Intimate partner violence and abortion among women in Nigeria

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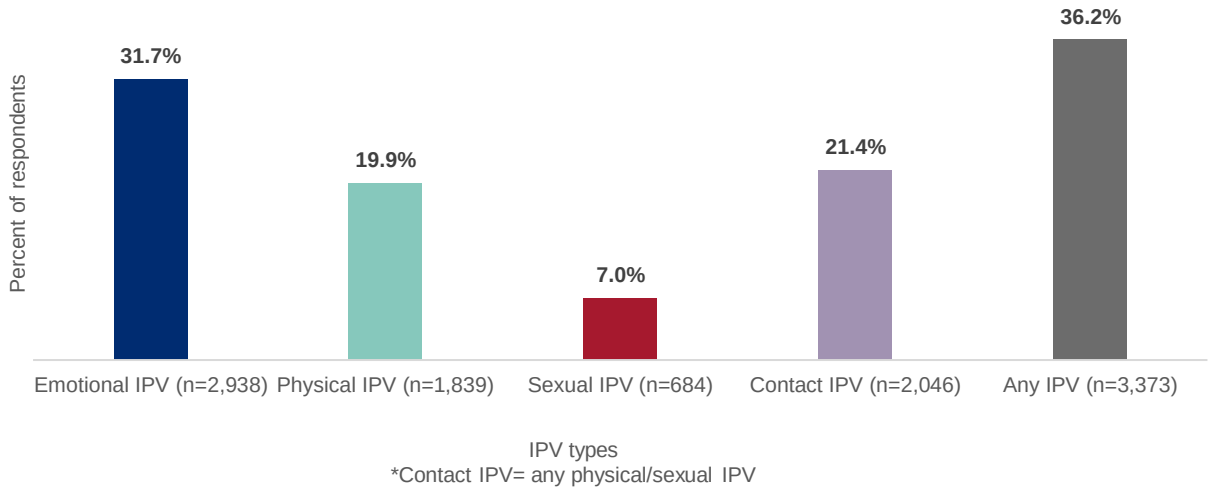
Why This Matters

- Intimate partner violence (IPV) is increasingly recognized as a public health problem, affecting 1 in 3 women globally.[1]
- Women in violent relationships are more likely to report an inability to prevent pregnancy due to experiences of sexual violence or a lack of autonomous contraceptive decision-making.[2]
- Across global contexts, IPV has been found to be associated with unintended pregnancy and induced abortion.[2,3,4]
- Induced abortion is on the rise globally; it is estimated that 73.3 million abortions occur annually worldwide, and of this, 38 per 1,000 occur in low-resource countries.[5]
- In Nigeria, where abortion is illegal, 1-2 million induced abortions are estimated to occur every year.[6] Most of these abortions are unsafe, frequently performed by untrained individuals or with non-recommended methods.[7] Unsafe induced abortion is one of the leading causes of maternal mortality worldwide and contributes to over 10% of maternal mortality in Nigeria.[8]
- Currently, more research is needed on IPV and induced abortion in Nigeria. Preventing IPV and related unintended pregnancy and induced abortion, particularly in contexts where unsafe abortion is common, such as Nigeria, could mitigate preventable maternal morbidity and mortality.

Key Findings

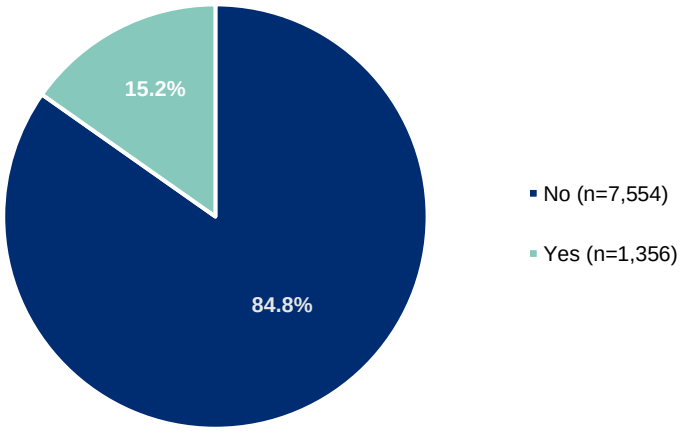
Approximately 36% of ever-partnered women in Nigeria have experienced IPV during their lifetime. Emotional IPV was the most common form of IPV experienced, at nearly 32%. Approximately one-fifth of women reported contact IPV, or any experience of physical and/or sexual IPV (21.4%).

