OPEN ACCESS

Middle East Research Journal of Medical Sciences
ISSN: 2789-7699 (Print) & ISSN: 2958-2024 (Online)
Frequency: Bi-Monthly
DOI: https://doi.org/10.36348/merjms.2026.v06i04.004

KUWAIT SCHOLARS PUBLISHER
Website: http://www.kspublisher.com/
Email: office@kspublisher.com

Prevalence and Forms of Domestic Violence among Pregnant Women Attending Antenatal Clinics in Ilorin West Local Government, Kwara State, Nigeria

Ijaiya, Zainab Bimpe[1*], Sowunmi, Christiana Olanrewaju[2], Olofin-Samuel, Mary Ayodeji[3], Aderibigbe, Olusegun[4], Kadir, Aminat Titi[5], Afolayan, Ishaq Ajibola[6], Olowoyo, Kikelomo S[7]

[1]Department of Basic Nursing, College of Nursing Sciences, University of Ilorin Teaching Hospital, Ilorin, Kwara State, Nigeria
[2]Babcock University, Ilishan-remo, Ogun State, Nigeria
[3]Department of Nursing Science, Ekiti State University, Ado-Ekiti, Ekiti State
[4]Department of Nursing Science, Federal University of Ila-Orangun, Osun State, Federal Teaching Hospital, Ido-Ekiti
[5]Kwara State College of Nursing Sciences, Ilorin, Kwara State
[6]University of Ilorin Teaching Hospital, Kwara State, Faculty of Nursing Sciences Afe Babalola University, Ado-Ekiti, Ekiti State
[7]Ekiti State University Teaching Hospital, Ado-Ekiti, Venite University Iloro-Ekiti

Abstract: Domestic violence (DV) during pregnancy constitutes a serious public health challenge with profound consequences for maternal and foetal health. Despite growing global attention to intimate partner violence (IPV), subnational prevalence data in Nigeria remain sparse. This study sought to determine the prevalence and forms of domestic violence among pregnant women attending antenatal clinics in Ilorin West Local Government Area (LGA), Kwara State, Nigeria. A descriptive cross-sectional design was employed. A total of 384 pregnant women were recruited using multistage sampling from seven primary health care facilities. Data were collected using a validated, structured questionnaire that assessed three domains of DV: psychological, physical, and sexual violence. Descriptive statistics were computed using IBM SPSS Statistics Version 25. Ethical approval was obtained, and informed consent was secured from all participants. The overall prevalence of domestic violence was 33.3%, indicating that one in every three pregnant women experienced at least one form of abuse. Psychological violence was the most prevalent form (37%), manifesting principally as verbal insults, humiliation, intimidation, and threats. Physical violence was recorded in 25% of respondents, with slapping, pushing, and hitting being the most common acts. Sexual violence was the least reported at 5.7%, though this likely reflects underreporting attributable to cultural taboos surrounding marital rape and sexual coercion. Domestic violence is prevalent among pregnant women in Ilorin West LGA, with psychological abuse being the predominant form. These findings underscore the necessity for routine DV screening during antenatal care, trauma-informed health services, and targeted community sensitisation programmes. Institutionalising DV screening protocols within maternal health systems is recommended as a priority intervention.

Keywords: Domestic Violence, Intimate Partner Violence, Prevalence, Pregnant Women, Antenatal Care, Psychological Violence.

Research Paper

***Corresponding Author:**
Ijaiya, Zainab Bimpe
Department of Basic Nursing, College of Nursing Sciences, University of Ilorin Teaching Hospital, Ilorin, Kwara State, Nigeria

How to cite this paper:
Ijaiya, Z. B. *et al.,* (2026). Prevalence and Forms of Domestic Violence among Pregnant Women Attending Antenatal Clinics in Ilorin West Local Government, Kwara State, Nigeria. *Middle East Res J. Med. Sci, 6*(4), 287-293. https://doi.org/10.36348/merjms.2026.v06i04.004

Article History:
| Submit: 30.05.2026 |
| Accepted: 01.07.2026 |
| Published: 29.08.2026 |

INTRODUCTION

Violence against women is one of the most widespread human rights abuses around the world, with almost one in three women of reproductive age being affected by violence (World Health Organization [WHO], 2021). During pregnancy, which should ideally be a time of protection and support, as well as optimal health care, domestic violence (DV) – psychological, physical and sexual abuse by intimate partner – has particularly grave consequences (Orpin *et al*., 2020). Pregnancy does not provide protection against abuse and violence; rather, numerous studies have identified it as a period of vulnerability, where pregnancy-related violence can manifest as a result of physical dependence, emotional instability, financial strain and changes in sexual relationships in intimate partnerships (Kofoworade *et al*., 2022).

