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Perceived social support and the experience of intimate partner violence among married and cohabiting young women in urban slums, Ibadan, Nigeria: a descriptive study

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Background Social support is an important factor for improving the outcome of intimate partner violence (IPV) among abused women. Gaps exist on the role of social support among young women who have experienced IPV in Nigeria. Therefore, this study examined the influence of social support on the experience of IPV married and cohabiting young women in urban slums of Ibadan, Nigeria.

Methods This study was a community-based household survey conducted in ten slum communities in the five local government areas of Ibadan municipality among 314 young women. Outcome variable was the experience of physical, psychological and any IPV. Socio-demographic characteristics were summarised using frequency and percentage. Level of statistical significance was set at $\alpha_{0.05}$.

Results The mean age of respondents was 22.25±1.75 years and the mean spousal age difference was 7.15±3.87 years. Majority of the respondents were married (62.1%), and have been in a union for 0–4 years (68.8%). More than half (56.4%) justified IPV perpetration. Majority of the respondents reported having experienced psychological IPV (66.6%) and at least one form of IPV (86.3%) but have never told anyone about their IPV experience (58.1%). Social support was a predictor of psychological and any IPV, but not physical IPV. Type of union and duration of union significantly predicted all forms of IPV.

Conclusion Prevalence of IPV is higher among women in cohabiting relationships. Social support from family and friends helps abused women cope with the experience of IPV. Thus, IPV prevention should target the social support system available to abused women.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Social support helps to mediate, buffer and improve the various outcomes of intimate partner violence (IPV) among abused women.

WHAT THIS STUDY ADDS

⇒ This study provides evidence on the role of social support in the experience of IPV by young women in urban slums in Ibadan, Nigeria. The study showed that IPV is more prevalent among women with low levels of social support, and this is higher among women in cohabiting relationships.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Further research should be conducted on the specific roles played by family members and friends during experience of IPV. In practice, IPV prevention programmes should target family and friends of abused women.

BACKGROUND

Intimate partner violence (IPV) is a prevalent public health problem characterised by the perpetration of physical, sexual or psychological harm by a current or former partner.[1 2] Globally, millions of women are victims of IPV each year and suffer numerous mental, sexual and reproductive consequences.[2 3] IPV is prevalent in Nigeria like other sub-Saharan Africa (SSA) countries with past-year prevalence ranging from 23.6%[4–6] to 70%.[7] IPV may lead to depression and suicide attempts as a result of associated trauma. Traumatic events such as IPV at a young age can lead to more violence in later adulthood, anxiety, isolation, depression and suicidal tendencies. Victims may also suffer low self-esteem which could lead to alienation from sources of help.[8]

It is imperative to identify resources that may help young women experiencing IPV overcome the aftermath of abuse. Evidence has shown that social support is an important factor for mediating, buffering and improving the outcome of IPV among abused women.[9–11] Victims/survivors of IPV mostly seek help from informal sources, such as family and friends.[9 12] Victims prefer these sources because they provide the needed support at the time of the abuse. Family, friends and acquaintances provide alternative housing,

medical care, childcare, social support and other care required by the survivor.[13] On the other hand, availability of social support helps abused women disclose their experience of IPV, and cope with associated mental stress that comes from being abused.

Often, women with low social support suffer more victimisation by an intimate partner.[14–16] In fact, research has shown that experience of IPV decreases with increased level of social support.[13 17 18] This could be because women with high level of social support are empowered to leave an abusive relationship, seek alternative dispute resolution and are less likely to be restricted by the social/traditional norms that encourage women to stay in abusive relationships.

On another hand, some studies have documented that severity of abuse may limit the extent of social support available to a woman.[13 19] Women who experience severe abuse may isolate themselves from close family and friends because of fear of discrimination and rejection.[13] It is also possible that victim's relationship with family and friends have been strained by abusive partner before the abuse became severe, thus, limiting their access to social support. This is common in Africa and particularly Nigeria due to patriarchy. A woman is sometimes made to choose between her partner and close associates when she is in a marital relationship. Often, women in this situation tend to report more experience and severe abuse.