Figure 1: Prevalence of lifetime IPV among ever-partnered women aged 15 to 49 years, weighted (n=8,910)



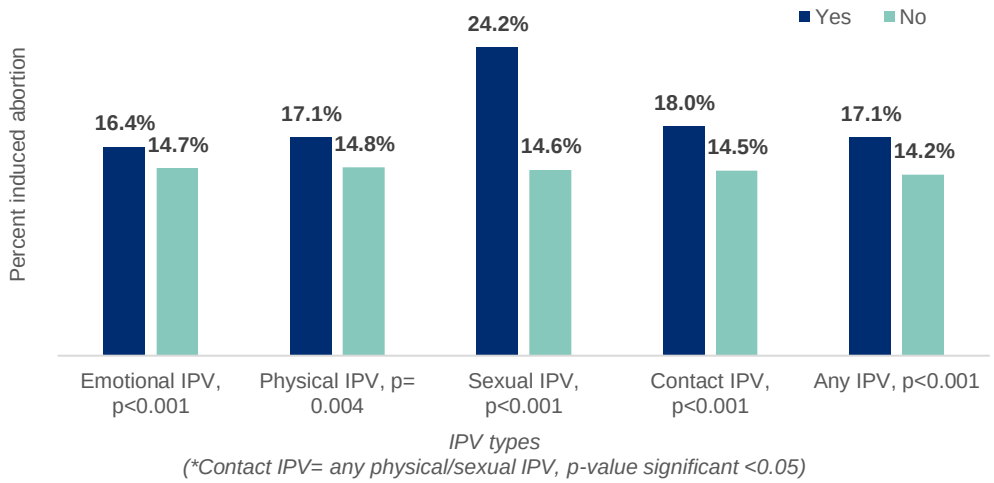
Approximately 15% (n=1,356) of ever-partnered women aged 15 to 49 years indicated ever having had an induced abortion.

Figure 2: Prevalence of induced abortion among ever-partnered women aged 15 to 49 years, weighted (n=8,910)



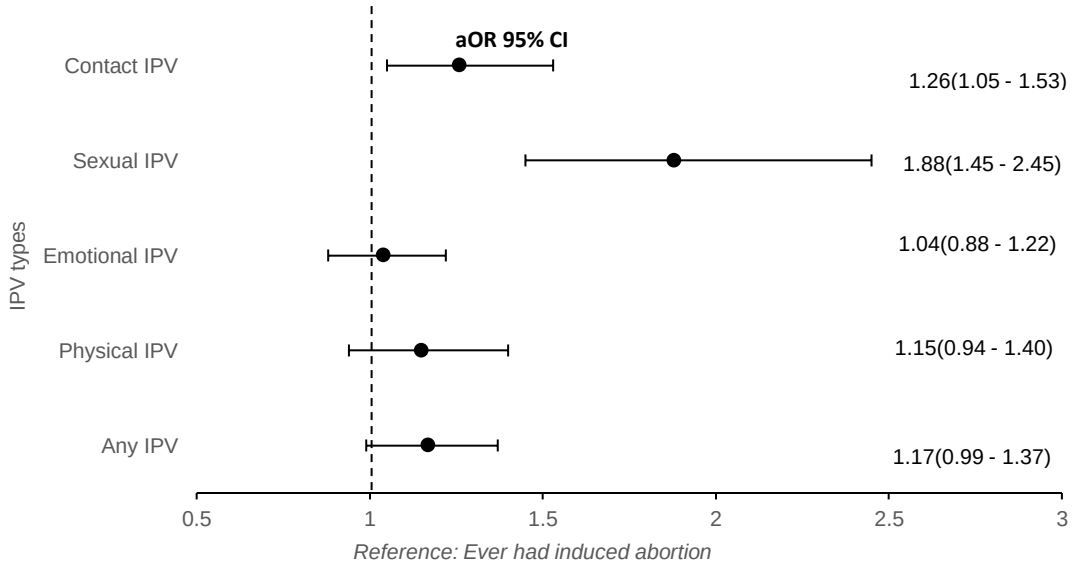
The prevalence of induced abortion was significantly higher for women who experienced IPV compared to those who had not (17.1% versus 14.2%, respectively). This difference was true for every form of IPV, most notably so for those who experienced sexual IPV (24.2% versus 14.6%, respectively).

