

Domestic Violence and Abuse in Pregnancy: Exploring Disclosure, Non-disclosure and Conflict Resolution Strategies in South-South, Nigeria

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Abstract

Background: Domestic violence and abuse (DVA) during pregnancy is a globally recognized and significant public health concern affecting about 25% of women worldwide. Despite the World Health Organization and other agencies efforts to prevent violence against women in several conventions and conferences, DVA remains prevalent especially in sub-Saharan Africa, Nigeria inclusive.

Objective: The aim of this study is to determine Domestic Violence and Abuse in pregnancy: Exploring disclosure, nondisclosure and conflict resolution strategies in South-South, Nigeria.

Methods: The research design is a concurrent triangulation mixed-method design as both quantitative and qualitative data were collected at the same time and analysed jointly.

A mixed study carried out on 1,720 pregnant women attending antenatal clinic at selected Primary Health Care Centres across Bayelsa and Rivers States (November, 2024 to April, 2025) using convenient sampling. Data was collected with Abuse Assessment Screen (ASS) and Indepth Interview guide. Chi-square tests and regression analysis, Thematic analysis to transcribe, code interview data using NVivo software.

Results: 52.9% and 69.2% of participants claimed to have been physically and psychologically abused respectively. It happens frequently (44.2%). Concern for children's wellbeing (50.6%) is the highest reasons for not disclosing the abuse to anyone followed by shame, embarrassment (13.4%). This result infers that most pregnant women experiencing DVA in Nigeria prefer to use the help of their parents as strategy to cope.

Conclusion: The findings suggest that DVA is a significant problem that requires attention from healthcare providers, policymakers, and community leaders.

Introduction

Domestic Violence and Abuse (DVA) is a globally recognised and significant public health concern. The World Health Organisation (WHO), non-governmental organisations (NGOs), and other agencies have recognised and advocated for governments to take necessary measures to prevent violence against women, as discussed in several conventions and conferences (Ayodapo et al., 2017). Nevertheless, DVA remains prevalent, affecting millions of women worldwide. This issue affects families of all socioeconomic, ethnic, cultural, and religious backgrounds, as well as their area of residence, and it hinders women's ability to fully engage in society (Bako & Saed., 2018).

Domestic Violence and Abuse, as defined by the World Health Organization (WHO), refers to harmful activity occurring inside an intimate relationship (WHO, 2021). This includes acts of aggression, sexual coercion, psychological abuse, and controlling behaviours, all of which inflict bodily, sexual, or psychological harm. Based on the 2013 Nigerian Demographic Health Survey (NDHS), 5.0% of women encountered violence during pregnancy, with the prevalence differing based on factors such as educational attainment, work position, and marital status. (Bola, 2016).

Domestic violence during pregnancy is a complex problem that is influenced by several factors such as societal norms, financial status, level of education, and accessibility to resources (Gashaw et al., 2018). Patriarchal systems and gender disparities prevalent in several societies contribute to the perpetuation of violence. Women, sometimes financially reliant on their abusive relationships, face additional obstacles in their efforts to flee or seek assistance. According to a recent comprehensive analysis of Domestic abuse during pregnancy, which examined 150 papers from more than 50 countries, the worldwide occurrence of any kind of intimate partner abuse during pregnancy was found to be 25% (Chalise et al., 2023). Europe had the lowest prevalence rate, which was 5.1% (Garrido-Miguel et al., 2019). Emotional/psychological violence is the most prevalent kind of violence when quantified, followed by physical violence, while sexual violence has the lowest occurrence rates (Capeda et al., 2022). Failing to report violence and abuse during pregnancy can lead to various negative consequences for a woman's sexual and reproductive health. These include unintended or unplanned pregnancies, unsafe or unwanted abortions, HIV infection, pregnancy complications, pelvic inflammatory disease, urinary tract infections, sexual dysfunction, physical and mental harm, and potentially even death (Agenagnew et al., 2020).

Domestic Violence and Abuse pose a serious danger to the objectives of the Safe Motherhood Initiative and the Sustainable Development Goals (SDGs), especially those related to health and well-being (Women UN, 2022). This is mostly due to the possible impacts on both the expectant woman and the developing foetus, which is a matter of significant concern. It has been associated with several adverse pregnancy outcomes, such as low birthweight, foetal distress, early rupture of the membranes, miscarriage, antepartum haemorrhage, and perinatal mortality (Ayodapo et al., 2017).

