

Knowledge, Attitude and Perception of Self-Harm in Pregnancy Among Women Attending Ante-Natal Clinics in South-Western Nigeria

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ABSTRACT

Self-harm is a major public health concern affecting thousands of women although it is an under-reported and neglected aspect of maternal health particularly in developing countries where there is a paucity of evidence regarding self-harm and it is rarely given attention. This study was a cross sectional quantitative study carried out to investigate the knowledge, attitude and perception of self-harm in pregnancy among 369 women attending antenatal clinics in a government owned hospital in southwest Nigeria. Respondents were selected using multi-stage sampling technique from ante natal clinics with the aid of semi-structured questionnaire to elicit information on their socio-demographic, knowledge, perception, and their attitude towards self-harm. Data were entered using SPSS version 25 and were analysed using descriptive and inferential Chi-square statistics at $p = 0.05$. Respondent's knowledge on self-harm in pregnancy was measured on 7 items and 7-point scale. Knowledge score of < 2 was rated as poor and ≥ 7 was rated as good. Perception of self-harm in pregnancy was measured on 16 items and 16-point scale, score < 8 was rated as negative and scores ≥ 8 was rated as positive. While respondents' attitude toward self-harm was measured on 11 items and 11-point scale, score < 6 was rated as negative and scores ≥ 6 as positive. Most respondents (85.4%) had a good knowledge of self-harm in pregnancy, good perception of (79.1%) and positive attitude of (85.9%). There should be public awareness and education campaigns on early detection,

screening and counselling of pregnant women on the effect and risks of self-harm in pregnancy.

Keywords: Knowledge, Attitude, Perception, Self-harm, Pregnancy, Hospital, Antenatal

INTRODUCTION

According to Lagadec, Steinecker, and Kapassi (2018) Pregnancy is a period of transition with important physical and emotional changes. Even in uncomplicated pregnancies, these changes can affect the quality of life of pregnant women, affecting both maternal and infant health. Pregnancy is a stressful period for many women and as a phase comes down with various psychological morbidities including depression, insomnia, self-harm and suicide (Usman, Akintayo, Peter, Olutoyin and Adetunji, 2018). These disorders when they occur in pregnancy have been found to be risk factors for adverse outcomes for mothers and children. General Consequences of these disorders include lack of compliance with antenatal visits and treatment, poor nutrition and self-care, self-medication, alcohol and drug use, suicidal thoughts, negative attitude towards the child and thoughts of harming the fetus (Carter and Kostaras, 2005).

The World Health Organization (WHO, 2016) defines self-harm as "an act with non-

fatal outcome in which an individual deliberately initiates a non-habitual behavior that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage and which is aimed at realizing changes that the person desires via the actual or expected physical consequences. According to Polling and Tulloch (2015) self-harm is a suicide attempt or self-injurious behavior, including cutting, burning, hitting, hanging, overdosing, poisoning and electrocuting using terms validated in another CRIS study on self-harm and Emergency Department attendances. According to Rodriguez, Mandell, Babayigit, Manohar, Weiss and Jones 2018 having experienced physical intimate partner violence within the previous 4 weeks increased the odds of experiencing self-harm during pregnancy and again at 12 months postpartum.

According to WHO, UNICEF, and UNFPA (2019) maternal mortality is a marker of population health and reducing maternal mortality rates is a priority for countries worldwide. It is estimated that between 2000 and 2017, there was a 38% reduction in global maternal mortality ratio (defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period). Despite this drop across the world, in the USA, the maternal mortality ratio increased by 26.6% between 2000 and 2014. Although part of this increase is attributed to improved methods of identifying maternal deaths, maternal mortality rates in the USA are the highest among developed countries MacDorman, Declerc, Cabral, Morton (2016).

In developing countries, maternal and infant morbidity still remain a global concern, most especially in many Sub-Saharan African Countries. Globally, women die every minute from health complications related to pregnancy and childbirth. According to WHO (2010) maternal mortality is a global public health challenge owing to the statistics indicating a lag in its

improvement? Every year worldwide, over 500 000 women die of pregnancy and childbirth related complications (WHO, 2014). In sub-Saharan Africa, the maternal mortality rate is the highest across the global at 500 per 100,000 live births whereas regions like Asia record 220 per 100,000 while Caribbean and Latin America is 80 per 100,000 (WHO, 2015). Preventable direct obstetric causes are the main contributor to the global burden of maternal mortality (MM), whereas indirect causes account for 27.5% of maternal deaths and continuing to increase.

The concept of obstetric transition was proposed and described at different stages in a dynamic process between and within countries. The transition (Stage I-V) ranges from high fertility and maternal mortality rates (MMR > 1000/100,000 live births) to low fertility and MMR (< 50/100,000 live births). It is also indicated that causes of MM shift in these stages from low access and quality of care, as well as direct obstetric causes to a high burden of indirect obstetric causes according to Souza, Tunçalp, Vogel, Bohren, Widmer and Oladapo (2014). While the global maternal health agenda offers a comprehensive approach towards ending preventable maternal mortality (WHO, 2015), some components are still neglected in many settings.

Thoughts of self-harm are defined as thoughts of causing harm to oneself, regardless of suicidal intent (Giallo, Pilkington, Borschmann, Seymour, Dunning and Brown, 2018). It has also been identified as a risk factor and distal predictor of suicide. In contrast, suicidal ideation is the experience of thoughts about taking one's own life and has been associated with future suicide attempt and completion (Tabb, Gavin, Guo, Huang, Debiec, and Katon, 2013). Although these terms have very distinct meanings, they are often misused in the literature. Moreover, the prenatal and postpartum periods are associated with fluctuations in hormone levels, and thoughts of self-harm/suicide,

the thoughts of self-harm may be influenced by the presence of depressive symptoms during perinatal and postnatal period, employment/income status, the presence of social support, experience of childhood physical and sexual abuse, marital status and education level, age, and partners' employment status (Giallo et al., 2018; Howard, Flach, Mehay, Sharp and Tylee, 2011).