Figure 3: Prevalence of induced abortion by lifetime IPV, overall and by IPV type, among ever-partnered women aged 15 to 49 years, weighted (n=8,910)



In the multivariable models, after adjusting for sociodemographic factors including age, education, employment status, region, witness to IPV as a child, and wealth, only sexual and contact IPV remained statistically significantly associated with ever had induced abortion.

Figure 4: Adjusted odds ratio of the relationship between ever induced abortion and IPV among ever-partnered women aged 15 to 49 years



Adjusted odds ratio (aOR): adjusted for age, education, employment status, region, witness to IPV as a child, and wealth.

Key Takeaways

- More than one-third of women (36.2%) in Nigeria have experienced IPV during their lifetime.
- Induced abortion is more prevalent among ever-partnered women with a previous experience of IPV, compared to those with no previous IPV, particularly for those who have experienced sexual IPV.

Action Steps

- Government and stakeholders in sexual and reproductive health should increase efforts to promote and expand contraceptive use in recognition of the pregnancy-related risks of IPV.
- There is a need for health care professionals to counsel women on the selection of the best contraceptive method for them and their current situation, including potential use of covert contraceptive methods if women are in a violent relationship where decisions are constrained.
- Health-care professionals should consider the possibility that women seeking induced abortion may be experiencing IPV, and they should be trained to screen for violence and make appropriate referrals to needed services.[9]
- Similarly, IPV survivors who seek health care should be screened for sexual IPV specifically, and be given or directed to appropriate services, such as emergency contraception, counseling, social support, and possible legal services.
- In recognition of the high prevalence of IPV, sexual and reproductive health providers should be trained in trauma-informed care.
- Government policies should ensure survivors of IPV have accessible avenues to justice.

Methods

This was a cross-sectional study that utilized secondary data from the Nigeria Demographic Health Survey (2018). Analysis included ever-partnered women aged 15-49 years who participated in the domestic violence module (n=8,910).

The main exposure variable was lifetime IPV. Secondary exposure variables were IPV sub-types including emotional IPV, physical IPV, and sexual IPV. Physical and sexual IPV were also explored together as “contact IPV”. All IPV variables were binary. The outcome variable was ever having reported an induced abortion (binary). Covariates included age, age at sexual debut, education, employment status, residence (rural/urban), religion, region, witness to abuse in childhood, and wealth.

Data was analyzed using Stata 17. Bivariate and multivariable logistic regression models were fit, with statistical significance set at $p<0.05$. Sampling weights were used to account for inclusion in the domestic violence module and complex sampling design.

Majority of ever-partnered women in the study were aged 35 years or older (41.1%). The mean (SD) age and age at sexual debut, in years, was 32.2 (8.4) years and 17.0 (4.2) years, respectively. A secondary level of education or higher was obtained by 42.3% of the women, and 71.9% were

employed. About half of the women (55.1%) were Muslims, 56.7% lived in rural localities, and 29.7% lived in the North West region of the country. Only 10.4% of the women witnessed abuse as a child.

Suggested citation:

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