

Intimate-Partner Violence and Coping Strategies among Pregnant Women in Keffi LGA, Nasarawa State

Helen Sadi Yiga PhD, Mohammed Ayuba Oche PhD & Mamman Matthew Samuel

Department of Sociology, Nasarawa State University, Keffi.

Corresponding author: sadiyiga2020@gmail.com

Abstract

Intimate partner violence especially against pregnant women has been identified as a social and public health problem affecting women globally and is considered as a violation of human rights with severe implications to safe motherhood. Despite this, previous studies have largely been skewed towards women with little attention given to the pregnant women. Hence, this study examined the prevalence of intimate partner violence and coping strategies among pregnant women in Keffi. The study was anchored on the Intersectional Feminist theory by Kimberlé Crenshaw. The study adopted a mixed-method design involving a survey of 361 pregnant women attending antenatal clinic in 4 hospitals in Keffi LGA, Nasarawa State, Nigeria through a multi-stage sampling technique. 8 key informant interviews were also conducted. Quantitative data were analysed using descriptive and inferential statistics while the qualitative data were analysed using thematic content analysis. Findings shows that intimate partner violence was prevalent at 47.1% among pregnant women attending Ante Natal Clinic (ANC) in the sampled hospitals and this occurs very often as indicated by 80.4% of the participants. In addition, age at marriage was found not to be significantly associated with the experience of IPV among pregnant women [$\chi^2_{(3)} = 8.165$, $P < 0.05$]. Also, results revealed that IPV among pregnant women takes the form of hitting, insults, sexual abuse, threat of death, controlling & domineering, financial denial, and denial of sexual intimacy. In addition, Regarding the effects of IPV on reproductive health outcomes, findings show that 17.6% of respondents have suffered complications during pregnancy due to IPV, 29.4% have lost pregnancy. Also, almost half (49.1%) revealed that they missed ANC, more than half said they were depressed (58.8%) while others lost their infants (23.5%) as a result of abusive partners' behaviours. Finally, pregnant women resort to prayer (39.2%), crying in silence (43.1%), complain to health workers during ANC (5.9%), family/friends (37.3%) separation (39.2%) as coping strategies. The study concludes that intimate partner violence poses a greater challenge to pregnant women. Therefore, it is urgent to sensitize women to speak out in the face of intimate partner violence. Even though they believe in God, appropriate steps should also be taken for the sake of their reproductive health and well-being.

Keywords: Intimate partner violence, Coping strategies, Reproductive health, Pregnant women.

Introduction

Intimate partner violence (IPV) is a form of gender-based violence that has remained a social and public health problem affecting women globally (Akindele, 2021). It is an act that clearly violates one of the dating partners or couple's rights and privilege over self, choice, and desire (Babu & Kusuma, 2016). It is seen as the aggression of any form toward partners in a legal or illegal sexual relationship. Many see it as coercive acts being carried out by

current or former spouse or partner, capable of causing death, which can occur among homo-sexual or heterosexual couples (Chimah, Adogu, Odeyemi & Ilika, 2015). The act is a domestic physiological or psychological harm adventure with the sole aim of brutalizing an offending partner in a relationship (Doi, Fujiwara & Isumi, 2019). According to the World Health Organization (WHO), it is an unacceptable and controlling behaviour within intimate relationships associated with present and past partners. Sociologists, counselors, and scholars have remarked that intimate partner violence entails socio-economic damages, emotional torture, and physical abuse on the weaker or less dominant person in a close relationship. Thus, this nefarious act has become enshrined in some people's traits and belief systems. It has undoubtedly affected victims' self-esteem concepts and personality (Fawole, Okedare & Reed, 2021).

According to United Nations (UNs, 2017) declaration on violence against women and girl-child; IPV is "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life." The World Health Organisation (WHO, 2016) estimated that about 1 in 3 (35%) of women worldwide had witnessed one of the four forms of intimate partner violence in their lifetime. To buttress the standpoint, the United States of America Centre for Disease Control and Prevention (US, CDC, 2019) asserts that pregnancy depicts a privileged opportunity for pregnant women to access health care provisions which makes it one of the most critical times of detecting and reporting intimate partners' violence whether during or after pregnancy still, the prevalence of intimate partner violence during pregnancy ranges from 4 to 29% across the world. This is to say that it does not only affect women's reproductive health but also places endemic and non-endemic adverse health challenges on the innocent fetus as a result of trauma, psychological and emotional effects, intentional stress the carrier go through right from previous experience faced and current abuses being witnessed (Benebo, Schumann & Vaezghasemi, 2018).