According to Bourgoin, Callahan and Séjourn (2012) pregnancy is a period of transition with important physical and emotional change. Thoughts of self-harm and suicide can increase the risk of adverse pregnancy and postpartum outcomes, including preterm labour, teratogenic effects as a result of self-poisoning, and early termination of pregnancy breastfeeding practices Zhong, Gelaye, Smoller, Avillach, Cai, and Williams (2018). Self-harm is estimated to occur in 75.5% of low-and middle-income countries (WHO, 2014). The mother's morbidity and maternal mental disorders may be linked to obstetric complications and developmental problems in the child. Self-harm increases the risk of low birth weight and has less positive effect among infants.

The UK Confidential Enquiries into Maternal Deaths and other studies have highlighted mental illness as a significant contributor to maternal deaths and also highlight a history of self-harm in a significant proportion of maternal suicides (Kurinczuk et al., 2014). The estimates of the prevalence of thoughts of self-harm and associated risk factors among women have the potential to inform mental health promotion and suicide prevention that are tailored to the unique circumstances of women of reproductive age, and among women who are pregnant or recently gave birth.

The rate of self-harm in pregnancy reportedly remained stable between 2006 and 2012 in the USA (Zhong et al., 2016). However, a recent large US general population registry study reported the prevalence of acts of self-harm in the year

preceding or following birth doubled between 2012 and 2017, describing this as a potential public health crisis according to Admon, Dalton, Kolenic, Ettner, Tilea, Haffajee and Zivin (2021). A study revealed that there is evidence that self-harm among young women in the UK is also increasing and there are renewed clinical concerns that self-harm during pregnancy may also be on the rise, Ayre, Dutta, and Howard (2020)

A study investigating the link between self-harm and mother-infant relationships among pregnant women in Southeast London found that self-harm ideation during pregnancy was associated with depressive symptoms and negatively impacted mother-infant relationships during postnatal period (Gordon, Nath, Trevillion, Moran, Pawlby, Newman, Howard, and Molyneaux, 2019). Other studies have found that thoughts of self-harm may be influenced by the presence of depressive symptoms during prenatal and postnatal period, employment/income status, the presence of social support, experience of childhood physical and sexual abuse, marital status and education level, age, and partners' employment status (Howard, Flach, Mehay, Sharp and Tylee, 2011).

According to Quarshie, Watermean and Hous (2020) young women and adolescent girls are particularly vulnerable to self-harm. While many of these women might be mothers, or at least of child-bearing age, there is very little research on thoughts of self-harm during the perinatal period (Ayre and Dutta, 2019). Despite evidence of risk during pregnancy, there are few routine screening programmes to identify thought of self-harm or suicidal ideation for pregnant women in developing countries. Both thought of self-harm and suicidal ideation are known antecedents of suicide attempts. Ruiz (2014) opined that early detection and prevention of thought of self-harm would have significant public health benefit. While the justification for early detection may be compelling, resistance to the introduction of time-intensive screening procedures in an already over-burdened public healthcare

system is likely to be high. Self-harm is a global public health concern affecting thousands of women. However, it is an under-reported and neglected aspect of maternal health, particularly in developing countries. In Nigeria, there is a paucity of evidence regarding self-harm, and it is rarely given attention.

MATERIALS & METHODS

The study was a descriptive cross-sectional study that utilised the semi-structured questionnaire to investigate the knowledge, attitude and perception of self-harm in pregnancy among women attending ante-natal clinics in Ife central Local Government Area.

The sample population was calculated using the Fischer's formula and a standard normal value of 1.96 at 95% confidence interval and a proportion of 32.2%. Multistage sampling technique was adopted in selecting the target population of 369 pregnant women from ante natal clinics in selected wards of Ife Central Local Government. Data collection was carried out randomly within 5days from the hours of 8 am -11 am and 12 pm -3 pm. The information obtained from respondents includes the socio-demographic characteristics, knowledge, perception, and attitude towards self-harm.

Data were coded and entered into the IBM statistical package for social sciences (SPSS version 25) to analyse data using descriptive and inferential Chi-square statistics at $p = 0.05$. Tables, inferences and charts were used for data representation.

Pregnant women attending Ante Natal Clinic in the study area who consented to participate were included in the study while Pregnant women that do not give consent to participate were excluded from the study.

Ethical approval was obtained from Osun State Ethics Review Committee of the Ministry of Health (OSHREC/PRS/569T/343) before the commencement of the

data collection. Respondents were reassured of anonymity/informed that the study was solely for a research survey.

RESULT

Socio-Demographic Characteristics

Three hundred and sixty-nine (369) pregnant women attending antenatal clinics were recruited for this study. Most (41.7 %) of the respondents belong to the age group 26 to 35 years and 40.1 % belong to the age group 18 to 25 years while 36 years above which is the smallest of the group constitute 18.2 % of the sample. The educational level of the respondents analysed showed that 30.1% of them had attained tertiary education, 48.8% attended secondary school only, 10.6% attained primary school leaving certificate while 10.6% of the respondents had no formal education. The majority of the pregnant women were Yoruba (66.1%), while Igbo (18.2.7%) and Hausa (10.4%) were the next most common ethnic groups. Most of the pregnant women were either traders 37.7% or Artisan (28.2%) while (10.6%) of the respondents were civil servant.

In relation to marital status, the majority of participants were married, constituting 97.8% of the sample. Occupational diversity was also evident within the sample. Traders constituted the largest occupational group, comprising 37.7% of the participants. Artisans and civil servants represented 28.2% and 10.6%, respectively. Unemployed individuals accounted for 15.4% of the sample, while students comprised 8.1%. Religious affiliation revealed a predominance of Christianity among the participants, with 65.9% identifying as Christians. The majority of participants (60.4%) fell within the income range of 5000-15000. Marriage type was examined, revealing that the 64.2% were in monogamous relationships, (Table 1).

