International Journal of Health and Pharmaceutical Research E-ISSN 2545-5737
P-ISSN 2695-2165 Vol. 10. No. 1 2025 www.iiardjournals.org Online Version

Intimate Partner Violence and Maternal Health in Lafia Metropolis, Nasarawa State, Nigeria

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DOI: 10.56201/ijhpr.vol.10.no1.2025.pg1.13

Abstract

Intimate Partner Violence (IPV) significantly impacts women's sexual and reproductive health, with profound implications for maternal health, including a heightened risk of injury or fatality. The objectives of this study were to identify the factors contributing to intimate partner violence, examine its effects on pregnant women, and assess its implications for breastfeeding mothers. A survey research methodology was employed, involving a sample of two hundred and four (204) women selected through random and cluster sampling techniques. Data were gathered using questionnaires and interviews, and the results were presented in tabular form with accompanying percentages. Analysis was conducted through triangulation, and the study utilized social learning theory to elucidate the variables involved. The findings revealed that factors such as substance abuse, anger, depression, unemployment, and poverty are significant contributors to intimate partner violence. Furthermore, pregnant women who have experienced IPV are at an increased risk of miscarriage, sexually transmitted diseases (STDs), preterm labour, and malnutrition. Additionally, the incidence of postpartum depression, haemorrhage, suicidal ideation, and perinatal mortality is notably higher among women who have encountered IPV. The study recommended, among other measures, the initiation of a comprehensive awareness campaign led by healthcare practitioners in collaboration with non-governmental organizations and private individuals to highlight the detrimental effects of intimate partner violence on maternal health. It is imperative for primary healthcare teams to take prompt and effective action to prevent and identify this issue, thereby enhancing the reproductive health of pregnant women.

Keywords: *Intimate partner violence, maternal health, pregnant women, breastfeeding mother's reproductive health.*

Introduction

Intimate partner violence (IPV) has emerged as a significant global issue, particularly in developing nations, where women are disproportionately affected, leading to severe repercussions for their reproductive health and maternal well-being. IPV is characterized by a spectrum of physically, psychologically, and sexually coercive behaviours perpetrated against adult and adolescent women by current or former male intimate partners (Howaida & Seham, 2018). The World Health Organization (2021) defined IPV as any form of physical, sexual, or emotional abuse inflicted by an intimate partner, ex-partner, or spouse upon a woman. The impact of IPV on

maternal health is profound, with a heightened risk of injury or fatality; it is estimated that 1.3 million individuals globally succumb to various forms of violence each year, representing 2.5% of total global mortality (WHO, 2022). Research by Eskedar, Dawit, Hagos, Azmera, and Genet (2019) indicated that the ramifications of IPV extend beyond women, affecting their children, families, and the broader community. IPV is acknowledged as a critical public health concern, with significant implications for women's physical, mental, sexual, and reproductive health. Howaida and Seham (2018) highlighted that pregnancy is a particularly high-risk period for IPV, with 20% of pregnancies experiencing violence-related complications, including fetal trauma, which can lead to death, premature delivery, fetal-maternal bleeding, amnionitis, and abruptio placenta.

Global estimates from the World Health Organization (2019) revealed that approximately one in three women (35%) worldwide have encountered either physical and/or sexual IPV or non-partner sexual violence during their lifetime. Furthermore, nearly one-third (30%) of women who have been in a relationship report experiencing some form of physical and/or sexual violence from an intimate partner at some point in their lives (WHO, 2021). In several African countries, including Nigeria, violence against women has a particularly detrimental impact on their sexual and reproductive health. According to Benebo, Schuman, and Vaezghasemi (2018), nearly one in four women in Nigeria have reported experiencing IPV.

In response to the rising incidence of IPV in Nasarawa State, the Nasarawa State House of Assembly (NSHA) convened a public hearing on the Gender-Based Violence Prohibition Bill 2020, aiming to develop a comprehensive framework to address issues of sexual violence against children and women within the state (Solomon, 2020). Given the recognition of IPV as a global concern, this paper seeks to examine the effects of intimate partner violence on maternal health in Lafia metropolis, Nasarawa State.

