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Prevalence and Factors Associated with Gender-Based Violence among Pregnant women Attending Antenatal Clinics in Nigeria: A Systematic Review

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Abstract

Background: Evidence on gender-based violence during pregnancy in Nigeria is heterogeneous, as pregnancies are at risk of maternal and fetal health problems. This systematic review aimed to summarise the prevalence, as well as factors, patterns, consequences, and disclosure, among pregnant women attending antenatal clinics in Nigeria.

Methods: Studies conducted between 2000 and 2026 August were identified through the three search engines: PubMed/MEDLINE, Scopus, and Web of Science, as well as CINAHL, African Journals Online, Google Scholar, and Nigerian repositories. The PRISMA 2020 guidelines were used for study selection, and methodological quality was evaluated using the Joanna Briggs Institute prevalence checklist.

Results: 1,903 records were identified, and of these, 33 reports were included; 28 prevalence evidence and 5 for thematic synthesis. The number of samples varied from 137 to 500. Prevalence estimates ranged from 2.3% to 72.0%, with a median prevalence of 31.8%. Psychological, emotional and verbal violence was the most common form of violence, followed by sexual and physical violence. The most common perpetrators were the husband or the intimate partner. Other contributing factors were having a low education, unemployment, poverty, polygamous marriages, alcohol use in the partner, multiple sexual partners and family dysfunction and past violence. This resulted in injury, anaemia, depression and suicidal thoughts, as well as in miscarriage, premature birth and low levels of disclosure and help-seeking.

Conclusion: There is a need for introducing a multi-dimensional prenatal screening of cases of survivors with a confidential pathway to medical, psycho-social, legal and protection referral.

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Keywords: antenatal care, domestic violence, gender-based violence, intimate partner violence, Nigeria, pregnancy, prevalence, risk factors

Introduction

Gender based violence (GBV) during pregnancy involves physical, sexual, psychological, emotional, verbal and economic abuse as well as coercive and controlling behaviour affecting a pregnant woman, likely perpetrated by her husband or intimate partner. Women who are pregnant are not immune to violence and may be at a higher risk for violence due to financial dependence, changes in sexual relationships, disputed paternity, and stress in household relationships and decision-making. Non-respect and issues of bodily integrity are not the only implications, but also levels of psychological suffering, inadequate use of ANC and detrimental maternal and fetal outcomes. But there are indications in Nigeria of a high, though variable burden. Other studies in

Nigeria found higher rates of domestic violence among attendees in Zaria (9.6%) and in Abuja (6.2%), as well as other Nigerian settings (Ameh & Abdul, 2004; Ezechi *et al.*, 2004; Efetie & Salami, 2007) [4, 17, 15], with Fawole *et al.* (2008) [19] recording a comparatively low prevalence of 2.3% in Abeokuta (Envuladu *et al.*, 2012) [16], 44.6% in Abakaliki (Onoh *et al.*, 2013) [34], 36.1% among tertiary-facility antenatal attendees (Ikeako *et al.*, 2017) [22], 59.6% in selected Primary Healthcare centres in Abuja (Ayeeni *et al.*, 2021) [12], 43.0% in Enugu (Njoku *et al.*, 2021) [28], 34.5% in Ilorin (Kofoworade *et al.*, 2022) [26], 40.0% in Abakaliki (Egwu *et al.*, 2023) and 27.3% in Chiejine *et al.* (2024) [13]. An extremely high IPV exposure of 72.0% has been reported in Oyo East by Ayodapo *et al.* (2017) [10], while Idowu and co-authors (2013) reported 7.4% for Northern Nigeria. There is a variety that could reflect actual differences in context. Still, it also clearly shows inconsistencies in the definition of violence, the instruments used, the data-collection timeframes, and the populations sampled. Research that includes psychological, emotional, verbal and/or controlling behaviours tends to show more impact than those that only include physical and/or sexual assault, indicating an underestimate of the amount of pregnancy-related violence in Nigeria when accounts of only physical and/or sexual violence are assessed.

The determinants of GBV in pregnancy occur at the individual, partner, household, clinical and community levels. It has been a continuous topic that low levels of education, unemployment and poverty, and with women's vulnerability to abuse (Abasiubong *et al.*, 2010; Fawole *et al.*, 2010; Iliyasu *et al.*, 2013; Dada *et al.*, 2022) [1, 20, 23, 14]. But the reasons and connections between economic independence and violence are not straightforward; Ansari *et al.* (2017) [7] discovered relations which became problematic if women's income and autonomy to use their income were contesting the existing gender dynamics. Low educational attainment, unemployment, alcohol use and multiple sexual partners are partner-level factors, while polygamous marriage, financial disputes, family dysfunction and past violence are relationship and familial-level factors linked to the pregnancies (Ameh *et al.*, 2008; Envuladu *et al.*, 2012; Isangadighi & Udeh, 2023; Ashimi & Amole, 2015; Ikeako *et al.*, 2017; Kofoworade *et al.*, 2022) [5, 16, 24, 9, 22, 26]. Consequences reported include injury, anaemia, depression and suicidal ideation, miscarriage/preterm delivery, and others (Onoh, 2013; Ayeeni *et al.*, 2021; Dada *et al.*, 2022; and Kofoworade *et al.*, 2022) [34, 12, 14, 26]. However, disclosure remains limited despite these consequences. As reported by Ayodapo *et al.* (2017) [10] and Tella *et al.* (2020) [35], women who experienced PV tended

