Tanzania Journal of Sociology Vol. 7, Issue, No.1, June 2021:62-79

Access to Antenatal Care: A Question of Domestic Violence among Mothers in Rural Kano, Nigeria

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Abstract

Domestic violence is pervasive, with one third of women having been domestically abused, has a negative influence on maternal health care. Domestic violence is bedeviled with a culture of silence; it is usually under-reported. The study was anchored on the cultural theory of violence. A total of 1,143 mothers from three rural Local Government Areas of Kano State were proportionally drawn using different sampling procedures. Quantitative data were collected by use of questionnaires. The data revealed that domestic violence is a common problem between couples in all the localities: one-quarter of pregnant women reported domestic violence experience during the last pregnancy. In contrast, one-third reported experience of a specific form of domestic violence. The results reveal a significant relationship between low access to antenatal care and experience of domestic violence during the last pregnancy (sig. α@0.05). Low access to antenatal care also leads to a high home delivery rate, mainly without any skilled birth attendant. Women with low education are also more likely to face abuse, resulting in inadequate access to antenatal services. In the light of the cultural theory, domestic violence is a significant cultural correlate of low access to antenatal care, and therefore, the cultural precepts favorable to domestic violence needs to be reversed. It is concluded that domestic violence predisposes mothers to antenatal care neglect. The general recommendation is that the government should intensify efforts on the awareness and legal measures that will discourage domestic violence.

Keywords: Domestic violence, Antenatal Care, Maternal health, Nigeria

Introduction

Domestic violence is a major problem facing mothers in the developing world (Bakare et al. 2010; Shah & Shah, 2010; Musa et al., 2019; Mai & Phyu, 2019). Domestic violence or intimate partner violence can be defined as a pattern of behaviour, be it physical, sexual, emotional, economic or psychological actions or threats of actions, including any behaviours that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone, in any relationship that is used to gain or maintain power and control over an intimate partner (UN, 2021). Almost one-third of women in West Africa have experienced domestic violence (Muluneh et al., 2020). Mothers exposed to domestic violence are likely to show poor maternal health due to frustration, suffering, and mental stress (Davries et al., 2010; Muluneh et al., 2020). Mothers who are not exposed to domestic violence are likely to develop positive maternal behaviour like patronizing antenatal care services and are more self-determined to pursue their maternal health and that of their foetus. In some communities, the experience and perception of domestic violence tend to expose women to difficult circumstances and injuries. For instance, in some communities in Nigeria, wife-beating is seen as normal behaviour, and defined as a family matter (Oyediran, 2016; Benebo et al., 2018). Whereas violence affects the victims' reproductive, social, physical, and psychological wellbeing, it causes preterm birth and low birth weight (Hoang, 2016).

A victim of domestic violence could develop depression, and may neglect her infant's health. Violence during pregnancy is associated with a mother's inability to obtain adequate nutrition and rest during pregnancy (Asling-Monemi et al., 2003; Asling-Moremi et al., 2008; WHO, 2017). Such a condition of malnutrition due to violence can aggravate negative maternal health behaviour. Domestic violence triggers poor maternal health behaviour like neglecting antenatal care, and thus, it can increase the risk of maternal morbidity and mortality (Quintanilla et al., 2018; Dhar et al., 2018; Tura & Licoze, 2019). The established direct health effects of physical domestic violence during pregnancy include increased likelihood of miscarriage, premature labour or delivery, low birth weight, high level of depression during and after pregnancy, and injury to women (Davries et al., 2010). The phenomenon of violence against women cannot be detached from the fact that in most traditions, women are in a disadvantaged position (Amzat, 2015). Women are more likely to be murdered in any situation of dangerous domestic violence (WHO, 2017). Domestic violence as a form of gender-based violence is a prevalent public health problem in Nigeria and worldwide (Amzat, 2015; Amzat & Magaji, 2019). It occurs in various

forms, such as sexual, psychological and physical assault, including hitting, slapping, kicking and beating, and psychological abuse like intimidation and humiliation. These variables are not different from the happenings in some rural areas where, during pregnancy, a mother can be abused, beaten and even sent out of her matrimonial home.

