



Factors Associated with Intimate Partner Violence and its Perceived Effect on Health Among Women of Child-Bearing age in Ilishan-Remo Community, Ogun State, Nigeria

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Abstract

Background: Intimate partner violence (IPV) has been reported to be a global public health problem and an issue of human rights concern. This study aimed to examine the factors associated with intimate partner violence (IPV) and its perceived health effects among women of childbearing age in Ilishan-Remo Community, Ogun State, Nigeria.

Methods: The study employed a descriptive cross-sectional design. One hundred and seventy-two women participated in this study using a stratified random sampling technique. Structured questionnaires were used to collect data from the respondents. The collected data were analyzed using SPSS version 27.0, and summarized using descriptive (frequencies, counts and percentages), and inferential statistics (chi-square tests) with the level of significance set at $p < 0.05$.

Results: The result of this study revealed that a greater percentage of the respondents were between the age range of 26 and 35 (36.0%). The majority (52.9%) of respondents had experienced some form of IPV, with 11.6% reporting a high level of exposure. The findings indicate a relatively low prevalence of IPV, with emotional abuse being the most common form. Economic hardship, substance abuse, and cultural beliefs were identified as key contributing factors. A significant association was observed between the level of education and IPV experiences ($p < 0.001$), indicating that higher education was linked to reduced IPV prevalence. Similarly, the type of marriage was significantly related to IPV experiences ($p < 0.001$), suggesting that marital structure influences the occurrence of IPV.

Conclusion: The study highlights a concerning level of IPV among women in the community, despite a notable proportion reporting no experience. These findings underscore the need for targeted interventions, community education, and the enforcement of legal measures by relevant stakeholders to address and prevent IPV.

Keywords: Cultural beliefs, Economic hardship, Factors, Intimate partner violence, Perceived effect on health, Substance abuse, and Women of childbearing age.

Background to the study

Intimate partner violence (IPV) has been reported to be a global public health problem and an issue of human rights concern [1]. Intimate partner violence was described by the World Health Organization (WHO) as "behaviour by an intimate or former partner that causes harm-physical aggression, sexual coercion, psychological abuse, and controlling

behaviour all fall under this category" [2]. It encompasses a wide range of behaviours, from emotional and financial abuse to physical and sexual assault [3]. These behaviours are known to affect psychological, social, physical, and reproductive health of the victims contributing to conditions such as unintended pregnancy, induced abortion, bleeding, HIV, and other sexual transmitted infection [4].

Globally, it has been estimated that out 30%-35% of women are victims of intimate partner violence [5,6]. Also, a world health organization report states that 1 in 3 women worldwide have experienced physical and sexual intimate partner violence or sexual violence in their lifetime [7]. In the regional context, the prevalence of IPV in Sub-Saharan is high especially among pregnant women showing varying rates in various African countries ranging from 15% - 61.8% in countries such as South Africa, Nigeria, Ethiopia and The Gambia [8]. In the Nigeria context, the national demographic health survey (NDHS) has reported that 33% of women of reproductive age in Nigeria have experienced intimate partner violence [9].

However, the occurrence of IPV is a complex social issue deeply rooted in the interaction of social, cultural, political, economic and biological factors [10]. Social, cultural and religious beliefs influence the perceptions, prevalence, and manifestations of IPV across societies [10]. Other risk factors such as childhood exposure to abuse, poor education, and early age of marriage have also been linked with experiencing IPV [11]. In addition, IPV is perceived as a cultural norm that is accepted as part of the rules guiding intimate partner relationships in many communities in different countries [12]. For instance, wife beating in countries such as Nigeria and some other traditional societies is largely seen as a man's right and responsibility to punish the wife [10].

Previous studies have also provided empirical evidence to support these factors, for instance a Tanzanian study conducted by [13], revealed that factors such as poverty, alcoholism, dissatisfaction in family and traditional factors were greatly associated with intimate partner violence [13]. Similarly, in a Nigerian study by [14], it was reported that the incidence and experience of intimate partner violence among the women in the past 12 months was only associated with their spouse's consumption and use of alcohol and substance drugs

It has also been established from previous studies that intimate partner violence has detrimental consequences on the physical and social wellbeing of the victims exerting its effects on employment outcomes, mental health status, and their sense of self-worth and integrity [16]. Also, the consequence also extends to the pregnant demography with reported consequences ranging from maternal complications such as abortions, miscarriages, preeclampsia, gestational diabetes, and placental abruption and neonatal complications such as intrauterine growth retardation, preterm delivery, and low birth weight with extended intensive hospitalization [16,17].

