VOL 1 NO 1: DECEMBER. 2024
AN OPEN ACCESS PEER-REVIEWED JOURNAL

Frontline Professionals Journal, 1(1), 25–36

Original Article

INTIMATE PARTNER VIOLENCE IN PREGNANCY: DISCLOSURE PATTERNS AND COPING PERCEPTIONS

Chiejine Gibson Ifechukwude[1], Nkiru Ezeama[1], Duluora Nneka Chidimma[1], Ngozi Miriam Amadi[2], Isenalumhe Ade Salami[3], Ogbiti Mark Imhonikhe[3], Handich Tarila Kai[4], Ohi Esther Sunday[5]

Affiliations: [1]Department of Community Medicine, Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria.
[2]Department of Health and Life Sciences, Coventry University, United Kingdom
[3] Department of Obstetrics and Gynaecology, Irrua Specialist Teaching Hospital, Nigeria
[4] Primary Health Care Department, Bayelsa State, Nigeria
[5]Department of Medicine, Nnamdi Azikiwe University, Nigeria.

Correspondence:
Chiejine Gibson Ifechukwude: drgib2002@gmail.com.

Citation: Chiejine Gibson Ifechukwude, Nkiru Ezeama, Duluora Nneka Chidimma, Ngozi Miriam Amadi, Isenalumhe Ade Salami, Ogbiti Mark Imhonikhe, Handich Tarila Kai, Ohi Esther (2024) Intimate partner violence in pregnancy: disclosure patterns and coping perceptions. *Frontline Professionals Journal*, 1(1), 25–36.

ABSTRACT

Intimate partner violence in pregnancy is a significant public health challenge with severe consequences on the mother, the unborn child and the society. Understanding the disclosure patterns is critical for effective interventions. The study assessed the disclosure pattern and coping perceptions of Antenatal attendees exposed to intimate partner violence. It implored a cross-sectional descriptive study with sample size of 400. The prevalence of IPV in pregnancy was 27.3%. Among the respondents who experienced IPV, 53.4% (86) did not disclose it. Among those that reported, 29.3% reported to health workers, 20.0% to their parents/siblings and 19.0% committed their spouse to praying. Factors that were statistically associated with disclosure of IPV were educational level ($\chi 2$: 15.023; P-value: 0.02), place of residence ($\chi 2$: 8.019; P-value: 0.018), and living arrangement ($\chi 2$: 8.834; P-value: 0.012).Most of the respondents (74.3%) said they are coping fine; 13.3% are managing to cope and 5.7% find it

stressful coping with IPV. Raising awareness, screening pregnant women, and demonstrating political will ameliorate IPV in pregnancy.

Keywords: Antenatal attendee, disclosure, Intimate partner violence, pregnancy

Introduction

Intimate partner violence (IPV) is a serious threat to public health and is becoming a ubiquitous social injustice against women in both developed and developing nations. It is among the most significant challenges of the day regarding gender, public health, and reproductive health and rights [1,2]. The accomplishment of the Safe Motherhood Initiative's (SMI) objectives is threatened by IPV [3]. Pregnancy-related intimate partner violence has serious impact on a woman's physical, emotional, and social wellbeing and makes it more difficult to fulfil the Sustainable Development Goals (SDGs) 3 and 5. Intimate partner violence is also called domestic violence, domestic abuse, family violence or wife abuse.

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 [4]. 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[5,6].

Intimate partner violence in pregnancy (IPVP) as an important public health and social challenge worldwide that 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[7]. IPVP presents with acute and chronic consequences; including direct, and indirect adverse health consequences on the woman. The poor parenting capacity due to continues IPV experience 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 being future IPV perpetrators or victims of IPV[8,9]. About 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime according to WHO Fact Sheet 2013, with the highest form of violence against women reported in the south-east Asia region (37.7%), followed by the eastern Mediterranean region (37.0%); and the African region which is consistently portrayed as the worst offender, surprisingly takes third place at 36.6% [10].

Six percent of ever pregnant women have experienced physical violence during pregnancy in Nigeria. [11,12] (Benebo et al., 2018; National Population Commission (NPC) [Nigeria] & ICF, 2019).

Disclosure of Intimate partner violence occurs when survivors of violence report or disclose their experience and access range of service aimed at dealing with the consequence of the abuse.
Understanding the prevalence and pattern of IPV disclosure during pregnancy is important as it will alert policy makers and stakeholders on the seriousness of the problem. Information on the prevalence of IPV disclosure will assist health educationists, human right activist and other stakeholders in designing interventions to promote IPV disclosure and subsequent strategies to stop violence against women and girls [13,14].