Table 1 Socio-demographic characteristics of respondents (N=369)

Socio demographics	Frequency	%
Age		
18-25	148	40.1
26-35	154	41.7
36 and above	67	18.2
Education		
None	39	10.6
Primary	39	10.6
Secondary	180	48.8
Tertiary	111	30.1
Ethnicity		
Yoruba	244	66.1
Hausa	39	10.6
Igbo	67	18.2
Others*	19	5.2
Marital		
Single	4	1.1
Married	361	97.8
Divorced	2	0.5
Widowed	2	0.5
Occupation		
Unemployed	57	15.4
Student	30	8.1
Trader	139	37.7
Artisan	104	28.2
Civil servant	39	10.6
Religion		
Christianity	243	65.9
Islam	114	30.9
African tradition religion	3.3	3.3
Monthly Income		
5000-15000	223	60.4
16000-25000	95	25.7
26000-35000	10	2.7
36000-45000	15	4.1
46000 and above	26	7.0
Marriage Type		
Monogamy	237	64.2
Polygamy	130	35.2
Parity		
None	78	21.1
One	81	22.0
Two	123	33.3
Three	70	19.0
Four	14	3.8
Five and above	3	8
Previous Psychiatric History		
No	354	95.9
Yes	15	4.1
Caesarian Birth		
No	305	82.7
Yes	64	17.3
Do you know about self-harm in pregnancy		
No	107	29.0
Yes	262	71.0
How did you know about self-harm in pregnancy		
Radio	8	2.2
Television	23	6.2
Social media	65	17.6
Peers/friends	45	12.2
Health workers	126	34.1

Knowledge of self-harm in pregnancy among women attending Antenatal clinics

The table presents the respondents' knowledge regarding self-harm in

pregnancy, displaying their responses to different knowledge statements. It provides valuable insights into the level of understanding and awareness among the

participants. A total of 92.4% of respondents, indicating a relatively high level of awareness were aware that self-harm involves intentionally initiating non-habitual behaviors resulting in self-harm or deliberately ingesting substances beyond prescribed dosages. The majority of respondents (94.6%) responded affirmatively to knowledge of the higher vulnerability of women in the perinatal period (pregnancy and postpartum) to self-harm compared to women in the general population., recognizing this increased vulnerability, while majority 95.1% of

respondents recognized self-harm as a mental health problem during pregnancy while 93.8% of respondents acknowledged the importance of counseling for individuals experiencing such thoughts, which includes contemplating or planning suicide. Majority 85.9% of respondents agreed that self-harm in pregnancy is more prevalent among younger individuals, while the majority of respondents (85.4%) recognized that thoughts such as self-harm thoughts during pregnancy can have both short-term and long-term adverse effects.

Table 2 Respondents knowledge of self-harm in pregnancy (N=369)

Knowledge Statement	Frequency	Percentage
Self-harm is an act in which person intentionally initiates a non-habitual behavior that will result in self-harm without the intervention of others or deliberately ingests a substance over the prescribed dosage	341	92.4
women in the perinatal period are (pregnancy and postpartum) are more prone to self-harm than women in the general population	349	94.6
thought of self-harm in pregnancy is a mental health problem that can occur in pregnancy	351	95.1
thought of self-harm in pregnancy is associated with depressive mood disorder	351	95.1
Recurrent thoughts of self-harm and death during pregnancy, which include thinking about or even planning suicide is a critical symptom of self-harm that needs counseling	346	93.8
Self-harm in pregnancy is associated with younger age	317	85.9
Thoughts of self-harm experienced during pregnancy can have short and long-term negative effects on maternal health and well-being	315	85.4

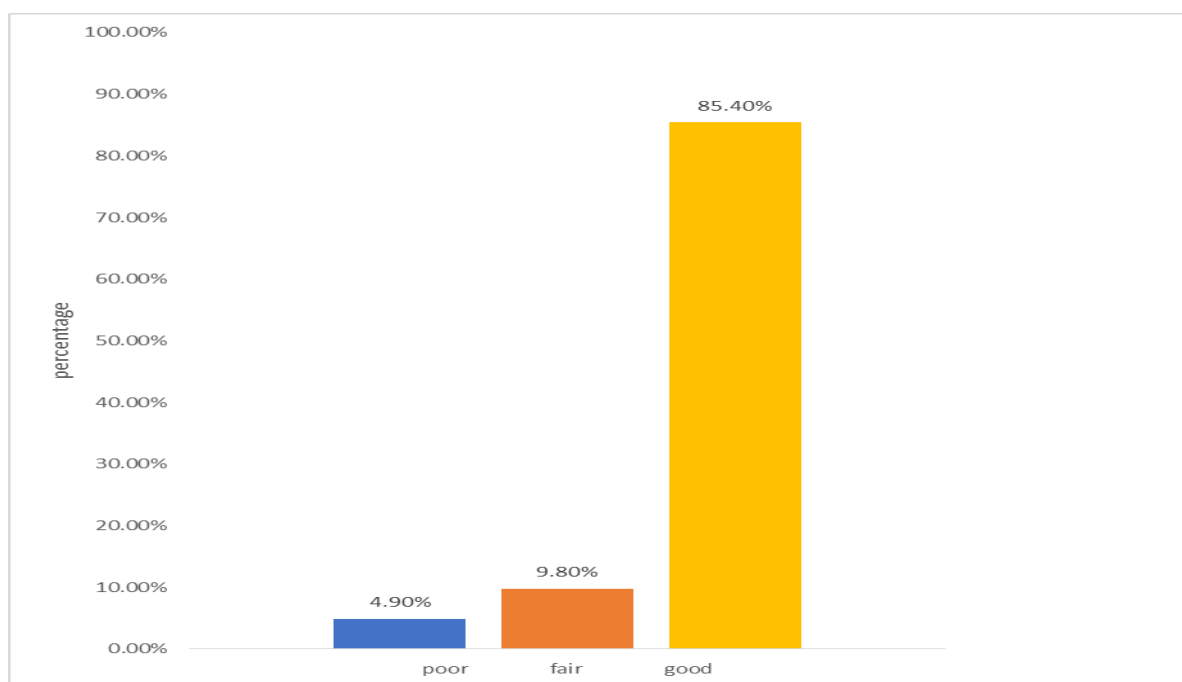


Figure 1 Rating of respondents according to their knowledge on self-harm (N=369)