For instance, a study conducted by [18] provides evidence that psychological and severe physical intimate partner violence during pregnancy was significantly associated with maternal postpartum depression. Also, a study conducted by [19] revealed that the negative health consequences of IPV to maternal and child health included postpartum depression, low birth weight and unwanted pregnancy.

Despite the global recognition of IPV as a grave social problem and the existence of several laws such as domestic violence protection orders, mandatory reporting laws, and specialized domestic violence courts to curb intimate partner violence, it has continued to remain a global health problem, especially among the pregnant population [20] and the postpartum women [21]. In a qualitative study by [21], the authors explored "a Cry for Dignity: Verbal, Physical, and Emotional abuse experienced by postpartum women in Nigerian Healthcare". Their study revealed five interconnected themes of OV—verbal abuse, abandonment of care, physical abuse, non-dignified care, and non-consented care—rooted in systemic issues such as poor resource allocation, staff shortages, sociocultural norms, and institutional neglect.

Hence, this study examined the knowledge gap associated with factors contributing to IPV and examined its perceived effects on health among women of childbearing age in Ilishan-Remo Community, Ogun State, Nigeria.

Methods Aim, design and setting of the study

This study was a descriptive cross-sectional study conducted to identify the factors associated with intimate partner violence and its perceived effect on health among women of childbearing age in Ilishan-Remo Community, Ogun State. The women were recruited for the study between 04/11/2024 and 20/12/2024

Sample

Sample size and data collection

A sample size of 172 was derived using the Leslie Kish formula [22] with 5% (0.05) level of precision. A stratified random sampling technique was employed in the selection of the respondents who fulfilled the inclusion criteria from the target population.

The data was collected using a structured questionnaire made up of four (4) sections comprising the socio-demographic characteristics of the women, the experience of intimate partner violence among the women, the factors associated with intimate partner violence, and the perceived effects of intimate partner violence among the women of childbearing age.

Inclusion and exclusion criteria

Women of childbearing age (typically defined as aged 15 to 49 years old) and who are currently or have previously been in intimate relationships, while women who have never been in an intimate relationship and are outside childbearing age at the time of the administration of instruments were excluded.

Statistical analysis

The data collected were analyzed with SPSS version 27. No missing data was recorded. Descriptive statistics were employed to present data in frequency and percentages, while inferential statistics (chi-square) were used to test the hypotheses.

Ethical consideration

Ethical approval was obtained from the study center, protocol number REDACTED. Written informed consent was duly sought from each respondent, and ethical principles of no harm, confidentiality, voluntary participation, and anonymity were observed.

Results

From Table 1 below, many of the women in this study were aged between 26-35 years (36.0%), identified as Christians (82.0%) and predominantly of Yoruba ethnicity (69.2%). The vast majority had attained tertiary education (72.7%), and their husbands were also mostly educated at the tertiary level (77.9%). Monogamy was the predominant marriage type (86.6%), and most had been married for more than five years (65.7%).

Table 1: Socio-demographic data of the women in the study

Variables	Sub-variables	Frequency	Percent (%)
Age as of last birthday Mean age=35.5±10.5	19-25 years	36	20.9
	26-35 years	62	36.0
	36-45 years	26	15.1
	Above 45 years	48	27.9
	Total	172	100.0
Religion	Christianity	141	82.0
	Islam	23	13.4
	Traditional	6	3.5
	Others	2	1.2
	Total	172	100.0
Ethnicity	Yoruba	119	69.2
	Igbo	39	22.7
	Hausa	8	4.7
	Others	6	3.5
	Total	172	100.0
Level of education	No formal education	12	7.0
	Primary	6	3.5
	Secondary	29	16.9
	Tertiary	125	72.7
	Total	172	100.0
Level of partner's education	No formal education	15	8.7
	Primary	6	3.5
	Secondary	17	9.9
	Tertiary	134	77.9
	Total	172	100.0
Marriage type	Monogamous	149	86.6
	Polygamous	23	13.4
	Total	172	100.0
Duration of marriage	Less than a year	17	9.9
	1-5 years	42	24.4
	More than 5 years	113	65.7
	Total	172	100.0
Employment status	Unemployed	8	4.7
	Employed	47	27.3
	Self-employed	117	68.0
	Total	172	100.0