Disclosure of IPV is poor in African societies and this could be due to the African kingship system, cultural and religious background where family issues are not expected to be discussed outside the marriage/relationship[15]. Furthermore, women are expected to be submissive to their husbands and disclosing information related to violence outside marriage is seen as immoral[7,16]

Coping mechanisms are the ways that people deal with stressful or traumatic situations including intimate partner violence (IPV). Women who experience IPV use various coping mechanisms, which include seeking help and support from formal or informal sources, such as police, domestic violence services, family, religious leaders or friends; regulating their emotions by expressing or suppressing their feelings, using positive self-talk, or finding meaning in their situation; avoiding or distracting themselves from the problem by focusing on other aspects of their lives, such as work, children, or hobbies; resisting or fighting back against the abuser, verbally or physically, or leaving the abusive relationship; appeasing the perpetrators, by complying with their demands, minimizing the abuse, or blaming themselves [17,18].

Poor coping strategies with IPV could increase the risk of mental health impairments such as depression, low self-esteem, psychological distress, and post-traumatic stress disorders according to several studies [19].

This study elucidated the disclosure pattern and the coping perceptions of victims experiencing IPV in pregnancy within the context of the economic and socio-cultural setting in Anambra state, Nigeria. It shows that the Antenatal care clinic (ANC) provides a window of opportunity for identifying women who experience intimate partner violence. It is often the only point of contact for pregnant women within the health-care setting, providing health services and support through the duration of a pregnancy, and the possibility for follow-up. 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 intimate partner violence and its consequences.

Materials and Methods

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 institution has four outstations that run routine antenatal clinics which include the Centre for Community and Primary Healthcare, Neni; the Centre for Community and Primary Healthcare, Ukpo; the Centre of Community/Primary Health Care, Umunya; and the Trauma Centre Oba.

The research was a descriptive cross-sectional study. Data collection was by a quantitative method using a questionnaire adopted from WHO Multi-Country Study on Women's Health and Domestic Violence.

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 study was 400 participants.

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 and signed consent was obtained from each participant

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). 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 followed by 47.0% (188) who had tertiary education. Respondents who had no formal education experienced IPV the most.

Disclosure Pattern of intimate partner violence

Table 2: Reporting of intimate partner violence

Respondent's action following IPV	**Frequency (%)**
Do not report or complain	86(53.4)
Report to health worker/hospital	22(13.7)
Prayers	19(11.8)
Report to parents/siblings	15(9.3)
Report to church leader/ pastor	7(4.4)
Report to partner parents/in-laws	10(6.2)
Report to friends	2(1.2)
Report to law enforcement	0(0.0)
Total	161(100) **

NOTE: **Multiple responses

Table 2 shows the disclosure of experience IPV.

Among the respondents who were positive to IPV screening 53.4% (86) of them did not tell anybody about it. Among those that reported, 29.3% reported to a health worker, 20.0% reported to their parents/siblings, 13.3% reported to the partner parents/in-laws, 9.3% reported to church leader, while 25.3% resorted to prayers. No report was made to the law enforcement agents.

Factors that were statistically associated with disclosure of IPV were educational level ($\chi 2$: 15.023; P-value: 0.02), place of residence ($\chi 2$: 8.019; P-value: 0.018), and living arrangement ($\chi 2$: 8.834; P-value: 0.012).

The more educated women tend to disclose IPV more than the less educated. Women in urban communities tend to disclose IPV more than those residents in rural areas. Women who are living with a partner and partner's relatives tend to disclose IPV less than women living with only their partners.

