# Domestic Violence During Pregnancy: Patterns, Drivers, and Health Consequences in Awka South LGA of Anambra State

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***Abstract***

***Background:*** *Domestic violence during pregnancy remains a significant global public health concern, particularly in low- and middle-income countries where gender inequality and weak enforcement of protective laws persist. In Nigeria, intimate partner violence during pregnancy is increasingly reported, yet community-based evidence from Awka South LGA remains limited.*

***Methods:*** *A mixed-methods cross-sectional study was conducted among women of reproductive age (15–49 years) in Awka South LGA, Anambra State, Nigeria. A total of 195 valid responses were analyzed from 204 distributed questionnaires using a multi-stage sampling technique. Quantitative data were analyzed using descriptive statistics and Chi-square tests, while qualitative data were analyzed thematically.*

***Results:*** *The study found high prevalence of domestic violence during pregnancy: sexual coercion, economic control and physical violence. Key determinants included partner substance use, financial stress and sociocultural norms supporting male dominance. Domestic violence was associated with physical injuries, pregnancy complications, and psychological distress. Education level was not significantly associated with experience of domestic violence ($p = 0.53$).*

***Conclusion:*** *Domestic violence during pregnancy in Awka South LGA is widespread and driven by structural gender inequality, substance use, and socioeconomic stressors. Strengthening legal enforcement, integrating IPV screening into antenatal care, and expanding community-based interventions are essential for improving maternal health outcomes.*

***Keywords:*** *Domestic violence, Emotional abuse, Empowerment, Intimate partner violence. Physical abuse, Sexual abuse*

## Introduction

Domestic violence refers to any behavior within the household that causes physical, sexual, or psychological harm (World Health Organization [WHO], 2021). During pregnancy, it is a serious public health concern because it occurs at a period of heightened maternal and fetal vulnerability and has been associated with poor antenatal care utilization, low birth weight, preterm birth,

miscarriage, and mental health problems such as anxiety and depression (Taillieu & Brownridge, 2018). Historically, domestic violence was often treated as a private family matter, limiting public intervention. However, international frameworks such as CEDAW, the Sustainable Development Goals, particularly SDG 5 on gender equality, and WHO evidence have reframed domestic violence as a human rights violation and a preventable public health emergency. In Nigeria, this shift is reflected in the Violence Against Persons (Prohibition) Act (VAPP) of 2015, which was domesticated in Anambra State in 2017.

Globally, about one in three women experience physical and/or sexual violence in their lifetime, mostly by an intimate partner (WHO, 2021). In sub-Saharan Africa, violence during pregnancy is common and is linked to depression, poor antenatal care, and adverse pregnancy outcomes (Shamu et al., 2020). Hospital-based studies in Nigeria report similarly high prevalence; for example, many pregnant women attending health facilities experience at least one form of domestic violence (Efetie & Salami, 2019). Common risk factors include low education, financial stress, partner alcohol or substance use, unintended pregnancy, and prior exposure to violence (Antai, 2011).

In Awka South and the wider Anambra State of Nigeria, intimate partner violence (IPV) against pregnant women is a significant public health concern. Studies conducted among pregnant women attending antenatal care in the region report that approximately one in five women experience IPV during pregnancy, with psychological abuse being the most prevalent form, followed by sexual and physical violence (Okonkwo et al., 2024). Key risk factors include low educational attainment, partner substance use, unemployment, and marital conflict (Okonkwo et al., 2024; Okoye & Onyemaechi, 2025). Exposure to IPV during pregnancy has been associated with increased psychological stress and higher risk of antepartum depression, which can negatively affect maternal health and antenatal care utilization (Okoye & Onyemaechi, 2025). These findings reflect the complex interplay of socioeconomic, relationship, and cultural factors that perpetuate violence against pregnant women in the area, highlighting the urgent need for screening, supportive interventions, and community-based awareness programs to protect maternal well-being (Okonkwo et al., 2024; Okoye & Onyemaechi, 2025).

Despite legal frameworks and interventions, sociocultural norms, fear of stigma, weak law enforcement, and limited screening in antenatal care continue to contribute to underreporting and persistence of abuse (Sprague et al., 2019). Although previous studies have documented the occurrence of domestic violence in Nigeria, there is still limited context-specific data on the extent, forms, and underlying determinants of such violence among pregnant women in Awka South LGA. Existing research (Okeke et al., 2024) often focuses broadly on intimate partner violence without adequately addressing the unique vulnerabilities associated with pregnancy or the interplay of socio-economic and cultural factors within the local setting.

This gap in empirical knowledge limits the development of effective, targeted interventions and policies aimed at protecting pregnant women and improving maternal health outcomes. Without a clear understanding of the patterns, drivers and health consequence of domestic violence against pregnant women in Awka South LGA, efforts to design preventive strategies, strengthen support systems, and enhance legal enforcement may remain inadequate. Therefore, this study seeks to address this gap by examining the patterns, drivers and health consequences of domestic violence against pregnant women in Awka South LGA, with the aim of generating evidence that will inform policy formulation, intervention programs, and advocacy efforts to safeguard maternal health and uphold women's rights.

