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Intimate partner violence among pregnant women in a tertiary hospital in Niger delta, Nigeria: The role of socioeconomic factors and cultural acceptance

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Abstract

Background: Intimate partner violence (IPV) represents a significant public health concern, particularly among pregnant women who face heightened vulnerability. This study assessed the prevalence, patterns, and determinants of IPV among pregnant women at Rivers State University Teaching Hospital (RSUTH), with a focus on the roles of socioeconomic status (SES) and cultural acceptance (CA).

Methods: In this cross-sectional study, 359 pregnant women attending antenatal care at RSUTH were surveyed using a structured questionnaire. The instrument collected data on socio-demographic characteristics and detailed IPV experiences including severe combined abuse, physical abuse, emotional abuse, and harassment. Data analysis was performed using descriptive statistics and One-Way MANOVA to evaluate the impact of SES and CA on IPV patterns.

Results: Overall, 68.0% of respondents reported experiencing IPV at least once. Severe combined abuse was observed in 51.3% of cases (with 48.7% reporting repeated episodes), while physical abuse was reported by 73.8% of women, and emotional abuse affected 56.3% once and 43.5% repeatedly. Harassment was notably prevalent, with 40.4% experiencing it once and 51.0% repeatedly. Analysis revealed that lower SES was significantly associated with a higher prevalence of physical abuse ($F=24.882, p<0.001$), whereas higher SES correlated with increased harassment ($F=8.546, P=0.004$). Furthermore, greater cultural acceptance was significantly linked to both physical abuse ($F=4.679, P=0.031$) and harassment ($T=8.077, P=0.005$).

Conclusion: The high prevalence of IPV among pregnant women at RSUTH, along with its significant association with socioeconomic and cultural factors, underscores the urgent need for culturally sensitive screening and intervention strategies. These findings highlight the importance of addressing both economic empowerment and cultural norms in efforts to mitigate IPV and improve maternal and neonatal health outcomes.

Keywords: Intimate partner violence, pregnancy, socioeconomic status, cultural acceptance, maternal health

Introduction

Intimate partner violence (IPV) is a significant global public health concern, encompassing physical, sexual, and psychological abuse disproportionately affecting women. IPV is defined as any behaviour that can cause physical, sexual, or psychological harm by a current or former intimate partner [2]. The World Health Organization (WHO) reports that nearly one in three women worldwide have experienced physical and/or sexual violence by an intimate partner or non-partner sexual violence. IPV takes various forms: physical violence, sexual violence, stalking, psychological aggression, etc.

Pregnancy is a period of increased vulnerability to IPV, with severe health consequences for both mother and foetus [3]. The physiological and psychological changes during pregnancy can exacerbate existing vulnerabilities or create new ones, making women more susceptible to abuse [4]. Moreover, pregnancy is a period that demands more partner commitment and increased resource supply. The prevalence of IPV during pregnancy varies across regions, with higher rates often reported in low- and middle-income countries (LMICs) [5]. In sub-Saharan Africa, for instance, four out of every ten women have experienced IPV [6, 7]. A systematic review highlights that IPV during pregnancy is associated with devastating maternal, perinatal, and neonatal health effects. The consequences of IPV during pregnancy include preterm birth, low birth weight, maternal mental health disorders, homicide, and suicide [3, 8].

In Nigeria, socioeconomic factors and cultural norms play a significant role in shaping the experiences of pregnant women, potentially influencing their exposure to IPV [9]. A study examining the effect of individual and community-level factors on IPV in Nigeria found that women's status and community norms are significant predictors of IPV [9].

Rivers State University Teaching Hospital (RSUTH) serves a diverse population within the state. Understanding the prevalence and patterns of IPV among pregnant women attending RSUTH is critical for developing targeted, culturally appropriate interventions. This study aims to examine the role of socioeconomic factors and cultural acceptance in the experience of IPV among pregnant women seeking antenatal care at RSUTH.