Some scholars like Balogun, and John-Akinola (2015), Becker and Bachman (2020), Akindele (2021) have reported a couple of cases of intimate partner violence. It is equally remarked that only selected, supported, and treated victims can make it open to the public due to stigmatization and discrimination. Bello, Obajimi and Adetayo (2018) and Akindele (2021) added that pregnant women exposed to intimate partner violence are likely to have health challenges than their counterparts not expose to the rigour and traumatizing experience of intimate partner violence. According to the Center for Disease Control and Prevention (2016), intimate partner violence is preventable, avoidable and treatable worldwide. However, in some societies in Africa, intimate partner violence (IPV) is not seen as a grave concern. Unlike many other continents, Africa celebrates male chauvinism, headship, and a patriarchal social system (WHO, 2016). Quite alarming is to note that in some quarters and communities in Africa, to be more specific in Nigeria, intimate partner violence has been perceived as a penal code or cultural norm to guide a relationship. Studies

such as Breiding, Basile, Smith, Black and Mahendra (2015) and Ali (2016) have generally documented various risk factors associated with intimate partner violence. Some can be at the individual, relational, societal, and even community levels and are liable to become perpetrators of intimate partner violence.

Also, intimate partner violence poses a severe threat to achieving the Safe Motherhood Initiative (SMI) and Sustainable Development Goals (SDGs). By implication, this reprehensible act against pregnant women is likely to debar the attainment of those goals that have to do with mothers' health and children's general wellbeing (Akindele, 2021). This is of paramount importance in pregnant women as its impact is massive and inimical to the woman and unborn baby. Intimate partner violence has also been culpable in adverse pregnancy outcomes such as antepartum hemorrhage, miscarriage, premature rupture of membrane, preterm delivery, low birth weight, fetal distress, and perinatal death (Durvasula, 2014). In addition, related studies have shown that violence against women in an intimate relationship is alarming. It is associated with short and long-term consequences, including health, mental, emotional, and sexual wellness (García-Moreno & Amina, 2016). There continue to be adverse effects on mainly women and children as dependent on the husband who is the sole principal in a family setup. Intimate partner violence in Nasarawa State and particularly Keffi LGA has continued to grow exponentially especially that the victims are pregnant women that are vulnerable to pregnancy related complications. While the menace is increasing the cases are under reported due to cultural and religious belief in the area. Cases of intimate partner violence against pregnant women in Keffi has results to miscarriage among women; in some instance the abusing partner often denies the victim any access to medical assistance in a bid to conceal their atrocities. The specific act of blocked access to medical care has caused many women to die in despair in the study area. In spite the above stated consequences, and its reoccurrence in Nasarawa state, several studies have skewed away from pregnant women. Thus, an understanding of the prevalence, patterns, and associated risks of intimate partner violence during pregnancy is essential to mitigating the effect and providing a safety net for such victims. Therefore, this study examined the incidence of intimate partner violence among pregnant women in Keffi Local Government Area of Nasarawa State, Nigeria with specific regards to the prevalence, patterns, consequences, and coping strategies adopted by pregnant women experiencing IPV.

Theoretical Framework

This study is anchored on the Intersectional Feminist Theory by Kimberlé Crenshaw in 1989 to explain the causes, magnitude, effects, and intervention strategies to reduce its occurrence on pregnant women.

Intersectional feminism was coined by Kimberlé Crenshaw in 1989, in her work on demarginalizing the intersection of Race and Sex." According to Crenshaw, intersectional feminism is the understanding of how women's overlapping identities including race, class,

sexual orientation, gender identity, ability, religion, age and immigration status impact the way they experience oppression and discrimination. The idea is that all women experience the world differently, so a feminism that's centered on one type of woman, the interconnecting and often overlapping systems of oppression is exclusive and incomplete. Feminist intersectionality is built upon the assumptions that every social group has unique qualities; that is, individuals are positioned within social structures that influence power relationships; and that there are interactions between different social identities, for example, race, gender, and class, that have multiplicative negative effects on health and well-being. Feminist intersectionality is a body of knowledge that is driven by the pursuit of social justice and seeks to explain the processes by which individuals and groups in various oppressed social positions, such as gender, race, ethnicity, class, age, sexual orientation, disability status, and religion, result in inequitable access to resources, which in turn results in societal inequities and social injustice. Intersectional feminism accounts for additional factors and complexities that intersect with gender to place women and other vulnerable groups at a disadvantage in establishing equitable power relationships with their partners and in society.