**Research Questions**

The following research questions have been designed to guide this study:

1. How prevalent is domestic violence against pregnant women in Awka south LGA?
2. What are the types of domestic violence experienced by pregnant women in Awka south LGA?
3. What are the determinants of domestic violence on the physical and mental health of pregnant women in Awka south LGA?
4. What are the measures put in place to reduce domestic violence against pregnant women in Awka south LGA?

**Theoretical Framework**

This study adopts the Feminist Theory to provide a comprehensive understanding of domestic violence against pregnant women in Awka South Local Government Area. The theory emphasizes the role of gender inequality and patriarchal power structures in perpetuating violence against pregnant women. This perspective recognizes that domestic violence is not merely a result of individual pathology or relationship dysfunction but rather a manifestation of broader societal structures that maintain male dominance and female subordination. In the Nigerian context, this includes traditional gender norms that emphasize male authority and female submission, as well as cultural practices that may limit women's autonomy and decision-making capacity.

**Study Hypothesis**

The following hypothesis have been formulated to guide this study.

1. Educated women are less likely to experience domestic violence than their non-educated counterparts during pregnancy.

**Methods**

This study adopted a mixed methods research design, integrating quantitative and qualitative approaches to provide a comprehensive understanding of domestic violence against pregnant women. The study was conducted in Awka South Local Government Area of Anambra State, Nigeria, an urban area comprising nine towns and serving as the administrative center of the state. The target population included women of reproductive age (15–49 years), estimated at about 65,780 based on population projections. The scope of the study was limited to examining the prevalence and determinants of domestic violence among pregnant women in the area. A sample size of 204 respondents was determined using Taro Yamane's formula, while a multi-stage sampling technique involving cluster, random, and systematic sampling was used to select participants. Data were collected using structured questionnaires and in-depth interview guides. Questionnaires were administered face to face with the support of trained research assistants, while four purposively selected participants took part in in-depth interviews. Quantitative data were analyzed using SPSS with descriptive statistics and chi-square tests, while qualitative data were analyzed thematically and used to complement the quantitative findings.

**Results**

Two hundred and four 204 questionnaires were administered by the researcher, 195 (95.6%) of the questionnaires were correctly filled and returned. Nine questionnaires were not completely filled. The analysis is consequently based on the correctly filled and returned 195 questionnaires.

**Socio-demographic Data of Respondents**

This sub-section deals with the socio-demographic data of respondents.

**Table 1: Distribution of respondents by their socio-demographic characteristics**

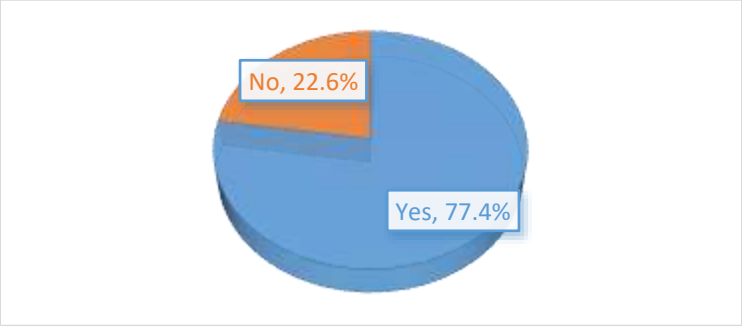
| Responses | Frequency | Percent |
|---|---|---|
| **AGE** | | |
| 18 - 26 | 35 | 17.9 |
| 27 - 35 | 50 | 25.6 |
| 36 - 44 | 73 | 37.4 |
| 45 - 53 | 33 | 16.9 |
| 54 - 62 | 3 | 1.5 |
| 63+ | 1 | 0.5 |
| **Total** | **195** | **100.0** |
| **MARITAL STATUS** | | |
| Married | 140 | 71.8 |
| Divorced | 17 | 8.7 |
| Separated | 7 | 3.6 |
| Widowed | 23 | 11.8 |
| Single (never married) | 8 | 4.1 |
| **Total** | **195** | **100.0** |
| **EDUCATIONAL ATTAINMENT** | 14 | 7.2 |
| No formal education | 5 | 2.6 |
| FSLC | 55 | 28.2 |
| SSCE | 11 | 5.6 |
| NCE/OND | 101 | 51.8 |
| B.Sc./HND | 9 | 4.6 |
| M.Sc./Ph.D. | **195** | **100.0** |
| **Total** | | |
| **OCCUPATION** | 63 | 32.3 |
| Civil servant | 96 | 49.2 |
| Trading/Business | 9 | 4.6 |
| Farming | 21 | 10.8 |
| Student | 4 | 2.1 |
| Unemployed | 2 | 1.0 |
| Others | **195** | **100.0** |
| **Total** | | |
| RELIGION | 194 | 99.5 |
| Christianity | 1 | 0.5 |
| Islam | **195** | **100.0** |
| **Total** | | |

