ORIGINAL ARTICLE

Prevalence and predictors for domestic violence among pregnant women in a rural community Northwest, Nigeria

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ABSTRACT

Background: Domestic violence (DV) against women constitutes a violation of human rights. This study aimed at determining the prevalence and predictors for DV among pregnant women in a rural community northwest Nigeria. **Materials and Methods:** A descriptive cross-sectional study which utilised an interviewer-administered semi-structured pretested questionnaire. This assessed the type of DV experienced, the perpetrators and the trigger factor. Logistic regression analysis was used to assess the relative effect of determinants, adjusting for other predictor variables. The dependent variable was the occurrence of DV classified as "Yes" or "No" and the covariates included variables that were significantly associated with DV. **Results:** Of the 314 respondents, 108 (34.3%) had experienced at least one form of DV and the types observed are: Verbal violence 79(68.5%); psychological violence72 (66.7%) and physical violence 55(50.9%). The perpetrators were the current husband in 40 (37.0%); co-wives in 33 (30.6%) and in-laws in 25 (23.1%). Of the cases, domestic issues were the trigger factor in 69 (63.9%) of cases and 54 (50%) of, the incidence was never reported. Ethnicity and type of marriage were significantly associated with occurrence of DV ($P \leq 0.05$) and both remained predictors for DV after controlling for confounders [Adjusted odds ratio (AOR) = 2.20 and 95% C.I = 1.42-11.9; AOR = 4.2 and 95% C.I = 1.36-3.57, respectively]. **Conclusion:** The prevalence of DV in pregnancy is high with women of Hausa/Fulani ethnicity and those in polygamous relationships at a higher risk. Effort should be made to screen pregnant women for DV during antenatal care.

Key words: Domestic violence, pregnant women, Northwest, Nigeria

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INTRODUCTION

According to the United Nations, violence against women is defined as "any act of gender-based violence that results in or is likely in, physical, sexual or psychological harm or suffering to women, including threats of such acts, as coercion or arbitrary deprivation of liberty whether occurring in public or private life".[1] This violence often take place at various levels of the society; it can be directed by the individual (e.g., self harm and suicide), or within members of the family (e.g., intimate partner violence and domestic violence).[2]

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Domestic violence (DV) is a global issue and it cuts across all types of families irrespective of social, racial, economic or religious background and place of residence.[3] It is of special concern in pregnancy because of the effect on the woman and the unborn baby; it is known to be associated with adverse pregnancy outcome such as miscarriage, preterm delivery, low birth weight and perinatal death.[4-7]

Worldwide, at least one in five female has been physically or sexually abused, many of which are young girls and pregnant women.[8] According to the Nigerian demographic health survey (NDHS) of 2013, 5.0% women experienced violence in pregnancy and this is influenced by the level of education, employment status and marital status. There were zonal variations as 9% of women from the south-south had experienced violence in pregnancy in contrast to 1.8% in the northwest zone.[9] However, facility-based prevalence of DV among pregnant women attending antenatal care in various part of the country varies from 7.4% in Kano[10] to 37.4% in Abuja.[11] In recent times, several studies have being done on DV in Nigeria, majority of which

are from urban-based centres and few are from the rural areas. We, therefore, sought to identify the prevalence, common types of DV occurring in this rural community and predictors; these findings would bring this problem to the attention of the public and would assist in planning interventions to reduce the prevalence and the associated consequences of DV in the community.

MATERIALS AND METHODS

This study was conducted at a health facility in Birnin-kudu and the study population consisted of pregnant women attending the antenatal clinic of the institution.

The study was descriptive and cross-sectional in design. The sample size was calculated from the expression $N = z^2pq/d^2$ where z is the normal standard deviate set at 1.96, confidence level specified at 95%, the tolerable error margin (d) at 5% and based on prevalence of 7.4% on DV in northern Nigeria.[10] A sample of 296 was obtained and adjusted to compensate for a non-response rate of 10%; the final minimum sample size was 326.

A structured interviewer-administered questionnaire adapted from 2008 Nigerian Demographic and Health Survey (NDHS)[9] was used. The instrument assessed the socio-demographic characteristics, the duration of pregnancy, husbands' occupation and social habits. It also assessed the occurrence of DV, the perpetrators, the response and support received.

The study proposal was approved by the Ethics and Research committee of the institution and informed consent was obtained from the participants.

The data was analysed using SPSS version 17.0. Qualitative variables were summarised using frequencies and percentages, while quantitative variables were summarised using mean and standard deviation. Association between socio-demographic characteristics and occurrence of DV was carried out using the Chi-square test or Fishers exact test as applicable. Statistical significance was considered achieved when the *P*-value was ≤ 0.05. Logistic regression analysis was used to assess the relative effect of determinants, adjusting for other predictor variables.

RESULTS

During the study period, 326 respondents were approached to participate in the study but 314 (96.3%) agreed to participate.

