigeria, Umeora et al. (2008) have reported 13.6%. The reported value in this study is however intermediate between the values of 2.3% and 28.7%, both reported from south-west Nigeria (Fawole et al. 2008; Ezechi et al. 2004), where this present study was also cited. Some workers have however, noted that the incidence is likely to be higher, as it is usually the abused women who refuse to confess abuse, fearing that disclosure might lead to reprisals (Muthal-Rathore et al. 2002; Ezechi et al. 2004).

The intimate partner (i.e. husband or boyfriend) was the most frequent perpetrator of domestic violence against pregnant women in this study and this is consistent with reports from various other studies in the country (Ameh and Abdul 2004; Umeora et al. 2008; Ezechi et al. 2004; Fawole et al. 2008). In the neighbouring country of Ghana, the finding was similar (Kwawukume and Kwawukume 2001). In Nigeria, there is societal prejudice against women and men are encouraged by relatives to 'whip' their wives into line. Women are supposed to be under the control of the husband without question and subject to his whims and caprices (Ezechi et al. 2004).

The commonest act of violence experienced was threat of abuse. Several workers reported verbal abuse as being the most common type of abuse in their studies (Fawole et al. 2008; Ezechi et al. 2004; Umeora et al. 2008). Both may however, be classified as psychological abuse. Psychological abuse may have serious consequences, as it may result in severe depression and/or suicide (Helton and Mcfarlane 1987). The implications of psychological abuse in pregnancy include: stress, depression and addiction to tobacco, alcohol and drugs, which may affect fetal growth (Lu et al. 2003). Generally, while many African societies disapprove strongly of physical abuse, women are viewed as their husbands' property and are therefore expected to submit without protest to his sexual demands (Umeora et al. 2008). This type of attitude may facilitate sexual abuse, including marital rape. Forced sex was reported by four women in this study.

Few women reported the experience of violence. A conspiracy of silence has been noted to surround the gender-based violence meted out on the women (Umeora et al 2008). Although, not explored in this study, reasons given for not reporting, include fear of reprisals, damage to the children, loss of shelter, protection of marriage and for religious and/or cultural acceptability (Umeora et al. 2008). Other reasons included fear of ridicule by friends and/or the whole extended family (Efetie and Salami 2007).

Women who were younger or who had fewer years of educational attainment were noted to experience more levels of abuse. A disturbing factor in relationships between men and women is connected with age and power differences. The age difference characteristic of many African relationships where the male is much older than the female partner may encourage dominance by the man (Dunkle et al. 2007; Umeora et al. 2008). 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 mother is particularly disadvantaged in such circumstances (Umeora et al. 2008). Women with higher educational attainment reported less domestic violence in this study. Women empowerment and economic power are linked to a woman's educational status and these lessen her dependence on the man (Olusanya et al. 1985; Umeora et al. 2008). An economically underpowered woman is bound to depend solely on her spouse for food, shelter, etc. (Dunkle et al. 2007; Umeora et al. 2008). A woman's financial independence, on the contrary, earns her respect from the male spouse and assures her of some decision-making power (Umeora et al. 2008). This tends to be supported by the fact

that the most frequent reason given for the abuse in this study was demand for money by the woman.

Women in polygamous unions reported higher rates of abuse. Umeora et al. (2008) noted that the external influence of 'the other woman' operational in the polygamous family setting is a significant source of marital violence. It must also be noted that in-laws and neighbours were reported as being involved in the perpetration of abuse in this study. The African preference for male offspring may trigger violence by the husband and his relatives against the pregnant woman (Umeora et al. 2008). However, having only female children did not feature prominently in the reasons given for the abuse in this study. In Nigeria and most cultures in Africa, the woman is married to the family of the man and not just to the man alone, and thus the relations of the man expect her to be submissive to them even to her detriment (Ezechi et al. 2004). Thus, in-laws may also perpetrate abuse, as was noted by five of the women in this study.

Women in Adeoyo maternity hospital reported higher levels of abuse than women surveyed at the University College Hospital. This maternity hospital is a secondary level health institution with a not-for-profit policy. Thus, it tends to attract clientele of lower socioeconomic status. The University College Hospital on the other hand is the apex referral centre in the state. It operates on a fee paying mandate and tends to attract a more educated clientele of higher socioeconomic status. Facility type in a broad sense may thus be a proxy for the socioeconomic status of the clientele. As previously noted, the economically empowered woman may be at lower risk of abuse.

In conclusion, domestic violence is not uncommon in this obstetric population, often being perpetrated by those closest to the women. It has been suggested that screening for violence should be done during antenatal care as for other medical conditions to enable early identification and management. Given its potential for negative impact on not only the mother and unborn child but also the community, it is essential that the care provider be vigilant and on the lookout for features of domestic violence among their obstetric population. Such screening should aim to institute effective interventions with a multidisciplinary approach. Empowering women by ensuring quality education and providing employment will contribute to reducing these acts against women. Finally, it will be necessary to have interventions that will rehabilitate these women and also assist the perpetrators to refrain from similar acts.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

Adeyemi BA, Irinoye OO, Oladimeji BY, Fatoye FO, Fatusi AO. 2005. Detection of indices of violence against women by health professionals in a Nigerian teaching hospital. Tropical Journal of Obstetrics and Gynaecology 22:27–32.