to report to family members and religious leaders, remain silent, avoid, or seek informal mediation. While the previous Nigerian systematic review included 17 studies up to June 2016, many studies have emerged from PHCs, communities, and tertiary facilities in Nigeria. The available evidence is thus larger, more geographically extensive, and methodologically sophisticated, and an update to the synthesis is needed. In view of this, this systematic review aimed at identifying the prevalence and pattern of GBV, individual, partnership, household and clinical factors associated with GBV, pattern of disclosure and health consequences, and differences by geographical zone, health

care level, type of violence and methodological quality among pregnant women attending ante-natal clinics in Nigeria.

Methodology

Review Design and Eligibility Criteria

This systematic review was done based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines and looked at the prevalence and factors associated with gender-based violence among pregnant women attending antenatal clinics in Nigeria. The exposure was gender-based violence, including domestic violence, intimate partner violence, spousal violence, physical violence, sexual violence, psychological violence, emotional violence, verbal violence, controlling violence, and economic violence. The outcomes were the prevalence of gender-based violence, the pattern of gender-based violence, the perpetrators of gender-based violence, and the factors associated with gender-based violence. Eligible studies for inclusion were original studies that focused on quantitative or mixed methods and that had pregnant women from Nigeria as participants, and assessed the prevalence of violence during the pregnancy of interest (index pregnancy) or during a previous pregnancy. The studies were designed in Primary, Secondary, and Tertiary settings, and in Public, Private, or Community/Public settings, and the events took place during pregnancy and/or the antenatal period. If a postpartum experience did not have a pregnancy experience, this was not included in the postpartum study. Reviews, editorials, protocols, case reports, studies with only qualitative results, and studies of mistreatment of healthcare workers during childbirth were excluded. If several reports had the same participants, then they were regarded as 'companion' publications and were considered as one study if there was no indication of different results.

Information Sources, Search Strategy and Search History

A systematic search was conducted (2000 - 26 August 23). A series of databases, which include: PubMed/MEDLINE, Scopus, Web of Science Core Collection, CINAHL, African Journals Online, Google Scholar, and Nigerian institutional repositories, were queried. Searches were conducted to examine the reference lists of eligible studies and prior systematic reviews, and to perform a forward search to identify newer publications. The key words used were: ("gender-based violence" OR "intimate partner violence" OR "domestic violence" OR "spousal violence" OR "partner abuse" OR "violence against women" OR "physical abuse" OR "sexual violence" OR "psychological abuse" OR "emotional abuse") AND ("pregnant women" OR pregnancy OR antenatal OR prenatal OR "antenatal clinic" OR "maternal health services") AND (prevalence OR magnitude OR pattern OR determinants OR predictors OR correlates OR "associated factors" OR "risk factors") AND (Nigeria OR Nigerian). Controlled vocabulary (Medical Subject Headings (MeSH)), truncation, proximity operators, and database-specific field codes were utilised. An iterative search was done. The initial search was only for pregnancy-related searches conducted at Primary Health-care Centres, which yielded four potentially eligible reports – three of those were conducted at Primary Health-care Centres, and one used both Primary and Secondary health-care Centres. However, this

excluded a significant amount of evidence from Nigeria, and the decision was made to expand the setting to include antenatal clinics (ANCs) across all levels of care. The search terms were subsequently varied to include a search for 'gender-based violence', in addition to 'domestic violence', 'intimate partner violence', 'spousal violence', 'partner abuse' and 'specific form of violence'. To identify studies that came before this systematic review, a backward citation search was used, while a forward citation search was used to identify studies that came after the previously conducted systematic review in Nigeria, up to June 2016 (17 articles). These were then checked for author, title, location, and DOI to certify the records and to determine whether there is a companion or duplicate record. 35 potentially eligible reports were found with the complete search. Based on preliminary screening of population, setting, outcomes, and sample overlap, 33 reports were initially retained for detailed full-text reviews.

Study Selection and Data Extraction

All the identified references were placed in the review database and deleted if they were duplicates based on Title, Author, Year of publication, Setting, and Digital Object Identifier(s). Titles and abstracts were screened independently, and potentially relevant full texts were assessed by two reviewers. Reports that did not report pregnancy-specific outcomes, did not specify the type of report (qualitative only or quantitative/qualitative), the setting was other than Nigeria, the population description was incorrect, or there was no numerical data were excluded.

Where disagreements arose, they were raised, with the assistance of a third reviewer where necessary. Categorisation of exclusion was performed, and the full-text review and selection process (study selection) were presented using the PRISMA 2020 flow diagram. The data extraction form included information on authorship, publication year, state, geopolitical zone, healthcare level, study design, sampling procedures, number of participants, participant

characteristics, definition of violence type, measuring instrument, reference period, perpetrator, overview of prevalence, overview of the various violences, associated factors, effect estimates, confidence intervals, and limitations. Violence was identified as being physical, sexual, psychological/emotional, verbal or economic/controlling behaviour. The data was collected from one of the scores

sheets and then cross-checked against the entire report using a second score sheet, which a different person reviewed.

