GENDER BASED VIOLENCE EXPERIENCED BY PREGNANT WOMEN ATTENDING ANTE NATAL CLINICS IN SELECTED HOSPITALS IN ABUJA

BY

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DEDICATION

This project is dedicated to my husband, my children, my mother, my sister and my brothers, with whose thoughtfulness and support, I was able to achieve my goal.

I also want to dedicate this to thousands of women who are either victims or survivors of Gender-based Violence, you are definitely not alone.

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ABSTRACT

Gender-based violence (GBV) is any physical, sexual, psychological, economic or socio-cultural harm perpetrated against someone which is as a result of power imbalance or distinction based on gender. Anecdotal records have shown that there is increasing prevalence of GBV in Northern Nigeria. Little is known about the extent and magnitude of this phenomenon as it affects pregnant women. This study determined the prevalence and types of violence experienced by women attending ante-natal clinics in Abuja, Nigeria.

The study adopted a cross-sectional design. A three-stage sampling technique was used to select 300 participants from six hospitals in the three out of the six Local Government Areas in the city. The instruments for data collection were a validated semi-structured questionnaire, a Focus Group Discussion (FGD) and an In-depth interview (IDI) schedule. Eight FGDs- four among pregnant women and four among married men- were conducted. Four IDIs were conducted among health workers, a community leader and a lawyer. Data from the questionnaires were analysed using descriptive statistics and chi-square tests, while those from the FGDs and IDIs were transcribed and analyzed using the thematic approach.

The mean age of the participants was 29.7±3.9 years. Forty three percent of the respondents had experienced at least one form of violence. Of those who had ever experienced violence, 32.2% were unemployed, 23.3% were housewives, 19.7% were civil servants and self-employed, while 4.9% were professionals ($p<0.05$). The forms of violence experienced were as follows: psychological (38.0%); physical (36.4%); sexual (13.2%); and financial (12.4%). Of those who had suffered economic violence, more than three-quarter had been married for 2 to 5 years. Most of those who suffered physical violence were the unemployed (32.0%) and housewives (23.8%). Spouses (89.1%) and sisters-in-law (6.2%) were the main perpetrators of the forms of violence. Partners of women who had ever suffered violence were the self employed (27.7%), professionals (25.5%), civil servants (21.3%) and farmers (10.6%). Alcohol abuse was reported as a cause of violence among 14.7% of the respondents. About 15.0% of the respondents were experiencing violence in their current relationships. The types of violence experienced were physical and psychological. Coping strategies for violence included dialogue with spouse (46.7%), ignoring the experience (30.3%), making up with sex (16.7%), providing

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gifts and special dishes (5.0%) and mediation by family members (1.3%). Wife battering was adjudged to be the most common form of violence against pregnant women among both FGD discussants and In-depth interviewees. There was also unanimity of opinions among the FGD discussants and IDI interviewees that GBV cannot be eradicated but can only be controlled.

Gender-based violence was common among pregnant women in the study area. Health promotion and education intervention strategies such as counselling, male involvement in sexual and reproductive health programs, advocacy for the promotion of women's health and right as well as use of appropriate culturally sensitive conflict resolution strategies are needed to ameliorate the situation.

Key Words: Gender-based violence, Pregnant women, Antenatal care, Coping strategies, Perpetrators of GBV

Word Count: 477

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CERTIFICATION

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Violence against women is a complex and multidimensional problem. The term violence against women refers to many types of harmful behaviour directed at women and girls because of their gender. The United Nations (UN) offered the first official definition of such violence when the General Assembly adopted the Declaration on the Elimination of Violence against Women. According to the declaration, violence against women includes: any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in private or public life (United Nations, 1993).

Within this broader definition of gender-based violence, researchers and programme managers have defined and sub-categorized violence in many different ways. For example, violence can be physical, sexual, psychological, emotional or economic. Violence can be categorized by the characteristics of the victim, for example by focusing on child sexual abuse versus sexual assault against an older adolescent or adult woman, or by certain kinds of perpetrators. For example, "intimate partner violence" groups all forms of violence against women that are perpetrated by their boyfriends or husbands. In addition, legal categories of violence differ from country to country (International Family Planning Perspectives [IFPP], 2000).

There is increasing consensus, as reflected in this declaration, that abuse of women and girls regardless of where and how it occurs, is best understood within a gender framework because it stems in part from women's and girls' subordinate status in society. Article 2 of the UN Declaration clarifies that the definition of violence against women should encompass, but not be limited to, acts of physical, sexual, and psychological violence in the family and the community. These acts include spousal battering, sexual abuse of female children, dowry-related violence, rape including marital rape, and traditional practices harmful to women, such as Female Genital Mutilation (FGM). They also include

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non spousal violence, sexual harassment and intimidation at work and in school, trafficking in women, forced prostitution and violence perpetrated or condoned by state such as rape in war.

Gender-based violence (GBV) is both a human right violation and a public health problem. It can have serious implications for a woman's sexual and reproductive health. GBV has been linked to increased risk of gynaecological disorders, unsafe abortion, pregnancy complications, miscarriages, low birth weight and pelvic inflammatory disease. Gender-based violence can pervade the entire life cycle of a woman — beginning with selective abortion of a female foetus to female genital cutting to domestic partner violence. GBV is usually perpetrated by men against women and girls, and it can take many forms: sexual abuse, physical violence, emotional or psychological abuse, verbal abuse, or beatings during pregnancy. GBV jeopardizes a woman's health and well-being and detracts from her reproductive health (Guedes, 2004). The World Bank has estimated that the health burden of Gender Based Violence on women aged 15 to 44 years is as heavy as that of HIV, tuberculosis, cancer and heart diseases combined. It also has significant economic consequences, reducing family income and increasing health care costs, job absenteeism and cost related to law enforcement (World Bank, 2000). Acts of Gender Based Violence violate a number of principles enshrined in international and regional human rights instruments, including the right to life, equality, security of the person, equal protection under the law and freedom from torture and other cruel, inhumane or degrading treatment (Reproductive Health Response in Conflict consortium [RHRC], 2005).

Reproductive health programs have also been among the first to address Gender-based Violence as they often seek to deal with the consequences of such violence (Population Action International, 2001). Age is no barrier- female children, adolescents and adults are all affected, suffering both physical and psychological injury, and in extreme cases, death. But it is women of reproductive health who face the most extensive consequences because violence may be associated with an inability to prevent unwanted pregnancies, pregnancy itself, pregnancy loss (miscarriage and stillbirths), abortion and abuse of women who present for abortion-related health care. Yet the possible links between violence, pregnancy and abortion remain an area of public-health policy that has received insufficient attention (de Bruyn, 2003).

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There are factors at the individual, household and societal level that put women at risk or alternatively may help to reduce the risk of violence. It is embedded within social and cultural norms that perpetuate inequality between women and men, and condone or even encourage discrimination against women, including the chastisement of women by men and others (Canadian Panel on Violence against Women, 1993). Domestic violence in particular is the epitome of unequal power relationships between women and men. The Canadian Panel on Violence Against Women states in the introduction to its report that "It is abundantly and indisputably clear that women will not be free from violence until there is equality, and equality cannot be achieved until the violence and the threat of violence is eliminated from women's lives" (Canadian Panel on Violence against Women, 1993).

The family has long been projected as the site of love, security and nurturance- an institution that has the potential to survive hardships and provide its members physical and emotional support. The bond between a man and his partner is seen as the binding element in the fabric of society. However, evidence from several research studies indicates an alarming proportion of domestic violence against women (Mitra, 1998). Violence in relationships is often justified, in fact seen as a measure of one's love for the person, who is violated. Normalizing violence within close relationships is reflected in societies' apathetic, even resistant attitude in addressing it as a major problem – one that is currently threatening the existence of the family as an institution of love, care and security (Mitra, 1998). Violence against women alone has enough detrimental effects, but experiencing it in pregnancy, has a larger scope of debilitating effect, not only on the women, but on the pregnancy outcome and a long term effect on societal development.

Domestic violence is a common problem during pregnancy and has been associated with increased risks of miscarriages, pre-term labour, foetal distress and low birth weight babies (Bates, Schuler, Islam and Islam, 2004). Even pregnant women are not immune from physical violence inflicted by partners. Violence directed toward women by their partners during pregnancy affects as many as 324,000 annually (Illinois Department of Public Health, 2003). McFarlane, in 1989 said "*Pregnant women are such a rich resource in ending violence against women because the one common experience of women worldwide is pregnancy. Up to 95 percent of women worldwide will have at least one pregnancy*", but this is not the issue, as domestic violence against pregnant women is a global issue

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If one looks at the reasons for domestic violence from past studies (Federal Ministry of Health, National HIV/AIDS & Reproductive Health Survey, NARHS, 2003) they were primarily around women's role as a wife, not cooking on time, not taking care of the children, and so on . Violence in an abusive relationship increases when a woman is pregnant. Batterers frequently target the women during pregnancy to further their power and control of the victim (Castro, Peek-Asa and Ruiz, 2003). In Mexico City, a survey of 342 randomly sampled women found that 20% of those battered reported blows to the stomach. In Costa Rica, 49% of a group of 80 battered women reported having been beaten during pregnancy; 7.5% of them reported miscarriages (United Nations, [illegible]).

1.2 Statement of the problem

Gender based violence is one of the harmful practices (others include wife inheritance, female genital cutting etc) that is prevalent in Nigeria (National Population Commission (NPC) [Nigeria] and ICF Macro, 2009) which exerts heavy toll on both mental and physical health. Increasingly, it is being recognized as a major public health and serious violation of basic human rights which has been called " the most pervasive yet least recognized human rights in the world" (Bates, Schuler, Islam and Islam, 2004). Its profound effect on reproductive health both directly and indirectly include unwanted pregnancy, gynaecological problems, unsafe abortion, as well as acting as a barrier to contraceptives by restricting access to family planning information. (United Nations Population Fund, [UNFPA], 2000).

Gender Based Violence is a major Public Health concern and a violation of human rights. The World Health Organization estimates that at least a man has physically or sexually abused one in every five of the world's female at some time in her life (Fawole, Ajuwon, Osungbade, and Faweya, 2003). The infliction of violence on intimate partners is common in many societies and affects millions of women throughout the world each year. Domestic violence's private nature has made it difficult to quantify its prevalence, understand its risk factors or address its consequences.

Domestic violence is considered a major risk in pregnancy while pregnancy is thought to be protective against violence (Oladepo, personal communication, 2004) findings have shown that women are abused during pregnancy (UNFPA, 2000). Violence is in fact common in pregnancy but pregnancy does not appear to be an initiating factor (Castro, Peek-Asa and

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Ruiz, 2003). On average, one out of every four pregnant women experiences violence and women with unplanned pregnancies have two to four times more risk of violence than women whose pregnancies were planned (Journal of the America Medical Association, 1996). Pregnant women are particularly vulnerable to gender based violence, some husbands become more violent during the wife's pregnancy even kicking or hitting their wives in the belly. These women run twice the risk of miscarriage or four times the risk of having low birth weight babies (www.unfpa.org retrieved on July 2007).

According to Akinyele (2005, lecture delivered), battering in pregnancy, sexual coercion, rape, are issues requiring urgent solutions, as women bear the greatest burden of reproductive health. Interestingly according to National Reproductive Health Survey (2003), women were more likely to justify marital violence. Ajuwon (2004) stated that men's role in women and children's health include preventing all forms of violence against women. Religious and cultural taboos and low educational status of Northern Nigeria females (percentage of literate females in North central zone is 43.3% compared to 86.6% in South Eastern zone, NPC and ICF Macro, 2009), place them at a disadvantage for various forms of violence ranging from physical battering to emotional abuse. Gender based violence, serves by intention or effect, to perpetuate male power and control which is sustained by a culture of silence which persists in the North and denial of the health consequences of the abuse (precipitated by its private nature). These might have made it difficult to quantify its prevalence, understand its risk factors and address its consequences which exact not only harm to the individual but also a social toll and places a heavy and unnecessary burden on health services (maternal mortality figure might be affected if high risk pregnancies are traced to violence in pregnancy). Violence against pregnant women, is thus a profound health problem that compromises women's health and erodes their self-esteem hence the need to provide violence screening and counselling (as proposed by previous studies) in antenatal care services might be justifiable.

Discussions with antenatal staff at the Wuse General Hospital, Abuja, revealed that when pregnant women present with spontaneous or threatened abortions or lacerations, they are usually traced to occurrence of domestic violence of different origins. This might also be the cause of high prevalence of elevated blood pressure (of unknown cause) experienced by most pregnant women. Reactions to physical forms of violence at times (International

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Family Planning Perspectives [IFPP] 2004) results in the pregnant women picking up habits that further compromise the pregnancy outcome, like tobacco use, alcohol etc.

