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Domestic Violence and Abuse in Pregnancy: Assessing Disclosure, Non-disclosure and Conflict Resolution Strategies in South-South, Nigeria

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ABSTRACT

Background: Domestic violence and abuse (DVA) during pregnancy is a globally recognized and significant public health concern affecting about 25% of women worldwide. Despite the World Health Organization and other agencies efforts to prevent violence against women in several conventions and conferences, DVA remains prevalent especially in sub-Saharan Africa, Nigeria inclusive.

Objective: The aim of this study is to determine Domestic Violence and Abuse in pregnancy: Exploring disclosure, nondisclosure and conflict resolution strategies in South-South, Nigeria.

Methods: A cross-sectional descriptive survey was adopted on 1,720 pregnant women attending antenatal clinic at selected Primary Health Care Centres across Bayelsa and Rivers States (November, 2024 to April, 2025) using convenience sampling method. Data were collected with adapted Abuse Assessment Screen (AAS) and analysed using descriptive statistics of frequency, percentage, mean and standard deviation.

Results: 52.9% and 69.2% of participants claimed to have been physically and psychologically abused respectively. It happens frequently (44.2%). Concern for children's wellbeing (50.6%) is the highest reasons for not disclosing the abuse to anyone followed by shame, embarrassment (13.4%). This result infers that most pregnant women experiencing DVA in Nigeria prefer to use the help of their parents as strategy to cope.

Conclusion: The findings suggest that DVA is a significant problem that requires attention from healthcare providers, policymakers, and community leaders. The patterns of DVA varies across different communities and contexts, and it is influenced by a range of factors, including substance abuse, low education, and anger/hostility.

Keywords: Domestic violence, Abuse, Pregnancy, Disclosure, Non-disclosure, South-South, Nigeria

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INTRODUCTION

Domestic Violence and Abuse (DVA) is a globally recognised and significant public health concern. The World Health Organisation (WHO), non-governmental organisations (NGOs), and other agencies have recognised and advocated for governments to take necessary measures to prevent violence against women, as discussed in several conventions and conferences (Ayodapo et al., 2017). Nevertheless, DVA remains prevalent, affecting millions of women worldwide. This issue affects families of all socioeconomic, ethnic, cultural, and religious backgrounds, as well as their area of residence, and it hinders women's ability to fully engage in society (Bako and Saed, 2018). Domestic Violence and Abuse, as defined by the World Health Organization (WHO), refers to harmful activity occurring inside an intimate relationship (WHO, 2021). This includes acts of aggression, sexual coercion, psychological abuse, and controlling behaviours, all of which inflict bodily, sexual, or psychological harm. Based on the 2013 Nigerian Demographic Health Survey (NDHS), 5.0% of women encountered violence during pregnancy, with the prevalence differing based on factors such as educational attainment, work position, and marital status. (Bola, 2016). Nevertheless, the occurrence of domestic violence among pregnant women who get prenatal care at different locations around the country varied from 2.3% to 46%.

Domestic violence during pregnancy is a complex problem that is influenced by several factors such as societal norms, financial status, level of education, and accessibility to resources (Gashaw et al., 2018). Patriarchal systems and gender disparities prevalent in several societies contribute to the perpetuation of violence. Women, sometimes financially reliant on their abusive relationships, face additional obstacles in their efforts to flee or seek assistance. The incidence of violence among pregnant women is often lower compared to the incidence of violence they report experiencing 12 months before becoming pregnant and/or throughout their lives (Alhusen et al, 2015). According to a recent comprehensive analysis of Domestic abuse during pregnancy, which examined 150 papers from more than 50 countries, the worldwide occurrence of any kind of intimate partner abuse during pregnancy was found to be 25% (Chalise et al, 2023). Europe had the lowest prevalence rate, which was 5.1% (Garrido-Miguel et al., 2019). Emotional/psychological violence is the most prevalent kind of violence when quantified, followed by physical violence, while sexual violence has the lowest occurrence rates (Capeda et al., 2022). Failing to report violence and abuse during pregnancy can lead to various negative consequences for a woman's sexual and reproductive health. These include unintended or unplanned pregnancies, unsafe or unwanted abortions, HIV infection, pregnancy complications, pelvic inflammatory disease, urinary tract infections, sexual dysfunction, physical and mental harm, and potentially even death (Agenagnew et al., 2020).