Social support and IPV

According to the stress, social support and buffering hypothesis, presence of social network and social resources have positive effects on health and well-being.[20] Social support acts as a buffer in the link between stress and health outcomes by enhancing coping. Social support measures availability of emotional support (care, trust, love and empathy), tangible support (aids and services); and informational support (advice, suggestions and getting information) to an individual that could help to cope with adverse situations like IPV.[21 22] Availability of social network is linked to an individual's overall well-being. Thus, social support is capable of providing an individual with needed stability and helps to avoid negative experiences such as economic or legal issues that could predict psychological problems or poor health outcomes.[20]

As it relates to IPV, social network available to a woman could protect against economic and psychological stress associated with IPV. This is possible when the people in an individual's social network provide support related to childcare, financial support for legal and medical services, shelter and other psychosocial support as needed by the abused woman. Similarly, availability of social support could help abused women report to formal agencies and integrate properly into the community without fear of discrimination or shame.

Understanding the context of intimate partner violence and social support in Nigeria

IPV is a common occurrence in Nigeria and widely accepted because of predominant patriarchy, social norms and low status of women in the society and at home.[23] Son preference has also been documented as another factor that encourages IPV.[24] Patriarchy, a sociocultural system contributes to gender inequality by supporting men domination of the women folk and giving special privilege to men such as good education, and economic actualisation. Similarly, prevailing social norms supports a man beating his wife as a form of correction and in some instances a show of love.[25] Second, the need to 'remain married' and children involvement make many Nigerian women tolerate abuse in their union because of the stigmatisation associated with divorce.[23 25 26]

In Nigeria, IPV is often considered a private affair to be handled within the family. It is widely believed that dispute should be settled between the couples, and not reported to a third party including family, friends or formal sources.[27 28] Thus, victims/survivors of abuse do not report their experiences and seek help.[12] Some established factors for non-reporting of IPV by women include; fear of partner,[29] financial dependence on partner,[30 31] involvement of children,[32] stigma and shame,[26 33] cultural beliefs,[34 35] lack of social support,[36] acceptance of violence,[37] young age,[28 38] among others.

However, the interference of family members in the union of young couples has been established in the Nigeria culture. The extended family system is quite popular where in-laws, especially mothers-in-law sometimes live with their sons or daughters in their matrimonial homes. This sometimes lead to quarrels between couples, and may lead to IPV if not well managed.[25 39] Again, family members are the first contact victims/survivors of abuse report to because of the unavailability and inaccessibility of formal social and legal services.[25] However, there has been documented evidence that in-laws do not provide the necessary support to the women during experience of abuse, and may accuse the woman of impatience.[25]

In this study, we defined social support as the existence of people who care about an individual and on whom she can depend on when need arises.[40] A slum is 'a contiguous settlement where the inhabitants are characterized as having inadequate housing and basic services'. Slums are characterised by inadequate access to safe water, sanitation and other infrastructure, poor quality housing and overcrowding.[41] Gaps exist on the role of social support among young women who have experienced IPV in Nigeria. Therefore, this study examined the influence of social support on the experience of IPV married and cohabiting young women in urban slums of Ibadan, Nigeria. The findings of the research will provide information on the role of social support and guide in designing programmes for abused young women.

Table 1 Socio-demographic characteristics of young women (n=314)

Characteristics	Frequency (%)
Age of respondents (years)	22.25±1.75
18–19	29 (9.2)
20–24	285 (90.8)
Age of partner (years)	29.40±4.17
<25	27 (8.6)
25 and above	287 (91.4)
Spousal age difference (years)	7.15±3.87
0–4	76 (24.2)
5–9	170 (54.1)
10+	68 (21.7)
Religion	
Christianity	123 (39.2)
Islamic	191 (60.8)
Ethnicity	
Yoruba	294 (93.6)
Others (Igbo, Hausa, Edo, Urhobo, Igbira)	20 (6.4)
Level of education	
Below secondary	43 (13.7)
Secondary and above	271 (86.3)
Employment status	
Unemployed	140 (44.6)
Employed	174 (55.4)
Type of union	
Legally/traditionally married	195 (62.1)
Cohabiting	119 (37.9)
Duration of union (years)	
0–4	216 (68.8)
5+	98 (31.2)
Currently have children	
No	41 (13.1)
Yes	273 (86.9)
Number of children	
1	194 (71.1)
>1	79 (38.9)
Acceptance of IPV	
No	137 (43.6)
Yes	177 (56.4)
Perceived level of social support	
Low	240 (76.4)
High	74 (23.6)
Experience of IPV	
Physical	128 (40.8)
Psychological	209 (66.6)
Any	271 (86.3)
Ever told anyone about IPV experience	
No	157 (58.1)
Yes	113 (41.9)

IPV, intimate partner violence .

