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Intimate partner violence, associated factors, and psycho-social support networks among pregnant women attending selected health facilities in Isingiro District, Ankole Sub-region, Uganda. A cross-sectional study

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Abstract

Background
Intimate partner violence (IPV) during pregnancy is a major public health concern with serious consequences for maternal and child health. This study assessed the prevalence, associated factors, and psychosocial support systems for pregnant women experiencing IPV in Isingiro District, Uganda.

Methods
A mixed-methods cross-sectional design was employed at Rwekubo and Kabuyanda Health Centre IVs, involving 371 participants selected through proportionate stratified sampling. Quantitative data were collected using researcher-administered questionnaires and analyzed with STATA 18, while qualitative data from in-depth interviews with IPV survivors were thematically analyzed using NVivo 15.

Results
The study enrolled pregnant women aged 20-46 and above, and a high IPV prevalence of 36.5%, higher at Rwekubo (39.2%) than Kabuyanda (32.6%) was found. Predictors included partner substance use (OR = 0.05, $p < 0.001$), unemployment (OR = 5.07, $p = 0.001$), and low income, while women earning above UGX 100,000 were less likely to experience IPV. Primary education increased IPV risk (OR = 2.80, $p = 0.025$). Cultural norms (OR = 27.49, $p < 0.001$) and limited service awareness (OR = 2.99, $p = 0.020$) were also significant. Though 56.6% of women reported access to legal protection, it was not statistically protective (OR = 0.72, $p = 0.240$).
Qualitative findings highlighted normalization of marital sexual abuse, stigma, and weak enforcement of services, though peer networks provided emotional support.

Conclusion
This study provides critical insights into the high prevalence. It demonstrates that IPV in these settings is shaped by a combination of socioeconomic vulnerabilities, partner-related risk factors, especially substance abuse, and entrenched patriarchal norms that normalize violence, particularly sexual and emotional abuse within marriage.

Recommendation
The study recommends routine IPV screening during ANC, awareness creation, and survivor-centered interventions tailored to rural sociocultural contexts.

Keywords: *Psycho-social support, Pregnant Women, Intimate Partner Violence, Isingiro District*
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Introduction

Intimate partner violence (IPV) remains a pervasive global public health challenge, contributing to approximately 38% of female mortality cases worldwide (WHO, 2021a). The burden is particularly severe in Sub-Saharan Africa, where 33% of pregnant women aged 15–49 years have experienced IPV at some point, and nearly 20% report incidents within the past year (WHO, 2021b). In Uganda, IPV prevalence is alarmingly high, with 45% of ever-partnered pregnant women reporting physical violence. Regional disparities are notable, with the Acholi Sub-region recording rates as high as 47% (UBOS, 2021). A study in southwestern Uganda further highlighted the magnitude of the problem, with 66.2% of women reporting intimate partner abuse (Arishaba et al., 2022).

Beyond physical violence, Ugandan women frequently experience sexual coercion, emotional abuse, and controlling behaviors that exacerbate vulnerability (UBOS, 2021; Nabaggala et al., 2021). Disclosure during pregnancy remains limited, as many women fear stigma, further violence, or harm to their pregnancy, hindering timely intervention (Chisholm et al., 2017; Katushabe et al., 2022a).

The consequences of IPV are profound. For mothers, IPV is associated with preterm labor, depression, substance use, inadequate antenatal care, hypertension, malnutrition, and traumatic injuries. For infants, IPV contributes to low birth weight, intrauterine growth restriction, preterm delivery, stillbirth, developmental delays, and even neonatal death (Van Parys et al., 2014).

Global responses have emphasized integrating IPV screening and response into antenatal care (ANC), complemented by psychosocial interventions and legal reforms (Ashburn et al., 2017). However, persistent sociocultural norms, underreporting, and weak enforcement structures undermine these efforts in low-resource settings. Strengthening IPV prevention and support systems is critical to safeguarding maternal and child health, promoting community resilience (Hatcher et al., 2013), and advancing Sustainable Development Goal 3: Good Health and Well-being (UNAIDS, 2021). Therefore, the objective of the study is to assess the prevalence of Intimate partner violence, associated factors, and psycho-social support networks among pregnant women at Kabuyanda HCIV and Rwekubo HCIV.

