TRIGGERS OF DOMESTIC VIOLENCE AGAINST PREGNANT WOMEN IN RIVERS STATE, NIGERIA

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Abstract
*The study was a cross-sectional survey aimed at determining the triggers of Domestic Violence against Pregnant Women in Rivers State. The Feminist, Social learning and Ecological theories provided the theoretical anchor for the study. The population for the study was 327, 639 pregnant women in the State. Data were collected from a sample of 2,388 pregnant women attending antenatal clinics in365 primary health centers, 37secondary health institutions and the two tertiary hospitals in Rivers State selected through a multistage sampling procedure. The instrument for data collection was a self-structured and validated*44 *item-questionnaire titledTriggers of Domestic Violence against Pregnant Women Questionnaire (TDVAPWQ). The instrument has a reliability index of 0.83 obtained using the test-re-test method and Pearson Product Moment Correlation co-efficient. The findings from the study revealed multiple triggers of domestic violence against pregnant women in Rivers State including past experience of DV (27.22%),negative influence of in-laws (16.80%), drug and substance abuse (15.62%), pregnancy induced factors (12.70%), intimate partner infidelity (9.90%), STD/HIV/AIDS positive status (4.26%), and male child preference (4.20%). However, past experience of domestic violence and pregnancy induced factors (3.88% respectively) were the most frequent triggers. Based on the findings, the study recommended among others that Government should collaborate with non-governmental organizations to gather data and implement the Violence Against Persons (Prohibition) Acts, towards eradicating DV during pregnancy in the State.*

Keywords: domestic violence, triggers, pregnant women, pregnancy

Introduction

In most African societies, pregnancy and pregnant women are usually regarded as source of joy as it signifies that a child is soon to be welcomed into the family. However, when pregnant woman for some reason receives abuse and hostility from those who are supposed to show her love and care, it leaves a sour taste in the mouth of the woman and becomes a cause for worry especially as it concerns the health and life of the mother and the foetus. Domestic violence against women has become an issue of global concern especially that which occurs during pregnancy. World Health Organisation (2005) reported that domestic violence against pregnant women is on the increase and estimated that one in five women will be abused during pregnancy. In Nigeria, five percent of women who have ever been pregnant reported that they experienced domestic violence during one or more of their pregnancies (National Demographic and Health Survey–NDHS, 2013).

Physiological changes place the woman at high risk to disease and injury. Hence, the pregnant woman becomes vulnerable due to additional demands and needs, such as physical, social, economic and emotional needs (Diorgu & Jonathan, 2014). The period of pregnancy for the woman and her family is, therefore, expected to be filled with peace, support and love. Stressing the importance of this period, Weiss (2013) opined that pregnancy is supposed to be a time of peace and safety, where the family turns its thoughts towards growing a healthy baby and raising the next generation. In addition, Ogbalu (2009) submitted that the interpersonal relationship between the woman and her husband during and after delivery should be cordial, where the man is supportive by making adequate provision of basic needs and encourage the woman to attend antenatal clinics.

In most cultures like Womack (2010) asserted, pregnant women have special status in the society and most times are particularly given gentle care. However, this is no longer the case for many pregnant women since pregnant women are now at a similar risk for abuse as non-pregnant women (Fisher et al., 2003; Fawole, Abass and Fawole, 2010). In fact, report from PAHO has it that pregnant women are 60 percent more likely to suffer from domestic violence than women who are not pregnant

(Regan, 2013). No wonder Weiss (2013) calls it unfortunate, since for many women, pregnancy can be the beginning of a violent time in their lives sometimes leading to injuries and even death.

Domestic violence during pregnancy is categorized as an abusive behaviour towards a pregnant woman, it is a focused attack that puts the pregnant woman and her foetus at risk (Envuladu et al. 2012). DV during pregnancy is any abuse deliberately directed at a pregnant woman that puts her and her unborn child in danger. It is worthy of note that it does not have to happen every day or every week for it to be termed domestic violence (WHO, 2005; Drouin, 2013).