The ages of the respondents ranged from 16 to 45 years with a mean of 24.7 ± 5.8 while the parity ranged from 0 to 12. They were all married, 179 (57.0%) were in a monogamous relationship while 135 (43.0%) were in polygamous relationship. Three-hundred and five (97.1%) were Muslims while 9 (2.9%) were Christians. Two-hundred and forty-two (77.1%) were of Hausa ethnicity and 116 (36.9%) had informal form of education only. One-hundred and thirteen (36.0%) were housewives, 114 (36.3%) were petty traders, 67 (21.3%) were Seamstresses while 20 (6.3%) were employed by the civil service. The gestational age of the pregnancy at enrollment for antenatal care varied from 8 to 40 weeks with a median of 28.0 ± 7.4 weeks. None of the women smoked cigarette nor consumed alcohol while 16 (5%) of their husbands smoked cigarette but none consumed alcohol. The husbands' occupations were civil service 146 (46.5%), trading 144 (45.9%), farming 15 (4.7%) and 2.9% others: Drivers, carpenters and tailors. Table 1 shows the socio-demographic characteristics of the respondents.

Of the 314 respondents, 108 (34.4%) had at least one form of violence with each occurring in various percentages as shown in Table 2. Physical form of violence was observed in 55 (50.9%) of the survivors while verbal abuse was noted in 74 (68.5%) of the survivors.

The perpetrators were current husband in 40 (37.0%); co-wives in 33 (30.6%) and in-laws in 25 (23.1%) of the cases of DV while the siblings and former husband/partner accounted for 10 (9.3%) and 5 (4.7%) of the cases, respectively.

The survivors never reported the incidence to anyone in 54 (50.0%) of cases but those that reported sought support with their own family in 27 (25.0%), from friends in 8 (7.4%), from husbands family in 7 (6.5%) and the law

Table 1: Socio-demographic characteristics (*N* = 314)

Socio-demographic characteristics	*n* (%)
Age	
<20	42 (13.1)
20-29	194 (61.8)
30-39	72 (22.9)
40≥	7 (2.2)
Parity	
0	76 (24.2)
1	48 (15.3)
2	40 (12.7)
3	34 (10.8)
4	28 (8.9)
5≥	88 (28.0)
Ethnicity	
Hausa	242 (77.1)
Fulani	55 (17.5)
Igbo	5 (1.7)
Others (Yoruba, Kanuri, Bareberi, Nupe, Higgi, Kushe)	12 (3.8)
Education	
Quranic	116 (36.9)
Primary	73 (23.3)
Secondary	85 (27.1)
Tertiary	40 (12.7)

enforcement agents in 5 (4.6%) of cases. The incidences were reported to the husbands in 4 (3.7%), to health-care workers and religious leaders in 2 (1.9%) and 2 (1.9%) cases, respectively.

The trigger factors for the incidence were domestic issues in 69 (63.9%) of cases, financial issues in 15 (13.9%) and attending antenatal care in 11 (10.2%). Others include having female children alone 7 (6.5%), unplanned pregnancy 5 (4.6%) while request to do HIV screening and unemployment were also identified as trigger factors in 3 (2.7%) cases each.

Ethnicity and marriage setting were significantly associated with socio-demographic characteristics as shown in Table 3. After controlling for confounders, ethnicity (P = 0.009, OR = 2.20 and 95% C.I = 1.42-11.9) and type of marriage (P = 0.001, OR = 4.2 and 95% C.I = 1.36 lower and upper limit 3.57) were identified as predictors for DV as shown in Table 4.

DISCUSSION

Although DV is common in the community as one in three of the pregnant women studied had experienced one form or another, a significant proportion remained unreported. Globally, there have been efforts directed at creating awareness, encouraging reporting and supporting survivors; but there appears to be little changes in rural communities. Psychological and verbal forms of violence as noted in other studies[11-17] were commoner among the women. These forms of violence are often difficult to recognise but may be more harmful and damaging to the survivor. About half of the survivors had physical forms of violence which could lead to loss of pregnancy, maternal morbidity and mortality. The perpetrators were the current husbands, the co-wives and the in-laws' with the main trigger factor being domestic issues. More of the women who suffered DV were of Hausa/Fulani ethnicity and in polygamous relationships. It is known that women in polygamous relationships are often suspicious of each other due to jealousy, perceived preference and search for husbands' attention[10] which may lead to DV especially when they all cohabit in the same house.

This study was facility based hence caution should be exercised in generalising the findings to the larger community since only 41% of pregnant women in northwest Nigeria receive antenatal care.[9] The survivors of the violence were not followed up to determine the outcome of the pregnancy and possible-associated complications. Also because of the sensitive nature of DV, the responses obtained from the participants surveyed may not be a true reflection of the situation. Finally, violence in pregnancy has been associated with low socio-economic status,[14] this was not considered in the design of the study because of difficulty in ascertaining the level among the study population. Nevertheless, useful information concerning DV in this setting were generated.

