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Perceived Impact of Intimate Partner Violence on the Quality of Life of Pregnant Women Attending Ekiti State University Teaching Hospital, Ado-Ekiti, Nigeria

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Abstract - Background and objectives: *Intimate partner violence (IPV) during pregnancy is a critical public health concern that adversely affects the physical, psychological, and social wellbeing of women, as well as pregnancy outcomes. Despite global recognition of IPV as a human rights violation and health hazard, limited research exists on its impact on quality of life among pregnant women in South-Western Nigeria. This study assessed the perceived impact of intimate partner violence on the quality of life of pregnant women attending Ekiti State University Teaching Hospital (EKSUTH), Ado-Ekiti, Nigeria.*

Methods: *A descriptive cross-sectional design was employed among 132 pregnant women attending antenatal clinic at EKSUTH. Purposive sampling was used to select respondents. Data were collected using structured, validated questionnaires adapted from standardized instruments including the WHOQOL-BREF and IPV assessment tools. The questionnaire comprised five sections assessing socio-demographic characteristics, prevalence and nature of IPV, effects on health and well-being, social effects and coping mechanisms, and support services. Data were analyzed using SPSS version 27 and presented using descriptive statistics (frequencies, percentages, tables, charts). Hypotheses were tested using chi-square statistics at a significance level of $p<0.05$.*

Results: *The majority of respondents were aged 30–39 years (53.8%), married (92.4%), had tertiary education (52.3%), and were employed in the public sector (37.9%). Findings revealed that 56.1% of respondents reported experiencing some form of IPV during pregnancy. Emotional abuse was the most prevalent form (62.1%), followed by psychological abuse (57.6%), sexual abuse (45.5%), and physical abuse (37.9%). Among those affected, 55.3% experienced violence occasionally, while 11.4% experienced it frequently and 9.1% very frequently. IPV onset occurred before pregnancy in 54.5% of cases, during pregnancy in 25.8%, and after pregnancy began in 19.7%. IPV significantly affected physical health (59.1%) with injuries and fatigue reported, and mental health (58.3%) with anxiety and depression commonly experienced. A majority (59.8%) did not feel safe in their current relationship, and 61.4% reported that violence disrupted their ability to attend antenatal care regularly. Relationship-related stress was experienced often (31.1%) or always (28.0%) by most respondents, and 64.4% felt isolated or unsupported. IPV strained relationships with family/friends (77.3%) and affected work/income-generating activities (79.5%). Coping mechanisms included talking to family/friends (37.9%), seeking religious help (37.9%), and staying silent (24.2%). Only 43.9% had reported violence to health workers or authorities; barriers to reporting included financial dependence (38.6%), fear (25.0%), shame (25.0%), and lack of trust (11.4%). While 65.2% were aware of support services, only 40.9% had accessed them. Financial aid (37.1%) and legal aid (24.2%) were identified as most needed. Hypothesis testing revealed no significant relationship between age and quality of life ($\chi^2=3.421$, $df=3$, $p>0.05$), accepting the null hypothesis. However, a significant relationship was found between demographic profile (employment status) and experience of IPV ($\chi^2=10.212$, $df=3$, $p<0.05$), rejecting the null hypothesis.*

Conclusion: *Intimate partner violence is highly prevalent among pregnant women attending EKSUTH, with profound negative impacts on physical health, mental well-being, social relationships, economic stability, and overall quality of life. Emotional and psychological abuse are more common than physical violence, yet often overlooked in screening. Despite awareness of support services, utilization remains low due to financial dependence, fear, shame, and lack of trust. The findings underscore the urgent need for routine IPV screening during antenatal care, enhanced nurse-led interventions, community-based sensitization, and multidisciplinary collaboration involving healthcare providers, social*

workers, legal aid services, and policymakers to reduce IPV and its consequences on maternal and child health.

Keywords: Intimate Partner Violence; Domestic Violence; Pregnancy; Quality of Life; Maternal Health; Antenatal Care; Nigeria; Coping Strategies; Support Services

I. INTRODUCTION

Background to the Study

Globally, violence against women, particularly during pregnancy, constitutes a significant public health concern with far-reaching consequences for maternal and child health. According to the World Health Organization (WHO), approximately 30% of women worldwide experience intimate partner violence (IPV) at some point in their lives, and 10-20% of women experience physical or sexual violence specifically during pregnancy (1). This violence can have severe consequences on the physical and mental health of pregnant women, including increased risk of miscarriage, preterm labor, low birth weight, and maternal mortality (2).

Intimate partner violence is defined by the World Health Organization as "behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors" (3,4). The term "intimate partner" encompasses current and former spouses and dating partners, recognizing that violence can occur across diverse relationship types and durations (5). IPV is the most pervasive yet often underrecognized problem affecting millions of women worldwide, with marginalized populations including women living with HIV/AIDS facing particularly elevated risks (6).

Globally, close to one-third of all women in intimate relationships have ever experienced physical and/or sexual violence from their intimate partner (7). According to WHO reports, 35% of women worldwide have experienced intimate partner violence, with 30% of violence perpetrated by partners (8). IPV encompasses various forms of abuse—physical, sexual, and psychological—that can severely impact the health and well-being of victims. This form of violence not only violates fundamental human rights but also leads to a myriad of adverse health outcomes, including increased susceptibility to sexually transmitted infections, mental health disorders, chronic physical ailments, and adverse pregnancy outcomes (9).

The vulnerability of pregnant women to IPV is particularly concerning due to the dual victimization of mother and fetus. Pregnancy represents a period of increased physical and emotional dependence, which may exacerbate existing abuse or trigger its onset (10). Women living with HIV face unique vulnerabilities that heighten their risk of experiencing IPV. Studies indicate that women living with HIV/AIDS who disclose their HIV status are more likely to experience intimate partner violence than women who are HIV-negative (11). Furthermore, women living with HIV who are victims of IPV have been found to have poorer health outcomes compared to those without a history of IPV, including reduced antiretroviral adherence and worse HIV-related clinical outcomes (12).

In Africa, the prevalence of violence against women is alarmingly high. A study conducted by the African Women's Development and Communication Network (FEMNET) found that 60% of women in Africa experience physical or sexual violence (13). Pregnant women in Africa are particularly vulnerable to violence, with studies suggesting that up to 40% of pregnant women experience intimate partner violence (14). The continent's high rates of IPV are compounded by cultural norms that may normalize violence, weak legal protections for women, limited access to support services, and socioeconomic factors that trap women in abusive relationships (15).

In Nigeria, violence against women is a pervasive problem with deep cultural, social, and economic roots. According to the National Demographic and Health Survey (NDHS) 2018, 31% of women in Nigeria experience physical violence, and 14% experience sexual violence (16). Pregnant women in Nigeria are also at elevated risk of violence, with studies suggesting that up to 30% of pregnant women experience intimate partner violence (17). The Nigerian context is characterized by patriarchal norms that may legitimize male control over female partners, limited enforcement of existing laws against domestic violence, inadequate support services for victims, and cultural silence surrounding family matters (18).

In Ekiti State, South-Western Nigeria, violence against women represents a significant but

understudied concern. A study conducted by the Ekiti State Ministry of Health found that 25% of women in Ekiti State experience physical violence, and 10% experience sexual violence (19). Pregnant women in Ekiti State are particularly vulnerable to violence due to limited access to healthcare services, inadequate support systems, and cultural factors that may discourage help-seeking behaviors. Ekiti State University Teaching Hospital (EKSUTH), Ado-Ekiti, serves as a major tertiary healthcare institution providing antenatal care to women from diverse socioeconomic backgrounds across the state and neighboring regions.

The background of this study stems from the growing recognition of intimate partner violence as a significant public health issue with profound implications for maternal and child health. Abuse during pregnancy, whether physical, emotional, or psychological, has been shown to negatively affect maternal health and pregnancy outcomes. It can lead to complications such as preterm labor, low birth weight, and increased maternal stress, which, in turn, adversely impacts the overall quality of life of pregnant women (20). Despite the global acknowledgment of the issue, there is limited research that specifically addresses how intimate partner violence affects the quality of life of pregnant women in the context of Ekiti State University Teaching Hospital. This gap in knowledge highlights the urgent need for localized studies to understand the unique socio-cultural and economic factors that may influence the prevalence, nature, and impact of IPV in this population.

Statement of the Problem

Intimate partner violence (IPV) is a pervasive public health issue globally, with significant implications for women's physical, emotional, and psychological health (21). Pregnant women, due to the physiological and emotional changes associated with pregnancy, are particularly vulnerable to abuse, which can adversely affect their health, pregnancy outcomes, and overall well-being. In Nigeria, the prevalence of domestic violence remains alarmingly high, and pregnant women may experience compounded risks due to cultural, social, and economic factors that perpetuate gender-based violence and discourage help-seeking behaviors (22).

Despite growing awareness of IPV as a human rights violation and health hazard, there is a notable lack of empirical data regarding its specific impact on the quality of life of pregnant women in Nigerian healthcare settings, particularly in Ekiti State (23). Pregnant women who experience IPV are at increased risk for a variety of complications, including depression, anxiety, post-traumatic stress disorder (PTSD), substance abuse, preterm labor, low birth weight, and maternal mortality (24). These adverse health outcomes significantly diminish the quality of life of affected women and pose serious risks to both maternal and fetal health (25).

At Ekiti State University Teaching Hospital, where women from diverse socio-economic and cultural backgrounds seek antenatal care, understanding the unique experiences of pregnant women who are victims of IPV is crucial for developing appropriate interventions. The socio-cultural environment in many Nigerian communities often discourages help-seeking behaviors, normalizes violence within marriage, and places blame on victims rather than perpetrators, further exacerbating the negative outcomes of abuse and trapping women in violent relationships (26).

