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Prevalence, Pattern and Correlates of Intimate Partner Violence among Postpartum Women in Osogbo, Nigeria

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Aim: Intimate partner violence (IPV) is a public health issue in both developed and developing countries. It is one of the most common forms of violence against women. It affects all ethnic groups and it is not impeded by cultural, socio-economic or religious barriers. IPV in postpartum women can increase the risk of homicide and suicide. The study aimed to assess the prevalence, pattern and correlates of IPV among postpartum women attending postnatal and infant welfare clinics of LAUTECH Teaching Hospital, Osogbo.
Study Design: This was a cross-sectional study.
Place and Duration of Study: This study was conducted at LTH, Osogbo Nigeria between September and November 2015.
Methodology: This was study conducted among 220 consenting postpartum women using Composite Abuse Scale and socio-demographic questionnaire. Data were analyzed using

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Statistical Package for Social Sciences (SPSS) version 21. The level of statistical significance was set at p-value less than 0.05.
Results: Prevalence of IPV was 26.8%, patterns of IPV were physical abuse 14.5%. Emotional abuse, 26.3, severe combined abuse 9.9% and Harassment 14.5%. IPV was significantly associated with support from respondents' partner during pregnancy ($\chi 2$= 5.470, p=0.019) and partner's religion. ($\chi 2$= 7.746, p= 0.010) The odd ratio for those who had partner's support was less than 1. (OR =0.337, p=0.014, CI=0.141-0.803).
Conclusion: The prevalence of IPV is high among postpartum women. Increased media campaign about intimate partner violence and preventive measures is urgently needed.

Keywords: Intimate partner violence; postpartum women; prevalence; pattern.

1. INTRODUCTION

IPV is one of the most common forms of violence against women [1,2]. It affects all ethnic groups and it is not impeded by cultural, socio-economic or religious barriers [3]. In sub-Saharan Africa, 13-49% of women were reported to have been hit or otherwise physically assaulted by an intimate partner in their lifetime, with 5 – 29% reporting physical violence in the year before the survey [4].

The prevalence of IPV in Nigeria varies with a range of 11-79% [1,3,5-8]. This wide range is believed to be a result of methodological differences in the estimation of IPV [3]. For example, the study population differs in the various studies, Onoh studied pregnant women, Fawole studied both men and women and Aimakhu studied practicing Obstetricians and Gynecologists [1,3,8]. The prevalence found for verbal abuse was 68.1% and 31.4% for both verbal and physical abuse amongst married women [9]. Fatusi and Alatise reported that 61.1% of women experienced psychological abuse, 19.9% sexual abuse and 7.3% physical abuse [10].

There are various types of intimate partner violence. Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm [11]. Physical violence includes, but is not limited to scratching, pushing, biting, choking, shaking, slapping, punching, burning, use of a weapon and use of restraints or one's body size or strength against another person [11,12].

Sexual violence encompasses three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability or the influence of alcohol or other drugs, or because of intimidation or pressure and 3) abusive sexual contact [12]. Threats of physical or sexual violence include the use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm [12].

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family and denying the victim access to money or other basic resources [12].

Factors that lead to IPV are complex and numerous. They include; poverty, patriarchal societies, unemployment, alcohol abuse, financial problems, interference of a third party especially in-laws [3,13]. In sub-Saharan Africa, poverty and gender inequality play definite roles in IPV [4]. In Nigeria, IPV has its root in socially sanctioned male domination of women and women's low social status [5]. The low social status of women is reflected in poor educational development, lower employment and economic opportunities.

The picture that emerges from the growing body of literature on religion-intimate partner violence linkage is that it is complex, full of ambiguities and contradictions. Religion can be a constructive force that reduces the risk of both perpetration and victimization [14]. Some religions proscribe early marriage for girls which may further distort the power dynamics in a relationship and increase the risk of IPV [15]. However, attendance at religious services is

associated with less perpetration of IPV by both men and women and also less victimization in women [16].