Methodology

Study design

A cross-sectional mixed-methods design was employed, combining quantitative surveys with qualitative in-depth interviews to assess intimate partner violence (IPV) among pregnant women.

Study site

The study was conducted at Rwekubo and Kabuyanda Health Centre IVs (HCIVs) in Isingiro District, Uganda. These facilities were chosen for their diverse patient populations and contrasting socio-cultural contexts, providing a comprehensive view of IPV experiences among pregnant women. The study was conducted over a period of three months.

Study population

The study population consisted of pregnant women aged 20–46 years and above who attended antenatal care (ANC) services at the selected health facilities. Women who were critically ill and unable to participate were excluded.

Sampling and sample size

For the quantitative phase, proportionate stratified consecutive sampling was used, with health facilities as strata. A total of 371 women were recruited—217 from Rwekubo HCIV and 154 from Kabuyanda HCIV. For the qualitative phase, purposive sampling was applied to select women identified as experiencing IPV during the survey until data saturation was achieved.

Table 1:Shows the proportion of women per facility and the sample frequency/interval

Health centre	Number of mothers (3 months)	Proportion of mothers	Number of mothers to be chosen	Sampling frequency/interval
Rwekubo HCIV	270	0.5844	0.5844/1 x371= 217	270/217=1.24
Kabuyanda HCIV	192	0.4156	0.4156/1 x 371= 154	192/154=1.25
Total	**462**	**1**	**317**	~2

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Study variables

Independent variables included obstetric factors (parity, gestational age, pregnancy complications), lifestyle factors (substance use, psychological stress), and community factors (social support, cultural norms, and law enforcement). The dependent variable was IPV among pregnant women.

Data collection tools

Quantitative data were collected using a researcher-administered questionnaire incorporating the Composite Abuse Scale Revised–Short Form. Qualitative data were obtained through a semi-structured interview guide designed to capture women's lived experiences of IPV. Both tools were translated into the local language, Runyankole.

Data collection procedure

After obtaining ethical approval, the study objectives were explained to participants in private settings, and informed consent was obtained. Questionnaires were administered face-to-face, taking 15-20 minutes. In-depth interviews with IPV survivors were conducted in private consultation rooms, lasted 45-60 minutes, and were audio-recorded to ensure accuracy.

Data quality control

Quantitative tools were pretested at Rugaga HCIV, and reliability was confirmed at Cronbach's $\alpha \geq 0.7$. Completed questionnaires were cross-checked for accuracy. For qualitative data, rigor was ensured through credibility, confirmability, dependability, and transferability. Strategies included peer review, prolonged engagement, reflexivity, member checking, and code–recode analysis.

Data analysis

Quantitative data were entered into Excel and analyzed in STATA. Univariate analyses summarized frequencies and percentages, bivariate associations were assessed using Chi-square tests, and multivariate regression identified predictors of IPV. Qualitative data were transcribed, translated, and thematically analyzed using NVivo, with codes and categories organized into overarching themes.

Ethical consideration

Ethical approval was obtained from the Bishop Stuart University Research and Ethics Committee (BSU-REC-2024- 441). An introduction letter was secured from the Head of the Department of Public Health and Biomedical Sciences to facilitate access and seek permission from relevant authorities, including the District Health Officer of Isingiro District. Informed consent was obtained from each participant following a detailed explanation of the study objectives, procedures, and confidentiality measures. Participants were clearly informed that their participation was entirely voluntary and that they had the right to withdraw from the study at any point without facing any consequences or needing to provide a reason.

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Results

Table 1: Demographic and Behavioral factors to IPV (n=348)

Variables	Values	n(%)
Age Group	18-25 26-35 36-45 46+	130(37.36) 133(38.22 74(21.26) 11(3.16)
Education	No formal education Primary Secondary Tertiary	63(18.1) 111(31.9) 96(27.6) 78(22.4)
Employment	Unemployed Employed/self-employed	186(53.4) 162(46.55)
Marital Status	Married Single Divorced Widowed	325(93.97) 19(4.89) 1(0.24) 3(0.9)
Substance use while pregnant	Engaged Not Engaged	42(11.85) 306(88.15)
Partner engaged in abusive use.	Engaged Not Engaged	114(32.76) 234(67.24)

The majority of respondents were aged 26–35 years (38.2%), followed closely by 18–25 years (37.3%), with only 3.2% aged 46 years and above. Most had attained primary education (31.9%), while 27.6% had secondary, 22.4% tertiary, and 18.1% no formal education. Over half of the women (53.5%) were unemployed, and 46.6% were self-employed. Nearly all participants (93.97%) were married, and among them, 34.9% reported experiencing IPV, reaffirming that violence predominantly occurred within ongoing relationships. Only small proportions were single (4.89%) or widowed (0.9%). Substance use during pregnancy was reported by 11.85% of women, while partner-induced substance use contributed to 32.76% of IPV cases.