Despite increasing global awareness of IPV, reliable data on the prevalence and determinants of IPV among pregnant women in Rivers State remain limited. This lack of comprehensive research hinders the development and implementation of effective prevention and intervention strategies. There is a pressing need to explore the specific patterns of IPV, the association between socioeconomic factors and IPV, the influence of cultural acceptance, and the combined effect of these factors on the experience of IPV among pregnant women attending RSUTH. The study will provide crucial data on the prevalence and patterns of IPV among pregnant women in Rivers State, contributing to a better understanding of this public health issue. The findings will inform the development of targeted interventions and support services for pregnant women experiencing IPV at RSUTH. The study will shed light on the role of socioeconomic factors and cultural acceptance in IPV, enabling the design of culturally sensitive prevention strategies. It will add to the limited research on IPV among pregnant women in the Nigerian context. It will emphasize the necessity for stronger healthcare system responses to IPV.

IPV is defined as physical, sexual, or psychological harm by a current or former intimate partner. The World Health Organization (WHO) identifies IPV as a major public health concern affecting millions of women worldwide [1]. IPV manifests in various forms, including physical aggression (hitting, kicking), sexual coercion, emotional abuse (insults, threats), and controlling behaviours (restricting access to healthcare, finances, or social networks) [3]. Pregnant women are particularly vulnerable due to physiological and emotional changes associated with pregnancy, which can exacerbate tensions in relationships [4].

Prevalence of IPV during pregnancy

The prevalence of IPV during pregnancy varies significantly across regions. James *et al.* in a meta-analysis found that IPV among pregnant women ranged from 2% to 57%, with the highest rates in low- and middle-income countries (LMICs) [5]. While their study provided a broad overview, one limitation was the heterogeneity of methodologies across studies included in the review, leading to potential inconsistencies in reported prevalence rates.

Makayoto *et al.* examined IPV prevalence in Kenya and found that 37% of pregnant women experienced some form of IPV.6 The study's strength lies in its focus on a specific regional context; however, it relied on self-reported data, which may introduce recall bias. Similarly, a study by Taillieu and Brownridge highlighted IPV patterns and risk factors, noting a high prevalence in African countries [8]. This study was notable for its rigorous methodological approach but was limited by its reliance on secondary data sources, restricting real-time insights.

Risk Factors for IPV during pregnancy

Several studies have identified common risk factors for IPV, categorized into individual, relational, community, and societal levels.

- **Socioeconomic Factors:** Yaya *et al.* examined the influence of economic factors on IPV and found that financial dependence on a partner during the pregnant state increased vulnerability to IPV [9]. While their study provided valuable insights, it lacked qualitative perspectives that could have further explored the lived experiences of affected women. Bolarinwa *et al.* conducted a spatial analysis of IPV predictors in Nigeria, offering a detailed understanding of regional disparities in IPV prevalence. However, the study's reliance on cross-sectional data limited its ability to establish causation [10].
- **Cultural Norms and Acceptance:** Benebo *et al.* explored the effect of community norms on IPV in Nigeria, concluding that cultural tolerance for IPV perpetuates its prevalence [11]. Benebo *et al.* found that IPV is often justified as a means of discipline, reinforcing societal acceptance. This multilevel study was methodologically robust; however, their study lacked qualitative testimonies from affected women, and its conclusions were drawn from secondary data, which may not fully capture contemporary social dynamics.
- **Partner-Related Factors:** In a meta-analytic review, Cafferky *et al.* linked substance abuse to IPV [12]. Their study was comprehensive, analyzing data from multiple sources, but it did not explore contextual differences between high-income and low-income settings. Widom *et al.* investigated childhood abuse as a predictor of IPV perpetration, finding strong correlations.13 However, their prospective design, while valuable, did not account for potential confounders such as socioeconomic shifts over time.
- **Pregnancy-Related Factors:** James *et al.* noted that pregnancy itself can trigger IPV, particularly in cases of unplanned pregnancies [5]. This assertion aligns with findings from Mandal *et al.*, who also identified postpartum mental health issues linked to IPV [14]. However, Mandal *et al.*'s study was cross-sectional, limiting its ability to assess long-term effects.
- **Lack of Legal Protection:** Kibuye and Kasungu noted that while Nigeria has laws against IPV, enforcement is weak. Kibuye focused on healthcare responses, whereas Kasungu examined societal perceptions, both offering complementary insights [15, 16].