It is being hypothesized in this study that violence leads to unintended pregnancy (since it acts as a barrier to contraceptives and in the African context, unprotected lovemaking is always used to end the feud of violence between partners). Though it could also be argued that unintended pregnancy precipitates abuse (if linked with financial handicap). Intimate partner violence is the most prevalent form of Gender Based Violence worldwide, and has been linked to numerous kinds of immediate and long term physical and psychological injury to women, which may also contribute to unwanted pregnancies and may increase the risks of sexually transmitted infections among victims by compromising their ability to dictate the terms of sexual relationships (Bates et al., 2004).

1.3 Justification

A nationwide survey revealed that wife battering occurs in about 20% of Nigerian households (Nigeria Demographic and Health Survey [NDHS], 2008). However most concise studies on Gender-Based Violence in Nigeria has been focusing on the Southern parts, there is a need to intensify studies including Northern parts of the country, so as to get a true picture as it affects Nigerian women. Violence against pregnant women, especially, domestic violence, is a common and serious issue in the Northern part of Nigeria (Women's Right Advancement and Protection Alternative (WRAPA), 2003) (though the extent and magnitude is not yet known). It is not only caused by the male partners, but also by other members from the husband's family. Although most studies have focused on Gender Based Violence by Intimate partners, few have explained the extent to which pregnant women have been victims. This study proposes to fill this gap.

1.4 Broad Objective

The broad objective of this study was to provide data on the types and prevalence of gender based violence among pregnant women attending antenatal care in selected hospitals in Abuja, Nigeria.

1.5. Specific Objectives

The specific objectives for the study were to

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1. Identify the various types of violence that pregnant women attending antenatal care in Abuja encounter or are exposed to
2. Document the prevalence of violence experienced by pregnant women
3. Identify and document victims' reaction to violence.
4. Document ways to eliminate violence in pregnancy from respondents' cultural perspective.

1.6. Research questions

The study answered the following research questions:

1. What constitutes violence in pregnancy?
2. How common is violence among pregnant women?
3. What are the factors influencing violence against women in pregnancy?
4. What are the pregnant women's health seeking behaviour towards violence?
5. What can be done to eliminate violence in pregnancy?

1.7. Hypotheses

The following hypotheses were tested by the study:

1. There is no significant relationship between experience of violence and women's socio-demographic characteristic such as age.
2. There is no significant relationship between types of violence experienced and women's socio-demographic profile.
3. There is no significant relationship between years of marriage and the experience of violence in pregnancy.
4. There is no significant relationship between types of violence experienced and years of marriage.
5. There is no significant relationship between violence and unintended pregnancy.
6. There is no significant relationship between types of violence experienced and unintended pregnancy.
7. There is no significant relationship in the experience of violence and alcohol consumption of partners.
8. There is no significant relationship between types of violence experienced and alcohol consumption of partners.

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Operational Definition of Terms

Violent episode: an act or series of acts of abuse or violence by one perpetrator or group of perpetrators. May involve multiple types of violence (physical, psychological, economical, sexual); and may involve repetition of violence over a period of minutes, hours or days (Reproductive Health Response in Conflict, [RHRC], www.rhrc.org, 2003).

Survivor: person who has experienced violence or other abuse (RHRC, 2003).

Secondary survivor: person impacted by the experience of gender-based violence inflicted upon the survivor. May include family members or others close to the survivor (RHRC, 2003).

Perpetrator: person, group or institutions that directly inflict or otherwise support violence or other abuse inflicted on another against his/her will (RHRC, 2003).

Intimate partner: includes current or former spouses (legal and common law), non marital partners (boyfriend, girlfriend, same sex partner, dating partner). Intimate partners may or may not be cohabiting and the relationship need not involve sexual activities RHRC, 2003).

Minor: person under the age of 18 (according to the United Nations Convention on the Rights of the Child) (RHRC, 2003).

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CHAPTER TWO

LITERATURE REVIEW

2.1. Definition/description of Gender-based Violence

The United Nations (UN) General Assembly in 1993 defined Gender-based violence as "any act that results or is likely to result in physical, sexual or psychological harm or suffering for men and women, including threats of such acts, coercion, or arbitrary deprivations of liberty whether occurring in public or private life". Gender-based violence (GBV) is an umbrella term for any harm that is perpetrated against a person's will that is the result of power imbalances that exploit distinctions between males and females, among males and among females. Violence may be physical, sexual, psychological, and economic or socio cultural. Perpetrators may include family members, community members or those acting on behalf of cultural, religious, state or intrastate institutions. Although not exclusive to women and girls, GBV principally affects them across all cultures (Ward, 2002). GBV encompasses, but is not limited to physical, sexual and psychological violence, including threats of violence, coercion, or arbitrary deprivation of liberty. Though GBV may take many forms, it almost always and across all cultures disparately impacts women and children. There has been increasing recognition that GBV is an affront to public health and universally accepted human rights guarantees (Ward, 2002).

2.2 Epidemiology of Gender-based Violence

In order to prevent and address a social problem like violence against women it is necessary to understand its causes. While many theories exist to explain violence against women, the understanding of its precise causes remains unclear. Studies have not been able to identify any specific personal and attitudinal characteristics that make certain women more vulnerable to battering, other than an association with having witnessed parental violence as a child (National Research Council, 1996). It appears that the major risk factor for domestic violence against women is being a woman. In other words this is a problem that affects women of all countries, social classes, religions, and ethnic groups. At the same time the rates at which this problem occurs does show variations across these variables (Garcia-Moreno, 1999).

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Research over the last 20 years, mostly from the United States, has identified factors which are associated with violence against women. However, much of this research has tended to focus on single, causal factors or has tried to explain one causal theory of violence against women (social learning, feminist, family systems, structural), focusing either on the perpetrator or on the victim. Recently more complex models for studying violence have been proposed, including multivariate statistical analysis. For example, when looking at the association between socio-economic status and violence against women, it is necessary to understand better which aspects of low socio-economic status are related to violence. Is it income, educational level, disparity between the husband and wife in terms of socio-economic status or resources, overcrowding or other variables? (Hoffman, Demo and Edwards, 1994.) It should be noted also that the literature on causal factors is mostly from developed countries and that much more work is needed to identify determinants and protective factors for violence in other settings (Garcia-Moreno, 1999).

Heise, in one of his articles, builds on the work of others to propose "an integrated, ecological framework" for studying and understanding violence against women (Heise, 1998). This framework looks at factors acting at four different levels: individual, family, community, and social and cultural context. What is important about this model is that it emphasizes the interaction between factors at these different levels. In other words it provides a model of embedded levels of causality in which there is not one single causal factor, but rather it is the interaction of factors operating at different levels that may promote or protect against violence. It is these factors and their interactions at these different levels that need to be better understood in different cultural contexts and settings. This will help to identify the different starting points and avenues for prevention and for other kinds of interventions (Garcia-Moreno, 1999).

Excessive use of alcohol and drugs has been identified as a factor behind gender abuse. Economic and social factors, such as unemployment, economic stress, overcrowding and unfavourable and frustrating work conditions, also lead to gender-based violence. Some researchers have also argued that violence is actually a learned behaviour. Today's violent husbands are yesterday's children of violent parents, they say (United Nations, 1995).

In fact, as one study in the US found, men who saw their parents attack each other, compared to those from non-violent families of origin, were three times more likely to hit

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their wives and ten times more likely to attack them with a weapon (United Nations, 1995). Men accused of violence against their wives sometimes try to shift the blame, claiming that their actions were provoked by the behaviour of their partners. Upon close examination researchers discovered that such behaviour was often linked to some form of failure or refusal on the part of the women to comply with or support their husbands' wishes and authority. As a study in the British Journal of Crime noted, to a violent husband/partner, almost anything seemed to be provocative: "Being too talkative or too quiet, too sexual or not sexual enough, too frugal or too extravagant, too often pregnant or not frequently enough" (United Nations, 1995).

A more universal reason behind gender-based violence, many people think, is the structural inequality between men and women in the family as well as in society. Studies from both developed and developing countries show violence against women to be a by-product of the societal structure in which men make all decisions and women are expected to obey (United Nations, 1995). High rates of psychiatric-related morbidity have been reported consistently. As well as depression, women who have experienced sexual violence often meet diagnostic criteria for anxiety, panic disorder, post traumatic stress disorder and substance use disorders (Roberts, 1996; Roberts, Lawrence, Williams and Raphael, 1998a and b).

Gender-Based Violence is devastating, affecting women and girls' long term physical and mental well-being. The ripple effects of Gender Based Violence compromise the well-being of families, communities and societies. It cuts across social and economic situations and is deeply embedded in cultures around the world- so much so that millions of women consider it a way of life (United Nations Population Fund [UNFPA], 2005). Ten to fifty percent of women have been victims of intimate partner violence. Women are at greater risk of violence from men they already know. It is a complex problem-cannot be attributed to one cause and the consequences include:

- Increased risk of physical/reproductive and mental health problems.
- Increased exposure to STIs and HIV.
- Increase in negative health behaviours (drug-use sexual risk-taking).
- Homicide, suicide, maternal mortality, miscarriage.

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In a study carried out by the Pan-American Health Organization (PAHO), where all the women interviewed were victims of physical and/or psychological sexual and economic violence, it was found that these women were generally unaware of their rights, that even when they took steps to resolving their situation, the women met with frustrating results. For the majority of the women, violence started following co-habitation or marriage, and was exacerbated by pregnancy, the women were found to tolerate abuse out of fear, social pressure or lack of financial resources (Ellsberg and Arcas, 2001).

Denial and fear of social stigma often prevent women from reaching out for help. Those who reach out do so primarily to family members and friends. Few have ever contacted the police (Heise, Ellsberg and Gottemoeller, 1999). Reasons why Gender Based Violence continue to be invisible in the health sector as given by the PAHO, PATH, CDC and WHO collaboration include:

- Lack of time to talk or perform special examination for women reporting violence.
- Women do not talk for fear that the husband will be put in jail and then no money will come into the household.
- Health workers- nurse, doctors, health inspectors- are men first before they are health workers.

According to UNFPA (1999), more research is needed but clinicians say that collecting data on violence during pregnancy has been difficult.

"Researchers are often worried that if you know a woman's name and ask her personal information, she won't be honest with you, so sometimes, there's need to do this anonymously" said Sandra Martin, Associate professor at University of North Carolina at Chapel Hill. However, preliminary studies have found that face-to-face interviews conducted during pregnancy may yield more accurate information. Higher rates of violence were reported when questions were repeated later in pregnancy (Gazmararian, Lazorick and Spitz, 1996).

The Washington Post exposes the extent of murder and violence directed at pregnant women and new mothers in the United States. The newspaper in a year-long study surveyed all 50 states and the District of Columbia for records of traumatic deaths of

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pregnant and post-partum women since 1990, receiving data from 37 states, and found that at least 1,367 such women had been murdered over that period. Most states said that their reports likely understate the total number as police do not regularly ask for maternal status when investigating homicides.

In compelling detail, the articles recount case examples of women stabbed, strangled and shot — nearly always by a husband or boyfriend at home. A full 67 percent were killed with a firearm. An in-depth study of homicides in Maryland, published in the Journal of the American Medical Association in 2001, concluded that a pregnant woman or recently pregnant women is more likely to be a victim of homicide than to die of any other cause — more than cardiovascular disorders, embolisms or accidents.

The surviving children of murdered women, most of who are then raised by grandparents or other relatives, often have lasting effects from the violence. These new findings suggest that a more focused effort at education and prevention must be made to reduce the toll (National Organization for Women, 2004). And despite all the joy that pregnancy can bring into a relationship, expectant mothers are not necessarily spared the danger of being slain. That is something advocates have known for years (Heise, Ellsberg and Gottemoeller, 1999).

Homicide was found to be the leading cause of death for pregnant women in Maryland, United States, according to a March 2001 study published in the Journal of the American Medical Association. Using death records and coroner reports, state health department researchers found 247 pregnancy-associated deaths between 1993 and 1998. Among those deaths, 50 were murders. By comparison, homicide was the fifth-leading cause of death among Maryland women. And, nationwide, the maternal mortality rate was just 9.9 percent in 1999, the most recent year for which statistics are available (National Organization for Women, 2003).

Nationally, homicide is a leading killer of young women-pregnant or not. In 1999, homicide was the second-leading cause of death among women ages 20 to 24. It was fifth among women ages 25 to 34. Accidents are the top cause of death in both age groups. Police records show that homicidal violence cuts across all races and classes (National Organization for Women, 2003).

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A house hold survey on Violence Against Women in the marital home, conducted from 1997-1999 in seven Indian cities with women between 15-49 yrs old, revealed that Violence Against Women in the marital home was pervasive across regions and socio-economic groups, with uniformly high prevalence of forced sex and violence during pregnancy. Most women interviewed experienced violent behaviours in multiple forms: 70% of women had experienced at least two forms of physical abuse and 50% had experienced all forms abuse identified in the survey. Violence in the home frequently operated as a means of gender subordination and there was a high level of acceptability of violence against wives within families and communities (Duvvury, 2000).