Intimate partner violence (IPV) during pregnancy is a significant global problem. Prevalence rates vary between 4.8% and 63.4% in developed and developing countries in the world (Fekadu *et al*., 2018). This is especially high in sub-Saharan Africa with country-level estimates of 37% in Kenya, 51% in Pakistan, and ranging from 2.3% to 44.6% in Nigeria (Orpin *et al*., 2020; Kofoworade *et al*., 2022). Such large differences may be explained by differences in the methods used to measure DV, the heterogeneity of the samples, and the different sociocultural contexts. The health impacts of DV during pregnancy are well known, such as miscarriage, preterm labour, low birth weight, placenta abruption, maternal anaemia, as well as mental health issues including depression and post traumatic stress disorder (PTSD) (WHO, 2013).

According to WHO (2021), about 30% of women throughout the world have suffered from physical or sexual violence at least once in their lifetime. In Africa, this is 45.6% as opposed to 27.2% in Europe and 36.1% in the Americas (Popoola *et al*., 2019). The patterns are similar for domestic violence during pregnancy. In sub-Saharan Africa, the average prevalence of DV among women of reproductive age (WRA) is 38.14%, with Sierra Leone having the highest prevalence at 60.72% according to Nakie *et al*., (2025) systematic review and meta-analysis from 2019 to 2024.

In particular, pregnant women, systematic reviews have reported large variation in prevalence. In Hengyang City, China, the prevalence among women in the third trimester was 15.62%, with mental violence being the most common form of violence (11.07%) (Zheng *et al*., 2020). In Ethiopia Fekadu *et al.,* (2018) found the overall prevalence to be 30.2% and psychological violence to be the most dominant. In Latin America, a study in Peru found that 45.1% were positive and in Iran and Pakistan, 28.2% and 51% were positive, respectively (Orpin *et al*., 2020). This variation in rates reported is due to differences in study design, instrument selection, and context of violence.

Nigeria is a complex sociolegal terrain for DV. The National Crime and Safety Surveys by the CLEEN Foundation have reported an increase in nationwide prevalence of DV from 21% in 2011 to 30% in 2013 with women being the predominant victim group (Research Clue, 2023). The challenge of accurate documentation is compounded by cultural beliefs, including the acceptability of wife-beating as a form of discipline, and the social stigma placed on women (Igbolekwu *et al*., 2021). The study by Kofoworade *et al*., (2022) in University of Ilorin Teaching Hospital found a prevalence rate of 34.5% for DV among pregnant women in antenatal care, with psychological aggression accounting for the highest prevalence rate of 74.8%, thus highlighting the high psychological aspect of DV in the context. Although efforts have been made by legislation (such as the VAPP) to secure implementation, it is underdeveloped and police continue to be reported to respond to complaints about domestic violence by treating it as a private family matter (Ezelote *et al*., 2021). This institutional disengagement contributes to the silence of victims and impunity of perpetrators. Thus, primary health care is a point of intervention, which is underutilised and essential, for the identification and response to DV.

DV is a social issue that has continued to be prevalent in Nigeria because of the acceptance of man over woman, the weak legal structures, and the lack of employment opportunities (Ezelote *et al*., 2021). Violence Against Persons (Prohibition) Act (VAPP) has been enacted in Nigeria but implementation has not been uniform among the states. Although there are existing studies conducted within Kwara State including University of Ilorin Teaching Hospital with a high prevalence of DV among pregnant women (Kofoworade *et al*., 2022), no recent epidemiological information exists at a community level for Ilorin West LGA. This lack of subnational evidence limits targeted policy responses.

