

Intimate Partner Violence Against Pregnant Women Attending Antenatal Care In Jos University Teaching Hospital: Prevalence, Causes And Consequences

¹Samuel Omuya Audu, ²Oba Preye Inimiesi

1. Department of Social Work, Faculty of Social Sciences, Federal University Otuoke, Bayelsa State-Nigeria

2. Department of Public Administration, Faculty of Social and Management Sciences, University of Africa
Toru-Orua, Bayelsa State, Nigeria.

ABSTRACT

Pregnancy-related domestic abuse is a serious social problem that has significant impact on the health of both the mother and the foetus. This study explores the prevalence, causes, and consequences of intimate partner violence (IPV) among pregnant patients at Jos University Teaching Hospital(JUTH) in Nigeria. Cross-sectional survey design involving the use of questionnaire as data collection instrument was used to capture the diverse character of IPV encounters to meet the study's objectives. 103 pregnant women participated in total. The results show that pregnant women receiving prenatal treatment at JUTH have a concerning high incidence of IPV, with 60% of them reporting having experienced financial, emotional, or physical abuse at the hands of their intimate partners. IPV is caused by several factors, including gender inequity, sociocultural norms, economic reliance, and a lack of knowledge about legal rights. Maternal health is greatly impacted by IPV as signified by the strong correlations found between IPV exposure and unfavourable pregnancy outcomes, such as preterm birth and low birth weight. The findings highlight how vital it is to combat IPV against pregnant women in Nigeria through multi-sectoral initiatives. To combat cultural norms that support IPV, recommendations include encouraging education and awareness campaigns, bolstering legal frameworks, and enabling women to seek treatment. Stakeholders may contribute to safer conditions for expectant mothers and their unborn children by putting these suggestions into practice, which will eventually improve maternal health and well-being in Nigerian society.

KEYWORDS:

Intimate partner,
Violence, Pregnancy,
Antenatal care.

Introduction

Intimate partner violence (IPV) is a pernicious and complex social issue that affects countless people worldwide and penetrates all demographics. According to the World Health Organization (WHO), violence against women continues to be a public health problem, depriving women globally of their human rights and preventing the achievement of the United Nation's (UN) sustainable development goals (World Health Organization, 2019; NPC, 2014). Worldwide, more than one-third (35%) of women have at some time in their lives been victims of physical and/or sexual abuse by an intimate partner or by a non-partner (World Health Organization, 2018). Social class, age, gender, or cultural background are all irrelevant in its reach. Fundamentally, intimate partner

violence takes the form of a pattern of abusive and coercive behaviour used by one spouse to control and dominate the other inside the intimate relationship. Its various forms, which include coercion that is financial, emotional, psychological, physical, or emotional, highlight the severity of intimate relationship violence (Saeed et al., 2023). The obvious scars and injuries caused by physical violence are not often as noticeable as the emotional and psychological harm caused by degrading treatment, manipulation, and intimidation. These wounds frequently last long after the bruises go. Sexual coercion is a violation of one's liberty and dignity that exacerbates trauma and increases the victim's sense of helplessness and solitude.

Intimate partner violence (IPV) is a serious and pervasive public health issue in Nigeria, mirroring the global situation in which IPV has a devastating impact on victims, families, and entire communities. Even with significant legal changes and increased public awareness campaigns, the threat of IPV remains, threatening the lives of innumerable women from a wide range of social, cultural, and geographic origins. In traditional societies, IPV is used to enforce compliance on the part of women (Benebo et al., 2018). IPV is used as a form of oppression to justify a false sense of male dominance, despite a lady's ostensibly economic accumulation or health status (Ajayi & Airewele, 2018).