For many women, chronically beaten or sexually assaulted, the emotional and physical strain can lead to suicide. Research in the United States, Nicaragua and Sweden has shown that battered women are at increased risk of attempting suicide (Abbott, 1995; Bailey, 1997; Kaslow, 1998; Bergman, 1991; Rosales, 1999). These deaths are dramatic testimony of the limited options for some women facing a violent relationship.

Male violence is not genetically-based; it is perpetuated by a model of masculinity that permits and even encourages men to be aggressive. Moreover, in the case of intimate partner violence, it is important to point out that men are often able to control their violence in certain settings (such as the work place), while choosing to become violent in others (at home). In spite of gender-based violence's pervasiveness, some anthropological studies have documented small-scale societies where domestic violence is virtually nonexistent (Counts, Brown and Campbell, 1992).

Within many societies, there is a widespread belief that wives deserve to be beaten by their husbands. In other cases, people want to believe that the aggressor was justified in using violence and that the victim is to blame in order to deny that a crime has taken place. Such is the case when it is suggested that a woman who was raped "asked for it" because of the way she dressed or acted. Blaming the victim is precisely the kind of attitude that has the potential to cause harm to a survivor of violence (International Planned Parenthood Federation, 2004).

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2.3. Prevalence of Gender-based Violence in Pregnancy

The most recent study of violence against pregnant women found that on average one of every fifteen pregnant women whose pregnancies end in a life birth experience violence, and that women with unplanned pregnancies have two to four times more risk of violence than women whose pregnancies were planned. The review of a selected number of well-designed, population-based surveys indicate that between 20% to over 50% of women report having been abused physically by an intimate male partner at least once in their lives (WHO, 1997).

Data on sexual abuse, particularly during childhood, is even more difficult to come by. Yet there is some evidence to suggest that it is far more common than had been thought previously. For example, a study in Barbados in a nationally representative sample of women and men aged 20 to 45 reported that 33% of women and 2% of men reported behaviour constituting sexual abuse during childhood or adolescence (Handwerker, 1993). A study in Switzerland found that 20% of women and 3% of men aged 13 to 17 had experienced sexual assault involving physical contact (Halperin, 1996). Several recent studies also document the extent to which the first sexual experience is unwanted or even forced. For example, in a national HIV/AIDS survey conducted in Central African Republic between September and December 1989, nearly 22% of female respondents reported that their first experience with intercourse was "rape" (Chapko, Somse and Kimball, 1999). A study of teenage mothers attending an antenatal clinic in Cape Town, South Africa (mean age: 16.3), found that 30% reported that their first intercourse was "forced" and 11.0% said they had been raped (Wood and Jewkes, 1997).

One in three Nigerian women reported having been physically abused by a male partner. Six in ten murder cases are accounted for by domestic violence in Zimbabwe. One out of every two women polled in a 2004 study in Zambia reported having been beaten by a male partner. Nigeria's former minister for women's affairs, Obong Rita Akpan comments on the issue: "It is like it is a normal thing for women to be treated by their husbands as punching bags. The Nigerian man thinks that a woman is his inferior. Right from childhood, right from infancy, the boy is preferred to the girl. Even when they marry out of love, they still think the woman is below them and they do whatever they want."

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In Nigeria, gender violence is still widespread. The preliminary report of a study being conducted by Pro-Hope International (2005), Port Harcourt, revealed that most women in Rivers State are not only routinely abused sexually, physically and verbally both at home as well as in the work place; most of these abuses are often taken meekly by the victims as the lot of women. Consequently, an overwhelming majority of these abuses go unreported; and when reported, no action is usually taken against the offenders. Discrimination and gender-based violence against women in Nigeria, and elsewhere occur in the home, at school, in the workplace, on the streets and at any point of interaction between men and women in the wider society (Pro-Hope International. 2005).

2.4. Types of violence

Physical/Intimate partner Violence: comprises use of physical force or weapons in attacks that injure or harm a woman, including beating, kicking, pulling hair, biting, acid throwing, burning, attacks with weapons and objects and murder (de Bruyn, 2003). Intimate partner abuse-also known as domestic violence, wife-beating, and battering-is almost always accompanied by psychological abuse and in one-quarter to one-half of cases by forced sex as well. The majority of women who are abused by their partners are abused many times. In fact, an atmosphere of terror often permeates abusive relationships (Heise, Ellsberg and Gottemoeller, 1999).while intimate Partner abuse is widespread, it is not universal. Anthropologists have documented small-scale societies-such as the Wape of Papua New Guinea-where domestic violence is virtually absent. This finding stands as a testament to the fact that social relations can be organized in a way that minimizes partner abuse (Counts, 1992, Levinson, 1989). Violence against women and female children, whether by known or unknown assailants, is probably the most prevalent and certainly the most emblematic gender-based cause of depression in adult women (Astbury, 2001). And while significantly increased rates of depression are the most frequently documented mental health outcomes of Sexual Violence against Women (SVAW) (Mullen, Martin, Anderson, Roman and Herbison, 1996; Campbell and Soeken, 1999), the psychological distress caused by Sexual Violence against Women is manifested in multiple forms.

Psychological violence: includes threats of harm, physical or sexual violence and abandonment. intimidation. humiliation; insults and constant criticism; accusations, attribution of blame; ignoring, giving insufficient attention or ridiculing the victim's needs;

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controlling what the victim can or cannot do; withholding basic needs (such as food, shelter and medical care) and deprivation of liberty (de Bruyn, 2003).

Sexual violence: comprises actions that force a person to engage in sexual acts against her (or his) will, without her consent; it includes economically coerced sex, date rape (including administering drugs to women), marital rape, gang rape, incest, forced pregnancy and trafficking in sex industry (de Bruyn, 2003). The recent World Report on Violence and health defines sexual abuse as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed at against a person's sexuality using coercion, by any person regardless of their relationship to the victim (World Health Organization, 2002).

Forced sex also appears to be a common occurrence. A 1998 Commonwealth Fund Survey on Women's Health in the United States reported that one of five women surveyed (21%), said they had been a victim of rape or assault (Collins, Schoen, Joseph, Duchon, Simantov and Yellowitz, 1999). Here again, however, there are enormous variations in the definitions of rape and sexual abuse used in studies, which make it impossible to compare figures. Rates vary enormously depending on whether the definition of sexual abuse includes physical contact only or non-contact forms of abuse. They also vary according to the definition of rape and attempted rape used. For example, in many countries the legal definition of rape only includes penile-vaginal penetration. In addition, there are different forms of sexual coercion, which vary from culture to culture. Keeping these caveats in mind, it has been estimated that one in five women world-wide has been forced to have sex against their will (WHO, 1997).

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Table 2.4.1: Gender Violence throughout a woman's life

PHASE	TYPES OF VIOLENCE
Prenatal	Sex-selective abortions, battering during pregnancy, coerced pregnancy (rape during war)
Infancy	Female infanticide, emotional and physical abuse, differential access to food and medical care
Childhood	Genital mutilation; incest and sexual abuse; differential access to food, medical care, and education; child prostitution
Adolescence	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
Reproductive	Abuse of women by intimate partner, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities
Old age	Abuse of widows, elder abuse (which affects mostly women)

Source: Heise, L. 1994 Violence Against Women: The Hidden Health Burden. World Bank Discussion Paper. Washington D.C.: The World Bank.

2.5 Factors promoting GBV

Studies have identified risk factors as well as factors that appear to be protective or mitigate violence. These can also provide important leads for the development of interventions. A study in Nicaragua documented the importance of having family that can respond or intervene when the violence occurs (Ellsberg et al, 1996). In Bangladesh belonging to a credit programme was associated with lower levels of domestic violence by both channelling resources to poor families through women and by organizing women to participate in regular meetings and exposure to outsiders (Schuler, 1996). The researchers noted that more could be made of this by the credit programme organizers through, as a minimum, more awareness raising and openness to discussing the issue. Globalization and the growing urbanization of developing countries however, may be contributing to the disappearance of some of these protective factors. They contribute to the isolation of women from their extended families and have also attenuated community sanctions (Finkler, 1997). Understanding and supporting traditional sources of support and or remedy could be important interventions, particularly in resource poor settings.

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The paucity of information on risk and protective factors is a major constraint to the design of locally relevant programmes and policies. More work needs to be done in this area. Until very recently, most of the response to violence against women, including the provision of care and support services has been provided by the non-governmental, voluntary sector, particularly women's organizations. Shelters for battered women and rape crisis centres are classic examples, and in many developed countries still form the basis of services for women experiencing violence, albeit with varying levels of government funding. A few countries, mostly in the North, have government policies and coordinating mechanisms that provide a framework for action, but in most the responses remain ad hoc. Following the Fourth World Conference on Women in Beijing, a number of developing countries, particularly in Latin America, have passed domestic violence laws. This is an important step, but much remains to be done before these laws can realistically be put in practice. Furthermore, legal reform is only one of the many changes needed to address violence against women.

2.5.1. Violence and Alcohol

Alcohol merits some mention since research has consistently found heavy drinking patterns related to intimate partner and sexual violence. However, the exact relationship between alcohol and violence remains unclear (National Research Council, 1996). Many people drink without engaging in violent behaviour and many battering incidents and sexual assaults occur in the absence of alcohol. However some evidence exists that violent men who abuse alcohol are violent more frequently and inflict more serious injuries on their partners than do men without alcohol problems (Frieze and Browne, 1989 in Heise, 1998) Addressing violence in alcohol dependence treatment programmes can be useful potentially to help reduce the incidence and severity of assaults, but not necessarily to end the violence.

2.5.2. Gender-based Violence and Family Background

In addition to the direct impact of violence on the woman and her life, several studies indicate that domestic violence against women also impacts on their children, whether they only witness the domestic violence or are themselves abused. These consequences include behavioural problems, which are often associated with child management problems, school problems, and lack of positive peer relations (Jaffe, Wolfe and Wilson, 1990). Children

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exposed to wife abuse also have a number of school adjustment difficulties, including dropping out of school.

Exposure to domestic violence between parents when growing up has been shown to be associated with domestic violence against women in studies from Nicaragua (Ellsberg, Pena, Herrera, Winkvist and Kullgreen, 1999), Cambodia (Nelson and Zimmerman, 1996), Canada (Johnson, 1995) and in the U.S.A., described earlier. One third of children who have been abused or exposed to parental violence become violent adults and sexual abuse in childhood has been identified as a risk factor in males for sexual offending as an adult (National Research Council, 1996).

A critical review of 52 studies conducted in the U.S. that included comparison groups by found that the only risk marker for women consistently associated with being the victim of physical abuse was having witnessed parental violence as a child. As regards sexual assault, Koss (1990) concluded that it was generally not predictable, but to the extent it could be, was accounted for by variables that represent the after effects of childhood sexual abuse, including influences on drinking, sexual values and level of sexual activity (National Research Council, 1996). This has been found in other studies such as the one in Barbados mentioned earlier (Handwerker, 1993)

In reviewing such studies it is important to note that although witnessing increases the risk of continuing patterns of violence it does not pre-ordain it. As Johnson states, "While it is true that the rate of wife beating is much higher for men who have witnessed violence by their own fathers, it is also true that the majority of abusive men were not exposed to violence in childhood. And, over half the men who did have this exposure have not been violent toward their own wives" (Johnson, 1996).

Jaffe reports the results of a study by Hughes of children residing in shelters, which showed that 55% of the sample of children studied, were characterized as withdrawn and 10% were described as having made suicidal gestures. Other reports refer to a high degree of anxiety, with children biting fingernails, pulling their hair, and having somatic complaints of headaches and "tight" stomachs. Studies have also found that children who witnessed higher frequencies and intensities of wife abuse, performed significantly less well on a measure of interpersonal sensitivity (the ability to understand social situations

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and the thoughts and feelings of persons involved in those situations) than did those children exposed to less frequent and intense wife abuse. This in turn is associated with "high risk behaviours", such as unsafe sex in later life (Jaffe et al, 1990)

A review of U.S.-based research by the National Academy of Science states that "one third of children who have been abused or exposed to parental violence become violent adults" (National Research Council, NRC, 1996). This is particularly the case for male children, whereas girls witnessing violence are more likely to end up as victims of violent relationships. Thus, it becomes difficult to separate causes from consequences, as growing up in a family where the mother is abused becomes an important way in which the cycle of domestic violence gets perpetuated. Furthermore, it serves to reinforce and perpetuate gender stereotypes and unequal gender relationships, which in turn will contribute to violence against women. Witnessing domestic violence also contributes to general violence, in that these children learn violence as the means by which to solve conflict.

In addition to witnessing, childhood victimization also perpetuates the cycle of violence in other ways. Childhood experiences of sexual abuse have been shown to be associated with low self-esteem, inability to say no to unwanted sexual relations and self-destructive behaviours including alcohol and drug abuse. It is also strongly associated with depression, other mental health problems and for subsequent abuse. A study in Barbados found that sexual abuse was the most important determinant of high risk sexual behaviour (Handwerker, 1993). Another study of 535 pregnant or recently delivered teenage mothers found that those abused before their first pregnancy, were more likely to have exchanged sex for money, drugs or a place to stay; were more likely to use alcohol and drugs during pregnancy; were less likely to use contraception and began intercourse one year or earlier on average than other study participants (13.2 vs. 14.5 years) and considerably earlier than their non-pregnant peers (16.2 years) (Boyer and Fine, 1992).