Table 2 presents the forms of intimate partner violence experienced among women in this study. Regarding physical violence, the majority (71.5%) had never been hit by their partner, (69.2%) had never been slapped, and 73.3% had never been threatened with a weapon. However, 61.6% of respondents had never been pushed by their partner. In terms of emotional violence, 62.2% had not experienced emotional abuse. For sexual violence, 70.3% had never been forced to perform sexual activities without consent, while 72.1% had not been blackmailed into sexual activities. Moreover, 76.2% had never undergone harmful traditional practices related to their sexual health, and 63.4% had not been deprived of sexual activities by their partner. Regarding financial violence, 69.2% had never been denied access to financial resources.

Table 2: Forms of intimate partner violence experienced among women of childbearing age

Variables	Never		Sometimes		Always	
	F	%	F	%	F	%
Physical violence						
Have you experienced action like hitting from your intimate partner	123	(71.5)	32	(18.6)	17	(9.9)
Have you been slapped by an intimate partner	119	(69.2)	39	(22.7)	14	(8.1)
Have you been threatened with a weapon by your intimate partner	126	(73.3)	32	(18.6)	14	(8.1)
Have you ever been pushed by an intimate partner	106	(61.6)	42	(24.4)	24	(14.0)
Emotional violence						
Have you experienced emotional abuse from your intimate partner	107	(62.2)	47	(27.3)	18	(10.5)
Have you been manipulated by your intimate partner	107	(62.2)	42	(24.4)	23	(13.4)
Have you experienced constant criticism from your intimate partner	111	(64.5)	40	(23.3)	21	(12.2)
Have you ever been isolated from friends and family by your partner	110	(64.0)	47	(27.3)	15	(8.7)
Have you ever been humiliated by your intimate partner	111	(64.5)	44	(25.6)	17	(9.9)
Have you been called derogatory names by your intimate partner	117	(68.0)	29	(16.9)	26	(15.1)
Sexual violence						
I have been forced to perform sexual activities without my consent	121	(70.3)	37	(21.5)	14	(8.1)
I have been blackmailed to perform sexual activities against my will	124	(72.1)	38	(22.1)	10	(5.8)
I have been made to undergo a traditional practice that is harmful to my sexual health by my partner	131	(76.2)	27	(15.7)	14	(8.1)
Have you ever been deprived of sexual activities by your intimate partner	109	(63.4)	46	(26.7)	17	(9.9)
Financial violence						
Have you ever been denied access to financial resources by your partner withholds money	119	(69.2)	32	(18.6)	21	(12.2)
Has money ever been withheld from you by your partner	116	(67.4)	33	(19.2)	23	(13.4)

Table 2 presents the levels of different forms of violence experienced. The findings reported that the majority (58.7%) had no experience of physical violence, 55.8% had no experience of emotional violence, 59.3% had no experience of sexual violence, and 65.1% had no experience of financial violence. However, a notable proportion of women reported experiencing these forms of violence, with 41.3% indicating experience with physical violence, 44.2% with emotional violence, 40.7% with sexual violence, and 34.9% with financial violence.

Table 2b presents the level of experience of intimate partner violence among respondents. The findings reported that the majority of respondents (47.1%) reported having no experience of intimate partner violence. Also, (41.3%), indicated a low level of experience with such violence, while a smaller group, 11.6%, reported a high level of experience with intimate partner violence.

Table 2b: Level of experience of intimate partner violence among respondents

Level of experience	Frequency	Percentages
No experience	81	47.1
Low experience	71	41.3
High experience	20	11.6
Total	172	100.0

Table 3 presents the social and economic factors that contribute to the perpetuation of intimate partner violence. The majority of respondents indicated that they were not exposed to violence during childhood (63.4%) and did not witness their parents or caregivers engaging in violent behaviour (65.7%). Most respondents described their relationship with their parents or caregivers as supportive (73.8%). In terms of social norms and community perceptions, intimate partner violence (IPV) was reported as very common by 64.0% of the women. Furthermore, the majority (70.3%) of respondents believed that IPV is a private matter rather than a community concern. Economic factors influence intimate partner violence. The majority of women in the study (62.8%) reported not being financially dependent on their partner. Furthermore, 71.5% had access to financial resources and support. Most respondents (80.2%) considered financial independence to be very important in a relationship, while 19.8% did not view it as important.