The peculiarity of DV against pregnant women is that it can be a long-standing problem in a relationship that continues after a woman becomes pregnant or it may commence during pregnancy. Throwing more light, Fawole et al. (2005) and Gyuse and Ushie (2009) posited that violence may begin or escalate during pregnancy, and is repetitive, giving rise to the concept of the 'Violence Cycle'. This could simply be explained as comprising of tension building phases, violent phases and the honeymoon phases (when the husband/partner becomes apologetic and remorseful, he tries to woo back his partner or make up for the abuse by being loving and gentle). When DV occurs during pregnancy, it is associated with negative pregnancy outcome such as pregnancy loss, preterm labour, pregnancy complications, hypertension, delivering low birth weight and physical injuries (Interagency Gender Working Group-IGWG, 2002; Moronkola, 2013); mental health outcomes such as depression and stress (IGWG, 2002; Dunn & Oths 2004). It has also been reported as a contributing cause of maternal deaths (Jeremiah, Kalio & Oriji, 2011).

Prevalence of DV in pregnancy in United Kingdom (UK), was 3.4% (Bacchus et al. 2004); United State of America (USA), 3.4 – 33.7% (Huth-Bocks, Levendosky & Bogat, 2002); Ireland 12.5% (O'Donnell, Fitzpatrick & McKenna, 2000); and Jordan 40.9 % (Okour & Badarneh, 2011).The prevalence of DV during pregnancy in the developing countries ranges from 2 -29% (Nasir & Hyder, 2003). Urmia in Iran had a prevalence of 55.9% (Farrokh-Esiamiou et al., 2014) and Zimbabwe, 63.1% (Shamu et al.,2013).

The National Demographic and Health Survey – NDHS (2008) reported that the prevalence of DV against pregnant women varied from region to region with the highest in the South-South (9.0%) and the lowest in the North Central region (7%). Similarly, NDHS (2013) documented the prevalence of DV during pregnancy in Nigeria, with the highest also in the South-South (9.0%) and lowest in the North-West (1.8%). In Northern Nigeria prevalence was 7.4% (Zubairu et al., 2012); North West 34.3% (Ashimi & Amole, 2015); Zaria, Kaduna State prevalence is 28% (Ameh & Abdul, 2003); Zaria, Kaduna, 28.4% (Ameh, Shittu & Abdul, 2009) and Abuja prevalence is 37.4% (Efetie &Salami, 2007). In Jos, Plateau State, prevalence was 12.6% in current pregnancy and 63.2% in previous pregnancies (Gyuse, Ushie & Etukidem, 2009), while later findings show that Jos, North LGA, Plateau State in particular had a prevalence of 28.9% (Envuladu et al., 2012).

In Southern Nigeria, DV prevalence was 43.5% during the 12 months before the pregnancy, 28.3% during the pregnancy and 4% in the puerperium (Olagbuji, Ezeanochie & Ande, 2010). In the South West, prevalence in Lagos was 28.7% (Ezechi et al., 2004); Abeokuta 2.3% while prevalence of violence within 12 months prior to pregnancy was 14.2% (Fawole, Hunyinbo & Fawole, 2008). Prevalence in Ibadan was 17.1% (Adesina, Oyugbo & Oladokun, 2011) and in Ile-Ife, 36.72 % (Mapayi et al.,2013).

Records from the South-East showed prevalence of 13.6% (Umeora, Dimejesi, Ejikeme, Egwuatu, 2008) and in Abakaliki 44.6% (Onoh et al., 2013). Oleh in Delta State South South, had a prevalence of 36% (Awusi Okeleke & Ayanwu, 2013), while In Port Harcourt, Rivers State it was 7.8% (Jeremiah, Kalio & Oriji, 2011). However, NDHS (2013) report from South-South showed that Rivers State had a prevalence of 11.1%, Cross Rivers State (12.2%), Bayelsa State (9.4%), Edo State (8.0%), Akwa Ibom State (8.0%) and Delta State having the lowest (3.8%) prevalence.

Different researchers have described different forms of DV as experienced by victims such as Physical, sexual and psychological (Okour & Badarneh, 2011; Farrokh- Esiamiou et al. 2014); verbal, physical, emotional and sexual violence (Oweis, Gharaibeh and Alhourani, 2010); verbal, physical and sexual violence (Awusi Okeleke & Ayanwu, 2013). Domestic violence can include coercion, threats, intimidation, isolation, jealousy, blame, physical, sexual, emotional, and economic abuse (NDHS, 2013).

When a pregnant woman is abused the unborn child is placed at risk of death, preterm birth, low birth weight and early childhood growth impairment (Asling-Monemi, Naved & Persson, 2009).