Coping with IPV by respondents who experienced IPV

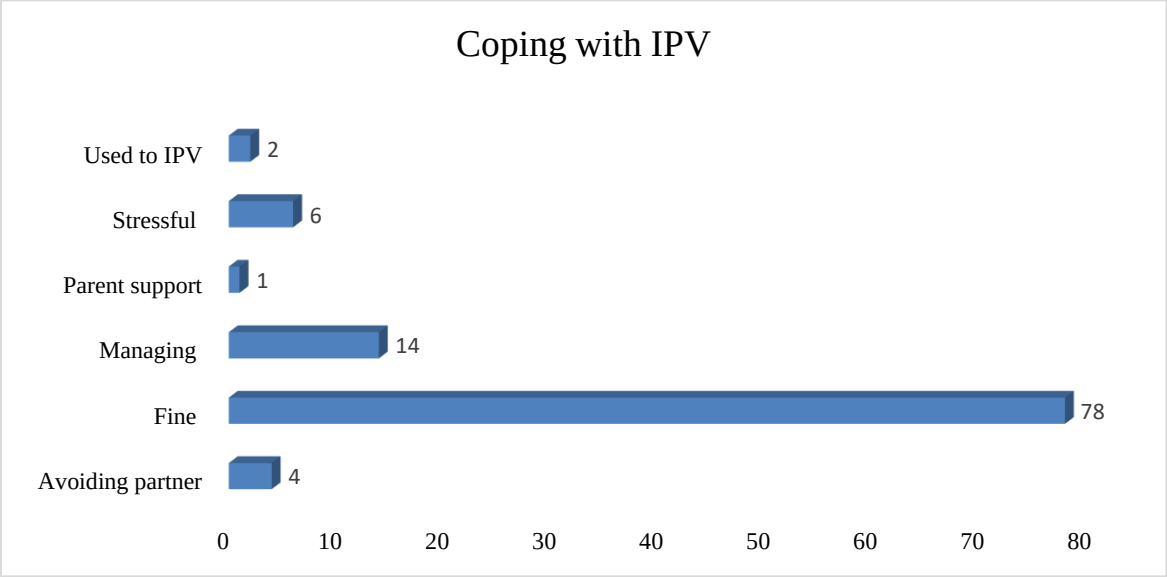

Figure 1: Coping with IPV

Most of the victims said they are coping fine; 14 said they are managing to cope and 6 victims find it stressful coping with IPV.

Discussion

The decision to disclose IPV during pregnancy is complex, influenced by various factors such as fear, stigma, and the potential repercussions for both the woman and

her unborn child. Understanding the barriers and facilitators to disclosure and exploring the coping strategies employed by pregnant women experiencing domestic violence is crucial for tailoring effective interventions and support systems that prioritize their safety and well-being. By examining the disclosure patterns and coping strategies in this specific population, researchers can contribute to reducing the harmful effects of domestic violence on both maternal health and infant outcomes.

From the study half of the respondents (53.4%) did not disclose their experience of IPV to anybody. This may be due to fear of reprisals from their husbands, desire to protect their marriage, ridicule from family members and friends, and religious considerations, to prevent their children from suffering from neglect and abuse. This may explain why a reasonable number of respondents (11.8%) seek divine help through prayers [20]. Most of the respondents that disclosed IPV to their parents sought help from their parents. This is similar to the study by Ayodapo *et al* (2017) where most of the respondents' report was to the family; This substantiates the role of the extended family in arbitrating marital conflicts, including violence, and suggest a divergence from capitalising on established institutions purported to protect women from abuse [20–22]. The believe in prayers by women experiencing IPV enables them to continue to stay and cope with IPV in the relationship. It gives them hope and they are also encouraged by their religious leaders to continue to endure in the relationship because God is against divorce.

No report was made to the law enforcement agents. This is similar to the study by Ayodapo *et al* (2017). One possible reason could be that IPV has been viewed as a private family matter that need not involve law enforcement agencies or criminal justice [22]. Another reason is that some respondents are used to the IPV and have adapted to it.

Most of the respondents experiencing IPV reported that they were coping very fine. The reason given was that they love their spouse (61.9%), and 24.8% said because of the children. The coping strategy could mean accepting IPV as a norm and the victims have adjusted to living in such conditions [5] .This was similar to a study by Katiti V *et al.* (2016) in Northern Tanzania where accepting IPV as a norm was emphasized in the qualitative survey; most of the participants said they were already used to the violence perpetrated by their partners and they are often not worried about it.

***Conclusion*:** Intimate partner violence violates basic human rights and it affects women physically, emotionally, sexually and psychologically. Most pregnant women neither sought help nor reported the incidents because of reasons rooted in culture and religion. While almost all the few that disclosed IPV reported informally. Coping with IPV was

based on accepting IPV as a norm and suffering in the relationship which is not healthy for the women and her unborn baby.

Recommendations: The key to the reducing IPV in pregnancy is first to identify the victims especially those who do not want to disclose IPV at will. It is recommended that screening for IPV should be included in the curriculum of the various health worker cadres and specifically in antenatal care services for antenatal attendees. This will help identify, evaluate, provide counselling and offer management services to victims. Antenatal services offer opportunity for spouses (husbands and male partners) to be invited, educated, and counselled on issues of IPV, so that they will be advocates against IPV. Support group formation will also help in follow-up and reporting of uncontrollable and intractable cases to the appropriate authorities.

Limitation of the study and suggestion for further research:

This study was conducted in a hospital setting, more caution should be considered when extrapolating the findings to the general population. Since this study is restricted to pregnant women visiting prenatal clinics in government-established hospitals, it is unable to make any claims on generalizability. Consequently, more researches utilizing community-based and longitudinal studies will promote a thorough understanding of IPV in pregnancy.

References

1. Shamu S, Munjanja S, Zarowsky C, Shamu P, Temmerman M. Intimate partner violence , forced first sex and adverse pregnancy outcomes in a sample of Zimbabwean women accessing maternal and child health care. 2018;1–10.

2. Shrestha M, Shrestha S, Shrestha B. Domestic violence among antenatal attendees in a Kathmandu hospital and its associated factors: A cross-sectional study. BMC Pregnancy Childbirth. 2016;16(1):1–10.