The aim of this study is to explore the complex mechanisms of both disclosing and non-disclosing instances of domestic abuse among pregnant women. The researcher's previous expertise in caring for women who have experienced violence in their relationships strengthens the justification for this work.

In Sub-Saharan African setting, abuse of women is seen as a norm especially when she fails to fulfill her role as a wife (Cools & Kotsadam, 2017). Researchers have contended that pregnancy is a time of increased vulnerability to domestic abuse, regardless of a woman's age, colour, socioeconomic class, or educational level (Vedam et al., 2019).

Instances when societal norms condone violence towards women frequently lead to victims experiencing feelings of shame and humiliation when they try to reveal instances of abuse, thereby prolonging the problem of underreporting Domestic Violence and Abuse (DVA) (Wessells & Kostelny, 2022). Moreover, cultural ideas and traditional practices may normalize or even rationalize violence against women, so posing substantial obstacles to obtaining assistance. Additionally, the negative perception associated with divorce or separation, the apprehension of facing revenge from the abuser, and the worry of being socially isolated further contribute to pregnant women's hesitancy in revealing instances of abuse (Tonsin & Barn, 2017). The repercussions of domestic abuse go beyond the immediate physical and psychological damage suffered by the victim. Children who experience violence while in the womb or during

their early years are more likely to face developmental delays, behavioural issues, and long-lasting psychological trauma (Shonkoff, 2015). Non-disclosure during pregnancy often leads to premature birth and intrauterine foetal mortality, as stated by Katushabe et al. in 2022.

In Nigeria, DVA prevalence rates vary with regions between 17% and 34% (Awolaran et al., 2021), greatly due to variations in deep-rooted gender inequality as well as perceptions and social acceptability of DVA and wife beating in the homes (Awolaran et al., 2021). Over time, Nigeria has sustained a relatively high maternal mortality and currently is still among the few countries that contribute to the highest maternal mortality ratio in Sub-Saharan Africa, with a rate of 630 per 100,000 live births in 2012 (Fapohunda & Orobato, 2013). 1,047 to 917 deaths per 100,000 live births ratio of accounting for roughly 28–29% of all global maternal deaths with an estimated 82,000 women dying annually from pregnancy related complications WHO 2017. (WHO et al, 2023)

Presently, there is a significant decrease in the collection of statistical data in the region, particularly in the field of epidemiology. Remarkably, the prevalence of domestic violence during pregnancy is more extensive than that of several disorders that are often examined (Alhusen et al., 2015). Currently, there is no widely accepted screening procedure in place during prenatal care to detect cases of domestic violence, unlike the established screening protocols for other medical disorders. Several investigations, carried out by Halpern-Meekin et al. (2019), Teshome et al. (2021), and Ezekwe-Anyia (2017) have found that over 97.2% of incidents are unaccounted for. Another issue arises when certain women are ignorant that the actions carried out against them by their spouses are classified as abusive or violent (Rajan, 2018).

Healthcare practitioners have a vital role in recognising and dealing with domestic abuse that occurs during pregnancy (McCauley et al., 2017). Nevertheless, research indicates that a significant number of healthcare personnel do not possess sufficient training in identifying and addressing domestic violence, resulting in missed chances to intervene (Arora et al., 2021).

Methods

This study employed a mixed-methods of quantitative and qualitative research methodologies on 1,720 pregnant women attending antenatal clinics at selected Primary Health Care Centres across Bayelsa and Rivers States (November, 2024 to April, 2025) using convenience sampling method.

Study Setting

The study area was antenatal clinics of Primary Health Care centres in Yenagoa of Bayelsa State and Port-Harcourt in Rivers state Nigeria. This region was selected due to its unique socio-cultural context and the challenges faced by pregnant women in accessing healthcare and support services related to DVA. Bayelsa is a state in southern Nigeria, with its capital at Yenagoa. It is bordered on the west by Rivers State, on the East and South by the Atlantic Ocean and on the North by Delta State. It has a population of 1,703,358 and occupies an area of 10,773 square kilometers. Some major cities include Amassoma, Brass, Ekeremor, Kaiama, Nembe, Odi, Ogbia, Oporoma, Otuoke, and Sagbama. (Etekpe, et al., 2015)

Rivers State is the most populated State in the Niger Delta region and sixth most populous State in Nigeria with a population of over 5 million people as given by the 2006 Census and projected to increase to over 7 million in 2015. Rivers State is one of the 36 states of Nigeria with its capital at Port Harcourt which is the largest city in the Niger Delta region and is economically significant as the centre of Nigeria's oil industry. (Obenade, et al., 2020)