The child is at risk in the womb, at birth and when growing up, having physical and mental challenges. The pregnant woman is at higher risk of physical health consequences which include physical injury, chronic pain and functional impairment (WHO, 2000), reproductive health consequences like sexually transmitted infections and high risk of pregnancy complications requiring medical attention such as miscarriage or abortion, prolong obstructed labour (dystocia) and injury to the uterus (WHO, 2000). Mental health consequences include; post-traumatic stress disorder, depression, anxiety, sexual dysfunction, low self-esteem and substance abuse (WHO, 2000; &Moronkola, 2013). The pregnant woman is not only in danger of health, social and economic challenges but also in danger of death.

In over 95% of DV during pregnancy, the man (husband, intimate partner, spouse or boyfriend) is the perpetrator (Ameh & Abdul, 2003; Awusi, Okeleke & Anyanwu, 2013; Efetie &Salami, 2007; Iorvaa, 2013). However apart from the man being the major perpetrator, some researchers have indicted the pregnant woman's parents, siblings, and others, while not leaving out the pregnant woman's intimate partners' parents, siblings and other relations as well (Ezechi, et.al., 2004; & Regina, 2013).

Although DV cut across women of all races, culture, social-economic status, religion and educational level, some factors are prone to trigger DV causing certain women to be more likely to be abused than others. The present study focused on such factors specifically past experience of domestic violence, pregnancy induces factors, intimate partner infidelity, STD/HIV/AIDS positive status, drug and alcohol abuse and negative influence of in-laws.

Rivers State is located in the South-South geopolitical zone of Nigeria. The State is one of the wealthiest states in Nigeria in terms of gross domestic product and foreign exchange revenue from the oil industry. This probably earned her the name Treasure Base of the nation (Rivers State Diary, 2006).There is uneven population distribution among the 23 local government areas (LGA) in the state, spanning from the upland to riverine areas with diverse cultural heritage, these LGAs are grouped into three main senatorial districts: Rivers West, Rivers East and Rivers South, with the population density concentrated in the more urban towns and the state capital (Rivers State Diary, 2006). Most of the residents in rural areas engage in fishing, farming and petty trading, while people in urban area (Port Harcourt Metropolis) work in various sectors of commerce and industry.

The objective of the study was therefore to determine the triggers of domestic violence against pregnant women in Rivers State, Nigeria.The corresponding research question was formulated to guide study: What could be the triggers of domestic violence against pregnant women in Rivers State?

Method

The study adopted a cross sectional survey design. The population for the study was 327, 639 pregnant women in the State. Data were collected from a sample of 2,388 pregnant women attending antenatal clinics in365 primary health centers, 37secondary health institutions and the two tertiary hospitals in Rivers State selected through a multistage sampling procedure. The instrument for data collection was a self-structured and validated38 item-questionnaire titledtriggers of Domestic Violence against Pregnant Women Questionnaire with Always, Occasionally, Rarely and Never response options. The test-re-test method and Pearson Product Moment Correlation co-efficient was used to determine the reliability coefficient of the instrument which stood at 0.83. Data collected with the instrument were analysed using frequency counts and percentage.

Results

Research Question: What could be the triggers of domestic violence against the pregnant women? Data answering the research question are presented in Table 1.

Data in Table 1 show that past experience of DV and pregnancy induced factors were the most frequent triggers of domestic violence against pregnant women in Rivers State (3.88% respectively). This is followed by drug and substance abuse (3.73%), negative influence of in-laws (3.55%), and intimate partner infidelity (2.95%). Male child preference and STD/HIV/AIDS status were the least frequent triggers of domestic violence against the pregnant women (1.23% & 1.03% respectively). In all, past experience of DV was the highest trigger of domestic violence among pregnant women in Rivers State accounting for 27.22% of positive responses (always = 3.88%,

occasionally = 14.46% & rarely = 8.88%) with 983 (41.2%) of the respondents reporting that they witnessed abuse in their homes (always =4.8%, occasionally = 23.7%, & rarely =12.7%), and 880 (36.8%) experienced abuse while growing up (always = 4.2%, occasionally = 20.0, & rarely = 12.6%). Furthermore, 485 (20.4%) of the respondents indicated that their intimate partners witnessed abuse while growing up (always = 3.9%, occasionally = 10.6% & rarely = 5.9%) and 510 (21.3%) experienced abuse (always = 3.6%, occasionally = 10.1%, & rarely = 7.6%).