IPV during pregnancy has significant consequences for maternal and foetal health, namely:

Maternal Health Complications: Studies by Taillieu and Brownridge and Mandal *et al.* showed that exposure to violence increases the risk of hypertension, premature rupture of membranes, and increased risk of infections. Both studies employed rigorous methodologies, but Mandal *et al.* failed to explore how healthcare systems could better support victims [8, 14].

Fetal and Neonatal Outcomes: Gantenbein and Kanaka-Gantenbein examined intrauterine growth restriction (IUGR) due to IPV and its link to future obesity. Their study's strength lies in its longitudinal approach, but it primarily focused on physiological impacts, neglecting psychological consequences.

Impact on Healthcare Utilization: Kibuye explored how IPV affects antenatal care (ANC) attendance in Kenya. The study's qualitative approach provided rich insights but lacked a large-scale quantitative component for broader applicability.

Negative health behaviours: IPV in pregnancy is associated with some harmful health behaviours such as smoking, alcohol indulgence, substance abuse, etc., all aimed at coping with the pressure and suffering from the IPV.

Despite extensive research on IPV, significant gaps remain; limited studies specifically examine the combined influence of socioeconomic factors and cultural acceptance on IPV among pregnant women in Rivers State. And more research is needed on the role of healthcare institutions in addressing IPV during pregnancy.

Materials and Methods

Study Design

This study employed a cross-sectional design to examine the prevalence, patterns, and influencing factors of intimate partner violence (IPV) among pregnant women attending Rivers State University Teaching Hospital (RSUTH). A structured questionnaire was used to collect data on socio-demographic characteristics, IPV experiences, and influencing factors such as socioeconomic status (SES) and cultural acceptance (CA).

Study Population

The study population comprised pregnant women attending antenatal care (ANC) at RSUTH. Inclusion criteria included women who were in any trimester of pregnancy and consented to participate in the study. Exclusion criteria involved women who declined participation or had high-risk pregnancies requiring urgent medical attention.

Sampling Technique and Sample Size

A convenient sampling technique was employed to ensure diverse representation of pregnant women across different socioeconomic backgrounds. The sample size consisted of 359 respondents, determined based on statistical power calculations to ensure reliability in assessing IPV prevalence and associated factors.

Data Collection Methods

A validated structured questionnaire was administered through face-to-face interviews. The questionnaire covered socio-demographic information (age, marital status, education, employment status), IPV prevalence and patterns (physical abuse, emotional abuse, harassment, severe combined abuse), Socioeconomic and cultural influences on IPV

Data Analysis

The collected data were analyzed using SPSS software. Descriptive statistics such as frequencies and percentages were used to summarize socio-demographic characteristics and IPV prevalence. Inferential statistical tests, including One-Way MANOVA, were conducted to assess the influence of SES and cultural acceptance on IPV experiences.

Ethical Considerations

Ethical approval was obtained from the RSUTH ethics committee. Participants provided informed consent, and confidentiality was maintained throughout the study.

Results

Socio-Demographic Characteristics

The socio-demographic analysis of respondents at Rivers State University Teaching Hospital highlights that IPV predominantly affects women in their reproductive years, with most (67.7%) aged 30-39 years, followed by 22.8% in the 20-29 age group. A smaller proportion (7.2%) fall between 40-49 years, and only 2.2% are under 20, with none above 50. The majority (94.4%) are married, while 3.9% are divorced, and 1.4% are separated. Educationally, 36.8% have tertiary education, 29.0% primary, 28.1% secondary, and 6.1% have no formal education. Employment-wise, all respondents work in either the private (22.8%) or public (77.2%) sectors, with none self-employed or unemployed. Despite financial independence, IPV persists across various educational and employment backgrounds, indicating that economic stability alone does not protect against abuse. These findings suggest that IPV is a widespread issue affecting women of different marital, educational, and occupational statuses.