Table 3: Social and Economic Factors That Contribute to the Perpetuation of Intimate Partner Violence

Variables	Frequency	Percent (%)
(Family dynamics)		
Were you exposed to violence in your childhood		
Yes	63	36.6
No	109	63.4
Did you witness your parents or caregivers engaging in violent behaviour?		
Yes	59	34.3
No	113	65.7
How would you describe your relationship with your parents or caregivers?		
Supportive	127	73.8
Abusive	11	6.4
Neglectful	34	19.8
(Gender roles and stereotypes)		
Do you believe that men should be the primary breadwinners in a household?		
Yes	122	70.9
No	50	29.1
Do you think women should be submissive to their partners?		
Yes	132	76.7
No	40	23.3
How important is gender equality in a relationship to you?		
Very important	142	82.6
Not important	30	17.4
(Social norms and community)		
How common is IPV in your community?		
Very common	110	64.0
Uncommon	62	36.0
Do you think IPV is a private matter or a community concern?		
Yes	121	70.3
No	51	29.7
How supportive is your community in addressing IPV?		
Very supportive	125	72.7
Not supportive	47	27.3

Economic factors' influence on intimate partner violence

Variables	Frequency	Percent (%)
How financially dependent are you on your partner?		
Dependent	64	37.2
Not dependent	108	62.8
Do you have access to financial resources and support?		
Yes	123	71.5
No	49	28.5
How important is financial independence in a relationship to you?		
Very important	138	80.2
Not important	34	19.8

Table 4 presents the media and media representation influence on intimate partner violence. The findings reported that the majority of respondents (44.8%) reported sometimes consuming media that portrays violence or aggression. Most respondents (68.0%) believed that media representation of relationships influences their expectations and beliefs. Also, cultural and religious beliefs influence intimate partner violence majority of respondents (87.8%) indicated that religion is very important in their lives. Furthermore, 63.4% believed that certain religious or cultural teachings condone intimate partner violence (IPV). However, most participants (76.7%) felt that their religious or cultural community is very supportive in addressing IPV, while 23.3% perceived their community as not supportive in this regard.

Table 4: Media representation, Cultural and religious beliefs influence on intimate partner violence

Variables	Frequency	Percent (%)
How often do you consume media that portrays violence or aggression		
Never	21	12.2
Rarely	60	34.9
Sometimes	77	44.8
Always	14	8.1
Do you think media representation of relationships influences your expectations and beliefs		
Yes	117	68.0
No	55	32.0
How important is media literacy in addressing IPV to you?		
Very important	121	70.3
Not important	51	29.7

Cultural and religious beliefs influence on intimate partner violence

Variables	Frequency	Percent (%)
How important is religion in your life?		
Very important	151	87.8
Not important	21	12.2
Do you believe that religious or cultural teachings condone IPV?		
Yes	109	63.4
No	63	36.6
How supportive is your religious or cultural community in addressing IPV?		
Very supportive	132	76.7
Not supportive	40	23.3

Table 5 presents the perceived effect of intimate partner violence on the health of the respondents. The findings reported that the majority of respondents agreed that intimate partner violence (IPV) has significant negative health effects.

Specifically, 62.2% agreed that IPV can lead to emotional or physical injuries, while 62.8% believed postpartum depression is a common consequence of IPV. Most respondents (58.1%) agreed that IPV can cause miscarriage, and 60.5% saw a high risk of suicide associated with IPV. Furthermore, 56.4% agreed that preterm labour can result from IPV, and 58.7% believed that IPV leads to poorer pregnancy outcomes. A majority (57.0%) agreed that IPV can cause psychological trauma, and 52.9% thought infertility could result from IPV. Lastly, 59.9% agreed that IPV could lead to the loss of a body part.