Methods

Study area and settings: The study was conducted in the five local government areas (LGAs) of Ibadan, the capital of Oyo State and the third largest metropolitan city in Nigeria. Ibadan is the second largest urban city in South-West Nigeria. The city has a current estimated population of 3 552 000 (2020).[42] It has 51% of the population as women, while adolescents and young women constitute 20% of the total female population. The principal inhabitants of the city are the Yoruba people. Ibadan metropolis has five LGAs - Ibadan North, North-East, North-West, South-East and South-West.

Study design: This study was a community-based household survey.

Study population: Study population were married or cohabiting young women between 18 and 24 years. Young women were eligible for inclusion if they are currently married (traditionally or legally) or cohabiting with their partner. Young women were excluded if they have never been married.

Sample size determination

Sample size was determined using a sample size formula for single proportions. Assuming IPV prevalence of 21% among young women in low-income communities in Ibadan,[43] type 1 error of 5%, 10% non-response rate, we obtained a minimum sample size of 281. A total of 314 young women were interviewed.

Sampling technique

A three-stage sampling technique was adopted, which involved selection of communities and respondents. Ibadan was purposively selected for this study, because it is an urban city with slum residence within the city centre. First, one ward with slum communities was randomly selected from the five LGAs within Ibadan municipality. Second, two slum communities were randomly selected from each ward Ibadan. Households with eligible young women in the communities were visited one after the other until the desired sample size was achieved.

Data collection

A modified version of the WHO Multicountry Study on Women's Health and Domestic Violence[44] and Multidimensional Scale of Perceived Social Support (MSPSS)[45] was used to elicit information from respondents. The MSPSS instrument measures emotional, tangible and informational support available to an individual. The MSPSS is a 7-point Likert scale questionnaire that contains 12 items and assessed support from friends, family and significant others. However, this study assessed adequacy of support from family and friends using 8 out of the 12 questions in MSPSS. For this study, we shortened the options to a 5-point Likert scale structure because of the level of understanding of our respondents. Responses 'very strongly agree/disagree' and 'strongly agree/disagree' were categorised as 'Strongly agree/disagree'. Thus, responses to each item ranges from strongly agree[5]