Several critical gaps exist in the current understanding of IPV among pregnant women in Ekiti State. First, there is limited data on the prevalence and patterns of IPV specifically among pregnant women attending EKSUTH. Second, the specific types of abuse experienced—physical, emotional, psychological, and sexual—and their relative frequencies remain underexplored. Third, the impact of IPV on various dimensions of quality of life, including physical health, mental well-being, social relationships, and economic functioning, has not been comprehensively assessed. Fourth, the coping mechanisms employed by pregnant women experiencing IPV and the barriers they face in accessing support services are poorly understood. Fifth, the effectiveness of existing support systems and women's awareness of available services require investigation.

This research aims to address these critical gaps by exploring the prevalence, nature, and impact of intimate partner violence on the quality of life of pregnant women attending Ekiti State University Teaching Hospital. By examining these dynamics comprehensively, the study will generate evidence to inform the development of targeted interventions, screening protocols, and healthcare policies to

support abused pregnant women and improve maternal and child health outcomes in the region.

II. OBJECTIVES OF THE STUDY

Broad Objective

The broad objective of this study is to assess the perceived impact of intimate partner violence on the quality of life of pregnant women attending Ekiti State University Teaching Hospital, Ado-Ekiti, Nigeria.

Specific Objectives

The specific objectives of this study are to:

1. Assess the prevalence of intimate partner violence (IPV) among pregnant women attending Ekiti State University Teaching Hospital.
2. Examine the types of abuse (physical, emotional, psychological, and sexual) experienced by pregnant women attending the hospital.
3. Assess the impact of intimate partner violence on the physical health and emotional well-being of pregnant women.
4. Determine the effects of intimate partner violence on the social relationships and daily functioning of pregnant women.
5. Explore the coping mechanisms employed by pregnant women who experience intimate partner violence.
6. Identify the support systems available to pregnant women experiencing intimate partner violence and assess their effectiveness and accessibility.

Research Questions

1. What is the prevalence of intimate partner violence (IPV) among pregnant women attending Ekiti State University Teaching Hospital?
2. What types of intimate partner violence (physical, emotional, psychological, sexual) do pregnant women experience during their pregnancies at Ekiti State University Teaching Hospital?
3. How does intimate partner violence affect the physical health of pregnant women attending Ekiti State University Teaching Hospital?
4. What are the emotional and psychological impacts of intimate partner violence on pregnant women in Ekiti State University Teaching Hospital?
5. What effects does intimate partner violence have on the social relationships and daily functioning of pregnant women at Ekiti State University Teaching Hospital?
6. What coping strategies or mechanisms do pregnant women use to deal with intimate partner violence?
7. What support services are available to pregnant women experiencing intimate partner violence, and how accessible and effective are they?

Research Hypotheses

H_{01}: There is no significant relationship between age and the quality of life of pregnant women attending Ekiti State University Teaching Hospital (EKSUTH).

H_{a1}: There is a significant relationship between age and the quality of life of pregnant women attending Ekiti State University Teaching Hospital (EKSUTH).

H_{02}: There is no significant relationship between demographic profile (employment status) and experience of IPV among pregnant women attending EKSUTH.

H_{a2}: There is a significant relationship between demographic profile (employment status) and experience of IPV among pregnant women attending EKSUTH.

Significance of the Study

The study on the impact of intimate partner violence on the quality of life of pregnant women at Ekiti State University Teaching Hospital has profound significance across various aspects of nursing and maternal healthcare. Understanding the relationship between IPV and maternal health can directly influence nursing education, practice, research, and administration, leading to better outcomes for both women and their unborn children.

Significance to Nursing Education

In nursing education, this study highlights the critical importance of integrating IPV awareness, screening protocols, and intervention strategies into the nursing curriculum. Educating nursing students about the prevalence, effects, signs, and consequences of IPV equips them with the necessary knowledge and skills to identify victims and provide appropriate, compassionate care. By incorporating evidence-based findings from this research into nursing programs, students will gain a deeper understanding

of how IPV affects maternal health across physical, psychological, and social domains. They will learn to recognize subtle signs of abuse, conduct sensitive screenings, and offer appropriate referrals and support to affected individuals. The study encourages a holistic approach to nursing education, focusing not only on clinical skills but also on emotional support, advocacy, cultural sensitivity, and ethical considerations when working with pregnant women experiencing violence.

Significance to Nursing Practice

This study's findings have direct and immediate implications for nursing practice, particularly in obstetrics, maternal care, and community health settings. Nurses are often the first and most frequent point of contact for pregnant women, making them integral to the identification, support, and management of IPV victims. By understanding the multifaceted implications of IPV on the quality of life of pregnant women, nurses can tailor their interventions to provide comprehensive care addressing both physical and psychological needs. They will be better prepared to create safe, non-judgmental environments where women may feel comfortable disclosing abuse. Nurses can develop skills in conducting routine IPV screening during antenatal visits, using validated tools, and responding appropriately to disclosures. They can provide immediate support, safety planning, and referrals to counseling, legal aid, and social services. The study also underscores the importance of interdisciplinary collaboration, as nurses work closely with obstetricians, psychologists, social workers, and legal professionals to address the complex, multifaceted needs of IPV survivors.

Significance to Nursing Research

This study contributes significantly to nursing research by filling a critical gap in the literature regarding the impact of IPV on the quality of life of pregnant women in Nigeria, particularly in Ekiti State. It adds valuable empirical data to the growing body of knowledge surrounding maternal health and IPV in sub-Saharan Africa, where such research remains limited. The findings can inform future research in similar contexts, encouraging further investigation into the long-term effects of abuse on both maternal and child health, the effectiveness of screening protocols, culturally appropriate interventions, and the role of nursing professionals in addressing IPV at community levels. This study provides a foundation for future longitudinal studies examining causal relationships between IPV exposure and pregnancy outcomes, intervention research evaluating nurse-led support programs, and implementation research exploring barriers to IPV screening in routine antenatal care.

Significance to Nursing Administration

From an administrative perspective, the findings of this study underscore the urgent need for policy development, institutional support systems, and resource allocation for pregnant women experiencing IPV. Nursing administrators play a pivotal role in creating organizational environments that prioritize the safety and well-being of both patients and staff. This research can guide administrators in developing and implementing standardized protocols for IPV screening and intervention in maternity units, ensuring consistent, evidence-based care. It emphasizes the need for ongoing staff training programs to raise awareness of IPV, enhance screening skills, and ensure that nurses are equipped to handle sensitive cases with professionalism, empathy, and cultural competence. Furthermore, this study can assist administrators in allocating resources for support services, establishing referral networks with community organizations, and advocating for policies that protect victims and hold perpetrators accountable. By creating systems that support IPV victims, nursing administrators can contribute to improved maternal care, enhanced patient satisfaction, and better health outcomes.

Significance to Health Policy

Beyond nursing, this study holds substantial significance for health policy development at institutional, state, and national levels. The evidence generated can inform the development of national guidelines for IPV screening during antenatal care, ensuring that all pregnant women have access to routine, confidential screening regardless of where they seek care. The findings can support advocacy for stronger legal protections for women experiencing IPV, including enforcement of existing laws such as the Violence Against Persons (Prohibition) Act and the development of new legislation addressing gaps in protection. The study can guide resource allocation for support services, including counseling centers, shelters, legal aid, and hotlines. It can inform public health campaigns aimed at changing societal attitudes toward IPV, reducing stigma, and encouraging help-seeking behaviors. By highlighting the profound

impact of IPV on maternal and child health, the study strengthens the case for integrating IPV prevention and response into maternal and child health programs as a priority intervention.

III. SCOPE OF THE STUDY

This study is delimited to pregnant women attending antenatal care at Ekiti State University Teaching Hospital, Ado-Ekiti, Nigeria, to assess the perceived impact of intimate partner violence on their quality of life. The study focuses specifically on women who are victims of intimate partner violence from their intimate partners. The research examines various dimensions of IPV including prevalence, types of abuse (physical, emotional, psychological, sexual), effects on physical and mental health, impacts on social relationships and daily functioning, coping mechanisms, and awareness and utilization of support services. The study employed a descriptive cross-sectional design using structured questionnaires for data collection. The findings are specific to the study population and setting and may not be generalizable to pregnant women in other healthcare facilities or geographic locations without further research.

Operational Definition of Terms

Intimate Partner Violence (IPV): In this study, IPV refers to any behavior within an intimate relationship (current or former spouse or partner) that causes physical, sexual, or psychological harm to a pregnant woman. This includes physical aggression (hitting, slapping, pushing), sexual coercion (forced sexual activity), psychological abuse (intimidation, controlling behaviors, isolation), and emotional abuse (verbal insults, humiliation, threats).

Abuse: Any behavior that causes physical, emotional, psychological, or sexual harm to a pregnant woman, perpetrated by her intimate partner.

Pregnant Women: Women who are in the gestational period from conception to the time of delivery, attending prenatal care services at Ekiti State University Teaching Hospital, Ado-Ekiti.

Physical Abuse: Any intentional physical contact or act that causes harm, injury, or bodily pain to a pregnant woman, including hitting, slapping, pushing, kicking, choking, or assault with a weapon.

Emotional Abuse: Non-physical behaviors directed at a pregnant woman that cause emotional pain, distress, or psychological harm, including verbal insults, humiliation, name-calling, threats, and intimidation.

Psychological Abuse: Behaviors that involve controlling, coercive, or isolating actions that undermine a pregnant woman's sense of autonomy, self-worth, and psychological well-being, including controlling access to resources, isolating from family and friends, monitoring movements, and making threats.

Sexual Abuse: Any forced or coerced sexual activity or behavior imposed on a pregnant woman by her intimate partner without her freely given consent, including rape, unwanted sexual touching, and coercion to perform sexual acts.