Quality Assessment and Data Synthesis

Each methodological quality assessment was conducted independently by two appraisers using the Joanna Briggs Institute Critical Appraisal Checklist for Studies Reporting Prevalence Data. The appropriateness of the sampling frame, sampling procedure, sample size, description of participants and settings, sample coverage, violence-measurement instrument, measurement consistency, statistical analysis, and response rate was evaluated in the appraisal. The analytical studies were also evaluated to control for and identify confounding factors. Studies were categorised as low-, moderate-, or high-risk of bias. Quality was not the only criterion for exclusion, and sensitivity analysis and interpretation of quality rating were performed. Each study was initially summarised narratively and presented in evidence tables that summarised its characteristics and findings. Distinctiveness of prevalence estimates was coded by geographic region (geopolitical zone), level of the healthcare (scope of healthcare), timeframe of the publication (date) and by measure of the violence (measurement period) and form of violence measured (type of violence).

Ethical Considerations

Ethical approval was not required because the review used published data and involved no direct contact with human participants.

Results and Discussion

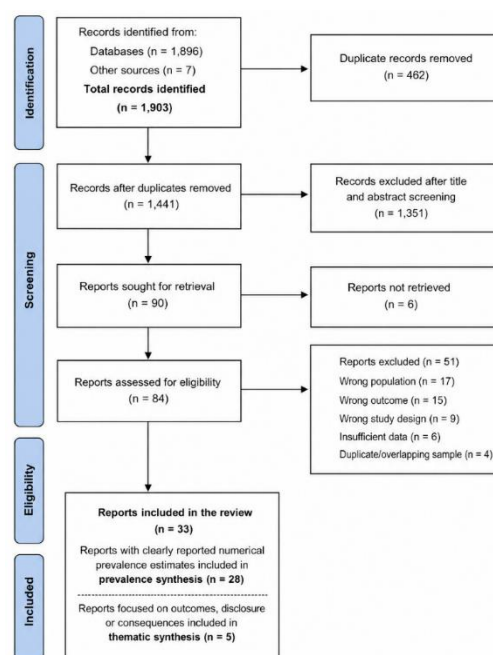


Fig 1: PRISMA 2020 Flow Diagram Showing the Identification, Screening, Eligibility Assessment, and Inclusion of Reports in the Systematic Review

The process of identifying and screening papers, as well as paper-number evaluation for eligibility and recursion in the present systematic review, is shown visually in Figure 1. A total of 1903 records were identified during the search across databases and other sources, indicating an increase over the preliminary search and signifying a substantial number of records. 33 reports were ultimately included after completing the sequential screening and eligibility assessment procedure. There were 28 of these reports, 7 that provided sufficiently detailed prevalence estimates in their statistics to be synthesised into the prevalence synthesis, and 5 that had a primary focus on outcomes, disclosure, or consequences, which could be synthesised into the thematic synthesis. This contrast can provide a template in which to integrate the critical contextual and experiential elements of violence towards women while using quantitative data. To ensure broader coverage of the review, an inclusive search strategy was used, encompassing primary and antenatal care, secondary and tertiary healthcare facilities, community settings, and mixed facilities. Including only studies conducted within the PHC limits the risk of missing applicable evidence originating at other levels of care. Other studies that were conducted in primary healthcare and population-based research studies include Enzuladu *et al.* (2012) ^[16]; Iyanam *et al.* (2018) ^[25]; and Ayeni *et al.* (2021) ^[12]; whilst others were conducted at the tertiary level, such as Iliyasu *et al.* (2013) ^[23]; Ikeako *et al.* (2017) ^[22]; and Kofoworade *et al.* (2022) ^[26]; Nwafor *et al.* (2024) ^[30]; and Chiejine *et al.* (2024) ^[13]. In addition, the literature indicates continued interest in the research, with efforts by Ameh and Abdul (2004) ^[4], Ezechi *et al.* (2004) ^[17], Egwu *et al.* (2023), Nwafor *et al.* (2024) ^[30], and Olabisi *et al.* (2026) ^[32]. It should be noted that the 33 reports included in the study are not necessarily representative of 33 distinct study populations. Multiple publications can stem from the same cohort, institution, or geographical context, leading to double-counting. This is important to consider for publications from Zaria (Ameh *et al.*, 2008) ^[5], where a careful comparison of recruitment periods, sample sizes, study settings, and reported outcomes is required. In addition, the results showed that the current evidence base is broader and more contemporary than the previous systematic review, which, after methodological appraisal, included only 17 of 19

potentially eligible articles. A large number of records (1,903) were found. In general, Figure 1 illustrates that the broader search scope resulted in full coverage of the evidence, and the PRISMA-based screening process was an appropriate way to narrow the broad literature sample to 33 included studies, which form the basis of the current review.