Domestic Violence and Abuse pose a serious danger to the objectives of the Safe Motherhood Initiative and the Sustainable Development Goals (SDGs), especially those related to health and well-being (Women UN, 2022). This is mostly due to the possible impacts on both the expectant woman and the developing foetus, which is a matter of significant concern. It has been associated with several adverse pregnancy outcomes, such as low birthweight, foetal distress, early rupture of the membranes, miscarriage, antepartum haemorrhage, and perinatal mortality (Ayodapo et al., 2017).

The aim of this study is to determine Domestic Violence and Abuse in pregnancy: Assessing disclosure, nondisclosure and conflict resolution strategies in South-South, Nigeria.

The aim of this study is to explore the complex mechanisms of both disclosing and non-disclosing instances of domestic abuse among pregnant women. The researcher's previous expertise in caring for women who have experienced violence in their relationships strengthens the justification for this work, since it offers vital insights into the complexity and difficulties faced by victims. Furthermore, the research aims to enhance the profession by suggesting a way to efficiently address conflicts that arise from cases of domestic abuse. This project aims to improve our comprehension of the factors that affect disclosure behaviours, as well as provide effective techniques for reducing the effects of domestic violence and promoting better relationships during pregnancy.

In Sub-Saharan African setting, abuse of women is seen as a norm especially when she fails to fulfill her role as a wife (Cools and Kotsadam., 2017). Given that pregnancy and its hormonal effects can make it challenging for many women to do various tasks. Researchers have contended that pregnancy is a time of increased vulnerability to domestic abuse, regardless of a woman's age, colour, socioeconomic class, or educational level (Vedam et al., 2019). Furthermore, pregnant women are rendered susceptible by aspects such as conjectured viewpoints about pregnancy, atypical emotional responses from their partners towards pregnancy, and a decrease in sexual intimacy (Greenberg et al., 2017).

Instances when societal norms condone violence towards women frequently lead to victims experiencing feelings of shame and humiliation when they try to reveal instances of abuse, thereby prolonging the problem of underreporting Domestic Violence and Abuse (DVA) (Wessells and Kostelny., 2022). Moreover, cultural ideas and traditional practices may normalize or even rationalize violence against women, so posing substantial obstacles to obtaining assistance. Additionally, the negative perception associated with divorce or separation, the apprehension of facing revenge from the abuser, and the worry of being socially isolated further contribute to pregnant women's hesitancy in revealing instances of abuse (Tonsin and Barn., 2017). The repercussions of domestic abuse go beyond the immediate physical and psychological damage suffered by the victim. Children who experience violence while in the womb or during their early years are more likely to face developmental delays, behavioural issues, and long-lasting psychological trauma (Shonkoff., 2015). Non-disclosure during pregnancy often leads to premature birth and intrauterine foetal mortality, as stated by Katushabe et al. in 2022.

In Nigeria, DVA prevalence rates vary with regions between 17% and 34% (Awolaran et al., 2021), greatly due to variations in deep-rooted gender inequality as well as perceptions and social acceptability of DVA and wife beating in the homes (Awolaran et al., 2021). Over time, Nigeria has sustained a relatively high maternal mortality and currently is still among the few countries that contribute to the highest maternal mortality ratio in Sub-Saharan Africa, with a rate of 630 per 100,000 live births in 2012 (Fapohunda and Orobaton., 2013). 1,047 to 917 deaths per 100,000 live births ratio of accounting for roughly 28-29% of all global maternal deaths with an estimated 82,000 women dying annually from pregnancy related complications WHO 2017 (WHO et al., 2023).

Presently, there is a significant decrease in the collection of statistical data in the region, particularly in the field of epidemiology. Remarkably, the prevalence of domestic violence during pregnancy is more extensive than that of several disorders that are often examined (Alhusen et al., 2015). Currently, there is no widely accepted screening procedure in place during prenatal care to detect cases of domestic violence, unlike the established screening protocols for other medical disorders. Several investigations, carried out by Halpern-Meekin et al. (2019), Teshome et al. (2021), and Ezekwe-Anya (2017) have found that over 97.2% of incidents are unaccounted for. Another issue arises when certain women are ignorant that the actions carried out against them by their spouses are classified as abusive or violent (Rajan, 2018). Providing a dispute resolution mechanism and establishing a structure to safeguard women who report incidents of abuse and violence is crucial.