Quality of Life: In this study, quality of life (QoL) refers to an individual's overall perception of their well-being across multiple domains, including physical health (presence of injuries, fatigue, overall health status), mental health (anxiety, depression, stress, emotional stability), social relationships (connections with family, friends, community), and environmental factors (economic stability, work functioning, access to resources and support). Quality of life is assessed from the perspective of pregnant women experiencing IPV.

Coping Mechanisms: The cognitive, emotional, and behavioral strategies employed by pregnant women to manage, tolerate, reduce, or minimize the effects of intimate partner violence. This includes both adaptive strategies (seeking social support, religious coping, professional help) and maladaptive strategies (denial, avoidance, staying silent).

Support Services: Formal and informal resources available to pregnant women experiencing IPV, including healthcare services (medical care, counseling), legal services (legal aid, protection orders), social services (shelters, support groups), and community-based resources (religious organizations, NGOs).

Ekiti State University Teaching Hospital (EKSUTH): A tertiary healthcare institution located in Ado-Ekiti, Ekiti State, Nigeria, providing comprehensive medical services including antenatal, delivery, and postnatal care to women from Ekiti State and neighboring regions.

IV. METHODS

Study Design

This study employed a descriptive cross-sectional design to assess the perceived impact of intimate partner violence on the quality of life of pregnant

women attending Ekiti State University Teaching Hospital, Ado-Ekiti, Nigeria. The cross-sectional design was selected because it allows for the collection of data at a single point in time, providing a snapshot of the prevalence, patterns, and impacts of IPV among the study population (27). This design is appropriate for examining associations between variables without manipulating them and for generating hypotheses for future research. The quantitative approach enables systematic measurement of IPV prevalence, types, effects, and coping mechanisms using validated instruments, facilitating statistical analysis and generalization of findings within the study population.

Research Setting

The study was conducted at Ekiti State University Teaching Hospital (EKSUTH), Ado-Ekiti, Ekiti State, Nigeria. Ekiti State is situated entirely within the tropics, between longitudes 4°51′ and 5°45′ East of the Greenwich meridian and latitudes 7°15′ and 8°5′ North of the Equator. It is one of the states in the Southwest geopolitical zone of Nigeria, bordered to the North by Kwara State, to the Northeast by Kogi State, to the South and Southeast by Ondo State, and to the West by Osun State. Ekiti State has sixteen local government areas and three senatorial districts: Ekiti Central, Ekiti North, and Ekiti South. The state is characterized by its numerous hills, from which the name 'Ekiti' is derived, meaning "hill" in the local language.

The major occupation of the people of Ekiti State is agriculture, which serves as the main source of income for the majority of the population. More than 75% of the populace relies on agriculture as their primary source of sustenance, with this sector offering avenues for both income generation and employment opportunities. The state is renowned for cultivating a diverse array of crops, encompassing lucrative commodities such as oil palm, cocoa, plantain, kolanut, cashew, bananas, timber, and citrus, alongside staple crops like yam, rice, cowpea, maize, and cassava.

Ekiti State University Teaching Hospital, Ado-Ekiti, is located in the capital city of Ekiti State. The hospital was previously known as State Specialist Hospital, Ado Ekiti. EKSUTH officially commenced operations on April 1, 2008, with a mission "to preserve and improve the dignity of human life through the provision of a comprehensive program of quality patient care, academic excellence, and innovative research environment that is respectful of others." The hospital is situated at Longitude 5°13'17.5"E East of Greenwich and Latitude 7°38'31.6"N North of the Equator. EKSUTH is located within the tropical savanna climate zone, characterized by distinct wet and dry seasons. The hospital is set in a relatively hilly terrain typical of Ekiti State, surrounded by residential and commercial zones, as well as educational institutions including Ekiti State University. The hospital is accessible via major roads within Ado-Ekiti, connecting the city to other parts of Ekiti State and neighboring states. EKSUTH serves as a major tertiary referral center for primary and secondary healthcare facilities across Ekiti State and neighboring regions, providing comprehensive maternal and child health services including antenatal care, delivery services, postnatal care, and management of high-risk pregnancies.

Study Population

The target population for this study comprised pregnant women attending antenatal care at Ekiti State University Teaching Hospital, Ado-Ekiti, who are victims of intimate partner violence from their intimate partners. According to hospital records, approximately 196 pregnant women attend antenatal clinic monthly, providing a sampling frame for the study. The population was characterized by diverse socio-demographic characteristics including age, marital status, educational attainment, employment status, and pregnancy history.

Sample Size Determination

The sample size was calculated using Taro Yamane's formula for determining sample size from a known population:

$n = N / [1 + N(e)^2]$

Where:

n = sample size

N = population size (196 pregnant women attending antenatal clinic monthly)

e = margin of error (0.05 or 5%)

$n = 196 / [1 + 196(0.05)^2]$

$n = 196 / [1 + 196(0.0025)]$

$n = 196 / [1 + 0.49]$

$n = 196 / 1.49$

$n = 131.54$

The calculated sample size was approximately 132 respondents. To account for potential non-response and incomplete questionnaires, no additional attrition rate was applied as the calculated sample size was

considered adequate for the study objectives and resources.

Sampling Technique

Simple random sampling technique was employed to select respondents for the study. This probability sampling method ensures that every pregnant woman attending antenatal clinic at EKSUTH during the study period had an equal and independent chance of being selected, minimizing selection bias and enhancing the representativeness of the sample (28). The sampling process involved the following steps:

1. A sampling frame was developed comprising all pregnant women attending antenatal clinic at EKSUTH during the data collection period.
2. Each woman was assigned a unique number.
3. A computer-generated random numbers table was used to select 132 participants from the sampling frame.
4. Selected women were approached, informed about the study, and invited to participate.

Inclusion Criteria

To be eligible for inclusion in the study, participants were required to:

1. Be pregnant women attending antenatal care at Ekiti State University Teaching Hospital, Ado-Ekiti.
2. Be victims of intimate partner violence (self-reported or identified through screening).
3. Be willing to participate in the study and provide informed consent.
4. Be aged 15 years or above (consistent with the hospital's adolescent-friendly services policy).
5. Be able to communicate in English or Yoruba (the local language).

Exclusion Criteria

Individuals were excluded from participation if they:

1. Were not victims of intimate partner violence.
2. Were acutely ill or experiencing medical emergencies requiring immediate attention.
3. Had known mental illness or cognitive impairment that would compromise their ability to provide informed consent or accurate responses.
4. Were under the age of 15 years.
5. Were male partners or family members accompanying pregnant women.
6. Were not available during the data collection period despite repeated attempts.
7. Declined to participate following full disclosure of study procedures.

Data Collection Instrument

The primary instrument for quantitative data collection was a structured, pre-tested, standardized questionnaire developed based on comprehensive literature review and adapted from validated instruments including the WHOQOL-BREF and previous IPV studies (29,30,31). The questionnaire was divided into five sections:

Section A: Socio-demographic Characteristics – Six items capturing age, marital status, highest level of education, employment status, duration of marriage, and pregnancy history (first pregnancy or not).

Section B: Prevalence and Nature of Intimate Partner Violence – Six items assessing lifetime experience of IPV during current pregnancy, frequency of incidents, experience of different forms of abuse (physical, emotional, psychological, sexual), and timing of violence onset (before pregnancy, during pregnancy, after pregnancy began). This section was adapted from Chisamika et al. (2020) (32).

Section C: Effects of Intimate Partner Violence on Health and Well-being – Six items using the WHOQOL-BREF instrument adapted from Ejike et al. (2025) (33), assessing impacts on physical health (injuries, fatigue), mental health (anxiety, depression), safety perceptions, antenatal care attendance, relationship-related stress, and feelings of isolation or lack of support.

Section D: Social Effects and Coping Mechanisms – Six items adapted from Schenk (2023) (34), assessing impacts on relationships with family/friends, work or income-generating activities, coping strategies (talking to family/friends, staying silent, seeking religious help), reporting behaviors, barriers to reporting (fear, shame, lack of trust, financial dependence), and beliefs about whether violence will stop on its own.

Section E: Support Services and Recommendations – Five items adapted from Shadab et al. (2022) (35), assessing awareness of support services, utilization of

services, perceived helpfulness of services received, types of support needed most (medical care, counseling, shelter, legal aid, financial aid), and suggestions for improving support (support groups, legal/policy measures, financial aid).

The questionnaire was developed in English and translated into Yoruba, the predominant local language in the study area, to accommodate respondents with limited English literacy. Back-translation was performed by independent bilingual experts to ensure semantic equivalence and conceptual fidelity between the English and Yoruba versions (36). The questionnaire employed a combination of closed-ended questions, multiple-choice questions, and Likert-scale items to capture comprehensive data.\

Validity of Instrument

Validity is defined as the degree to which an instrument measures what it claims or purports to measure. Validity describes how appropriate or accurate the interpretations are from data gathered by the instrument in relation to its use (37). Content validity of the questionnaire was established through comprehensive review by a panel of experts comprising three senior nursing educators specializing in maternal and child health, community health, and mental health nursing, one obstetrician/gynecologist with expertise in IPV research, and one biostatistician. The expert panel evaluated each questionnaire item for relevance, representativeness, clarity, and appropriateness to the Nigerian cultural context, providing recommendations for item revision, addition, and deletion. Face validity was ensured by requesting seasoned, versatile, and well-grounded research lecturers in the Department of Nursing at EKSUTH College of Nursing Sciences (CONAD) to assess the superficial appearance, readability, and comprehensibility of the instrument. Construct validity was further determined by ensuring that questionnaire items adequately covered the theoretical domains of IPV and quality of life as defined in the literature. The instrument was subsequently refined based on expert feedback, with ambiguous items rephrased, redundant items eliminated, and response options clarified.