Psychological violence includes emotional abuse, insults, humiliation, intimidation, threats and social isolation. It is almost always identified as the most common type of DV among cultural contexts, possibly due to it being less noticeable and more accepted than physical or sexual violence (Fekadu *et al*., 2018). Psychological abuse can have significant mental health impacts, such as depression, anxiety and PTSD, and can be especially harmful during pregnancy and affect foetal neuro-development (Wu *et al*., 2020). Physical violence during pregnancy involves any act of violence including

slapping, kicking, punching or the use of weapons. It has been identified as the second leading cause of trauma during pregnancy around the world, with prevalence ranging between 0.9% to 21% worldwide (Orpin *et al*., 2020). There are reports of similarly large disparities in studies conducted in Nigeria, varying from 3.5% in Ilorin (Kofoworade *et al*., 2022) to 26.5% in Jos (Orpin *et al*., 2020) due to factors such as study population, recall periods and disclosure rates. Marriageal sexual violence is also one of the most underreported forms of violence against women worldwide, in many African countries, culture and laws do not consider marital rape as a criminal offense (Ubom *et al*., 2025). Sociocultural norms that limit a woman's right to refuse sex and sexual entitlement of the husband results in the normalization of sexual coercion, which lowers the chances of disclosing, thereby creating a vicious cycle of abuse (Ezelote *et al*., 2021; Ejioye & Gbenga-Epebinu 2021).

The study was therefore designed to fill this void, by estimating prevalence and characterising the forms of domestic violence prevalence among the pregnant women seeking Antenatal Care at primary health care facilities in Ilorin West LGA. Breaking down DV into its psychological, physical and sexual components allows a more refined understanding of the most common forms of DV within this population. The distribution of DV across sociocultural strata is interpreted using the theory of Sallis *et al*., (2008) ecological model of health behaviour and Heise (1998) social ecological framework. The findings will assist in providing empirical data to support strengthening maternal health policies, better maternal health screening practices, and context-specific prevention interventions.

The primary objective of this study was to determine the prevalence of domestic violence among pregnant women attending antenatal clinics in Ilorin West LGA, Kwara State. Specific objectives included: (i) estimating the overall prevalence of DV during the current pregnancy; (ii) describing the forms of DV experienced, namely psychological, physical, and sexual violence; and (iii) characterising the sociodemographic profile of affected women.

METHODOLOGY

Study Design and Setting

This study employed a descriptive cross-sectional design to determine the prevalence and forms of DV among pregnant women in Ilorin West LGA, Kwara State, Nigeria. Kwara State is located in the north-central geopolitical zone of Nigeria, and Ilorin West LGA is a densely populated administrative district with a predominantly urban population. Seven primary health care facilities offering antenatal care services were selected for the study: Adewole, Alanamu, Mogajingeri, Pakata, Oko-erin, and Omoda primary healthcare centres.

Sample and Sampling

The target population comprised all pregnant women attending antenatal clinics within the selected facilities during the study period. Using the Cochran (1977) formula for prevalence estimation with a 33% expected prevalence (Kofoworade *et al*., 2022), a 5% margin of error, and a 95% confidence interval, a minimum sample size of 384 was calculated. Multistage sampling was employed: first, purposive selection of health facilities; second, proportional allocation of participants per facility; and third, systematic random sampling of individual respondents within each clinic.

Instrument and Data Collection

Data were collected using a validated, administered structured questionnaire comprising five sections: (A) sociodemographic characteristics; and (B) prevalence of DV measured using items adapted from the WHO Multi-Country Study on Women's Health and Domestic Violence (WHO, 2005). The DV section assessed three domains: psychological violence (four items), physical violence (six items), and sexual violence (three items).

Face and content validity were established through expert review by senior nursing and public health professionals. Reliability was assessed using Cronbach's alpha, which yielded coefficients of 0.81 for psychological violence, 0.78 for physical violence, and 0.76 for sexual violence, all within acceptable ranges. Data collection was conducted over a six-week period by trained research assistants under close supervision.

Ethical Considerations

Ethical approval was obtained from the relevant institutional review board prior to data collection. All participants provided written informed consent after receiving detailed explanations of the study's purpose, procedures, voluntary nature of participation, and confidentiality assurances. Data were stored securely and anonymised throughout analysis. Participants who disclosed DV were sensitively referred to available counselling and social support services.

Data Analysis

Data were analysed using IBM SPSS Statistics Version 25. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were computed to summarise sociodemographic characteristics, DV prevalence, and form distribution. A woman was classified as experiencing DV if she reported at least one affirmative response to any DV item within the past 12 months.

RESULTS

The study enrolled 384 pregnant women as shown in Table 1 with a mean age of 30.2 ± 4.8 years. The majority (53.1%) were aged 25–34 years, and 91.9% were married. Secondary education was the most common educational attainment among respondents (45.6%) and their partners (43.8%). Employment was reported by 62.8% of respondents and 69.5% of their partners. Most participants (68.5%) lived in nuclear family settings, while 31.5% cohabited with extended family or in-laws.