Healthcare practitioners have a vital role in recognising and dealing with domestic abuse that occurs during pregnancy (McCauley et al., 2017). Nevertheless, research indicates that a significant number of healthcare personnel do not possess sufficient training in identifying and addressing domestic violence, resulting in missed chances to intervene (Arora et al., 2021). The key factors contributing to women's reluctance in disclosing their experiences of Domestic Violence and Abuse include fear of the abuser, unease with medical experts, and the belief that DVA is not a significant problem (Rose et al., 2011)

METHODOLOGY

Study Area

The study area was antenatal clinics of Agudama comprehensive health centre and Family Support Primary Health Care centre in Yenagoa of Bayelsa State and Obio Cottage Hospital, Rumubiakani,

Model Primary Health centre, Rumukurushi, Model Primary health centre Iriebe and Primary health centre Oyigbo in Rivers state Nigeria. This region was selected due to its unique socio-cultural context and the challenges faced by pregnant women in accessing healthcare and support services related to DVA. Bayelsa is a state in southern Nigeria, with its capital at Yenagoa. It is bordered on the west by Rivers State, on the East and South by the Atlantic Ocean and on the North by Delta State. It has a population of 1,703,358 and occupies an area of 10,773 square kilometers. Some major cities include Amassoma, Brass, Ekeremor, Kaiama, Nembe, Odi, Ogbia, Oporoma, Otuoke, and Sagbama (Etekpe et al., 2015).

Rivers State is the most populated State in the Niger Delta region and sixth most populous State in Nigeria with a population of over 5 million people as given by the 2006 Census and projected to increase to over 7 million in 2015. Rivers State is one of the 36 states of Nigeria with its capital at Port Harcourt which is the largest city in the Niger Delta region and is economically significant as the centre of Nigeria's oil industry. (Obenade et al.,2020).

Study Procedure/Data Collection

The survey included sections on demographic information, types of abuse, frequency of incidents, and healthcare experiences. Domestic violence screening score (HITS: Hurt, Insult, Threaten and Scream) was used to select the participants. The HITS scale is a short screening tool for domestic violence which is contained of four questions about partner violence. Score values could range from 4 to 20 (score more than 10 indicate existence of DVA). (KM Sherin et al., 1998). Data were collected with adapted Abuse Assessment Screen (AAS) and analysed using descriptive statistics of frequency, percentage, mean and standard deviation.

Research Assistants were used at the designated health centres of the Research study on each clinic days. These assistants were one person each that are representatives of DVA Committee members of the Health Centre.

Ethical Approval

A letter of introduction was collected from the Africa Centre of Excellence for Public Health and Toxicological Research University of Port Harcourt to the secretary of the Primary Health care Management Boards of Bayelsa State and Rivers State.

Ethical clearance form was obtained from university of Port-Harcourt ethical committee, this was taken to the clearance committee of Primary Health Care Board of Bayelsa and Rivers States to get permission to get access to the designated health centres in Yenagoa and Port Harcourt metropolis. Informed consent was obtained from all participants. Confidentiality was maintained by ensuring that all data collected were kept confidential and anonymized because domestic violence research carries psychological and safety risks, interviews were conducted privately within the clinic setting. Participants were assured that declining participation will not affect their medical care.

Sample size determination

In the determination of the sample size Yamane's (1967) formula was used.

Yamane's formula: $n = \frac{N}{(1+N(e)2}$

n= sample size

N= population

e= this is 5%

Sample Population

This study employed a cross-sectional descriptive survey adopted on 1,720 pregnant women attending antenatal clinic at selected Primary Health Care Centres across Bayelsa and Rivers States (November, 2024 to April, 2025) using convenience sampling method.