Respondents’ perception of self-harm in pregnancy

A majority of 55.8% strongly agreed with the statement “not receiving help and adequate care can potentially lead to

thoughts of self-harm during pregnancy”, while 39.0% agreed. Only a small percentage of 1.1% strongly disagreed. A significant proportion of respondents (57.2%) strongly agreed that the experience

of intimate partner violence is influential in terms of thoughts of self-harm during pregnancy. while 39.8% agreed and strongly disagreed or disagreed was relatively low at 1.4% and 1.6% respectively. Having an unsupportive partner was identified as another potential factor leading to thoughts of self-harm and suicide during pregnancy. The majority of respondents (58.8%) strongly agreed with this statement, while 37.4% agreed. A small percentage of 0.5% strongly disagreed. Unplanned pregnancy was perceived as a factor that could result in thoughts of self-harm, with 53.7% of respondents strongly agreeing and 42.3% agreeing. The percentage of those who strongly disagreed or disagreed was 5.0% and 3.5% respectively. Respondents also acknowledged the association between low income and thoughts of self-harm during pregnancy.

Approximately 53.7% strongly agreed and 38.8% agreed that women with lower incomes who struggle to meet their vital needs and daily living costs may be at risk. Only a small percentage of 1.9% strongly disagreed. The respondents believed that women with poor decision-making power in their families were more likely to attempt self-harm during pregnancy. While 50.7% agreed with this statement, 37.9% agreed and 10.3% disagreed. The percentage of those who strongly disagreed was 1.1%. The young age of the mother was seen as an influential factor in thoughts of self-harm during pregnancy. A majority of 58.8% strongly agreed, and 29.8% agreed with this statement. The percentages of those who strongly disagreed and disagreed were 3.5% and 7.9% respectively.

Table 3 Respondents' Perception of self-harm in pregnancy (N=369)

Perception statement	Strongly Disagree Freq (%)	Disagree Freq (%)	Agree Freq (%)	Strongly Agree Freq (%)
Not receiving help and adequate care can result to thought of self-harm in pregnancy	4 (1.1)	15 (4.1)	144 (39.0)	206 (55.8)
Experience of intimate partner violence can influence thought of self-harm in pregnancy	5 (1.4)	6 (1.6)	147 (39.8)	211 (57.2)
having an unsupportive partner can lead to thought of self-harm and suicide in pregnancy	2 (0.5)	12 (3.3)	138 (37.4)	217 (58.8)
Unplanned pregnancy can result to thought of self-harm	2 (5.0)	13 (3.5)	156 (42.3)	198 (53.7)
Thought of self-harm in pregnancy can occur in women with lower incomes that cannot fulfill vital needs and may not be able to satisfy daily cost of living	7 (1.9)	21 (5.7)	143 (38.8)	198 (53.7)
Women who has poor decision-making power in the family can attempt self-harm than those who had good decision-making power	4 (1.1)	38 (10.3)	140 (37.9)	187 (50.7)
Young age of the mother can influence thought of self-harm in pregnancy	13 (3.5)	29 (7.9)	110 (29.8)	217 (58.8)
Women with intimate partner violence can attempt self-harm as a way of expressing unpleasant emotions brought on by domestic or emotional abuse,	13 (3.5)	45 (12.2)	142 (38.5)	169 (45.8)
Women with low monthly household income has lower autonomy over their health and is at risk of developing self-harm thought in pregnancy	5 (1.4)	13 (3.5)	128 (34.7)	223 (60.4)
Mood disorder can result to self-harm in pregnancy	8 (2.2)	22 (6.0)	129 (35.0)	210 (56.9)
Personality disorder can result to self-harm in pregnancy	21 (5.7)	36 (9.8)	132 (35.8)	180 (48.8)
Anxiety disorder can lead to self-harm during perinatal period	23 (6.2)	35 (9.5)	121 (32.8)	190 (51.5)
Psychotropic drug treatment can lead to self-harm in pregnancy	6 (1.6)	31 (8.4)	166 (45.0)	166 (45.0)
Substance abuse at any stage of pregnancy can result to self-harm and affect the unborn fetus	6 (1.6)	101 (27.4)		262 (71.0)
substance misuse, smoking during pregnancy can lead to thought of self-harm	5 (1.4)	4 (1.1)	74 (20.1)	286 (77.5)
Thought of self-harm during pregnancy is associated with a history of child abuse or Domestic violence	20 (5.4)	39 (10.6)	88 (23.8)	222 (60.2)

