

OBSTETRIC OUTCOME IN PREGNANT WOMEN SUBJECTED TO DOMESTIC VIOLENCE

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ABSTRACT

Objective: To determine the prevalence of domestic violence and its relationship to adverse obstetric outcomes amongst pregnant women who deliver at a tertiary level hospital in Zaria, Nigeria.

Method: A cross-sectional study involving 310 women who delivered at the labour ward. Questionnaires were administered to parturient women. Details of their socio-demographic characteristics and obstetric outcome were compiled and the relationship to experiences of domestic violence studied.

Results: The prevalence of domestic violence was 28.4%. There was positive relationship between domestic violence during pregnancy, non-supervision of pregnancy and poor attendances to antenatal clinic ($p < 0.05$). There was however, no statistically significant relationship between domestic violence, and complications of labour and neonatal outcome ($p > 0.05$).

Conclusion: The prevalence of domestic violence in pregnancy is high in this environment. Poor attendances to the antenatal clinic is a significant association.

Key Words: Domestic violence, pregnancy, obstetric outcome

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INTRODUCTION

Violence against women refers to any type of harmful behaviour directed at women and girls on account of their sex and includes domestic violence.¹ Domestic Violence (DV) against women, whether pregnant or not, is a common occurrence all over the world, cutting across age, ethnicity, religion and educational barriers.¹ Violence against women can take various forms and can be physical, psychological or sexual. It can be in the form of threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.² A new and extreme dimension has been added to domestic violence, in the form of use of acid baths to discipline erring girlfriends or wives.³ Factors which lead to domestic violence are many and range from no offence, to minor or major offences and both the victim and the culprit may justify the act.³ Various studies of violence against women show different prevalence rates, ranging from one in every 3-4 women, to 9 in every 10 women and 17%-37%.⁴ When DV involves pregnant women, it calls for closer attention at their care because of higher attendant risks. There have been limited studies on the risks to mothers and fetuses associated with physical or sexual abuse during pregnancy. One

study suggested an increased risk of low-birth-weight babies in women abused during pregnancy.⁷ DV has been associated with psychiatric illnesses like depression, anxiety, post-traumatic stress disorder and suicide.⁸ It can also lead to none or poor attendance at antenatal clinics, poor health seeking behaviours, drug or substance abuse and even pregnancy loss.⁸ There is thus a need to adequately evaluate the effects of domestic violence on the obstetric outcome of pregnant women, especially in communities where it is still prevalent.

MATERIALS AND METHODS

The Ahmadu Bello University Teaching Hospitals (ABUTH), Zaria is located just outside the ancient city of Zaria. Zaria was founded in 1537AD and is one of the leading Hausa cities in northern Nigeria, with an estimated population of 400, 000 people. The inhabitants of Zaria are predominantly Hausa/Fulani, and are essentially farmers, traders, craftsmen, cattle rearers, small scale businessmen and clerical workers. The metropolitan Zaria is co-inhabited by Hausa/Fulani and people from other parts of Nigeria who are businessmen and women, civil servants or workers in the education sector. This study was a cross sectional study conducted at the labour ward of ABUTH Zaria, Nigeria from June to August 2003. All consecutive consenting parturients seen within the period were recruited into the study in order to complete 310 questionnaires. The sample size, N

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was obtained using the formula: $N = Z^2 \frac{PQ}{d^2} = 310$. Where Z alpha = standard normal deviate at 95% confidence interval = 1.96. P = proportion or prevalence of the condition = 0.28. Q = 1-p = 0.72 and d = precision limit = 0.05. The prevalence of 0.28 was obtained from a previous study on domestic violence amongst pregnant women.⁹ Women with multiple pregnancy and placental praevia were excluded because both conditions were associated with similar adverse pregnancy outcomes as were being investigated for DV.

The questionnaires were structured to obtain information on the socio-demographic characteristics of the parturient; information on the presence or absence of DV in the index pregnancy; booking status and the obstetric outcome of the index pregnancy. Upon delivery, the baby's weight, Apgar scores and any other adverse outcome to the baby were documented. The first author and two trained obstetric resident doctors conducted the interviews on the pregnant women and entered the information into the questionnaires. A chi-square test was applied to determine the relationship between DV in pregnancy and the outcome of pregnancy. Level of statistical significance was p value <0.05.