Table 2: Distribution of types of Domestic violence in pregnancy (N = 108)

*Types of Domestic violence	N (%)
Hurt your feelings deliberately	72 (66.7)
Verbally abused you	69 (63.9)
Slapped you	28 (25.9)
Kick, drag or beat you	17 (15.7)
Twisted your arm or pulled your hair	16 (14.8)
Pushed, shake or throw something at you	14 (13.0)
Physically forced to have sexual intercourse against your will	11 (10.2)
Punched you	10 (9.3)
Try to choke or burn you on purpose	8 (7.4)
Threaten to attack you with a weapon	5 (4.6)

*Multiple responses observed

Table 3: Association between occurrence of domestic violence and socio-demographic characteristics of respondent (N = 314)

Socio-demographic characteristic	Domestic violence		Chi-squared test (χ^2)	P-value
	Yes N (%)	No N (%)		
Age, years			0.25	0.62
<30	79 (73.1)	156 (75.7)		
≥30	29 (26.9)	50 (24.3)		
Ethnicity			5.85	0.016
Hausa/Fulani	98 (90.7)	199 (97.1)		
Others	10 (9.3)	7 (2.9)		
Religion			Fishers	0.07
Islam	102 (94.5)	203 (98.5)		
Christianity	6 (5.6)	3 (1.5)		
Occupation			0.92	0.34
Unemployed	35 (32.4)	78 (37.9)		
Employed	73 (67.6)	128 (62.1)		
Education			0.049	0.83
Informal	39 (36.1)	77 (37.4)		
Formal	69 (63.9)	129 (62.6)		
Parity			1.75	0.42
0	26 (24.1)	50 (24.3)		
1-4	47 (43.5)	103 (50.0)		
≥5	35 (32.4)	53 (25.7)		
Marriage setting			9.1	0.003
Monogamous	49 (45.4)	130 (63.1)		
Polygamous	59 (54.6)	76 (36.9)		

Table 4: Predictors of domestic violence among pregnant women

Predictor	Crude OR	Adjusted OR (95%CI)	P
Marriage setting			
Polygamous	2.06 (1.28-3.30)	2.20 (1.36-3.57)	0.001
Monogamous	Referent		
Ethnicity			
Others	Referent		0.009
Hausa/Fulani	3.38 (1.20-9.58)	4.2 (1.42-11.9)	

Although it may be difficult to compare studies with different methodologies, research instruments and study population, the prevalence of DV reported by pregnant women in this study of 34.3% is similar to 37.4% reported

by Efetie in Abuja[11] but is higher than the 7.4% reported by Iliyasu from Kano[10] and the 11.8% by Ameh from Zaria[15] all in the same geopolitical zone as well as 12.6% reported by Gyuse from Jos.[16] It is also higher than the 4%-29% reported in Asian countries by Nasir.[17] The verbal form of violence was the commonest in this study, noted in 68.5% of the survivors and it is similar to the 66.2% from Abeokuta[12] but higher than the 52.3% from Lagos[13] though this was also the commonest form observed in that survey. The psychological form of violence was observed in 66.7% of survivors and it is similar to the 66.4% from Abuja[11] but departs from the findings from Kano where physical violence was the commonest form of violence accounting for 58.6%;[10] while in Jos[18] the sexual violence was the commonest form of DV occurring in 60.9% of the cases. The main perpetrators' in most of the cases were the current husband which was noted in 37.0% followed by co-wives in 30.6%. The spouse was noted to be the commonest perpetrator in the study in Zaria[19] and Kano[10] accounting for 34% and 58.6%, respectively. It is interesting to note that majority (50%) of the survivors kept this incidence to themselves and never sought support; this is similar to findings from Zaria[19]but departs from the findings from Kano,[10] Abeokuta[12] and Lagos.[13]

Healthcare workers in this community should be aware of the existence of DV in pregnancy and that many of the cases are unreported possibly due to fear of reprisal. It is imperative for healthcare workers to have a high index of suspicion and screen for DV especially physical violence during antenatal care. Domestic violence constitutes a violation of human rights and policy makers may need to consider strengthening the laws on violence against women to encourage prosecution in the community.

This study did not establish if the survivors of DV in this study had being abused by their current husband/ partners or family members before the index pregnancy and should they have been violated, was there any change in the frequency and the type of violence? Based on the above, we would recommend a prospective population based study of survivors of DV in pregnancy; this study should take into cognizance the occurrence of DV before pregnancy and should explore the outcome of pregnancy among the survivors.

CONCLUSIONS

The prevalence of DV in pregnancy is high in the community with women of the Hausa/Fulani ethnic group and those in polygamous relationships more susceptible. Effort should be made to screen pregnant women for DV during antenatal care since majority of the cases are unreported.

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