There is a simple conclusion to be drawn from all this: no one is born violent, but if children grow up amidst violence, they may end up being violent themselves. If violence against women is to be resisted, it must start where it begins, in the family.

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2.6. Interventions to reduce GBV

There is currently a growth in projects aimed at developing and/or improving the response by the formal sectors towards women experiencing violence. Interventions have traditionally focused on the police, the legal and judicial system (judges and others), and increasingly the health sector. Mostly they involve training to improve the identification and response to women experiencing violence. There are several limitations to this approach:

a) Training is often an isolated intervention, with little follow-up. It becomes the end rather than the means.

b) Training is focused exclusively on technical content and does not address the attitudes and values of the providers. For example, a health care setting which is not welcoming and where women are not treated respectfully or listened to, as a matter of course, can hardly provide an appropriate environment for addressing violence against women

c) Institutions such as the police and the legal and health systems reflect the same gender stereotypes and prevailing norms that underpin this violence in society. Occasionally the training may include looking at the social construction of gender and power relationships, but most often it does not and training programmes rarely address the structural barriers that may make it difficult to put the training into practice. In the case of the health sector, many providers may feel that addressing violence is beyond their reach. They may lack basic knowledge, time or empathy, or simply not know what to do or where to refer those women. In many situations, they may be experiencing violence themselves

Basic information on domestic violence and sexual assault needs to be systematically included in all medical and nursing curricula in order to, as a minimum, raise awareness of the fact that the problem exists. Training programmes in health care settings would be most useful if they address broader issues of interaction and communication with patients, and gender and sexuality, rather than focusing exclusively on violence. In order for training to be effective, there must be long-term goals and strategies to ensure that the necessary structural changes accompany the training. This requires political and administrative commitment, and the development of policies and protocols for the different levels of providers

d) The focus is on the service rather than the woman. Health providers, particularly doctors, often feel that they have 'to make things right'. This may lead to judgmental attitudes and undue pressure on the woman to leave the violent relationship or situation

Providers must learn to listen and treat women as the experts, delicately balancing the

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provision of support and guidance and a concern for women's safety with respect for their decisions, even if this is to stay with the violent partner. She may judge that this is the safest option and in many cases will be right. This fine line is a difficult one, which those working in this area must learn to walk.

While the provider usually focuses on the battering, for the woman this is often only one aspect of a complex relationship and her interpretation of the situation is coloured by this different understanding. She may be balancing the risks of staying in the relationship with those of extreme poverty for her and her children or with being ostracised by the family and others. While individual women require and should have high quality care for the consequences of violence, it is important to keep in mind that the underlying problem is male violence. It is important that providers and the institutions that are meant to help her, give a clear message that the violent behaviour is not acceptable and that women do not deserve to be abused in any circumstance.

As is evidenced by this review, the majority of the published literature on violence against women comes from northern countries, particularly the United States. While there are a number of recent prevalence studies on domestic violence against women from developing countries, data from these countries remains scarce. There is a need for prevalence and incidence data that is comparable across-cultures and that also starts to elucidate the determinants as well as the protective factors, which operate in different settings. This research is essential to improve our understanding of the magnitude and the nature of the problem, to provide guidance to the development of interventions and to be able to monitor their impact. It will also provide baseline data from which to understand trends and patterns.

The focus of many of the efforts of women's organisations and others, understandably, has been on responding to the needs of women experiencing abuse. Yet, dealing with the victims of violence is only the "tip of the iceberg". Responding to the needs of individual women experience violence is of course necessary. It may also serve to prevent the reoccurrence of violence or further health consequences, death or disability. However, it is necessary to pay equal or more attention to the search for strategies for primary prevention. A public health approach focuses on prevention and emphasises opportunity for early intervention. It is based on science, includes a social analysis of health, and an

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interdisciplinary approach, all of which are essential to addressing the problem of violence against women. Work in this area needs to be based on sound data describing the magnitude and nature of the problem, the risk and protective factors, and the evaluation of interventions for their effectiveness, feasibility and replicability.

Preventive strategies need to be context specific, and address the particular risk factors that are relevant to each setting. Important elements in prevention are interventions to change the social norms and values that discriminate against women and that condone for example, the physical chastisement of women by their husbands. Some places have started "Zero Tolerance Campaigns" which use mass media and other information and education channels to promote a culture that does not tolerate violence against women or children. Another approach has been the use of community "sanctions" as a deterrent for men to abuse women. Examples such as the beating of pots outside of the house of an abuser by women in India, neighbourhood watches and whistle blowing in Peru or other strategies to identify and shame an abuser, are creative ways of thinking of sanctions. In many situations these may be more effective than using the formal sanctions of the police and judiciary, which can often act against women.

Behaviour change is never easy and it is a long-term process, as anyone who has attempted a change, however small, can testify. There is, however, a growing body of experience on behaviour change in relation to prevention of HIV and AIDS and of smoking, where public health and health promotion have been harnessed to achieve this change. Those working on violence against women need to build on this knowledge and apply it to changing attitudes, values and beliefs that serve to perpetuate violence against women. There are also difficulties in measuring the impact of many of these preventive strategies. So far, few evaluations exist of the effectiveness of these programmes, so it is essential that any intervention programmes build monitoring and evaluation into their work.

2.6.1. GBV and the Constitution

The experience of using law to address the issue of domestic violence in Africa contains both positive and negative lessons for gender-equality campaigners (Manuh, 2007). The protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa was ratified by the required fifteen member-states, and came into force on 26 November 2005 (http://www.achpr.org/english/_info/women_en.html retrieved on June

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2007). It places an obligation on state-parties to take measures to address not only violence against women but also other aspects of women's rights: in public or private life, in peacetime and during periods of war or conflict. It also explicitly includes marital rape and other forms of forced or unwanted sex.

Women activists have been emboldened by these developments to push states as far apart as Mauritania and Rwanda to enact legislation addressing gender-based violence. Sierra Leone is the latest country to have successfully enacted legislation (although the practice of female genital mutilation has not yet been outlawed). Uganda, Kenya, Nigeria and Ghana have also attempted to pass domestic-violence laws; here, however, the experience has been disparate (Manuh, 2007).

In Kenya, a sexual-offences bill that seeks harsher penalties for perpetrators of sexual violence became mired in controversy when a legislator (male, as were 204 of the 222 expected to vote on the bill) alleged that some provisions would criminalize men's advances towards women. Civil-society groups demanded that their votes should be transparent; when gun-toting policemen blocked activists from entering parliament to press this demand, they chanted anti-rape songs and chanted at the police: "Kill us today so that we do not get raped tomorrow (Manuh, 2007).

The Ugandan situation represents a further interesting contrast. In December 2003, a domestic-relations bill was tabled before parliament, containing a host of provisions to deal with discriminatory laws and practices in marriage, divorce, inheritance, property ownership, and violence and equality within marriage and the family. Sylvia Tamale charts what happened next: the bill reached the committee stage in early 2005, only to generate massive controversy that stretched beyond parliament to the media and the streets ("The Right to Culture and the Culture of Rights: A Critical Perspective on Sexual Rights in Africa", Feminist Legal Studies http://www.dfid.gov.uk/casestudies/files/africa/uganda-domestic-violence.asp retrieved on June 2007). A scathing attack on the bill's contents by the legal and parliamentary affairs committee was echoed in a demonstration on 29 March 2005 by hundreds of women (the majority of them wearing the hijab) in the streets of Kampala. They described the bill as a "coup against family decency", and swore to oppose its passage. A few weeks later, parliament shelved the bill for "more extensive consultations." *When President Yoweri Museveni declared during the election campaign in*

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February 2006 that "it (the domestic-relations bill) was not urgently needed", the debate was effectively closed. It was a severe setback for Uganda's women's movement (Manuh, 2007).

A more positive legislative outcome was witnessed in Ghana. Here, a domestic-violence bill was subject to more than three years of extensive national consultations led by the government ministry of women's and children's affairs; the Domestic Violence Coalition, formed to support the passage of the bill, also played a key role in the process (http://www.peacewomen.org/news/Ghana/May05/Violence.html). There was early resistance from a surprising source, the then minister of women's affairs (who argued that the law would "destroy families"); and the coalition's demand for the repeal of S42 (g) of the criminal code (the so-called "marital-rape exemption" also caused bitter acrimony. Those opposed to the bill portrayed it and its gender-activist supporters as purveying "foreign" ideas that threatened Ghanaian cultural beliefs and practices - in particular, the sanctity of marriage and men's rights within it (Manuh, 2007). This reaction highlighted the lack of understanding of gender-based violence as an equality issue that surrounded the debate over the proposed legislation in Ghana. Even within the state and among the general public, fixed and regressive attitudes remained prevalent - that women in social life and within marriage had an inferior status, and that women were to blame for provoking acts of violence by the way they dressed or for being unfaithful (Manuh, 2007).

In the event, the Domestic Violence Act was passed on 21 February 2007, without the express repeal of S42 (g), although with the provision that "(the) use of violence in the domestic setting is not justified on the basis of consent" (http://www.thestatesmanonline.com/pages/news_detail.php?newsid=3311§ion=1)

However, within a few weeks of the passage of the law, the statute law commissioner, acting on his own initiative, removed the offending S42 (g) from the statute-book (Manuh, 2007). This new legislation has been hailed as a triumph, but much work remains to be done to ensure that it is fully implemented. This will require - so activists and human-rights advocates in Ghana argue - a comprehensive, nationwide domestic action plan and the provision of necessary human and budgetary resources (partly in light of the fact governments have in practice relied on donors to fund gender work in Ghana). Some aspects of the social environment - in which most Ghanaian women still live in poverty,

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depend on men, and are surrounded by attitudes and codes that tolerate oppressive behaviour or allow serious violations of women's rights to be "settled" without justice or accountability - reinforce the argument that implementation mechanisms are vital (Manuh, 2007).

In Nigeria, a draft domestic-violence bill prepared by the Legislative Advocacy Coalition on Violence against Women has been lodged in the house of representatives (the lower house of parliament) since 2003, but has not even been listed in the order paper for hearing. The provision on marital rape, which some view as "western" and "against the culture of Nigeria" has been invoked to explain the slow progress of the bill: settling it would, it is claimed, allow the bill to be passed into law. The contradiction here is that Nigeria has already ratified the protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which prohibits marital rape without any reservations (Manuh, 2007).

"Imagine a world in which three to four million people are suddenly struck by a serious, recurring illness. There is chronic pain, trauma and injury. Authorities fail to draw any connection between individual bouts with the disease and the greater public threat. Many suffer in silence." Joseph R. Biden, former chairman of the US Senate Judiciary Committee, is describing his own country, the United States of America, and the "disease" is domestic violence. The vast majority of victims are women. In the US, one woman is physically abused every eight seconds and one is raped every six minutes. Spouse abuse is more common in the US than automobile accidents, mugging and cancer deaths combined, notes a 1992 US Senate Judiciary Committee report.

"A wife married is like a pony bought. I will ride her and whip her as I like." This proverb, no matter how old, is still relevant. Whether it is beating a wife at the end of a bad day or preying on an unsuspecting evening jogger at a city park, most gender-based violence against women is inextricably linked to male power, privilege and control. Culture and tradition, which often are reflected in national laws, only help to perpetuate the idea of male dominance (United Nations, 1995).

Victims of domestic violence are likely to suffer long lasting psychological and health problems including persistent fear, low self esteem, sexual dysfunction, chronic pain,

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disability, substance abuse, depression and suicide. Violence against Women has an enormous impact on women's lives. It causes physical and psychological harm (including homicide and suicide) and on-going health problems, it reduces women's autonomy and destroys their quality of life, it affects their ability to care for themselves and their families, and it diminishes their productivity in wider society and in the processes of development (Garcia-Moreno, 1999).

Violence against women hinders their participation in development projects and lessens their contribution to social and economic development. In Mexico, a study that sought to learn why women often stopped participating in development projects found that men's threats were a major reason. Men perceived the growing empowerment of their wives as a threat to their control and beat them to try to stop it (Carrillo, 1992). In Papua New Guinea some husbands have prevented their wives from attending meetings by locking them in the house, by pulling them off vehicles taking them to the meetings, or by pursuing and dragging them home (Bradley, 1994).

In places like the Democratic Republic of the Congo, GBV contributes to the erosion of the social and economic fabric as women play important roles in the maintenance of local economies. Lack of security has forced women to abandon their jobs while abduction of women and girls has further contributed to economic breakdown due to lack of productive workers. Women and girls are also weakened by rape-related illnesses and trauma (Reproductive Health Response in Conflict, [RHRC], 2004).