Study Procedure/Data Collection Process

The survey included sections on demographic information, types of abuse, frequency of incidents. Domestic violence screening score (HITS: Hurt, Insult, Threaten and Scream) was used to select the participants. Score values could range from 4 to 20 (score more than 10 indicate existence of DVA and analysed using descriptive statistics of frequency, percentage, mean and standard deviation. Thematic analysis was employed to transcribe and code interview using NVivo software. Key themes and patterns related to barriers to disclosure, and socio-cultural factors were identified. Triangulation was used to cross-validate findings from quantitative and qualitative data to ensure robustness and reliability. Thematic analysis complements these results by revealing meanings, emotions, and cultural interpretations that cannot be captured numerically.

Study Population

The study focused on pregnant women attending antenatal clinics (ANC) in Bayelsa and Rivers States. Below is the statistics of antenatal clients at 6 major different health centres across Bayelsa and Rivers States which were used for the study. These health centres were selected due to the fact they are the most frequent used Primary health care centres in the States and because they have DVA committee members in each of them.

List of health centres		Population (Number of clients)	Sample size: Using Yamane's formula
1	Model primary health centre, Rumuokurushi	4,441	367
2	Comprehensive health centre, Agudama Epie Bayelsa	1,106	294
3	Model primary health centre, Iriebe	1,048.	289
4	Obio cottage hospital, Rumubiakani	1,719	324
5	Primary health centre, Oyigbo	948	281
6	Family support health centre Yenagoa	276	165
Total		9,538	1720

Sample size determination

In the determination of the sample size Yamane's (1967) formula was used.

Yamane's formula: $n = N/(1+N(e)^2)$

n= sample size

N= population

e= this is 5%

Ethical Approval

Ethical clearance form was obtained from University of Port-Harcourt ethical committee, this was taken to the clearance committee of Primary Health Care Board of Bayelsa and Rivers States to get permission to get access to the designated health centres in Yenagoa and Port Harcourt metropolis. Informed consent was obtained from all participants. Confidentiality was maintained by ensuring that all data collected were kept confidential and anonymized because domestic violence research carries psychological and safety risks. Participants were assured that declining participation will not affect their medical care.

Results

Table 1: The age distribution of respondents shows that out of 1,720 pregnant women, the largest proportion were 18-24 years, with 680 respondents representing 39.5%. This indicates that most of the participants, about three-quarters (1,290 women), were below 35 years, reflecting the dominance of younger women in antenatal care attendance.

Of the 1,720 respondents, 430 (25.0%) had no formal education, 360 (20.9%) had primary education, 360 (20.9%) had secondary education, and 570 (33.1%) had tertiary education. This shows that although a fair proportion of women had higher education, a significant number still had low or no educational attainment

Out of 1,720 respondents, most were married (67.4%), followed by single (17.4%), separated (9.9%), and divorced/widowed (5.2%). This shows that the majority of pregnant women attending prenatal clinics were in marital unions.

Table 2: The result of the analysis 51.7% of the respondents somewhat agreed that he makes them feel unsafe even in their own home, 22.1% strongly agreed, 18.6% agreed a little while 7% disagreed a little. The respondents (81.4%) strongly agreed that they are afraid to disclose of what he might do to them and 13.4% somewhat agreed.

In-depth Interview Analysis for the qualitative study

The respondents attribute nondisclosure to various factors, including concern for their children's well-being, fear of social judgment, financial constraints, and lack of confidence.

Respondent 1 her major discussion with us highlighted that "fear of social judgment is a major factor that prevents victims from disclosing DVA, as they may be afraid of being ostracized or blamed by their community as well as financial constraint since some of the women don't have family support." But for Respondent 2 she majorly highlighted that "financial constraints can limit victims' ability to seek help, as they may not have the resources to access support services or to leave their abusive partner and she said this is related to another factor like who will help me to raise the children. She indicated that most victim gain confidence after several abuse to disclose but these major factors hindered them from coming forward" But Respondent 6 highlighted base on personal experiences with a neighbour "lack of confidence is a significant barrier to disclosure, as victims may feel powerless or helpless to change their situation due to the fact that some victims are capable financially but still find it difficult to open up."