The prevalence of IPV in Nigeria highlights structural issues ingrained in gender dynamics, institutional frameworks, and societal norms. The majority of this epidemic's victims are women, who suffer from mistreatment on all fronts—physical, mental, and financial—that erodes their sense of well-being and social cohesiveness. The effects of intimate partner violence are far-reaching, affecting generations to come, impeding societal advancement, and sustaining cycles of pain and inequity. Coordinated efforts must be made to undermine deeply ingrained patriarchal norms, fortify support networks, and promote cultures of empowerment and accountability as Nigeria struggles with the many aspects of this issue. Nigeria can only hope for a day when every person is assured the basic right to safety, dignity, and autonomy in their relationships by working together and with unshakable dedication.

Pregnant women are a particularly vulnerable subset of the population within the complex web of intimate partner abuse, negotiating a complex web of particular difficulties and significant hazards. Christina et al (2023), adduced that, IPV is a predominant concern for pregnant women globally. Urquia et al, (2011) reported that un-attention has been given to IPV during pregnancy as a global public health problem due to its adverse health consequences. Although pregnancy is often associated with optimism and excitement, it also brings with it increased emotional, physical, and psychological vulnerability for expecting mothers, making them more vulnerable to the destructive influence of IPV. When intimate partner violence and pregnancy come together, it signals the beginning of a complex relationship with far-reaching effects that go beyond the person and into

the areas of the mother's health, foetal health, and the delicate balance of family dynamics.

Research has indicated that pregnant women in Nigeria are more likely to be victims of domestic violence, which can have negative effects on infant mortality, mother health, and the general development of society. Tella et al, (2018) reported on IPV among pregnant women in South-South Nigeria and found physical IPV to be higher in rural (43.6%) compared to urban (23.7%); sexual violence was least reported, higher in rural (15.1%) than urban (9.7%). The subtle existence of abuse throughout pregnancy not only endangers the expecting mother's bodily and mental well-being but also puts a pall over the developing life inside her womb, sowing the seeds of pain and misfortune that might last for a very long time. The underreporting and normalization of abuse in intimate relationships is a major obstacle to tackling IPV against pregnant women. Due to fears of retaliation, social shame, or financial dependency on their abusers, pregnant women may be reluctant to reveal experiences of IPV. The abuse cycle is sustained by this culture of silence, which also makes it more difficult to act quickly to safeguard vulnerable women and their unborn children. The physical and psychological effects of IPV on pregnant women's health and well-being may worsen as a result of their continued under treatment and lack of access to crucial support services. Intergenerational trauma and conflict are perpetuated by the consequences of intimate partner violence (IPV) during pregnancy. These consequences shape the trajectory of familial ties and the well-being of offspring. An urgent cry for comprehensive interventions, strong support networks, and unwavering advocacy to protect the sanctity of pregnancy, foster maternal resilience, and pave the way for healing, empowerment, and renewal is heard as society faces the harsh realities of this intertwined crisis.

It becomes pertinent to note that previous studies have examined the issue of intimate partner violence in society.

For instance, in a research by Benebo et al, (2018) in their study titled "Intimate partner violence against women in Nigeria: a multilevel study investigating the effect of women's status and community norms, found that almost one in four women in Nigeria reported having ever experienced intimate partner violence. The study further revealed that having adjusted for other relevant covariates, higher women's status reduced the odds of IPV. In a similar study by Fareo (2015), found that the level of violence against women in Nigeria is increasing by the day with two out of every three women in certain communities experiencing violence in the family. The study equally revealed that many women do not report the abuse as they are ashamed that their marriages are not working and for most women in Nigeria, divorce is not an option at all. So they suffer in silence.

However, in spite of the litany of literature, none of these studies captured the particular experience of Jos and the unique perspective of pregnant receiving prenatal care. Jos, the capital city of Plateau State, presents a compelling context

for examining this phenomenon due to its diverse population, socio-cultural dynamics, and the presence of a major healthcare institution like the Jos University Teaching Hospital (JUTH). An essential part of the region's healthcare system for expectant mothers receiving prenatal treatment is the Jos University Teaching Hospital (JUTH). Pregnancy-related intimate partner abuse can be identified and addressed during antenatal care visits, which is a vital opportunity. Still, there is a dearth of research on the prevalence and contributing factors of IPV in this particular healthcare context. This study intends to close this gap in the literature by concentrating on women receiving prenatal care at JUTH and to further our understanding of the interrelated factors impacting experiences of IPV during pregnancy.