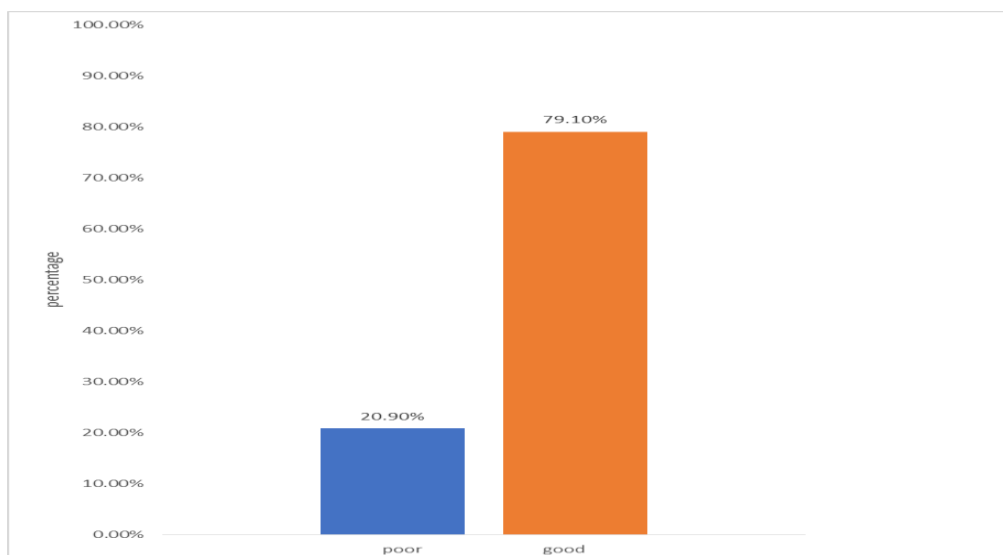


Figure 2 Rating of respondents according to their perception of self-harm (N=369)

Respondents Attitude towards self-harm in pregnancy

The majority of the participants, 13.0%, strongly disagreed, while 22.0% disagreed, 40.4% agreed, and 24.7% strongly agreed that all pregnant women are at risk of developing self-harm in pregnancy. Regarding the perception that mothers experiencing thoughts of self-harm are sometimes scared to seek help, 1.9% strongly disagreed, 1.9% disagreed, 35.8% agreed, and 60.4% strongly agreed. Participants were asked about the belief that thoughts of self-harm are a mental health condition more likely to occur without social support. The responses indicated that 1.1% strongly disagreed, 8.0% disagreed, 32.2% agreed, and 65.9% strongly agreed with this statement. When it comes to the impact of social support networks on mothers' mental health during the perinatal period, 8.0% of the participants strongly disagreed, 1.4% disagreed, 41.5% agreed, and 56.4% strongly agreed.

The statement suggesting that thoughts of self-harm in pregnancy can lead to maternal

suicide without adequate help received responses. Among them, 1.4% strongly disagreed, 9.2% disagreed, 34.7% agreed, and 54.7% strongly agreed. Participants were also asked about the association between thoughts of self-harm in pregnancy as a mental health condition and a higher chance of developing in women with a history of psychiatric disorders. The responses showed that 8.0% strongly disagreed, 1.9% disagreed, 31.2% agreed, and 66.1% strongly agreed.

The belief that mothers experiencing thoughts of self-harm downplay the severity of self-harm on maternal and neonate health, making it more difficult for them to be screened on time for adequate health counseling and support received responses. Among them, 8.0% strongly disagreed, 1.4% disagreed, 35.8% agreed, and 62.1% strongly agreed. Mothers with thoughts of self-harm in pregnancy should undergo screening for early detection, 5.0% of the participants strongly disagreed, 3.0% disagreed, 39.6% agreed, and 59.6% strongly agreed.

Table 4 Respondents attitude toward self-harm in pregnancy (N=369)

Attitude Statement	Strongly Disagree Freq (%)	Disagree Freq (%)	Agree Freq (%)	Strongly Agree Freq (%)
All pregnant women are at risk of developing self-harm in pregnancy	48 (13.0)	81 (22.0)	149(40.4)	91 (24.7)
Mothers experiencing thought of self-harm are sometimes scared to seek for help	7 (1.9)	7 (1.9)	132(35.8)	223(60.4)
Thought of self-harm is a mental health condition that is more likely to occur without social support	4 (1.1)	3 (8.0)	119(32.2)	243 (65.9)
Mothers mental health during perinatal period can be greatly affected by social support networks	3 (8.0)	5 (1.4)	153(41.5)	208 (56.4)

Thought of self-harm in pregnancy can precede to maternal suicide if adequate help is not provided	5 (1.4)	34(9.2)	128(34.7)	202 (54.7)
Thought of self-harm in pregnancy as a mental health condition is associated with a higher chance of developing in women with psychiatric disorders history	3(8.0)	7 (1.9)	115(31.2)	244 (66.1)
Mothers experiencing thought of self- harm downplay the severity of self-harm on maternal and neonate health, making it more difficult for them to be screened on time for adequate health counseling and support	3 (8.0)	5 (1.4)	132(35.8)	229 (62.1)
Mothers with thought of self-harm in pregnancy should undergo screening for early detection	2 (5.0)	1 (3.0)	146(39.6)	220 (59.6)
Thought of self-harm in pregnancy is a mental health condition that requires treatment	2 (5.0)	8 (2.2)	143(38.8)	216 (58.5)
Women's empowerment and participation in decision-making will increase the perception of strong social support, which will lessen self-harming sentiments in pregnancy	4 (1.1)	5 (1.4)	131(35.5)	229 (62.1)
Thought of self-harm can occur in women do not desire to get pregnant	2 (5.0)	12 (3.3)	128(34.7)	227 (61.5)

Four hypotheses were tested in this study.

Hypothesis 1

The null hypothesis states that there is no significant association between socio-demographic characteristics (educational status, marital status, occupation, religion and marriage type) and knowledge of self-harm in pregnancy among women attending ante-natal clinics in Ife Central Local Government Area, Osun State. (Table 5) For the test of association between Educational Status and knowledge self-harm in pregnancy among women attending ante-natal clinics, P-value is 0.001 which is less than 0.05, therefore there is a significant association between the Educational Status of the respondents and knowledge self-harm in pregnancy among the respondents. Hence, the researcher rejects the null hypothesis. For the test of association between marital status of the respondents and their knowledge of self-harm in pregnancy, p-value is 0.005 which is less than 0.05, therefore there is a significant association between marital status

respondents and knowledge of self-harm in pregnancy, hence we reject the null hypothesis. Pearson Chi-Square was used in testing this hypothesis; it was observed that there is a significant association between Occupation of respondents and knowledge of self-harm in pregnancy, where p-value is 0.014 which is less than 0.05. Hence, the researcher rejects the null hypothesis. For the test of association between religion of the respondents and the knowledge of self-harm in pregnancy, p-value is 0.001 which is less than 0.05, therefore there is a significant association between religion of the respondents and knowledge of self-harm in pregnancy, hence we reject the null hypothesis. While the test of association between marriage type of the respondents and knowledge of self-harm in pregnancy, p-value is 0.104 which is greater than 0.05, therefore there is no significant association between the between marriage type and knowledge of self-harm in pregnancy among the respondents. Hence, the researcher fails to reject the null hypothesis.