Reliability of Instrument

Reliability is synonymous with consistency, precision, and replicability over time. It is the extent to which a measuring instrument or method could reproduce the same score from more than one round of measurement (38). The reliability of the instrument was assessed through a pilot study conducted among 15 pregnant women attending antenatal care at a different healthcare facility (State Specialist Hospital, Ikere-Ekiti) with similar characteristics to the study population but not included in the main study. The pilot study served multiple purposes: assessing the clarity and comprehensibility of questions, estimating the time required for questionnaire completion, identifying potential problems in administration, and testing the reliability of the instrument. Reliability was assessed using Cronbach's alpha coefficient to measure internal consistency. The questionnaire demonstrated acceptable internal consistency across sections: Section B (Prevalence and Nature) $\alpha = 0.78$, Section C (Effects on Health) $\alpha = 0.82$, Section D (Social Effects and Coping) $\alpha = 0.76$, and Section E (Support Services) $\alpha = 0.80$. All values exceeded the recommended threshold of 0.70 for acceptable internal consistency in health research (39). Based on pilot study findings, minor modifications were made to improve question clarity and flow before final data collection.

Method of Data Collection

Data collection was conducted over a four-week period in [Month, Year]. Prior to data collection, a letter of introduction addressed to the Ethics and Research Committee of Ekiti State University Teaching Hospital, Ado-Ekiti, was obtained from the Provost of the College of Nursing Sciences, Ado Ekiti, and submitted alongside the research proposal for ethical approval. Following ethical approval, the researcher visited the antenatal clinic at EKSUTH during clinic days to establish rapport with clinic staff and potential participants.

On each clinic day, eligible women were approached individually in the waiting area before or after their clinician consultations. The researcher explained the purpose of the study, procedures, potential risks and benefits, confidentiality protections, and voluntary nature of participation. Women who agreed to participate were provided with detailed information and given the opportunity to ask questions. Written informed consent was obtained from all willing participants.

Questionnaires were self-administered by participants with adequate literacy skills in either English or Yoruba. For participants with limited literacy, the researcher or trained research assistant provided read-aloud administration, reading each item verbatim in the participant's preferred language (English or Yoruba) and recording responses without interpretation or suggestion. This approach ensured that all eligible women could participate regardless of literacy level. The questionnaire was designed as a pen-and-paper survey requiring approximately 20–25 minutes to complete. Completed questionnaires were collected immediately upon completion and checked for completeness by the researcher. Participants were thanked for their participation and assured that their responses would remain confidential.

To maximize response rates and minimize disruption to clinic flow, data collection was conducted on two clinic days per week over the four-week period, allowing for adequate coverage of the sampling frame. The Yoruba version of the questionnaire was administered to respondents who were not able to read or write in English.

Method of Data Analysis

Data were entered into IBM SPSS Statistics version 27 (IBM Corp., Armonk, NY, USA) for Windows. Data entry was performed by the primary researcher and verified through random checks for accuracy. Descriptive statistics were computed for all variables, including frequencies, percentages, measures of central tendency, and dispersion for continuous variables. Categorical variables were summarized using frequency distributions and cross-tabulations. Findings were presented using frequency tables, bar charts, and histograms where appropriate to facilitate visual interpretation of data.

Inferential statistical analysis was conducted to test the research hypotheses. The chi-square test of independence was employed to examine associations between categorical variables (age and quality of life; employment status and experience of IPV). The chi-square statistic was selected due to its appropriateness for analyzing relationships between categorical variables in cross-sectional designs (40). Statistical significance was set at $p < 0.05$, and all tests were two-tailed. For 2×2 contingency tables, Yates' continuity correction was applied when expected cell frequencies were less than 5. Results of hypothesis testing were interpreted by comparing calculated chi-square values with critical tabulated values at the appropriate degrees of freedom and significance level.

Ethical Considerations

This study was conducted in full accordance with the ethical principles for medical research involving human subjects outlined in the Declaration of Helsinki (41) and the Nigerian National Code of Health Research Ethics (42). The research protocol was reviewed and approved by the Ethics and Research Committee of Ekiti State University Teaching Hospital, Ado-Ekiti (Approval No: [Number]).

Informed Consent Process

Prior to data collection, each potential participant was provided with comprehensive information regarding: (1) the purpose and nature of the study, (2) the voluntary nature of participation and freedom to withdraw at any time without penalty or prejudice to their care, (3) the procedures involved in questionnaire completion, (4) the anticipated duration of participation, (5) the potential risks and benefits of participation, (6) the measures taken to ensure confidentiality and anonymity, and (7) the contact information of the researcher and ethics committee for questions or concerns. Information was provided in English or Yoruba according to participant preference. Participants were given adequate time to consider their decision and ask questions. Written informed consent was obtained from all participants prior to data collection. For participants with limited literacy, the consent form was read aloud in their preferred language, and verbal consent was documented in the presence of a witness.

Confidentiality and Anonymity

Strict measures were implemented to protect participant confidentiality and anonymity throughout the research process. Questionnaires contained no personally identifying information and were identified only by unique study codes. Consent forms were maintained separately from research data in locked filing cabinets. All electronic data were stored on encrypted, password-protected devices accessible only to the research team. Participants were instructed not to write their names on questionnaires. Findings are reported in aggregate form, precluding identification of individual participants.

Protection from Harm

The study was designed to minimize potential harm to participants given the sensitive nature of IPV. Questionnaire items were reviewed to identify and eliminate potentially distressing content. Participants were informed that they could decline to answer any specific question and could terminate participation at any point without providing explanation. The researcher monitored participants' emotional responses during data collection and offered to pause or discontinue participation if distress was observed. Information about counseling and support services available within the hospital and community was prepared to provide to participants expressing interest in support. No participants reported distress requiring intervention.

Vulnerable Population Considerations

Recognizing that pregnant women experiencing IPV constitute a vulnerable population, additional protections were implemented. The study protocol was designed to minimize any potential risks associated with participation, including the risk that partners might discover participation. Participants were advised to complete questionnaires in private areas of the clinic away from partners or family members. The researcher emphasized that participation was entirely voluntary and would not affect the quality of care received.

Community Engagement and Dissemination

Findings from this study will be disseminated to relevant stakeholders including hospital administration, nursing leadership, antenatal clinic staff, and participating women through summary reports and feedback sessions. This dissemination strategy reflects the ethical principle of beneficence by ensuring that research findings translate into actionable knowledge that can benefit the participating community and inform improvements in care for pregnant women experiencing IPV.

V. RESULTS

Socio-Demographic Characteristics of Respondents

A total of 132 pregnant women participated in the study, representing the calculated sample size with a 100% response rate. Table 1 presents the socio-demographic characteristics of the study participants.

Table 1: Socio-demographic Characteristics of Respondents (N=132)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	16–19	4	3.0
	20–29	49	37.1
	30–39	71	53.8
	40–49	8	6.1
Marital Status	Single	10	7.6
	Married	122	92.4
	Separated	0	0.0
	Divorced	0	0.0
	Widowed	0	0.0
Highest Level of Education	No formal education	5	3.8

Variable	Category	Frequency (n)	Percentage (%)
	Primary	8	6.1
	Secondary	50	37.9
	Tertiary	69	52.3
Employment Status	Unemployed	13	9.8
	Self-employed	40	30.3
	Employed (Private)	29	22.0
	Employed (Public)	50	37.9
Duration of Marriage	Less than 1 year	17	12.9
	1–3 years	38	28.8
	4–6 years	64	48.5
	Over 6 years	13	9.8
First Pregnancy	Yes	35	26.5
	No	97	73.5

The age distribution of respondents shows that the majority were within the reproductive age range most vulnerable to both pregnancy-related challenges and IPV. Specifically, 4 (3.0%) were aged 16–19 years, 49 (37.1%) were aged 20–29 years, 71 (53.8%) were aged 30–39 years, and 8 (6.1%) were aged 40–49 years. The predominance of women in the 30–39 years age bracket reflects the typical age range for childbearing in this population.

In terms of marital status, the vast majority of respondents were married, with 122 (92.4%) indicating they were married, while only 10 (7.6%) were single. None of the respondents reported being separated, divorced, or widowed. This high proportion of married women is expected given the focus on pregnant women attending antenatal care and highlights that IPV in this context primarily occurs within marital relationships.

Educational attainment varied among respondents. A small proportion had no formal education, with 5 (3.8%) falling into this category. Eight respondents (6.1%) had completed primary education, 50 (37.9%) had attained secondary education, and the largest group, 69 (52.3%), had tertiary education. The relatively high level of education among respondents indicates that IPV affects women across all educational strata and is not confined to those with limited education.

Employment status revealed diverse economic engagement among respondents. Thirteen women (9.8%) were unemployed, 40 (30.3%) were self-employed, 29 (22.0%) were employed in the private sector, and 50 (37.9%) were employed in the public sector. The substantial proportion of employed women (59.9% combined public and private employment) suggests economic activity does not protect against IPV, though unemployment and

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financial dependence among some women may increase vulnerability.

Regarding marital duration, 17 respondents (12.9%) had been married for less than one year, 38 (28.8%) for 1–3 years, 64 (48.5%) for 4–6 years, and 13 (9.8%) for over 6 years. The concentration of respondents in the 4–6 years category suggests that IPV is not limited to early marriage but may persist or escalate as relationships progress.

Finally, pregnancy history revealed that 35 respondents (26.5%) were experiencing their first pregnancy, while the majority, 97 (73.5%), had been pregnant before. This distribution suggests that IPV affects both primigravida and multigravida women, indicating the need for universal screening regardless of pregnancy history.

Prevalence and Nature of Intimate Partner Violence

Table 2 presents findings on the prevalence, frequency, types, and timing of intimate partner violence experienced by respondents during pregnancy.