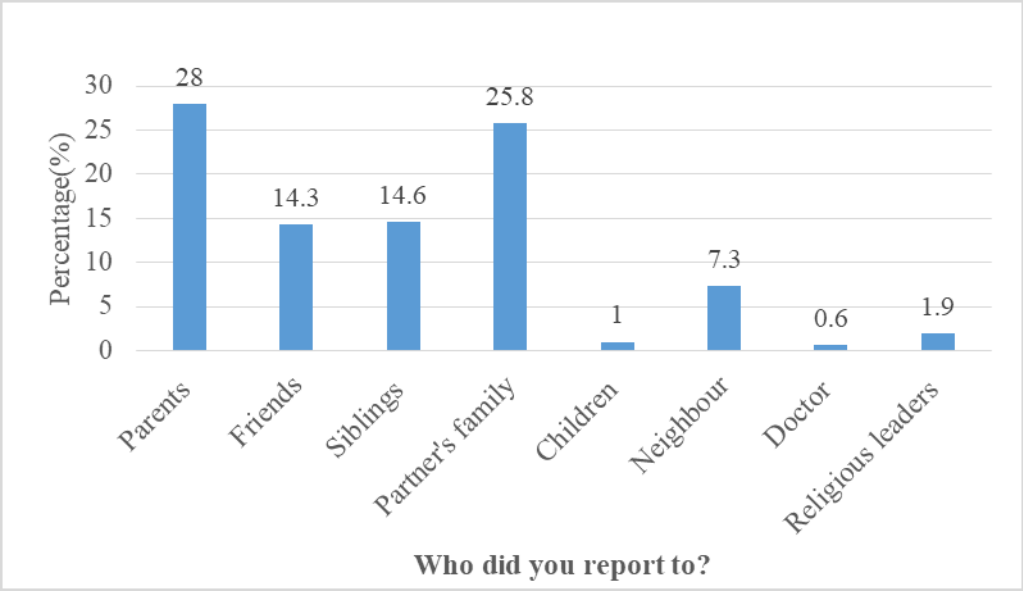

Figure 1 Chart showing respondents' help seeking.

to strongly disagree.[1] Higher score indicates a higher level of perceived social support. Mean±1 SD was used to categorise social support to high or low.

The instrument for data collection was developed in the English language and translated to Yoruba language. Questionnaire was interviewer-administered. Written and verbal consent was obtained from each respondent after explaining the purpose of the study. Data were collected in private spaces provided by the respondents, and discussion changed to menstrual hygiene when there were interruptions. The study did not obtain any identifier, rather respondents were assigned numbers. Respondents who requested for help as related to their experience of IPV were referred to a non-governmental organisation that could assist them.

Data analysis

Socio-demographic characteristics of respondents and partners, experience of IPV and disclosure of IPV were summarised using frequency and percentage used to. Similarly, score for MSPSS was used to categorise the level of support as high and low. Scores above the mean±1 SD were classified as high level of social support and scores below as low social support. Association between IPV, social support and other demographic characteristics were tested using χ^2 test and multivariate analysis was performed using binary logistic regression. Level of statistical significance was set at $\alpha_{0.05}$.

MEASURES

The dependent variable for this study was experience of IPV within 12 months prior to the study. This was measured as a report of at least one experience of either any or all of physical, sexual, psychological IPV in the last 12 months.

The independent variables were: respondent's age (18–24 years)—the age of the respondents was categorised during analysis; religion (Christianity, Islam), ethnicity (Yoruba, others), employment status (unemployed, employed), having children (no, yes), number of children (1, >1), acceptance of IPV (no, yes), perceived level of social support (low, high), ever told anyone of IPV experience (no, yes).

Patient and public involvement

Patient and the public were not involved in the design, conduct, writing and dissemination of the research.

RESULTS

Socio-demographic characteristics of respondents

The mean ages of respondents and partners were 22.25±1.75 years and 29.40±4.17 years, respectively, and the mean spousal age difference was 7.15±3.87 years. Majority of the respondents were in the age group 20–24 years (90.8%), married (62.1%) and have been in a union for 0–4 years (68.8%). More than half justified perpetration of IPV (56.4%). Majority of the respondents reported having experienced psychological IPV (66.6%) and at least one form of IPV (86.3%) but have never told anyone about their IPV experience (58.1%) (table 1). Among abused women that reported experience of IPV, the highest proportion of respondents reported to family members and friends (figure 1).

Experience of IPV by respondents

Table 2 shows the distribution of women by the type of IPV experienced. At the bivariate level, respondent's religion, level of education, type of union, duration of union and acceptance of IPV were significantly associated with physical IPV ($p<0.05$), while religion, type of union, duration of union and perceived level of social support were

