

Intimate Partner Violence Among Pregnant Women Attending Antenatal Clinic at Federal Medical Center Gusau, Zamfara State, Nigeria

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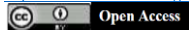
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ABSTRACT

Intimate partner violence (IPV) is a significant public health issue affecting women globally, with pregnancy representing a period of heightened vulnerability. This study aimed to determine the magnitude, forms, knowledge, and factors associated with IPV among pregnant women attending the Federal Medical Center (FMC) Gusau. A cross-sectional study was conducted among 136 pregnant women attending the antenatal clinic at FMC Gusau. A systematic sampling technique was employed. Data were collected using a structured researcher-administered questionnaire covering socio-demographics, obstetric history, knowledge of IPV, and experiences of abuse. The majority of respondents (57.0%) were aged 20–29, and most (93.4%) were married. While 58.1% had heard of IPV, controlling behaviors were prevalent, with 66.9% reporting partner jealousy and 42.7% reporting partners getting angry if they spoke with other men. Physical violence (e.g., pushing, kicking) was reported by 7.6% of respondents, while economic violence (refusal to let work) was reported by 21.8%. Despite high awareness of IPV's harmful effects, 50.9% of victims took no action following abuse, largely due to fear and forgiveness. Only 3.8% sought help from health providers. IPV is prevalent among pregnant women in Gusau, characterized primarily by psychological abuse and controlling behaviors. Although awareness of IPV is relatively high, help-seeking behavior remains low. Integrating routine screening and intervention into antenatal care is strongly recommended.

Introduction

Intimate partner violence (IPV) is a pervasive public health and human rights issue that affects women across all societies and socio-economic groups. It encompasses physical, sexual, psychological, and controlling behaviors perpetrated by a current or former intimate partner and has been linked to significant adverse health, social, and economic consequences for women and their families [1, 2]. Globally, IPV remains one of the most common forms of violence against women, with prevalence varying widely across regions and cultural contexts.

In sub-Saharan Africa, IPV is particularly prevalent, with studies reporting rates ranging from approximately 28% in some Southern African settings to over 60% in parts of West and East Africa [1, 3]. High prevalence has also been documented in non-sub-Saharan regions, including parts of the Middle East, underscoring the global nature of the problem [3, 4]. Variations in reported prevalence are influenced by differences in study design, cultural norms, and willingness to disclose abuse, particularly in conservative settings.

Pregnant women represent a particularly vulnerable population with respect to IPV. Beyond the direct physiological risks posed by violence during pregnancy including miscarriage, placental abruption, preterm birth, and low birth weight IPV during this period has been associated with poor mental health outcomes, delayed care-seeking, and reduced utilization of maternal health services [1, 5]. Importantly, pregnancy does not necessarily confer protection against violence; in some settings, it may exacerbate existing patterns of abuse or introduce new forms of control and coercion.

Antenatal care (ANC) services provide a unique and strategic platform for addressing IPV. Pregnancy is often one of the few periods when women have repeated, structured contact with the health system, offering critical opportunities for identification, counseling, referral, and early intervention. Integrating IPV screening and support into ANC has been shown to be feasible and acceptable in low-resource settings and can contribute to improved maternal and neonatal outcomes [2, 6]. However, the effectiveness of such interventions depends on context-specific evidence to guide policy and practice.

In Nigeria, IPV remains widespread, with studies reporting varying prevalence across regions and populations [7, 8]. Despite this growing body of evidence, there is a marked paucity of data from Zamfara State, particularly among pregnant women attending antenatal care. The sociocultural context of Zamfara State characterized by conservative gender norms and limited documentation of gender-based violence may further influence both the occurrence and reporting of IPV. Generating localized evidence is therefore essential to inform culturally appropriate screening, prevention, and response strategies within maternal health services.

This study aims to assess the prevalence, forms, and help-seeking behaviors related to intimate partner violence among pregnant women attending antenatal care at Federal Medical Centre, Gusau. By focusing on this population, the study seeks to provide baseline data to inform the integration of IPV screening and support into antenatal care services in Zamfara State and similar settings.