Target population in statistics is the specific population about which information is desired. A population is a well-defined or set of people, services, elements, events, group of things or households that are being investigated (Saunders and Lewis, 2019). The study focused on pregnant women attending antenatal care (ANC) clinics in Bayelsa and Rivers States. Below is the statistic of antenatal clients at 6 major different health centres across Bayelsa and Rivers States which were used for the study. These health centres were selected

due to the fact they are the most frequent used Primary health care centres in the States. Also, they have DVA committee representatives in each of these centres

Table 1: Statistics of antenatal clients at six major different health centres across Bayelsa and Rivers State

S/N	List of health centres	Population (Number of clients)	Sample size: Using Yamane's formula
1	Model primary health centre, Rumuokurushi	4,441	367
2	Comprehensive health centre, Agudama Epie Bayelsa	1,106	294
3	Model primary health centre, Iriebe	1,048.	289
4	Obio cottage hospital, Rumubiakani	1,719	324
5	Primary health centre, Oyigbo	948	281
6	Family support health centre Yenagoa	276	165
	Total	9,538	1720

RESULTS

The age distribution of respondents (Table 2) shows that out of 1,720 pregnant women, the largest proportion were 18- 24 years, with 680 respondents representing 39.5%. This was followed by those aged 25–35 years, with 610 respondents accounting for 35.5%. Women aged 36–50 years were 330 in number, representing 19.2%. This indicates that most of the participants, about three-quarters (1,290 women), were below 35 years, reflecting the dominance of younger women in antenatal care attendance.

Out of 1,720 respondents, most were married (67.4%), followed by single (17.4%), separated (9.9%), and divorced/widowed (5.2%) (Table 3). This shows that the majority of pregnant women attending prenatal clinics were in marital unions.

Marriage, while socially valued, is also the main setting where intimate partner violence occurs, making married women particularly vulnerable. Separated and divorced women, though fewer, may have higher past exposure to abuse, while single women may still face violence from partners or family members. In line with the Domestic Abuse Act (2021), all categories are legally recognised as potential victims, but the dominance of married women suggests interventions should prioritize addressing abuse within spousal relationships during pregnancy

Table 2: Age of the respondents

Age	Frequency	Percentage
18-24 year	680	39.5
25-35 years	610	35.5
36-50 years	330	19.2
Above 50 years	100	5.8
Total	1720	100.0

Table 3: Marital Status

Marital status	Frequency	Percentage
Single	300	17.4
Married	1160	67.4
Separated	170	9.9
Divorced/Widowed	90	5.2
Total	1720	100.0

Table 4: Respondents Education

Education	Frequency	Percentage
No formal education	430	25.0
Primary	360	20.9
Secondary	360	20.9
Tertiary	570	33.1
Total	1720	100.0

Table 5: Employment Distribution

Employment	Frequency	Percentage
Unemployed	500	29.1
Employed (part-time)	580	33.7
Employed (full-time)	390	22.7
Self employed	250	14.5
Total	1720	100.0

Of the 1,720 respondents, 430 (25.0%) had no formal education, 360 (20.9%) had primary education, 360 (20.9%) had secondary education, and 570 (33.1%) had tertiary education (Table 4). This shows that although a fair proportion of women had higher education, a significant number still had low or no educational attainment. Among the 1,720 respondents, the largest share were engaged in part-time work (580; 33.7%), followed by the unemployed (500; 29.1%), those in full-time employment (390; 22.7%), and the self-employed (250; 14.5%) (Table 5). This shows that while many women had some form of income-generating activity, stable or secure employment was less common.

Table 6: Factors that influence Disclosure

Items	Frequency	Percentage
Why have you not disclosed the abuse to anyone?		
Fear of partner's reaction	180	10.5
Shame or embarrassment	230	13.4
Concern for children's wellbeing	870	50.6
Lack of trust in authorities	200	11.6
None	240	14
Do you have access to any support systems (family, friends, & community groups) that you can talk to about the abuse?		
No	430	25
Yes	1290	75
Are there cultural beliefs or practices that discourage women from reporting DVA		
Yes	0	0
No	1720	100
How does the community view DVA?		
Acceptable	60	3.5
Unacceptable but common	1620	94.2
Unacceptable and rare	40	2.3

The results in table 6 show the factors that influence disclosure of domestic violence and abuse among pregnant women. The reasons for not disclosing the abuse to anyone identified by the respondents included, fear of partner's reaction (10.5%), shame or embarrassment (13.4%), concern for children's wellbeing (50.6%), lack of trust in authorities and (11.6%). The result indicated the primary reason why pregnant women experiencing DVA do not disclose to anyone is because of the concern for their children's well-being. This shows that these women are scared and do not want to risk separation from their children therefore, they prefer to keep on suffering in an effort to protect their children.