Negative influence of in-laws ranked second with a cumulative positive response of 16.8% (always = 4.0%, occasionally = 9.25% & rarely = 3.55%) with seventy-four (3.1%) of the pregnant women reporting that their in-laws always instigated their partners to abuse them. Following closely was drug and substance use with a cumulative positive response of 15.62% (always = 3.73% occasionally = 9.04 % & rarely = 2.85). Nine hundred and sixty-five (40.3%) of the respondents admitted that their intimate partners drink alcohol (always =6.7%, occasionally = 25.0% & rarely = 8.6%) and 175 (7.3%) reported that they get abused when their intimate partner gets drunk (always = 1.8%, occasionally = 4.1% & rarely = 1.4%). Again, pregnancy induced factors had a cumulative positive response of 12.7% (always = 3.88%, occasionally = 6.14% & rarely = 2.68%). The responses from the pregnant women showed that 372 (15.6%) of them started experiencing DV when they became pregnant (always = 4.4%, occasionally = 7.6% & rarely =3.6%) while DV persisted during pregnancy for 417 (17.5%) of them (always = 6.1%, occasionally = 6.9% & rarely = 4.5%).

Male child preference had the lowest cumulative positive responses (4.2%) as a trigger of DV against the pregnant women (always = 1.23%, occasionally = 2.57% & rarely = 0.4%). One hundred and eight (4.4%) of the respondents reported that their intimate partner was angry at them because they have had no female child (always = 1.3%, occasionally = 2.6% & rarely = 0.5%), also 108 (4.5%) admitted that their intimate partners forced them to become pregnant because they wanted a male child (always = 1.5%, occasionally = 2.8% & rarely 0.2%).

Table 1: Triggers of domestic violence against pregnant women (n=2388)

S/N	Items	Always		Occasionally		Rarely		Never	
		(f)	%	(f)	%	(f)	%	(f)	%
	Past experience of DV								
	As a child, did you witness abuse in your home?	115	4.8	565	23.7	303	12.7	1405	58.8
1.	As a child, were you abused by anyone?	101	4.2	478	20.0	301	12.6	1508	63.1
2.	Did you experience abuse in your previous pregnancy?	70	2.9	189	7.9	79	3.3	2050	85.8
3.	Did your intimate partner witness abuse in his home?	93	3.9	252	10.6	140	5.9	1903	79.7
4.	When your intimate partner was a child was he abused by anyone?	87	3.6	242	10.1	181	7.6	1878	78.6
			3.88		**14.46**		**8.82**		**73.20**
	Pregnancy induced factors								
5.	Does your partner abuse you because he did not plan for the pregnancy?	57	2.4	88	3.7	43	1.8	2200	92.1
6.	Did you start experiencing Domestic Violence now that you are pregnant?	87	3.6	182	7.6	81	3.4	2038	85.3
7.	Does he abuse you whenever you are pregnant?	69	2.9	118	4.9	75	3.1	2126	89.0
8.	Did domestic violence increase when you became pregnant?	104	4.4	181	7.6	87	3.6	2016	84.4
9.	Does domestic violence persist when you became pregnant?	146	6.1	164	6.9	107	4.5	1971	82.5
			3.88		**6.14**		**2.68**		**86.66**
	Drug and substance abuse								
10.	Does your intimate partner drink alcohol?	161	6.7	598	25.0	206	8.6	1423	59.6
11.	Does he abuse you when he is drunk?	42	1.8	99	4.1	34	1.4	2213	92.7

12. Does your intimate partner smoke?	70	2.9	101	4.2	25	1.0	2192	91.8
13. Does he abuse you when he has smoked?	15	0.6	62	2.6	24	1.0	2287	95.8
14. Was he drinking alcohol before you got pregnant?	161	6.7	342	14.3	99	4.1	1786	74.8
15. Was he smoking before you got pregnant?	89	3.7	102	4.3	25	1.0	2172	91.0
		3.73		**9.04**		**2.85**		**84.28**
Negative Influence of In-laws								
16. Do you have problems with your husband because of your in-laws?	96	4.0	259	10.8	118	4.9	1915	80.2
17. Do your in-laws instigate your intimate partner to abuse you?	74	3.1	185	7.7	75	3.1	2054	86.0
		3.55		**9.25**		**4.0**		**83.10**
Intimate partner infidelity								
18. Does your intimate partner abuse you because you have sexual relationship with someone else?	26	1.1	73	3.1	21	0.9	2268	95.0
19. Does your intimate partner abuse you because he has sexual relationship with someone else?	98	4.8	167	7.0	69	2.9	2054	86.0
		2.95		**5.05**		**1.90**		**90.50**
STD/HIV/AIDs positive status								
20. Does your husband abuse you because he thinks you infected him with sexual transmitted disease?	20	0.8	73	3.1	14	0.6	2281	95.5
21. Does your intimate partner abuse you when you accuse him of contracting sexual transmitted disease?	38	1.6	68	2.8	26	1.1	2256	94.5
22. Does your intimate partner abuse you because you have HIV/AID?	18	0 .8	56	2.3	10	0.4	2304	96.5
23. Does your intimate partner abuse you because he has HIV/AIDS?	21	0 .9	52	2.2	10	0.4	2305	96.5
		1.03		**2.60**		**0.63**		**95.75**
Male child preference								
24. Does your intimate partner get angry at you because you have not had a male child?	32	1.3	63	2.6	13	0.5	2280	95.5
25. Does your intimate partner mock at you because you have not given him a male child?	21	0.9	54	2.3	11	0.5	2302	96.4
26. Does your intimate partner insist you get pregnant against your wish because he wants a male child?	35	1.5	68	2.8	5	0.2	2280	95.5
Cluster %		**1.23**		**2.57**		**0.40**		**95.80**

