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Knowledge and Prevalence of Intimate Partner Violence among Pregnancy Women Attending Antenatal Clinic at Primary Health Centers in Oyo East

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Abstract

Intimate partner violence (IPV) during pregnancy is a public health concern with implications for maternal and fetal well-being. This study assessed IPV knowledge and prevalence among pregnant women attending antenatal clinics at primary health centers in Oyo East. A cross-sectional design was employed, involving 206 pregnant women selected through random sampling. Data were collected using a researcher-developed questionnaire covering IPV knowledge, experiences, and related factors and analyzed using descriptive statistics. Most respondents had good knowledge of IPV, while reported prevalence was low. Factors reported in relation to IPV included a history of violence, pregnancies that partners did not want, low educational attainment, limited employment opportunities, substance use during pregnancy, inadequate social support, and financial stress. The findings highlight the importance of addressing IPV within antenatal care and inform nurses' roles in early identification, counseling, advocacy, and referral. Confidential and supportive care environments are recommended to encourage disclosure, alongside community

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awareness initiatives and multidisciplinary collaboration to strengthen support and protection for pregnant women experiencing IPV.

Keywords: Intimate Partner Violence; Pregnancy; Antenatal Care; Prevalence; Nursing Practice

INTRODUCTION

Violence against women is a major public health and human rights concern, with intimate partner violence and sexual violence being among the most pervasive forms of violence against women (Jatta, 2021). Although women can be violent in relationships with men, the most common perpetrators of violence against women are male intimate partners or ex-partners. Until recently, most governments have considered violence against women (particularly "domestic" violence by a husband or other intimate partner) to be a relatively minor social problem. In recent times, however, violence against women has been recognized as a global concern (Oche, 2020). Intimate partner violence (IPV) is defined as threatened', attempted, or completed physical or sexual violence or emotional abuse by a current or former intimate partner (Maruyama, 2023). It describes the physical, sexual, or psychological harm by a current or former intimate partner or spouse, and this type of violence can also occur among heterosexual or same-sex couples (Oche, 2020). The World Health Organization (WHO, 2021) defines intimate partner violence as a behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion and psychological abuse and controlling behavior.

According to World Health Organization, IPV is the most common form of violence against women. Violence by an intimate partner is manifested by physical, sexual, or emotional abusive acts as well as controlling behaviors; although violence occurs in different forms and settings including the workplace, school, and community, violence at home by intimate partner violence is considered as the most prevalent form (Benebo, 2020). The act of physical violence includes slapping, kicking, pushing, and beating, as well as forced sexual intercourse and other forms of sexual coercion. Psychological abuse involves insults, belittling, constant humiliation, threats of harm, or controlling behaviors that consist of isolating a person from friends and families; monitoring their movements; and restricting access to financial resources, employment, education, or medical care (Dorothy,2020).

Women have the same rights as everyone else, including the right to life, the right to be free from torture and other cruel or inhumane treatment or punishment, the right to liberty, and personal security, the right to equal protection under the law, the right to equality in the family and the right to justice, however these rights are been infringed upon in the name of intimate partner violence (Lasong *et al.,* 2020)

Globally, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime (Sanz-barbero *et al.,* 2019). Global estimates published by WHO indicates that about 1 in 3 (35%) women worldwide have experienced some form of physical and sexual intimate partner violence or non-partner sexual violence in their lifetime. As many as 38% of numbers of women are admitted by a male intimate partner (Garcia, 2020).

According to the WHO report, the global prevalence of Intimate partner violence during pregnancy was 38%, with the highest prevalence accounted in Africa (33%). Furthermore, the overall Intimate partner violence during pregnancy is higher in developing countries (27.7%) than in developed countries (13.3%). The prevalence of Intimate partner violence among pregnant women was 28.74%, 33%, and 37% in Ethiopia, Nigeria, and Kenya respectively (Asmamaw *et al.,* 2023).

In Nigeria, one in four women have experienced a form of Domestic Violence, common among young women and dwellers of rural areas. Reports from the Nigerian national population commission estimated women's lifetime exposure to intimate partner Violence from their current husband or partner at 19% for emotional violence, 14% for physical domestic violence, and 5% for sexual violence. Previous studies from Nigeria have shown the prevalence of Intimate partner violence to range from 31 to 61% for psychological/emotional violence, 20 to 31% for sexual violence, and 7 to 31% for physical violence (Benebo *et al.,* 2020).