Women's participation in the development process especially in such areas as family planning, environmental protection and education is crucial. Yet when women are faced with violence, their ability to participate fully in these and other aspects of development is hampered. In many countries, husbands resist women's work outside the home, since they fear this may lead to women's empowerment. Men often use force or threats in order to divert or extort women's income (United Nations, 1995).

Gender-based violence has long been tolerated in most societies, letting the perpetrators go unpunished, their crime tacitly condoned. Based on the popular view that a wife is the property of her husband and that therefore he may do with her whatever he thinks fit, legal systems in some countries have recognized a husband's right to chastise or even kill his

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property of her husband and that therefore he may do with her whatever he thinks fit, legal systems in some countries have recognized a husband's right to chastise or even kill his wife if she is considered disobedient or is thought to have committed adultery. In Papua, New Guinea, a parliamentarian taking part in a debate on wife battering went as far as to say, "Wife beating is an accepted custom. We are wasting our time debating this issue." Such violence is often covered by a veil of secrecy and denial. Very rarely are gender-based abuses reported or recorded.

2.6.2. GBV and Research

While ethical and safety standards should be met in all research, safety, confidentiality, interview skills and training are extremely important in research on violence against women. Consequently, the World Health Organization has specified and elaborated on eight key recommendations for research on domestic violence against women.

These recommendations are:

1. Recognition that the safety of the researchers and respondents is critical and should be considered in all decisions.
2. Prevalence studies should be designed to build upon current research and minimize under-reporting.
3. Confidentiality is a key to protect women's safety and the data quality.
4. Researchers should be selected carefully and trained for their specific task.
5. Research must include actions to reduce distress for the participants by the research.
6. Researchers should be able to refer women seeking help to support services. If none are available, the team should set up short-term services.
7. Researchers and donors should insure that their findings are interpreted correctly and further policy and intervention development.
8. Violence questions should only appear in surveys for other general purposes when these guidelines are met.

Lack of confidentiality can be particularly devastating, as well as placing women at risk for further abuse (Watts, Ndlovu and Keogh, 1997).

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2.7. Reactions to Gender-based Violence

In general, women in situations of violence make many attempts to obtain help and to leave a violent relationship. There are numerous barriers, however, that may keep women from leaving. These include financial dependence on the abuser for the survival of herself and/or her children, pressure from society and family to maintain the relationship, a lack of options regarding where to go and fear of retribution (Jacobson, 1999). Many women rightly fear that the abuser will harm or even kill them if they attempt to leave the relationship.

Violence often continues and may even increase after a woman leaves her partner (Jacobson, Gottman, Gortner, Berne and Shortt, 1999). In fact, a woman's risk of being murdered is greatest immediately after separation (Campbell, 1995). The reasons why women do not choose to leave a violent relationship are complex, and may depend upon a variety of factors such as established gender roles, economic considerations, concern for her own safety and her children's wellbeing and love. Understanding these reasons can help the provider offer better care and support the woman without judgment (IPPF, 2002).

2.7.1. Gender Roles

Traditional gender roles often contribute to a woman feeling obligated to stay in a relationship, even if it is abusive. Women are taught from a very early age to nurture and care for the needs of others before taking care of themselves. As a result, they often define themselves through how they relate to others; they are considered to be "good" or "selfless" for caring for men at the expense of their own individuality, dreams and goals. Furthermore, women are often expected not to abandon a marriage, and they may consider themselves a failure if they leave their husband. If they have seen a model of a violent relationship in their own homes when they were children, their situation of violence may not seem unusual or wrong; rather, they may assume that violence is just part of life and marriage. Reassuring women that violence is unacceptable can help them overcome the sense of guilt that women who are victims of violence often feel.

2.7.2. Concern for Her own Safety and Her Children's Well Being

Studies have shown that deciding to leave a violent relationship can be more dangerous for the women than staying in that relationship. A woman who is living in a situation of violence is probably the best judge of whether and when to it is safe for her to leave. In many cases, the woman may fear for her children's safety in the event that she decides to

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leave a relationship as they may become the targets for future violence. Furthermore, the male is often the financial provider for the family, and the woman may feel that she simply cannot provide for her children without the financial support of the partner. Stereotypes about the father being the sole provider for children, and the need for children (particularly boys) to "have a man around" may further influence the woman's decision to stay with a violent partner. Therefore, including children in safety planning is a key step that providers can help women to take.

2.7.3. Economic/Financial Concerns

Traditional gender roles generally place the man as the economic provider for the family. As a result, many women have not developed the skills they would need to provide for themselves financially. In other cases, even if women are earning money, the man in the relationship may control the couple's finances. Without access to money, women's options for leaving a relationship are limited, particularly when there are not adequate services to help her in the transition to economic independence (IPPF, 2002).

2.7.4. Lack of Quality Services

Even if a woman feels ready to leave a violent relationship, there may not be quality services available to support her in this decision. For example, if she does not have family members or friends who will provide housing for her and her children, the woman will need to have access to a shelter that can guarantee her safety and well being, as well as that of her children. In addition, the police and legal systems that are responsible for dealing with cases of gender-based violence are often not sensitized to this issue. As a result, they tend to condone GBV, blame the woman for the violence, and/or recommend conciliatory measures rather than support the woman's decision to leave (IPPF, 2002).

2.7.5 Love Often women choose not to leave a violent relationship out of sheer love. They want to be with their partner, and may hold out hope that he will change and stop being abusive.

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2.8. Effect of Violence on Reproductive Health

2.8.1. Violence, Sex Bargaining Power and Unwanted pregnancies

Violence is increasingly recognized as a cause of injury among women, but its impact on women's mental health and on their sexual and reproductive health is less well recognized. Forced sex, whether by a partner or a stranger, can directly lead to an unwanted pregnancy or a sexually transmitted infectionincluding HIV. Violence and/or fear of violence can also indirectly affect sexual and reproductive health, as they impact on women's ability to negotiate safer sex, including use of condoms, and their use of contraception. Data for the United States shows that an estimated 32,101 pregnancies are the result of rape each year, the majority of them among adolescents. Fifty percent of these ended in abortions and 5.9% placed the infant for adoption (Holmes, Resnick, Kilpatrick and Best, 1996).

Studies have linked abuse to unwanted pregnancies, especially among adolescent females, and violence greatly limits married women's ability to use contraceptives. Furthermore, a history of domestic violence is commonly found to be more prevalent in families with many children (Ellsberg, Pena, Herrera, Liljestrand and Winkvist, 2000). In many countries, violence against women is still predominantly perceived as a legal or human rights issue. Yet, such violence has a wide-ranging health consequence. Although national data are scarce, a number of small scale, community-based study indicate that domestic violence is an important cause of morbidity and mortality, and an important factor affecting women's reproductive health (Heise et al., 1999).

Even when physical violence is not used to control a woman's behaviour, the fear of violence may greatly influence her sexual and reproductive decision-making. The fear of violence is commonly cited by married women as a barrier to using condoms with their husbands for STIs and pregnancy prevention (Blanc, Wolff, Gage, Ezeh, Neema and Ssekamatte-Ssebuliba, 1996).

2.8.2. Gender-based Violence and HIV and AIDS

Gender-based violence and HIV and AIDS are inextricably linked. The experience of violence affects the risks of HIV and other Sexually Transmitted Infections (STIs) directly when it interferes with women's ability to negotiatecondom use. Fear of violence not only hinders women's ability to propose condom use but may also keep them from Voluntary

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HIV Counselling and Testing. Furthermore, women may be at risk of violence after disclosing their HIV status to their partners (Guedes, 2004). Presently, it has been recognized that women's vulnerability to HIV is as a result of lack of knowledge and access to information, economic independence, and, in many cases, forced sex with their regular partners (Nkoli, 2002).

In 2002, more than 42 million people were living with HIV and AIDS, almost 70% of whom were in sub-Saharan Africa. In this region, 58.0% of HIV-positive adults are female, making African women the group most severely affected by HIV and AIDS worldwide. Thus, for effective prevention and control of the epidemic, deepening our understanding of women's HIV risk is crucial. Researchers and policy makers have increasingly cited GBV and gender inequality as essential determinants of women's HIV risk, both worldwide and within sub-Saharan Africa.

GBV and HIV are clearly interrelated and a small but growing body of literature has begun to explore these connections. A recent review of some of the existing studies suggests that GBV makes women vulnerable to HIV through three mechanisms (Maman and Campbell, 2000). First and most obviously, there is the possibility of direct transmission through forced or coerced sexual act. Secondly, the trauma associated with violent experiences can impact later sexual behaviour. Thirdly, violence or the threat of violence may limit women's ability to adopt safer sex practices within ongoing relationships. Violence and the threat of violence may impact women's ability to implement HIV protective behaviours.

An understanding of the size and nature of these associations is necessary for the development of appropriate intervention strategies- yet, to date, the methodology and scope of empirical research on the topic is remain a limited. In Africa, there are already six women with HIV for every five men (United Nations Joint Committee on AIDS [UNAIDS], 1999). This increase in the number of HIV positive women reflects their greater biological vulnerability to the disease.

It is also a consequence of the social constructions of female and male sexuality as well as the profound inequalities that continue to characterize many heterosexual relationships in Nigeria. Many women find the heterosexual relationship a difficult one to negotiate as strategy for their own safety. Generally, and culturally, sex continues to be defined

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primarily in terms of male desire with women being the relatively passive recipient of male passions (Heise et al., 1999).

Under these circumstances, women often do not articulate their own needs and desires and their own pleasure may be of little concern. Even in marriage most women cannot assert their wish for safer sex, for their partner's fidelity, or for no sex at all. As a result their health and invariably that of others are put at grave risk. It is estimated that in parts of Africa 60-80% of women infected with HIV have only had one sexual partner (Panos, 1994).

For women in sub-Saharan Africa, the withdrawal (or threatened withdrawal) of material benefits if they refuse sex or use contraceptive against their partner's wishes can act as a powerful inhibitor of their sexual freedom and safe sex practices (Adongo et al., 1997). Violence has also been found to result from reproductive or sexual health problems and issues. Several researches have shown that women's refusal of sex is often cited as a justification for violence (Blanc et al., 1996).

2.8 Violence and Pregnancy

Violence occurs during pregnancy, with consequences not just for the woman, but also on the foetus or the infant. A review of studies from the United States found the prevalence of abuse during pregnancy to range from 0.9 to 20% with the majority of studies reporting a prevalence rate between 4% and 8.3% (Gazmararian et al., 1996). Violence during pregnancy has been associated with miscarriage, still birth, pre-term labour and birth, foetal injury and death (McFarlane, Parker and Soeken, 1996). Several studies have also found an association with low birth-weight (LBW). For example, Bullock and McFarlane (1989) found significantly increased rates of LBW among battered women (12%) compared with non-battered women (6%), even after controlling for other variables like smoking, alcohol consumption, prenatal care and maternal complications. The same association was found in a study in Nicaragua. Another study in India found a powerful association between women's experiences of "wife-beating" and infant and foetal loss, even after controlling for education and parity (Jejeebhoy, 1998).

Although studies are inconclusive as to whether violence is likely to begin or escalate during pregnancy, research has demonstrated that violence does not necessarily stop when

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a woman becomes pregnant. Worldwide, as many as one in every four women is physically or sexually abused during pregnancy, usually by her partner (Heise, Ellsberg, and Gottemoeller, 1999). In fact, research suggests that violence may be more common during pregnancy than are other conditions, such as gestational diabetes, for which providers routinely screen during pregnancy. Such findings highlight the importance of asking about violence during prenatal care visits.

It becomes clear that addressing gender-based violence in general and specifically sexual violence few studies have documented the rate of pregnancy as a result of rape. Record review in a Mexico City public sector rape crisis centre showed that 15 to 18% of women attended were pregnant from sexual assault (Krug et al., 2002). In the United States, a study based on a national representative survey found that rape-related pregnancy rate was 5% (Holmes 1996). A study conducted in India revealed unplanned (or forced) pregnancy was almost three times (2.6) more likely among wives of abusive men, especially sexually abusive men who used force (Martin, Kilgallen, Tsui, Maitra, Singh and Kupper, 1999). Pregnancy resulting from rape among adolescents is yet undocumented but quite often early pregnancy is linked to unsafe abortion. An estimated 2.5 million, or almost 14% of all unsafe abortions in the world each year in developing countries are experienced by women under the age of 20 (World Health Organization, WHO, 2004). In short, women who are pregnant as a result of sexual assault are more likely to experience death or disabilities in pregnancy than women whose pregnancies are intended. Addressing gender-based violence in general, and specifically sexual violence, is key to reaching two of the Millennium Development Goals (MDGs), improving maternal health by reducing maternal mortality, and promoting gender equality and empowering women.

Violence in pregnancy may pose a threat to the life and health of the mother and the foetus. Physical violence during pregnancy is associated with miscarriage, late entry into prenatal care, stillbirth, premature labour and birth, and low birth weight (Krug et al., 2002). In a study of 400 villagers in India, 16% of all deaths during pregnancy resulted from partner violence.