Discussion

The findings of the study have revealed that there were multiple triggers of DV such as past experience of DV (3.88%), pregnancy induced factors (3.88%), negative influence of in-laws (3.55%), intimate partner infidelity (2.95%), drug and substance abuse (2.10%) male child preference (1.23%) and STI/HIV/AIDS positive status (1.03%). This finding which is an indication that no one single factor can be pinned down as the trigger of DV during pregnancy agrees with the Ecological theory proposed by Heise (1998) which says that DV is a multi-faceted phenomenon grounded in an interaction among several factors across personal (or individual) relationship, family, community and more broadly societal spheres of influence.

Past experience of DV was the highest trigger of DV among the pregnant women. This is quite surprising but agrees with the findings of other researchers such as Shamu et.al. (2011), and Finnbogadóttir, Dykes and Wann-Hansson (2014) who also found that the strongest risk factor for DV during pregnancy was family history of DV. Similarly, Castro and Ruaz (2004) established significant

association between parental background of fighting and women being beaten. This finding supports the social learning theory by Bandura (1977 & 1989) who proposed that exposure to DV in childhood may determine if the individual would become violent or become victim of violence in adulthood by means of observations and imitations Ofili and Ofili (2012), Diorgu and Abere (2014), all had posited that no one is born violent but violence is learnt from family members (parents, relatives and siblings), peers and role models.

As many as 983 (41.2%) of the women indicated that they witnessed abuse in their childhood at various frequencies and 880 (36.8%) were abused in their childhood. This can be explained by the postulation of the social learning theory that girls who witnessed or experienced DV in childhood would likely become victims of DV by their intimate partners in adulthood. The finding agrees with Makayoto et al (2013) who reported, that women who experienced DV during pregnancy were more likely to have witnessed maternal abuse in childhood. Simply put, girls whose mothers were abused may eventually end up being abused.

Also worthy of note is that 485 (20.4%) of pregnant women indicated that their intimate partners witnessed abuse in their childhood and 510 (21.3%) said their partners were abused in their childhood. This implies that boys whose fathers were abusers would become abusers themselves. Similar finding was made by Zora (2003) who found that boys who witnessed abuse in their homes were seven times more likely to batter. Castro, Peek-Asa and Ruiz (2003), Clark et al (2009) and Goldsmith (2006) opined that with exposure to parental violence, children who witnessed or were the victims of violence may learn to believe that violence is a reasonable way to resolve conflict between people and so will resort to being violent themselves

Some of the pregnant women experienced DV for the first time in their current pregnancy Centers for Disease Control (2011) had submitted that one in six abused women reported that her partner first abused her during pregnancy and also at least 4 to 8 percent of pregnant women report suffering abuse during pregnancy and 25% of women were abused for the first time during pregnancy. A number of reasons can be adduced for this, first, some pregnant women experience mood changes and become irritable at some point in their pregnancy, hence, a partner who is not experienced or is not aware that such change is pregnancy induced may not be patient with the pregnant partner. Again when a partner did not expect a pregnancy and is not prepared for it, he is more likely to take out his frustrations on the woman blaming her for the pregnancy as was shown by 188 (7.9%) of the respondents in the study who indicated that intimate partners abused them because they did not plan for the pregnancy.This is unfortunate because pregnancy, especially in an African home is usually welcomed with joy and expectation, and so one would have thought that the intimate partner would treat the pregnant woman with so much affection and care in order not to hurt the unborn child. However, with the current economic crisis in the country, pregnancy, especially one that comes after more than one child or outside wedlock may no longer be a thing of joy to the family especially the bread winner. Hence, unplanned pregnancy is likely to trigger DV against the pregnant woman where the intimate partner is not ready to be a father or is unable to provide financial support for the baby, especially in teenage pregnancy. In this case, perpetrators may include family members and relations.