A study conducted in Lagos, Southwest Nigeria, on the prevalence and predictors of intimate partner violence exposure showed a one-year prevalence of 29%, with significant proportions reporting psychological (23%), physical (9%), and sexual (8%) abuse. while in Oyo, there is 31.1% prevalence of wife beating among women of reproductive age. This indicates a significant public health concern in the state and shows

that nearly 1 in 3 women have experienced physical violence from their intimate partner violence which is slightly higher than the prevalence reported in Lagos.

A study conducted in Ibadan, the capital city of Oyo State, reported that by 2021, 17.1% of women had experienced physical violence since the age of 15. Another study in Eruwa, a rural community in Oyo State, found that 74% of men had perpetrated some form of IPV, with psychological violence being the most prevalent at 67.2%. In Northern Nigeria, studies conducted among pregnant women in Zaria and Jos showed 28% and 63.2% of the respondents, respectively, experienced some form of abuse (Oche, 2020).

Although the prevalence of IPV is quite high in Nigeria, far fewer cases are reported. This is probably because of the influence of religion and culture especially in many parts of Africa, where culture may allow couples to solve their problem by the use of violence, since most cases of violence against an intimate partner are not seen as wrong. Nigeria remains patriarchal in nature, where men are regarded as "gods" of the household, controlling every affair, including the women's right to reproductive capabilities. Incidents are underreported because doing so is viewed as causing indignity to the husband and disrespecting family members and elders whose roles include arbitrating in such matters. As a result, the problem's true magnitude is relatively unknown and unexamined (Oche, 2020).

Improving knowledge and prevalence of intimate partner violence among pregnant women is crucial for preventing and addressing this issue. Health care providers can play a key role in educating pregnant women about intimate partner violence and providing support and resources to those who are experiencing abuse. Therefore, this current study is very important as it assess the knowledge and prevalence of intimate partner violence among pregnant women attending antenatal clinic in selected primary health centers in Oyo.

METHODS

Research Design

This study design was a descriptive cross-sectional study exploring the knowledge and prevalence of intimate partner violence among pregnant women in selected primary healthcare centers in Oyo East LGA.

Research Setting

The research was conducted in four primary health centers (PHCs) located in Oyo East Local Government Area (LGA) of Oyo State, Nigeria namely, Ajagba, Oba Adeyemi, Olori, and Araronmi PHCs. These centers were strategically selected to ensure broader geographic representation across different wards within the LGA. Each of the selected PHCs was among the most active in its respective ward, with a high volume of antenatal clinic attendees, thereby providing access to a diverse population of pregnant women. The study setting was specifically chosen to explore the knowledge and prevalence of intimate partner violence (IPV) among pregnant women utilizing antenatal services in the area. This location within Oyo East LGA, in the southwestern region of Nigeria, was deemed suitable due to its demographic relevance and the critical role of these health centers in maternal healthcare delivery. The choice of these PHCs facilitated in-depth engagement with participants and enhanced the generalizability of findings within the local context.

1. Ajagba Primary Health Center

Ajagba Primary Health Center is a public healthcare facility located in ward 2 – AJAGBA of Oyo East Local Government Area in Oyo State, Nigeria. As part of the state's commitment to improving healthcare delivery, the facility is owned and operated by the Oyo State Government. Among the services provided are: outpatient care, maternal and child health service, infant welfare clinic, tuberculosis care, family planning services and laboratory service. They also collaborate with Non-Governmental Organizations (NGOs) to enhance service deliveries.

2. Oba Adeyemi Primary Health Center

Oba Adeyemi Primary Health Center is also a public healthcare facility located in ward 10 – ARAROMI of Oyo East LGA, Oyo State, Nigeria. It serves as a pivotal point for primary healthcare delivery, catering to the health needs of residents in Oyo Town and its environs. Services provided are limited to; outpatient services, inpatient service, obstetrics gynecology, pediatrics, family planning, laboratory services, dental services and emergency services. The center operates 24 hours daily, ensuring continuous healthcare availability to the community.

3. Olori Primary Health Center

Olori Primary Health Center is located in ward 2 – Ajagba of Oyo East LGA, Oyo State, Nigeria. It is managed by the Oyo State Government and plays a crucial role in delivering essential healthcare services to the residents of Oyo East. Olori PHC operates 24 hours a day, ensuring continuous healthcare availability to the community. Services offered are: outpatients services, inpatient services, obstetrics and gynecology, pediatrics, surgical services, dental services, laboratory services, pharmacy services and mortuary services

4. Araromi Primary Health Centre

Araromi Primary Health Centre, also located in ward 10 – Araromi Oyo East LGA of Oyo State, Nigeria, managed by the state government. It operates 24 hours, ensuring continuous healthcare availability to the people. Among the services offered are: outpatient services, inpatient services, obstetrics and gynecology, pediatrics, surgical services, dental services, laboratory services, pharmacy services, mortuary services

Target Population

The target population comprised of all pregnant women attending antenatal clinics at the selected PHCs in Oyo East LGA during the study period. These women were considered suitable for the study because they are in frequent contact with the health care system and might have had experiences or knowledge related to IPV that could inform the study's objectives.