Table 5: Perceived effect of intimate partner violence on health of the respondents

Variables	Strongly disagree		Disagree		Agree		Strongly agree	
	F	%	F	%	F	%	F	%
Intimate partner violence can lead to emotional/ physical injuries	20	11.6	10	5.8	107	62.2	35	20.3
Postpartum depression is a common consequence of IPV	19	11.0	24	14.0	108	62.8	21	12.2
Miscarriage can occur due to intimate partner violence	16	9.3	13	7.6	100	58.1	43	25.0
There is high risk of suicide when someone experienced intimate partner violence	19	11.0	18	10.5	104	60.5	31	18.0
Preterm labour can result from IPV	18	10.5	23	13.4	97	56.4	34	19.8
Poorer pregnancy outcomes can occur	19	11.0	20	11.6	101	58.7	32	18.6
IPV can cause psychological trauma	19	11.0	19	11.0	98	57.0	36	20.9
Infertility might occur as a result of IPV	17	9.9	31	18.0	91	52.9	33	19.2
IPV can lead to loss of one's body part	20	11.6	16	9.3	103	59.9	33	19.2

Table 6 presents the relationship between the level of education of respondents and intimate partner violence; the analysis reveals a statistically significant association between them, with a P value of $p < 0.001$. Hence, the null hypothesis is rejected.

Table 6: Relationship between the level of education of respondents and intimate partner violence (IPV)

Variables	Experience categories			Chi-square (Statistics)		
	No experience	Low experience	High experience	χ^2	df	P-value
Level of education				55.390	6	<0.001
No formal education	3 (25.0%)	6 (50.0%)	3 (25.0%)			
Primary	0 (0.0%)	6 (100.0%)	0 (0.0%)			
Secondary	0 (0.0%)	19 (65.5%)	10 (34.5%)			
Tertiary	78 (62.4%)	40 (32.0%)	7 (5.6%)			

Table 7 presents the relationship between the type of marriage and experiences of intimate partner violence (IPV) among respondents. The analysis reported that there is a statistically significant association between them with a $p < 0.001$. Hence, the null hypothesis is rejected.

Table 7: Relationship between the marriage type of respondents and intimate partner violence (IPV)

Variables	Experience categories			Chi-square (Statistics)		
	No experience	Low experience	High experience	χ^2	df	P-value
Marriage type				19.485	2	<0.001
Monogamous	80 (53.7%)	54 (36.2%)	15 (10.1%)			
Polygamous	1 (4.3%)	17 (73.9%)	5 (21.7%)			

Table 8 below presents the relationship between the level of education of husbands and experiences of intimate partner violence (IPV) among respondents. The finding reveals a statistically significant association. Hence, the null hypothesis is rejected.

Table 8: Relationship between the level of husband's education of respondents and intimate partner violence (IPV)

Variables	Experience categories			Chi-square (Statistics)		
	No experience	Low experience	High experience	χ^2	df	P-value
Level of partner's education				36.213	6	<0.001
No formal education	3 (20.0%)	6 (40.0%)	6 (40.0%)			
Primary	2 (33.3%)	3 (50.0%)	1 (16.7%)			
Secondary	0 (0.0%)	12 (70.6%)	5 (29.4%)			
Tertiary	76 (56.7%)	5 (37.3%)	8 (6.0%)			

Discussion

Experience of intimate partner violence among women of childbearing age

In this present study, the findings reported that the majority of participants had no experience of intimate partner violence (IPV), with less than half reporting varying degrees of IPV. This low IPV prevalence aligns with a South African study by [23], where fewer than half of the women reported experiencing IPV. One possible explanation for the low prevalence in both studies may be cultural or societal factors that reduce the incidence of IPV, such as legal protections, improved gender equality, or increased awareness and education about IPV in these regions. However, a higher prevalence of IPV was observed in a study conducted in Uganda by [24], where the majority of respondents reported various forms of IPV.

This difference might be due to differences in culture that influence the acceptance or reporting of IPV. In Uganda, gender inequality, poverty, or a lack of access to legal or psychological support might increase the vulnerability of women to IPV, leading to higher rates being reported. In terms of the specific types of violence faced by the respondents in this present study, emotional abuse ranked the highest. This finding is consistent with a Nigerian study by [25], where emotional abuse also ranked the highest. Emotional abuse often goes underreported but can be prevalent in cultures where direct physical violence is more stigmatized or legally discouraged. Similarly, this finding is aligned with studies conducted in Nigeria and Ethiopia by [26] and [27], respectively, where psychological violence was reported as the most common form of IPV, and sexual violence was the least.