**Field Survey, 2025**

The socio-demographic data indicate that respondents were largely within the economically active and middle-age brackets, with the highest proportion aged 36–44 years (37.4%), followed by 27–35 years (25.6%) and 18–26 years (17.9%), while older age groups such as 54–62 (1.5%) and 63 years and above (0.5%) were minimally represented, suggesting that responses mainly reflect the views of young and middle-aged adults. In terms of marital status, the majority of respondents

were married (71.8%), while smaller proportions were widowed (11.8%), divorced (8.7%), single (4.1%), or separated (3.6%), indicating a predominantly family-oriented sample. Educational attainment shows that most respondents were well educated, with over half holding B.Sc./HND qualifications (51.8%), followed by SSCE holders (28.2%), while very few had no formal education (7.2%) or only FSLC (2.6%), suggesting a population with substantial educational exposure. Occupationally, nearly half were engaged in trading or business (49.2%), followed by civil servants (32.3%), with fewer respondents involved in farming (4.6%), studentship (10.8%), unemployment (2.1%), or other occupations (1.0%), reflecting active economic participation. Religiously, the respondents were overwhelmingly Christian (99.5%), with only 0.5% practicing Islam, indicating strong religious homogeneity. Overall, the data reflect a predominantly married, educated, economically active, and Christian population whose socio-economic background is likely to shape their perceptions and responses.

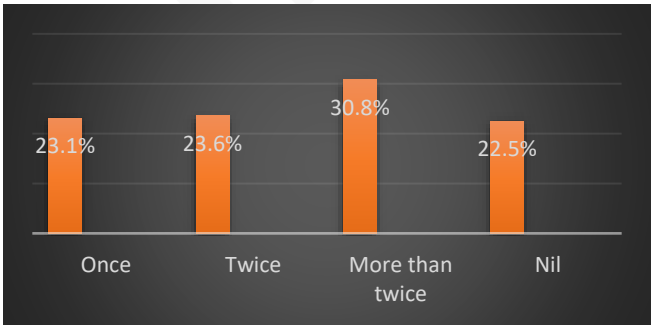
**Research Question 1**: How prevalent is domestic violence against pregnant women in Awka south LGA? Questionnaire items 7-11 were designed to answer this research question. The findings are presented below:




**Field Survey, 2025**

**Fig. 1: Respondents' views on if they have ever been pregnant**

The data in Figure 1 reveals that 77.4% of respondents have been pregnant, while 22.6% have never experienced pregnancy. This indicates that the majority of respondents have experienced pregnancy at some point, highlighting its prevalence within the surveyed population. The substantial proportion of respondents with pregnancy experience may have implications for health service utilization, maternal support needs, and reproductive health awareness programs among the group. Conversely, the 22.6% who have never been pregnant represent a smaller segment whose experiences and perspectives may differ, emphasizing the importance of considering both groups in related interventions and policy planning.




**Field Survey, 2025**

**Fig. 2: Respondents' views on how many times they have been pregnant**

The data reveals that 30.8% of respondents have been pregnant more than twice, with another 23.6% having been pregnant twice, and 23.1% experiencing pregnancy once. This means that a combined 77.5% of respondents have had at least one pregnancy, highlighting the high prevalence of pregnancy among the surveyed population. Meanwhile, 22.5% of respondents have never been pregnant. The distribution indicates that multiple pregnancies are relatively common, which may have implications for reproductive health services, maternal support programs, and awareness initiatives within the community.

**Table 2: Respondents' views on whether their partner had hit, slap, kick, or physically hurt them during pregnancy**

| Responses | Frequency | Percent |
|---|---|---|
| Never | 122 | 62.6 |
| Once | 18 | 9.2 |
| A few times | 30 | 15.4 |
| Many times | 25 | 12.8 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

The data in Table 2 reveals that 62.6% of respondents reported that their partner never hit, slapped, kicked, or physically hurt them during pregnancy, while 9.2% experienced such violence once. Another 15.4% reported it occurring a few times, and 12.8% experienced it many times. This means that a combined 37.4% of respondents have experienced physical violence from their partner during pregnancy, highlighting a significant incidence of domestic abuse within this group. The high proportion of those affected suggests that intimate partner violence during pregnancy remains a serious concern, with potential implications for maternal health, psychological well-being, and the safety of both mother and child. According to an IDI participant:

> During my pregnancy, my partner never hit, slapped, or physically hurt me. We had disagreements like most couples, but he was careful and supportive, especially because of the baby. I felt safe at home and could attend antenatal care without fear. Emotional arguments happened sometimes, but they never became physical. I believe the pregnancy made him more protective and calmer toward me (Female, 39 years, Trader, Awka).

However, another IDI participant stated:

> Yes, during my pregnancy, my partner slapped me once and pushed me during an argument. It was a difficult time because I felt scared and stressed, which affected my peace of mind. I did not report it because I feared stigma and family interference. I tried to endure it quietly for the sake of the pregnancy, although the experience caused emotional pain and anxiety throughout that period (Female, 32 years, Hairdresser, Awka).