The prevalence of intimate partner violence among pregnant women attending selected health facilities of Isingiro District

The findings provide insight into the extent of IPV in this population and form the basis for targeted interventions to improve maternal well-being and safety.

Table 2: Prevalence of IPV based on Forms of Abuse (n=348)

Variables	Values	n(%)
Sexual Abuse	No abuse Abuse	282(81.03) 66(18.97)
Emotional Abuse	No Abuse Abuse	255(73.28) 93(26.72%)
Physical Abuse	No Abuse Abuse	229(65.8) 119(34.2)

Among the 348 respondents, physical abuse was the most prevalent form of IPV during pregnancy, reported by 119 women (34.2%). Emotional abuse was experienced by 93 women (26.7%), highlighting its significant yet often overlooked psychological impact. Sexual abuse, though the least reported, affected 66 women (19.0%), indicating that nearly one in five pregnant women faced sexual coercion. These findings demonstrate that more than one-third of women are exposed to physical IPV, while substantial proportions also experience emotional and sexual abuse,

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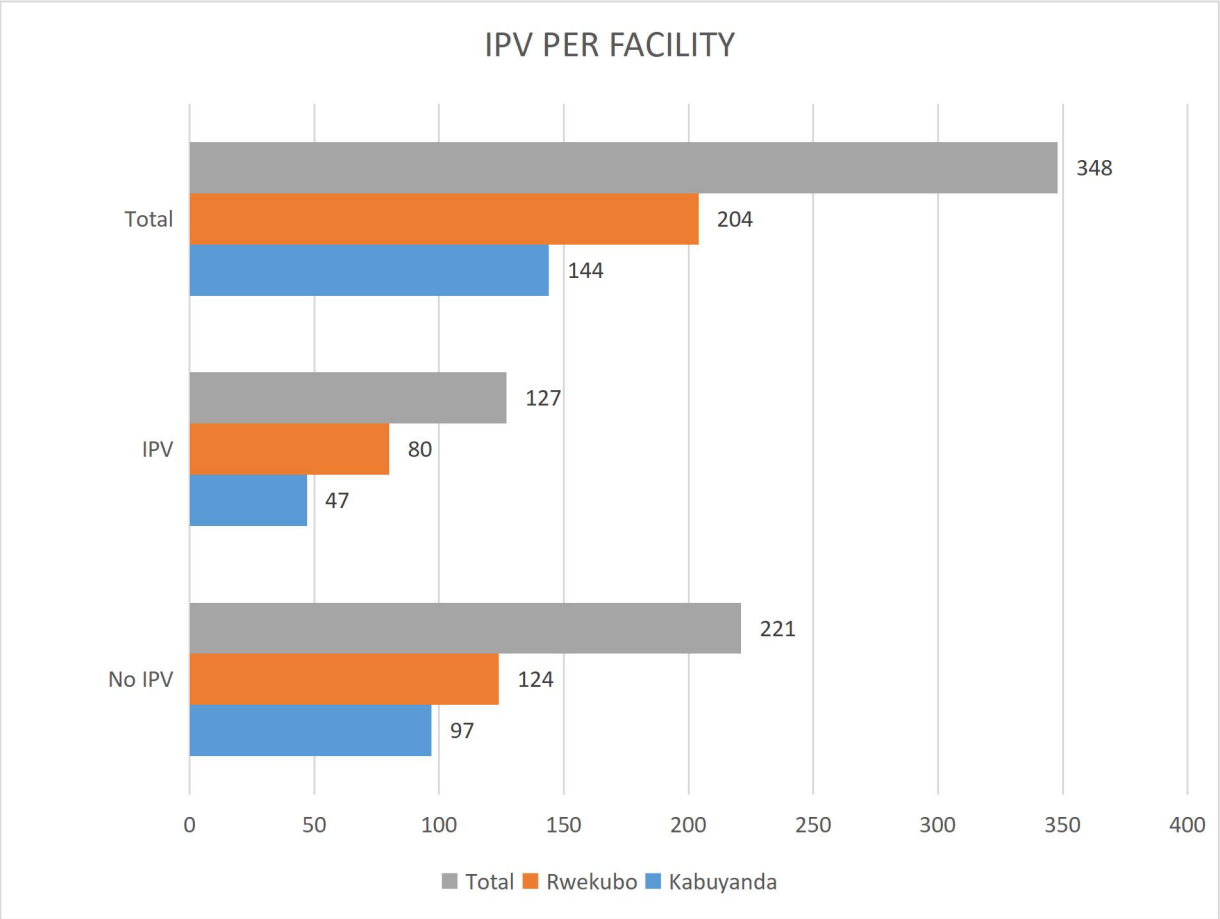
underscoring the urgent need for routine psychosocial screening in antenatal care.