Consequences of IPV in women include headache, injury, chronic pain, disability, sexually transmitted infections, perinatal infections, miscarriages, premature rupture of membranes, preterm labour, fetal distress, substance use and abuse, posttraumatic stress disorder, anxiety, depression and death [7,17]. IPV poses a great threat to attainment of goals of Safe Motherhood Initiative and the Sustainable Development Goals especially those concerned with reduction of maternal and child morbidity and mortality [3].

1.1 Prevention of IPV

1.1.1 Primary level

The goal of the prevention is simply to stop IPV though it is as complex as the problem. Preventive efforts are targeted towards promoting healthy, respectful and non-violent relationships in families by fostering healthy parent-child relationship [18]. Media and advocacy campaigns are organized to raise awareness about existing legislation but sensitization has not stopped the cultural norm [19]. Furthermore, social and economic empowerment of women and girls should be promoted, although economic empowerment is not a sole protective factor but it was found that working women who were exposed to IPV sought more help from different sources [20,21]. Economic empowerment together with higher education and modified cultural norms against women, may protect women from IPV [21].

1.1.2 Secondary level

This is immediate response after IPV has occurred to deal with short-term consequences and prevent future perpetration or victimization. Judges and Police are sensitized about IPV and perpetrators are held responsible by enforcing laws adequately and consistently [11]. The Nigerian police has made provision for family support units as well as human right officers that deal with the complaints on intimate partner violence [22]. Shelters are provided by some states and Non-governmental organization.

1.1.3 Tertiary level

This involves long-term response after violence has occurred to deal with the lasting consequences of IPV and offender treatment intervention. Some states in Nigeria like Lagos, Ekiti, Ebonyi, Jigawa and Cross River now have state-level domestic violence legislation**,** an example of such is 'a law to provide protection against domestic violence and connected purposes' of Lagos State but the laws are still quite poorly implemented. The reasons for poor implementation include: lack of awareness of the legislation on domestic violence, inability of victims to afford the costs associated with pursuing a case, unwillingness of victims to take action in the courts, refusal of family members to testify in court and court's 'insensitivity to domestic violence victims with frequent adjournments and delays' in the judicial process [23].

1.2 Justification

Intimate partner violence (IPV) is a worldwide public health concern and a chronic stressor which predominantly affects women of reproductive age [24]. The postpartum period may be a particularly vulnerable time for experiencing harms associated with intimate partner violence, with deleterious effect on maternal and child health [1,24]. Furthermore, the postpartum period provides a good opportunity to screen for IPV as women (those who did not attend antenatal nor deliver in hospital inclusive) bring their children for immunization (which is free) and women tend to trust and confide in health workers. Previous studies have focused mainly on various study population but no study in the catchment area of this study has examined intimate partner violence among postpartum women.

Thus, there is the need to increase the awareness of psychiatrists and other health workers involved in women health on the burden of intimate partner violence. This will encourage routine screening of intimate partner violence among women during hospital visit for prompt diagnosis and intervention so that these women can achieve optimal performance in their personal, family, occupational and social functioning.

Without objective information derived from empirical analysis of intimate partner violence in postpartum women, it will be difficult to plan meaningful screening of postpartum women routinely. Therefore, investigating intimate partner violence among postpartum women as an important area of research is essential because it will provide empirical evidence

of baseline data in our environment and provide the basis for the formulation of preventive strategies aimed at improving maternal and child health.

2. MATERIALS AND METHODS

2.1 Study Location

The study was conducted at the infant welfare and postnatal clinics of Ladoke Akintola University of Technology (LAUTECH) Teaching hospital (LTH) Osogbo, Osun State. It is a three hundred and ten bed capacity hospital which provides primary, secondary and tertiary health care services in all specialties of medicine. It is located at the centre of Osogbo, the capital of Osun State, where it is easily accessible to the indigenes. It is situated in Olorunda Local Government area of Osogbo in the South-Western part of Nigeria. Yoruba is the language widely spoken by the people, although other Nigerian tribes are present. LTH is a referral centre to other hospitals in the city and its environs.The hospital provides services for patients mainly from Osun state and neighbouring states like Oyo, Ondo and Ekiti.

2.2 Study Population

The study population comprised of women of age group 18-45 years who were in the postpartum period attending postnatal and infant welfare clinics of the hospital.