**Table 3 Respondents' views on whether their partner had forced them to have sexual intercourse when they did not want to**

| Responses | Frequency | Percent |
|---|---|---|
| Never | 96 | 49.2 |
| Once | 16 | 8.2 |
| A few times | 51 | 26.2 |
| Many times, | 32 | 16.4 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

Almost half of the respondents (49.2%) indicated that their partner had never forced them to have sexual intercourse against their will. However, 8.2% experienced it once, 26.2% a few times, and 16.4% reported it happening many times. Altogether, this shows that 50.8% of respondents have been subjected to sexual coercion by their partner during pregnancy, revealing that more than half of the surveyed population has faced violations of consent. This highlights a critical concern regarding sexual violence in intimate relationships during pregnancy, with serious implications for both physical and psychological health, as well as the need for targeted interventions to protect maternal rights and well-being. This finding is in line with the opinion of an IDI participant:

> During my pregnancy, my partner never forced me to have sexual intercourse when I did not want to. There were times I felt uncomfortable or tired, and he respected my decision without pressuring me. We communicated openly about my condition, and he understood that pregnancy can affect desire and comfort. That mutual respect made me feel safe and emotionally supported throughout the period (Female, 31 years, Civil Servant, 2025).

**Table 4: Respondents' views on whether their partner controlled their access to money or prevent them from working**

| Responses | Frequency | Percent |
|---|---|---|
| Never | 114 | 58.5 |
| Once | 14 | 7.2 |
| A few times | 35 | 17.9 |
| Many times, | 32 | 16.4 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

A majority of respondents (58.5%) reported that their partner never controlled their access to money or prevented them from working. However, 7.2% experienced this once, 17.9% a few times, and 16.4% many times. This means that a combined 41.5% of respondents have faced financial control or restrictions from their partners, indicating a notable prevalence of economic abuse within intimate relationships during pregnancy. Such control can limit autonomy, increase dependency, and heighten vulnerability, underlining the importance of addressing financial empowerment and support mechanisms for expectant mothers. An IDI participant stated:

> During my pregnancy, my partner did not control my access to money or stop me from working. I continued my small business, and he supported me financially when needed. We discussed household expenses together, and I could decide how to use my earnings. That

> freedom helped me feel independent and reduced stress during the pregnancy, as I did not feel trapped or dependent on him alone (Female, 42 years, Trader, 2025).

**Table 5: Respondents' views on the stage of pregnancy when violence was first experienced**

| Responses | Frequency | Percent |
|---|---|---|
| First trimester (1-3 months) | 64 | 32.8 |
| Second trimester (4-6 months) | 13 | 6.7 |
| Third trimester (7-9 months) | 1 | .5 |
| Not applicable | 117 | 60.0 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

The data shows that 32.8% of respondents experienced violence for the first time during the first trimester of pregnancy, 6.7% during the second trimester, and only 0.5% during the third trimester. Meanwhile, 60% indicated that this was not applicable to them, meaning they did not experience violence at any stage. The findings suggest that when partner violence occurs, it is most likely to begin early in pregnancy. This early onset of abuse can have serious implications for maternal and fetal health, emphasizing the need for early screening, support, and intervention strategies to protect pregnant women from intimate partner violence.

**Research Question 2**: What are the types of domestic violence experienced by pregnant women in Awka south LGA? Questionnaire items 12-13 were designed to answer this research question. The findings are presented below:

**Table 6: Respondents' views on forms of violence experienced during pregnancy**

| Responses | Frequency | Percent |
|---|---|---|
| Being physically (e.g., hit, pushed or injured) | 29 | 14.9 |
| Being insulted, threatened, or isolated | 38 | 19.5 |
| Being forced into sexual activity | 13 | 6.7 |
| Having your money or resources controlled | 7 | 3.6 |
| None of the above | 108 | 55.4 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

The data shows that 14.9% of respondents experienced physical violence such as hitting, pushing, or injury during pregnancy, while 19.5% were insulted, threatened, or isolated. Additionally, 6.7% reported being forced into sexual activity, and 3.6% had their money or resources controlled by their partner. A majority of 55.4% did not experience any of these forms of violence. Overall, this indicates that while more than half of respondents were spared abuse, a significant proportion, nearly 45% experienced one or more forms of violence during pregnancy. The diversity of abuse types underscores the need for holistic interventions that address physical, emotional, sexual, and economic forms of violence against pregnant women. An IDI participant stated:

> During pregnancy, some women experience different forms of violence beyond physical abuse. From what I have seen and heard, violence can include constant insults, shouting, and threats, which cause emotional pain. There is also economic violence, where a

> partner withholds money or refuses to support the woman financially. These actions create stress and fear, which can affect both the mother's health and the unborn baby (Female, 32 years, Hairdresser, Awka).

**Table 7: Respondents' views on knowledge of anyone who has experienced violence during pregnancy**

| Responses | Frequency | Percent |
|---|---|---|
| Yes | 113 | 57.9 |
| No | 82 | 42.1 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

More than half of the respondents (57.9%) reported knowing someone who had experienced violence during pregnancy, while 42.1% did not. This indicates that experiences of partner violence during pregnancy are not only common but also widely recognized within the community. The prevalence of such knowledge highlights the social visibility of domestic abuse and underscores the importance of community-based awareness, reporting mechanisms, and interventions to address and prevent violence against pregnant women. An IDI participant stated:

> Yes, I know a neighbour who experienced violence during her pregnancy. Her husband often beat her, especially when he was angry or drunk. We noticed she stopped attending antenatal clinics regularly and always looked withdrawn. Although some people advised her to seek help, she was afraid of shame and family pressure. The situation affected her health and caused serious concern among those close to her (Female, 42 years, Trader, 2025).