Sample Size

The number of the respondents was achieved by subsequent four times (4) visit to each of the health centers.

Average population of pregnant women attending antenatal clinic at AJAGBA primary health center was 100, 92 at Oba Adeyemi , 65 at OLORI, and 85 at ARAROMI.

Table 1: Monthly Population Distribution by Healthcare Center

S/N	HEALTHCARE	POPULATION ON MONTHLY BASIS	PERCENTAGE
1	AJAGBA	100	100/342*100=29.24%
2	OBA ADEYEMI	92	92/342*100=26.9%
3	OLORI	65	65/342*100=19.0%
4	ARAROMI	85	85/342*100= 24.85%
TOTAL		342	

Using Taro Yamane formula;

n = N/(1+(Ne^2)) ---------- **equ. 1**

n = number of sample (sample size)

N = total population (target Population)

e = Error margin (0.05)

n = ?

N = 342

n =342/ 1+342· (0.05) ^2

n =342/1+342·0.0025

n= 342/1+0.855

n=342/1.855

n=184.36

10% attrition rate =184.36/0.90=204.81

=205

Sampling Technique

Proportionate sampling technique was used to select two hundred and five pregnant women attending antenatal clinic in selected primary health centers.

Table 2: Proportional Sample Technique Based on Monthly Population per Healthcare Center

S/N	HEALTHCARE	POPULATION ON MONTHLY BASIS	PERCENTAGE	PROPORTIONAL SAMPLE TECHNIQUE
1	AJAGBA	100	100/342*100=29.24%	29.24/100*205=59.95
2	OBA ADEYEMI	92	92/342*100=26.9%	26.9/100*205=55.15
3	OLORI	65	65/342*100=19%	19/100*205=38.95
4	ARAROMI	85	85/342*100=24.85%	24.85/100*205=50.94
	TOTAL	342		204.99=205

Inclusion and Exclusion Criteria

This section outlines the specific criteria that will be used to determine which individuals were eligible or ineligible to participate in the study. Defining inclusion and exclusion criteria is essential in ensuring the selection of a relevant and homogenous sample, enhancing the internal validity of the research findings, and minimizing potential biases. These criteria will help to identify pregnant women with experiences pertinent to the study objectives while safeguarding ethical standards and ensuring participant safety.

Inclusion Criteria

The study will include pregnant women who met the following conditions:

i. Were attending antenatal clinic in Ajagba, Olori, Araromi and Oba Adeyemi Primary Health Centers in Oyo, Oyo State and are willing to participate in the study.

ii. Who gave informed consent and were willing to participate in the study.

iii. Who had been in a relationship or cohabiting with a male partner for at lEast six months prior to the time of data collection.

Exclusion Criteria

The following groups will be excluded from the study:

i. Pregnant women who were seriously ill or mentally unstable and therefore unable to participate or provide reliable responses.

ii. Women who had no history of cohabitation or relationship with a male partner in the six months preceding the study.

iii. Pregnant women that do not attend antenatal clinic Ajagba, Olori, Araromi and Oba Adeyemi Primary Health Centers in Oyo, Oyo State.

Instruments for Data Collection

A self-developed questionnaire was used to collect data for the study. The questionnaire was designed to assess the knowledge and prevalence of intimate partner violence among pregnant women attending antenatal clinic in selected primary health centers Oyo East local government Oyo, Oyo state. It contains 4 sections

Section A: Socio-demographic characteristics which consist of ten (10) questions.

Section B: Knowledge of intimate partner violence which consist of seven (7) questions.

Section C: Prevalence of intimate partner violence which consist of five (5) questions.

Section D: Risk factors associated with intimate partner violence which consist of seven (6) questions.

Reliability of Instrument

The corrected and validated version of the instrument was administered to pregnant women outside the sample area maintaining similar characteristics and the

reliability of the instruments will be tested using Cronbach's Alpha Model technique to ensure internal consistency. The reliability test result was considered reliable 0.75

Method of Data Collection

A face-to-face administration of questionnaire was employed for this study and the questionnaire was administer for a period of 4 weeks. The researcher meet with respondents, administered the questionnaire, allowed the respondents sufficient time to fill them, and retrieved same before leaving the field.