Characteristics of the Included Studies

As shown in Table 1, the included studies exhibited wide variation in geography, healthcare and methodological aspects, and sample size. Evidence was generated from each of Nigeria's six geopolitical zones, though not evenly distributed across them. The areas included Zaria, Kano, Sokoto, Jos, Abuja, Ilorin, Ekiti, Ibadan, Abeokuta, Benin City, Oleh, Uyo, Itu, Abia, Enugu, and Abakaliki. This coverage is relevant because factors such as socioeconomic inequality, marriage, gender norms, and family organisation relate to gender-based violence and vary across regions. For example, Ansari *et al.* (2017) ^[7] reported prevalence rates of 22% in Cross River State and 9% in Bauchi State, indicating subnational differences. On average, women recruited as samples in various studies conducted in PHCs or rural communities, such as Ashimi and Amole (2015) ^[9], Enzuladu *et al.* (2012) ^[16], and Iyanam *et al.* (2018) ^[25], may not have the same socioeconomic or healthcare experience as women sampled in tertiary healthcare, as in Iliyasu *et al.* (2013) ^[23], Ikeako *et al.* (2017) ^[22], Kofoworade *et al.* (2022) ^[26], and Nwafor *et al.* (2024) ^[30]. Sample sizes also varied, from a minimum of 137 (Nwafor *et al.*, 2024) ^[30] to a maximum of 500 prenatal attendees (Umeora *et al.*, 2008). Estimates should not be given equal weight for two reasons: first, the statistical precision of the estimates varies, and second, the estimates reflect the sample sizes of the corresponding studies. Finally, because most of the research was cross-sectional, it is difficult to interpret the results and implications for related factors and violence, as these are measured at the same time. Additionally, there was variation in the time period measured (current pregnancy, last 12 months, lifetime experiences of PRVs). The screening devices, definitions of disclosure, and interview contexts may also impact disclosure. Table 2, therefore, confirms that evidence is available for Nigeria and indicates methodological differences.

Table 1: Characteristics of the included reports

Study	Location	Setting/design	Sample	Principal outcome or reported prevalence
Ameh and Abdul (2004)	Zaria, Kaduna State	Antenatal facility; cross-sectional	NR	Prevalence and forms of domestic violence during pregnancy
Ezechi <i>et al.</i> (2004)	South-East Nigeria	Antenatal clinic; cross-sectional	418	Current-pregnancy violence: 28.7%
Efetie and Salami (2007)	Abuja FCT	National Hospital ANC; cross-sectional	NR	Domestic violence: approximately 37.4%; psychological abuse predominated
Fawole, Hunyinbo and Fawole (2008)	Abeokuta, Ogun State	Antenatal clinic; cross-sectional	NR	Current-pregnancy violence: 2.3%
Ameh, Shittu and Abdul (2008)	Zaria, Kaduna State	Antenatal clinic; risk-assessment study	NR	Developed risk indicators for domestic violence
Umeora <i>et al.</i> (2008)	South-East Nigeria	Referral-centre prenatal clinic; cross-sectional	500	Violence prevalence: 13.6%; assessed patterns and determinants
Awusi, Okeleke and Anyanwu (2009)	Oleh, Delta State	Suburban antenatal population; cross-sectional	NR	Domestic violence during pregnancy: prevalence and correlates examined
Gyuse, Ushie and Etukidem (2009)	Jos, Plateau State	Hospital ANC; cross-sectional	NR	Pregnancy-related violence and its different forms
Abasiubong <i>et al.</i> (2010)	Uyo, Akwa Ibom State	Antenatal population; cross-sectional	NR	Demographic risk factors and domestic violence
Fawole, Abass and	Ibadan, Oyo State	Antenatal clinics; cross-sectional	NR	Violence during pregnancy and associated