Table 1: Socio-demographic analysis of the respondents

Variables	Sub-variables	Frequency (Percentage)
Age of the respondent	Less than 20yrs	8(2.2%)
	20-29yrs	82(22.8%)
	30-39yrs	243(67.7%)
	40-49yrs	26(7.2%)
	More than 50yrs	0 (0%)
Marital status	Single	1 (.3%)
	Separated	5(1.4%)
	Married	339(94.4%)
	Divorced	14(3.9%)
	Cohabiting	0(0%)
	Widowed	0 (0%)
Educational Level	None at all	22(6.1%)
	Primary	104(29.0%)
	Secondary	101(28.1%)
	Tertiary	132(36.8%)
Employment Status	Unemployed	0(0%)
	Employed with private	82(22.8%)
	Employed with public	277 (77.2%)
	Self-employed	0(0%)

Prevalence and patterns of intimate partner violence among pregnant women attending Rivers State University Teaching Hospital

The analysis of IPV among pregnant women at Rivers State University Teaching Hospital highlights a significant prevalence of abuse. Severe combined abuse affects 51.3% of women at least once, with 48.7% experiencing repeated instances, though none report frequent or daily occurrences, suggesting episodic rather than continuous abuse. Physical abuse is also widespread, with 73.8% experiencing it once and 7.2% multiple times, while 18.9% report never experiencing it. Emotional abuse is prevalent, affecting 56.3% once and 43.5% repeatedly, indicating psychological violence as a major issue. Harassment is highly reported, with 40.4% experiencing it once, 51.0% repeatedly, and 1.3% daily, suggesting a persistent form of IPV. Overall, 68.0% of respondents have experienced IPV at least once, with 32.0% facing multiple instances, emphasizing the widespread nature of IPV, particularly emotional abuse and harassment, even if not occurring daily.

Table 2: Number count and percentage of Prevalence and patterns of intimate partner violence among pregnant women attending a Nigerian healthcare facility

Pattern of IPV	Frequency of Occurrence of IPV	Prevalence of IPV
Severe Combined Abuse	Never	0(0%)
	Once	184(51.3%)
	Several Times	175(48.7%)
	Once Monthly/Weekly (Frequently)	0(0%)
	Daily	0 (0%)
Physical Abuse	Never	68(18.9%)
	Once	265(73.8%)
	Several Times	26(7.2%)
	Once Monthly/Weekly (frequently)	0(0%)
	Daily	0 (0%)
Emotional Abuse	Never	0(0%)
	Once	203(56.3%)
	Several Times	156(43.5%)
	Once Monthly/Weekly (Frequently)	0(0%)
	Daily	0 (0%)
Harassment	Never	0(0%)
	Once	145(40.4%)
	Several Times	183(51.0%)
	Once Monthly/Weekly (Frequently)	31(8.6%)
	Daily	2 (1.3%)
Overall Abuse/Violence	Never	0(0%)
	Once	244(68.0%)
	Several Times	115(32.0%)
	Once Monthly/Weekly (Frequently)	0(0%)
	Daily	0(0%)

Influence of socioeconomic factors on intimate partner violence among pregnant women attending Rivers State University Teaching Hospital

The analysis of socioeconomic status (SES) on IPV among pregnant women at RSUTH reveals varying trends across different abuse patterns. Severe combined abuse and emotional abuse show no significant differences between high and low SES groups, suggesting that these forms of IPV affect women regardless of economic status. However, physical abuse is significantly more prevalent among low SES women (F=24.882,

P=.000), likely due to financial stress and dependency. Conversely, harassment is more pronounced among high SES women (F=8.546, P=.004), possibly linked to controlling behaviors and emotional manipulation. Overall, while IPV affects women across all SES levels, physical abuse is more common among lower SES women, whereas harassment is higher among those with higher SES. The multivariate test confirms that SES significantly influences different IPV patterns (Wilk’s Λ = 8.112, P=.000).