Table 2 Distribution of women by type of IPV experienced

Characteristics	Physical violence	χ^2 value (p value)	Psychological violence	χ^2 value (p value)	Any IPV	χ^2 value (p value)
Age (years)						
18–19	12 (41.4)	0.01	21 (72.4)	0.49	26 (89.7)	0.30
20–24	116 (40.7)	(0.547)	188 (66.0)	(0.316)	245 (86.0)	(0.416)
Spousal age difference (years)						
0–4	33 (43.4)		46 (60.5)		68 (89.5)	
5–9	65 (38.2)	0.99	113 (66.5)	2.73	144 (84.7)	1.03
10+	30 (44.1)	(0.610)	50 (73.5)	(0.256)	59 (86.8)	(0.599)
Religion						
Christianity	61 (49.6)	6.53	92 (74.8)	6.16	110 (89.4)	1.67
Islamic	67 (35.7)	(0.007)*	117 (61.3)	(0.009)*	161 (84.3)	(0.130)
Ethnicity						
Yoruba						
Others (Igbo, Hausa,	118 (40.1)	1.58	192 (65.3)	3.49	251 (85.4)	3.39
Edo, Urhobo, Igbira)	10 (50.0)	(0.453)	17 (85.0)	(0.175)	20 (100.0)	(0.184)
Level of education						
Below secondary	27 (62.8)	10.01	28 (65.1)	0.05	41 (95.3)	3.45
Secondary and above	101 (37.3)	(0.001)*	181 (66.8)	(0.478)	230 (84.9)	(0.043)*
Employment status						
Unemployed	60 (42.9)	0.46	87 (62.1)	2.22	122 (87.1)	0.15
Employed	68 (39.1)	(0.287)	122 (70.1)	(0.086)	149 (85.6)	(0.414)
Type of union						
Legal/traditional	69 (35.4)	6.17	121 (62.1)	4.70	162 (83.1)	
Cohabiting	59 ((49.6)	(0.009)*	88 (73.9)	(0.020)*	109 (91.6)	4.54 (0.023)*
Duration of union (years)						
0–4	81 (37.5)	3.05	132 (61.1)	9.23	180 (83.3)	
5+	47 (48.0)	(0.053)*	77 (78.6)	(0.002)*	91 (92.9)	5.17 (0.015)*
Have children						
No	13 (31.7)	1.60	48 (68.3)	0.06	37 (90.2)	0.62
Yes	115 (42.1)	(0.136)	181 (66.3)	(0.476)	234 (85.7)	(0.305)
Acceptance of IPV						
No		7.53	88 (64.2)	0.59	112 (81.8)	4.26
Yes	44 (32.1) 84 (47.5)	(0.004)*	121 (68.4)	(0.258)	159 (89.8)	(0.029)*
Perceived level of social support						
Low	102 (42.5)	1.27	167 (69.6)	4.12	216 (90.0)	11.76
High	26 (35.1)	(0.161)	42 (56.8)	(0.030)*	55 (74.3)	(0.001)*

*Significant at p<0.05.
IPV, intimate partner violence .

associated with psychological IPV; and level of education, type of union, duration of union, acceptance of IPV and perceived level of social support were associated with any type of IPV (p<0.05).

Association between IPV, social support and other demographic characteristics

The data presented in table 3 shows the results of an adjusted logistic regression model of IPV, social support and demographic characteristics. For physical, psychological and any IPV, the odds reduced consistently as the level of social support increased. The likelihood of experiencing psychological and any IPV was lower among respondents with high level of social support than among those with a low level of social support. Social support was not found to be significantly related to physical IPV. The results showed that social support was a predictor of psychological and any IPV, but not physical IPV. Type of union and duration of union also significantly predicted all three forms of IPV. Other identified predictors of physical IPV were religion, level of education and acceptance of IPV, while other predictor of psychological IPV was religion.

DISCUSSION

This study examined the prevalence of IPV among married and cohabiting young women aged 18–24 years in urban slums of Ibadan, Nigeria, and the role of social support. Younger women (18–19 years), women with at least secondary education, in cohabiting relationship and have been in a relationship for less than 5 years

Table 3 Adjusted logistic regression model of IPV experience according to social support and demographic characteristics