Method of Data Analysis

Data generated from this study were sorted out using statistical package for social science (SPSS version 27) software for both descriptive and inferential statistical analysis. Descriptive statistics of percentage, frequencies were used to present the summary tables for relevant variables. Pie charts were used to present part of the results

Ethical Consideration

An Introduction letter was obtained from the Department of Nursing Science, AFE BABALOLA University to execute this study. The introduction letter obtained will be taken to the research and ethical committee at ministry of health Ibadan, Oyo state. Approval was sought. Respondents were informed about the study and only those who agree to participate were given questionnaire to fill. The consent form contains information about the topic, objectives of the study, procedure for data collection and storage. No respondent was coerced into participating in the study. Besides, respondents were informed that they can withdraw their participation anytime they desired without penalty. In addition, respondents were assured of the anonymity of their person and the confidentiality of the information they volunteered.

RESULTS

Table 3. Demographic Data.

Variable		Frequency (n)	Percentage (%)
Age	15-20 years	23	11.2
	21-30 years	126	61.5
	31-40 years	56	27.3
Religion	Christianity	50	24.4

	Islam	141	68.8
	Traditional	14	6.8
Ethnic group	Yoruba	201	98.0
	Hausa	2	1.0
	Igbo	2	1.0
Marital status	Single	63	30.7
	Married	142	69.3
Educational Level	None	3	1.5
	Primary	56	27.3
	Secondary	90	43.9
	Tertiary	56	27.3
Family Type	Monogamous	138	67.3
	Polygamous	67	32.7
Parity	None	27	13.2
	1-4	175	85.4
	5 and above	3	1.5
Occupation	Unemployed	45	22.0
	Employed	160	78.0
Financial monthly income	10000	65	31.7
	20000	46	22.4
	≥30000	94	45.9
Partner consumes alcohol\ drug	Yes	11	5.4
	No	194	94.6
	Total = 205 (100%)		

Demographic data, as seen in Table 3, provide a clear view of the nature of the respondents, which will put their knowledge and prevalence of intimate partner violence into its context in the primary health centers in Oyo East, which are represented in the form of antenatal clinics.

These background demographic data are essential to understanding the ensuing data on IPV since age, religion, and ethnicity are often associated with different experiences and attitudes towards violence in intimate relationships (Asmamaw et al., 2023). As an example, the belief systems of religions may affect the social perceptions of gender roles, as well as domestic conflicts, which may affect the readiness of women to report abuse or request help (Jatta & Ouédraogo, 2021). Equally, the acceptability of some behaviors can be determined based on cultural norms embedded in ethnic groups and affect the

expression and reporting of IPV (Armah-Ansah et al., 2025). The given demographic breakdown, in turn, serves as an important prism through which to interpret the complex connection between the socio-cultural variables and the occurrence and perception of intimate partner violence in this particular population (Babandi et al., 2024).

The average age of the respondents is about 41.8 years, which is in line with the general population statistics in Nigeria that show that the demographic is mostly young (Akinyugha et al., 2022). Nonetheless, the age distribution with the majority of those aged between 21 and 30 years old is indicative of a potential cohort of women in their first or second pregnancies, which may be a critical age period of both susceptibility to and response to IPV (Abrha et al., 2024; Melkam et al., 2024). Moreover, awareness of IPV, as well as access to support resources, may be dependent on educational attainment, which is commonly linked with age (Ubom et al., 2024).

Such a demographic analysis is crucial to comprehending the general picture of IPV rates and the demand for specific intervention targeting age groups, education levels, and cultural backgrounds.

Table 4: Showing the Level of Knowledge of Intimate Partner Violence Among Pregnant Women

Variable		Frequency (n)	Percentage (%)
Can intimate partner violence occur during pregnancy	Yes	131	63.9
	No	74	36.1
Does intimate partner violence refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm?	Yes	129	62.9
	No	76	37.1
Can intimate partner violence occur in any type of relationship irrespective of socio-economic status and educational level?	Yes	166	81.0
	No	39	19.0
Is emotional abuse such as threats insults or controlling behavior a form of intimate partner violence?	Yes	131	63.9
	No	74	36.1
Does violence pose significant risks to both pregnant women and unborn baby?	Yes	175	85.4
	No	30	14.6
Can intimate partner violence during pregnancy lead to adverse health outcomes such as preterm labor and maternal depression?	Yes	188	91.7
	No	17	8.3
Can emotionally abuse during pregnancy influence the mental health of the mother and potentially affect the development of the child?	Yes	163	79.5
	No	42	20.5
	Total = 205 (100%)		