Fawole (2010)				factors
Olagbuji <i>et al.</i> (2010)	Benin City, Edo State	Referral centre; repeated cross-sectional/trend analysis	NR	Pregnancy-related violence trends and determinants
Adesina, Oyugbo and Olubukola (2011)	Ibadan, Oyo State	Antenatal clinic; cross-sectional	NR	Prevalence and pattern of violence in pregnancy
Arulogun and Jidda (2011)	Abuja FCT	Selected hospitals; cross-sectional	NR	Experiences and forms of violence among pregnant women
Envuladu <i>et al.</i> (2012)	Jos North, Plateau State	PHC antenatal clinic; cross-sectional	201	Current-pregnancy violence: 31.8%; previous-pregnancy violence: 28.9%
Iliyasu <i>et al.</i> (2013)	Kano State	Tertiary antenatal facility; cross-sectional	392 analysed	Current-pregnancy violence: 7.4%
Onoh <i>et al.</i> (2013)	Abakaliki, Ebonyi State	Federal Medical Centre ANC; cross-sectional	NR	Index-pregnancy IPV: 44.6%
Ashimi and Amole (2015)	Northwest Nigeria	Rural/community antenatal population; cross-sectional	NR	Domestic violence in pregnancy and independent predictors
Ansari <i>et al.</i> (2016/2017)	Cross River and Bauchi states	Household survey with qualitative component	Large two-state sample	Physical IPV in the last pregnancy: 22% in Cross River and 9% in Bauchi
Ayodapo <i>et al.</i> (2017)	Oyo East LGA, Oyo State	Three PHCs and one secondary facility; cross-sectional	350	IPV exposure: 72.0%; disclosure among exposed women: 28.6%
Ikeako <i>et al.</i> (2017)	Enugu State	Tertiary antenatal clinic; cross-sectional	NR	IPV during pregnancy: 36.1%
Iyanam, Udoh and Morgan (2018)	Itu, Akwa Ibom State	PHC antenatal clinic; cross-sectional	200	Domestic violence prevalence and risk factors
Iwuoha, Ekeleme and Ezirim (2018)	Abia State	Tertiary institutions; cross-sectional	NR	Determinants and consequences of IPV
Ezeudu <i>et al.</i> (2019)	Enugu State	Maternal and child health facilities: mixed-method study	NR	IPV before and during pregnancy; prevalence during pregnancy is approximately 37.2%
Oche <i>et al.</i> (2020)	Sokoto State	Antenatal clinic; cross-sectional	NR	IPV knowledge and experience; psychological and controlling behaviours assessed
Tella <i>et al.</i> (2020)	Niger Delta region	Rural and urban antenatal settings; comparative cross-sectional	NR	Domestic violence, risk factors, coping and help-seeking
Ayeni, Yusuf and Musa (2021)	Karu and Jikwoyi, Abuja FCT	Two PHCs; cross-sectional	384	GBV prevalence: 59.6%
Njoku <i>et al.</i> (2021)	Enugu State	Pregnant antenatal attendees; cross-sectional	400	Ever abused during pregnancy: 43.0%
Kofoworade <i>et al.</i> (2022)	Ilorin, Kwara State	University teaching hospital ANC; cross-sectional	370	Domestic violence: 34.5%
Dada <i>et al.</i> (2022)	Ado-Ekiti, Ekiti State	Tertiary antenatal clinic; cross-sectional	NR	IPV prevalence: 7.9%
Egwu <i>et al.</i> (2023)	Abakaliki, Ebonyi State	Federal teaching hospital ANC; cross-sectional	165	Any domestic violence: 40.0%
Nwafor <i>et al.</i> (2024)	Nigeria	Booked antenatal population; cross-sectional	137	IPV prevalence: 52.6% (72/137)
Chiejine <i>et al.</i> (2024)	Asaba, Delta State	Antenatal clinic; cross-sectional	NR	Overall IPV prevalence: 27.3%
Olabisi <i>et al.</i> (2026)	Nigerian healthcare facilities	Antenatal attendees; cross-sectional	NR	IPV experience: approximately 28.4%

Prevalence and Patterns of Gender-Based Violence

From the above analysis in Table 2, the expectant women are exposed to different levels of gender-based violence (GBV), with the range starting from 2.3 % as per Fawole *et al.* (2008) [19] to 72.0 % per Ayodapo *et al.* (2017) [10] in OYO East. It was a descriptive median of ~31.8%, which did not allow interpretation as a pooled national prevalence because it did not account for sample size, variance, or methodological quality, and it presented a high level of violence among attendees at the antenatal clinic. The variations may be attributed in part to variations in the definition of violence and the screening devices used. Some of the studies were only for physical violence, and mostly, there was a lower level of prevalence of violence. In contrast, studies of violence of any type, including psychological, verbal, sexual and controlling,

also had high prevalence, including a study by Ansari *et al.* (2017) [7]. For instance, Ayeni *et al.* (2021) [12] indicated the prevalence at 59.6%, and nearly all the cases were emotional abuse, while Chiejine *et al.* (2024) [13] indicated a higher prevalence for psychological violence and controlling behaviour than physical violence. A regional difference was also observed due to the difference between the reports by Iliyasu *et al.* (2013) [23] (Northern Nigeria), which found 7.4, Onoh *et al.* (2013) [34] at 44.6 in Abakaliki, Njoku *et al.* (2021) [28] at 43.0 in Enugu and Kofoworade *et al.* (2022) [26] at 34.5 in Ilorin. The higher prevalence estimates of 40.0% by Egwu *et al.* (2023) and 52.6% by Nwafor *et al.* (2024) [30] may reflect better sensitisation and reporting of nonphysical violence rather than an increase in prevalence over time. Psychological and/or verbal abuse was the most prevalent form of abuse by

Onoh *et al* (2013) ^[34], Ikeako *et al* (2017) ^[22], Ayeni *et al* (2021) ^[12], Kofoworade *et al* (2022) ^[26] and Egwu *et al* (2023), which implies that any screening tool that does not identify psychological and/or verbal abuse will severely underestimate the problem. For this reason, in statistical

pooling, it is important to distinguish overall violence, physical, sexual and psychological violence and also to distinguish between current pregnancies (where there is violence) and violence in life.