The study is guided by the cultural theory of domestic violence. The theory holds that domestic violence is embedded in cultural norms and traditions. The implication is that "the power of tradition and norms within African culture as the reason behind the prevalence of domestic violence among couples, arguing that wife battering is regarded as normal within traditional African culture" (Bowman, 2003:853). The preceding argument is a sweeping generalization only to the high prevalence of domestic violence, but it (domestic violence) remains objectionable in many African communities. However, cultural tradition explains the unequal power distribution within traditional African marriages with the husband's dominant power over the wife. It is not only the husband; in some instances, the extended family can also exert control over the wife, especially the male members (Jennnings et al., 2012; Parales et al., 2021). Domestic violence ensues through the enforcement of traditional roles for women and dominance for their husbands. The theory neglects some cultural transitions over the years—with some modernizing trends, some traditional norms have been reformed. African rural society is still highly traditional, and many urban dwellers also “import” the traditional norms into urban and modern culture. This study focuses on rural Kano, Nigeria. The ratification of cultural violence might be high in rural areas (Amzat & Magaji, 2019). It should be noted that cultural norms encouraging violence should never be an excuse for violence; such norms need to be changed to guarantee women’s rights in every culture.

The magnitude of the problem of domestic violence might have been underestimated because studies are not available that determine the prevalence of domestic violence across the various ethnic groups and socioeconomic strata in the country (Bakare et al., 2010). Many studies have documented other factors influencing access to antenatal care (see Hirose et al., 2017; Okedo-Alex et al., 2019; Alanazy & Brown, 2020). Hence, looking at domestic violence as a determinant of a mother's neglect of antenatal care can be one of the many possible ways of understanding maternal health issues. Therefore, this study examines the influence of domestic violence on mothers' antenatal care behaviour in selected areas in rural Kano. The independent variable is in this research work is domestic violence—this study focuses more on physical violence. The maternal

health behaviour used in this research work as a dependent variable is seeking antenatal care. The research work can appraise the strength of and predictive association between the independent and dependent variables. In an attempt to determine the association between a mother's domestic violence experience and a mother's seeking of antenatal care, the two factors are subjected to some inferential analysis. It is hypothesized that there is no significant association between a mother's experience of domestic violence and access to antenatal care.

Methodology

In this study, only a quantitative method was used. The method helped to survey a large sample size as a cross-sectional survey. The quantitative method consisted of survey research (using copies of questionnaires to obtain data) from a sample, which is a subset of the study population. The questionnaire in this research was translated into the Hausa language by trained field assistants to benefit the respondents who are not literate in English. It also employed the use of secondary data (which is an analysis of existing data). The study relied on a multistage cluster sampling method for the selection of the respondents. Diversity and variation were also important so that the survey would not concentrate on one area. Hence, remote areas were purposively included as part of the study area. There are three political-administrative divisions in Nigeria, namely Federal, State and Local Governments. The Kano State, in north-western Nigeria, consists of 44 Local Government Areas as administrative divisions. The Local Government Areas are divided into wards. The first stage involves the purposeful selection of three hard-to-reach Local Government Areas out of the lists of the three senatorial districts in Kano State, which are Kunchi, Gezawa and Rogo. These areas are far rural areas with inadequate transportation means and modern facilities. There are areas where the burden of reproductive ill-health may be higher even though there is still a lot to be explored about rural maternal health behaviour. There is a difference in health services between rural and urban inhabitants, with many health services and clinics located in urban areas (Lambu & Dan, 2015).

The second stage involved a random selection of three wards from each of the local government areas. The third stage involved a systematic selection of localities for the distribution of the questionnaires. The questionnaires were distributed based on the population of the houses in each ward. The wards with lower population density were given fewer questionnaires, while those with higher density were given more questionnaires.

The six locations in each ward were randomly selected based on first settlement, middle settlement, and last settlement as classified by the village leaders. Target sampling was used in selecting houses from each location. Women respondents (mothers) were drawn based on their availability. The sample unit of the study was household, where no household fitted the description of the respondents; the next household was chosen and added at the end. The quantitative data were analysed using the statistical package for social sciences (SPSS); and both descriptive and inferential statistics were used. The study relied on the chi-square to test the central hypothesis of the study, which connects domestic violence to maternal health.

Results

An examination of the distributional percentage frequencies of the respondents by age reveals that 83 (7.3%) of the respondents were aged 15-19 years; 251 (22.0%) were aged 20-24 years; 313 (27.4%) respondents were aged 25-29 years; while 199 (17.4) respondents were aged 30-34 years. Furthermore, 144 (12.6%) respondents were in the 35-39 years age category, and 153 (13.4%) respondents were in the category of 40-44 years. The cumulative percentage distribution results suggest that 56.6% of the study population was below the age of 29 years. In comparison, 43.4% were 30 years and above.