This pattern could be attributed to cultural taboos or stigma surrounding the discussion of sexual violence, which may lead to underreporting. However, this result contrasts with a Nigerian study by [28], which found that sexual violence was reported as the least experienced form of violence. This discrepancy could arise from variations in how violence is defined, cultural factors influencing what forms of violence are considered socially acceptable, or the willingness of respondents to disclose sensitive experiences such as sexual violence.

Factors associated with intimate partner violence among women

In this present study, respondents identified several factors associated with IPV experiences ranging from social factors, media factors, cultural and religious factors and economic factors. These factors show IPV can be caused many factors across various aspect and level of the society. The presence of economic hardship as a key factor is supported by a Nigerian study by [6], where financial constraints were the most frequently reported cause of abuse. Economic hardship often creates stress in households, which can lead to violence, as financial instability might diminish the decision-making power of one partner, often leading to control or coercion by the other. Interestingly, the [6] study also found that having no male child was a significant factor in IPV, reflecting deep-rooted cultural beliefs regarding gender preference. In some communities, male children are viewed as more valuable, and the inability of women to bear male offspring may result in psychological, emotional, or even physical abuse as a form of punishment or frustration from the partner. This cultural expectation creates additional pressures that can contribute to IPV, reinforcing gender inequality within households. Ethnic differences were reported as the least reason for abuse, suggesting that while cultural variations exist, other socio-economic factors might play a more dominant role in triggering IPV. Similarly, [29] identified financial problems, domestic issues, and extramarital affairs as common IPV triggers. These factors vary in significance across different settings but highlight the recurring influence of economic instability and relationship conflicts on IPV. Financial problems, for example, may erode trust and collaboration between partners, while extramarital affairs might lead to feelings of betrayal, jealousy, or power struggles, increasing the risk of abuse.

The role of substance abuse in IPV is evident in an Ethiopian study by [30], which revealed that the substance-using habits and behavioural factors of women's intimate partners were key contributors to IPV. Substance abuse often leads to impulsive and aggressive behaviour, impairing judgment and increasing the likelihood of conflict. Also, a Nigerian study by [17] examined how respondents' social characteristics, such as age at marriage, religion, and socio-economic class, influenced IPV experiences. Younger women, particularly those married early, may be more vulnerable due to their limited life experience or dependence on their spouses.

Religion and socio-economic class also play crucial roles, as certain religious doctrines or societal expectations may enforce traditional gender roles that normalize or justify abusive behaviour. Similarly, lower socio-economic status may increase the risk of IPV due to associated stressors like unemployment or limited access to support services.

Perceived effects of intimate partner violence among women

Regarding the respondents' perception of the consequences of intimate partner violence (IPV), the study reported unanimous agreement that IPV can lead to emotional and physical injuries. This acknowledgment reflects a growing awareness of IPV's multifaceted impact on women's health. The consensus on emotional and physical injuries underscores the pervasive nature of IPV and its recognition as a public health concern. The majority of respondents also acknowledged depression as a common consequence of IPV, which may stem from the chronic stress and trauma associated with such violence. Victims often experience feelings of helplessness and hopelessness, which can exacerbate mental health issues. This aligns with findings from [31], [32], and [33], where incidents of IPV among pregnant women were linked to various mental health problems such as postpartum depression, insomnia, and somatic symptoms. These studies highlight the intricate relationship between IPV and mental health, suggesting that the stressors of IPV can lead to significant psychological distress during and after pregnancy.

Furthermore, a majority of respondents recognized the potential for pregnancy complications due to IPV. This perception may arise from increasing awareness among healthcare professionals and the public about the dangers IPV poses to maternal and foetal health. The finding is consistent with a study conducted in Egypt by [34], which reported an association between IPV in pregnancy and complications such as preterm labour and premature rupture of membranes. The physiological effects of stress and trauma from IPV can contribute to these complications, indicating a direct link between psychological and physical health during pregnancy. Furthermore, this finding is supported by a systematic review by [35], which noted that pregnant women exposed to IPV have higher rates of maternal and neonatal complications, leading to poorer pregnancy outcomes. This may be due to both the direct physical harm caused by IPV and the indirect effects related to the mental health of the mother, which can influence her ability to access healthcare, adhere to prenatal care guidelines, and maintain overall health during pregnancy. As such, the recognition of IPV's potential consequences reflects not only personal experiences but also a broader understanding of its impact on reproductive health.