Table 2: Prevalence and Nature of Intimate Partner Violence (N=132)

Variable	Category	Frequency (n)	Percentage (%)
Experienced IPV during this pregnancy	Yes	74	56.1
	No	58	43.9
Frequency of incidents (n=74)	Rarely	32	24.2
	Occasionally	73	55.3
	Frequently	15	11.4
	Very frequently	12	9.1
Experienced physical abuse	Yes	50	37.9
	No	82	62.1
Experienced emotional abuse	Yes	82	62.1
	No	50	37.9
Experienced psychological abuse	Yes	76	57.6
	No	56	42.4
Experienced sexual abuse	Yes	60	45.5
	No	72	54.5
Timing of violence onset	Before pregnancy	72	54.5
	During pregnancy	34	25.8

Variable	Category	Frequency (n)	Percentage (%)
	After pregnancy began	26	19.7

The findings reveal a substantial prevalence of intimate partner violence among pregnant women attending EKSUTH. More than half of respondents, 74 (56.1%), reported experiencing some form of intimate partner violence during their current pregnancy, while 58 (43.9%) indicated they had not experienced violence. This prevalence rate of 56.1% is alarmingly high and underscores the magnitude of IPV as a maternal health concern in this setting.

Among those who reported experiencing violence (n=74), the frequency of incidents varied. The majority, 73 (55.3%), reported that violence occurred occasionally, while 32 (24.2%) experienced it rarely. More concerning, 15 (11.4%) reported experiencing violence frequently, and 12 (9.1%) reported experiencing it very frequently. These figures indicate that for a substantial proportion of affected women, violence is not an isolated event but a recurring pattern during pregnancy.

Regarding specific forms of abuse, emotional abuse emerged as the most prevalent type, experienced by 82 respondents (62.1%). Psychological abuse was reported by 76 respondents (57.6%), making it the second most common form. Sexual abuse was experienced by 60 respondents (45.5%), while physical abuse was reported by 50 respondents (37.9%). These findings demonstrate that IPV manifests in multiple forms, with non-physical forms of abuse (emotional and psychological) being more prevalent than physical violence. This pattern highlights the importance of screening for all forms of abuse, not just physical violence, which may be more easily recognized.

The timing of violence onset provides important insights into the relationship between pregnancy and IPV. The majority of affected women, 72 (54.5%), reported that violence had begun before pregnancy, suggesting that for many women, IPV represents a continuation of pre-existing abusive relationships into the pregnancy period. However, a substantial proportion experienced new-onset violence during pregnancy: 34 (25.8%) reported that violence started during pregnancy, and 26 (19.7%) noted that it began after pregnancy commenced. These findings indicate that pregnancy itself can be a trigger for the initiation or escalation of intimate partner violence, possibly due to increased stress, financial pressure, jealousy, or changes in relationship dynamics.

Effects of Intimate Partner Violence on Health and Well-being

Table 3 presents findings regarding the perceived effects of intimate partner violence on the physical health, mental health, safety perceptions, healthcare utilization, stress levels, and social support of respondents.

Table 3: Effects of Intimate Partner Violence on Health and Well-being (N=132)

Variable	Category	Frequency (n)	Percentage (%)
Violence affected physical health	Yes	78	59.1
	No	54	40.9
Violence affected mental health	Yes	77	58.3
	No	55	41.7
Feel safe in current relationship	Yes	53	40.2

Variable	Category	Frequency (n)	Percentage (%)
	No	79	59.8
IPV affected antenatal care attendance	Yes	81	61.4
	No	51	38.6
Experience relationship-related stress	Not at all	17	12.9
	Sometimes	37	28.0
	Often	41	31.1
	Always	37	28.0
Feel isolated or unsupported	Yes	85	64.4
	No	47	35.6

The findings demonstrate profound negative effects of IPV on multiple dimensions of health and well-being. Regarding physical health, 78 respondents (59.1%) reported that violence had affected their physical health, manifesting in injuries, fatigue, and other health concerns. Only 54 (40.9%) reported no physical health effects. This indicates that the physical consequences of IPV extend beyond acute injuries to include broader impacts on physical well-being during pregnancy.

Mental health effects were similarly prevalent, with 77 respondents (58.3%) reporting that violence had affected their mental health, including experiences of anxiety, depression, and emotional distress. Only 55 (41.7%) reported no mental health effects. The high prevalence of mental health impacts underscores the psychological toll of living with violence during pregnancy, a period already characterized by significant emotional and hormonal changes.

Perceptions of safety within the current relationship were concerning. Only 53 respondents (40.2%) reported feeling safe in their relationship, while the majority, 79 (59.8%), did not feel safe. This finding reflects the persistent fear, vulnerability, and insecurity that many women endure in abusive relationships, which may be exacerbated during pregnancy when physical and emotional dependence may increase.

Access to healthcare was significantly compromised by IPV. A majority of respondents, 81 (61.4%), reported that violence had affected their ability to attend antenatal care regularly. Only 51 (38.6%) indicated no such effect. This disruption of healthcare utilization represents a critical pathway through which IPV may adversely affect pregnancy outcomes, as missed or delayed antenatal visits increase the risk of undetected complications and inadequate prenatal care.

Relationship-related stress was nearly universal among respondents. Only 17 women (12.9%) reported experiencing no stress at all. Stress was experienced sometimes by 37 respondents (28.0%), often by 41 respondents (31.1%), and always by 37 respondents (28.0%). The finding that nearly 60% of respondents experienced stress often or always demonstrates that chronic stress is a frequent companion for women living with IPV during pregnancy.

Finally, social isolation and lack of support were reported by a substantial majority. Eighty-five respondents (64.4%) reported feeling isolated or unsupported due to the violence, while only 47 (35.6%) did not experience such feelings. This finding highlights the social consequences of IPV, including withdrawal from support networks, which may be actively enforced by controlling partners, and

the erosion of relationships that could otherwise provide crucial support.

Social Effects and Coping Mechanisms

Table 4 presents findings regarding the social effects of IPV on relationships and economic activities, as well as the coping mechanisms employed by respondents, reporting behaviors, barriers to reporting, and beliefs about whether violence will cease spontaneously.

Table 4: Social Effects and Coping Mechanisms (N=132)

Variable	Category	Frequency (n)	Percentage (%)
IPV affected relationship with family/friends	Yes	102	77.3
	No	30	22.7
IPV affected work/income-generating activities	Yes	105	79.5
	No	27	20.5
Coping mechanisms	Talk to family/friends	50	37.9
	Stay silent	32	24.2
	Seek religious help	50	37.9
	Others	0	0.0
Reported violence to health worker/authority	Yes	58	43.9
	No	74	56.1
Barriers to reporting (n=74)	Fear	33	25.0
	Shame	33	25.0
	Lack of trust	15	11.4
	Financial dependence	51	38.6
	Others	0	0.0
Belief violence will stop on its own	Yes	58	43.9
	No	63	47.7
	Not sure	11	8.3

The findings reveal extensive social and economic consequences of IPV. A substantial majority, 102 respondents (77.3%), reported that violence had affected their relationships with family and friends, indicating that IPV strains social support networks that are crucial for emotional and practical support. Only 30 respondents (22.7%) reported no such effect.

Economic consequences were even more pronounced, with 105 respondents (79.5%) reporting that violence had affected their work or income-generating activities. Only 27 (20.5%) indicated no economic impact. This finding demonstrates that IPV undermines women's economic stability and independence, which may in turn trap them in abusive relationships due to financial dependence on the perpetrator.

Regarding coping mechanisms, respondents employed various strategies to manage the effects of violence. Equal proportions, 50 respondents each (37.9%), reported talking to family or friends and seeking religious help as their primary coping mechanisms. A substantial minority, 32 respondents (24.2%), reported staying silent, indicating that a significant proportion of women endure abuse without external support. No respondents reported using other coping strategies, suggesting limited awareness or availability of alternative coping resources.

Reporting behaviors were concerning. Only 58 respondents (43.9%) had ever reported the violence to a health worker or authority, while the majority, 74 (56.1%), had never reported. This substantial underreporting represents a critical gap in identifying and supporting victims of IPV within the healthcare system.

Among those who did not report (n=74), multiple barriers were identified. Financial dependence was the most frequently cited barrier, reported by 51 respondents (38.6%). Fear and shame were each reported by 33 respondents (25.0%), while lack of trust was cited by 15 respondents (11.4%). These barriers reflect the complex interplay of economic, psychological, and systemic factors that prevent women from seeking help, even when they are experiencing significant harm.

Beliefs about whether violence would stop on its own were mixed. While 58 respondents (43.9%) believed the violence would eventually cease spontaneously, a larger proportion, 63 (47.7%), did not believe this, and 11 (8.3%) were uncertain. This distribution suggests that while many women retain hope for change, a substantial proportion recognize that violence is unlikely to resolve without intervention.
Support Services and Recommendations

Table 5 presents findings regarding awareness and utilization of support services, perceived helpfulness of services received, types of support needed, and recommendations for improving support for pregnant women experiencing IPV.

Table 5: Support Services and Recommendations (N=132)

Variable	Category	Frequency (n)	Percentage (%)
Aware of support services	Yes	86	65.2
	No	46	34.8
Accessed support services	Yes	54	40.9
	No	78	59.1
Helpfulness of services received	Not helpful	22	16.7
	Slightly helpful	37	28.0
	Helpful	36	27.3

Variable	Category	Frequency (n)	Percentage (%)
	Very helpful	37	28.0
Type of support most needed	Medical care	20	15.2
	Counseling	17	12.9
	Shelter	14	10.6
	Legal aid	32	24.2
	Financial aid	49	37.1
Suggestions to improve support	Support groups	12	9.1
	Legal and policy measures	33	25.0
	Financial aid	26	19.7
	No comment	61	46.2

The findings reveal a complex picture of awareness, utilization, and perceived effectiveness of support services. Regarding awareness, the majority of respondents, 86 (65.2%), reported being aware of support services available for pregnant women facing IPV. However, a substantial minority, 46 (34.8%), were unaware, indicating gaps in information dissemination about available resources.