Statement of Problem

Intimate partner violence is a pervasive global issue that transcends all social and economic strata, garnering increasing attention from healthcare professionals, non-governmental organizations, private individuals, and governmental bodies due to its status as a significant contributor to preventable morbidity, mortality, and infertility. This phenomenon is emerging as a critical public health concern. Atsiya and Atsiya (2020) asserted that intimate partner violence can lead to unintended pregnancies and elevate the risk of sexually transmitted infections among women during pregnancy and postpartum. Furthermore, it is associated with heightened risks of miscarriage, preterm labour, fetal distress, and low birth weight. The World Health Organization (2018) has reported that women of reproductive age experiencing intimate partner violence face an increased likelihood of complications, including abortion, premature labour, and depression.

In a study conducted in Abuja, Nigeria, Agbo and Choji (2014) documented the harrowing experiences of a mother subjected to physical abuse by her husband, resulting in the loss of two pregnancies due to this violence. Usman and Salami (2020) identified additional contributing

factors to violent behaviour, such as low self-esteem and exposure to parental violence during childhood.

In Lafia metropolis, Nasarawa State, there have been numerous instances of intimate partner violence among married couples, leading to various chronic health issues and fatalities. Amnesty International (2020) reported that women are subjected to physical abuse, mistreatment, sexual assault, and even murder by their partners on a daily basis. Such violence is often overlooked and tolerated rather than condemned. The majority of these acts are perpetrated by husbands, partners, and fathers. Ekele (2022) highlighted the inaction of both federal and state governments of Nigeria in addressing this violence, thereby endangering the lives of millions of women. These pressing issues have prompted the researcher to investigate the impact of intimate partner violence on maternal health in Lafia metropolis, Nasarawa State.

Theoretical Framework

Social Learning Theory

The research employed the social learning theory as its analytical framework. Social Learning Theory, proposed by Albert Bandura (1977), provides a compelling framework for understanding the complex relationship between Intimate Partner Violence (IPV) and maternal health, particularly in the context of Lafia Metropolis, Nasarawa State. The theory's basic tenet suggests that individuals learn behaviours through observation, imitation, and modelling of others, especially within their immediate social environment (Bandura & Walters, 1963).

In the context of IPV and maternal health, Social Learning Theory explains how violent behaviours are often transmitted intergenerationally. Children who witness domestic violence are more likely to either perpetrate or become victims of IPV in adulthood (Ehrensaft et al., 2003). This is particularly relevant in Lafia Metropolis, where traditional patriarchal structures and cultural norms often normalize violence against women.

The theory's application to maternal health in Lafia Metropolis can be understood through various mechanisms. Women who experience IPV often face restricted access to healthcare, increased stress during pregnancy, and higher rates of pregnancy complications (Campbell, 2002). The learned helplessness that victims develop through repeated exposure to violence can prevent them from seeking necessary maternal healthcare services (Walker, 2009). Furthermore, social learning patterns in healthcare-seeking behaviour are influenced by community norms and family traditions, which can either facilitate or hinder access to maternal health services.

Social Learning Theory has received support from numerous studies demonstrating the cycle of violence in families (Widom & Wilson, 2015). However, critics argue that the theory may oversimplify complex social issues and doesn't adequately account for individual agency and resilience (Dutton, 2006). Additionally, some researchers contend that the theory doesn't sufficiently address the role of structural factors such as poverty, education, and healthcare access in perpetuating IPV and affecting maternal health outcomes (Heise, 2011).

Research Objectives

1. To find out factors responsible for intimate partner violence in Lafia Metropolis, Nasarawa State.
2. To examine the effect of Intimate partner violence on pregnant women in Lafia Metropolis, Nasarawa State.
3. To find out how intimate partner violence affect breast feeding mothers in Lafia Metropolis, Nasarawa State.