Materials and Methods

Study Design and Setting

This study employed a hospital-based cross-sectional research design and was conducted at the Antenatal Care (ANC) clinic of the Federal Medical Centre (FMC), Gusau, Zamfara State, Nigeria. FMC Gusau is a tertiary referral health facility that provides comprehensive maternal and child health services. It serves as a major center for antenatal care in Zamfara State and also receives referrals from surrounding states.

Study Population

The study population comprised pregnant women attending the antenatal clinic of FMC Gusau for routine antenatal care during the study period.

Inclusion and Exclusion Criteria

Pregnant women aged 15–40 years who attended the antenatal clinic during the study period and provided informed consent were included in the study. Women who declined participation, were critically ill, or had known psychiatric conditions that could impair effective communication were excluded.

Sample Size Calculation

The sample size was determined using Cochran's formula for estimating a single population proportion:

$$n = \frac{Z^2 \times p(1 - p)}{d^2}$$

Where:

- n = minimum required sample size
- Z = standard normal deviate at 95% confidence level (1.96)
- p = estimated prevalence of intimate partner violence
- d = margin of error

A prevalence (p) of 28% was adopted from a previous study on intimate partner violence among pregnant women in Northern Nigeria. A confidence level of 95% ($Z = 1.96$) and a margin of error (d) of 7.5% (0.075) were used.

$$\begin{aligned} n &= \frac{(1.96)^2 \times 0.28 \times (1 - 0.28)}{(0.075)^2} \\ n &= \frac{3.8416 \times 0.2016}{0.005625} \\ n &\approx 137 \end{aligned}$$

To account for possible non-response and incomplete questionnaires, a 10% attrition rate was added, giving an adjusted sample size of approximately 150 respondents. However, due to constraints related to the study period and completeness of responses, data from 136 respondents were included in the final analysis.

Sampling Technique

A systematic sampling technique was used to select study participants. The sampling interval (k) was calculated by dividing the average monthly antenatal clinic attendance by the required sample size. A random starting point between 1 and k was selected, after which every k -th eligible pregnant woman attending the clinic was recruited until the desired sample size was achieved. Participants who were ineligible or declined participation were replaced by the next eligible respondent. Four trained nurses served as research assistants during data collection.

Data Collection Tool

Data were collected using a structured, researcher-administered questionnaire adapted from the World Health Organization (WHO) Domestic Violence Against Women questionnaire. This instrument has been widely validated and used in similar studies. The questionnaire was modified to suit the local context and study objectives while retaining core items on physical, sexual, psychological, economic, and controlling forms of abuse.

The questionnaire consisted of four sections covering socio-demographic characteristics, obstetric history, knowledge of intimate partner violence, and experiences of abuse. Prior to the main study, the questionnaire was pre-tested among 20 pregnant women at General Hospital Farida, a nearby health facility. Feedback from the pre-test led to minor adjustments in wording and sequence to improve clarity and cultural appropriateness. The reliability of the instrument was assessed using Cronbach's alpha, which yielded a coefficient of 0.82, indicating good internal consistency. Interviews were conducted in private settings by trained female research assistants to ensure confidentiality and reduce social desirability bias.

Operational Definition of Intimate Partner Violence

In this study, intimate partner violence (IPV) was defined as the experience of at least one act of physical, sexual, psychological abuse, or controlling behavior perpetrated by a current or former intimate partner during the current pregnancy. This definition aligns with World Health Organization guidelines and previous IPV studies and was used in determining prevalence estimates.

Ethical Considerations

Ethical approval for the study was obtained from the Health Research Ethics Committee of the Federal Medical Centre, Gusau. Written informed consent was obtained from all participants after a clear explanation of the study objectives. Confidentiality was ensured by excluding personal identifiers from the questionnaires. Participants who reported severe forms of abuse were referred to the hospital's social welfare unit for counseling and support, and information on available support services was provided to those who disclosed experiences of violence.

Statistical Analysis

Data were cleaned, coded, and entered into the Statistical Package for Social Sciences (SPSS) version 26.0 for analysis. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to summarize socio-demographic variables and the prevalence of different forms of intimate partner violence. Inferential analysis using the Chi-square test was conducted to assess associations between IPV and selected socio-demographic factors. A p -value of less than 0.05 was considered statistically significant. Results were presented using tables and charts for clarity.