Table 1: Some Socio-demographic characteristics of respondents

Age Bracket	Frequency	Percent
15-19years	83	7.3
20-24years	251	22.0
25-29years	313	27.4
30-34years	199	17.4
35-39years	144	12.6
40-44years	153	13.4
Total	1143	100
Level of Mother's Education	Frequency	Percent
Primary	341	29.8

Secondary	241	21.1
Higher Education	34	3.0
Quranic	476	41.6
No Education	51	4.5
Total	1143	100
Spouse's Level of Education	Frequency	Percent
Primary	87	7.6
Secondary	277	24.2
Higher Education	333	29.1
Quranic	399	34.9
No Education	47	4.1
Total	1143	100

The data presented in Table1 also reveals that cumulatively, 29.1% of their male partners had education, compared with a lower percentage (3.0%) of mothers with higher education. Besides, 46.1% of the respondents had either Quranic education or no education. Female education in the rural Kano State is still facing some critical challenges. The relatively low level of education of the mothers strengthens the notion that female education is still lagging behind in Kano. The data presented and described reveals that, cumulatively, up to 60.9% of the respondents' male spouses have some education. Therefore, male spouses were better educated than their wives.

Table 2: Respondents' experience with domestic violence during the last pregnancy

Responses	Frequency Distribution	
	Frequency	Percent
Yes	278	24.3
No	622	54.4
No response	243	21.3
Total	1143	100.0
Types of domestic violence experienced by mothers		
Specific types	Frequency	Percent
Push you, shake you, throw something at you	90	7.9
Slap you with his hands	159	13.9
Twist your arm or pull your hair	42	3.7
Punch with fist or object	30	2.6
Kick, drag, or beat up	85	7.4
Denied access to food	19	1.7
None of the above	177	15.5
No Response	541	47.3
Total	1143	100.0

Table 2 shows the distribution of the respondents on the issue of mothers' exposure to domestic violence during the last pregnancy. The Table shows that 278 (24.3%) of respondents had experienced domestic violence; 622 (54.4%) have never been engaged in domestic violence; 243 (21.3%) of respondents did not respond. The data have revealed that domestic violence is a common problem among the married respondents in all the localities. It should be noted that a culture of silence exacerbates domestic violence; it is one of the under-reported crimes or deviant behaviour. Due to the culture of

violence, domestic violence is hardly reported. It is often treated as a private matter, domestically settled within the family despite injuries, mainly on the side of women.

Table 2 further presents the type of domestic violence that some mothers had experienced before the survey. Mothers were asked whether they have ever been exposed to listed types of physical violence from their partners. The question on types of domestic violence experienced was not skipped despite the negative response on ever experienced domestic violence. The Table shows an increase in the number of experienced domestic violence before the survey to 387 (33.9%), i.e., 1 out of 3 respondents. From the Table, several mothers, 47.3%, did not respond, and 15.5% had never experienced any type. Only a few mothers, 13.9%, were ever slapped, pushed (7.9%), and kicked and dragged (7.4%). Few others have at some point in time been punched (2.6%), denied access to food (1.7%), and twisted on the arm (3.7%).

Table 3: Cross-tabulations of attendance at antenatal care experienced and other core variables

Experience of domestic violence during the last pregnancy				
	Response	Yes	No	Total
Attendance at antenatal care during the last pregnancy	Yes	87 (10.2%)	145 (17.0%)	232 (27.1%)
	No	180 (21.1%)	443 (51.8%)	623 (72.9%)
	Total	267 (31.2%)	588 (68.8%)	855 (100%)
				X^2 =5.832; X -tab =3.84 ; Df: 1; α@0.05
Feeling about Domestic Violence				
	Response	Normal	Frustrating	Total
Attending antenatal care during the last pregnancy	Yes	142 (17.9%)	86 (10.8%)	228 (28.8%)
	No	345 (43.5%)	220 (27.7%)	565 (71.2%)
	Total	487 (61.4%)	306 (38.6%)	793 (100%)
				X^2 =0.102; X-tab = 3.84; Df: 1; α@0.05
Place of last delivery				
	Response	Home	Community	Total

			clinic/Midwife	
Attending antenatal care during the last pregnancy	Yes	202 19.2%	93 (8.8%)	295 (28.0%)
	No	667 (63.3%)	91 (8.6%)	758 (72.0%)
	Total	869 (82.5%)	184 (17.5%)	1053 (100%)
	X^2 =56.111; X-tab =3.84 ;Df: 1; α@0.05			
Attendance at antenatal care during the last pregnancy				
	Response	Yes	No	No response
Level of education	Primary	73 (21.4%)	254 (74.5%)	14 (4.1%)
	Secondary	68 (28.2%)	161 (66.8%)	12 (5.0%)
	Higher Education	31 (91.2%)	2 (5.9%)	1 (2.9%)
	Qur'anic	117 (24.6%)	336 (70.6%)	23 (4.8%)
	None	16 (31.4%)	32 (62.7%)	3 (5.9%)
	Total	305 (26.7%)	785 (68.7%)	53 (4.6%)
	X^2 =78.493; X-tab = 9.49; Df: 4; α@0.05			