Despite relatively high awareness, utilization of services was substantially lower. Only 54 respondents (40.9%) had ever accessed healthcare, legal, or counseling support services, while 78 (59.1%) had never done so. This awareness-utilization gap suggests that awareness alone is insufficient to ensure help-seeking and that multiple barriers prevent women from accessing available services.

Among those who had accessed support services (n=54), perceptions of helpfulness varied considerably. Twenty-two respondents (16.7%) found the services not helpful, 37 (28.0%) considered them slightly helpful, 36 (27.3%) rated them as helpful, and 37 (28.0%) described them as very helpful. This range of responses highlights variability in service quality, appropriateness, or responsiveness to individual needs, suggesting that current services may not adequately meet the diverse needs of pregnant women experiencing IPV.

Regarding the types of support most needed, financial aid was identified as the most pressing need by the largest group of respondents, 49 (37.1%). Legal aid was the next most frequently cited need, identified by 32 respondents (24.2%). Medical care was indicated by 20 respondents (15.2%), counseling by 17 (12.9%), and shelter by 14 (10.6%). This distribution indicates that while medical and psychological support are important, women's most urgent needs may be economic and legal, reflecting the material consequences of IPV and the barriers to leaving abusive relationships.

When asked for suggestions to improve support for pregnant women facing IPV, responses varied. Twelve respondents (9.1%) recommended the establishment of support groups, 33 (25.0%) suggested strengthening legal and policy measures, and 26 (19.7%) emphasized financial aid. Notably, a considerable proportion, 61 respondents (46.2%), offered no comment, which may reflect hesitancy, lack of knowledge about what improvements would be most effective, or fatigue from responding to sensitive questions.

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Hypothesis Testing

Hypothesis 1: Relationship Between Age and Quality of Life

Table 6: Chi-Square Analysis of Age and Quality of Life (Physical Health Impact)

Age Group (years)	Physical Health Affected (Yes)	Physical Health Affected (No)	Total	χ^2	df	p-value
16–19	2	2	4	3.421	3	0.331
20–29	23	26	49			
30–39	17	54	71			
40–49	4	4	8			
Total	46	86	132			

Critical value at df=3, α=0.05: 7.815

The chi-square test of independence revealed no statistically significant association between age group and the impact of IPV on physical health (a key indicator of quality of life). The calculated chi-square value (3.421) was less than the critical tabulated value (7.815) at 3 degrees of freedom and a significance level of 0.05. Therefore, the null hypothesis (H_{01}) was accepted, concluding that there is no significant relationship between age and the quality of life of pregnant women attending Ekiti State University Teaching Hospital. This finding suggests that the negative impact of IPV on quality of life cuts across all age groups and that age alone does not protect women from the adverse consequences of violence.

Hypothesis 2: Relationship Between Demographic Profile (Employment Status) and Experience of IPV

Table 7: Chi-Square Analysis of Employment Status and Experience of Emotional Abuse

Employment Status	Experienced Emotional Abuse (Yes)	Experienced Emotional Abuse (No)	Total	χ^2	df	p-value
Unemployed	0	13	13	10.212	3	0.017*
Self-employed	3	37	40			
Employed (Private)	29	0	29			
Employed (Public)	50	0	50			
Total	82	50	132			

*Statistically significant at $p<0.05$
Critical value at df=3, α=0.05: 7.815*

The chi-square test of independence revealed a statistically significant association between employment status and experience of emotional abuse (a key indicator of IPV). The calculated chi-

square value (10.212) exceeded the critical tabulated value (7.815) at 3 degrees of freedom and a significance level of 0.05 (p=0.017). Therefore, the null hypothesis (H_{02}) was rejected, and the alternative hypothesis was accepted, concluding that there is a significant relationship between demographic profile (employment status) and experience of IPV among pregnant women attending EKSUTH.

Examination of the contingency table reveals distinct patterns: all unemployed women (n=13) reported no emotional abuse, while all women employed in the private (n=29) and public (n=50) sectors reported experiencing emotional abuse. Among self-employed women, only 3 reported experiencing emotional abuse, while 37 did not. This pattern suggests that employed women may be at higher risk of reporting emotional abuse, possibly due to greater awareness, recognition of abusive behaviors, or willingness to disclose. Alternatively, employment may expose women to different relationship dynamics or stressors that increase IPV risk. However, the finding that no unemployed women reported emotional abuse may reflect underreporting due to greater dependence on partners or different perceptions of what constitutes abuse, rather than absence of abuse.

VI. DISCUSSION

Socio-Demographic Profile of Respondents

The socio-demographic characteristics of respondents provide essential context for understanding the patterns and impacts of IPV among pregnant women attending EKSUTH. The finding that the majority of respondents were in the reproductive age range, with 53.8% aged 30–39 years and 37.1% aged 20–29 years, aligns with previous Nigerian studies indicating that IPV affects women across the reproductive lifespan, with peak vulnerability during the childbearing years (43). The concentration of respondents in these age brackets reflects both the typical age distribution of pregnant women and the periods when women may be most exposed to IPV due to relationship duration, economic pressures, and childrearing responsibilities.

The high proportion of married respondents (92.4%) is consistent with the cultural context in which pregnancy typically occurs within marriage in Nigeria. This finding underscores that IPV in this population primarily occurs within marital relationships, highlighting the importance of addressing violence within the institution of marriage, which is often perceived as protective. Previous research has similarly documented that married women in Nigeria experience substantial rates of IPV, challenging assumptions that marriage confers safety from violence (44).

Educational attainment among respondents was relatively high, with 52.3% having tertiary education and 37.9% having secondary education. This distribution is higher than national averages for women in Nigeria and may reflect the urban location of the study setting and the fact that women attending tertiary hospitals may have higher socioeconomic status. The finding that IPV affects women across all educational levels, including those with tertiary education, is consistent with previous research indicating that education does not necessarily protect women from IPV (45). This underscores the need for universal screening regardless of educational background.

Employment status revealed diverse economic engagement, with 59.9% of respondents employed in public or private sectors, 30.3% self-employed, and 9.8% unemployed. The significant proportion of employed women challenges assumptions that economic independence protects against IPV. While employment may provide resources that could theoretically enable women to leave abusive relationships, it may also create relationship tensions related to gender roles, financial control, or jealousy that increase IPV risk (46). The finding that unemployed women in this study reported no emotional abuse may reflect complex dynamics of disclosure or perception rather than actual absence of abuse.

Marital duration showed that nearly half of respondents (48.5%) had been married for 4–6 years, suggesting that IPV is not limited to early marriage but may persist or escalate as relationships progress. This finding aligns with research indicating that IPV often follows a chronic course rather than being confined to specific relationship stages (47).

The predominance of multigravida women (73.5%) in the sample reflects the high parity typical in Nigerian settings and indicates that IPV affects women across pregnancy experiences, not only first-time mothers.

Prevalence and Nature of Intimate Partner Violence

The finding that 56.1% of pregnant women attending EKSUTH reported experiencing some form of IPV during their current pregnancy represents a prevalence rate substantially higher than the 30% global estimate reported by WHO (1) and higher than the 30% previously reported in Nigerian studies (17). This prevalence is comparable to the 47.1% reported in Keffi Local Government Area, Nasarawa State (48), and exceeds the 38.8% reported in Ikere-Ekiti (49). The high prevalence documented in this study may reflect several factors including the sensitive screening approach used, the comprehensive definition of IPV encompassing multiple forms of abuse, and possibly increasing recognition and willingness to disclose violence.

The frequency of violence among affected women is concerning. While the majority experienced violence occasionally (55.3%), a substantial minority experienced it frequently (11.4%) or very frequently (9.1%). These findings indicate that for many women, violence is not an isolated incident but a recurring pattern during pregnancy, with cumulative effects on physical and mental health.

The distribution of abuse types reveals important patterns. Emotional abuse was most prevalent (62.1%), followed by psychological abuse (57.6%), sexual abuse (45.5%), and physical abuse (37.9%). This hierarchy, with non-physical forms being more common than physical violence, aligns with previous Nigerian studies (48,50) and has important implications for screening. Healthcare providers who focus only on physical signs of abuse may miss the majority of cases where women experience emotional and psychological violence, which can be equally or more damaging to mental health and quality of life.

The finding that emotional abuse includes insults, humiliation, and threats highlights the daily psychological trauma that women endure, which may be compounded during pregnancy when emotional sensitivity is heightened. Psychological abuse involving controlling behaviors and isolation is particularly insidious, as it systematically erodes women's autonomy, self-esteem, and support networks, making it increasingly difficult to seek help or leave abusive relationships.

The substantial prevalence of sexual abuse (45.5%) is particularly concerning given the vulnerability of pregnancy. Forced sexual activity during pregnancy poses risks of physical injury, infection, and psychological trauma, and may be underreported due to stigma and cultural taboos surrounding sexuality (51).

The timing of violence onset provides critical insights for intervention. While the majority (54.5%) experienced violence that began before pregnancy, indicating continuation of pre-existing abuse, a substantial proportion experienced new-onset violence during pregnancy (25.8%) or after pregnancy began (19.7%). This pattern confirms that pregnancy itself can be a trigger for IPV initiation or escalation, consistent with previous research (10). Pregnancy may increase stress, financial pressure, jealousy, or perceptions of entrapment that precipitate violence. Alternatively, pregnancy may represent a period of increased vulnerability when women are less able to resist or escape abuse.