Research objectives

Against the above background, the study pursued the following objectives:

- a. Examined the extent to which women attending antenatal care in Jos University Teaching Hospital (JUTH) have experienced domestic violence.
- b. Analysed the nature of intimate partner violence suffered by women attending antenatal care in Jos University Teaching Hospital (JUTH).
- c. Examined the reasons associated to their abuse by their intimate partner
- d. Determined the effects of stigmatization on the willingness of pregnant women to openly complain or resist IPV especially when it involves their spouses.

The Literature

Intimate partner violence

Intimate partner violence (IPV), also referred to as domestic violence, is a widespread social problem that includes coercion of any kind—physical, emotional, sexual, and financial—in intimate relationships. According to Fareo (2015), it is a pattern of abusive behaviour in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. In the same vein, the Nigerian Violence Against Persons (Prohibition) Act of 2015 defined domestic violence as any act perpetrated on any person in a domestic relationship where such act causes harm or may cause imminent harm to the safety, health or well-being of any person. Intimate partner violence represents a serious abuse of power within family, trust or dependency relationships (Chris, 2021). According to the definition, "anyone, regardless of race, age, sexual orientation, religion, or gender, can experience IPV, which often occurs behind closed doors, shrouded in secrecy and shame." It can take many different forms, such as physical abuse, sexual abuse, emotional, economic, or psychological abuse, and the victim is typically the one who denies it (Fareo, 2015; Office of Violence Against Women, 2007; Manpreer & Lavjit, 2023). While physical abuse

frequently results in obvious wounds, bruises, and scars, emotional and psychological abuse may be just as harmful, destroying a victim's sense of self-worth, independence, and mental health. It is challenging for victims of manipulative behaviours, such as gaslighting, coercion, and isolation, to ask for assistance or leave abusive relationships because they are caught in a vicious cycle of fear and dependence. It flourishes in settings where structural injustices, gender inequality, and power disparities are prevalent, feeding trauma and damage cycles. By using their might and influence to manipulate their victims into fear and intimidation, perpetrators of violence can create a cycle of violence that lasts for generations. Many victims suffer for a long time despite more knowledge and activism because of social shame, reliance on money, and insufficient support networks.

When children witness or experience IPV, it can have a profoundly negative emotional and psychological impact that goes well beyond the immediate victims. Dodd (2009) provided evidence to support the claim that a kid who witnesses domestic violence throughout their childhood would experience developmental and psychological problems. Such exposure may hinder their development and result in behavioural problems, subpar academic results, and long-term mental health difficulties. Comprehensive interventions that address prevention, intervention, and support for survivors are required because IPV puts a load on social services, law enforcement, and healthcare systems. A multifaceted strategy is needed to interrupt the pattern, one that includes accessible tools that enable people to leave abusive relationships, legislative reforms, and community education.

Intimate partner abuse must be stopped, and an equitable and respectful society must be promoted. These can only be achieved via advocacy, empathy, and teamwork. Society may break down the structural obstacles that support domestic violence by opposing negative gender stereotypes, encouraging healthy relationships, and holding offenders responsible (Manpreet & Lavjit, 2023). For survivors to heal and rehabilitate, it is crucial to provide them with resources, housing, legal support, and counselling services. By working together and being steadfastly committed, we can build safer spaces where each person is respected, heard, and shielded from the evil that is intimate partner abuse.