Table 4 gives the level of knowledge of intimate partner violence (IPV) among pregnant women. Among the 205 respondents, 63.9% indicated that intimate partner violence is possible during pregnancy, whereas 36.1% of the respondents did not. Emotional abuse was also identified by the respondents to be a significant element of intimate partner violence (IPV), with 70.1% of the respondents recognizing emotional abuse as such. This underscores the increased awareness about the fact that IPV is not limited to physical abuse, buTablet also to psychological abuse (Omotayo et al., 2025). This recognition is crucial because emotional and psychological abuse is underreported and can significantly affect the mental health of the victims in the long term (Armah-Ansah et al., 2025). It is also always identified that psychological and emotional violence is one of the most common types of IPV, and in some cases, it is even more common than physical violence (Bedada et al., 2023).

Also, economic abuse, which is manipulation of a partner financially, is a vital yet quite ignored aspect of IPV. The economic maltreatment may result in increased reliance on the abuser, and thus, victims become more difficult to get out of the violence loop (OLATUNDE, 2025). This abuse usually overlaps with other types of violence, which contributes to the reinforcement of power relationships in relationships, making the victim even more vulnerable. It is essential to identify all aspects of IPV (physical, psychological, sexual, and financial abuse) to build a multi-dimensional support system and intervention to protect pregnant women and enhance their overall well-being (Jatta & Ouédraogo, 2021; Katushabe et al., 2026).

Knowing the extent of IPV, both emotional and economic, health care providers, policymakers, and communities can develop more comprehensive programs to meet the need of IPV victims, especially during pregnancy, where the effects on the mother and unborn child can be devastating.

Table 5: Showing the Prevalence of Intimate Partner Violence Among Pregnant Women

Variable		Frequency (n)	Percentage (%)
Has your husband ever kicked or dragged you violently	NEVER	179	87.3
	RARELY	26	12.7
Have you ever been threatened with a knife, gun, or any other weapon?	NEVER	183	89.3
	RARELY	14	6.8
	SOMETIMES	8	3.9

Has your husband ever physically forced you to have unwanted sex?	NEVER	173	84.4
	RARELY	31	15.1
	SOMETIMES	1	.5
Has your husband ever insulted you or made you feel bad?	NEVER	159	77.6
	RARELY	33	16.1
	SOMETIMES	12	5.9
	ALWAYS	1	.5
Have you ever been teased or humiliated in front of other people?	NEVER	185	90.2
	RARELY	4	2.0
	SOMETIMES	16	7.8
	Total = 205 (100%)		

The insight in Table 5 on the occurrence of intimate partner violence (IPV) among pregnant women reveals that there is a wide discrepancy in abuse types and frequency at which it occurs. Most of the respondents were not exposed to severe physical violence, including being kicked or dragged against their will by their husbands, with 87.3% saying never and 12.7% saying it rarely happened. In the same way, the majority of respondents (89.3%) did not report having been threatened with a knife, gun, or any other weapon; 6.8% said they were threatened occasionally, and 3.9% said they were threatened infrequently. These findings indicate that considerable physical violence was common among a small proportion of respondents, but extreme cases of violence were rare.

On sexual violence, the statistics show that 84.4 percent of the respondents had never been forcibly involved in unwanted sex, 15.1 percent had such an experience infrequently, and 0.5 percent had such an experience occasionally. These observations are in line with the global trends, which imply that though sexual violence is common, it is less reported during pregnancy (Ma and Zhang, 2025). Although 22.4% reported psychological abuse (insults and belittling), 5.9% did it sometimes, and 0.5% always. The prevalence of emotional abuse is high and, therefore, consistent with the general data available on the subject globally, which suggests that emotional abuse plays a prominent part in IPV throughout pregnancy (Manandhar et al., 2023).

Moreover, 90.2% of the individuals never teased or humiliated other people in front of people, though 9.8% were abused, and 7.8% were sometimes abused. Although these findings imply a reduced prevalence of some types of IPV in comparison with other types of violence (physical or sexual), they demonstrate the presence of the problem of psychological and emotional violence among pregnant women. These results highlight the

necessity of comprehensive IPV treatment approaches that consider both physical and emotional dimensions of the abuse when pregnant (Brunelli et al., 2025).

The results of this research indicate that although the general prevalence of severe IPV may be lower in comparison with other research, it remains a key public health issue. The prevalence of IPV in pregnancy has been reported to range between 6.5 and 15.9 percent of all women in the world (Ma and Zhang, 2025), and the results of the present study align with these findings. The inconsistency in the prevalence of IPV in various studies is due to the effect of methodology, including the definition of IPV and assessment instruments (Mojahed et al., 2021). Such discrepancies demonstrate the necessity of the context-specific and individualized intervention and prevention of IPV, especially during the perinatal period when the physical and emotional health of both the mother and child are in question. Also, since psychological violence is often mentioned as the most prevalent type of IPV during pregnancy (Manandhar et al., 2023), there is an evident necessity of the inclusion of all types of violence in the interventions, not only physical violence.