The result also showed that 25% of the respondents do not have access to any support system while 75% of the respondents have access to support systems. It shows that quite a good number of the respondents have access to support systems however, 25% still do not have access to support systems.

Factors that Influence Non-disclosure

Table 7 shows the result of the analysis on the factors that influence non-disclosure by victims of domestic abuse. The result of the analysis 51.7% of the respondents somewhat agreed that he makes them feel unsafe even in their own home, 22.1% strongly agreed, 18.6% agreed a little while 7% disagreed a little. The result of the analysis showed that 11.6% strongly agreed that they are ashamed of the things done to them, 30.2% agree somewhat, 32.6% agree a little, 0.6% disagree somewhat, 0.6% disagree strongly. The respondents (81.4%) strongly agreed that they are afraid to disclose of what he might do to them and 13.4% somewhat agreed.

Furthermore, 52.3% of the respondents strongly agreed that they feel like they are programmed to react in a certain way to him. About 40% of the respondents stated that their partner makes them feel like a prisoner, 16.9% somewhat agreed while 16.9% agreed a little. Half of the respondents (50%) stated that their partner makes them feel like they have no control over their own life, 16.9% somewhat agreed while 5.2% of the respondents agreed a little.

Likewise, almost all the respondents (84.3%) hide the truth because they are afraid, 70.9% strongly agreed that they feel owned and controlled by their partners, 21.5% somewhat agreed. Other reasons stated by the respondents for non-disclosure include "He can scare me without laying a hand on me" (32%), "He has a look that goes straight through me and terrifies me" (54.7%), "My partner often puts me down, yells at me, calls me names or tells me I'm worthless" (43%).

Coping Strategies Utilized by the Pregnant women Experiencing DVA

Table 8 shows the coping strategies utilized by pregnant women experiencing DVA. From the analysis, 17.4% utilize Police, 5.8% utilize national domestic violence hotline, 65.1% utilize parents while 11.6% utilize anonymous people. This result infers that most pregnant women experiencing DVA in Nigeria prefer to use the help of their parents before the police or an unknown person.

DISCUSSION

Age of the respondents

This finding has important implications for domestic violence and abuse (DVA). Younger women are generally more vulnerable to abuse due to limited economic independence, lower decision-making power, and higher dependence on partners, which can expose them to controlling behaviours. The 25–35 years group, which represents peak reproductive age, is also a high-risk category, as pregnancy may intensify stress and power imbalances in relationships, thereby heightening the risk of abuse. Although older women (36 years and above) form a smaller proportion of respondents, research shows that when they experience abuse, it often goes underreported and can have cumulative health and psychological effects. The Domestic Abuse Act of 2021 in the UK recognizes abuse among individuals aged 16 and above, covering all the age categories represented in this study.

Marital Status

Marriage, while socially valued, is also the main setting where intimate partner violence occurs, making married women particularly vulnerable. Separated and divorced women, though fewer, may have higher past exposure to abuse, while single women may still face violence from partners or family members. In line with the Domestic Abuse Act (2021), all categories are legally recognised as potential victims, but the dominance of married women suggests interventions should prioritize addressing abuse within spousal