With regards to drug and substance abuse, 965 (40.3%) of the respondents admitted that their intimate partners drink alcohol (always =6.7%, occasionally = 25.0% & rarely = 8.6%). Alcohol has the potential to affect emotion, behaviour, body and social relationships due to the altering of good judgment affecting ones mental state (Achalu, 2005, Ofili & Ofili , 2012), this could be the reason why it is associated with DV against women. It is therefore not surprising that 175 (7.3%) of the respondents reported that their intimate partners abused them when they were drunk (always = 1.8%, occasionally = 4.1% & rarely = 1.4%). Other researchers have also found that alcohol consumption by an intimate partner was significantly associated with DV during pregnancy (Olagbuji, Ezeanochie & Ande, 2010; Fawole, Abass & Fawole, 2010; Jeremiah, Kalio & Oriji, 2011; Shamu et al., 2013).

In the African context, it has been argued that the widespread abuse of partners emanates from the uneven distribution of power within traditional African marriage relationships and the exercise of power by the extended family over the married couple (Dutton & Nicholls, 2005; Chikwe & Ekechukwu, 2009). No wonder negative influence of in-laws ranked second in this study as the highest trigger of DV (always = 4.0%, occasionally = 9.25% & rarely = 3.55%). In many cases, the in-laws instigate the intimate partners to abuse the women as was found in this study (3.1%). This is not surprising because in Nigeria, Rivers State inclusive, in-laws have great influence in decision

making which sometimes impact negatively on the couple. In some cases, the woman's in-laws are the cause of problems in marriages. The finding of this study is also similar to Tokus, Ekuklu and Avcioglu (2010) who found that Turkish women who lived with more than four people in their homes, was a risk factor for physical violence. Cengiz, Kanawati and Tombul (2014) also reported that women who lived with large extended families were at significantly higher risk of DV during pregnancy in comparison with the pregnant women who lived within a core family.

The finding that male child preference was a trigger of DV, though the lowest among the pregnant women with a cumulative positive response of 4.2% (always = 1.23%, occasionally = 2.57% & rarely = 0.4%) is disheartening but not unexpected. The pregnant women reported that their intimate partners insisted they got pregnant against their wish (always 1.5%, occasionally 2.8%), got angry at them (always 1.3%, occasionally 2.6%) and mocked them (always 0.9%, occasionally 2.3%) because they did not have male children for them. This finding is disheartening because it corroborates Iwuji's (2014) position that male child preference still exist in Nigeria especially in the Southern part. The society still places more value on having male children than female children, placing the girl child at a disadvantaged position in the society (Federal Ministry of Women Affairs and Social Development, 2006). In this age and time, the least that is expected of Nigerians is to live beyond the primitive mentality of not having equal regards for female and male children. This mentality, unfortunately, is found also among the highly educated and well placed individuals who have been exposed to Western civilization. This finding is similar to that of Margaret (2008) in a study found that male child preference was a trigger of DV. This is unfortunate and unacceptable because it goes to show that women are still held responsible for not giving birth to male children. This avoidable situation may cause tension and strain in relationships and the likelihood of having other wives or infidelity which will further trigger DV. Also the intimate partner insistence that the women get pregnant against her wish speaks of control over the woman's reproductive life which has been adjudged a form of DV.

Conclusions

Based on the findings of this study, it is concluded that there are multiple triggers of domestic violence against pregnant women in Rivers State. Domestic violence is learned especially from the home and societal and cultural issues such as the extended family system, and male child inheritance aids domestic violence.

Recommendations

Based on the conclusions of the study the following recommendations are made.

1. Government should collaborate with non-governmental organizations like The Nigeria Stability and Reconciliation Programme (NSRP), Rivers State Observatory on Violence Against Women and Girls, to gather data and implement VAPP Act towards eradicating DV in the State.
1. 2.Government should create more awareness by collaborating with private television and radio stations to anchor free forum where health and social consequences of domestic violence can be aired frequently not just on international women's' day.

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