Table 3: One-Way MANOVA analysis of the influence of socioeconomic Status (SES) factors on intimate partner violence among pregnant women attending Rivers State University Teaching Hospital

IPV Pattern	SES Level	Mean	Std. Dev	N	Uni Test(f)	Sig	Multi (t)	Sig
Severe Combine	High SES	15.9615	4.34033	26	.000	.999	.8.112	.000
	Low SES	15.9610	3.86695	333				
	Total	15.9610	3.89652	359				
Emotional	High SES	18.1154	4.76090	26	.302	.583		
	Low SES	18.5285	3.59676	333				
	Total	18.4986	3.68666	359				
Physical	High SES	7.0769	1.57285	26	24.882	.000		
	Low SES	9.4925	2.42802	333				
	Total	9.3175	2.45621	359				
Harassment	High SES	10.5769	1.83680	26	8.546	.004		
	Low SES	9.2913	2.18204	333				
	Total	9.3844	2.18230	359				

Influence of cultural acceptance on intimate partner violence among pregnant women attending Rivers State University Teaching Hospital

The analysis of cultural acceptance (CA) on IPV among pregnant women at RSUTH reveals distinct patterns across different forms of abuse. Cultural acceptance does not significantly influence severe combined abuse (F=.003, P=.958) or emotional abuse (T=.094, P=.760), suggesting that these forms of IPV are normalized across different cultural settings. However, physical abuse is significantly higher among women

with high CA (F=4.679, P=.031), indicating that those who accept cultural norms justifying IPV are more likely to experience physical violence. Similarly, harassment is more prevalent among women with high CA (T=8.077, P=.005), potentially due to societal expectations that pressure women into tolerating controlling behaviours. Overall, while CA does not impact all IPV types equally, it significantly influences physical abuse and harassment. The multivariate test (F=4.106, P=.003) confirms that cultural acceptance levels statistically affect different IPV patterns, highlighting the role of cultural norms in

sustaining IPV experiences.

Table 4: One-Way MANOVA analysis of the influence of extent of cultural acceptance (CA) factors on intimate partner violence among pregnant women attending Rivers State University Teaching Hospital

IPV Pattern	CA Level	Mean	Std. Dev	N	Uni (t)	Sig	Multi	Sig
Severe Combine	High CA	15.9758	2.63949	124	.003	.958		
	Low CA	15.9532	4.42337	235				
	Total	15.9610	3.89652	359				
Emotional	High CA	18.5806	3.15223	124	.094	.760		
	Low CA	18.4553	3.94529	235				
	Total	18.4986	3.68666	359				
Physical	High CA	9.7016	1.88697	124	4.679	.031	4.106	.003
	Low CA	9.1149	2.69052	235				
	Total	9.3175	2.45621	359				
Harassment	High CA	9.8306	1.64649	124	8.077	.005		
	Low CA	9.1489	2.38746	235				
	Total	9.3844	2.18230	359				

Influence of socioeconomic factors (SES) and extent of cultural acceptance on intimate partner violence among pregnant women attending Rivers State University Teaching Hospital

The analysis of SES and CA on IPV among pregnant women at RSUTH shows varying effects across different forms of abuse. Severe combined abuse and emotional abuse do not exhibit statistically significant differences based on SES and CA levels ($F=3.138$, $P=.077$; $F=3.737$, $P=.054$), though high SES women with high CA report slightly higher emotional abuse levels. Physical abuse also shows weak associations, with women who have high CA experiencing slightly higher abuse, but the overall test statistic ($F=.929$, $P=.336$) suggests no significant impact of SES. However, harassment demonstrates a statistically significant difference ($F=5.812$, $P=.016$), with women of high SES and high CA reporting the highest levels. This suggests that cultural acceptance, particularly among higher SES groups, may contribute to normalized controlling behaviors. Despite these findings, the multivariate test (Wilk's $\Lambda = 2.229$, $P=.059$) indicates that SES and CA do not have a statistically significant overall influence on IPV patterns among pregnant women.