Causes of Intimate partner violence

The complex problem of domestic violence against women is shaped by several overlapping elements that are ingrained in cultural norms, societal systems, and individual behaviours. A single method doesn't seem to work in every situation, as is the case with many phenomena related to human experience. Fundamentally, power disparities and deeply ingrained gender norms that uphold control and inequality in close relationships are the foundation of domestic violence. Fareo, (2015) alluded to this when he reported that abusers abuse to establish and maintain control over the partner. Patriarchal structures

perpetuate ideas of male dominance and female submission, which makes it easier for abuse and other types of control to be asserted. Chris (2021) provided evidence to back the aforementioned claims, claiming that women who object to their husband's authority over them, ask for household money, or leave the house without permission risk assault. Men are led to believe their ideas about what it means to be a man and how much influence they have over their wives as a result of this process. This supports the theory that violence against women in intimate relationships is a reflection of historically uneven power dynamics between men and women. Offenders use their strength and influence to dominate their victims by intimidating and instilling fear in them. In addition, the frequency of domestic violence in a variety of cultural and socioeconomic circumstances is influenced by social views that normalize aggressiveness, support violence, and undermine the autonomy of victims.

Furthermore, the Social Learning Theory provides explanations for the persistence of domestic violence by suggesting that people learn behavioural patterns through observation, imitation, and reinforcement. People frequently observe or experience violence in familial and social situations, which normalizes its occurrence and causes them to internalize aggressive behaviours as appropriate means of resolving conflicts or asserting control. According to Fareo, (2015:27);

*If one observes violent behaviour, one is more likely to imitate it.
If there are no negative consequences and the victim also accepts
the violence with submission; then the behaviour will likely
continue.*

Furthermore, drug addiction heightens the dynamics of domestic violence by decreasing inhibitions, impaired judgement, and intensifying confrontation. Misuse of alcohol and drugs increases aggressiveness and erratic behaviour, which raises the risk of violent altercations in close relationships. Insecure or possessive relationships that are marked by jealousy can result in controlling behaviours, emotional manipulation, and the use of coercive techniques and physical violence to retain perceived authority or impose dominance. Many cases of domestic violence against women occur due to jealousy when the spouse is either suspected of being unfaithful or is planning to leave the relationship (Fareo, 2015). Intimate relationships characterized by poor communication, financial strain, and social isolation foster animosity and power struggles, which intensify disputes into violent altercations.

Furthermore, poverty also acts as a structural factor that increases the likelihood of domestic violence because it increases family tensions and restricts survivors' access to resources and support systems, which are necessary for seeking safety and aid. Due to heightened stress and disagreements about money and other issues, couples living in poverty may be more prone to domestic violence (Jewkes, 2002). The interplay of these variables highlights the necessity of all-encompassing interventions that tackle structural injustices, advance gender

parity, and cultivate community-based approaches to successfully prevent and manage domestic abuse.

Effects of Intimate Partner Violence on Society

Domestic violence is a complex and pernicious kind of abuse that affects women daily and has a severe negative impact on their physical, mental, and financial well-being. Physically, women who experience domestic violence face a variety of injuries, from life-threatening attacks and chronic health disorders to bruises, lacerations, and broken bones (Jones cited in Fareo, 2015; Miller & McCaw, 2019). Their physical health is compromised by the violent cycle that never stops, leaving them with permanent scars that serve as a reminder of the trauma they have experienced.

Domestic abuse also has a psychological toll on survivors' mental and emotional well-being, leaving them feeling powerless, ashamed, and afraid. Survivors often grapple with symptoms of anxiety, depression, post-traumatic stress disorder (PTSD), and diminished self-esteem, as the emotional abuse and manipulation perpetrated by their abusers erode their sense of agency and autonomy (Fareo, 2015). According to Marianna et al, (2021), partner violence has been associated with many mental health consequences: Depression, anxiety, Post-Traumatic Stress Disorder, eating disorder, suicidal behaviour, alcohol and drug abuse, sexual problems with concentration, somatization, social, educational, or occupational difficulties, as well as a feeling of blame and guilt or reproach. In women of reproductive age, IPV has been linked with poor reproductive health and poor sexual health (unintended pregnancy and sexually transmitted infections) and heightened risks of obstetrical and gynecologic complications (pregnancy-associated death, preterm birth, low birth weight) and represent a risk factor for peripartum depression (Miller & McCaw, 2019).