Table 6: Showing the Risk Factors Associated with Intimate Partner Violence Among Pregnant Women

Variable		Frequency (n)	Percentage (%)
Previous history of intimate partner violence increases the risk of violence during pregnancy	Agree	107	52.2
	Strongly agree	16	7.8
	Disagree	80	39.0
	Strongly disagree	2	1.0
Intimate partner violence occurs as a result of unwanted pregnancy by the perpetrator	Agree	73	35.6
	Strongly agree	62	30.2
	Disagree	68	33.2
	Strongly disagree	2	1.0
Low education attainment and limited employment opportunities triggers intimate partner violence	Agree	91	44.4
	Strongly agree	73	35.6
	Disagree	39	19.0
	Strongly disagree	2	1.0
Intimate partner violence occurs more among pregnant women who	Agree	95	46.3
	Strongly agree	49	23.9
	Disagree	58	28.3

uses drugs or alcohol during pregnancy	Strongly disagree	3	1.5
Lack of social support during pregnancy cause more violence	Agree	67	32.7
	Strongly agree	90	43.9
	Disagree	46	22.4
	Strongly disagree	2	1.0
Financial stressor prone women to intimate partner violence.	Agree	112	54.6
	Strongly agree	52	25.4
	Disagree	39	19.0
	Strongly disagree	2	1.0
	Total = 205 (100%)		

Table 4 shows that intimate partner violence (IPV) in pregnant women is linked to a number of risk factors that are critical. These risk factors, including former abuse and socio-economic difficulties, are a useful point of view on the dynamics that make pregnant women more susceptible to IPV.

More than half of the respondents (52.2% and 7.8% strongly agree) said that a history of intimate partner violence is a risk factor of violence in pregnancy, whereas 39.0% disagreed. It implies that the women who have experienced IPV in the past are potentially at risk of being abused again during pregnancy, which is in line with the findings of other researchers that past IPV exposure is a powerful predictor of subsequent abuse (Ahinkorah, 2021; Asmamaw et al., 2023).

Concerning pregnancy intention, a composite 65.8% said there was an agreement or strong agreement that unwanted pregnancy by the perpetrator would lead to IPV. It is in line with the literature indicating that unwanted pregnancies in most of the instances result in power imbalances within relationships, where perpetrators employ violence as control mechanisms (Ali et al., 2019; Asmamaw et al., 2023). Abusive behaviors can be worsened by emotional and psychological stress caused by unwanted pregnancy, which will only enhance the risk of IPV.

The low level of educational attainment and the lack of jobs were considered to be important risk factors of IPV, and a substantial percentage of respondents (44.4% agreed and 35.6% strongly agreed) supported this statement. This is consistent with the past research that has demonstrated that socio-economic vulnerability may generate abuse

cycles, especially where women have less resources or control (Benebo et al., 2020; Kebede et al., 2022). The less educated and poor women are more reliant on their partners, and this may expose them to violence.

An important 46.3 percent of the respondents said that they agreed and 23.9 percent strongly agreed that drug or alcohol use during pregnancy raises the chances of IPV. The risk factor of IPV is well documented, as substance abuse tends to increase the severity of aggressive behavior and disrupt judgment, making it more challenging for women to avoid or escape violent situations (Heath et al., 2020; Oche et al., 2020).

Most of the respondents (32.7% agreed and 43.9% strongly agreed) replied that the absence of social support during pregnancy is a factor contributing to IPV. The result supports the value of having a supportive social network in safeguarding women against violence. It has been constantly demonstrated that women deprived of the support of their relatives, acquaintances, or society face an increased risk of becoming the victims of IPV as they have fewer means to address the issue or leave the abusive environment (Kebede et al., 2022; Mojahed et al., 2021).

Monetary problems were also identified as a significant contributory factor, as 54.6% responded in the affirmative to the question, and 25.4% strongly affirmed that financial stress predisposes the risk of IPV. Financial strain may cause strain in the relationship, and in many cases, financial insecurity is the triggering force to violence. Economic reliance on a partner has also been found to cause a power imbalance, which makes women more difficult to leave abusive relationships (Heath et al., 2020; Asmamaw et al., 2023).