Hypothesis discussion

In this present study, the relationship between women's level of education, their husbands' level of education, marriage type, and the experience of intimate partner violence (IPV) was tested, revealing a significant association between these variables.

This finding shows the complexity of how educational attainment influences IPV. Women with higher education may have different expectations and levels of freedom within their relationships, which can impact their vulnerability to IPV. This finding is supported by a Nigerian study by [36], which reported that women with secondary education had higher odds of experiencing any form of intimate partner violence compared to uneducated women. This result may reflect that woman with some level of education are more aware of their rights and, consequently, more likely to report instances of violence, as opposed to uneducated women who may feel powerless to speak out. A similar finding was observed in a study by [37], where a significant relationship was found between women's education and experiences of physical violence. This shows that while education can empower women, it may also lead to increased risk if it disrupts existing power dynamics within intimate relationships. For example, educated women may seek greater independence, which could threaten partners who feel challenged by these changes, leading to increased violence. Furthermore, the husbands' levels of education and the type of marriage may further complicate this relationship. Men with lower educational attainment may struggle with insecurities regarding their roles as providers or decision-makers, potentially resorting to violence as a means of asserting control. Similarly, the type of marriage, whether traditional, monogamous, or polygamous, may influence power dynamics and the prevalence of IPV, underscoring the need for nuanced approaches to understanding these associations.

Limitation of the Study

Responses were based on self-reporting, which may be influenced by social desirability or fear of disclosure.

Strengths of the Study

Focus on understudied area: The study examined IPV in relation to socio-demographic factors, a critical yet under-researched area in certain communities.

Statistical Rigour: Use of Chi-square analysis provides robust evidence of associations.

Policy-Relevant Findings: The results offer actionable insights for social workers, healthcare providers, and policymakers.

Implications for Nursing Practice

The findings of this study have significant implications for nursing practice, particularly in the areas of patient assessment, education, advocacy, and interdisciplinary collaboration. Nurses play a frontline role in recognizing and responding to intimate partner violence (IPV), making it imperative that nursing practice evolves to meet the complex needs of IPV survivors. These implications include: routine screening and early detection, trauma-informed care, maternal and reproductive health interventions, culturally sensitive practice, addressing socioeconomic and structural factors, substance abuse interventions, interdisciplinary collaboration and referral systems, and empowerment and advocacy.

Recommendations

Promote public education on IPV and the negative impacts of polygamy and low educational attainment on relationship health. Encourage male education and engagement in IPV prevention programs. Establish community-based support centers for IPV victims, especially targeting women in polygamous marriages. Advocate for stricter enforcement of laws against IPV and promote educational equity. Conduct longitudinal studies and include qualitative components to deepen understanding of IPV dynamics.

Conclusion

This study explored the prevalence, associated factors, and perceived effects of intimate partner violence (IPV) among women of childbearing age in Ilishan-Remo, Ogun State. The findings revealed that while a significant proportion of women reported no experience of IPV, over half had experienced some form, with emotional abuse being the most common. Factors contributing to IPV included economic hardship, cultural expectations (such as the preference for male children), substance abuse, and socio-demographic characteristics such as education level, marriage type, and early age at marriage. These findings underscore the complex and multifaceted nature of IPV, influenced by personal, social, economic, and cultural factors.

List of abbreviations

IPV: Intimate partner violence

SPSS: Statistical Package for the Social Sciences.

WHO: World Health Organization.

Declarations

Ethical approval and consent to participate

Ethical approval was obtained from the study center, protocol number REDACTED. Written informed consent was duly sought from each respondent, and ethical principles of no harm, confidentiality, voluntary participation, and anonymity were observed.

Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Consent to participate: Written and verbal consent was sought and obtained from the study participants before participation.

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AUTHOR CONTRIBUTION STATEMENT

CEA: Conceptualization, supervision, literature review, research design, data collection, data interpretation, writing original draft, reviewing and editing the manuscript.

CK: Conceptualization, research design, data collection, editing the manuscript.

CA: Data collection, Formal analysis, data interpretation, manuscript editing

BH: Data interpretation, editing manuscript

AOO: Data analysis, validation, editing the manuscript.

CAO: methodology, validation, editing manuscript

FOO: Data analysis, validation, manuscript review

DATA AVAILABILITY STATEMENT

The data sets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Consent for publication: All authors consent to the publication of this study

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