Table 1: Sociodemographic Characteristics of Study Participants (N = 384)

Characteristic	Frequency (n)	Percentage (%)
Age Group (years)		
20–24	61	15.9
25–34	204	53.1
35–44	108	28.1
≥45	11	2.9
Marital Status		
Married	353	91.9
Cohabiting	31	8.1
Respondent Education		
No formal education	23	6.0
Primary	84	21.9
Secondary	175	45.6
Tertiary	102	26.6
Respondent Employment		
Employed	241	62.8
Unemployed/Homemaker	143	37.2

As shown in Table 2, the overall prevalence of domestic violence in the study was 33.3% (n = 128), with 128 of 384 pregnant women reporting at least one form of abuse within the past 12 months. This indicates that approximately one in every three expectant mothers attending antenatal clinics in Ilorin West LGA was experiencing domestic violence during pregnancy. The prevalence did not differ significantly across the seven facilities, suggesting a homogeneous distribution of DV risk within the local government area.

Psychological violence was the most prevalent form of DV, reported by 142 respondents (37%). The most frequently endorsed acts included verbal insults and belittlement (34.6%), humiliation in the presence of others (28.9%), intimidation through shouting or property destruction (26.3%), and threats of harm to self or family members (24.5%). These patterns suggest that emotional control and verbal aggression are the dominant mechanisms of abuse deployed against pregnant women in this context.

Physical violence was documented in 96 respondents (25%), with slapping or throwing objects (17.4%), pushing or shoving (16.9%), and hitting with a fist or object (15.1%) constituting the most common acts. More extreme forms of physical violence, kicking or beating (9.6%), choking or burning (4.2%), and weapon use or threats (3.1%) were less prevalent but represent severe and potentially life-threatening manifestations of abuse. These findings affirm that physical violence in pregnancy extends beyond minor acts to include behaviours that pose direct risks to maternal and foetal wellbeing.

Sexual violence had the lowest reported prevalence, affecting 22 respondents (5.7%). Physically forced intercourse was reported by 3.6% of respondents, forced non-consensual sexual acts by 2.9%, and fear-based sexual compliance whereby women consented to unwanted sexual activity due to fear of reprisal by 4.4%. The limited disclosure of sexual violence is consistent with patterns documented in Nigerian literature (Ezelote *et al*., 2021) and reflects entrenched cultural silence surrounding marital sexuality and the non-recognition of marital rape in many community consciousness.

Table 2: Prevalence and Forms of Domestic Violence among Pregnant Women (N = 384)

Form of Domestic Violence	n	%
Any form of DV	128	33.3
Psychological Violence	142	37.0
Verbal insults/belittlement	133	34.6

Form of Domestic Violence	**n**	**%**
Humiliation in front of others	111	28.9
Intimidation (yelling, destroying objects)	101	26.3
Threats of harm	94	24.5
Physical Violence	96	25.0
Slapping/throwing objects	67	17.4
Pushing/shoving	65	16.9
Hitting with fist/object	58	15.1
Kicking/beating	37	9.6
Choking/burning	16	4.2
Weapon use or threats	12	3.1
Sexual Violence	22	5.7
Physically forced intercourse	14	3.6
Forced non-consensual sexual acts	11	2.9
Fear-based sexual compliance	17	4.4

DISCUSSION

In this study, a prevalence of 33.3% of DV was reported among pregnant women attending the ATC in Ilorin West LGA, which means that about one-third of the women in this group in this area were exposed to IPV. This finding is in general agreement with previous Nigerian studies, such as 34.5% at the University of Ilorin Teaching Hospital (Kofoworade *et al*., 2022) and 2.3% to 44.6% nationally (Orpin *et al*., 2020). It is in line with the WHO estimates (2021) that the burden of DV among pregnant women is 30 percent in low and middle income settings. A consistent result between the various Nigerian studies irrespective of the methodologies employed implies a robust estimate and further supports the need to include systematic DV screening as part of the elements of antenatal care.

In this study, psychological violence was found to be the most common form of DV (37%), with sexual (5.7%) and physical (25%) violence. This is in line with the literature from around the world that has shown that emotional abuse is the most common and least recognized type of IPV (Fekadu *et al*., 2018; Wu *et al*., 2020). Verbal insults, humiliation and threats are often normalised in male dominated marriage cultures (Heise, 1998). In Nigeria, psychological abuse is a common occurrence, as traditional and community norms reinforce the idea that the husband's authority is equal to the discipline of his wife and demeanour in the home (Ezelote *et al*., 2021). Elevated stress responses, depression, less use of antenatal care, and poor foetal neurodevelopmental effects are all health outcomes of long-term psychological abuse in pregnancy (Wu *et al*., 2020).