2.3 Inclusion Criteria

1. Subjects aged 18 years to 45 years.
2. Women who are currently or formerly married or cohabiting with a male partner for at least 12 months or women who have been in an intimate relationship within the past one year.

2.4 Exclusion Criteria

1. Women without live birth

2.5 Study Design

This was a hospital based cross-sectional descriptive survey.

2.6 Sample Size Estimation

The prevalence of intimate partner violence among postpartum women in a study by Hind was 11% [24]. This was used to calculate the minimum sample size for the study.

The minimum sample size for the study was calculated using

$$\text{Sample size } (n) = \frac{Z^2pq}{d^2}$$

(sample size for population > 10,000)(25)

Where,

n = Sample size
Z = Standard normal deviation = 1.96 corresponding to 95% confidence interval
P = The estimated proportion of an attribute that is present in the population (i.e known prevalence of the condition being studied) = 11% (0.11)
Q = 1.0 – P
D = Degree of accuracy desired, set at 0.05
N = $(1.96)^2$x0.11x0.89/$[0.05]^2$ =150.4 approximately 150

An attrition rate of 10% gives 150 x 10/100 = 15

150 +15= 165

However, because the study population is below 10,000, the true sample size (nf) is estimated from the above, as follows:

$$n_f = \frac{n}{1 + (n) / (N)}$$ [25]

Where,

n_f = The desired sample size when population is less than 10,000.
n = The desired sample size when the population is more than 10,000
N = The estimate of the population size, with the value of 1000, which is the population of postpartum women from the age of 18 to 45 years in 2014 at the postnatal clinic and infant welfare clinic of LAUTECH Teaching Hospital.

$$n_f = \frac{165}{1 + (165)/(1000)} = 141$$

n_f = 141

The sample size was increased to 220, to make it more robust.

2.7 Sampling Method

The infant welfare clinic of LAUTECH Teaching Hospital holds on Monday, Tuesday and Wednesday while the postnatal clinic holds on Friday. The Monday clinic is for age group 6 weeks to 14 weeks, Tuesday is for new-borns while Wednesday clinic is for children age 9 months and above. The postnatal clinic is at 6 weeks post-delivery. For the purpose of this study, the Wednesday clinic was excluded because the mothers' postnatal age were more than six months which was the postpartum period chosen for this study. The number of mothers attending the postnatal and infant welfare clinics was estimated to be about 15 per day. Those that fell within the age range of 18-45 years were included in the study. The recruitment for the study lasted 8 weeks.

Women attending these clinics were consecutively selected and those who met the inclusion criteria and gave informed consent after explaining the aim and objectives of the study to them were recruited for the study until the sample size was achieved. A removable identification sticker was left on all patients' card until the completion of the study to avoid a repeat selection. A resident doctor in psychiatry department who speaks and writes in Yoruba and English was recruited as a research assistant in order to help administer questionnaires to those who could not read in Yoruba or English. She was trained about the administration of the questionnaires. She was trained over 6 hours in 3 divided sessions each lasting 2 hours on 3 consecutive days before the data collection.

The self-administered questionnaires were filled by all mothers that met the inclusion criteria at the same time. For those who were not able to read in Yoruba or English, the research assistant helped to administer the questionnaire to them after obtaining informed consent. The interview was conducted in a private office, the respondents were put at ease and rapport was established before administration of the instrument. The questionnaires administration and completion was built into the normal waiting time for clinic. This helped to avoid prolonging the waiting time.

2.8 Measures

Data collection was done using the following instruments:

2.8.1 Socio-demographic questionnaire

The socio-demographic information of respondents, including age, residence, marital status, number of husband's wives, position among husband's wives, family settings, family size, sex of index child, sex of previous children, level of education of both participant and partner, employment status of respondent and partner's monthly income were enquired about.

2.8.2 Questions on pregnancy related factors

This aspect of the questionnaire enquired about support during pregnancy, mode of delivery, duration of delivery and no of weeks since delivery.