Characteristics	Physical IPV AOR (95% CI)	Psychological IPV AOR (95% CI)	Any IPV AOR (95% CI)
Perceived level of social support			
Low (ref)	1.00	1.00	1.00
High	0.76 (0.43 to 1.37)	0.54 (0.31 to 0.95)*	0.32 (0.16 to 0.65)*
Religion			
Christianity (ref)	1.00	1.00	
Islamic	0.52 (0.32 to 0.85)*	0.51 (0.30 to 0.86)*	
Level of education			
Below secondary (ref)	1.00	1.00	1.00
Secondary and above	0.37 (0.19 to 0.75)*	1.29 (0.62 to 2.67)	0.33 (0.07 to 1.48)
Employment status			
Unemployed		1.00	
Employed		1.49 (0.90 to 2.47)	
Type of union			
Legal/traditional (ref)	1.00	1.00	1.00
Cohabiting	1.60 (0.98 to 2.61)	1.94 (1.13 to 3.32)*	2.48 (1.13 to 5.48)*
Duration of union (years)			
0–4 (ref)	1.00	1.00	1.00
5+	1.59 (0.95 to 2.65)*	2.26 (1.27 to 4.02)*	2.46 (1.02 to 5.91)*
Acceptance of IPV			
No (ref)	1.00	1.00	1.00
Yes	1.89 (1.16 to 3.07)*	1.21 (0.74 to 1.99)	1.92 (0.97 to 3.80)*

*Significant at p<0.05.
AOR, adjusted OR; IPV, intimate partner violence .

significantly reported higher level of social support. Multivariate analysis revealed that women in cohabiting relationship, who have been in a relationship for more than 4 years and accepted IPV had significantly higher odds of experiencing IPV, while young women with high level of social support had significantly lower odds of experiencing IPV.

The prevalence of IPV found in this study is higher than the prevalence documented from other studies in SSA[6 46 47] and the National Demographic Survey.[5] These studies were conducted among older women, using data from many countries and the general population. Similarly, the prevalence documented in our study is higher than that reported by a study among female youths in similar setting.[43] Our study was conducted among married and cohabiting young women in the slums and these are established factors that increase experience of IPV.[48 49] The high level of acceptance of IPV could also have accounted for the high prevalence of IPV in our study.

This study showed that younger aged women between 18 and 19 years have a higher level of social support compared with women between 20 and 24 years. In the context of the research area, women in the age group 18–19 years were victims of teenage pregnancy. It is a common practice in the slum for parents to send (‘marry’ off not legally) their pregnant teenage daughters to the man responsible for the pregnancy. It is believed that she is married, even though marriage rites may not be performed. The high level of social support can be connected to the duration of the union among the younger women. In the first few years of marriage, parents still support their newly ‘married’ daughters by providing financial, emotional and other forms of support needed.[50]

We found that high level of social support was protective against IPV as it has been earlier documented that family support is an important protective resource against IPV in some low/middle income countries (LMIC) settings.[13 32 51] IPV may be connected to family member’s involvement in the marriage of their children, and thus allow them to intervene on a woman’s behalf. Similarly, the family members often provide resources that buffer effects of IPV, such as finances, safe space, child support, mediation and emotional support.[32]

Furthermore, young women who were cohabiting had a higher likelihood of experiencing IPV. This is similar to other studies that reported that being married reduces the odds of experiencing IPV.[46 52 53] This can be explained that women in cohabiting relationships do not have the support of their families to be in such union, and as such do not have the necessary social support when they face abuse from their partners. Second, it has been established women in cohabiting relationships have low decision-making power in their relationships,[54] a factor that could predispose to IPV.

This is one of the few studies to study the role of social support in the experience of IPV among married and cohabiting young women in urban slums of Ibadan, Nigeria. The findings could be used to design effective

interventions to prevent and reduce IPV among young women. Some of the limitations of the study included the cross-sectional nature of the study design that does not allow for causality to be established. An advanced mathematical model that uses more variables might provide more inference on the role of social support in the experience of IPV. In addition, qualitative and mixed-method design will provide in-depth understanding about the actual form of support women who experience abuse get from their support systems. Thus, we recommend that future studies could consider a longitudinal and mixed-method design.

CONCLUSION

Prevalence of IPV is high among young women in this study, and particularly higher among women in cohabiting relationships. However, availability of social support from family and friends reduces the experience of IPV. Thus, interventions to prevent and reduce IPV should strengthen these support systems through adequate knowledge. Second, there is a need to focus on reducing IPV among young women in cohabiting relationships.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Consent obtained directly from patient(s).

Ethics approval This study involves human participants and was approved by University of Ibadan/University College Hospital Joint Ethics Institutional Board (Approval Number: UI/EC/20/0122). Participants gave informed consent to participate in the study before taking part.

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