Table 7: Factors that Influence Non-disclosure

Description of how your partner makes you feel:	**Agree strongly**	**Agree somewhat**	**Agree a little**	**Disagree a little**	**Disagree somewhat**	**Disagree strongly**	**MS**	**SD**
He makes me feel unsafe even in my own home	380 (22.1%)	890 (51.7%)	320 (18.6%)	120 (7%)	0 (0%)	10 (0.6%)	4.87	0.876
I feel ashamed of the things he does to me	200 (11.6%)	520 (30.2%)	560 (32.6%)	420 (24.4%)	10 (0.6%)	10 (0.6%)	4.26	1.012
I try not to rock the boat because I am afraid of what he might do	1400 (81.4%)	230 (13.4%)	0 (0%)	80 (4.7%)	0 (0%)	10 (0.6%)	5.70	0.781
I feel like I am programmed to react in a certain way to him	900 (52.3%)	170 (9.9%)	8 (4.7%)	160 (9.3%)	130 (7.6%)	280 (16.3%)	4.41	1.976
I feel like he keeps me prisoner	690 (40.1%)	290 (16.9%)	290 (16.9%)	250 (14.5%)	30 (1.7%)	170 (9.9%)	4.49	1.628
He makes me feel like I have no control over my life, no power, no protection	860 (50%)	290 (16.9%)	90 (5.2%)	260 (15.1%)	100 (5.8%)	120 (7%)	4.69	1.648
I hide the truth from others because I am afraid not to	1450 (84.3%)	60 (3.5%)	110 (6.4%)	0 (0%)	0 (0%)	100 (5.8%)	5.55	1.244
I feel owned and controlled by him	1220 (70.9%)	370 (21.5%)	30 (1.7%)	40 (2.3%)	10 (0.6%)	50 (2.9%)	5.51	1.040
He can scare me without laying a hand on me	550 (32%)	410 (23.8%)	120 (7%)	150 (8.7%)	290 (16.9%)	200 (11.6%)	4.10	1.826
He has a look that goes straight through me and terrifies me	940 (54.7%)	70 (4.1%)	330 (19.2%)	80 (4.7%)	80 (4.7%)	22 (12.8%)	4.61	1.805
My partner often puts me down, yells at me, calls me names, or tells me I'm worthless.	740 (43%)	480 (27.9%)	170 (9.9%)	110 (6.4%)	40 (2.3%)	180 (10.5%)	4.72	1.613

Table 8: Coping Strategies Utilized by the Pregnant woman Experiencing DVA

Coping Strategies	**Frequency**	**Percentage**
Police 911	300	17.4
National domestic violence hotline	100	5.8
Parents	1120	65.1
Anonymous	200	11.6

Respondents Education

Education is an important factor in shaping vulnerability to domestic violence. Women with little or no education often have reduced awareness of their rights, limited access to support systems, and weaker economic independence, which can increase susceptibility to abuse. Conversely, women with tertiary education may be more empowered to recognise, resist, or report abuse, though they are not exempt from it.

Employment Distribution

In terms of domestic violence, women without steady employment are often at greater risk because financial dependence can limit their choices and increase tolerance of abuse. Part-time and casual work, though reported by 580 respondents, may provide only minimal autonomy, whereas the 390 in full-time employment or the 250 who were self-employed may enjoy more independence. However, research shows that abuse can still occur regardless of economic status, underscoring the need for interventions that also address economic abuse alongside physical or emotional violence.

Women without steady employment are often at a heightened risk of experiencing domestic violence, as financial dependence on a partner can significantly restrict their autonomy and increase their tolerance for abuse (Frost et al., 2023; Ikuteyijo et al., 2025; Shamu et al., 2011; Stiller et al., 2022). Pregnancy can exacerbate this economic dependence, as women may face limitations in their ability to work, particularly during the later stages of gestation (Stiller et al., 2022; Sigalla et al., 2017). This reliance on a partner's income can create substantial barriers to leaving abusive relationships, as financial insecurity often prevents women from seeking safety (Ikuteyijo et al., 2025).

While part-time and casual employment, reported by a significant number of women, may provide some income, it often offers limited economic autonomy. In contrast, women in full-time or self-employment are generally more financially independent, which may enable them to recognize, resist, or report abuse. However, research consistently demonstrates that economic independence does not fully shield women from violence (Stiller et al., 2022; Das et al., 2013). In certain African contexts, economic empowerment among women can, paradoxically, lead to increased violence, as it may challenge traditional gender roles and disrupt male partners' perceived authority (Stiller et al., 2022; Gunarathne et al., 2023).

Thus, interventions must address not only physical and emotional violence but also economic abuse, which involves controlling a woman's access to financial resources, regardless of her employment status (Orpin et al., 2017; Katushabe et al., 2023; Okoror et al., 2024). The diverse employment landscape necessitates nuanced approaches to supporting pregnant women, acknowledging that both financial vulnerability and perceived threats to a partner's economic role can act as drivers of domestic violence and abuse.