Methodology

The study was carried out in Lafia Metropolis, Nasarawa State. Lafia is the capital of Nasarawa state and lies in the southern part of the state. The area occupies a geographical area of 2,730 square kilometre of the landmass with an estimated population of 330,712 people based on 2006 National Population Census (NPC) figure. Lafia town is situated on latitude 3.340E and longitude 8.300N of equator and had a tropical region. In the Northwest, it is bounded by Nasarawa Eggon Local Government Area, in Obi Local Government Area to the south bounded by Plateau State, to the east and south west is bounded to Doma Local Government Area of Nasarawa State. The area lies between the foothill of Jos-Plateau and the Benue River Basin, generally described as flatland area of savannah region of Nigeria. The area is compose of diverse ethnic groups, each distinctly different from the other both culturally and linguistically. Among the ethnic groups are Kanuri, Migili, Gwandara, Hausa/Fulani, Alago, Eggon, Tiv, Igbo and so on. The area is the most famous agricultural zone and commerce in the state. Which has and it attracts a large population of immigrants into the Area as well as Civil servants who works both at State and Federal level alongside with private companies in the area. The population of women in Lafia based on 2006 population census is 164,291 persons and is projected to be 257,659 in 2024 using 3.0 annual growth rate.

The study adopted survey research design, this method affords the researcher opportunity to collect a large amount of data in a relatively short period. The population of the study were married women age 18 and above who had given birth before or is pregnant. Out of the total population of 257,659 women in the study area, 204 respondents were drawn for the research using Taro Yamane's (1967) sample size determination formula. The research made use of random and cluster sampling. Using the cluster sampling technique, the metropolis was divided into 5 clusters. On the other hand, simple random sampling was used to select the respondents for the study. Through this technique, questionnaires that were administered to members of the public were randomly contacted in their houses, markets and offices.

Method of Data Collection

The study employed quantitative and qualitative methods of data collection. Both methods were used to provide a deeper understanding of intimate partner violence and maternal health in Lafia metropolis, Nasarawa State. Questionnaire and key informant interview were the instruments used in collecting data from the sampled respondents. The data used in the study was collected using self-administration method. Slow ball technique was used to select the key informant interviewers.

The informed consent of the questionnaire respondents and Key Informant Interview (KII) participants were gotten before the beginning of each process.

Presentation and Analysis of Data

Descriptive statistics was used for the data of the study. Statistical Package for Social Sciences (SPSS) was used to analyse the quantitative data. The data was first coded and entered into the computer for analysis. The data were presented using frequency distribution table and percentage. A total of 204 respondents were sampled and questionnaires administered to them. However, only 196 questionnaire were retrieved and used for analysis.

Socio-demographic characteristics of respondents

The study sought information on some socio-demographic attributes of respondents. The reason was to enable the researchers understand their respondents better. Data on socio-demographic attributes of respondents was presented in table 1 below:

Table 1: Distribution of Respondents Based on Socio-Demographic Attributes

Attributes	Frequency	Percentage
Age		
18-28	25	12.8
29-39	84	42.9
40-49	60	30.6
50 and above	27	13.8
Total	**196**	**100**
Marital Status		
Married	162	82.7
Divorced	20	10.2
Widowed	14	7.1
Total	**196**	**100**
Occupation		
Trader	61	31.1
Civil servant	64	32.7
Student	24	12.2
Farmer	47	24.0
Total	**196**	**100**
Level of education		
Non formal	27	13.8
Primary	80	40.8
Secondary	57	29.1
Tertiary	32	16.3
Total	**196**	**100**
Religion		
Christianity	84	42.9

Islam	94	48.0
African Tradition	18	9.2
Total	**196**	**100**

Source: Survey, 2024

Table 1 showed the socio-demographic attributes of respondents. Result from the table shows that almost half of the respondents 43% were within the age of 29-39 years old, close to one third 30.6% of the respondents were within the age of 40-49 years old, and above one tenth 12.8% were 18-28, while 13.8% were 50years and above. This age distribution highlights that IPV is a significant concern primarily affecting women during their reproductive years, which has direct implications for maternal health outcomes. Also, regarding the marital status, the table showed that majority of the respondents 82.7% were married, one tenth 10.2% were divorced and less than one tenth 7.1% were widowed. This suggests that IPV within the context of marriage is likely a predominant issue in this demographic. Perceptions from divorced and widowed respondents provides essential perspectives on the long-term ramifications of IPV.