Another IDI participant also opined:

> I am aware of a friend who was emotionally and physically abused while pregnant. Her partner would insult her and sometimes push or slap her during arguments. She confided in me but said she could not leave because of financial dependence. The stress affected her mental health, and she was always anxious. Sadly, many people around her treated it as a normal family issue rather than violence (Female, 39 years, Trader, Awka).

**Research Question 3**: What are the determinants of domestic violence on the physical and mental health of pregnant women in Awka south LGA? Questionnaire items 14-15 were designed to answer this research question. The findings are presented below:

**Table 8: Respondents' views on perceived causes of violence during pregnancy**

| Responses | Frequency | Percent |
|---|---|---|
| Partner's substance use | 84 | 43.1 |
| Stress or money issues | 75 | 38.5 |
| Family or cultural issues | 30 | 15.4 |
| Other | 6 | 3.1 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

The data shows that respondents perceive multiple factors as contributing to violence during pregnancy. A plurality of 43.1% cited their partner's substance use, while 38.5% attributed it to stress or money-related issues. Family or cultural factors were mentioned by 15.4%, and 3.1% pointed to other causes. These findings suggest that partner behavior, financial strain, and sociocultural influences are key drivers of violence during pregnancy. Understanding these perceived causes is crucial for designing targeted interventions that address substance abuse, economic stress, and harmful cultural norms to reduce the incidence of intimate partner violence. According to an IDI participant:

> I believe violence during pregnancy often happens because of stress and misunderstandings between partners. Some men feel frustrated by financial problems or work pressure and take it out on their wives. Others may believe that pregnancy gives them the right to control or discipline their partners. Lack of communication and jealousy also seem to contribute, making the home environment tense and unsafe for pregnant women (Female, 39 years, Trader, Awka).

Another IDI participant opined:

> I think violence during pregnancy is often caused by cultural beliefs and gender expectations. Some men think women should obey them completely, and if the woman disagrees or fails to meet their expectations, they respond with aggression. Alcohol and substance abuse, financial difficulties, and family interference also appear to trigger violence. Pregnant women become more vulnerable because partners sometimes think they can dominate them without consequences (Female, 42 years, Trader, 2025).

**Table 9: Respondents' views on perceived health effects of violence during pregnancy**

| Responses | Frequency | Percent |
|---|---|---|
| Physical injuries (e.g., bruises, bleeding) | 117 | 60.0 |
| Pregnancy complications (e.g., premature labor, miscarriage) | 50 | 25.6 |
| Feeling depressed or anxious | 16 | 8.2 |
| Fear or sleep problems | 10 | 5.1 |
| None of the above | 2 | 1.0 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

The data shows that the majority of respondents (60%) perceive physical injuries, such as bruises or bleeding, as a key health effect of violence during pregnancy. Additionally, 25.6% identified pregnancy complications, including premature labor or miscarriage, as consequences. Smaller proportions reported emotional and psychological effects, with 8.2% mentioning depression or anxiety and 5.1% citing fear or sleep problems. Only 1% indicated no perceived health effects. These findings highlight that violence during pregnancy is widely recognized for its serious physical and reproductive health consequences, while the psychological impact, though less frequently acknowledged, remains significant. An IDI participant stated:

> I think violence during pregnancy can seriously affect both the mother and the unborn baby. Women who experience abuse may suffer physical injuries, stress, and anxiety, which can lead to complications like high blood pressure or preterm labor. Emotional abuse also affects mental health, causing depression or fear. I have seen some women lose weight or become very weak because of the constant stress and mistreatment from their partners (Female, 32 years, Hairdresser, Awka).

**Research Question 4**: What are the measures put in place to reduce domestic violence against pregnant women in Awka south LGA? Questionnaire items 16-18 were designed to answer this research question. The findings are presented below:

**Table 10: Respondents' views on awareness of support services for women experiencing domestic violence**

| Responses | Frequency | Percent |
|---|---|---|
| Yes | 143 | 73.3 |
| No | 52 | 26.7 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

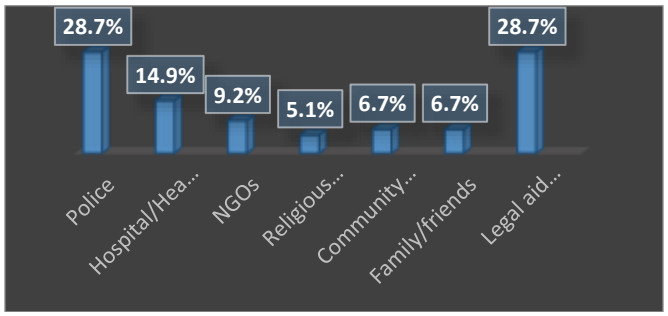
The data shows that 73.3% of respondents are aware of support services available for women experiencing domestic violence, while 26.7% are not. This high level of awareness suggests that information about available assistance, such as counseling, shelters, or legal support, has reached a majority of the population. However, the fact that over a quarter of respondents remain unaware highlights gaps in outreach and underscores the need for broader education and communication strategies to ensure that all women know where to seek help when facing domestic violence. According to an IDI participant"

> I am aware that there are support services for women experiencing domestic violence, but many people don't know how to access them. Some NGOs and government agencies offer counseling and legal help, and there are hotlines, but most women in my community are afraid of stigma or family backlash. Personally, I think awareness is still low, and more education is needed so that women know where to go for help (Female, 31 years, Civil Servant, 2025).