To explain IPV the intersectional feminist theory provides a nuanced yet complex understanding of the multifaceted positions of inequity and injustice in which women who experience IPV are placed by oppressive social structures, social agencies/professional helpers, and health care providers, such as religious groups, family/friends, the police, court systems, and health care systems and providers. These systems can be hindrances to help seeking for abused women, particularly those with multiple subordinate group identities (class, gender, race, ethnicity, religion). In other words, women simultaneously have multiple social identities, and each of these identities intersects with one another to form a person's unique experience of the world, particularly as it relates to their marginalization and encounters with oppression. The forms and responses to IPV are shaped by diversity (intersectionality), this suggests that women's responses to IPV are inherently associated, and at times dependent, on the influence of oppressive systems on their lives. For example, mothers' overt or public responses to the violence may depend on their perceptions of or experiences with children's protective services or society. They might not disclose the abuse to anyone for fear of having their children removed from their custody, or they may be penalized for the abuser's behaviour because of their (the women's) "failure to protect". Ineffective responses by police or court systems will prompt women to respond differently than if they had received the legal assistance they were seeking, perhaps staying in the relationship and managing the violence as best as they can. These women may find that existing community resources are not accessible to them or that legal and health care systems and providers are incognisant and ill-equipped to address their particular needs. Understanding the complex and often oppressive contexts of women's responses to IPV is essential to understanding the complexity of their active and adaptive responses to it.

Method

A cross-sectional survey design (a method where a researcher collects data once) was adopted where both descriptive and explanatory research methods were utilized to examine the prevalence and effects of IPV among pregnant women and the coping strategies they adopt. The study location was Keffi LGA and specifically the General Hospital and Kofar Hausa Hospital in Keffi Local Government Areas, Nasarawa State, Nigeria. The population of the study consists of all pregnant women married and unmarried that are accessing antenatal care service (ANCs) in the selected hospitals in Keffi LGA. The total population of pregnant women registered in the selected hospitals in the preceding 7 months was 6013, out of which the sample size of 361 adopted using the Krejcie and Morgan (1970) sample size determination formula. Furthermore, a purposive sampling technique was used to select the following ANC facilities; General Hospital, Kofar Hausa Hospital, Lafiya Lau Hospital, and Rayan Hospital, Keffi. The purposive technique was more efficient as it provided access to a self-selected population (that is, registered pregnant women) for the research. A snowball sampling technique was also used to reach pregnant women that were currently experiencing intimate partner violence. The technique helped the researcher to reach the 'hard-to-reach' group. The study conducted eight (8) interviews comprising of five pregnant women who were experiencing intimate partner violence as at the time of this study and three health professionals were selected as participants. This is because they are considered knowledgeable about the study.

A semi-structured questionnaire instrument was used to elicit responses from the participants on the prevalence, patterns and coping strategies of IPV among pregnant women. In addition to that, a key informant interview (KII) guide was utilized to obtain qualitative data for the study. Thus, the quantitative data collected was analysed using the Statistical Package for Social Science (SPSS v20). Descriptive (frequencies and percentages) and inferential (chi-square and crosstabulation) statistics were used to summarize the result. The statistical significance were determined at a p-value less than 0.05. finally, the content analysis was used to analyzed the qualitative data collected using the KII.

Results

Socio-demographic characteristics of participants

Table 1 shows the socio-demographic characteristics of participants. Most of the participants (92.2%) are above 19 years with some level of formal education considering the urban nature of Keffi LGA. In addition, majority of the participants have ever married and 83.8% are either employed or self-employed. However, more than half (54.9%) of the respondents earn below ₦50,000 monthly. By extension, even as most respondents are engaged in different economic activities, their monthly earnings making them dependent on their partners which further expose them to exploitation and abuse.