More so, on occupation of the respondents, the table showed that one third 32.7% of the respondents were civil servants, close to one third 31.1% were traders, one fourth 24.0% were farmers, while 12.2% were students. These occupational categories reflect a range of socio-economic backgrounds, which may influence the dynamics of IPV and access to maternal healthcare services. Additionally, concerning the level of education, close to half 40.8% of the respondents had primary education, more than one fourth 29.1% had secondary education, 16.3% had tertiary education, while more than one tenth 13.8% had no formal education. Limited educational opportunities may heighten vulnerability to IPV and hinder awareness or access to maternal health services. Lastly, regarding religion, nearly half 48.0% of the respondents were Muslims, while 42.9% were Christians and less than one tenth were traditional worshippers. These religious affiliations shapes perceptions of IPV, coping strategies, and the willingness to seek maternal health services.

Table 2: Rate of intimate partner violence in Lafia Metropolis.

Knowledge Level	Frequency	Percentage (%)
High	127	65.0
Low	69	35.0
Total	**196**	**100**

Source: Survey, 2024

Table 2 shows how respondents are distributed according to their awareness of intimate partner violence (IPV) in Lafia Metropolis. Most of the participants (65.0%) showed a strong understanding of IPV, while 35.0% demonstrated a minimal awareness. This suggests that although knowledge of IPV is fairly common in the study area, a considerable population is still poorly informed.

Table 3: Factors responsible for IPV

Factors	Response frequency/Percentage (%)		
	Yes	**No**	**I don't know**
Drug use	159 (81.1)	28 (14.3)	9 (4.6)
Anger	164 (83.7)	19 (9.7)	13 (6.6)
Young age	140 (71.4)	51 (26.0)	5 (2.6)
Depression	131 (66.8)	55 (28.1)	10 (5.1)
Unemployment	170 (86.7)	23 (11.7)	3 (1.5)
Poverty	180 (91.8)	14 (7.1)	2 (1.0)

Source: Survey, 2024

Concerning factors responsible for IPV, majority of the respondents agreed that drug use, anger issues, younger couple, depression, unemployment and poverty are attributed to intimate partner violence. A participant in one of the KII stated that:

> My brother do not use drugs, but he drinks heavily. Whenever he is drunk, he beats his wife like a common criminal. As for my husband, he has a hot temper. When we were newly married, he would beat me, claiming it was to correct me. He often became angry when there was no money in the house, and for the slightest issue, both the children and I would face his wrath. One day, he beat me so badly that I started bleeding, and my neighbours rushed me to DASH hospital. The doctor told me I had lost a two-month pregnancy. However, in the past few months, after we visited a marriage counsellor, he has stopped. *(Female, 36/ Lafia East).*

Another KII participant observed that:

> I got married at a very young age, and my husband is 15 years older than me. For every minor issue, he would take out a belt and beat me severely. In fact, he keeps a special cane in our bedroom just for that purpose. He drinks and smokes, though I am not certain if that influences his behaviour towards me. I have observed that most of our fights happen when he is short on money or upset with someone else. Even after 22 years of marriage, I still feel afraid of him *(Female, 48/ Lafia modern market).*

Table 4: Effect of IPV on pregnant women

Factors	Response frequency/Percentage (%)		
	Yes	**No**	**I don't know**
Miscarriage	173 (88.3)	11 (5.6)	12 (6.1)
Internal bleeding	139 (70.9)	7 (3.6)	50 (25.5)
STDs	176 (89.8)	11 (5.6)	9 (4.6)
Preterm labour	163 (83.2)	27 (13.8)	6 (3.1)
Malnutrition	144 (73.5)	39 (19.9)	13 (6.6)

Source: Survey, 2024

Table 4 sought to show the effect of intimate partner violence on pregnant women, result from this table indicates that majority of the respondents agreed that IPV led to miscarriage, internal bleeding, sexually transmitted diseases, preterm labour, and malnutrition among pregnant women.