Distribution of IPV by location.

Figure 1: Distribution of Facility by IPV in pregnancy(n=348)



In Figure 1, Rwekubo Health Center IV reported 80 IPV cases (39.2%), while Kabuyanda HCIV had 47(32.6%) out of 144. Despite Rwekubo having more respondents (204), its IPV prevalence is still proportionally higher.

Factors associated with intimate partner violence among pregnant women attending selected health facilities in Isingiro District

These findings highlight the key demographic, socio-economic, and relational dynamics linked to IPV in this setting.

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Table 3: Factors associated with IPV

Variables	Values	UOR(95% CI)	P-value	AOR(95% CI)	P-value
Age-group	18-25 26-35 36-45 46+	1 0.93(0.564- 1.544) 1.10 (0.6120 - 19.98) 0.64(0.162 - 2.23)	 0.789 0.748 0.525		
Marital Status	Single Married	1 2.78(1.28-6.02)	 0.010	1 10.81(3.71- 31.56)	 0.000
Education	No formal education Primary Secondary Tertiary	1 3.16(1.63- 6. 14) 1.19(0.60-2.39) 0.65(0.30-1.40)	 0.010 0.619 0. 268	 1 4.41(1.72 -11.3) 2.09(0.70-624) 1.62(0.47-5.55)	 0.002 0.184 0.442
Employment	Employment Self Employment	1 1.28(0.82-1.97)	 0.276		
Income	Less than 100000 100000-150000 150000+	1 0.68(0.40-1.16) 0.43(0.25-0.75)	 0.156 0.0003	1 0.36(0.15-0.87) 0.33(0.12-0.94)	 0.024 0.039
Substance use during pregnancy	No Abuse Abuse	1 0.14(0.07-0.30)	 0.000	 1 0.67(0.25-1.7)	 0.398
Substance use in partners	No Abuse Abuse	1 0.05(0.03-0.82)	 0.000	 1 0.37(0.02-0.08)	 0.000

Bivariate analysis showed that marital status was significantly associated with IPV, with women in certain marital categories having 2.8 times higher odds ($p = 0.010$). Educational status also mattered, as women with secondary education faced nearly threefold higher odds of IPV ($p = 0.001$), while higher education was not protective. Household income had a protective effect, with women in the highest category showing a 57% reduced risk of IPV ($p = 0.003$). Partner substance use emerged as a strong predictor, with substantially increased risk ($p < 0.001$). Women's own substance use was significant in unadjusted analysis ($p < 0.001$), while age group and employment status showed no associations.

In multivariate analysis, marital status remained the strongest predictor, conferring more than tenfold higher odds of IPV ($p < 0.001$). Secondary education continued to significantly increase IPV risk by over fourfold ($p = 0.002$), while higher income remained protective, reducing IPV odds by 65–67% ($p < 0.05$). Partner's substance use was the most powerful factor, with women nearly 27 times more likely to experience IPV ($p < 0.001$). In contrast, women's own substance use and age were no longer significant after adjustment.