3. Flaathen EME, Henriksen L, Småstuen MC, Schei B, Taft A, Noll J, et al. Safe Pregnancy intervention for intimate partner violence: a randomised controlled trial in Norway among culturally diverse pregnant women. BMC Pregnancy Childbirth. 2022;22(1):1–15.

4. United Nations. Declaration on the elimination of violence against women,. United Nation; 1994.

5. WHO. Understanding and addressing violence against women [Internet]. Geneva: World Health Organization; 2012. p. 12. Available from: http://apps.who.int/iris/bitstream/10665/77434/1/WHO_RHR_12.37_eng.pdf

6. WHO UNDP. United Nations Office on Drugs and Crime. Geneva: WHO; 2014.

7. Agenagnew L, Tebeje B, Tilahun R. Disclosure of Intimate Partner Violence and Associated Factors among Victimized Women, Ethiopia, 2018: A Community-Based Study. Int J Reprod Med. 2020 Jul 22;2020:1–9.

8. Nabavi RT, Bijandi MS. Bandura's Social Learning Theory & Social Cognitive Learning Theory Title: Bandura's Social Learning Theory & Social Cognitive Learning Theory [Internet]. 2012. Available from: https://www.researchgate.net/publication/267750204

9. Artz S, Jackson MA, Rossiter KR, Nijdam-Jones A, Géczy I, Porteous S. A Comprehensive Review of The Literature on The Impact of Exposure to Intimate Partner Violence for Children and Youth. International Journal of Child, Youth and Family Studies. 2014;5(4):493–587.

10. Azene ZN, Yeshita HY, Mekonnen FA. Intimate partner violence and associated factors among pregnant women attending antenatal care service in Debre Markos town health facilities, Northwest Ethiopia. PLoS One. 2019 Jul 1;14(7).

11. Benebo FO, Schumann B, Vaezghasemi M. Intimate partner violence against women in Nigeria: A multilevel study investigating the effect of women's status and community norms. BMC Womens Health. 2018 Aug 9;18(1).

12. National Population Commission (NPC) [Nigeria], ICF. The DHS Program ICF Rockville, Maryland, USA. 2019 [cited 2021 Mar 25]. p. 748 Nigeria Demographic Health Survey 2018. Available from: https://dhsprogram.com/publications/publication-fr359-dhs-final-reports.cfm

13. Envuladu EA, Chia L, Banwat ME, Lar LA, Agbo HA, Zoakah AI. Domestic violence among pregnant women attending antenatal clinic in a PHC facility in Jos north LGA Plateau State Nigeria. Vol. 1, E3 Journal of Medical Research. 2012.

14. Katiti V, Sigalla GN, Rogathi J, Manongi R, Mushi D. Factors influencing disclosure among women experiencing intimate partner violence during pregnancy in Moshi Municipality, Tanzania. BMC Public Health. 2016 Aug 4;16(1).

15. Sigalla GN, Mushi D, Gammeltoft T. "Staying for the children": The role of natal relatives in supporting women experiencing intimate partner violence during pregnancy in northern Tanzania – A qualitative study. PLoS One. 2018 Jun 1;13(6).

16. Chirwa ED, Sikweyiya Y, Addo-Lartey AA, Alangea DO, Coker-Appiah D, Adanu RMK, et al. Prevalence and risk factors of physical or sexual intimate violence

perpetration amongst men in four districts in the central region of Ghana: Baseline findings from a cluster randomised controlled trial. PLoS One. 2018 Mar 1;13(3).

17. Aysun Babacan Gümüş, Sevinç Şıpkın ÖE. The prevalence of intimate partner violence against women and women's methods of coping with partner violence*. J Psychiatr Nurs. 2020;11(2):79–87.

18. Gormley R, Nicholson V, Parry R, Lee M, Webster K, Sanchez M, et al. Help-Seeking to Cope With Experiences of Violence Among Women Living With HIV in Canada. Violence Against Women. 2021;(X).

19. Barez MA, Babazadeh R, Roudsari RL, Bazaz MM, Najmabadi KM. Women ' s strategies for managing domestic violence during pregnancy : a qualitative study in Iran. Reprod Health. 2022;19(1):1–13.

20. Gormley R, Nicholson V, Parry R, Lee M, Webster K, Sanchez M, et al. Help-Seeking to Cope With Experiences of Violence Among Women Living With HIV in Canada. Violence Against Women. 2021;(X).

21. Ayodapo AO, Sekoni OO, Asuzu MC. Pattern of intimate partner violence disclosure among pregnant women attending ante-natal clinic in Oyo East Local Government , Nigeria. South African Family Practice. 2017;59(2):67–71.

22. Sere Y, Roman N V., Ruiter RAC. Coping With the Experiences of Intimate Partner Violence Among South African Women: Systematic Review and Meta-Synthesis. Vol. 12, Frontiers in Psychiatry. Frontiers Media S.A.; 2021.