2.8.3 Questions on past history of exposure to violence

This section of the questionnaire enquired about experience of physical violence from home of origin before the age of 18 years, witnessing physical abuse in home of origin before age of 18 years, experience of sexual abuse before 18 years and witnessing sexual abuse before 18 years.

2.8.4 Questions on alcohol use

This section of the questionnaire enquired about alcohol use of respondents and their partners' alcohol use.

2.8.5 Composite Abuse Scale (CAS)

It is a 30-item validated self-administered research instrument [26]. It is based on a concept of intimate partner violence (IPV) that includes coercion and not simply violent acts arising out of conflict [26]. It is recommended as an IPV research assessment tool by the National Centre for Injury Prevention and Control [1,27] because it has demonstrated a high level of reliability and validity in self-reported prevalence of IPV [1,27]. The CAS measures four dimensions of abuse (1) physical abuse, (2) emotional abuse, (3) severe combined abuse and (4) harassment. There are physical, emotional, severe combined abuse and harassment have 7, 11, 8 and 4 items respectively. Each item has response categories of never, only once, several times, once/month, once/ week and daily which are scored 0,1,2,3,4,5 respectively. The CAS was scored by adding the response categories chosen by the participants. A preliminary cut-off score of 7 divides respondents into abused and non-abused [1]. It has high internal consistency (Cronbach's

alpha) of at least 0.90 for each subscale and an all item total score correlation of 0.6 [1,26]. It was selected for its comprehensiveness and strong psychometric properties. It has been validated with a large sample of patients in primary care practice setting [26]. The CAS has been used in Nigeria and showed face validity and good internal consistency with a Cronbach's alpha of 0.82 [1]. A cut off score of 7 was adapted for this study in accordance with the findings of Hegarty et al. [26]. The range of scores for CAS is from 0 to 150 [27]. The range of scores for each dimension is 0 to 40, 0 to 55, 0 to 35 and 0 to 20 for severe combined abuse, physical abuse, emotional abuse and harassment respectively [27]. For the four subscales, the cut off score was ≥ 1, ≥1, ≥3 and ≥ 2 for severe combined abuse, physical abuse, emotional abuse and harassment respectively [27].

2.9 Data Analysis

At the end of data collection, the administered questionnaires were sorted out and coded serially. All data collected were analyzed using the Statistical Package for Social Sciences (SPSS) software (version 21). Results were presented using frequency distribution tables and relevant statistics such as percentages, means and standard deviations. Cross tabulations were done to compare the outcome variables for IPV Chi square statistic, and logistic regression were used to evaluate the association between variables. Statistical significance was set at $P< 0.05$.

Table 1. Socio-demographic characteristics of the respondents (N = 220)

	Frequency (n=220)	Percentage
Age (years)		
≤ 20	2	0.9
20 -29	89	40.4
30 -39	124	56.4
≥40	5	2.3
Mean age 30.12 (± 4.76)		
Marital Status		
Cohabiting	25	11.4
Married	195	88.6
Marriage/Cohabitation pattern		
Monogamous	200	90.9
Polygamous	20	9.1
Employed		
Yes	167	75.9
No	53	24.1
Level of Education		
No formal education	1	0.5
Primary	11	5.0
Secondary	57	25.9
Tertiary	151	68.6
Tribe		
Yoruba	216	98.2
Igbo	3	1.3
Others Specified (Ishan)	1	0.5
Place of Residence		
Urban	214	97.3
Rural	6	2.7
Religion		
Christianity	140	63.6
Islam	79	35.9
Traditional	1	0.5
Income pattern		
Income<18000	117	53.2
Income≥18000	103	46.8

3. RESULTS

3.1 Socio-Demographic Characteristics of the Respondents

Two hundred and twenty questionnaires were administered to the study group and all the questionnaires were completed, giving a response rate of 100%.

The socio-demographic characteristics of the respondents are as shown in Table 1. The mean age of the respondents was 30.12 (± 4.76) years. Women whose ages ranged between 30 and 39 years constituted more than half of the entire respondents. Christians constituted about two-third of the respondents. Majority of the women had education beyond the primary school level. More than half of the respondents earn less than the current minimum wage of 18,000 Naira.