This result is similar to the one obtained through KII session as one of the participant had this to say:

> I recall when I was four months pregnant, about five years ago. One day, my husband and I had an argument when he returned from work, and he started beating me. Blood started gushing from my private part, and he rushed me to the hospital. The next day, the doctor informed me that I had lost the pregnancy. I also remember a friend of mine from Bukan Sidi, Lafia; her husband beat her to death. When I went to deliver at M&D Hospital last year, a woman was rushed in. The people who brought her said her husband had beaten her and fled, and she ended up delivering a premature baby.

Table 5: Implications of intimate partner violence on breast feeding mothers

Factors	Response frequency/Percentage (%)		
	Yes	**No**	**I don't know**
Postpartum Depression	169 (86.2)	17 (8.7)	10 (5.1)
Hemorrhage	166 (84.7)	18 (9.2)	12 (6.1)
Suicide thought	144 (73.5)	46 (23.5)	6 (3.1)
Isolation	130 (66.3)	34 (17.3)	32 (16.3)
Perinatal death	142 (72.4)	32 (16.3)	22 (11.2)

Source: Survey, 2024

Table 5, revealed that 86.2% of the respondents opined that IPV led to postpartum depression among breast feeding mothers while 14% disagreed, 84.7% agreed that haemorrhage as a result of IPV affect breast feeding mother while nearly one fifth 15.3% disagreed. It was agreed in the study by 73.5% of the respondents that breast feeding mothers who have suffered IPV suffers from

suicide thought, while 26.6% disagreed. Isolation is an implication of IPV on breast feeding mothers, this was agreed by two third 66.3% of the respondents, while one third 33.6% disagreed. The study found that IPV has an implication on breast feeding mothers, as such health care practitioner, family members and government should pay attention on breast feeding mother to alleviate this implications.

This result is similar to the one obtained through KII session:

> My husband and I were constantly fighting, and most times, he would use a plank or anything he could find to hit me. Things got worse when I started giving birth to baby girls. He would get angry over the smallest issues and never gave me any money. He even instructed his relatives not to assist me in any way. Honestly, there were moments when I thought about ending both my baby's life and my own because life felt unbearable at that time *(Female, 53/ neighbourhood market Lafia).*

Another KII participant observed that:

> When I gave birth to my third child prematurely due to frequent physical abuse from my husband, I started experiencing excessive bleeding after a few days. I had to use my business funds and salary for treatment, while my husband and his family showed no concern whatsoever *(Female, 41/ ministry of works Lafia).*

Discussion of Findings

The quantitative study's results showed that 81.1% of participants agreed that drug use contributes to IPV, while 14.3% disagreed. This result differs from the work of Sharps, Campbell, and Campbell (2019), which indicated that serious alcohol and tobacco issues heighten the risk of women experiencing violent victimization in intimate partner relationships. Anger, as a contributor to IPV in the study area, is notably high at 83.7%, aligning with the findings from Birkley and Eckhardt (2015), who discovered that IPV perpetration was linked to anger and hostility. The research further indicated that 71.4% believed that being young contributes to IPV among couples, whereas 66.8% cited depression and 86.7% pointed to unemployment as factors contributing to IPV in the area of study. These results aligned with those of Meisel, Chandler, and Rienzi (2003), as well as Carlson, Worden, VanRyn, and Bachman (2000), who found that intimate partner violence was associated with unemployment. In their investigation, nearly half of the women reported severe domestic violence, encompassing depression, stress disorders, and anxiety.