In addition, the financial consequences of domestic abuse increase the susceptibility of survivors because perpetrators utilize economic control strategies to limit their access to resources, undermine job prospects, and maintain their financial reliance. To acquire housing, pay for needs, and start over on their own, women who are victims of domestic abuse must deal with unstable finances. The medical cost that accompanies IPV can disrupt and follow people throughout their lives (Maggie, 2019). This is one of the greatest obstacles facing victims of domestic violence, and the strongest fact that can discourage them from leaving their perpetrators (Stop Violence against Women, 2010). The intertwined components of financial, psychological, and physical trauma highlight how critical it is to treat domestic abuse holistically, protect the rights of survivors, and remove structural obstacles standing in the way of their empowerment, safety, and rehabilitation.

Theoretical Framework

In furthering this research work, the study adopts the Intersectional feminism theory as its theoretical framework. The theory as advanced by Kimberlé Crenshaw, posits that various forms of social stratification, such as race, class,

gender, and others, do not exist separately from each other but are interwoven and interact on multiple and often simultaneous levels (O'Connell, Joseph & Bongar, 2023). For instance, a pregnant woman's vulnerability to intimate partner violence (IPV) may be impacted by the intersection of variables such as socioeconomic position, cultural views, resource accessibility, and social support networks. According to the theory, these systemic disparities may make it more difficult for women from marginalised communities—such as those from lower socioeconomic status or minority groups—to obtain support services, and they may also make them more susceptible to intimate partner violence.

Furthermore, there may be a connection between pregnancy and IPV. Pregnancy can be a tool used by certain abusers to gain control or influence over their victims, which can result in more violence throughout the pregnancy. Additionally, the prenatal care environment at JUTH may either offer a safe space to recognize and manage intimate partner violence (IPV) or it may create new difficulties, such as stigma or fear of consequences for reporting abuse. A more thorough understanding of the dynamics of IPV against pregnant women accessing JUTH prenatal care may be attained by looking at the intersectionality of characteristics including race, class, gender, pregnancy status, and access to healthcare. This knowledge can help develop support programmes and treatments that are more successful and cater to the unique needs of these women.

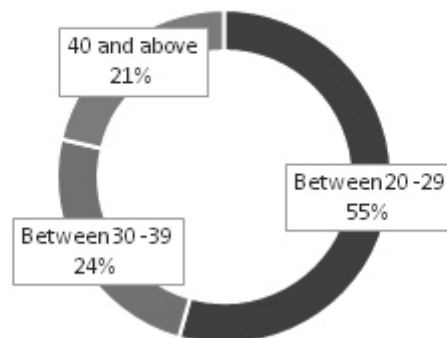
Design and Method

Cross-sectional survey research design was used. The study was conducted at the JUTH while pregnant women receiving prenatal care at the time were studied. The exact population of the pregnant women attending antenatal care at the study location was undermined but a sample of 103 pregnant women were covered by the study. The respondents were chosen through the use of the purposive sampling approach. In the inquiry, non-probability sampling techniques were applied. Purposive and convenient sampling strategies are among these methods. The Jos University Teaching Hospital (JUTH) was chosen as the research site via purposive sampling. Then, easily reachable pregnant patients receiving prenatal care were selected using the convenience sample approach. Primary data for the study came from a questionnaire, while secondary data came from published sources. The purpose of the study and all of the additional participant rights, such as anonymity, were explicitly disclosed to the respondents. The data in this investigation were interpreted using the descriptive-analytical approach. Metrics of central tendency and frequencies were used to summarize the data. Descriptive statistics were used to analyse the information gathered from the questionnaire.

Findings and Discussion

Socio-Demographic Information

Fig 1: Age distribution of respondents



Source: fieldwork, 2023

Figure 1 above shows that 54.4% (n=56) of the respondents are between the age bracket of 20-29, 24.3% (n=25) are within the range of 30 -39, and 21.4% (n=22) are above 40 years. This shows that more than 70% of the respondents are within the age bracket of knowing their left from their right and should be able to seek redress if bartered.