Results

Socio-Demographic Profile The study included 136 pregnant women. As shown in Table 1, the majority were young adults (aged 20–39), married, and of the Hausa ethnic group (80.9%). Educational attainment was relatively high, with nearly half of the participants holding tertiary degrees (49.3%), though a large proportion were housewives (43.3%).

Table 1: Socio-Demographic Characteristics of Respondents (n = 136)

Variable	Category	N (%)
Age Group	15–19 years	13 (9.6)

Education	20–29 years	77 (56.6)
	30–39 years	46 (33.8)
	Primary / None	29 (21.3)
	Secondary	40 (29.4)
	Tertiary	67 (49.3)
Marital Status	Single / Widowed / Divorced	9 (6.6)
	Married	127 (93.4)
Occupation	Unemployed / Student / Others	24 (17.6)
	Housewife	63 (46.3)
	Self-Employed	26 (19.1)
	Paid Employment	23 (16.9)
Tribe	Hausa	110 (80.9)
	Others	26 (19.1)
Religion	Islam	109 (80.1)
	Christianity / Others	27 (19.9)

Partner Dynamics and Knowledge of Intimate Partner Violence

Partner characteristics (Table 2) show that most partners were well educated, with nearly three-quarters having tertiary education. However, controlling behaviors such as jealousy were common. Awareness of intimate partner violence (IPV) was moderate, and the media was the main source of information.

Table 2: Partner Dynamics and Awareness of IPV (n = 136)

Variable	Category	N (%)
Partner Education	Graduate / Post-Graduate	100 (73.6)
	Secondary / Others	36 (26.4)
Partner Jealousy	Yes	91 (66.9)
	No	45 (33.1)
Decision Making	Joint (Both partners)	129 (94.9)
	Unilateral	7 (5.1)
Permission for Healthcare	Required by partner	50 (36.8)
	Not Required	86 (63.2)
Heard of IPV	Yes	79 (58.1)
	No	57 (41.9)
Source of Information	Media	63 (50.0)
	Health Worker	28 (22.2)
	Personal Experience	28 (22.2)
	Others	8 (6.3)

Forms of Intimate Partner Violence

Table 3 presents the prevalence of different forms of IPV. Psychological and controlling behaviors were the most commonly reported. Economic abuse affected over one-fifth of respondents, while physical abuse was reported by a smaller proportion.

Table 3: Prevalence of Specific Forms of IPV (n = 136)

Type of Violence	Specific Acts	Reported Prevalence N (%)
Controlling Behaviors	Partner gets angry if speaking to other men	56 (42.7)
	Insists on knowing whereabouts	51 (38.9)
	Restricted from seeing friends	20 (14.7)
Economic Abuse	Refused to let woman work	25 (21.8)
	Denied money to hurt woman	19 (16.9)
Sexual Abuse*	Intercourse due to fear of partner	14 (25.0)
	Forced sexual acts	4 (3.1)
Psychological Abuse	Ignored / treated indifferently	21 (18.3)
	Insulted / made to feel bad	14 (10.6)



Physical Abuse	Pushed / shoved / hair pulled	10 (7.6)
	Kicked / dragged / beaten	8 (6.1)
	Slapped / objects thrown	7 (5.3)

* Percentages for sexual abuse were calculated among respondents who were sexually active during pregnancy (n = 56).

Factors Associated with Intimate Partner Violence

Bivariate analysis revealed significant associations between IPV and partner jealousy, partner alcohol use, and requirement of permission to access healthcare. These associations were further confirmed using logistic regression.