Table 1: Socio-Demographic Characteristics of Respondents

Variables	Frequency	Percentages
Age		
15-19	28	7.8
20-24	42	11.8
25-29	70	19.6
30 and above	217	60.8
Total	357	100
Highest Educational Attainment		
No formal Education	87	24.4
Primary	207	58.0
Secondary	35	9.8
Tertiary	28	7.8
Total	357	100
Marital status		
Single	21	5.9
Married	224	62.7
Separated	77	21.6
Divorce	35	9.8
Total	357	100
Religion		
Christianity	126	35.3
Islam	224	62.7
Traditional Worshipper	7	2.0
Total	357	100
Employment status		
Employed	98	27.5
Self-employed	201	56.3
Unemployed	58	16.2
Total	357	100
Level of income		
Less than N50,000	236	54.9
N51,000-N100,000	79	33.3
N101,000-150,000	28	7.8
N151,000 & above	14	3.9
Total	357	100

Source: field survey, 2021

Prevalence of Intimate Partner Violence

As shown in Table 2 below, 47.1% of pregnant women attending ANC in the sampled hospitals have experiences intimate partner violence. And this occurs very often as

indicated by 80.4% of the participants. The table further reveals that this violence has occurred across different time frame ranging from the beginning of marital union to at least five years of marriage. This means IPV occurs more at the initial stage of marital unions.

Table 2: Prevalence of Intimate Partner Violence

Variables	Frequency	Percentage
Experienced violence with an Intimate Partner		
Experienced	168	47.1
Never Experienced	182	50.9
Maybe	7	2.0
Total	357	100
Frequency of experience of violence		
Very often	287	80.4
Often	35	9.8
Not very often	31	5.9
Not at all	14	3.9
Total	357	100
Experience of violence in time frame		
Since we got married	147	41.2
2 years after	112	31.4
4 years after	49	13.7
5 years and above	49	13.7
Total	357	100
Spouse addicted to alcohol and other form of hard substance		
Yes	126	35.3
No	210	58.8
Maybe	21	5.9
Total	357	100
Factors responsible for abuse		
Income	147	41.2
Religion	63	17.6
Culture	91	25.5
Alcohol/Substance use	21	5.9
Low educational background	35	9.8
Total	357	100

Source: field survey, 2021

In addition, responses indicate that about 35.3% of women who experienced IPV, their husbands abuse alcohol or other hard substances. Besides that, the table equally shows that

income, culture, and religion are the leading causes of violence among intimate partners with 41.2% been adduced to income-related issues.

Comments from interview with participants supported the findings above on the prevalence of intimate partner violence. The participant's view was captured thus:

Yes, my husband has beaten me many times, and I feel this is an act of cowardice and wickedness towards you're a woman that you call your wife. Every time, he opens his mouth to insult me and sometimes slaps me depending on how he feels or gets angry (KII/General Hospital Keffi/2021).

The above extract submits that most victims understand what intimate partner violence is, however, they find it difficult to express themselves as they consider IPV an issue of shame and prefer not to talk about it. This culture of silence on intimate partner violence is validated by a healthcare professional whose opinion was captured below;

Violence within the family setting or home between women happens a lot but you will notice only a few cases are being reported due to some personal reasons they (women) give. But you cannot doubt the IPV occurs frequently with a daring impact among pregnant women. Because during interface with pregnant women, much is revealed as many of them do not want to talk about it. I think they are helpless (KII/Rayan Hospital Keffi/2021).

To further show the prevailing rate of intimate partner violence among pregnant women in Keffi, chi-square analysis was done to examine the relationship between some socio-demographic variables and experience of violence. Below are the chi-square results.

As shown in Table 3, age at marriage was not significantly associated with the experience of IPV among pregnant women. Since the chi-square obtained is 8.165 with a degree of freedom of 3 and p-value (0.226) greater than 0.05, there is no significant association between age at marriage and the experience of violence among pregnant women in Keffi LGA. This indicates that regardless of a woman's age she can be abused by an intimate partner [$\chi^2_{(3)}=8.165$, $P>0.05$].