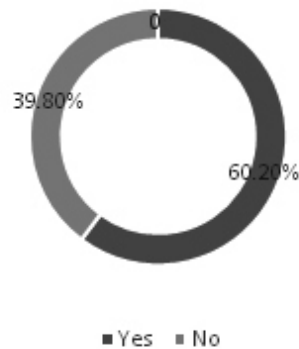
Substantive Findings

In this section, the objectives are restated and the related data are presented in charts to enable a pictorial understanding of the results derived. This is followed by the presentation of the test of the hypotheses and interpretation of the results. Not all respondents responded to all of the questions; therefore the percentages reported correspond to the total number of respondents who responded to the individual questions.

Evaluation of objectives

Objective 1: Examine the extent to which women attending antenatal care in Jos University Teaching Hospital (JUTH) have experienced domestic violence.

Fig2: Distribution of Respondents on whether they have been domestically violated by their spouse during their current pregnancy.

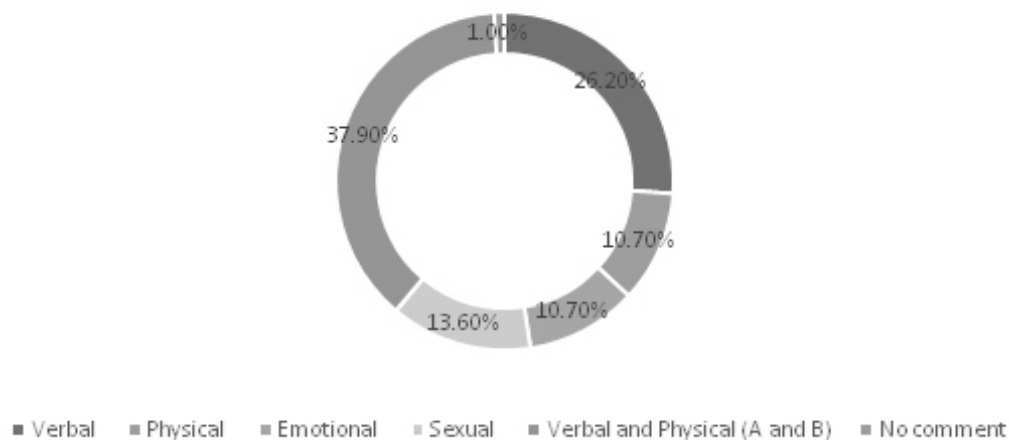


Source: fieldwork, 2023

From the figure above, 60.2% (n=62) of the respondents said that they had been domestically violated by their spouses during pregnancy while 39.8% (n=41) of the respondents said they had not been hurt. This goes further to state that women are more prone to abuse by their spouses during pregnancies.

Objective 2: To ascertain the nature of intimate partner violence suffered by women attending antenatal care in Jos University Teaching Hospital (JUTH).

Fig 3: Distribution of Respondents on the nature of intimate partner violence suffered by women attending antenatal care in Jos University Teaching Hospital (JUTH).