Assessing the factors that influence a pregnant woman's decision to disclose experiences of DVA by pregnant women attending antenatal clinics in South-South, Nigeria.

The respondents identify several factors that influence disclosure, including victims' feelings of hopelessness and helplessness, as well as their perception of safety in their homes. These factors highlight the complex and nuanced nature of DVA disclosure.

The result also showed that 25% of the respondents do not have access to any support system while 75% of the respondents have access to support systems. It shows that quite a good number of the respondents have access to support systems however, 25% still do not have access to support systems. In the landscape of domestic violence and abuse among pregnant women, it is still very high because every life is important. All these can influence disclosure.

Furthermore, it can be seen from the result that there are no cultural beliefs or practices that discourage women from reporting DVA. Lastly, the results showed that concerning the perception of the community towards DVA, 3.5% of the respondents

responded with acceptable, 94.2% of the respondents responded with unacceptable but common while 2.3% responded with unacceptable and rare. This shows that the community views DVA as unacceptable but common. This further establishes the fact that DVA is seen as a common occurrence in the Nigerian community.

Assessing the factors that influence a pregnant woman's decision to Nondisclosure of DVA in South-South, Nigeria

From the analysis, the major factors influencing non-disclosure by victims of abuse include fear, shame, feeling like a prisoner, no protection, low self-esteem. If these issues can be tackled, more victims of DVA will be able to save their lives and that of their children.

The results of this study illuminate several critical factors influencing pregnant women's non-disclosure of Domestic Violence Abuse in South-South, Nigeria, aligning closely with existing literature while offering regional specificity. The findings underscore that fear, shame, and the pervasive effects of coercive control are paramount in preventing disclosure, creating a complex web of barriers that significantly hinder help-seeking behaviors.

A dominant theme emerging from the data is the profound role of fear. A staggering 81.4% of respondents strongly agreed, and an additional 13.4% somewhat agreed, that they are "afraid to disclose of what he might do to them." This is directly corroborated by the 84.3% who hide the truth due to fear and the substantial percentages (51.7% somewhat agree, 22.1% strongly agree) who feel unsafe even in their own homes. This pervasive fear of repercussions, including intensified violence, retaliation from the partner, or even the loss of children, is a well-documented barrier to disclosure globally (Barez et al., 2022; Finnbogadóttir et al., 2016; Humphreys et al., 2010). Pregnant women, in particular, may fear for the safety of their unborn child and themselves, a fear that perpetrators often exploit to maintain silence. The qualitative responses further highlight the insidious nature of this fear, with 32% reporting "He can scare me without laying a hand on me" and 54.7% stating "He has a look that goes straight through me and terrifies me." These experiences underscore that non-physical forms of intimidation are highly effective in maintaining a climate of fear, even without overt physical violence, an aspect often under-recognized but equally potent in preventing disclosure (Martín-de-las-Heras et al., 2019).

Shame and stigma also emerged as significant deterrents to disclosure. While not as universally strong as fear, a considerable portion of respondents indicated shame, with 11.6% strongly agreeing, 30.2% somewhat agreeing, and 32.6% agreeing a little that "they are ashamed of the things done to them." This aligns perfectly with literature asserting that IPV disclosure is heavily stigmatized, leading to women feeling judged, blamed, or experiencing a loss of social reputation (Barez et al., 2022; Katushabe et al., 2021; Marais et al., 2018; Yndo et al., 2018). In many cultural contexts, including Nigeria, there are strong taboos around discussing family problems outside the home, and IPV can be seen as a personal failure or source of dishonor (Ayodapo et al., 2017; Katushabe et al., 2021). This internalized shame and fear of social judgment can lead to isolation and secrecy, making it even more difficult for women to confide in others, including healthcare professionals (Kataoka et al., 2010; Katushabe et al., 2021).

According to Akyüz et al., ((2012), for many women, physical and sexual violence continues during pregnancy. A wide range of prevalence rates of domestic violence during pregnancy has been estimated from 3 to 30 percent (Van Parys et al., 2014). Domestic violence (DV) during pregnancy is not simply a severe public health issue that jeopardizes maternal and foetal health, but also a violation of human right.