Table 3: Cross-tabulation of Respondents Age at Marriage and Experience of IPV

Present Age	Experience of IPV				Chi-Square χ^2	df	P-value
	Yes	No	Maybe	Total			
15-19	14	14	0	28	8.165	3	0.226
20-24	14	21	7	42			
25-29	28	42	0	70			
30 and above	105	112	0	217			
Total	161	189	7	357			

*= statistically significant at $p<0.05$

Source: field survey, 2021

Also, in Table 4, since p-value (0.001) is less than 0.05, there is a significant association between marital status and experience of intimate partner violence.

Table 4: Cross-tabulation of Respondents' Marital-status and Experience of IPV

Marital status	Experience of IPV				Chi-Square	df	P-value
	Yes	No	Maybe	Total			
	χ^2						
Single	0	7	14	21	22.764	6	0.001
Married	7168	49	224				
Separated	07	70	77				
Divorced	00	35	35				
Total	7182	168	357				

*= statistically significant at $p < 0.05$

Source: field survey, 2021

This implies that married women are more likely to experience IPV than women who are not married due to a number of factors which are not limited to low income and education, young age at marriage, abuse of alcohol, mental ill-health [$\chi^2_{(6)} = 22.764$, $P < 0.05$].

Patterns of intimate partner violence experienced by pregnant women

Here, the patterns of IPV experienced by respondents are discussed. And this includes physical, psychological and social patterns of IPV.

Table 5 reveals that the intimate partner violence (IPV) experienced by pregnant women in Keffi LGA takes the form of hitting (37.3), insults (43.1%), sexual abuse (33.3%), the threat of death (31.4%), controlling & domineering (31.9%), financial denial (40.9%), and lack of sexual intimacy (33.3%). Although these are not the highest respondents' percentages, the gravity of the issue raised makes these percentages very significant.

Table 5: Patterns of IPV Experienced by Pregnant Women in Keffi LGA

Variables	Frequency	Percentage
Physical IPV		
He slaps me at the slightest provocation		
Agree	133	37.3
Undecided	42	11.8
Disagree	182	51
Total	357	100
My husband threatened to kill or harm me		
Agree	112	31.4
Undecided	28	7.8
Disagree	217	60.8
Total	357	100
He hits me with a physical object when angry with me		
Agree	112	31.3
Undecided	56	15.7

Disagree	189	53
Total	357	100
Psychological IPV		
My husband usually calls me names and insults me		
Agree	154	43.1
Undecided	7	2.0
Disagree	196	54.9
Total	357	100
My husband often denies me attention whenever I need him		
Agree	119	33.3
Undecided	56	15.7
Disagree	182	51
Total	357	100
He often abuses me sexually		
Agree	119	33.3
Undecided	42	11.8
Disagree	196	54.9
Total	357	100
Social IPV		
Domineering and controlling		
Agree	114	31.9
Undecided	35	9.8
Disagree	208	58.3
Total	357	100
Financial and material denial		
Agree	146	40.9
Undecided	27	7.6
Disagree	184	51.5
Total	357	100
Checking of mobile phone		
Agree	84	23.5
Undecided	28	7.8
Disagree	245	68.7
Total	357	100

Source: field survey, 2021

The findings in Table 5 above corroborates with the experiences of some KII participants. One of the participants confirmed that;

My husband is hot tempered, he slaps and kicks me at the slightest event, and I get scared that he will kill me one day. But I do report to family and they usually talk to him and they tell me to be patient with him and be prayerful (KII/Kofar Hausa Hospital Keffi/2021).

Another participant added that "I consider intimate partner violence as constant fighting between husband and wife. For me I think is verbally because my husband shout at me a lot even in public. This usually affect me emotionally and often affect my self-esteem" (KII/GeneralHospital Keffi/2021).

Excerpt affirming experience of sexual abuse captures a participant view thus; "I often suffer sexual abuse from my husband, he doesn't know when someone is tired. He wants it whenever he likes even when I am not in the mood and has threatened to bring in another woman if I refuse him" (IDI/Lafiya Lau Hospital Keffi/2021).

The extracts above expose the various patterns that intimate partner violence takes among different families in our communities which call for urgent and sustained action to improve safety within the family settings.

Effects of IPV on Reproductive Health Outcomes

As shown Table 6 below, there are various effects of intimate partner violence on reproductive health outcomes. The table indicates that about 17.6% of respondents have suffered complications during pregnancy due to IPV, 29.4% have lost pregnancy.