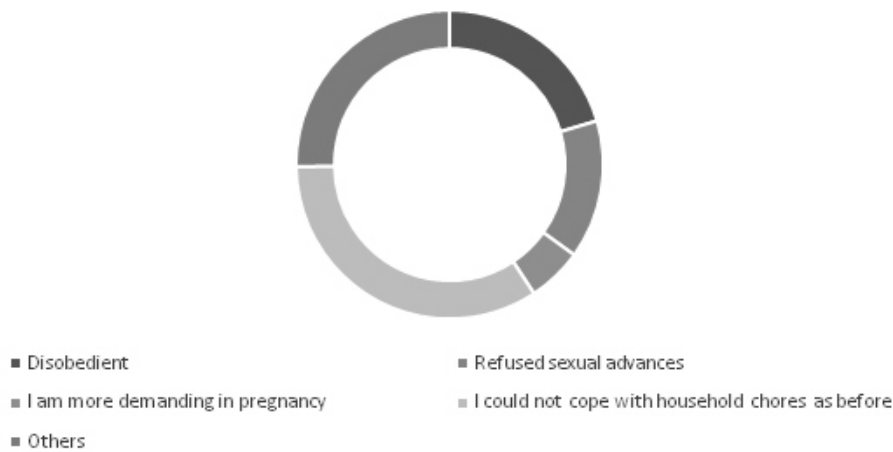


Source: fieldwork, 2023

From the Figure above, 37.9% (n=39) of the respondents said that they experience verbal and physical abuse most in their relationships with their spouses, 24.3% (n=25) of the respondents stated that they experienced both sexual and emotional abuse the most, while only 1.0% (n=1) of the respondent remained indifferent. This goes to show that the majority of women faced all forms of violence in the home, particularly during pregnancy. This may be a result of their inability to cope with house chores and sexual demands from their spouse as they used to be.

Objective 3: To examine the reasons associated with the abuse by their intimate partner

Fig 4: Distribution of Respondents on why they were abused.



Source: fieldwork, 2023

From the Figure above, 20.4% (n=21) of the respondents accepted the fact that they had been abused based on the fact that they were disobedient, 14.6% (n=15) said because they refused sexual advances, 5.8% (n=6) of the respondents feel they were not demanding in pregnancy. 34% (n=35) of the respondents felt they were bartered because they could no longer cope with household chores, while 25.2% (n=26) of the respondents saw other reasons as responsible for them being bartered since the majority of the women sampled during the antenatal section noted that they have been abused in one way or the other on the basis that they could not cope with household chores or as a result of their refusal to have sex with their spouses during pregnancy.

Objective 4: To find out whether stigmatization affects the willingness of pregnant women to openly complain or resist intimate partner violence especially when it involves their spouses.

Fig 5: Distribution of Respondents on whether stigmatization affects their willingness to openly complain or resist intimate partner violence especially when it involves their spouses.



Source: fieldwork, 2023

Figure 5 above shows whether stigmatization affects their willingness to openly complain or resist IPV especially when it involves their spouses. The data shows that 64% (n=66) of the aggregate respondents boldly reported that the stigmatization associated with IPV affects their willingness to openly complain or resist it, especially when it involves their spouses, 25.2% (n=26) disagreed while 10.7% (n=11) were indecisive about the subject matter. It suffices to conclude that the stigmatization effect on the psychology of the victims in most cases affects their willingness to openly complain or seek redress especially when it involves their spouses.

Discussion

The discussion of findings is done in line with the research objectives. Several things were discerned in the course of this study. The first finding in this study dealt with objective 1 and the relevant data were presented in Figure 2 above. The result captured that an average of 60.2% of the aggregate respondents reported that they have been violated by their intimate partner amidst the current status of pregnant women. This finding supports that of World Health Organization, 2018 who reported that more than one-third (35%) of women have at some time in their lives been victims of physical and/or sexual abuse by an intimate partner or by a non-partner.

The second finding from the study dealt with objective 2 and the relevant data were presented in Figure 3 above. The result captured that an average of 37.9% of

the respondents have received both verbal and physical abuse from their spouses. Additionally, the data shows that the majority of women faced all forms of violence in the home, particularly during pregnancy. This finding supports that of Fareo, (2015) who established in their study that IPV can take many different forms, such as physical, psychological, etc.

The third finding from the study dealt with objective 3 and the relevant data were presented in Figure 4 above. The result captured that disobedience and the inability to cope with household chores as before represented the major reasons for their victimization by their intimate partner during pregnancy with an average of 20.4% and 34% respectively. The fourth finding from the study dealt with objective 4 and the relevant data were presented in Figure 5 above. The result captured that the stigmatization effect on the psychology of the victims in most cases affects their willingness to openly complain or seek redress especially when it involves their spouses, with an average of 64.1%. This finding supports that of Hulley et al, (2023) who established that the stigma associated with divorce and the blame attached to women for marriage break-ups commonly served as barriers to *help-seeking*.