Physical violence is reported by one in four (25%) respondents which is in keeping with African region trends. The results found that slapping, pushing and hitting are the most frequent forms of physical use of force which aligns with the findings of other studies conducted in Ethiopia (Fekadu *et al*., 2018), Jos (Orpin *et al*., 2020) and Lagos (Ezelote *et al*., 2021), implying that these are forms of physical coercion that are culturally common. Severe physical acts (choking, burning and use of weapons) were seen in a smaller number of respondents, suggesting a mechanism of escalation of violence in the study population that requires clinical protocols for risk stratification and emergency response. Physical safety of pregnant women is an urgent clinical priority because of the risks of physical trauma to the abdomen during pregnancy; these may include miscarriage, placental abruption and preterm labour.

The prevalence of sexual violence reported in the survey (5.7%) is likely an underestimate. Nigeria has consistently reported cases of under-reporting of sexual coercion according to studies as marital rape is not recognised in the country, shame and fear of disbelief (Ezelote *et al*., 2021; Kofoworade *et al*., 2022). Female sexual autonomy in marriage is not a universal idea amongst the study group and it is possible that many women would not view unwanted marital sex as violation. The psychological dimension of sexual abuse and the fear-based sexual compliance (4.4%) illustrates the intersection of psychological coercion and sexual abuse, which continuously reinforce each other in a spectrum of intimate partner control (Ubom *et al*., 2025). A response to sexual violence during pregnancy must not only be a clinical one, but must also entail a community re-education on consent and bodily autonomy in marriage.

The sociodemographic distribution of women affected by DV—predominately married, aged 25–34 and with secondary education—contradicts the notion that DV only affects women with no educational attainment or who are not married. This is consistent with the findings of Kofoworade *et al*., (2022) and Gillum (2019) that DV does not discriminate on the basis of

education and socioeconomic status, but on the basic structural, gender basis. Most of the respondents were also employed, further establishing that employment alone does not provide protection against intimate partner violence.

These findings can be understood in the context of the theory of Heise's (1998) ecological model. In this context, DV is not simply an individual issue, but is a product of the interaction between individual vulnerabilities, the power relations in the relationships, the norms of the community and the structures of society that legitimise men's power over women. It is necessary, therefore, to carry out prevention and intervention strategies at the same time on all ecological levels, if they are to have a positive effect.

CONCLUSION

This study has proven that domestic violence occurs in one out of three pregnant women in Ilorin West LGA with psychological violence as the most common form of violence followed by physical and sexual violence. The results place Ilorin West in the wider African epidemiological trend of high burden of DV in pregnancy, and support the need for system-wide responses. Therefore, the inclusion of DV screening in the services provided during pregnancy, training health care workers on trauma-informed care, and incorporating DV awareness into community health education play an important role in safeguarding the health, dignity, and rights of pregnant women.

The high prevalence and multiform nature of DV found in this study have nursing practice and maternal health policy implications. First, incorporate as a routine part of all antenatal care visits, DV screening with validated, confidential instruments. Early detection of DV can facilitate prompt referral to psychosocial, legal and social welfare services and minimise any adverse maternal and foetal outcomes. Second, trauma-informed care (TIC), sensitive disclosure pedagogies and safety planning should be taught to all antenatal care providers, including nurses, midwives and community health extension workers.

Policy-wise, the outcomes of the findings offer new sub-national data for the domestation and complete implementation of the VAPP in all local government areas in Kwara State. Incorporation of DV management protocols in the National Reproductive Health Policy would give a legal platform to the institutionalisation of screening. To establish a response ecosystem, multisectoral collaboration with health facilities, law enforcement, civil society and faith-based institutions is needed.