3.2 Prevalence of Intimate Partner Violence among the Respondents

The prevalence of Intimate partner violence is as depicted in Fig. 1. A little above one fourth of the respondents (59) were exposed to IPV using CAS score of 7 and above. More than two third of the respondents (161) were not exposed to IPV.

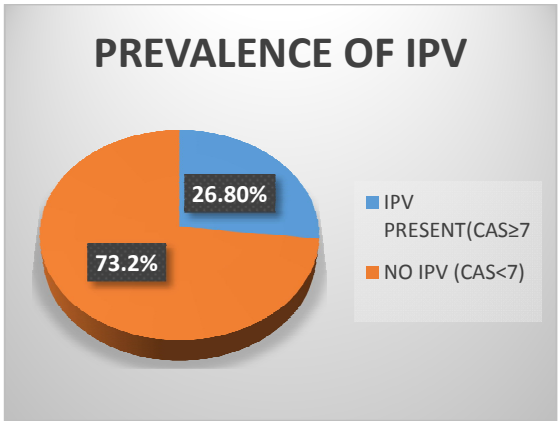

Fig. 1. Prevalence of intimate partner violence

3.3 Types of Intimate Partner Violence Experienced

Table 2, shows the prevalence of each type of IPV in the study population. The most prevalent type of IPV was emotional abuse (26.3%).

Table 3, shows the socio-demographic and clinical factors associated with intimate partner violence among the respondents. There was a statistically significant association between intimate partner violence and support from respondents' partner during pregnancy. Fourteen (43.8%) respondents who had no support from partner during pregnancy experienced IPV while 23.9% of those who had support from partner during pregnancy experienced IPV ($\chi 2=5.470$, 0.019).

Table 2. Type of intimate partner violence experienced in the study population (N =220)

Variables	Frequency	Percent (%)
Severe combined abuse	22	9.99
Emotional abuse	58	26.30
Physical abuse	32	14.50
Harassment	32	14.50

There was also a significant association between intimate partner violence and husband's religion. Thirty one (37.3%) of those whose partners were adherents of Islam were exposed to IPV while significantly less proportion (20.6%) of those whose partners were Christians were exposed to IPV ($\chi 2=7.746$, p=0.010).

There were no statistically significant associations between IPV and other variables such as age, marital status, marriage pattern, respondents' religion, educational status, occupational status, previous infertility problem, experience of physical and sexual abuse while growing up, witnessing physical and sexual abuse while growing up.

Association between intimate partner violence and other variables in respondents using logistic regression are as shown in Table 4 above. Variables were individually entered into a binary logistic regression model with intimate partner violence as the outcome variable and the significant predictor of intimate partner violence is as depicted in Table 4 above. The Odds for IPV in those who had husband support was less than 1 (0.337).

4. DISCUSSION

Majority of the respondents were married in monogamous family settings and reside in the urban area. This finding may be explained by the fact that the study was conducted in a teaching hospital which is a tertiary level of care and provides services more to the elite population, and which is also located in an urban centre.

Table 3. Association of Intimate partner violence with socio-demographic and clinical characteristics of respondents

Variable	Intimate Partner Violence		$\chi 2$	*df*	*p* value
	Yes no (%)	No no (%)			
Age group (years)					
< 30	25 (27.5)	66 (72.5)	0.034	1	0.854
≥ 30	34 (26.4)	95 (73.6)			
Marital Status					
Cohabiting	9 (36.0)	16 (64.0)	1.212	1	0.271
Married	50 (25.6)	145 (74.4)			
Marriage Pattern					
Monogamous	51 (25.5)	149 (74.5)	1.948	1	0.163
Polygamous	8 (40.0)	12 (60.0)			
Religion					
Christianity	31 (22.1)	109 (77.9)	4.920#	2	0.059
Islam	28 (35.4)	51 (64.6)			
Traditional	0 (0.0)	1 (100.0)			
Partner's Religion					
Christianity	28 (20.6)	108 (79.4)	7.746#	2	0.010*
Islam	31 (37.3)	52 (62.7)			
Traditional	0 (0.0)	1 (100.0)			
Educational Status					
Primary education and below	5 (41.7)	7 (58.3)	1.426	1	0.312
Secondary and above	54 (26.0)	154 (74.0)			
Support from Partner					
Yes	45 (23.9)	143 (76.1)	5.470	1	0.019*
No	14 (43.8)	18 (56.2)			
Experienced Physical abuse while growing up					
Yes	4 (36.4)	7 (63.6)	0.538#	1	0.491
No	55 (26.3)	154 (73.7)			
Witness Physical abuse while growing up					
Yes	1 (25.0)	3 (75.0)	0.007#	1	1.000
No	58 (26.9)	158 (73.1)			
Experienced sexual abuse while growing up					
Yes	2 (33.3)	4 (66.7)	0.133#	1	0.660
No	57 (26.6)	157 (73.4)			
Witness sexual abuse while growing up					
Yes	1 (25.0)	3 (75.0)	0.007#	1	1.000
No	58 (26.9)	158 (73.1)			
Previous Infertility Problem					
Yes	5 (29.4)	12 (70.6)	0.063#	1	0.802
No	54 (26.6)	149 (73.4)			