Table 3: The respondents were asked how often their partners physically hurt them, the mean value of 3.47 indicates that the respondents are hurt fairly often by their partners. When asked about the frequency with which their partners insult or talk down to them, the mean value of 3.67 indicates that it happens frequently (44.2%).

Table 4 shows the coping strategies utilized by pregnant women experiencing DVA. From the analysis, 17.4% utilize Police, 5.8% utilize national domestic violence hotline, 65.1% utilize parents while 11.6% utilize anonymous people.

Table 1 Socio Economic Characteristics of the respondents

Age	Frequency	Percentage
18-24 years	680	39.5
25-35 years	610	35.5
36-50 years	330	19.2
Above 50 years	100	5.8
Total	1720	100.0
Education	Frequency	Percentage
No formal education	430	25.0
Primary	360	20.9
Secondary	360	20.9
Tertiary	570	33.1
Total	1720	100.0
Marital status	Frequency	Percentage
Single	300	17.4
Married	1160	67.4
Separated	170	9.9
Divorced/Widowed	90	5.2
Total	1720	100.0

Table 2 Factors that Influence Non-disclosure

Description of how your partner makes you feel:	Agree strongly	Agree somewhat	Agree a little	Disagree a little	Disagree somewhat	Disagree strongly	MS	SD
He makes me feel unsafe even in my own home	380 (22.1%)	890 (51.7%)	320 (18.6%)	120 (7%)	0 (0%)	10 (0.6%)	4.87	0.876
I feel ashamed of the things he does to me	200 (11.6%)	520 (30.2%)	560 (32.6%)	420 (24.4%)	10 (0.6%)	10 (0.6%)	4.26	1.012
I try not to rock the boat because I am afraid of what he might do	1400 (81.4%)	230 (13.4%)	0 (0%)	80 (4.7%)	0 (0%)	10 (0.6%)	5.70	0.781
I feel like I am programmed to react in a certain way to him	900 (52.3%)	170 (9.9%)	8 (4.7%)	160 (9.3%)	130 (7.6%)	280 (16.3%)	4.41	1.976
I feel like he keeps me prisoner	690 (40.1%)	290 (16.9%)	290 (16.9%)	250 (14.5%)	30 (1.7%)	170 (9.9%)	4.49	1.628
He makes me feel like I have no control over my life, no power, no protection	860 (50%)	290 (16.9%)	90 (5.2%)	260 (15.1%)	100 (5.8%)	120 (7%)	4.69	1.648
I hide the truth from others because I am afraid not to	1450 (84.3%)	60 (3.5%)	110 (6.4%)	0 (0%)	0 (0%)	100 (5.8%)	5.55	1.244
I feel owned and controlled by him	1220 (70.9%)	370 (21.5%)	30 (1.7%)	40 (2.3%)	10 (0.6%)	50 (2.9%)	5.51	1.040
He can scare me without laying a hand on me	550 (32%)	410 (23.8%)	120 (7%)	150 (8.7%)	290 (16.9%)	200 (11.6%)	4.10	1.826
He has a look that goes straight through me and terrifies me	940 (54.7%)	70 (4.1%)	330 (19.2%)	80 (4.7%)	80 (4.7%)	22 (12.8%)	4.61	1.805
My partner often puts me down, yells at me, calls me names, or tells me I'm worthless.	740 (43%)	480 (27.9%)	170 (9.9%)	110 (6.4%)	40 (2.3%)	180 (10.5%)	4.72	1.613

Table 3. Prevalence and patterns

How Often Does Your Partner	Never	Rarely	Sometimes	Fairly Often	Frequently	MS	SD
Physically hurt you	240 (14%)	180 (10.5%)	310 (18%)	520 (30.2%)	470 (27.3%)	3.47	1.361
Insult or talk down to you	230 (13.4%)	170 (9.9%)	290 (16.9%)	270 (15.7%)	760 (44.2%)	3.67	1.455
Threaten you with harm	270 (15.7%)	360 (20.9%)	460 (26.7%)	270 (15.7%)	360 (20.9%)	3.05	1.356
Scream or curse at you	210 (12.2%)	330 (19.2%)	430 (25%)	280 (16.3%)	470 (27.3%)	3.27	1.368

Table 4 Coping Strategies Utilized by the Pregnant woman Experiencing DVA

	Frequency	Percentage
Police 911	300	17.4
National domestic violence hotline	100	5.8
Parents	1120	65.1
Anonymous	200	11.6

Discussion

Age of Respondents

This finding has important implications for domestic violence and abuse (DVA). Younger women are generally more vulnerable to abuse due to limited economic independence, lower decision-making power, and higher dependence on partners, which can expose them to controlling behaviours. The 25–35 years group, which represents peak reproductive age, is also a high-risk category, as pregnancy may intensify stress and power imbalances in relationships, thereby heightening the risk of abuse. Although older women (36 years and above) form a smaller proportion of respondents, research shows that when they experience abuse, it often goes underreported and can have cumulative health and psychological effects. The Domestic Abuse Act of 2021 in the UK recognizes abuse among individuals aged 16 and above, covering all the age categories represented in this study.