Conclusion

The purpose of the study was to examine the prevalence, characteristics, and effects of IPV against pregnant women receiving prenatal care at Jos University Teaching Hospital (JUTH) on the victims, the state, and the nation as a whole. The study concludes that all facets of society must work together to combat IPV. The study uncovered a startling reality: a sizable majority of expectant mothers reported having experienced verbal and physical abuse from their spouses, among other forms of violence. This puts the expectant mother's physical safety and emotional sanctity in jeopardy and also casts a terrifying shadow over the developing life inside her womb, sowing the seeds of trauma and adversity that may linger long into the future. The primary reasons for this domestic violence that have been found include disobedience and the belief that one's pregnancy has made one less capable of doing household responsibilities. These reasons highlight the pervasive power disparities and gender dynamics in intimate relationships. Based on the results, the study highlights the necessity of larger societal initiatives to question patriarchal norms and advance gender equality in addition to the urgent need for comprehensive treatments addressing IPV within the prenatal care context. A variety of strategies, such as community-based education programmes, legal assistance, and counselling services, should be incorporated into effective interventions. These strategies should strive to

empower women, increase men's understanding, and create supportive settings that promote healthy, violence-free relationships. Lastly, the plans below outline how to ensure that society is safe, secure, and at peace.

Recommendations

The widespread problem of intimate partner violence (IPV) poses multifaceted obstacles to the health, stability, and advancement of society. Based on the thorough analysis carried out in this study—despite its limitations, including possible biases, stigma-induced underreporting, and difficulties in fully capturing the spectrum of IPV—sensible conclusions have been drawn, which open the door to several evidence-based recommendations intended to lessen the incidence and effects of IPV in our communities. These recommendations are intended to serve as both a response mechanism and a preventive measure, promoting a society in which safety, respect, and dignity are unconditional standards for all.

1. Central to addressing IPV is empowering victims to break the silence surrounding their experiences. The stigma and concern attached to reporting abuse frequently prevent victims from getting assistance. It is imperative to promote victims' coming forward and use of existing support systems, including the Human Rights Commission and the State Ministry of Women Affairs. These organizations must have the necessary resources and power to provide victims with adequate help and protection. This will ensure that the process is secure and confidential, therefore encouraging more persons to come forward.
2. Offenders must face consequences from the law to demonstrate society's commitment to ending IPV. To prevent future offenders, the legal system must be strengthened to guarantee prompt and harsh punishments for IPV offences. To safeguard victims' rights and dignity, the judicial system must collaborate with social services, making it abundantly evident that violence against partners is a serious human rights violation that will not be tolerated.
3. In the end, society's comprehension and condemnation of such violence determines how effective laws and initiatives against IPV will be. Public education campaigns have the power to fundamentally alter cultural norms and perceptions of intimate partner violence. These educational programmes can create a cultural environment in which intimate partner violence (IPV) is universally despised and rejected by clarifying the detrimental effects of IPV on people, families, and society as a whole, as well as by encouraging healthy relationship models.
4. One of the first groups of people to witness the psychological and physical repercussions of IPV is the medical community. Nonetheless, there is an urgent need for healthcare practitioners to be more aware of IPV and how it affects reproductive health. Initiating timely interventions requires knowledge of the health implications of intimate partner violence (IPV) as well as its indicators of it. The medical community may be better

equipped to address this issue by implementing IPV education into medical training, holding continuing education seminars, and running awareness campaigns.

5. In addition to knowledge, medical professionals need specific training in recognizing, assisting, and guiding victims of intimate partner violence. Healthcare personnel also need to be trained on the social resources that victims can access, including as counselling, legal assistance, and shelter services. By taking this strategy, healthcare personnel are guaranteed to be able to assist victims in finding the larger support system that is essential for their safety and rehabilitation, in addition to providing medical care.

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