Qualitative findings on socio-economic factors associated with IPV

The analysis identified five key themes on socio-economic factors driving IPV;

Theme 1: partner substance abuse

Most men when they are drunk, it was reported that they fight their wives, chase them from houses and they sleep

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outside, denies them access to food in the house, *"When he drinks, he turns into a different person. He becomes aggressive and starts shouting. Sometimes, he throws things or hits me without any reason. I live in fear every time he drinks."* (Participant 2)

Theme 2: Financial dependence and economic insecurity

Financial reliance and lack of exit options: *"I don't have a job and I depend on him for everything. Even when he hurts me, I stay because I have nowhere to go. He knows that, and it makes him even more controlling."* (Participant 10)

Theme 3: Educational inequality and power imbalance

Negative reactions to educated women. *"He always mocks my education and says I act like I'm better than him. It hurts because he does it in front of the children. I worked hard to go to school, but now he uses it against me."* (Participant 10)

Theme 4: Cultural norms and patriarchal beliefs

Social tolerance of IPV *"My mother always says that a woman must be patient, no matter what. Even when he beats me, they say it's normal for a man to discipline his wife. I feel trapped by their beliefs."* (Participant 7)

Theme 5: Sexual coercion and marital rape

Normalization of forced sex in marriage. *"He forces himself on me even when I beg him not to. I used to think it's just part of being married, but now I realize it's not right. Still, I feel like I can't say no."* (Participant 1), which influences IPV.

Psychosocial support networks for pregnant women experiencing intimate partner violence in Rwekubo HCIV and Kabuyanda HCIV

The findings shed light on the sources, accessibility, and effectiveness of support systems within these communities.

Table 4: Psychosocial support networks, and Access for victims of IPV(n=348)

Variables	Values	n(%)
External support (Security, medical, spiritual)	Available Not Available	229(65.8) 119(34.20)
Stress Reduction Activities	Engaged Don't Engaged	233(66.95) 115(33.05)
Access to psychosocial teams (counselors, social workers)	Helpful Not helpful Not sure	172(73.82) 20(8.58) 41(17.60)
Community Support (host communities)	Supported Not supported	218(52.64) 130(37.36)
Barriers to Psychosocial Support		
Lack of awareness	Aware Not Aware	116(33.33) 232(66.67)
Stigma	Stigma No stigma	262(75.29) 86(24.71)
Cultural barriers	Evident Non evident	77(22.13) 271(77.87)
Legal protection	Accessible Non accessible	125(56.6) 66(52.0)
Discrimination	Experienced Not Experienced	53(41.7) 21(9.5)

Among 348 pregnant women, 65.8% reported access to external psychosocial support systems, while 34.2% lacked such access. Two-thirds (66.9%) engaged in stress-reduction activities, most of whom (73.8%) found them

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helpful, highlighting the value of coping strategies, though a minority remained uncertain or dissatisfied, indicating a need for professional psychological services.

Community-based support was reported by 62.6% of women, but 37.4% lacked community involvement, potentially exacerbating feelings of helplessness. Barriers to accessing support were substantial: 66.7% were unaware of available services, 75.3% feared community gossip, and 77.9% lacked cultural support, reflecting the normalization of IPV and stigma-related deterrents. Legal protection was reported by 56.6% of women without IPV versus 52% of IPV survivors, suggesting underutilization or weak integration of legal services. Additionally, 41.7% of IPV survivors experienced discrimination compared to 9.5% of non-IPV women, emphasizing stigma as a critical barrier to help-seeking and psychosocial well-being.

Table 5: Psychosocial Support factors associated with IPV

Variables	Values	OR(95% CI)	P-value
Community support	Not Available Available	1 3.53(1.91-6.55)	0.000
legal_protection	Not Available Available	1 0.72(0.42-1.23)	0.240
Discriminated	No Yes	1 0.21(0.19-0.39)	0.000
Campaign	No Yes	1 3.53(0.40-1.56)	0.498

Multivariate analysis revealed that reduced community support was strongly associated with IPV, with women experiencing lower support having 3.5 times higher odds of IPV (OR = 3.53, 95% CI: 1.91–6.55, $p < 0.001$), highlighting the protective role of psychosocial networks. Experiencing discrimination when seeking help significantly increased IPV risk, with a 79% reduction in the odds of avoiding IPV (OR = 0.21, 95% CI: 0.11–0.39, $p < 0.001$). Exposure to awareness campaigns was protective, increasing the odds of not experiencing IPV by 3.5-fold (OR = 3.53, 95% CI: 1.90–6.56, $p < 0.001$). Legal protection showed a 28% reduction in IPV odds (OR = 0.72, 95% CI: 0.42–1.25), though this was not statistically significant, likely reflecting challenges in enforcement or accessibility.