Violence before and during pregnancy can have serious health consequences for women and their children. Pregnant women who have experienced violence are more likely to delay seeking prenatal care (Curry, Perrin, and Wall, 1998; Dietz, Gazmararian, Goodwin,

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Bruce, Johnson and Rochat, 1997,) and to gain insufficient weight (Berenson, 1997). They are more likely to have a history of STIs (. Martin, Matza, Kupper, Thomas, Daly and Cloutier, 1999; Amaro, Fried, Cabral and Zuckerman, 1990), unwanted or mistimed pregnancies, vaginal and cervical infections.

For many women, pregnancy does not halt the beatings. Pregnant adolescents may face an even higher rate of abuse (Gazmararian, Lazorick and Spitz, 1996). Some women are first abused during pregnancy, while for others, the violence is part of an ongoing pattern. Unintended pregnancy may result from violence. An unintended pregnancy may also contribute to violence (Gazmararian et al., 1995). Women who are beaten during pregnancy are more likely to miscarry or have low-birth-weight babies and they are more likely to postpone prenatal care. Physical abuse may contribute substantially to maternal mortality in some countries (Heise, Pitanguy and Germain, 1994).

Fear of violence also leaves many women open to disability or death from STDs. But trying to convince a violent man to use a condom may endanger a woman in a more immediate way. In many cultures, condom use is linked with infidelity, the suspicion of which often triggers domestic violence.

Partner homicide has also been identified as an important cause of maternal deaths (Parsons and Moore, 1997). And although data from Africa are limited, recorded partner violence was the fourth leading cause of maternal death at Maputo Hospital in Mozambique (Krug, 2002). On the Indian subcontinent, violence may be responsible for a sizeable but under recognized proportion of pregnancy-related deaths (Ganatra, Coyaji and Rao, 1996).

Violence has also been shown to lead to high-risk sexual behaviour. Children who have been sexually abused often engage in sexual behaviour, as adolescents and as adults, that puts them at risk of unintended pregnancies and sexually transmitted infections. Some researchers view the risky sexual behaviour of abuse victims as an effort to gain control or mastery of a childhood experience in which they felt violated and powerless (Finkelhor, and Browne, 1985).

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In spite of the growing recognition of violence against women and progress made in recent years, there is still a lack of basic information on the magnitude of the problem, the understanding of its root causes, and the factors that may be protective (Garcia-Moreno, 1999). This is particularly true for developing countries. Responses have been fragmented and have tended to focus on providing care for those already experiencing violence, rather than on the search for effective prevention strategies. It is time to move from the stated concern about violence against women to the concrete allocation of the necessary funds to develop a better understanding of the problem, test interventions for their effectiveness and replicability, and begin to address this problem in realistic and cost-effective ways (Garcia-Moreno, 1999).

Others note that the experience of incest and sexual abuse can make it difficult for victims to form healthy intimate relationships. One researcher has observed that a victim's "heightened need for intimacy, coupled with the sexualisation of affection, may lead her to seek warmth and closeness through repeated sexual encounters" (Donaldson, Whalen and Anastas 1989).

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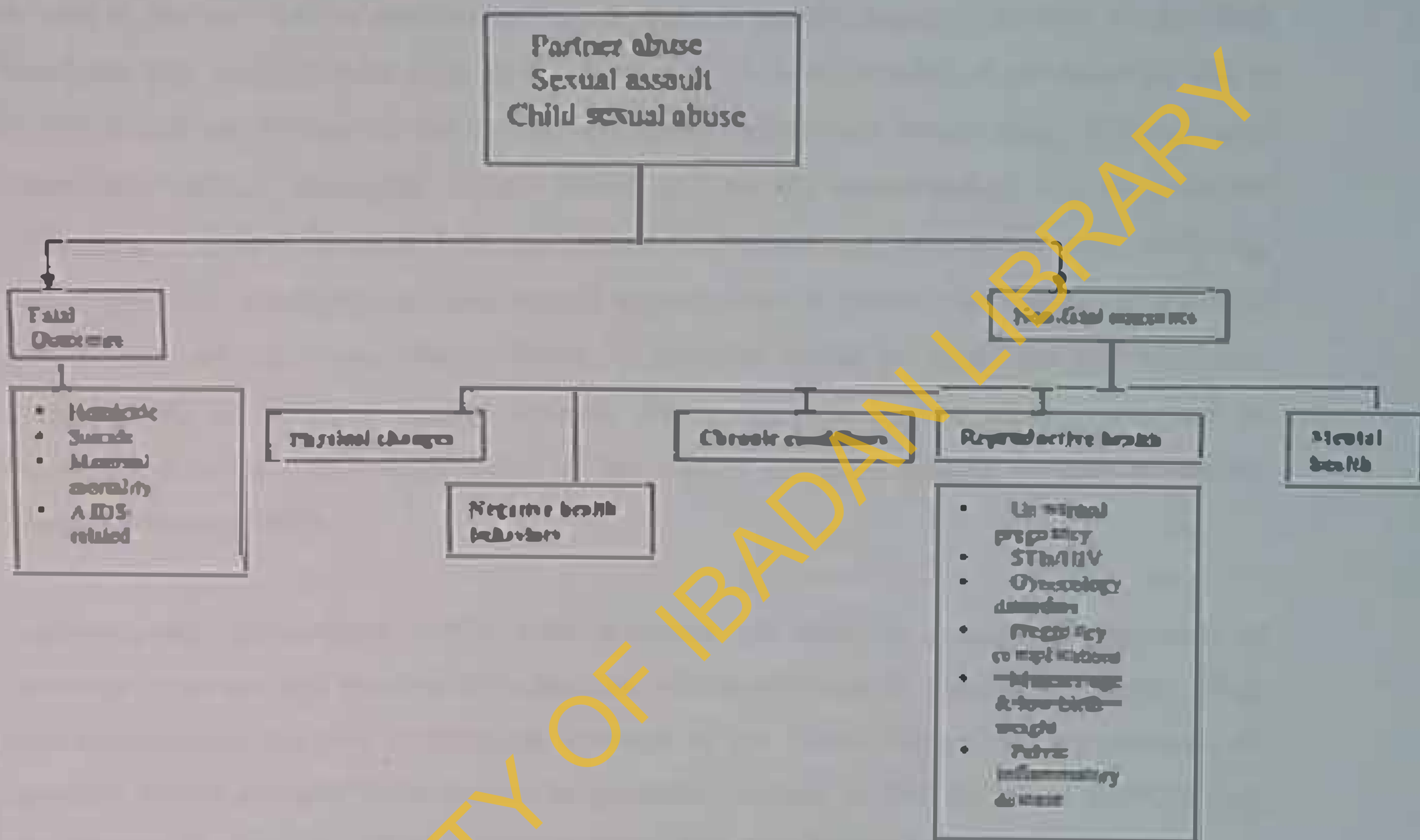

Fig. 2.1: Health Outcomes of Violence against Women
(Source: Heise, Ellsberg and Gottemoeller, 1999)

2.9. The costs of violence against women

Violence against women is much more than a health issue; it is an infringement of women's human rights, for example, the right to bodily integrity. It also impinges on their ability to exercise other human rights, such as the right to the highest attainable standards of health, and their sexual and reproductive rights. Violence is reinforced and condoned by the many forms of discrimination which women experience in society. Many countries still need to ratify human rights conventions such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which provides the framework for

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revising laws that will begin to support the redress of existing inequalities between women and men, and problems like violence against women.

There is a limited amount of information on the costs of violence against women, although one may assume that these are substantial. There are the direct costs in terms of lives lost as well as the cost of the services provided such as health, legal, protection, and others. There are also indirect costs such as the days of work lost or reduced productivity due to violence, and its impact on the overall economy. There are many other indirect costs (sometimes called "intangible costs") which are mostly unaccounted for, as they are difficult to measure. These include the cost of lives shattered, of chronic pain, suffering, fear, depression, attempted suicides, loss of opportunities to pursue one's goals, and loss of self-esteem, among many others. While it may be useful to consider the economic consequences of violence against women, the social and human aspects are just as important to include in considerations of the cost of violence against women to society (Garcia-Moreno, 1999).

Laurence and Spalter-Roth (1995) have reviewed the data for measuring the costs of domestic violence and the cost-effectiveness of interventions in the United States. They cite estimates for the cost of domestic violence in the United States ranging between $5 and $10 billion annually in losses due to domestic violence to $67 billion in a 1995 study on the cost of crime to victims.[3] They conclude that few studies include indirect costs and that even those limited to direct costs tend to be narrowly focused. Most studies consider only the costs of injury and deaths. However, there are costs not only to the victim, but to the families of victims, the resources and institutions of communities and societies at large, as well as costs associated with programs for perpetrators. Furthermore, violence against women contributes to other problems like homelessness, foster care, and mental health problems, which are often not included in the calculations (Laurence and Spalter, 1996). More studies are now being done to come up with estimates for the cost of domestic violence. A recent one in Switzerland estimated the annual direct cost of domestic violence as 409,750,000 SwFr (equivalent to US Dollars 273,166,000 at the 1999 exchange rate of 1.50) (Yodanis, Godenzi, and Stanko, 2000).

According to the word bank, in established market economies, gender-based violence is responsible for one out of every five healthy days of life lost to women of reproductive

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age. Recent studies reveal that GBV is a significant cause of death and illness in women, resulting from beatings during pregnancy, marital rape, sexual abuse of girls, forced sterilization, abortions performed in unsanitary conditions, malnutrition, restricted access to health services and a number of other abuses (Pro-Hope International, 2005).

Another big knowledge gap in the domestic violence field is on the cost-effectiveness of interventions for domestic violence. To date there has been no attempt to document this (Laurence and Spalter-Roth, 1996.) Yet this is essential information to guide policy makers, funders and activists in the identification of effective, feasible and sustainable interventions to address this violence. Cost effectiveness studies can, by providing guidance on where resources can be used most efficiently, help to transform the understanding of violence against women into something actionable for decision-makers.

2.10. Conceptual framework

Gender-based violence (GBV) is a complex phenomenon, shaped by forces that operate at different levels. The ecological model was used to explain how violence links with the community, family and individual variables. In this model, violence against women results from the interaction of factors at different levels of the social environment. Researchers have therefore used this model that combines individual level risk factors with community and society level factor, as a way to examine the combination of risk factors that increase the likelihood of violence against women in a particular setting.

Although the ecological model framework has gained the broad acceptance for conceptualizing violence, there have been few attempts to explore how individual and community level risk factors relate to each other and ultimately influence women's vulnerability to violence (Morrison, Ellsberg, and Bott, 2004). The model can be visualized as four concentric circles. The innermost circle represents the biological and personal history that each individual brings to his or her behaviour in relationships. It talks about the individuals' characteristics, their knowledge, skills, life experience, attitude and behaviours as they interface with environment and society.

The second circle represents the immediate context in which abuse takes place-frequently the family or intimate or acquaintance relationships. It relates to the immediate physical environment and social network in which an individual lives. The third circle represents

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the institutions and social structures, both formal and informal, in which relationships are embedded-neighbourhood, workplace, social networks, and peer groups. It relates to commercial organizations, social institutions, associations and clubs which have structure, rules and regulations enabling them to pursue specific objectives and have direct influence over the physical and social environments maintained within their organization.

The fourth, outermost circle is the economic and social environment, including cultural norms. It refers to a larger system, often defined along political boundaries, possessing the means to distribute resources and control the lives development of their constituent communities.