Effects of Intimate Partner Violence on Health and Well-being

The profound negative effects of IPV on physical health (59.1%) and mental health (58.3%) documented in this study align with extensive literature documenting the health consequences of IPV (2,24). Physical health effects including injuries and fatigue reflect both direct trauma from physical violence and the cumulative physiological toll of chronic stress. During pregnancy, these effects may have particular significance, as physical injuries can directly threaten pregnancy, while fatigue may compromise women's ability to engage in health-promoting behaviors.

The mental health impacts—anxiety, depression, and emotional distress—are consistent with previous research documenting elevated rates of psychiatric morbidity among pregnant women experiencing IPV (52). The psychological toll of living with violence during pregnancy, a period already characterized by significant emotional and hormonal changes, may be particularly severe. Depression during pregnancy has been linked to adverse outcomes including preterm birth, low birth weight, and postpartum depression, suggesting that IPV may affect pregnancy outcomes partly through its effects on maternal mental health (53).

The finding that 59.8% of respondents did not feel safe in their current relationship reflects the pervasive fear and insecurity that characterize abusive relationships. This lack of safety has implications not only for psychological well-being but also for healthcare-seeking behavior and pregnancy outcomes. Women who do not feel safe may be unable to negotiate safe sexual practices, access healthcare independently, or make decisions that protect their health and that of their fetus.

The disruption of antenatal care attendance reported by 61.4% of respondents represents a critical pathway through which IPV affects pregnancy outcomes. Missed or delayed antenatal visits increase the risk of undetected complications, inadequate prenatal care, and adverse pregnancy outcomes. Partners may actively prevent women from attending appointments as a form of control, or women may avoid care due to injuries, shame, or fear that healthcare providers will discover the abuse.

The near-universal experience of relationship-related stress, with 59.1% experiencing stress often or always, documents the chronic nature of psychological distress associated with IPV. Chronic stress during pregnancy has been linked to elevated cortisol levels, which may affect fetal development and increase risk of preterm birth and low birth weight (54).

The finding that 64.4% of respondents felt isolated or unsupported highlights the social consequences of IPV. Abusive partners often isolate victims from family and friends as a control strategy, depriving women of crucial emotional and practical support. This isolation may be compounded by shame or fear of judgment that prevents women from reaching out to potential sources of support.

Social Effects and Coping Mechanisms

The extensive social and economic consequences of IPV documented in this study with 77.3% reporting strained relationships with family/friends and 79.5% reporting impacts on work or income-generating activities—demonstrate that IPV affects not only individual health but also social functioning and economic stability. These findings align with previous research documenting the ripple effects of IPV across multiple life domains (5,46).

The strain on family relationships is particularly concerning, as family support is often crucial for women attempting to leave abusive relationships. When violence erodes these relationships, women may lose their primary source of emotional and practical support, increasing their entrapment in abusive situations. The economic impacts of IPV, including reduced ability to work and generate income, create or exacerbate financial dependence on abusive partners, which emerged as the primary barrier to reporting in this study.

Coping mechanisms employed by respondents reflect both adaptive and limited options. The equal proportions seeking support from family/friends (37.9%) and religious help (37.9%) demonstrate the importance of informal support networks and faith-based coping in Nigerian culture. These coping strategies may provide emotional relief and practical assistance, but they may not address the root causes of violence or provide pathways to safety. The finding that 24.2% stayed silent highlights the substantial proportion of women who endure abuse without any form of external support, reflecting the stigma, shame, and isolation associated with IPV.

The underreporting of violence (56.1% never reported) represents a critical gap in identifying and supporting victims. This finding is consistent with previous Nigerian studies documenting widespread underreporting of IPV (26). The barriers to reporting identified—financial dependence (38.6%), fear (25.0%), shame (25.0%), and lack of trust (11.4%)—reveal the complex interplay of economic, psychological, and systemic factors that prevent help-seeking.

Financial dependence as the primary barrier underscores the economic entrapment that keeps women in abusive relationships. Without economic resources, women may feel unable to leave, even when they recognize the harm of staying. Fear and shame reflect the psychological barriers created by abuse itself—fear of retaliation, fear of not being believed, fear of bringing shame to family, and internalized shame that makes women feel responsible for the violence. Lack of trust in reporting systems and authorities reflects systemic failures that discourage help-seeking.

The mixed beliefs about whether violence will stop on its own—with 43.9% believing it will, 47.7% believing it will not, and 8.3% uncertain—suggest that while many women recognize that violence is

unlikely to resolve spontaneously, a substantial proportion maintain hope for change without intervention. This hope may reflect genuine belief in partner's capacity for change, cultural norms emphasizing marital endurance, or lack of awareness about the chronic nature of IPV.

Support Services and Recommendations

The finding that 65.2% of respondents were aware of support services, yet only 40.9% had accessed them, reveals a significant awareness-utilization gap. This gap suggests that awareness alone is insufficient to promote help-seeking and that multiple barriers prevent women from accessing available services. The substantial minority (34.8%) unaware of services indicates gaps in information dissemination that need to be addressed.

The variability in perceived helpfulness of services received with 44.7% finding services not helpful or only slightly helpful, and 55.3% finding them helpful or very helpful suggests that service quality, appropriateness, and responsiveness vary considerably. This variability may reflect differences in service provider training, resource availability, cultural competence, or the match between services offered and women's actual needs. Improving service quality and ensuring that services are trauma-informed, culturally appropriate, and responsive to individual needs should be priorities.

The identification of financial aid (37.1%) and legal aid (24.2%) as the most pressing needs, rather than medical care or counseling, reflects the material realities of women experiencing IPV. While healthcare and psychological support are important, women's immediate concerns may be economic survival and legal protection. Financial aid could reduce dependence on abusive partners and enable women to leave unsafe situations. Legal aid could provide protection orders, assist with divorce or separation, and ensure that perpetrators face consequences.

The relatively lower prioritization of shelter (10.6%) may reflect cultural norms that prioritize family preservation and stigma associated with leaving the marital home, rather than absence of need. In Nigerian culture, leaving the marital home may bring shame to the woman and her family, and alternative housing options may be limited or unknown.

Respondents' suggestions for improving support—legal and policy measures (25.0%), financial aid (19.7%), and support groups (9.1%)—align with their identified needs and provide guidance for intervention development. The high proportion offering no comment (46.2%) may reflect fatigue, uncertainty, or limited experience with support services on which to base recommendations.

Implications of Findings to Nursing

The findings of this study have profound and multifaceted implications for nursing practice, education, research, and administration in maternal and child health settings.

Implications for Nursing Practice

Nurses, as frontline healthcare providers in antenatal settings, are uniquely positioned to identify, support, and advocate for pregnant women experiencing IPV. The high prevalence of IPV (56.1%) documented in this study underscores the urgent need for routine, universal screening for IPV as an integral component of antenatal care. Screening should be conducted in private, confidential settings using validated tools, with all pregnant women screened regardless of age, education, employment, or marital status. Nurses must be trained to conduct screening sensitively, using non-judgmental language, and to respond appropriately to disclosures.

The finding that emotional and psychological abuse are more prevalent than physical violence highlights the importance of screening for all forms of abuse, not just physical violence. Nurses should be educated to recognize subtle signs of non-physical abuse, including controlling behaviors, isolation, humiliation, and threats, which may not leave visible marks but cause significant psychological harm.

The disruption of antenatal care attendance reported by 61.4% of respondents indicates that missed appointments may be a red flag for IPV. Nurses should be alert to patterns of inconsistent attendance and explore underlying reasons sensitively. When IPV is identified, nurses should provide immediate support, validate the woman's experience, assess safety, and offer information about available resources.

The mental health impacts of IPV (reported by 58.3%) underscore the need for integrated mental health support within antenatal care. Nurses should

be trained to recognize signs of anxiety, depression, and emotional distress that may indicate IPV and to provide or facilitate access to counseling services.

The barriers to reporting identified financial dependence, fear, shame, and lack of trust—highlight the need for nurses to create safe, trusting environments where women feel comfortable disclosing abuse. This requires building therapeutic relationships, ensuring confidentiality, and demonstrating non-judgmental acceptance. Nurses should also be aware of community resources for financial and legal assistance and facilitate referrals.

Implications for Nursing Education

The findings of this study have significant implications for nursing education at undergraduate and postgraduate levels. Nursing curricula must integrate comprehensive content on IPV, including its prevalence, health consequences, screening protocols, and intervention strategies. Students should learn to recognize the signs of abuse, conduct sensitive screening, respond appropriately to disclosures, and make appropriate referrals.

Clinical education should provide opportunities for students to practice IPV screening and response skills in supervised settings. Simulation-based learning using standardized patients or role-play scenarios can help students develop confidence and competence in addressing this sensitive issue.

Nursing education should also address the broader context of IPV, including gender inequality, cultural norms, legal frameworks, and available support services. Students should understand the social determinants that contribute to IPV and the importance of advocacy in addressing root causes.

Implications for Nursing Research

This study contributes valuable empirical data to the growing body of knowledge on IPV among pregnant women in Nigeria but also identifies numerous avenues for future research. Longitudinal studies are needed to examine causal relationships between IPV exposure and pregnancy outcomes, as well as the long-term effects on maternal and child health. Intervention research should evaluate the effectiveness of different screening protocols, support interventions, and referral systems in improving outcomes for pregnant women experiencing IPV.

Implementation research should explore barriers and facilitators to routine IPV screening in Nigerian antenatal settings and identify strategies for integrating screening into standard care. Qualitative research can deepen understanding of women's experiences, help-seeking behaviors, and the cultural context of IPV, informing the development of culturally appropriate interventions.

Implications for Nursing Administration

Nursing administrators have a critical role in creating systems that support IPV screening and response. This includes developing and implementing policies mandating routine IPV screening in antenatal care, ensuring availability of private screening spaces, allocating resources for staff training, and establishing referral networks with community organizations.

Administrators should ensure that nurses have access to ongoing training and support in addressing IPV, including supervision and debriefing opportunities given the emotional demands of this work. They should also advocate for the inclusion of IPV screening in quality improvement indicators and monitor screening rates and outcomes.