Education of Respondents

Women with lower levels of education often have reduced awareness of their rights, limited access to support systems, and diminished economic independence, all of which can exacerbate their susceptibility to abuse (Ikuteyijo et al., 2025). Conversely, women with tertiary education are generally more empowered to recognize, resist, or report abuse; however, they are not immune to IPV (Ahinkorah et al., 2018). These findings emphasize the pivotal role of education in determining women's ability to seek help and break the cycle of violence, yet they also demonstrate that IPV transcends educational attainment, affecting women at all levels of education.

Marital Status

Marriage is the main setting where intimate partner violence occurs, making married women particularly vulnerable. Separated and divorced women, though fewer, may have higher past exposure to abuse, while single women may still face violence from partners or family members (Nyemgah et al., 2024). In line with the Domestic Abuse Act (2021), all categories are legally recognised as potential victims, but the dominance of married women suggests interventions should prioritize addressing abuse within spousal relationships during pregnancy.

Factors that Influence Non-disclosure

From the analysis, the major factors influencing non-disclosure by victims of abuse include concern for children, fear, shame, no protection, low self-esteem. According to Heron & Eisma, (2021) victims may fear social judgment or rejection, which can prevent them from disclosing DVA. Financial constraints may also limit victims' ability to seek help. Lack of confidence may also be a significant barrier to disclosure, highlighting the need for support systems and resources that empower victims to take control of their lives (Heron & Eisma., 2021). Similarly, Dhungel (2017) highlighted that economic dependence on the abuser is a significant factor influencing non-disclosure. Women who rely financially on their partners often remain silent to avoid destabilizing their living situation.

Coping Strategies Utilized by the Pregnant woman Experiencing DVA

The table 4 shows the coping strategies utilized by pregnant women experiencing DVA. From the analysis, 17.4% utilize Police, 5.8% utilize national domestic violence hotline, 65.1% utilize parents while 11.6% utilize anonymous people. This result infers that most pregnant women experiencing DVA in Nigeria prefer to use the help of their parents before the police or an unknown person.

The high percentage of pregnant women seeking help from their parents is consistent with findings across sub-Saharan Africa, where family, particularly natal relatives, often serve as the primary source of support for women experiencing intimate partner violence (Sigalla et al., 2018). In Nigeria, marriage is often perceived as a family affair rather leading women to report IPV to family members, before approaching formal institutions (Ayodapo et al., 2017). This preference is deeply rooted in socio-cultural norms, where familial intervention is seen as a means to resolve marital conflicts and preserve family honour (Ayodapo et al., 2017). Studies in Kenya and Tanzania also confirm that women often prefer sharing IPV experiences with their biological mothers rather than health professionals or others (Hatcher et al., 2013; Katushabe et al., 2023).

Conclusion

The study's results from South-South, Nigeria, firmly corroborate and amplify the findings in existing literature regarding the multi-faceted nature of non-disclosure in DVA during pregnancy. The interconnectedness of concern for children, intense fear, deeply ingrained shame, and sophisticated patterns of coercive control creates formidable barriers that prevent pregnant women from revealing their abuse. Recognizing these dynamics is paramount for designing effective interventions that go beyond merely asking about violence to address the underlying psychological, social, and cultural factors that silence survivors, ultimately aiming to empower them to seek safety and support for themselves and their unborn children

Declarations

Ethics approval and consent to participate

This study received ethical approval from research ethics committee of the University of Port-Harcourt at its 112th meeting.

Consent to participate: Written informed consent to publish non-identifiable data was given by all participants after explaining issues of privacy and confidentiality.

Consent for Publication

Not applicable

Competing Interests

No competing interests

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Nil

Availability of data and Materials

The data of this study are available from the corresponding author upon request.

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Authors Contributions

Not Applicable

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