Table 4: Factors Associated with IPV among Pregnant Women (n = 136)

Variable	Category	IPV Yes N (%)	IPV No N (%)	Total N (%)	Chi-Square (p-value)
Age Group	15–29 years	30 (56.6)	53 (63.9)	83 (61.0)	0.98
	30+ years	23 (43.4)	30 (36.1)	53 (39.0)	
Education	≤ Secondary	25 (47.2)	39 (47.0)	64 (47.1)	0.98
	Tertiary	28 (52.8)	44 (53.0)	72 (52.9)	
Partner Education	Secondary / Others	12 (22.6)	24 (28.9)	36 (26.5)	0.41
	Tertiary	41 (77.4)	59 (71.1)	100 (73.5)	
Partner Jealousy	Yes	45 (84.9)	46 (55.4)	91 (66.9)	<0.001*
	No	8 (15.1)	37 (44.6)	45 (33.1)	
Permission for Healthcare	Required	28 (52.8)	22 (26.5)	50 (36.8)	0.002*
	Not Required	25 (47.2)	56 (73.5)	86 (63.2)	
Partner Alcohol Use	Yes	18 (34.0)	10 (12.0)	28 (20.6)	0.003*
	No	35 (66.0)	73 (88.0)	108 (79.4)	

*Statistically significant at $p < 0.05$.

Table 5: Logistic Regression of Factors Associated with IPV (n = 136)

Factor	IPV Yes N (%)	IPV No N (%)	Chi-Square	p-Value	OR (95% CI)
Age (15–29 years)	30 (36.1)	53 (63.9)	1.22	0.27	
Education (Tertiary)	32 (47.8)	35 (52.2)	0.43	0.51	
Occupation (Housewife)	18 (28.6)	45 (71.4)	0.72	0.40	
Partner Jealousy (Yes)	45 (44.1)	46 (55.9)	15.2	<0.001	3.5 (1.7–7.2)
Permission for Healthcare (Required)	25 (50.0)	25 (50.0)	5.4	0.02	2.1 (1.1–4.2)

Response to Intimate Partner Violence

Among respondents who experienced IPV, most took no formal action. When assistance was sought, it was largely from informal sources such as family members.

Table 6: Response to IPV Experienced (n = 53)

Variable	Category	N (%)
Frequency of Violence	Once	28 (77.8)
	Frequently	4 (11.1)
Action Taken	Did nothing	27 (50.9)
	Reported to relations	13 (24.5)
	Quit relationship	5 (9.4)



	Sought help (Friends/Health)	6 (11.4)
Medical Care Sought	In-patient admission	18 (54.5)
	Out-patient	15 (45.5)

Note: Medical care data refer to respondents who sustained physical injuries requiring treatment (n = 33).

Discussion

This study assessed the magnitude, forms, and responses to intimate partner violence (IPV) among pregnant women attending antenatal care at FMC Gusau. The findings confirm that IPV remains a significant public health concern in this setting, with psychological abuse and controlling behaviors emerging as the most prevalent forms, while physical violence was reported less frequently.

The predominance of controlling behaviors particularly partner jealousy, restrictions on social interaction, and insistence on knowing women's whereabouts observed in this study is consistent with findings from Sokoto State and other parts of Northern Nigeria, as well as the wider sub-Saharan African literature [8, 9]. Bivariate analysis in this study confirmed that partner jealousy is significantly associated with the experience of IPV ($p < 0.001$). These behaviors are increasingly recognized as central components of intimate partner violence and frequently precede or coexist with physical abuse, reflecting deeply entrenched gender power imbalances. Their persistence during pregnancy, a period when women are culturally expected to receive heightened care and protection, underscores the normalization of coercive control within intimate relationships.

The prevalence of physical violence in this study (7.6%) was notably lower than the 63.2% reported in Jos and 28% in Zaria, as well as the 29–31% prevalence reported in South-West Nigeria [6, 7, 8]. Unlike the interpretation in previous studies, these figures suggest that Gusau has a significantly lower reported rate of physical abuse compared to these other regions. This disparity may be attributed to several factors. First, the conservative cultural and religious norms predominant in Zamfara State may foster a higher threshold for what constitutes "violence" worth reporting, or encourage concealment due to the stigma associated with disclosing family matters. Second, under-reporting remains a significant limitation in cross-sectional surveys of sensitive topics; women may fear retaliation or believe that physical discipline is a private matter [12]. Despite the lower prevalence, the presence of acts such as pushing, kicking, and beating remains clinically significant due to their strong association with adverse maternal and fetal outcomes, including placental abruption, preterm labor, and fetal injury [1, 5].