Table 2.10.1: Risk factors often associated with violence against women: an ecological model

Individual level: biological and personal history factors among both victims and perpetrators
Relationship level: proximal social relationships, most importantly those between intimate partners and within families
Community level: the community context in which social relationships are embedded, including peer groups, schools, workplaces and neighbourhoods
Societal level: larger societal factors that "create an acceptable climate for violence, reduce inhibitions against violence". (Adapted from Krug, 2002)

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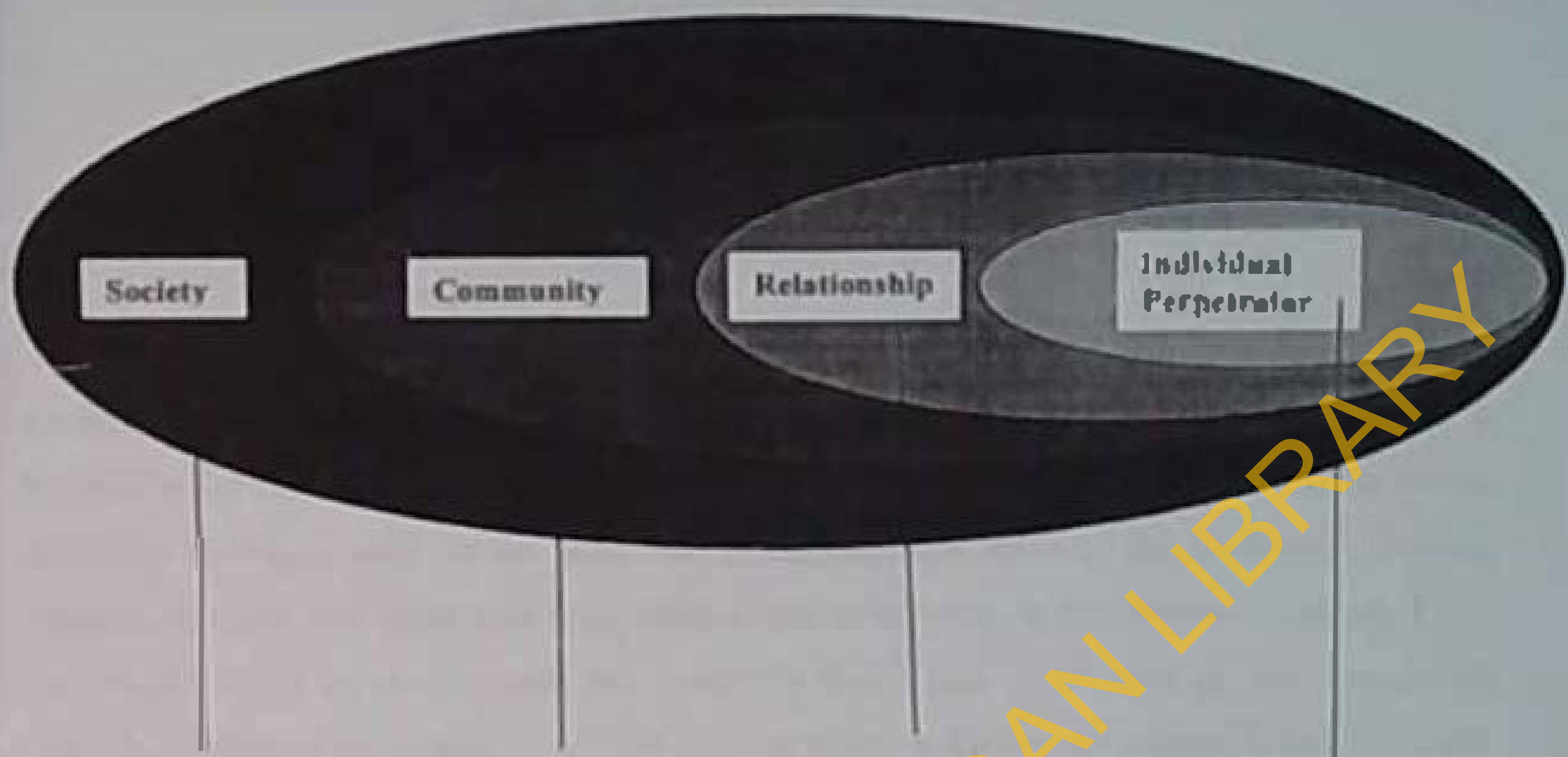

- Norms granting men control over female behaviour
- Acceptance of violence as a way to resolve conflict.
- Notion of masculinity linked to dominance, honour or aggression
- Rigid gender roles

- Poverty, low socio-economic status, unemployment
- Association with delinquent peers
- Isolation of women

- Marital Conflict
- Male control of wealth and decision making in the family
- Early age at marriage

- Being male
- Witnessing marital violence as a child
- Absent or rejecting father
- Being abused as a child
- Alcohol abuse

Fig 2.2: Ecological model of factors associated with gender based violence (Source: Adapted from Heise, Ellsberg and Gottemoeller, 1999)

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CHAPTER THREE

METHODOLOGY

3.1. Study area/Settings

The study was carried out in Federal Capital Territory (FCT), Abuja, a North central territory and the administrative headquarters of the Federal Republic of Nigeria. It is located in the centre of Nigeria, just north of the confluence of the Niger and Benue rivers, bordered by Niger State to the West and North, Kaduna State to the Northeast, Plateau State to the east and south and Kogi State to the southwest. It lies between latitude 6.45° and 9.20° North of the equator and longitude 6.45° and 7.39° east of the Greenwich Meridian Abuja's geography is defined by Aso Rock, a 400-metre monolith left by water erosion. The Federal Capital Territory (FCT) has a landmass of approximately 8000km², of which the actual city occupies 250sq km. It is known for being the best purpose-built city in Africa as well as being one of the wealthiest.

The FCT experiences three weather conditions annually. This includes a warm, humid rainy season and a blistering dry season. In between these two seasons, there is a brief interlude of harmattan, occasioned by the North east trade wind, with the main feature of dust haze, intensified coldness and dryness. The high altitudes and undulating terrain of the FCT act as moderating influence on the weather of the territory.

Abuja's vegetation falls within the Savannah Zone vegetation of the West African sub-region. Patches of rain forest, however occur in the Gwagwa plains, especially in the gullied train to the south and the rugged south eastern parts of the territory. These areas of the FCT form one of the surviving occurrences of the mature forest vegetation in Nigeria. The dominant vegetation is however classified into three savannah types, the Park or Grassy Savannah, the Savannah Woodland and the Shrub Savannah. Abuja has an estimated population of 1,405,201(Federal Republic of Nigeria Official Gazette, May, 2007) out of which approximately 740,489 are males and 664,712 are females (Federal Republic of Nigeria Official Gazette, May, 2007). The women aged 15-49 years are estimated to be half of this figure.

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Abuja metropolis is divided into six Local government areas (LGAs) called area councils, namely; Abuja Municipal Area Council (AMAC) which is structured into districts in three (3) phases, namely; phase1-central district, Garki, Wuse, Maitama and Asokoro, phase 2-Kado, Durumi, Gudu, Utako and Jabi, Phase 3- Mabuchi, Katampe, Wuye and Gwarimpa. There are also five (5) sub-urban districts, which are Nyanya, Karu, Kubwa and Jukwoyi. Other local Government Areas include: Kuje, Kwali, Gwagwalada, Abaji and Bwari (www. fct.gov.ng, June, 2008). AMAC has a total of five government hospitals and sixty one registered private hospital. Bwari LGA has one government hospital and a total of thirteen registered private hospital, Kuje LGA has one government hospital and three registered private hospitals, Kwali has one government hospital and one registered private hospital, while Gwagwalada LGA has two government hospitals and a total of six registered private hospitals (see appendix for list).

Abuja lacks pre-existing data on gender-based violence against pregnant women. However, there exist well established, accessible and well attended antenatal clinics, located within both private and government hospitals. Also being the Federal Capital territory there is a potential for local follow-up (through subsequent studies), based on this research findings. Majority of the people are either civil servants or into various types of businesses.
Ante-natal clinics are located within hospitals. The government hospitals operate them on a daily basis from Mondays to Fridays, while the private hospitals operate on an average of three days per week, usually Mondays, Wednesdays and Fridays.

3.2. Study Design

The study design was a cross-sectional one which aimed at obtaining data on gender based violence among pregnant women attending ante-natal clinics in Abuja.

3.3. Sample size

The minimum sample size was calculated using the formula

$$n = \frac{z^2 pq}{d^2}$$ where

n = sample size

d = degree of accuracy = 0.05

z = confidence interval = 1.96

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p = reasonable estimate of key propotions = 20% (i.e GBV is estimated to occur in 20.0% of households in Nigeria, Pro-Hope International, 2005)

q = 100 – 20% = 80%

therefore $n = \frac{1.96^2 \times 0.2 \times 0.8}{(0.05^2)}$

$= \frac{0.614656}{0.0025}$ = 246 = approximately 250

A sample size of 300 was chosen to increase the validity of the study and take care of losses and possible attrition.

3.4. Study Population

Abuja has an estimated population of 1,405,201(Federal Republic of Nigeria Official Gazette, May, 2007), out of which 740,489 are males and 664,712 are females. The study population comprised of pregnant women attending antenatal at the selected hospitals in Abuja.

3.5. Eligibility criteria

The inclusion criterion for this study was any woman who was pregnant and attending Ante-natal Clinic in Abuja within the study period.

3.6. Sampling Technique

Multi-stage sampling techniques which consist of three stages was used. The first stage consisted of the random selection of three local government areas from the six local government areas in Abuja, using the ballot method. The LGAs selected were Abuja municipal area council (AMAC), Bwari and Gwagwalada local government areas.

The second stage involved the construction of a sample frame for the government and registered private hospitals within the selected LGAs, from the Federal Capital Development Authority (FCDA). AMAC has a total of five government hospitals and sixty one registered private hospital. Bwari LGA has one government hospital and thirteen registered private hospitals while Gwagwalada LGA has two government hospitals and six

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registered private hospitals. A simple ballot system was used to select one government hospital in AMAC and Gwagwalada LGAs, while the only one in Bwari was chosen. One private hospital was purposively selected in each LGAs, because from record review, these were the hospitals where most women go for antenatal care.

The third stage involved selection of pregnant women from these hospitals. From previous visits and records, an average of two hundred (200) pregnant women attend ante-natal clinics in government hospitals daily, from Mondays to Fridays, while an average of fifty (50) pregnant women attend ante-natal in registered private hospitals during stipulated ante-natal days. The pregnant women were therefore selected using the ratio 4:1 that is, for every four pregnant women taken in a government hospital, only one pregnant woman is taken in a private hospital. Hence, 80 pregnant women were chosen from government hospitals in each L.G.A, while 20 pregnant women were chosen from private hospitals in each selected L.G.A. Through systematic random sampling, every fourth pregnant woman was given a questionnaire in the government hospital while every second pregnant woman was given a questionnaire in a private hospital.

3.7. Development of Instruments for data collection

The following instruments were developed for data collection

i. Focus group discussion (FGD) guide
ii. Questionnaires
iii. In-depth interview guide

3.7.1 Focus group discussions (FGD) guide

A focus group discussion guide for the pregnant women was developed. The developed Focus group discussion guide, after review and approval by the research supervisor, was pre-tested among pregnant women attending ante natal and among married men at Suleja, Niger State. The pre-test further enhanced the validity and suitability of the questions asked, and this was used to modify the FGD guide. The guide highlighted major topics for discussions which explored among other things,

i. family lifestyles,
ii. culture,
iii. family background and upbringing,
iv. causes of violence, victims and perpetrators

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v. nature and attitude of women during pregnancy towards their general environment.

vi. nature/attitude of men towards their pregnant spouses and suggested probes having to do with violence in pregnancy.

vii. Things that can be done to curb violence

The same guide was also used for married men.

3.7.2 Questionnaire

A semi-structured questionnaire was developed for the pregnant women. It was divided into six sections namely, socio-demographic characteristics; believes and attitudes on GBV; factors considered as risk factors for gender based violence, jealousy, sex bargaining power, dependency rate, stress and lifestyle; violence variables; pregnancy outcome and perception about marital relationship (see Appendix II). Unambiguous questions were incorporated into the questionnaires to elicit contextual information about the type of violence experienced, pregnancy outcomes, what sources of help were sought and their comparative and emotional status. Respondents were asked if their partners, husband's relatives or others during this pregnancy or previous pregnancies, had ever hit them and the intensity of the hitting, the part of the body it was directed at. Respondents were also asked questions about their general happiness and health, and their sexual health and satisfaction and weight of babies.

3.7.3 In-depth Interview guide

This was used to obtain data from health workers, legal practitioner and community leaders about their experiences with domestic violence, the victims, the perpetrators, involvement of pregnant women, existing training for dealing with issues of violence. The health workers interviewed were the care givers of the pregnant women present at the time of the ante-natal visits and they included the senior matron and the attending physician. The legal practitioner was a lawyer with vast experience on GBV while the community leaders were the traditional district leaders where the hospitals were situated and who are recognised in the community for settling disputes relating to GBV.

3.8. Training of research assistants

Six research assistants were recruited to assist in the collection of data for this study. The research assistants even though experienced in data collection involving gender based

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violence, were subjected to a two day training which was conducted by the researcher in collaboration with experts from the Society for Family Health, Abuja (SFH). The training started with a basic introduction to gender based violence focusing on gender based violence in pregnancy, information on the effect of GBV on the survivors and the contents of the questionnaire. The training laid emphasis on confidentiality as a critical component of reducing risks to research team members and participants. The research assistants were made to practice the skill acquired at the training through a role play where feedback on their competency were given to each of them.

3.9 Pre-testing

A pilot testing of the instrument was carried out in Suleja area in Niger state as the residents exhibit same characteristics as the Abuja people. The questionnaires were administered on fifty pregnant women at Suleja General Hospital. 18 (36.0%) of whom were Hausas, 12 (24.0%) Yorubas, 10 (20.0%) Ibos while the remaining others 10 (20.0%) consisted of Nupes, Idomas, Ebiras, e.t.c. they asked for clarifications on some questions in the questionnaire, which led to rephrasing of some question. This further validated the questionnaires. Two FGDs were also conducted; one with pregnant women and one with married men. The men were gathered at the Suleja central motor park. Their questions and answers helped validate the FGD guides.