The results of this study clearly indicate that a significant number of respondents believe that poverty causes IPV. This aligned with the results of Dugan, Nagin, and Rosenfeld (2003), where it was noted that extreme poverty and its related stressors heightened the likelihood of intimate partner violence. As household income decreases, the reported rate of intimacy partner violence increases.

The study identified several significant impacts of intimate partner violence (IPV) on pregnant women, including miscarriage, internal bleeding, sexually transmitted diseases (STDs), preterm labour, and malnutrition. The findings regarding miscarriage and internal bleeding aligned with the World Health Organization's report (2007), which indicated that unwanted pregnancies, miscarriage, and internal bleeding are potential risk factors closely associated with IPV during pregnancy. A population-based survey conducted in the United States further corroborated these findings, revealing that women who experienced miscarriage or internal bleeding reported significantly higher levels of abuse during pregnancy compared to those who did not experience IPV.

Additionally, the study's findings on STDs are consistent with research conducted by Wingood, DiClemente, and Raj (2018), which indicated that women subjected to sexual abuse are more likely to have a history of multiple STDs within their abusive relationships. Furthermore, 83.2% of participants acknowledged that pregnant women suffering from IPV are more likely to experience preterm labour. This assertion is supported by the work of Sigalla, Mushi, Meyrowitsch, Manongi, Rogathi, Gammeltoft and Rasch (2017), which found that women exposed to IPV during pregnancy face an increased risk of preterm labour, particularly if they have previously experienced adverse pregnancy outcomes.

Quantitative data from this study also indicated that 72.4% of respondents believed that pregnant women who endure IPV are likely to suffer from malnutrition. This finding is corroborated by Rahman, Poudel, Yasnoka, Otsuka, Yoshikwa and Jimba (2012), who reported a significant association between maternal exposure to IPV and malnutrition, highlighting that partner violence adversely affects maternal and child health by compromising nutritional status. The study also revealed that breastfeeding mothers who have experienced IPV are at risk of postpartum depression. In this context, James, Taft, Amir and Agius (2004) noted that IPV is prevalent among new mothers and has detrimental effects on their physical and emotional well-being. Similarly, Alice, Darcy, and George (2004) posited that women often encounter various forms of domestic violence post-birth, with IPV being linked to haemorrhaging and uncontrolled bleeding even weeks after childbirth. Moreover, approximately 72.4% of respondents concurred that IPV contributes to perinatal death among breastfeeding mothers. This assertion is supported by the findings of Guadalupe, Isabel, Jesus and Dafina (2020), which indicated that pregnant women experiencing IPV during and after pregnancy are three times more likely to suffer perinatal death compared to those who do not experience such violence.

Conclusion/ Recommendations

This study identified factors contributing to intimate partner violence (IPV) in the Lafia metropolis, as reported by the respondents. A significant majority agreed that drug use, anger management issues, youth, depression, unemployment, and poverty are key contributors to IPV. The findings suggests that when a man engages in any of these identified factors, he is more likely to perpetrate abuse against his partner.

Regarding the implications of IPV on pregnant women, the study indicated that those who experience IPV are at a higher risk for miscarriage, internal bleeding, sexually transmitted

diseases, preterm labour, and malnutrition. Our results demonstrated that women who have encountered IPV are more likely to terminate their pregnancies compared to those who have not experienced any form of domestic violence, which ultimately impacts community development and population growth. Furthermore, the study highlights the consequences of IPV on breastfeeding mothers, which include postpartum depression, haemorrhage, suicidal ideation, social isolation, and perinatal mortality.

In light of the identified factors contributing to IPV, it is imperative that health practitioners, in collaboration with non-governmental organizations and private individuals, initiate a comprehensive awareness campaign regarding the detrimental effects of IPV on maternal health. It is essential that all stakeholders work collectively to address and mitigate this pressing issue. Urgent action is required from primary healthcare teams to prevent and detect violence against pregnant women, thereby enhancing both their overall and reproductive health.

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