However, another IDI participant opined:

> No, I am not aware of any support services for women facing domestic violence. Whenever someone is abused, people usually

just advise them to tolerate it or talk to relatives. I have never come across a place or program that offers professional help or legal support. It seems like women suffering in silence have nowhere reliable to turn to in our community (Female, 39 years, Trader, Awka).




**Field Survey, 2025**

**Fig. 3: Respondents' views on awareness of available support services for women experiencing domestic violence**

The data shows that respondents are aware of multiple avenues of support for women experiencing domestic violence. Police and legal aid services were the most recognized, each cited by 28.7% of respondents. Hospitals or health centers were mentioned by 14.9%, NGOs by 9.2%, religious organizations by 5.1%, while community leaders and family/friends were each identified by 6.7%. These findings indicate that formal support systems, particularly law enforcement and legal services, are the most visible or trusted sources of help, while informal or community-based support is less recognized.

**Table 11: Respondents' views on measures to reduce domestic violence against pregnant women**

| Responses | Frequency | Percent |
|---|---|---|
| Public awareness campaigns | 21 | 10.8 |
| Counseling services | 14 | 7.2 |
| Economic empowerment programmes | 7 | 3.6 |
| Stricter law enforcement | 93 | 47.7 |
| Community education | 46 | 23.6 |
| Support groups | 7 | 3.6 |
| Others | 7 | 3.6 |
| Total | 195 | 100.0 |

**Field Survey, 2025**

The data indicates that respondents support a range of measures to reduce domestic violence against pregnant women. The most frequently suggested measure was stricter law enforcement, cited by 47.7% of respondents, followed by community education at 23.6%. Public awareness campaigns were mentioned by 10.8%, counseling services by 7.2%, and economic empowerment programmes, support groups, and other measures each by 3.6%. Overall, this shows that nearly 72% of respondents prioritize legal and community-based interventions, highlighting a strong belief in the need for structured, enforceable, and socially grounded strategies to prevent domestic violence during pregnancy. According to an IDI participant:

> I think to reduce domestic violence against pregnant women, there needs to be more education for both men and women about respecting rights and understanding the risks of abuse. Couples should learn better communication and conflict management. Communities can also organize awareness campaigns, and authorities should enforce laws against violence (Female, 31 years, Civil Servant, 2025).

Another IDI participant opined:

> For me, one way to stop violence during pregnancy is to make sure men understand that hitting or abusing their wives could get them arrested. Women should feel safe to report abuse, and men should know it's not something that will be ignored. Couples should also try to talk calmly and solve issues without violence (Female, 32 years, Hairdresser, Awka).

**Test of Hypothesis**

In this section, the hypothesis formulated to guide this study was tested using chi-square inferential statistics and interpreted.

**Hypothesis one:** $H_1$: Educated women are less likely to experience domestic violence than their non-educated counterparts during pregnancy.

**Table 12 Relationship between level of education and experience of domestic violence during pregnancy**

| | | | Have you or anyone you know experienced violence during pregnancy? | | |
|---|---|---|---|---|---|
| | | | Yes | No | Total |
| What is your highest formal educational qualification? | No formal education | Count | 6 | 8 | 14 |
| | | Expected Count | 8.1 | 5.9 | 14.0 |
| | FSLC | Count | 1 | 4 | 5 |
| | | Expected Count | 2.9 | 2.1 | 5.0 |
| | SSCE | Count | 27 | 28 | 55 |
| | | Expected Count | 31.9 | 23.1 | 55.0 |
| | NCE/OND | Count | 7 | 4 | 11 |
| | | Expected Count | 6.4 | 4.6 | 11.0 |
| | B.Sc./HND | Count | 64 | 37 | 101 |
| | | Expected Count | 58.5 | 42.5 | 101.0 |
| | M.Sc./Ph.D. | Count | 8 | 1 | 9 |

| | | | | |
|---|---|---|---|---|
| | Expected Count | 5.2 | 3.8 | 9.0 |
| Total | Count | 113 | 82 | 195 |
| | Expected Count | 113.0 | 82.0 | 195.0 |

**$X^2$=10.932, DF=5 P-value=0.53**

**Field Survey, 2025**

The chi-square test results show $X^2$ = 10.932 with 5 as the degree of freedom and a p-value of 0.53. Since the p-value is greater than 0.05, the null hypothesis is accepted, indicating that there is no statistically significant relationship between level of education and the experience of domestic violence during pregnancy. This means that individuals across different educational qualifications appear equally likely to have experienced or known someone who experienced domestic violence during pregnancy.