RESULTS

The pregnant women were aged 16 - 40 years (mean 26.7years). Eighty eight (28.4%) of the women experienced domestic violence (DV) in the index pregnancy. Of those who experienced DV, 40 (45.5%) were forced to have sex, 20 (22.7%) had psychological torture, 15 (17.0%) experienced deprivation (Table 1). Most of the culprits of the DV were the husbands 55 (62.5%), women's in-laws 20(22.7 %), neighbours 10 (11.4 %), and co-mates 3 (3.4 %). None of the women needed to take any drugs as a result of the DV they experienced but most of them (99.2 %) consoled themselves by discussing the problem with their friends or relatives, while the others (0.8 %) did nothing. Five (5.7%) of the 88 women who experienced DV did not book for antenatal care while 7 (3.2%) of 222 who did not experience DV did not book (p <0.05). Similarly, 13 (14.8%) of those who had DV were poor attendees at antenatal clinic (0 - 2 visits) compared to 17 (7.7%) of those who did not have DV (p<0.05). Compared to women who did not have DV, more women who experienced DV had adverse outcome in labour, abnormal mode of delivery, stillbirths, low birth weight babies and babies admitted to the special care baby unit (Table 2): these differences however did not reach statistical significance (p>0.05).

Table 1: Types of Domestic Violence Experienced By 88 Parturients.

Types of Violence	No. (%)
Forced to have sex	40 (45.5)
Psychological torture/beaten up	20 (22.7)
Any form of deprivation	15 (17.0)
Slapped	5 (5.7)
Objects thrown at her	5 (5.7)
Beaten up	3 (3.4)
Total	88 (100)

Table 2: Outcome of Labour and Delivery in Women Who Had DV and Those Who Did Not Have DV.

Outcome	Had DV (%) N=88	Did Not Have DV (%) N=222	X ²	P Value	Significance
Adverse outcome in labour	30 (34.1)	72 (32.4)	0.078	2.70	Not significant
Baby admitted into SCBU	20 (22.7)	58 (26.1)	0.387	0.46	Not significant
Birth weight <2.5kg	19 (21.6)	38 (17.1)	0.840	0.06	Not significant
Abnormal mode of delivery	18 (20.5)	40 (18.0)	0.246	1.64	Not significant
Stillbirth	13 (14.8)	36 (16.2)	0.098	2.71	Not significant

DISCUSSION

The most frequent age group affected by DV in this study are women aged between 26 and 30 year. This is the most fertile age group and is similar to findings reported from south-eastern Nigeria and Ghana.^{10, 11} All the pregnant women involved in this study were married and most educated up to the secondary school level, as in other parts of Nigeria.¹⁰ The prevalence rate of 28.4% compares with reports from other parts of Nigeria and Africa (9%, 46.3%).^{10, 11} Booking status was affected by DV; those who experienced DV in pregnancy were more likely not to book for antenatal care and were also poor attendees. The women who experienced deprivation, reported that they were denied clothes; transport money to attend antenatal clinic; funds for carrying out antenatal clinic investigations; and funds to pay for folic acid and fersolate tablets that were prescribed at the Antenatal clinic respectively. These forms of DV obviously have the potential of impairing the women's adherence to Antenatal clinic instructions relating to visit schedules and appointments, timeliness and accuracy of clinical diagnosis and effectiveness and efficiency of treatment. Pregnant women who experienced DV in this study compared to those without DV were less likely to have a complication during labour and delivery, and to have stillbirths, low birth weight babies and babies who needed special care at birth; the differences however did not reach statistical significance. This is in contrast to reports from other parts of the world

where DV was found to adversely affect these outcomes of pregnancy and delivery.¹⁴ These differences may be cultural. Various factors have been suggested to cause adverse obstetric outcome when pregnant women experience DV. These factors could be mechanical, for example if a pregnant woman experienced physical or sexual violence, she risks developing abruptio placenta, ruptured uterus or a pre-labour rupture of the foetal membranes. Any of these factors could further lead to complicated labour and delivery of a low birth weight baby, an asphyxiated or stillborn infant.¹⁴ During the course of this study, one such case was encountered. A woman who had had 5 previous mid trimester spontaneous abortions presented to the labour ward with a complaint of spontaneous drainage of liquor at 7 months of pregnancy. After examination, she was found to have a pre-term labour and she subsequently delivered a set of twins that each weighed 800 gm. On closer questioning she disclosed how she was beaten up by her husband just before the drainage of liquor ensued. Her offence was that she cooked a meal that was not delicious to him. The preterm birth may well have been precipitated by the violence. Psychological torture could arise when a pregnant woman is deprived of essential needs such as food, antenatal care, personal and baby clothes and antenatal drugs. These may lead to stress that may predispose to elevated blood pressure, abruptio placenta and intra uterine growth restriction.¹⁴ Obstetricians should have a high index of suspicion to identify victims of DV as this will assist in reducing the toll of DV on pregnant women and their unborn children. When detected, affected women will require medical and social assistance and support to remedy sequelae of past experiences of DV and avert further occurrences. The formation of support groups to help victims of DV has been shown to reduce the suffering of the victims and to provide succour for them. National and state governments also have key roles to play in the control of DV; they need to legislate against it and specify punishment for offenders.

Poor recall regarding DV and its type, as well as types of complications in pregnancy may possibly affect accuracy of data. A longitudinal study should minimise the possible effect of poor recall.

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