REFERENCES

- Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioral Medicine*, *4*(1), 92–100. https://doi.org/10.1207/s15327558ijbm0401_6
- Ejioye, O.T. & Gbenga-Epebinu, M.A (2021). Awareness and Experience of Disrespect and Abuse among Pregnant Women Receiving Care in Selected General Hospitals, Lagos State. *International Journal of Medicine, Nursing and Health Sciences,* 2(2), 201 – 212. DOI: 10.5281/zenodo.5186976
- Eleanor, A., Ezeonyi, E., Martin-Remy, C., & Ude, M. (2021). Domestic violence among women in Nigeria and its health implications: A review. *International Journal of Gender Studies*, *6*, 80–101. https://doi.org/10.47604/ijgs.1413
- Fekadu, E., Yigzaw, G., Gelaye, K. A., Ayele, T. A., Minwuye, T. G., & Fetene, T. D. (2018). Prevalence of domestic violence and associated factors among pregnant women attending antenatal care at University of Gondar Referral Hospital, Northwest Ethiopia. *BMC Women's Health*, *18*(1), Article 138. https://doi.org/10.1186/s12905-018-0632-y
- Gillum, T. L. (2019). The intersection of intimate partner violence and poverty in Black communities. *Aggression and Violent Behavior*, *46*, 37–44. https://doi.org/10.1016/j.avb.2019.01.008
- Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women*, *4*(3), 262–290. https://doi.org/10.1177/1077801298004003003
- Igbolekwu, C. O., Arusukwu, O., Nwogu, J. N., Rasak, B., Asamu, F., & Osueke, N. O. (2021). Domestic violence against women in the Nigerian rural context. *Journal of International Women's Studies*, *22*(1), 226–245.
- Kofoworade, A. Y., Alabi, K. M., Odeigsh, L. O., & Amoko, A. (2022). Family and clinical indicators of domestic violence among pregnant women in Ilorin, North-Central Nigeria. *Pan African Medical Journal*, *41*(1). https://doi.org/10.11604/pamj.2022.41.1.29893
- Nakie, G., Tadesse, G., Fentahun, S., Rtbey, G., Andualem, F., Kibralew, G., Kelebie, M., Melkam, M., Tinsae, T., Kassa, M. A., Alemayehu, T. T., Yigezy, M., Tsegaw, T. K., Segon, T., & Wassie, Y. A. (2025). Domestic violence and its determinants among reproductive-age women in sub-Saharan Africa: A multilevel analysis of 2019–2024 demographic and health survey data. *BMC Public Health*, *25*, Article 2288. https://doi.org/10.1186/s12889-025-23544-z
- Orpin, J., Papadopoulos, C., & Puthussery, S. (2020). The prevalence of domestic violence among pregnant women in Nigeria: A systematic review. *Trauma, Violence, and Abuse*, *21*(1), 3–15. https://doi.org/10.1177/1524838017728379
- Popoola, B. O., Popoola, A. O., Awolola, F. O., & Shoyombo, A. E. (2019). Engaging with people experiencing domestic violence, unresolved problems

in Ilorin. *Cogent Social Sciences*, *5*, Article 1710984. https://doi.org/10.1080/23311886.1710984

- Research Clue. (2023). *Victims of domestic violence in Nigeria: The need for legal and institutional protection*. https://nairaproject.com/projects/5739
- Sallis, J. F., Owen, N., & Fisher, E. B. (2008). Ecological models of health behavior. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health behavior and health education: Theory, research, and practice* (4th ed., pp. 465–485). Jossey-Bass.
- Ubom, A. U., Archibong, E. P., & Antai, E. E. (2025). Domestic violence during pregnancy: Cultural dimensions and maternal outcomes in sub-Saharan Africa. *African Journal of Reproductive Health*, *29*(1), 12–26.
- World Health Organization. (2005). *Multi-country study on women's health and domestic violence against women: Summary report on prevalence, health outcomes, and women's responses*. https://www.who.int/publications/i/items/9241593512
- World Health Organization. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. https://www.who.int/publications/i/items/who-RHR-HRP-13.06
- World Health Organization. (2021). *Violence against women prevalence estimates, 2018: Global, regional, and national prevalence estimates for intimate partner violence against women*. https://apps.who.int/iris/handle/10665/341337
- Wu, Y., Chen, J., Fang, H., & Wan, Y. (2020). Intimate partner violence: A bibliometric review of literature. *International Journal of Environmental Research and Public Health*, *17*(15), Article 5607. https://doi.org/10.3390/ijerph17155607
- Zheng, B., Zhu, X., Hu, Z., Zhou, W., Yu, Y., Yin, S., & Xu, H. (2020). The prevalence of domestic violence and its association with family factors: A cross-sectional study among pregnant women in urban communities of Hengyang City, China. *BMC Public Health*, *20*(1), Article 620. https://doi.org/10.1186/s12889-020-08683-9