**Discussion of Findings**

This study found that a large proportion of women in Awka South LGA have experienced or know someone who experienced domestic violence during pregnancy, indicating that partner violence against pregnant women is a common issue in the community. More than half of the respondents (57.9%) reported knowing someone who had experienced violence during pregnancy, while 42.1% did not, showing that such experiences are widely recognized within the community. This finding aligns with evidence from Nigeria showing that intimate partner violence during pregnancy is a significant public health concern. For example, Orpin, et al. (2020) in their systematic review reported that studies from across Nigeria documented physical, sexual, psychological, and verbal abuse against pregnant women, with husbands or intimate partners frequently identified as perpetrators, highlighting the widespread nature of the problem. Similarly, Agboola et al. (2025) found that intimate partner violence, including controlling behaviour, was commonly experienced by pregnant women in Osun State, suggesting that violence during pregnancy is not isolated to specific regions but occurs across diverse Nigerian settings. Collectively, these studies affirm that the high prevalence of violence observed in Awka South reflects broader patterns of domestic abuse experienced by pregnant women in Nigeria.

The study's findings show that pregnant women in Awka South LGA experience a range of abuse types, including physical, emotional, sexual, and economic violence. About 37.4% of respondents reported experiencing physical violence during pregnancy, while 50.8% experienced sexual coercion and 41.5% reported economic control by their partners. In addition, emotional abuse was reported by 19.5% of respondents, physical abuse by 14.9%, sexual abuse by 6.7%, and economic abuse by 3.6%, indicating that violence during pregnancy often takes multiple forms. This pattern is reinforced by broader research indicating that intimate partner violence during pregnancy frequently involves more than one type of abuse. Ubom et al. (2025) identified psychological or emotional violence as the most commonly reported form of intimate partner violence during pregnancy, while Okoror & Ehigiegba (2021) found that emotional and physical violence co-occurred alongside controlling behaviours. These consistent findings support the conclusion that domestic violence experienced by pregnant women in Awka South encompasses several abusive behaviours rather than a single type of abuse.

Respondents in this study identified partner substance use and financial stressors as key perceived causes of violence during pregnancy. Nearly half of the respondents (43.1%) attributed violence to their partner's substance use, while 38.5% linked it to stress or money related issues, and 15.4%

associated it with family or cultural factors. Respondents also recognized serious health effects of violence during pregnancy. Physical injuries such as bruises or bleeding were identified by 60.0% of respondents, while 25.6% mentioned pregnancy complications including miscarriage or premature labour. Psychological effects were also noted, with 8.2% reporting depression or anxiety and 5.1% reporting fear or sleep problems. These findings are consistent with Nigerian research showing that partner behaviours such as alcohol use increase the risk of intimate partner violence during pregnancy. Adebowale & James (2020) found that partner alcohol use significantly predicted intimate partner violence among pregnant women in Southern Nigeria, while Orpin et al. (2020) emphasized that violence during pregnancy leads to adverse physical and mental health outcomes.

The study found that many respondents are aware of support services available to victims of domestic violence and that they prioritize stricter law enforcement and community education as crucial strategies to reduce violence against pregnant women. A majority of respondents (73.3%) reported being aware of available support services, while 26.7% were not. Nearly half of the respondents (47.7%) identified stricter law enforcement as the most important measure for reducing domestic violence, followed by community education (23.6%) and public awareness campaigns (10.8%). This aligns with other research emphasizing the need for strengthened legal protection, structured support mechanisms, and community-based interventions. Agboola et al. (2025) recommended enhancing screening and referral systems for intimate partner violence in antenatal care settings, while Oluwole et al. (2020) highlighted the importance of policies that support early identification, referral, and protection of pregnant women experiencing violence.

The study also showed no statistically significant association between women's level of education and their experience of domestic violence during pregnancy. This suggests that women across different educational backgrounds were affected by partner violence. This finding aligns with broader research indicating that education alone does not consistently protect women from intimate partner violence. Ubom et al. (2025) similarly reported that although education was considered a potential predictor, partner behaviour and contextual factors played a stronger role in shaping women's vulnerability to abuse.

These findings can be explained through feminist theory, which conceptualizes domestic violence as a manifestation of unequal gender relations and patriarchal power structures that position men in dominant roles and women in subordinate ones. From this perspective, the high prevalence of domestic violence during pregnancy in Awka South LGA reflects entrenched societal norms that legitimize male control over women's bodies, labour, and reproductive roles, particularly during pregnancy when women may be more economically and physically dependent. The occurrence of multiple forms of abuse; physical, emotional, sexual, and economic aligns with feminist arguments that violence is not merely episodic but a strategic tool used to maintain male dominance and enforce compliance. The identified drivers of violence, such as partner substance use and financial stress, are understood within feminist theory as contextual triggers that intensify power struggles rather than root causes, since the underlying issue remains gendered power imbalance.

## Conclusion

Domestic violence during pregnancy in Awka South LGA is widespread, systemic, and not limited by education or social status. The findings show that abuse particularly sexual coercion and economic control is patterned and often begins early in pregnancy, reflecting entrenched gender power imbalances rather than isolated incidents. Although awareness of support services is relatively high, stigma, fear, and weak institutional response significantly hinder their use,

exposing a gap between policy presence and real protection. Key factors such as partner substance use and financial stress act more as triggers than root causes, which lie in persistent patriarchal norms. Overall, the study underscores that meaningful reduction in domestic violence requires more than legal frameworks and awareness campaigns. Effective change depends on addressing structural gender inequalities, strengthening enforcement, and ensuring that support systems are accessible, trusted, and responsive to women's realities.