**Significant #Fisher's test used*

4.1 Prevalence of IPV among Respondents

In this study, the prevalence of IPV among respondents was 26.8%. This prevalence lies between 10 to 69%, the global range of prevalence of IPV [5,13]. Violence pervades the lives of many people around the world and touches all of us in some ways. To many people, staying out of violence's pathway is a matter of locking doors-and-windows and avoiding dangerous places. To others, escape is not possible, the threat of intimate partner violence is behind those locked doors and windows, well hidden from the public view [4].

In this study, all forms of abuse by an intimate partner (physical, sexual and

emotional/psychological) were reported and falls within the limit of annual rates reported in worldwide studies using clinical sample [11].

The rate in this study is consistent with other studies in low- and middle-income countries [3,6,17,28,29]. For example, rates ranging from 11-79% have been reported in different parts of Nigeria [1,3,5-8]. In Zaria, Ameh and Abdul reported a rate of 28% in their study [17] while a study on the prevalence, pattern and consequences of intimate partner violence during pregnancy at Abakaliki Southeast Nigeria by Onoh et al found a prevalence of 44.6% [3]. This present observation therefore reinforces the fact that IPV is here with us, is very common, even among postpartum women and thus, urgent action is required to stem the tide in view of its deleterious effects on the mother and baby.

4.2 Factors Associated with Intimate Partner Violence among the Respondents

There was a statistically significant association between partners' religion and intimate partner violence. This finding is different from a previous study in Nigeria, in which Okenwa reported that Catholic women experienced significantly higher sexual abuse than Muslim women and no comparable significant differences were found in physical and psychological abuse between Muslim participants and their Catholic counterparts [30]. Other studies in Nigeria have not reported a similar association between Islam religion and intimate partner violence hence this may be a subject for further research. However, it agrees with findings of other studies outside Nigeria on partners' religion and intimate

Table 4. Association between intimate partner violence and other variables in respondents using logistic regression

Variables	B	Odds ratio	*p* value	95% CI for EXP (B)	
Age (years)					
< 30 (ref)	1	1			
≥30	-0.158	0.854	0.644	0.437	1.668
Number of Children					
1 (ref)	1	1			
≥2	0.516	1.676	0.138	0.847	3.316
Mode of delivery					
Vaginal(ref)	0.148	1.159	0.730	0.501	2.684
CS					
Level of education					
Primary school and below(ref)	1	1			
Secondary school and above	-0.537	0.585	0.403	0.166	2.060
Average monthly Income					
<18000(ref)	1	1			
≥18000	0.082	1.085	0.810	0.558	2.110
Partner's average monthly income					
<18000(ref)	1	1			
≥18000	-0.376	0.687	0.492	0.235	2.005
Witnessed sexual abuse while growing up					
No (ref)	1	1			
Yes	-0.887	0.412	0.473	0.037	4.635
Support from Husband's relatives					
No (ref)	1	1			
Yes	0.026	1.026	0.936	0.542	1.945
Support from Husband					
No (ref)	1	1			
Yes	-1.088	0.337	0.014	0.141	0.803
Hours of delivery					
0 to 12 hours(ref)	1	1			
>12 hours	1.092	2.980	0.097	0.820	10.827