The study examined the possible association that exists between the two variables contained in the stated hypothesis. The responses on the two variables are cross-tabulated, and the results show that the two variables under investigation are statistically related (Table 3). The statistical judgment signifies an association between a mother's experience with domestic violence and mothers seeking antenatal care. This conclusion is also confirmed by the pattern of frequency distribution in the contingency table. The data reveal that most mothers who do not experience domestic violence feel free to seek antenatal care. In contrast, most of those who have domestic violence reported that they do not have the freedom to seek antenatal care. Table 3 is specific about attending antenatal care during the last pregnancy versus the experience of violence during pregnancy. The result reveals a significant relationship between low access to antenatal care and experience of violence during the last pregnancy. The chi-square calculated value is higher than the table value in all the tested relationships except for the test between attendance at antenatal care and feeling about

domestic violence. Table 3 further shows no significant relationship between attending antenatal care and feeling about domestic violence. Women tend to conceal the issue of violence due to the fear of consequences and being ridiculed—these call for further research, with different additional instruments that will yield more specific results.

Domestic violence is a practice that is prevalent among people in the rural communities of Kano. Although the cultural support for domestic violence is weak in the study area, when it happens, there is no cultural sanction for it. Hence, many respondents affirmed that they had experienced one form of domestic violence or the other from their husbands. Table 3 shows a significant relationship between the low attendance rate at antenatal care and the high rate of home delivery. There is also a significant relationship between education and attendance at antenatal, as many women with a low level of education have the highest percentage of not attending antenatal care.

Discussion

This study found that domestic violence is correlated with low access to antenatal care, which is also associated with home delivery. These findings signify some basic facts that emerged from the literature review that revealed a significant association between exposure of women to domestic violence and the neglect of antenatal care. In a systematic review, Musa et al. (2019) reported that the experience of intimate partner violence is correlated with a lower likelihood of receiving adequate antenatal care and skilled delivery care. Apart from the direct effects of women's exposure to domestic violence during pregnancy, research has also confirmed that such action could affect the maternal health-seeking behaviours of such women (Davries et al., 2010; Stockl et al., 2010; Paul & Mondal, 2020). Mothers who are not exposed to domestic violence are likely to develop positive antenatal care behaviour and self-determination to pursue their maternal health and their foetus. Good marital life also benefits maternal health by increasing the odds of timely and adequate care and improving emotional wellbeing during and after pregnancy. Spousal support reduces high-risk behaviours like drunkenness and smoking during pregnancy (Kimbro, 2008). This study does not investigate the effects of domestic violence on pregnancy outcomes, but other studies have found that it has an adverse impact on pregnancy outcomes (Alhusen et al., 2015; Mai et al., 2019).

Alhusen et al. (2015) reported that the devastating effects of intimate partner violence (IPV) on maternal health, including poor nutrition, inadequate weight gain, substance use, the likelihood of depression), and adverse

neonatal outcomes (e.g., low-birth weight [LBW]) and preterm birth [PTB]) and maternal and neonatal death (cf. Davries et al., 2010). Domestic violence also has negative impacts on infant survival (Paul & Mondal, 2020). Benebo et al. (2018) also reported that IPV adversely affects a woman's decision-making power regarding maternal health, thereby exposing her to many adverse maternal health outcomes. Similar to this study in context and findings, Oche et al. (2020) reported that one-third of pregnant women reported IPV in Sokoto, Nigeria. Oche et al.'s study reported that physical violence was the most prevalent form, but mostly unreported. More so, domestic violence affects the reproductive, social, physical, and psychological wellbeing of a victim, and it causes preterm birth and low-birth-weight (Ahmed et al., 2006; Hossain et al. 2014; Hoang, 2016). It destroys a woman's sense of self-esteem and increases anxiety, frustration and loneliness. Violence during pregnancy is also associated with a mother's inability to obtain adequate nutrition and rest during pregnancy (Asling-Moremi et al., 2008; WHO, 2017). Such a condition of unrest due to violence can aggravate negative maternal health behaviour.

The magnitude of the domestic violence might have been underestimated because studies are not available that determine the prevalence of domestic violence across the various ethnic groups and socioeconomic strata in many countries (Bakare et al., 2010). In Tanzania, more than one-third of women experiencing violence at home reported that it started during pregnancy (Stockl et al., 2010). In the report, the violence was significantly associated with adverse maternal health behaviour and outcomes, including drug abuse, drinking, and stillbirth.