Table 6: Barriers to psychological support and its association with IPV

Variables	Values	OR(95% CI)	P-value
lack of awareness	No Yes	1 2.99 (1.19-7.55)	0.020
cultural barriers	Not Available Available	1 27.49 (7.01-107.55)	0.000
lack of resources	No Yes	1 0.37(0.13-1.04)	0.060
Stigma	No Yes	1 1.09(0.29-4.10)	0.898

The results in Table 6 indicated that a **lack of IPV awareness** significantly increased risk, with women unaware of support or prevention strategies having threefold higher odds of experiencing IPV (OR = 2.99, 95% CI: 1.19–7.55, p = 0.020). **Harmful cultural norms** were the strongest risk factor, associated with a 27-fold increase in IPV odds (OR = 27.49, 95% CI: 7.01–107.76, $p < 0.001$). Reduced access to resources showed a trend toward increased vulnerability, corresponding to a 36% lower odds of avoiding IPV (OR = 0.36, 95% CI: 0.13–1.04, p = 0.060). **Fear of gossip** was not significantly associated with IPV (OR = 1.09, 95% CI: 0.29–4.10, p =

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0.898), possibly reflecting overlap with other socio-cultural factors.

Qualitative findings: psychosocial support networks

To complement quantitative results, in-depth interviews captured pregnant women's lived experiences of IPV in rural Uganda, highlighting contextual factors influencing access to support.

Theme 1: Awareness and accessibility of services

Many women were unaware of available IPV support services, including counseling, shelters, or legal aid, and perceived marital issues as private matters. One participant explained, *"I never knew there were services that help women like me. I thought once you're married, you just have to handle things on your own."*

Theme 2: Stigma

Fear of community judgment and societal pressure to maintain marital harmony discouraged disclosure, with silence often viewed as a coping strategy. As one woman described, *"I fear being judged and shamed by my neighbors… So I keep quiet and cry in silence."*

Theme 3: Legal protection

Even when legal avenues were sought, systemic barriers limited effectiveness, with authorities often dismissing complaints as family matters. A participant noted, *"I reported him once, but they told me it's a family issue… I feel like the law doesn't protect women like me."*

Theme 4: Community Support

Support from churches, women's groups, and local leaders provided emotional reinforcement and practical assistance. One woman shared, *"The church women helped me open up… Since then, he has changed a lot. I'm thankful I wasn't alone."*

Theme 5: Coping mechanisms

Personal strategies, including prayer, counseling, and peer support groups, helped women manage IPV-related trauma. A participant reflected, *"Talking to others and seeing a counselor has helped me feel less broken."*

These qualitative insights underscore the importance of awareness, accessible services, community engagement, and psychosocial support in mitigating the impact of IPV on pregnant women.

Discussion

Prevalence of intimate partner violence among pregnant women attending selected health facilities of Isingiro District

This study demonstrates that IPV remains a significant concern among pregnant women in rural Uganda, with sexual abuse, physical abuse, and emotional abuse being the primary forms identified. The prevalence observed exceeds national estimates (Kebede et al., 2022) and is higher than figures from neighboring Ethiopia (Liyew et al., 2022), reflecting heightened vulnerability in underserved rural areas shaped by structural barriers, gender inequities, and entrenched patriarchal norms. Geographical variation was evident, with Rwekubo HCIV showing higher IPV rates than Kabuyanda HCIV, potentially due to differences in community mobilization, availability of psychosocial services, local leadership, and disclosure practices influenced by stigma or cultural norms. This suggests that contextual factors are critical in shaping both the occurrence and reporting of IPV.

Factors associated with intimate partner violence among pregnant women attending selected health facilities in Isingiro District

Women with primary education were more likely to experience IPV compared to those with no formal education, consistent with Azene et al. (2023), though qualitative insights indicate that education can sometimes provoke partner resentment in households where it challenges traditional gender roles. Unemployment significantly increased IPV risk, aligning with Jewkes (2002) on financial dependence, while higher personal income offered partial protection, though potential male backlash remains a concern (Vyas & Watts, 2009). Partner substance abuse emerged as the strongest risk factor, consistent with findings by Alhusen et al. (2015) and Gebrezgi et al. (2017). Sexual abuse was prevalent, but underreported due to the normalization of marital coercion, challenging claims of declining sexual IPV trends (Teshome et al., 2021).