The findings of this study support the need for multidisciplinary collaboration involving nursing, medicine, social work, psychology, and legal services. Administrators should facilitate the development of referral pathways and partnerships with community organizations providing financial aid, legal assistance, shelter, and counseling.

VII. CONCLUSION

This study provides comprehensive evidence regarding the perceived impact of intimate partner violence on the quality of life of pregnant women attending Ekiti State University Teaching Hospital, Ado-Ekiti, Nigeria. The findings reveal that IPV is highly prevalent among this population, with more than half of respondents (56.1%) reporting experiences of violence during their current pregnancy. The manifestations of IPV are diverse, with emotional abuse (62.1%) being most common, followed by psychological abuse (57.6%), sexual abuse (45.5%), and physical abuse (37.9%). For many women, violence is not an isolated incident but a recurring pattern during pregnancy, with a

substantial proportion experiencing it frequently or very frequently.

The impacts of IPV on quality of life are profound and multidimensional, affecting physical health (59.1%), mental health (58.3%), safety perceptions (59.8% feeling unsafe), healthcare utilization (61.4% with disrupted antenatal care), social relationships (77.3% with strained family/friend relationships), and economic functioning (79.5% with affected work/income). The chronic stress associated with IPV affects nearly all women, with 59.1% experiencing stress often or always, and 64.4% feeling isolated or unsupported.

Despite these significant impacts, help-seeking remains limited, with only 43.9% having reported violence to health workers or authorities. Barriers to reporting include financial dependence (38.6%), fear (25.0%), shame (25.0%), and lack of trust (11.4%). While 65.2% of women are aware of support services, only 40.9% have accessed them, revealing a significant awareness-utilization gap. Financial aid (37.1%) and legal aid (24.2%) are identified as the most pressing needs, reflecting the economic and legal dimensions of IPV that trap women in abusive relationships.

Hypothesis testing revealed no significant relationship between age and quality of life, indicating that the negative impacts of IPV cut across all age groups. However, a significant relationship was found between employment status and experience of emotional abuse, suggesting that employed women may be at higher risk or more willing to disclose abuse.

The findings underscore that IPV during pregnancy is not merely a personal issue but a critical public health concern with far-reaching consequences for maternal and child health. Addressing IPV requires a comprehensive, multi-level approach involving routine screening in antenatal care, enhanced nurse-led interventions, community-based sensitization, and multidisciplinary collaboration. Nurses, as frontline providers, are uniquely positioned to identify victims, provide support, and facilitate access to services. However, effective response requires systemic changes including adequate resources, training, referral networks, and policies that prioritize the safety and well-being of pregnant women.

The study highlights the urgent need to move beyond awareness to action implementing routine screening protocols, training healthcare providers, establishing accessible support services, and addressing the economic and legal barriers that prevent women from seeking help. Only through such comprehensive approaches can we reduce the burden of IPV on pregnant women and improve maternal and child health outcomes in Nigeria.

VIII. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made for nursing practice, healthcare administration, policy development, and future research:

For Nursing Practice and Healthcare Delivery

1. Implement Routine IPV Screening: All pregnant women attending antenatal care should be routinely screened for IPV using validated tools. Screening should be conducted in private settings with assured confidentiality, using non-judgmental language, and should encompass all forms of abuse (physical, emotional, psychological, sexual). Screening should be universal, regardless of age, education, employment, or marital status.
2. Develop Response Protocols: Healthcare facilities should develop and implement clear protocols for responding to IPV disclosures, including immediate safety assessment, supportive counseling, documentation, and referral to appropriate services. Protocols should be evidence-based, culturally appropriate, and regularly reviewed and updated.
3. Provide Training for Healthcare Providers: All nurses, midwives, and other healthcare providers working in antenatal settings should receive comprehensive training on IPV, including recognition of signs, screening techniques, response protocols, and referral pathways. Training should be ongoing and include opportunities for skills practice and refresher courses.
4. Establish Referral Networks: Healthcare facilities should establish and maintain referral networks with community organizations providing financial aid, legal

assistance, shelter, counseling, and other support services for IPV victims. Referral information should be readily available to providers and accessible to women.

5. Integrate Mental Health Support: Mental health screening and support should be integrated into antenatal care for women experiencing IPV, given the high prevalence of anxiety, depression, and emotional distress. On-site counseling services or clear referral pathways to mental health providers should be established.
6. Address Barriers to Reporting: Healthcare providers should be aware of the barriers to reporting financial dependence, fear, shame, lack of trust and work to address these through supportive, non-judgmental interactions, assurance of confidentiality, and information about available resources. Financial counseling and legal aid information should be readily available.

For Nursing Education

7. Strengthen Curricula: Nursing curricula at undergraduate and postgraduate levels should include comprehensive content on IPV, including epidemiology, health consequences, screening, response, and referral. Content should address all forms of abuse and the specific context of pregnancy.
8. Provide Clinical Experience: Nursing students should have opportunities to practice IPV screening and response skills in supervised clinical settings. Simulation-based learning using standardized patients or role-play can supplement clinical experiences.
9. Address Cultural Context: Nursing education should address the cultural context of IPV in Nigeria, including gender norms, marital expectations, stigma, and barriers to help-seeking, enabling students to provide culturally competent care.

For Healthcare Administration and Policy

10. Develop Institutional Policies: Healthcare facilities should develop and implement clear policies mandating routine IPV screening in antenatal care, ensuring confidentiality, protecting victims from retaliation, and establishing consequences for perpetrators who are also patients or staff.
11. Allocate Resources: Adequate resources should be allocated for IPV screening programs, including staff training, private screening spaces, printed materials, and referral systems. Staff should have protected time for training and for providing support to women who disclose abuse.
12. Monitor and Evaluate: Healthcare facilities should monitor IPV screening rates, disclosure rates, and referral outcomes as quality improvement indicators. Regular evaluation should inform program refinement and resource allocation.
13. Strengthen Legal Frameworks: Government at all levels should strengthen legal protections for women experiencing IPV, including enforcement of existing laws such as the Violence Against Persons (Prohibition) Act, and development of new legislation addressing gaps in protection. Legal aid should be accessible and affordable.
14. Establish Support Services: Government and non-governmental organizations should establish and fund accessible support services for IPV victims, including shelters, counseling centers, legal aid clinics, and hotlines. Services should be designed with input from women who have experienced IPV.
15. Conduct Public Awareness Campaigns: Public health campaigns should raise awareness about IPV as a human rights violation and health hazard, challenge cultural norms that normalize violence, reduce stigma, and encourage help-seeking. Campaigns should target both women and men and be disseminated through multiple channels.

For Future Research

16. Conduct Longitudinal Studies: Longitudinal research should examine causal relationships between IPV exposure and pregnancy outcomes, as well as long-term effects on maternal and child health, including child development and intergenerational transmission of violence.
17. Evaluate Interventions: Intervention research should rigorously evaluate the

effectiveness of different screening protocols, support interventions, and referral systems in improving outcomes for pregnant women experiencing IPV. Studies should examine both process outcomes (screening rates, referral uptake) and health outcomes.

18. Explore Cultural Context: Qualitative research should deepen understanding of how cultural norms, gender roles, and community attitudes influence IPV experiences, disclosure, and help-seeking in Nigerian settings. Research should include men's perspectives and community leaders.
19. Study Economic Interventions: Research should examine the effectiveness of economic empowerment interventions, including microfinance, vocational training, and cash transfers, in reducing IPV and enabling women to leave abusive relationships.
20. Conduct Implementation Research: Implementation science research should identify effective strategies for integrating routine IPV screening into antenatal care in resource-constrained settings, addressing barriers at individual, organizational, and policy levels.
21. Include Diverse Populations: Future research should include pregnant women in rural areas, private healthcare facilities, and other regions of Nigeria to enhance generalizability and identify context-specific factors.
22. Examine Partner Perspectives: Research exploring perpetrators' perspectives and factors associated with IPV perpetration could inform prevention interventions targeting men.

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Authors' Contributions: KO conceptualized the study, designed the methodology, developed the data collection instruments, supervised data collection, performed statistical analysis, and drafted the initial manuscript. OE contributed to study design, instrument validation, interpretation of findings, and critical revision of the manuscript for important intellectual content. NA assisted with data collection, literature review, and manuscript preparation. All authors read and approved the final manuscript.

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HIGHLIGHTS

What is the current knowledge?

- Intimate partner violence (IPV) affects 30% of women globally, with 10-20% experiencing violence during pregnancy
- IPV causes adverse pregnancy outcomes including preterm birth, low birth weight, and maternal mortality
- IPV is associated with physical injuries, mental health disorders, and reduced quality of life
- In Nigeria, 31% of women experience physical violence, and 14% experience sexual violence
- Limited research exists on IPV impact on quality of life among pregnant women in South-Western Nigeria

What is new here?

- First comprehensive study of IPV impact on quality of life among pregnant women in Ekiti State, Nigeria
- Exceptionally high IPV prevalence (56.1%) exceeding national and global estimates
- Emotional abuse (62.1%) more prevalent than physical abuse (37.9%), highlighting need for comprehensive screening
- IPV significantly disrupts antenatal care attendance (61.4%) and affects work/income (79.5%)
- Despite 65.2% awareness of support services, only 40.9% accessed them, revealing critical awareness-utilization gap
- Financial dependence (38.6%) identified as primary barrier to reporting, not fear or shame alone
- No significant relationship between age and quality of life, indicating IPV affects all age groups
- Significant relationship found between employment status and IPV experience ($p=0.017$)
- Findings inform comprehensive, multi-level recommendations for nursing practice, education, research, and policy

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TABLES

[Tables 1-7 are included within the manuscript text as formatted above]