Some social practices and beliefs have positive values, while some are uncertain and negatively affect maternal behaviour. For instance, societal definitions and perceptions of domestic violence tend to expose women to more challenging circumstances. In some communities in Nigeria, wife battering is seen as normal behaviour and defined as a family matter or family affair, but remains intolerable among the majority. Marital issues are often perceived as private and beyond the state's control in most African societies (Bakare et al., 2010). Namasivayam (2012) reported that the nature and pattern of gender relations of power between women and men are not easy to understand in their full complexity. Therefore, the social relationship dynamics between a woman and her husband could determine maternal health behaviour and access to healthcare. It can also lead to various partner control behaviours, such as gender-based violence (Abdollahpour et al., 2020; Doku et al., 2020). The relationships that husbands or male partners have with their wives can impact women's maternal health behaviour and

outcomes. In another study conducted earlier by Lau and Chan (2007), domestic violence includes substance abuse, delay in seeking antenatal clinics, insufficient weight gains during pregnancy, and reduced breastfeeding. Even though the mother's body is fragile and vulnerable in the state of pregnancy due to changes occurring in her physiological body and psychological mind (due to pregnancy), the delicate situation is compounded by violence during pregnancy. Violence against women results from gender discrimination (Amzat & Grandi, 2011; Bagade et al., 2019; Abdollahpour et al., 2020).

The African Charter on Human and People's Rights (1986) urged member-states to eliminate every violence and discrimination against women and protect women's rights. Although Nigeria is a signatory to most of these treaties, violence against women is still prevalent among ethnic groups in Nigeria (Ilika, 2005). NDHS (2008) reported that women in urban areas are more likely than their rural counterparts to have experienced physical violence. Perhaps such findings resulted from the fact that most research is often urban-based and not much rural-based research. Domestic violence as a kind of gender-based violence is a prevalent public health problem in Nigeria and worldwide. It happens in numerous forms, such as physical assault like hitting, slapping, kicking and beating, and psychological abuse like constant belittling, intimidation, humiliation, and coercive sex. It frequently includes inhuman behaviours such as isolating a woman from family and friends, monitoring her movement and restricting her access to resources (Ilika & Okonkwo, 2002). The situation is not different from the happenings in northern Nigeria, where a mother can be abused, beaten, and sent out of her matrimonial home to her parents during pregnancy.

Conclusion

Domestic violence adversely affects access to antenatal services. The limited access to antenatal services resulting from domestic violence is also associated with high home delivery. In most developing settings, domestic violence is viewed as a normal phenomenon that does not attract severe sanctions. Thus, in the study area, women are victims of domestic violence. Irrespective of the foregoing argument, it is important to acknowdge that some international conventions against domestic violence has been domesticated. While there have been some improvements, domestic violence is still a significant social problem worldwide.

In explaining the phenomenon of violence against women, Apenda (2007) argued that such actions against women could not be detached from the fact that the state of women in most traditional Nigerian communities is

subservient to the male counterpart. Studies have observed that mothers exposed to domestic violence are likely to develop negative behaviour and response towards their maternal health due to frustration, suffering and mental stress (Davries et al., 2010; Oche et al., 2020). The study has concluded that domestic violence has implications for maternal health behaviours of women in rural communities. Domestic violence has been found in this study to set limits on seeking antenatal health, which is positive maternal health behaviours. Therefore, the study concludes that explanations for health behaviours could be situated within cultural and social practices, which affect the ways mothers behave towards health matters.

The first limitation of this research was that it focused on particular rural communities that still adhere to their cultural practices. Secondly, mothers are very secretive when it comes to giving information on the issue of domestic violence. Most mothers prefer to hide the problem of battering and violence for fear of being ridiculed and for fear of more future violence from husbands and in-laws due to the information they reported. As such, the incidence of domestic violence might have been underreported. Thirdly, the study is quantitative only; future research might benefit from an addition of qualitative methods. In general, there is still a lot to be done to curtail domestic violence and their effect on women in Nigeria. Therefore, future research can rely on mixed-methods to further deepening the understanding of cultural precepts favouring domestic violence and their implication for maternal health. Women of childbearing age must be counselled about the importance of positive maternal health behaviours like seeking antenatal care. Village leaders can be engaged in championing change by reprimanding their subjects, husbands, or in-laws who engage in the violation and abuse of women. Lastly, there should be effective implementation of the laws and conventions against domestic violence in Nigeria.

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