Table 6: Effects of IPV on Reproductive Health Outcomes

Variables	Frequency	Percentage
Ever suffered from any complications during pregnancy due to violence with your husband		
Suffered complications	63	17.6
Had no complications	252	70.6
I don't know	42	11.8
Total	357	100
Ever lost any pregnancy due to IPV		
Lost pregnancy	105	29.4
No pregnancy lost	217	60.8
I don't know	35	9.8
Total	357	100
Had STDs as a result of IPV		
Yes	161	45.1
No	126	35.3
I don't know	70	19.6
Total	357	100

Missed antenatal because of abuse		
Yes	175	49.1
No	182	50.9
Total	357	100
Experienced effects of Intimate Partner Violence		
Depression	210	58.8
Infant mortality	84	23.5
Unwanted pregnancy/ abortion	49	13.7
Still birth	7	2.0
Suicidal ideation	7	2.0
Total	357	100

Source: field survey, 2021

Also, almost half of the respondents (49.1%) revealed that they missed ANC while the majority of the respondents have been depressed (58.8%) and others lost their infants (23.5%) as a result of abusive partners behaviours. Findings from the qualitative study also support these evidences. As some of the responses were captured thus:

The violence affected my last baby because he (husband) pushed me and I fell on my stomach and started bleeding. So, based on this kind of experience, I will not want to be pregnant again because I don't want to experience losing a baby again except, I know he has changed and won't hit me again (KII/Rayan Hospital Keffi/21)

Another participant revealed further that; As we know that any woman carrying baby are to be taken care of in all faces be it physically, emotionally, financially. There have been cases of beating that led to miscarriages and made us to deliver the baby before time because of the severity of the case. And on these occasions, their husbands don't follow them for treatment (KII/Lafiya Lau Hospital Keffi/2021)

From the above, one can deduce that there is a relationship between intimate partner violence and women reproductive health outcomes, as many women lack care and may not want to get pregnant again due to violence experienced during pregnancy.

Coping strategies Adopted by Respondents

Table 7 reveals some of the coping strategies adopted by women who are experiencing IPV, this includes; prayer (39.2%), crying in silence (43.1%), complain to health workers during ANC (5.9%), family/friends 37.3%).

Table 7: Coping Strategies Adopted by Respondents

Variables	Frequency	Percentages
Management of abuse		
Prayer	140	39.2
I cry in silence	154	43.1
Cover up with makeup	56	15.7

Listen to music	7	2.0
Total	357	100
Ever reported to anyone		
Yes	154	43.1
No	203	56.9
Total	357	100
Those complained to		
God	196	54.9
Family/Friends	133	37.3
Health worker at ANC	21	5.9
Police	7	2.0
Total	357	100
My husband takes me out often for hangouts, vacation, and on special treats		
Yes	273	76.5
No	84	23.5
Total	357	100
Considered leaving partner to avoid abuse		
Yes	140	39.2
No	217	60.8
Total	357	100
Believe the children will fight your cause		
Yes	217	60.8
No	140	39.2
Total	357	100

Source: field survey, 2021

Other strategies adopted was the believe that children will fight their cause (60.8%) others consider leaving their husbands (39.2%) while others are given treat inform of vacation or hangouts by their husbands to help them deal with IPV.

Furthermore, a participant from the key informant interview reiterated that;

I don't report to anyone because I don't want people to laugh at me and I don't want anything that will annoy my husband more. I also did not like the response I got when I reported the issue first few times, he beat me so I decided to talk to God instead (KII/Lafiya Lau Hospital Keffi/2021).

Another added that; I pray about my husband every day and I believe God can still change my husband and he will love me more. More so, my children are there as my source of joy.

So, I have nothing to worry about. He will change some day (KII/Kofar Hausa Hospital Keffi/2021).

These excerpts are a revelation to how most women are dying in silence instead of reporting to get the necessary help. This further reinforces perpetrators to do more.