Psychosocial support networks for pregnant women experiencing intimate

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Access to community support systems reduced women's vulnerability to IPV, supporting Mabetha et al. (2022) on social capital as a protective mechanism. However, many participants were unaware of available services, highlighting gaps in outreach and trust-building. Fear of stigma, community gossip, and experiences of discrimination emerged as key barriers to help-seeking, echoing Richardson et al. (2022). Legal protections were often ineffective without proper enforcement, consistent with concerns raised by Human Rights Watch (2020). Informal support networks, including peer groups and faith-based counseling, provided resilience and improved emotional well-being, in line with WHO (2013) recommendations. Cultural norms and limited awareness shaped both IPV exposure and help-seeking behavior, emphasizing the importance of culturally sensitive, accessible, and confidential interventions.

Conclusion

This study highlights the high prevalence (36.5%) and multifaceted drivers of intimate partner violence (IPV) among pregnant women in rural Uganda, exceeding national averages. IPV in these settings is influenced by a combination of socioeconomic vulnerabilities, partner-related risk factors—particularly substance abuse and entrenched patriarchal norms that perpetuate sexual and emotional abuse within marriage.

These findings underscore the need for targeted, multi-sectoral interventions that are context-specific, culturally sensitive, and survivor-centered, addressing structural, community, and individual-level determinants to effectively prevent and mitigate IPV during pregnancy.

Recommendations

To the Ministry of Health and national policymakers

The findings call for the Ministry of Health to prioritize the integration of routine IPV assessment into both antenatal and postnatal care services across all levels of the healthcare system. Screening for IPV should become a standard part of maternal health services, with clearly defined protocols, confidential reporting mechanisms, and referral pathways in place. Moreover, policy support should be extended to programs that involve men in IPV prevention and substance abuse rehabilitation, while promoting shared decision-making and gender equity within households.

To local governments, Rwekubo HCIV and Kabuyanda HCIV

At the sub-county level, local governments should focus on enhancing community structures that support IPV identification, prevention, and survivor support. Routine IPV screening should be enforced not only during antenatal visits but also during postnatal follow-ups, child immunization appointments, and family planning consultations to capture cases that emerge or escalate after childbirth.

Additionally, local authorities should support the development of safe spaces within or near these health facilities where women can access psychosocial support, legal guidance, and stress-relief services.

To NGOs and Community-Based Organizations (CBOs)

These organizations should work with health facilities to support the implementation of structured IPV screening tools that can be used during both antenatal and postnatal care, accompanied by survivor referral and follow-up mechanisms.

Community-based organizations can also conduct home visits for postpartum women who may be unable or unwilling to return to health facilities, thereby expanding the reach of IPV response services. NGOs should invest in integrated programming that combines mental health care, economic empowerment, legal aid, and family counseling, ensuring services are accessible, confidential, and survivor-led. These efforts must also include male engagement components to address potential backlash, foster accountability, and transform traditional masculinities.

To researchers and academic institutes

Future research should delve deeper into the effectiveness and feasibility of routine IPV screening across the continuum of maternal care, from the first antenatal visit to postnatal follow-ups and child health appointments. Studies could explore how repeated contact with the healthcare system can be leveraged to identify, track, and support IPV survivors over time. It is also important to explore how disclosure during pregnancy or after childbirth differs, and what factors encourage or hinder help-seeking in each period.

Longitudinal studies are needed to understand how IPV evolves during and after pregnancy, and how it affects not

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only maternal mental health but also infant development, bonding, and long-term family dynamics.

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List of abbreviations

ANC Antenatal Care
IPV Intimate Partner Violence
LMICs: Low- and Middle-Income Countries
MoH Ministry of Health
NPSV Non-partner Sexual Violence
SSA Sub-Saharan Africa
UDHS Uganda Demographic Health Survey
UBOS Uganda Bureau of Statistics
WHO World Health Organisation

Source of funding

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Conflict of interest

The authors declare no conflict of interest.

Data availability

Data is available upon request from the author.

Author biography

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