**Recommendations**

Based on the findings of this study, the following recommendations have been made:

1. The government and law enforcement agencies should prioritize stricter enforcement of laws protecting pregnant women from domestic violence. Clear policies and penalties should be communicated, and regular monitoring conducted to ensure that perpetrators are held accountable, reducing tolerance for abuse in the community.
2. Healthcare centers, community organizations, and social services should set up accessible counseling, shelter, and referral services specifically for pregnant women experiencing violence. These services should be well-publicized, staffed with trained personnel, and coordinated to provide timely and comprehensive assistance.
3. Both governmental and non-governmental organizations should dedicate funds for community-based education campaigns on domestic violence. Programs should target partners, families, and community leaders to raise awareness about the causes, consequences, and prevention of abuse during pregnancy.
4. Healthcare facilities should routinely screen pregnant women for signs of abuse during antenatal visits. A standardized protocol for identification, counseling, and referral should be implemented, ensuring that women at risk are quickly connected to appropriate support services.

**References**

Adebowale, O., & James, B. (2020). The association between intimate partner violence, psychiatric morbidity amongst pregnant women and partner alcohol use in southern Nigeria. African Journal of Primary Health Care & Family Medicine, 12(1), e1–e7. https://doi.org/10.4102/phcfm.v12i1.2226

Agboola, I. A., Bamgboye, E., Olowolafe, D. T. A., & Amuda, M. A. (2025). Prevalence of depression and intimate partner violence among pregnant women attending antenatal care sessions in Orolu Local Government, Osun State, Nigeria. International Journal of Health and Medical Information, 8(3), 167–186. Retrieved from https://icidr.org.ng/index.php/Ijhmi/article/view/1820

Antai, D. (2011). Controlling behaviour, power relations within intimate relationships and intimate partner physical and sexual violence against women in Nigeria. BMC Public Health, 11, 511.

Efetie, E. R., & Salami, H. A. (2019). Domestic violence on pregnant women in Nigeria: A systematic review. Tropical Journal of Obstetrics and Gynaecology, 36(2), 142–151.

Okeke, N. C., Ogboke, E. O., Okoye, B. E., & Onwurah, E. C. (2024). Prevalence and perceptions towards gender-based violence against women of reproductive age in Aguata LGA. Interdisciplinary Journal of African & Asian Studies, 10(1).

Okonkwo, B. C., Ezeama, N. N., Edeh, G. C., Okolo, S. A., Chiekezie, C. F., Anagwu, C. P., & Awugosi, M. C. (2024). Intimate partner violence among pregnant women in Anambra State, Nigeria: Prevalence, pattern, determinants and coping strategies. Current Medicine Research and Practice, 14(5), 200–207. https://doi.org/10.4103/cmrp.cmrp_105_24

Okoror, C. E. M., & Ehigiegba, A. E. (2021). Intimate partner violence during pregnancy among women attending antenatal clinic in Southern Nigeria. Tropical Journal of Obstetrics & Gynaecology, 37(3), 511–524.

Okoye, C. F., & Onyemaechi, C. I. (2025). Domestic violence and age as correlates of antepartum depression among pregnant women in Anambra State. Ojukwu Journal of Psychological Services. https://doi.org/10.5281/zenodo.17482592

Oluwole, E. O., Onwumelu, N. C., & Okafor, I. P. (2020). Prevalence and determinants of intimate partner violence among adult women in an urban community in Lagos, Southwest Nigeria. The Pan African Medical Journal, 36, 345. https://doi.org/10.11604/pamj.2020.36.345.24402

Orpin, J., Papadopoulos, C., & Puthussery, S. (2020). The prevalence of domestic violence among pregnant women in Nigeria: A systematic review. Trauma, Violence, & Abuse, 21(1), 3–15. https://doi.org/10.1177/1524838017731570

Shamu, S., Abrahams, N., Temmerman, M., Musekiwa, A., & Zarowsky, C. (2020). A systematic review of African studies on intimate partner violence against pregnant women: Prevalence and risk factors. PLOS ONE, 15(2), e0228881.

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., & Bhandari, M. (2019). Barriers to screening for intimate partner violence. Women & Health, 59(10), 1159–1176.

Taillieu, T. L., & Brownridge, D. A. (2018). Violence against pregnant women: Prevalence, patterns, risk factors, theories, and directions for future research. Aggression and Violent Behavior, 38, 85–95.

Ubom, A. E., Ohachenu, C. P., Auwal, S. S., Usman, S. F., Opoku, A. B., Ansing, C. A., … Fasubaa, O. B. (2025). Prevalence and determinants of intimate partner violence in

pregnancy: A multicentre, binational study. BMC Pregnancy and Childbirth, 25(1), 124. https://doi.org/10.1186/s12884-025-07177-z

World Health Organization. (2021). Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. World Health Organization.