Table 2: Numerical synthesis of reported prevalence estimates

Study	Overall prevalence	Physical violence	Sexual violence	Psychological/emotional/verbal violence
Ezechi <i>et al.</i> (2004)	28.7%	Reported	Reported	Reported
Fawole <i>et al.</i> (2008), Abeokuta	2.3%	Principal measured form	NR	NR
Umeora <i>et al.</i> (2008)	13.6%	Reported	Reported	Verbal/psychological abuse is prominent
Envuladu <i>et al.</i> (2012)	31.8% current; 28.9% previous pregnancy	Reported	Reported	Reported
Iliyasu <i>et al.</i> (2013)	7.4%	58.6% of abused women	13.8% of abused women	Reported
Onoh <i>et al.</i> (2013)	44.6%	Approximately 21% of reported forms combined with emotional abuse	Reported	Verbal abuse accounted for approximately 60.1% of reported forms
Ansari <i>et al.</i> (2016/2017)	22% Cross River; 9% Bauchi	Physical IPV measured	Not the principal outcome	Not the principal outcome
Ayodapo <i>et al.</i> (2017)	72.0%	Reported	Reported	Reported
Ikeako <i>et al.</i> (2017)	36.1%	Reported	No sexual violence reported	Verbal abuse: 14.4%
Ayeni <i>et al.</i> (2021)	59.6%	28.5% of survivors/cases	13.6%	99.4% of survivors/cases
Njoku <i>et al.</i> (2021)	43.0% ever abused in pregnancy	Reported	Reported	Reported
Kofoworade <i>et al.</i> (2022)	34.5%	Physical assault with injury: 3.5%	Reported	Psychological aggression: 74.8% of the violence pattern
Dada <i>et al.</i> (2022)	7.9%	Included in WAST assessment	Included	Included
Egwu <i>et al.</i> (2023)	40.0%	The second most common form	Reported	Psychological violence is the most common
Nwafor <i>et al.</i> (2024)	52.6% (72/137)	Reported	Reported	Reported
Chiejine <i>et al.</i> (2024)	27.3%	5.0%	Reported	Psychological IPV: 17.0%; controlling behaviour: 16.0%
Olabisi <i>et al.</i> (2026)	Approximately 28.4%	Reported	Reported	Reported

Associated Factors

Table 3 suggests that there is interactive individual, partner, household, clinical and community predictors of pregnancy-related gender-based violence and not any one predictor. A shared theme was that of socioeconomic disadvantage. Regardless, low maternal education was associated with adverse outcomes in Fawole *et al.* (2008) ^[19], Abasiubong *et al.* (2010) ^[1], and Iliyasu *et al.* (2013) ^[23], and unemployment and low income were significant factors in Dada *et al.* (2022) ^[14]. These factors may reduce women's knowledge and awareness of access to effective protection options, reduce agency within the household to make decisions and place a greater financial strain on women who endorse a need to exit an abusive relationship. Some research has, however, shown that women earners could be more vulnerable to violence if there is an idea of danger to the established gender dynamics in the home, as this is perceived as endangering their access to income (Ansari *et al.*, 2017) ^[7]. Partner attributes were of great importance, too. Unemployment of partners (Ikeako *et al.*, 2017) ^[22], alcohol consumption (Envuladu *et al.*, 2012) ^[16], low education status of sexual partners, low level of education and HIV status of the clients were all factors found

to be associated with violence. According to Ameh *et al.* (2008) ^[5], a combination of indicators could be a better way to identify a child for early help than relying on a single indicator. Polygamous marriage was a risk factor in Envuladu *et al.* (2012) ^[16] and Ashimi and Amole (2015) ^[9], which could be attributed to the jealousy, competition for household resources and unequal decision making. Family dysfunction was seen to be a significant correlate of violence in adolescent pregnancy. It was also blamed on the same violence-adolescent pregnancy association by Kofoworade *et al.* (2022) ^[26], while Dada *et al.* (2022) ^[14] attributed anaemia to it. Community norms were also considered, as the extent of violence reported in the community positively predicted an individual's risk, consistent with Ansari *et al.* (2017) ^[7]. All of these indicate the need for a multidimensional assessment during pregnancy, including assessment of socioeconomic status, partner behaviour, family functioning, and maternal status. The majority of these studies were cross-sectional in design and therefore identified only associations; prospective studies are needed to understand the direction of these associations better.