Table 5: Association between socio-demographic information of respondents' and their knowledge of self-harm in pregnancy among women attending ante-natal clinics (N=369)

Socio demographic characteristics	Knowledge categorization on self-harm in pregnancy			χ^2	df	p-value
	Good Freq (%)	Fair Freq (%)	Poor Freq (%)			
Educational Status						
None	28 (71.8)	9 (23.1)	2 (5.1)	26.868 ²	6	0.001
Primary	29 (74.4)	7 (17.9)	3 (7.7)			
Secondary	150 (83.3)	17 (9.4)	13 (7.2)			
Tertiary	108 (97.3)	3 (2.7%)	0 (0.0)			
Marital Status						
Single	2 (50.0)	0 (0.0)	2 (50.0)	18.524 ^a	6	0.005
Married	309 (85.6)	36 (10.0)	16 (4.4)			
Divorced	2 (100.0)	0 (0.0%)	0 (0.0)			
Widowed	2 (0.0%)	0 (0.0%)	0 (0.0%)			
Occupation						

Unemployed	44 (77.2)	12 (21.1)	1 (1.8)	19.215 ^a	8	0.014
Student	27 (90.0)	2 (6.7)	1 (3.3)			
Trader	114 (82.0)	13 (9.4)	12 (8.6)			
Artisan	92 (88.5)	8 (7.7)	4 (3.8)			
Civil servant	38 (97.4)	1 (2.6)	0 (0.0)			
Religion						
Christianity	214 (88.1)	14 (5.8)	15 (6.2)	25.036 ^a	4	0.001
Islam	95 (83.3)	17(14.9)	2 (1.8)			
African traditional religion	6 (50.0)	5 (41.7)	1 (8.3)			
Marriage Type						
Monogamy	206 (86.9%)	18(7.6%)	13 (5.5%)	4.379 ^a	6	0.626
Polygamy	107 (82.3%)	18 (13.8%)	5 (3.8%)			

Hypothesis 2

The null hypothesis states that there is no significant association between socio demographic characteristics (educational status, marital Status, occupation, religion and marriage type) and perception of self-harm in pregnancy among women attending ante-natal clinics in Ife Central Local Government Area, Osun State (Table 6). For the test of association between Educational Status and perception self-harm in pregnancy among women attending ante-natal clinics, p-value is 0.001 which is less than 0.05, therefore there is a significant association between the educational Status of the respondents and perception self-harm in pregnancy among the respondents. Hence, we reject the null hypothesis.

For the test of association between marital status of the respondents and their perception of self-harm in pregnancy, p-value is 0.303 which is greater than 0.05, therefore there is no significant association, between respondents' marital status and perception of self-harm in pregnancy, hence

we fail to reject the null hypothesis. Pearson Chi-square was used in testing this hypothesis, it was observed that there is a no significant association between occupation of respondents and the perception of self-harm in pregnancy, where p-value is 0.157 which is greater than 0.05. Hence, the researcher fails to reject the null hypothesis. For the test of association between religion of the respondents and the perception of self-harm in pregnancy, p-value is 0.001 which is less than 0.05, therefore there is a significant association between religion of the respondents and perception of self-harm in pregnancy, hence we reject the null hypothesis. While the test of association between marriage type of the respondents and perception of self-harm in pregnancy, p-value is 0.015 which is less than 0.05, therefore there is no significant association between the between marriage type and perception of self-harm in pregnancy among the respondents. Hence, we reject the null hypothesis.

Table 6: Association between socio-demographic information of respondents' and their perception of self-harm in pregnancy among women attending ante-natal clinics (N=369)

Socio demographic characteristics	perception categorization on self-harm in pregnancy		χ^2	df	p-value
	Poor Freq (%)	Good Freq (%)			
Educational Status					
None	14 (35.9)	25 (64.1)	15.810 ^a	3	0.001
Primary	13 (33.3)	26 (66.7)			
Secondary	38 (21.1)	142 (78.9)			
Tertiary	12 (10.8)	99 (89.2)			
Marital Status					
Single	2 (50.0)	2 (50.0)	3.641 ^a	3	0.303
Married	74 (20.5)	287 (79.5)			
Divorced	1 (50.0)	1 (50.0)			
Widowed	0 (0.0)	2 (100.0)			
Occupation					
Unemployed	17 (29.8)	40 (70.2)	6.631 ^a	4	0.157
Student	6 (20.0)	24 (80.0)			
Trader	32 (23.0)	107 (77.0)			
Artisan	18 (17.3)	86 (82.7)			
Civil servant	4 (10.3)	35 (89.7)			

Religion					
Christianity	39 (16.0)	204 (84.0)	16.379 ^a	2	0.001
Islam	31 (27.2)	83 (72.8)			
African traditional religion	7 (58.3)	5 (41.7)			
Marriage Type					
Monogamy	38 (16.0)	19 (84.0)	10.447 ^a	3	0.015
Polygamy	39 (30.0)	91 (70.0)			