Discussion

This study sought to establish the prevalence of IPV, the patterns, effects and coping strategies adopted by pregnant women who are experiencing IPV. Findings regarding prevalence, results revealed that 47.1% of pregnant women attending ANC in the sampled hospitals have experienced intimate partner violence. And this occurs very often as indicated by 80.4% of the participants. In addition, age at marriage was found not to be significantly associated with the experience of IPV among pregnant women which indicates that regardless of a woman's age she can be abused by an intimate partner [$\chi^2_{(3)} = 8.165$, $P < 0.05$]. Also, there is a significant association between marital status and experience of intimate partner violence. This implies that married women are more likely to experience IPV than women who are not married due to a number of factors which are not limited to low income and education, young age at marriage, abuse of alcohol, mental ill-health [$\chi^2_{(6)} = 22.764$, $P < 0.05$]. This corroborates Benebo, Schumann and Vaezghasemi (2018) who stated that intimate partner violence cut across all ages in marriage. Equally, Parker, McFarlane, Soeken, Torres and Campbell (1993) identified an association between women of younger age and pregnancy IPV. Similarly reports by Saltzman, Johnson, Gilbert and Goodwin (2003) suggest a nearly double risk of pregnancy IPV for women under 20. In contrast, the findings disapprove with the assertion of the Intersectional feminist theory that age among others places women at a disadvantaged and oppressive position in the society thereby making them victims of spousal abuses.

Regarding the patterns of IPV experienced by pregnant women in Keffi LGA, the study found that it takes the form of hitting, insults, sexual abuse, the threat of death, controlling & domineering, financial denial, and denial of sexual intimacy. This finding is in agreement with the findings of Fawole, Salawu, & Olarinmoye (2010) who found that there is a lifetime prevalence of intimate partner violence as these manifested in physical abuse (25.1%), psychological violence (44.4%), carried out sexual violence (29.3%), and economic challenges (23.2%).

On the effects of IPV on reproductive health outcomes, the study equally found that there are various effects of intimate partner violence on reproductive health outcomes. Findings shows that 17.6% of respondents have suffered complications during pregnancy due to IPV, 29.4% have lost pregnancy. Also, almost half of the respondents (49.1%) revealed that they missed ANC, more than have been depressed (58.8%) while others lost their infants (23.5%) as a result of abusive partners' behaviours. These findings are in line with Taylor and Jennifer's (2021) submission that some potential pregnancy complications like preterm delivery, low birth weight, placental abruption, uterine rupture, haemorrhaging, foetal

injuries, and in the worst scenarios, miscarriages, stillbirth or mothers' death. In related studies, Keating (2015); Nwabunike and Tenkorang (2017) and Pamela, Regan, Ramani and Durvasula (2015) revealed that inconsistent condom use, induced abortion, STD's non-monogamous relationship, unplanned pregnancy among others has indirect links with intimate partner violence.

Finally, on the coping strategies adopted by pregnant women to deal with IPV, the study found some women resort to prayer (39.2%), crying in silence (43.1%), complain to health workers during ANC (5.9%), family/friends 37.3%). Other strategies adopted was the believe that children will fight their cause (60.8%) while others consider leaving their husbands (39.2%). These findings coincide with the intersectional feminist theory, which emphasizes the positions of inequity and injustice in which women who experience IPV are placed by oppressive social structures, social agencies/professional helpers, family. The findings also corroborated Bhandari, Bullock, Anderson, Danis, & Sharps (2011) study, which opined that due to social norms, many pregnant women have been forced to adopt prayers and other subtle means for a change of partner's hearts and acceptance of abuse to stay long in their marriage.

Conclusion

The study found a high prevalence of IPV among pregnant women in Keffi LGA and this takes the form of physical, psychological and social patterns with very negative effects on their reproductive health outcomes. To cope with this, women adopt different strategies which most times are not targeted at prevention but mitigation. Therefore, it is urgent to sensitize women to speak out in the face of intimate partner violence. Even though they believe in God, appropriate steps should also be taken for the sake of their reproductive health and well-being.

Recommendations

As a panacea to every study, this study has made the following recommendations

- There is the urgent need for government and other relevant stakeholders to create awareness among would be and married couples on the dangers of intimate partner violence especially as it relates to pregnant women in Keffi LGA. Husband (male partners) should be enlightened on the need to protect pregnant women in Keffi and Nasarawa State generally.
- Existing legal frameworks that protect human rights should be broadened to cover the rights of pregnant women against hitting, insult, sexual and financial denial, and threats of death in Keffi and Nasarawa State.
- Government and other relevant agencies should introduce welfare for abused pregnant women to help them cope with intimate partner violence in Keffi and Nasarawa State

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