Discussion

In this cross-sectional study, a total of 359 pregnant women were interviewed. The results show that severe combined abuse affects 51.3% of women at least once, with 48.7% experiencing repeated instances. This study showed that IPV is common among pregnant women. This finding aligns with previous research, demonstrating that IPV is widespread among pregnant women, particularly in LMICs [1, 15]. The prevalence is higher than the report of a prevalence of 9.2% by Stiller M *et al.* in Kenya, a population-based study in which pregnant women with IPV are likely to be underestimated. More so, women are more likely to volunteer information within the privacy of the health facility than in the community for fear of further violence. A lower prevalence of 2% and 10.6% was demonstrated in a cross-sectional study by Eikemo R. *et al.* and Van Parys *et al.*, probably due to the cultural differences in Western society. [19, 20] However, this result might have been affected by recall bias. The commonest type of IPV in this study was physical abuse (73.8%) in contrast to psychological abuse (74.4%) in a descriptive study by Jalili M *et al.* [21] Variation in the type of IPV is likely due to differences in geographical location and the likely impact of the laws in the land. Educationally, 36.8% have tertiary education, 29.0% primary, 28.1% secondary, and 6.1% have no formal education. And with respect to occupation, most study participants are gainfully employed, yet IPV persists

across various educational and employment backgrounds, indicating that economic stability alone does not protect against abuse. This reflects the fact that educational advancement did not disrupt the traditional patriarchal norms. This contrasts with results from Kebede *et al.*, which showed that some form of education reduces the risk of IPV, with better outcomes when the partner's educational status is adequate [22]. It could be that education is a means of empowering and developing self-esteem in women; however, results were based on secondary data, and participants were not exclusively pregnant women. Moreover, some participants in their study practice female-headed households, which is in favour of the female foes. The significant association of physical abuse with low SES in this study aligns with several studies indicating that increased financial stress during pregnancy, when the woman is more dependent, increases IPV risk [9, 24]. Conversely, the higher prevalence of harassment among high SES women suggests that IPV of some form is not limited to economically disadvantaged groups [8], it reaffirms the patriarchal practice in most African societies where a husband sees harassment and violence as a way of discipline for the woman to keep her in check irrespective of her SES. This is similar to results from the municipality of São Luís, which showed a similar rate of IPV in all SE levels [24].

Cultural acceptance's role in IPV, particularly in justifying physical abuse, underscores the need for culturally sensitive interventions [6]. IPV is viewed as an unavoidable aspect of marriage partnership; hence, it is underreported. While education and financial independence are expected to reduce IPV risk, this study suggests that socio-cultural norms continue to play a crucial role in sustaining IPV, as women with high CA tend to experience physical abuse and harassment [14]. These women perceived such treatment as normal, not reporting cases of abuse as it is viewed as causing indignity to the husband. This is consistent with findings by Bamiwuye SO, *et al.*, Aleibe *et al.*, and Agde *et al.* [25-27], but the result analysis did not involve the combination of determinants.

Limitations of the Study

This study explored the association between socioeconomic factors, cultural acceptance, and IPV. The study's limitations include its cross-sectional design, which limits the ability to establish causality. Additionally, the findings may not be fully generalizable to all pregnant women in Rivers State. The study only focused on female determinants, excluding male characteristics that might be contributory, thus influencing the results.

Conclusion

This study confirms that IPV is prevalent among pregnant women at RSUTH, with significant associations between IPV patterns, SES, and cultural acceptance. While financial instability increases physical abuse risk, cultural norms contribute to IPV persistence across socio-economic groups. This study emphasizes the need to detect and address IPV in this population, requiring multi-faceted interventions targeting both economic empowerment and cultural transformation. Efforts should be made to screen for IPV and possibly intervene to remarkably reduce the impact.

Conflict of Interest

Not available

Financial Support

Not available

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