Hypothesis 3

The null hypothesis states that there is no significant association between socio-demographic characteristics (educational status, marital Status, occupation, religion and marriage type) and attitude towards self-harm in pregnancy among women attending ante-natal clinics in Ife Central Local Government Area, Osun State. (Table 7). For the test of association between Educational Status and attitude towards self-harm in pregnancy among women attending ante-natal clinics, p-value is 0.111 which is greater than 0.05, therefore there is no significant association between the Educational Status of the respondents and attitude towards self-harm in pregnancy among the respondents. Hence, the researcher fails to reject the null hypothesis. For the test of association between marital status of the respondents and their attitude towards of self-harm in pregnancy, p-value is 0.719 which is greater than 0.05, therefore there is no significant association, between respondents' marital status and attitude towards of self-harm in pregnancy, hence

we fail to reject the null hypothesis. Pearson Chi-Square was used in testing this hypothesis, it was observed that there is a no significant association between Occupation of respondents and the attitude towards of self-harm in pregnancy, where p-value is 0.588 which is greater than 0.05. Hence, the researcher fails to reject the null hypothesis. For the test of association between religion of the respondents and the attitude towards of self-harm in pregnancy, p-value is 0.019 which is greater than 0.05, therefore there is no significant association between religion of the respondents and attitude towards of self-harm in pregnancy, hence we fail to reject the null hypothesis. While the test of association between marriage type of the respondents and attitude towards of self-harm in pregnancy, p-value is 0.495 which is greater than 0.05, therefore there is no significant association between the between marriage type and attitude towards of self-harm in pregnancy among the respondents. Hence, the researcher fails to reject the null hypothesis.

Table 7: Association between socio-demographic information of respondents' and their attitude towards self-harm in pregnancy among women attending ante-natal clinics (N=369)

Socio demographic characteristics	attitude categorization on self-harm in pregnancy		χ^2	df	p-value
	Negative	Positive			
Educational Status					
None	7 (17.9)	32 (82.1)	6.020 ^a	3	0.111
Primary	10 (25.6)	29 (74.4)			
Secondary	23 (12.8)	157 (87.2)			
Tertiary	12 (10.8)	99 (89.2)			
Marital Status					
Single	0 (0.0)	4 (100.0)	1.341 ^a	3	0.719
Married	52 (14.4)	309 (85.6)			
Divorced	0 (0.0)	2 (100.0)			
Widowed	0 (0.0)	2 (100.0)			
Occupation					
Unemployed	9 (15.8)	48 (84.2)	2.821 ^a	4	0.588
Student	3 (10.0)	27 (90.0)			
Trader	24 (17.3)	115 (82.7)			
Artisan	11 (10.6)	93 (89.4)			
Civil servant	5 (12.8)	34 (87.2)			
Religion					
Christianity	31 (12.8)	212 (87.2)	7.895 ^a	2	0.019
Islam	16 (14.0)	98(86.0)			
African traditional	5 (41.7)	7 (58.3)			

religion					
Marriage Type					
Monogamy	29 (12.2)	208 (87.8)	2.394 ^a	3	0.495
Polygamy	23 (17.7)	107 (82.3)			

Hypothesis 4

The null hypothesis states that there is no significant association between knowledge and attitude towards self-harm in pregnancy among women attending ante natal clinics in Ife Central Local Government Area, Osun State (Table 8). For the test of association between knowledge and attitude towards self-harm in pregnancy among women attending ante-natal clinics, p-value is 0.002 which is less than 0.05, therefore there is a significant association between the educational status of the respondents and attitude towards self-harm in pregnancy

among the respondents. Hence, the researcher rejects the null hypothesis.

Among participants with poor knowledge, 33.3% had a negative attitude towards self-harm in pregnancy, while 66.7% had a positive attitude. In the group with fair knowledge, 27.8% had a negative attitude, while 72.2% had a positive attitude. Among respondents with good knowledge, only 11.4% had a negative attitude, while a substantial majority of 88.6% had a positive attitude towards self-harm in pregnancy (Table 8).

Table 8: Association between respondents' knowledge and attitude (N=369)

Knowledge	Negative Freq (%)	Positive Freq (%)	χ^2	df	p-value
Poor knowledge	6 (33.3)	12 (66.7)	12.920 ^a	2	0.002
Fair knowledge	10 (27.8)	26 (72.2)			
Good knowledge	36 (11.4)	279 (88.6)			

DISCUSSION

Socio-demographic characteristics

From the study, a large number of the respondents were between the age group of 26 to 35 years. The ethnic distribution showed that the majority of pregnant women were Yoruba and this could be because the study was carried out in the South West Geopolitical zone of Nigeria which is densely populated by the Yoruba tribe. Occupational diversity was also evident within the sample. Traders constituted the largest occupational group. Religious affiliation revealed a predominance of Christianity among the participants. Also important to note that majority of the respondents are married, and are in monogamous marriages which indicates early marriage was not prominent in the study area.

Respondents' knowledge on self-harm

Knowledge according to concise oxford dictionary is information and skills acquired through experience and/or education.

Majority of the respondents knew what self-harm was all about as an act in which a person intentionally initiates a non-habitual behavior that will result in self-harm without the interventions of others, or deliberately ingests a substance over the prescribed or generally recognized therapeutic dosage this is in line with (WHO, 2010) definition of self-harm in pregnancy. Many respondents believe Self-harm in pregnancy is associated with younger age and that thought of self-harm is a mental health problem that can occur in pregnancy this is in line with the study carried out by Ayre, Gordon, Dutta, Hodsoll, and Howard (2020) which identified younger age, as key correlates of maternal self-harm

Majority of the pregnant women agreed to the question that women in the perinatal period (pregnancy and postpartum) are more prone to self-harm than women in the general population, this is in line with the findings of (Gelaye and Williams,2016) which reported that women in the perinatal

period (pregnancy and postpartum) are more prone to self-harm than women in the general population

Respondent's perception of self-harm

The study's findings indicate that half of the participants agreed that unplanned pregnancy could trigger thoughts of self-harm. This aligns with a study conducted by Tiguh, Wondie, Gessesse, Tsega, Aklil, et al. (2022), which found that self-harm was 2.7 times more prevalent among women with unplanned pregnancies compared to those with planned pregnancies. Similar conclusions were drawn in a study conducted in the United Kingdom by Newport, Levey, Pennell, Ragan, and Stowe (2007), as well as the research conducted by Bahk, Yun, Kim, and Khang (2015), indicating that unintended pregnancy has an impact on women's mental health. The reasons behind this association may be attributed to the fact that unplanned pregnancies are often unwanted, which can cause additional distress and potentially lead to self-harm. To address this issue, it is crucial to minimize the unmet need for family planning by expanding its accessibility to all women of reproductive age, also women of child bearing age should be encouraged and sensitized on the benefits of family planning. By reducing the stress associated with unintended pregnancies, it may be possible to decrease the incidence of self-harm.