Aimakhu CO, Olayemi OO, Adeniji AR, Shoretire KA, Ojoko IE, Oluyemi FA, et al. 2004. Domestic violence: the role of the Nigerian obstetrician. Tropical Journal of Obstetrics and Gynaecology 21:46–48.

Ameh N, Abdul MA. 2004. Prevalence of domestic violence amongst pregnant women in Zaria, Nigeria. Annals of African Medicine 3:4–6.

Campbell JC, Kub J, Rose L. 1996. Depression in battered women. Journal of the American Medical Women's Association 51: 106–110.

Cokkinides VE, Coker AL, Sanderson M, Addy C, Bethea L. 1999. Physical violence during pregnancy: maternal complications and birth outcomes. Obstetrics and Gynecology 93:661–666.

Diaz-Olavarrieta C, Paz F, Abubara K, Martinez-Ayala HB, Kolstad K, Palermo T. 2007. Abuse during pregnancy in Mexico City. International Journal of Gynaecology and Obstetrics 97: 57–64.

Donnay F. 1997. Violence against women and girls: a global violation of human rights. WHO/FIGO Pre-congress Workshop on Violence against Women, 30–31 July.

Dunkle KL, Jewkes R, Nduna M, Jama N, Levin J, Sikweyiya Y, et al. 2007. Transactional sex with casual and main partners among young South African men in the rural Eastern Cape: Prevalence, predictors and associations with gender-based violence. Social Science and Medicine 65:1235–1248.

Efetie ER, Salami HA. 2007. Domestic violence on pregnant women in Abuja, Nigeria. Journal of Obstetrics and Gynaecology 27:379–382.

Ezechi OC, Kalu BK, Ezechi LO, Nwokoro CA, Ndububa VI, Okeke GCE. 2004. Prevalence and pattern of domestic violence against pregnant Nigerian Women. Journal of Obstetrics and Gynaecology 24:652–656.

Fawole OI, Ajuwon AJ, Osungbade KO, Faweya CO. 2003. Prevalence and nature of violence to young female hawkers in motor parks in south western Nigeria. Health Education Research 102:230–238.

Fawole AO, Hunyinbo KI, Fawole OI. 2008. Prevalence of violence against pregnant women in Abeokuta, Nigeria. Australian and New Zealand Journal of Obstetrics and Gynaecology 48:405–414.

Garcia-Moreno C. 2002. Dilemmas and opportunities for an appropriate health service response to violence against women. Lancet 359:1509–1514.

Gelles RJ. 1975. Violence and pregnancy: A note on the extent of the problems and needed services. Family Coordinator 24:81–86.

Harwin N. 1997. Understanding women's experience of abuse. In: Bewley S, Friend J, Mezey G, editors. Violence against women. London: RCOG press. p 59–75.

Helton A, Mcfarlane J. 1987. Prevention of battering during pregnancy: Focus on behavioural change. Public Health Nursing 4:166–174.

Kwawukume EY, Kwawukume SB. 2001. Violence against pregnant women – the patient's perspective. Nigerian Journal of Clinical Practice 4:76–79.

Lu MC, Lu JS, Halfin VP. 2003. Domestic violence and sexual assault. In: Decherney AH, Nathan L, editors. Current obstetric and gynecologic diagnosis and treatment. 9th ed. New York: Lange Medical books/McGraw-Hill. p 1087–1093.

Muthal-Rathore A, Tripathi R, Arora R. 2002. Domestic violence against pregnant women interviewed at a hospital in New Delhi. International Journal of Gynaecology and Obstetrics 76:83–85.

Naumann P, Langford D, Torres S, Campbell J, Glass N. 1999. Women battering in primary care practice. Family Practice 16:343–352.

Ogbuji CQ. 2004. Violence against women: impact on their reproductive health. Tropical Journal of Obstetrics and Gynaecology 21:61–64.

Olusanya O, Okpere EE, Ezimokhai M. 1985. The importance of social class in voluntary fertility control in a developing country. West African Journal of Medicine 3:205–212.

Petersen R, Gazmararian JA, Spitz AM, Rowley DL, Goodwin MM, Saltsman LE, et al. 1997. Violence and adverse pregnancy outcomes: a review of the literature and directions for the future research. American Journal of Preventive Medicine 13:366–373.

Schmuel E, Sshenker JG. 1998. Violence against women: the physician's role. European Journal of Obstetrics, Gynaecology and Reproductive Biology 80:239–245.

Shane B, Ellsberg M. 2002. Violence against women: effects on reproductive health. Outlook 20:1–8.

Stark E, Elicraft A. 1995. Killing the beast within: Woman battering and female suicidality. International Journal of Health Services 25:43–64.

Umeora OUJ, Dimejesi BI, Ejikeme BN, Egwuatu VE. 2008. Pattern and determinants of domestic violence among prenatal clinic attendees in a referral centre, South-east Nigeria. Journal of Obstetrics and Gynaecology 28:769–774.

WHO. 1996. Violence against women. WHO Consultation. Women, health and development; family and reproductive health. Geneva: World Health Organization.

WHO. 1997. Violence against women information. Available at: www.who.int/frh-who/VAW/infopack/English/VAW-info pack-htm