Coping Strategies Utilized by the Pregnant woman Experiencing DVA

The analysis of coping strategies utilized by pregnant women experiencing domestic violence abuse reveals a striking pattern: an overwhelming preference for informal support systems,

particularly parents, over formal institutional channels. The data indicates that 65.1% of respondents primarily turn to their parents, while a significantly smaller proportion utilize formal resources such as the police (17.4%) or national domestic violence hotlines (5.8%). A notable 11.6% relied on anonymous individuals, suggesting a reluctance to engage with known formal entities or perhaps a desperate search for any form of external assistance. This pronounced reliance on familial support aligns strongly with existing literature on help-seeking behaviors in patriarchal societies, especially within African contexts, and highlights critical barriers to accessing formal protective mechanisms.

The high percentage of pregnant women seeking help from their parents is consistent with findings across sub-Saharan Africa, where family, particularly natal relatives, often serve as the primary source of support for women experiencing intimate partner violence (Sigalla et al., 2018; Yirgu et al., 2023). In Nigeria, marriage is often perceived as a family affair rather than solely a private or public concern, leading women to report IPV to family members, friends, or religious leaders before approaching formal institutions (Ayodapo et al., 2017). This preference is deeply rooted in socio-cultural norms, where familial intervention is seen as a means to resolve marital conflicts and preserve family honor (Ayodapo et al., 2017). Studies in Kenya and Tanzania also confirm that women often prefer sharing IPV experiences with their biological mothers or natal relatives rather than health professionals or others (Hatcher et al., 2013; Katushabe et al., 2023). Family members are part of crucial community networks that women engage during pregnancy, and their role in providing social support is considerable (Sigalla et al., 2017).

Conversely, the low utilization rates for formal resources such as the police and domestic violence hotlines (17.4% and 5.8%, respectively) echo broader patterns observed in low- and middle-income countries. Research indicates that many IPV survivors rely heavily on informal networks, while formal IPV services often see persistently low awareness and utilization (Decker et al., 2013; Yirgu et al., 2023). There are multiple reasons for this divergence. In African settings, societal norms can lead to IPV being viewed as a "normal" part of marriage or a private matter to be kept within the home, discouraging external disclosure (Odero et al., 2013; Orpin et al., 2017). Women may also perceive formal services as ineffective or lacking the capacity to create change (Decker et al., 2013). For instance, survivors in Peru found police responses to be lacking or the justice system ineffective (Cripe et al., 2010). Furthermore, there is often a fear of retaliation or increased abuse from partners if cases are reported to formal authorities, making women reluctant to seek help from the police (Yirgu et al., 2023). This fear is compounded by the potential for victim-blaming within both informal and formal settings, which can further discourage women from disclosing their experiences (Yirgu et al., 2023).

The preference for informal support, while culturally embedded, presents both advantages and disadvantages. While family members can provide immediate emotional and sometimes practical support, they may also encourage women to tolerate violence to maintain the marriage, particularly if the family has received a bride price or if divorce is culturally frowned upon (Ayodapo et al., 2017; Katushabe et al., 2023). This can result in women "staying for the children" despite ongoing abuse (Sigalla et al., 2018). The fact that only a fraction of women in a Nigerian study reported their IPV experience to law enforcement, with even fewer cases leading to prosecution, further substantiates the limited trust and perceived ineffectiveness of formal channels (Ayodapo et al., 2017)

CONCLUSION

In conclusion, the analysis and interpretation of the respondents' perceptions of DVA highlight the complexity and multifaceted nature of the issue. The findings suggest that DVA is a significant problem that requires attention from healthcare providers, policymakers, and community leaders. The pattern of DVA varies across different communities and contexts, and it is influenced by a

range of factors, including substance abuse, low education, and anger/hostility.

The analysis also highlights the importance of recognizing the different forms that abuse can take, including verbal assault, deprivation of resources, and physical abuse. The findings suggest that emotional abuse is a significant aspect of DVA, and that it can have long-lasting effects on victims' mental health and well-being.

AUTHORS CONTRIBUTION

The first author is editor and corresponding author, others are supervisors.

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CONFLICT OF INTEREST

No competing interests

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