Table 3: Thematic synthesis of factors associated with gender-based violence

Domain	Associated factor	Direction of association	Supporting studies
Woman's characteristics	Low educational attainment	Generally increased risk	Fawole <i>et al.</i> (2008); Iliyasu <i>et al.</i> (2013); Abasiubong <i>et al.</i> (2010)
Woman's characteristics	Unemployment	Increased vulnerability	Dada <i>et al.</i> (2022); Iliyasu <i>et al.</i> (2013)
Woman's characteristics	Low income/economic dependence	Increased risk	Dada <i>et al.</i> (2022); Ansari <i>et al.</i> (2016/2017)
Woman's characteristics	Personal income with control over spending	Context-specific increased risk	Ansari <i>et al.</i> (2016/2017)
Woman's characteristics	Younger maternal age	Frequently associated with increased vulnerability	
Partner characteristics	Low partner education	Increased risk	Envuladu <i>et al.</i> (2012); Fawole <i>et al.</i> (2008)
Partner characteristics	Partner unemployment or unstable occupation	Increased risk	Ikeako <i>et al.</i> (2017); Envuladu <i>et al.</i> (2012)
Partner characteristics	Alcohol consumption	Strongly increased risk	Envuladu <i>et al.</i> (2012);
Partner characteristics	Multiple sexual partners	Increased risk	Envuladu <i>et al.</i> (2012)
Relationship factors	Polygamous marriage	Increased risk	Envuladu <i>et al.</i> (2012); Ashimi and Amole (2015)
Relationship factors	Family dysfunction	Increased risk	Kofoworade <i>et al.</i> (2022)
Relationship factors	Financial disagreement	Common precipitating factor	Iliyasu <i>et al.</i> (2013); Efetie and Salami (2007)
Relationship factors	Previous history of violence	Increased likelihood of recurrence	Envuladu <i>et al.</i> (2012); Ezechi <i>et al.</i> (2004)
Clinical factors	HIV-positive status	Increased risk	Envuladu <i>et al.</i> (2012)
Clinical factors	Anaemia	Associated with violence	Kofoworade <i>et al.</i> (2022)
Mental health	Depression	Positively associated with IPV	Dada <i>et al.</i> (2022)
Mental health	Suicidal ideation	Associated with IPV	Dada <i>et al.</i> (2022)
Community factors	Community-level normalisation of violence	Increased individual risk	Ansari <i>et al.</i> (2016/2017)
Protective factors	Greater household wealth	Reduced risk	Ansari <i>et al.</i> (2016/2017)
Protective factors	Higher partner education	Reduced risk	Ansari <i>et al.</i> (2016/2017); Envuladu <i>et al.</i> (2012)

Perpetrators, Disclosure and Help-Seeking

Table 4 shows that husbands and current intimate partners are the most prevalent actors of violence against pregnant women, which agrees with the results of Efetie and Salami (2007) ^[15], Onoh *et al.* (2013) ^[34], Ikeako *et al.* (2017) ^[22] and Ayeni *et al.* (2021) ^[12]. This only corroborates an earlier report that intimate partner violence (IPV) is the most prevalent type of pregnancy-related gender-based violence (GBV) in Nigeria. But, numerous cases of abuse by boyfriends, relatives, co-wives and in-laws have been reported, suggesting that the notion of screening based on the assumption of abuse by a husband is incorrect. This is particularly pertinent in the context of extended-family/having more than one partner, where conflictual situations regarding financial resources/property, reproductive aspirations/choices, and access can involve more than one family member. The low disclosure rate recorded by Ayodapo *et al.* (2017) ^[10], for instance, is alarming. 350 respondents (350 women) reported exposure, and 72 women (28.6% of survivors) reported exposure. This suggests that the burden is significantly underestimated in both formal case reporting and police statistics. In addition to disclosure to trusted family members, there are also informal

coping and help-seeking interventions that were identified by Tella *et al.* (2020) ^[35] as silence, avoidance, family intervention and religious help. Informal networks can provide emotional support and help facilitate continued living and/or reconciliation without addressing further risk issues. 46.2% of the respondents indicated that they would seek legal action in the case of physical violence, which may be attributed to fear of repercussion, economic dependence and stigma (as reported by Ikeako *et al.*, 2017) ^[22], as well as their fear of the breakup of the family, and limited trust in formal institutions. It is relevant to fieldwork in antenatal care. Violence screening should be conducted in the absence of partners/relatives by trained personnel using culturally sensitive, nonjudgmental questions. Ongoing mental health care/social welfare, emergency housing, legal counsel, and/or law enforcement protection must be available, and there should be a confidential referral system within health care facilities that connects survivors with these services. Community and religious leaders, who are usually the first to be affected during times of disclosure, should also receive appropriate training. If no confidential, well-resourced and survivor-centred system is in place to respond, then screening may be costly.

Table 4: Perpetrators, disclosure and responses to violence

Theme	Main result	Study evidence
Primary perpetrator	Husband or current intimate partner was the dominant perpetrator	Efetie and Salami (2007); Onoh <i>et al.</i> (2013); Ikeako <i>et al.</i> (2017); Ayeni <i>et al.</i> (2021)
Other perpetrators	Boyfriends, relatives, co-wives and in-laws were occasionally identified	Benin City and South-East studies
Disclosure	Only a minority of exposed women disclosed violence	Ayodapo <i>et al.</i> (2017): 72/252 or 28.6%
First disclosure point	Relatives, friends and religious leaders were preferred	Ayodapo <i>et al.</i> (2017); Tella <i>et al.</i> (2020)
Formal reporting	Reporting to health professionals, police, or legal authorities was uncommon.	Ayodapo <i>et al.</i> (2017); Ikeako <i>et al.</i> (2017)
Legal response	Limited willingness to seek legal redress	Ikeako <i>et al.</i> (2017): 23.8% indicated willingness in cases of physical violence
Coping strategy	Silence, endurance, avoidance, family mediation and religious support were reported.	Tella <i>et al.</i> (2020)
Medical consequences	Injury, anaemia, miscarriage and preterm delivery were reported	Kofoworade <i>et al.</i> (2022); Ayeni <i>et al.</i> (2021)