This study identified several factors significantly associated with IPV. Notably, partner alcohol use emerged as a significant risk factor. This aligns with global evidence indicating that substance abuse impairs judgment, lowers inhibitions, and increases the likelihood of aggressive behavior [10]. The finding that alcohol use was prominent in the narratives of respondents and statistically linked to abuse suggests that interventions targeting substance abuse could be a critical component of IPV reduction strategies in this setting.

Furthermore, the study found that women who required permission from their partners to access healthcare were significantly more likely to experience IPV. This requirement for permission acts as a proxy for restricted autonomy and controlling behavior. It reinforces the concept that economic and social dependency limits women's ability to seek help or protect themselves, increasing their vulnerability during pregnancy when healthcare needs are more frequent. Economic abuse (e.g., refusal to let women work) was reported by over one-fifth of respondents, mirroring observations from studies in Tanzania and Uganda where economic dependence is a major barrier to safety [9, 11].

Interestingly, while the study population had a relatively high level of formal education (both for the women and their partners), educational attainment was not found to be a protective factor against IPV. This challenges the assumption that education alone mitigates the risk of violence and supports the argument that deeply ingrained cultural norms and patriarchal traditions often supersede the mitigating effects of formal schooling. IPV was reported across educational and socio-economic strata, indicating that it is driven more by social norms and power dynamics than by individual literacy or economic status.

The study also revealed a stark disconnect between knowledge and action. Despite moderate awareness of IPV and its harmful effects, help-seeking behavior was strikingly low. More than half of affected women (50.9%) took no action following abuse. This pattern is consistent with reports from Ethiopia and Northern Uganda, where fear of retaliation, the desire to preserve family unity, and

religious expectations discourage disclosure [11, 12]. The low rate of disclosure to health workers is particularly concerning, given that the antenatal clinic represents a critical, underutilized opportunity for identification and intervention.

The findings of this study highlight the importance of translating legal frameworks into functional protection mechanisms. While Zamfara State has domesticated the VAPP Law, the observed burden and patterns of violence suggest that implementation and enforcement remain limited. In all states, including those yet to domesticate the VAPP Law, translating and widely disseminating the legislation in local languages, strengthening the capacity of justice, security, and health actors, and establishing functional SGBV response and case-tracking systems are critical. Engagement of traditional and religious leaders is also essential to challenge harmful norms, reduce stigma, and promote reporting.

Limitations

The cross-sectional design limits causal inference, and the small, facility-based sample ($n = 136$) may reduce statistical power and generalizability, particularly to women not accessing antenatal care who may face higher IPV risk [2, 13]. Social desirability bias may also have led to under-reporting of violence. Despite these limitations, the study provides critical baseline data for Zamfara State and supports the need for routine, culturally sensitive IPV screening in antenatal care.

Conclusion

Intimate partner violence during pregnancy is a common occurrence among women attending FMC Gusau, characterized predominantly by psychological abuse, controlling behaviors, and sexual coercion. While physical violence rates are lower than in some other Nigerian regions, the prevalence remains concerning. Key drivers include partner alcohol use, jealousy, and restrictions on women's autonomy, such as requiring permission to seek healthcare. High educational levels did not confer protection against abuse.

Recommendations

Clinical Integration: Routine screening for IPV should be integrated into antenatal care services at FMC Gusau. Healthcare workers require specific training to ask about violence sensitively, handle disclosures confidentially, and provide appropriate referrals.

Community & Policy Action: Public health education must target community norms that justify or conceal IPV. There is an urgent need to operationalize the Violence Against Persons Prohibition (VAPP) Act at the state level in Zamfara. Strengthening the implementation of this legal framework will provide survivors with better protection and recourse, moving beyond mere awareness to legal enforcement.

Targeted Interventions: Given the association with alcohol use, collaborating with community leaders to address substance abuse could serve as an indirect but effective strategy for reducing IPV incidence.

Implications for Practice and Policy

The findings reinforce the importance of integrating IPV screening, counseling, and referral into routine antenatal care, alongside community-level interventions that challenge norms supporting violence against women. Strengthening health worker capacity and engaging religious and community leaders may be particularly effective in conservative settings like Zamfara State.

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