Ref reference point which is the variable to which others are being compared

partner violence [3,30,31]. Rahman et al noted a significant relationship between partners' religion and intimate partner violence [32]. In this study, 37.3% of the respondents whose partners were Muslim experienced IPV compared to 20.6% of those whose partners were Christians. This is in keeping with what was found in an Egyptian study on domestic violence against women. The study found a higher prevalence levels of IPV (18.4%) among Muslims compared to their Christian counterparts (14%) [33]. Three studies conducted in Bangladesh reported that Muslim women were more likely to experience all forms of IPV than their non-Muslim counterparts [32,34,35].

Going by empirical observations, it appears religion is one of the factors that play a role in IPV. It is important to understand the interplay between IPV and Religion. A qualitative analysis in the United States found that religious leaders from Christian, Jewish and Muslim faiths expressed concerns that religious teachings of male leadership and female submission could be interpreted to support abusive behavior [36].

Although the two prominent religions (Christianity and Islam) practiced in Nigeria advocate peaceful coexistence among mankind, abusers could misuse and distort scripture to justify their choice to harm the other person [15]. IPV is not allowed in Islam. Verse 4:34 in the Qur'an prescribes a step-by-step process for husband to address a wife's behaviour if she is acting in a manner that would threaten the integrity of the family unit. The Arabic word that has often been translated as 'beat her' also has many other meanings, such as 'leave her'. Scholars who choose the translation of 'beat' emphasize that it is symbolic and should leave no mark or injury. These scholars suggest that the husband might use the equivalent of a tissue or blade of grass to make his point. Abusers may take this verse out of context and forget the multiple teachings that emphasize equity, mutual compassion and respect in marital relationship.

There was a statistically significant association between support from partner and intimate partner violence. In this study, 43.8% of the respondents whose partners did not support them during pregnancy experienced IPV compared to 23.9% of respondents who had partners support. Although findings about support has not been reported in previous studies in Nigeria, it is in keeping with findings from other studies outside Nigeria [37,38]. Support could mean those who care for their spouse and would understandably be expected not to inflict violence on them at the same time. There was no statistically significant association between marital status, marriage pattern, sex of index child, employment status, monthly income and intimate partner violence. Their high education may not reflect the true status of the community, hence complementary community based studies may be needed to give the complete picture among the women in the community.

5. CONCLUSION

The prevalence of intimate partner violence is high among postpartum women. The burden of IPV represents a major challenge especially in the African setting where the act is concealed by the victims. Early identification of IPV during pregnancy and postpartum period is a gateway to detecting, preventing and ameliorating negative health conditions but IPV remains an issue marked by stigma, silence and dismissal. Increased media campaign about intimate partner violence and preventive measures is urgently needed. Furthermore, screening for IPV should be included in the curriculum of health care workers, especially in the infant welfare and postnatal care. This will help in identifying, evaluating, counseling and offering immediate solutions to victims.

6. LIMITATIONS OF THE STUDY

The study is subject to both recall and reporting bias because measures of IPV were based on self-report, though it is expected that the estimates derived from this study will be no less reliable than those of other self-report surveys. The respondents who filled questionnaires themselves were not compared with those who were helped by the research assistant. Study population was drawn from a hospital which may not truly reflect characteristics of the general populations.

7. RECOMMENDATIONS FOR FUTURE RESEARCHERS

This study found statistically significant associations between religion and IPV which is different from the previous findings in Nigeria; this may be a subject for further study.

CONSENT

All participants gave a written informed consent.

ETHICAL APPROVAL

Approval to undertake the study was obtained from the Ethics and Research Committee of LAUTECH Teaching Hospital to ascertain that the methodology does not contravene guidelines for research involving human subjects.

Ethical issues like non-disclosure to others, opportunity to decline interview at any stage and non-exposure to risk were discussed with each respondent. The participants bore no financial burden for the study.

The respondents with intimate partner violence were properly counseled on the need for help and were referred appropriately to a psychiatric facility for expert management.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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