These results indicate that a complex interaction of the previous experiences, socio-economic status, drugs and alcohol use, and the absence of support contribute to IPV during pregnancy. These risk factors are high enough to highlight the necessity of specific interventions, which would not only consider the societal determinants of IPV but also specific assistance to at-risk pregnant women (Mojahed et al., 2021; Kebede et al., 2022). By implementing healthcare systems, policy modifications, and community-based support, one can address these factors to reduce the risks of IPV in the course of pregnancy.

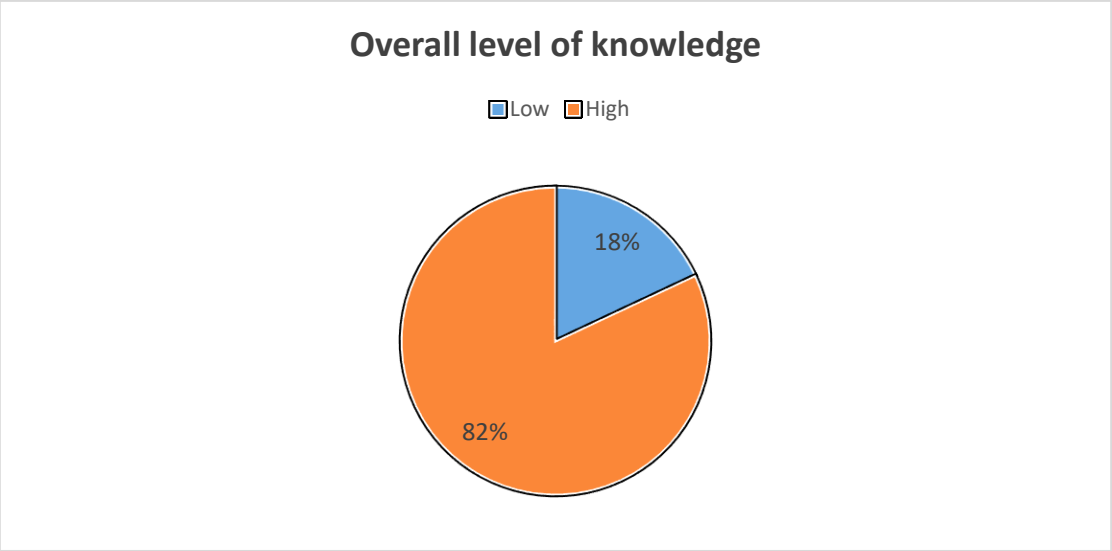


Figure 1: Overall Level of Knowledge

The result in Figure 1 and Table 4 shows general awareness about intimate partner violence (IPV) among pregnant women who visit antenatal clinics in Oyo East. The findings indicate that 82% of the respondents are well-informed about IPV and 18% portray poor knowledge. This implies that IPV is generally well-known and that a considerable share of pregnant women are aware of its presence and the way it affects the health of both the mother and the fetus.

Table 4 also highlights important results regarding the intellectual awareness of the respondents in respect of IPV. A significant percentage (63.9) confirmed that IPV may take place when a woman is pregnant, and 62.9% said that IPV is the presence of physical, psychological, or sexual abuse. The fact that IPV may be present regardless of socio-economic status and level of education was backed up by 81.0 percent of the respondents. Also, 63.9% identified emotional abuse, including threats, insults, and controlling behavior, as a type of IPV, which is a wider interpretation that IPV is not limited to physical violence (Omotayo et al., 2025).

The awareness of the risks of IPV in pregnancy was also high, as all the respondents (93.25) concurred that IPV is a major risk to both the pregnant women and their unborn children. Moreover, almost all the respondents (91.7) were aware of the possibility of negative health effects of IPV in pregnancy, including preterm labor and maternal depression. This observation is supported by the literature available to date

highlighting the harmful health consequences of IPV, particularly during the prenatal phase (Jatta and Ouedraogo, 2024; Katushabe et al., 2026).

Furthermore, most respondents (79.5%) realized that emotional abuse during pregnancy may affect the mental health of the mother and, consequently, affect the development of the child. This emphasizes the need to treat not only physical violence but also psychological and emotional abuse, which can have a lasting impact on the health of both the mother and the child (Asmamaw et al., 2023).

Although most of them exhibited a good level of understanding on IPV, this paper shows that more needs to be done by society to strengthen the existing awareness, early detection, and intervention. The differences in the knowledge of IPV between various regions and demographic groups, such as rural and urban population, and differences in educational background should be prioritized in order to implement more efficient awareness campaigns and support systems (Jatta and Ouédraogo, 2021; Katushabe et al., 2026). Such activities will play a significant role in ensuring women are empowered, societal norms that prevent reporting of IPV are challenged, and the overall quality of maternal care is improved among the affected communities.