The majority of respondents agreed that women who experience intimate partner violence may engage in self-harm as a means of expressing negative emotions resulting from domestic or emotional abuse. This finding is consistent with Tiguh, Wondie, Gessesse, Tsega, Aklil, et al. (2022), who reported that women subjected to intimate partner violence were 1.93 times more likely to engage in self-harm compared to those who had not experienced such violence. Similar conclusions were drawn in a study conducted in Australia by Giallo, Pilkington, Borschmann, Seymour, Dunning, and Brown (2017), as well as a

study by Rodriguez, Mandell, Babayigit, Manohar, Weiss, Jones, et al. (2018), which demonstrated that intimate partner violence is associated with suicidal ideation among perinatal women.

Wong, Wang, Meng, and Phillips (2011) also provided evidence suggesting that intimate partner violence contributes to self-harm. This can be attributed to the fact that women who experience intimate partner violence may resort to self-harm as a way to express their distress due to abuse or as a desperate measure to escape the violence when all other options have been exhausted and they can no longer tolerate it. To challenge cultural norms and attitudes and empower women regarding intimate partner violence, it is crucial to enhance community awareness of the detrimental impact of such violence through educational campaigns and media dissemination of information.

A significant proportion of the respondents, believed that women with limited decision-making power within their families are more prone to engaging in self-harm compared to those with greater decision-making power. This aligns with the findings of Chien, Tai, and Yeh (2012), who reported that women with poor decision-making power were 1.7 times more likely to attempt self-harm than those with higher decision-making power. This association can be attributed to situations where women are not involved in decision-making regarding household matters, leading to feelings of disapproval and inferiority within the family. Consequently, these women may resort to self-harm as a means of coping. It is important to note that poor decision-making power has previously been linked to mental health issues during the perinatal period.

Majority of the respondents are in support of the statement that suggests thought of self-harm in pregnancy occur in women with lower incomes that cannot fulfill vital needs. This is in line with the findings of Nigatu and Gebremariam (2014) which reported that the possible explanation of self-harm during perinatal period could be due to the fact that women with lower

incomes cannot fulfill vital needs and may not be able to satisfy their cost of living, which may result into additional stress for women which can lead to self-harm. Women who have a better monthly household income have higher autonomy over their health and will be able to make good health informed decisions.

Respondents' attitude towards self-harm

More than half of the respondent Women's empowerment and participation in decision-making will increase the perception of strong social support, which will lessen self-harming sentiments in pregnancy this is in line with the findings of Tiguh, Wondie, Gessesse, Tsega, Aklil, s (2022) which states women's empowerment and participation in decision-making will increase the perception of strong social support, which will lessen self-harming sentiments. Assessing women's mental health status at maternal healthcare services is an important technique for determining women who are at an increased risk of postnatal self-harm.

Majority of the respondents believed that mother's mental health during perinatal period can be greatly affected by social support networks. This aligns with the findings of Hope, Pierce, Osam, Morgan, John and Abel (2022) which opined that the structure and support many women experience during pregnancy may have beneficial effects. This may be particularly true for women with mental health issues. Also, it is likely that during pregnancy women have more social contacts and feel less socially isolated at other times will likely not engage in self-harm than women who feel isolated and has less social contact during perinatal period. In addition, the increased focus on maternal well-being may increase attention to self-care and may facilitate the early identification of breakthrough symptoms during pregnancy, factors which may mitigate risk for recurrence of illness and self-harm.

More than half of the respondents agreed that thought of self-harm in pregnancy as a

mental health condition is associated with a higher chance of developing in women with psychiatric disorder history. This finding is in line with the study of (Borschmann, Molyneaux, Spry, Moran, Howard and Macdonald, 2019) which opined that parental psychiatric history and prior history of self-harm were risk factors for self-harm in pregnancy as well as the postnatal period. Pre-conception self-harm between women of younger age is associated with an increased risk of later perinatal depression and mother-infant bonding difficulties, compared with preconception self-harm as an adolescent

CONCLUSION

This study investigated the knowledge and perception of self-harm among women attending ante natal clinics in Ife central Local Government Area. The findings from the study highlight the association between various factors and self-harm among women attending antenatal clinics. The study demonstrated that unplanned pregnancies, intimate partner violence, and limited decision-making power within families are all significant factors linked to an increased risk of self-harm. These findings have important implications for health promotion and education efforts.

To address these issues, it is crucial to raise awareness through targeted awareness and education campaigns. These campaigns should focus on providing information about the impact of unplanned pregnancies, intimate partner violence, and limited decision-making power on women's mental health and the potential risk of self-harm. Integrated care within antenatal clinics, involving mental health screening and support services, can help identify at-risk women and provide appropriate interventions.

Empowering women is a key aspect of health promotion and education. Providing access to information, resources, and support networks can enable women to make informed decisions about their reproductive health, relationships, and

overall well-being. Additionally, collaboration and partnerships among healthcare providers, community organizations, policymakers, and women themselves are crucial for developing comprehensive approaches that address the complex interplay of factors contributing to self-harm.

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