Pregnancy and Health Consequences

Table 6 reveals that there is an association between GBV during pregnancy and the mother experiencing physical injuries, psychological distress, clinical complications and adverse pregnancy outcomes. The findings in the study by Kofoworade *et al.* (2022) ^[26] revealed a significant relationship between domestic violence and anaemia, indicating that the survivors might receive poor nutrition, have restricted access to food, and might have problems taking medicine that enhances the absorption of iron, or frequent doctor checkups. Even the less common physical assault in that study does not suggest the assault was small in any regard; however, as there is no physical manifestation with some of the other forms of abuse, namely psychological and controlling abuse, certain health effects may be significant. Dada *et al.* (2022) ^[14] revealed that there is a positive correlation between IPV & depression suicidal thoughts, indicating a great mental health problem among the abused pregnant mothers. The results also confirm the literature, indicating that the level of disclosures is low (Ayodapo *et al.*, 2017) ^[10] and the results of Tella *et al.* (2020) ^[35], which indicate that coping is a problem because silence or lack of support from others may worsen fear, isolation, and

psychological distress. There were also other undesirable pregnancy complications. Of the 27.6% of the relevant physically-abused group who suffered from miscarriage, most of whom (6.9%) had suffered from previous preterm delivery. Unfavourable obstetric outcomes are also associated with domestic violence, as done by Ameh *et al.* (2008) ^[5] and Onoh *et al.* (2013) ^[34]. Those mechanisms can be a direct accident to the abdomen, over-stimulation of maternal stress response, inadequate food intake, greater risk of infection, postponing care and less adherence to carer guidelines. Most, however, were retrospective self-reports/cross-sectional, making it impossible to determine cause and effect, and there could have been recall bias. Prospective cohort studies should adjust for medical conditions, substance use, prior pregnancy and birth, poverty and age of mother. The clinical implications of the results indicate that the screening for violence should be a routine part of the assessment of injury, anaemia, depression, suicidal risk and obstetric complications. The social needs are strongly interwoven and linked with psychological and obstetric needs, and identified survivors cannot be referred but instead should be cared for in a coordinated manner.

Table 5: Maternal and pregnancy consequences

Consequence	Evidence	Numerical finding
Physical injury	Ezechi <i>et al.</i> ; Kofoworade <i>et al.</i>	Physical assault with injury constituted 3.5% of the pattern in Kofoworade <i>et al.</i>
Anaemia	Kofoworade <i>et al.</i> (2022)	Significant association
Depression	Dada <i>et al.</i> (2022)	$r=0.151$, $p=0.012$
Suicidal ideation	Dada <i>et al.</i> (2022)	$p=0.04$
Miscarriage	Ayeni <i>et al.</i> (2021)	27.6% among the relevant previously abused group
Preterm delivery	Ayeni <i>et al.</i> (2021)	6.9%
	Ameh <i>et al.</i> (2008) and related studies	-
Reduced disclosure and care-seeking	Ayodapo <i>et al.</i> (2017); Tella <i>et al.</i> (2020)	Disclosure among exposed women: 28.6% in Oyo East

It is safe to suggest that from this systematic review, gender-based violence is a significant and embedded problem of maternal health for pregnant women attending antenatal clinics in Nigeria. Descriptive prevalence rates ranged from 2.3% to 72.0%, with a median of approximately 31.8% across the studies included. The overall span is due to the wide range of studies on their location, health care contexts, baseline characteristics of the persons studied, the definition of violence, the time period covered, and the instruments of

measurement. It should not be interpreted as an overall national-level prevalence. The most common were psychological, emotional and verbal violence; followed by physical and sexual violence; thus, screening that is limited only to physical injuries will seriously underestimate the burden. Husbands or husbands-to-be and current boyfriends were the main perpetrators, but boyfriends, relatives, co-wives and in-laws were also reported as perpetrators of violence. Factors repeatedly mentioned were low levels of

education, unemployment, poverty, polygamous marriage, partner drinking, frequent sexual partners, family dysfunction and prior victimisation/experience of violence and power inequality. Important consequences were also found for maternal and fetal well-being, with violence also associated with anaemia, depression, suicidal ideation, physical injury, miscarriage and preterm delivery. Disclosure and formal help-seeking were low, with survivors more likely to talk to relatives, friends, and religious leaders than to seek help from healthcare providers, law-enforcement agencies, or legal services. Antenatal clinics should thus provide for private and confidential screening for all forms of violence and referral pathways to link survivors with medical, psychological, social, legal and protection services should be made effective. Healthcare workers need to be trained to be able to identify nonphysical abuse, ascertain the level of safety and respond accordingly, without any bias or discrimination. Unhelpful gender norms, economic vulnerability, alcohol abuse and the imbalance in relationships must be addressed in the broader spectrum of prevention. Validated instruments, the same reference period, and the same samples/designs, with a national approach in future investigations, are recommended. All of these are critical to protecting pregnant women, improving pregnancy outcomes, and advancing progress towards SDG 3 and 5 in Nigeria.

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