Table 7: Level of Prevalence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	High	30	14.6	14.6	14.6
	Low	175	85.4	85.4	100.0
	Total	205	100.0	100.0	

Table 7 shows the general prevalence of intimate partner violence (IPV) among pregnant women during the antenatal clinics in the primary health centers in Oyo East. Based on the findings, 14.6 percent of the respondents were the ones who experienced a high level of IPV, whereas 85.4 percent were the ones who experienced a low level of prevalence. It means that some women were considerably affected by violence, whereas most of the participants had low rates of IPV, which is a comparatively less severe case in the selected study sample.

Additional details, as in Table 3, give the breakdown of the kind of IPV that the respondents were exposed to. Most of the respondents (87.3%) stated that they had never been kicked or dragged violently by their husbands, and 89.3% had never been threatened with a knife or a gun, among other weapons. Likewise, 84.4% did not have to be physically coerced into unwanted sex, and 77.6% of them had not been insulted or made to feel bad

by their husbands. Also, 90.2% were not teased or humiliated in front of other people. These results imply that IPV is present in this group, but most women were not exposed to the more severe categories of physical and psychological violence that are often linked to high levels of prevalence.

This general low prevalence of IPV in the current study (14.6) is quite aligned with the results in a study that was carried out in North-Central Nigeria, where the prevalence rate was 14.8% (Abtew et al., 2025). The rate, however, is less than the regional and globally estimated rates, and the prevalence of IPV in studies in Sub-Saharan Africa is 34.9% pooled (Engmann et al., 2024). The level of IPV in Nigeria is also quite fluctuating, and research indicates that in Oyo State (Bedada et al., 2023) and Abuja (56.3%), the prevalence ranges are very high, which indicates that IPV experiences differ in different locations. Conversely, the prevalence rate of this study is greater than that of the studies done in Belgium, Japan, South Africa, Guatemala, and India but less than those done in Ethiopia, Vietnam, Kenya, Rwanda, South Korea, and Gambia (Sharma and Kaphle, 2023).

Such disparity in the prevalence of IPV underscores the multifaceted nature of the determinants of intimate partner violence, including socio-cultural variations, health care access, and social constructs on gender-based violence. Although the low rate of severe IPV in Oyo East might be an indicator of relatively lower rates of violence, one should also consider that such violence might be underreported due to cultural stigmas, fear of retaliation, and ignorance or insufficient support to the victim (Ubom et al., 2024). Consequently, continuous communal health campaigns and interventions that foster awareness, provide assistance, and promote reporting are important in preventing IPV and its detrimental impacts on pregnant women.

CONCLUSION

This paper was an attempt to determine the prevalence and the knowledge of the intimate partner violence (IPV) by pregnant women visiting the antenatal clinics of primary health centers in Oyo East. The results indicated that most of the respondents possessed good knowledge of intimate partner violence, but the general prevalence of IPV among the respondents was low; 85.4% of the respondents recorded low levels of IPV. The researchers established a number of risk factors related to IPV in pregnancy, like past experience of violence, pregnancy by the perpetrator, low level of education, low

employment opportunities, substance use, lack of social support, and financial pressure. The findings highlighted the immense role of healthcare professionals, particularly nurses, in the early identification, counseling, and referral of pregnant women who suffer IPV. This is essential because the IPV may pose serious threats to both the maternal and fetal well-being of pregnant women, which may result in undesirable consequences, including preterm delivery, maternal depression, and other forms of complications. Based on the results, it is suggested that healthcare providers should establish a more conducive and confidential setting to facilitate the reporting and disclosure of IPV, and awareness programs on the issue of IPV should be enhanced to reduce the consequences of IPV on the health of mothers. Moreover, the research highlights the necessity of an interdimensional and multilevel approach to IPV prevention and intervention, which does not just include physical violence but also the emotional, psychological, and economical abuse. The policies and initiatives that could be used to tackle IPV must take into account the different socio-economic and cultural influences that affect the experiences and perceptions of violence among women. With the use of IPV education in routine antenatal care and encouraging interdisciplinary collaboration, health systems can further support pregnant women and decrease the occurrence and effects of IPV during pregnancy. Although the prevalence of IPV among pregnant women in Oyo East is less than in other regions and worldwide averages, the results do still note the significance of targeted interventions that would encompass the complex socio-cultural, economic, and psychological factors of IPV By means of continuous education, timely identification, and the full provision of support, pregnant women will have a greater chance to avoid the negative consequences of intimate partner violence.IPV.

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