3.10. Data collection Procedure

3.10.1 Qualitative Data

Focus group discussions were used to elicit qualitative data from the respondents. A total of eight FGDs were conducted in the three LGAs. Four FGDs were conducted among pregnant women and four with married men to further buttress and provide in-depth understanding and explanations to the findings from the questionnaires. This was carried out within a period of one week in the selected hospitals with the help of six female research assistants. Participants were drawn on purpose, with at least eight persons per group. Research assistants assisted in the recruitment of participants to come up with homogeneous groups. The age bracket for the pregnant participants and married men were 27 - 35 years and 37 - 56 years respectively. Discussions were recorded after obtaining participants' consent. The discussions among the pregnant women were held in private rooms at the hospitals, while those of the married men were done in areas devoid of distractions in the community. Each session lasted for about 50 minutes on the average.

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3.10.2 Questionnaire administration

This was carried out within a period of one week in the selected hospitals by both the researcher and the research assistants. All errors noticed were corrected on the spot and feedback given to the research assistants to reinforce standards. For easy identification and consequent coding, all questionnaires were serially numbered before administration and each research assistants was asked to write her name in pencil behind each questionnaire administered.

3.11. Validity of Instrument

Questions relevant to Gender Based Violence were compiled from literature reviews and past studies (Federal Ministry of Health. NARHS, 2003) related to GBV to meet with the objectives of the study. They were given to research experts at the research department of the Society for Family Health, Abuja (SFH) for necessary review and suggestions. The questions were then submitted to my supervisor for corrections and necessary suggestions. The instrument was also subjected to peer-review at the departmental seminar.

After the pre-test, the following questions were rephrased for better understanding:

1. "Women cannot make as good decisions on important matters as men can" was rephrased as "Men can make good decisions on important matters than women".
2. "Men should be proactive in sex and take the lead, while women should be cooperative and acquiescent" was rephrased as "Men should be ones in control during sex, while the women should agree and be cooperative"
3. "Has any of your babies been underweight?" The weight was included i.e. less than 2.5Kg.

3.12. Reliability

The questionnaire was pre-tested in Suleja area of Niger state, to enable the researcher make final adjustments and to find out how reliable and consistent the questions were.

To further confirm the reliability of the questionnaire, the pre-test data was subjected to Cronbach's Alpha correlation coefficient of the Statistical Package for Social Sciences (SPSS) test. This was done to ascertain the psychometric properties of the instrument. Using the test, a result showing correlation coefficient greater than 0.05 is said to be

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reliable. The result of the analysis of the data collected during the pre-test was 0.741 which showed that the instrument was reliable.

3.13. Data Management

The questionnaire data was sorted out, edited and coded manually by the researcher. Further analysis was carried out using the SPSS (Statistical Package for Social Sciences). The results were cross tabulated using the Chi-square test to determine the relationships between the variables. They were further organized into tables to give a clearer view of the relationships between the variables. Attitude scores were compiled based on a score of '2' for correct response, '1' for don't know and '0' for incorrect response. A total score of 28 was thus arrived at for a 14 item attitude section. The analysis of variance (ANOVA) technique was used to test significance of difference in attitude scores across levels of respondents' characteristics. Audiotapes from the FGD and in-depth interviews were transcribed and content analysis was carried out on them. It was important here to use the highest quality data that are obtainable, but this often requires a trade-off with what it is feasible to obtain. The quality data for this study was obtained through the triangulation of data from several sources mentioned above.

3.14. Ethical considerations

This study was committed to ensure that all matters pertaining to the ethical conduct of the study was considered, hence, informed consent forms (See Appendix VII) were provided explaining the purpose of the study. These were made available to Medical Directors and health workers at first entry. It was also presented to the Federal Capital Development Authority (FCDA) prior to provision of hospital sample frame. Verbal informed consent was also sought from each participant before questionnaire administration and participation in FGDs and the IDIs.

3.7. Limitations of the study

The topic was considered very sensitive in nature. To overcome this limitation, expert research assistants who had previous experience in collecting data on gender based violence (assistants who did the NARHS) had to be recruited to assist the researcher in data collection.

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CHAPTER FOUR

RESULTS

The findings from this study are presented in this section. They are organized into the following sections: socio-demographic characteristics; utilization of Family planning/child spacing method; sex bargaining power, marital security and unintended pregnancy; prevalence of violence and experiences relating to GBV; attitude towards risk factors for GBV; perception about marital relationship; outcome of violence experience and test of hypotheses.

4.1 Socio-demographic Characteristics.

Table 4.1.1 below shows the percentage distribution of respondents' socio-demographic characteristics. Majority, 122 (40.7%) of the respondents were between the ages 25-29 years, followed by those aged between 30-34 years 117 (39.0%), the least were those less than 25years of age, who were 29 (9.7%) in number. The distribution of respondents based on ethnicity showed that Hausa, Ibo and Yoruba were almost equally represented. Seventy three respondents (24.3%) were Hausas, 85 (28.3%) were Ibos, while 84 (28.0%) were Yorubas. The remaining 58 (19.3%) were a mixture of all other minor ethnic groups' such as, Ebiras, Nupes, Igalas, Urhobo. Majority, 262 (87.3%) of the respondents, were married. 7 (2.3%) were divorced, 17 (5.7%) were single, while the remaining 14 (4.7%) were living together without formal solemnization. There were more (57.4%) of Christians than Muslims (38.3%) and other religion faiths among respondents. More 139 (46.3%) of the respondents' husbands, were civil servants, while 7 (2.3%) engage in farming and 19 (6.3%) of them were unemployed. Among the respondents, 82 (27.3%) of them were civil servants, 74 (24.7%) were self employed/artisan while 68 (22.7%) were housewives.

Majority of the respondents 108(41.3%) were married to men with 1 to 2 wives, followed by 101(38.5%) married to men with 3-4 wives, while 53(20.2%) of them were married to men with more than 4 wives. On the number of children by respondents, 41(13.8%) of them were carrying their first pregnancy, 142(47.3%) respondents had between 1-2 children, 102(34.0%) had between 3-4 children, and 15(5.0%) had more than 4 children. Nineteen (7.3%) of them were in their first year of marriage, 171(65.3%) had been married for 2-5 years while 72(27.4%) had been married for 6years and above, with a mean value

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of 4.2±2.2years. Husbands/partners of 286(95.3%) of the respondents were non-smokers, while 14(4.7%) of the respondents were married to smokers. Two hundred and eighty respondents (93.3%) claimed their husbands/partners do not drink alcohol, while 20(6.7%) have husbands/partners who drink alcohol.

Table 4.1.1: a) Socio demographic characteristics of respondents

Respondents' description	№	%
Age of respondents		
<25yrs	29	9.7
25-29yrs	122	40.7
30-34yrs	117	39.0
35+yrs	32	10.8
Total	300	100
Ethnic group		
Hausa	73	24.4
Yoruba	84	28.0
Ibo	85	28.3
Others (Ebiras, Nupes, Igalas, e.t.c.)	58	19.3
Total	300	100
Marital status		
Married	262	87.3
Single	17	5.7
Divorced/separated	7	2.3
Living together	14	4.7
Total	300	100
Religious affiliation		
Islam	115	38.3
Christianity	172	57.3
Traditional	5	1.7
Others	8	2.7
Total	300	100

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Table 4.1.1: b) Socio demographic characteristics of respondents

Respondents' description	N	%
Years of marriage		
0-1 yr	19	7.3
2-5yrs	171	65.3
6+	72	27.4
Total	262	100.0
Respondents' occupation		
Professional	19	6.3
Civil servant	82	27.3
Self employed	74	24.7
Unemployed	57	19.0
House wife	68	22.7
Total	300	100
Partners' occupation		
Professional	80	26.8
Civil servant	139	46.3
Farmer	7	2.3
Self employed	55	18.3
Unemployed	19	6.3
Total	300	100

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4.2 Utilization of Family Planning (FP)/Child Spacing Method (CSM)

When asked if they had ever discussed family planning with their husband, 163(54.3%) said "yes", 131(43.7%) said "no", while the remaining 6(2.0%) claimed they "don't know". Of the 131 respondents (43.7%) who said "No", 58 of them (44.3%) did not discuss the issue for religious reasons, 26(19.8%) harboured fear for their partners' reaction towards the topic while 12(9.4%) were embarrassed to talk about the topic with their partners. Other reasons mentioned by the remaining 35(26.7%) were, the topic of FP never came up, respondents not seeing the need to discuss the issue and using FP before marriage. Two hundred and forty nine (83.0%) of the respondents reported "yes" to ever using a method of Family Planning. The decision to use was taken by self in 130(52.2%), joint decision was 98(39.4%), decision by partner was 18(7.2%) while the remaining 3(1.2%) were of the opinion that relatives should participate in the decision.

4.3. Sex bargaining power, marital security and unintended pregnancy

Bargaining power within marital relationship was assessed by looking at the issue of sex, marital security and unintended pregnancy. On ability to refuse sex, 57 (19.0%) were very confident that they can refuse sex with their partners, 114 (38.0%) were confident they can refuse, 84 (28.0%) were not confident and 45 (15.0%) did not know. Majority 178 (59.3%) reportedly derive satisfaction from their sexual relationships with their partners, 12 (4.0%) do not derive any satisfaction from having sex with their partners while 110 (36.7%) are only relatively satisfied when they have sexual intercourse with their partners. Only 80 (26.7%) of the respondents are very confident that they can initiate sex with their partners, 115 (38.3%) are just confident, 41 (13.7%) are not confident while 64 (21.3%) do not know if they can initiate sex with their partners. Two hundred and forty seven (82.0%) of the respondents said they had never felt insecure in their relationship with their partners, while 53 (17.7%) of them had felt insecure. Reasons given for feeling unsecured in their marital relationships included: impending polygamy 11 (20.8%), financial dependence of respondent on partner 22 (41.5%) wife rivalry 2 (3.8%), unemployment 14 (26.4%) and inter-tribal issues 4 (7.5%). Fifty four (18.0%) of the respondents said they had reasons to feel jealous in their relationships and gave reasons as husbands keeping girlfriends 28 (51.9%), 16 (29.6%) jealous of partners' jobs, 7 (12.9%) jealous of co-wives, while 3 (5.6%) gave negligence as their reason. Seventy nine (26.3%) of the respondents had

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gotten pregnant without planning for it and 64 (21.3%) of them did not plan for their current pregnancies.

Report from the FGD and IDI showed that majority of the participants declared that refusal of sex by the woman will always result in violence as corroborated by the following statements from the FGDs and IDIs.

"I am sorry, we are looking for facts now, there are some men who cannot do without having contact or sleeping with their wives. And there are some wives, the moment they are carrying a pregnancy, they will not want their husbands to come close to them for that reason, they must be having clashes all night when the husband demands and the wife says no, to me it will result in violence" (speaker 4 married men group in Bwari)

"Like some maybe in the night the man says madam it is time o and she says wallahi I have headache, I cannot be able to submit myself. You know most men get angry on that. Maybe you marry a woman for a particular something, by the time you suppose to do the something and the woman will not be able ......if it is someone that cannot bear, so he has to force you. He will beat you now..." (Speaker 5, pregnant women group in Bwari)

"...but what normally happen to pregnant women is rape (marital rape), by the husband because if he wants to have sex by all means and the woman does not want to consent, that is a form of rape ... ... and they are so brutal while having sex, they even bruise their wives....the type that always in the night is usually the case of I want to do and I no wan do.. another instance was when a man drove in and said "nurse, there is an emergency for you o, we asked what happened when we brought the woman out and he said " I just want her to know that I am the head of the house" and she was pregnant" (IDI with a matron)

4.4. Prevalence of Violence and Experiences relating to GBV

Of the 300 respondents, 129 (43.0%) had ever experienced violence. Specifically, the study looked at gender based violence in pregnancy. The types of violence experienced by respondents included psychological/emotional 49(38.0%), physical 47(36.4%), sexual 17(13.2%) and financial 16(12.4%) violence. Experience of respondents showed that 18(6.0%) reported being kicked during pregnancy, one (5.6%) claimed the kick was directed to their heads, 6(33.3%) said the kick was directed at their legs, 7(38.9%) said it

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was directed at their stomachs, while the remaining 4(22.2%) said it was directed at other places. Only 37(28.7%) of the 129 who had ever experienced GBV responded to the frequency of the violence. Of these, 21(56.7%) claimed it happened frequently, while 16(43.3%) said it was sometimes. Report from the focus group discussions (FGD) showed that gender-based violence exists. According to participants, the most common of all forms of violence is physical violence. The following statement by one of the participants corroborated this:

"*Very common (GBV). Like one in my compound. The woman got pregnant when her marriage was just three months. Since the woman started pregnant till date, they have been fighting everyday till last night. The woman had miscarriage. After they finish fighting when the man beat hell out of her and stand on her tummy* ..." (Speaker 5, pregnant women group in Bwari).

Report from one of the in-depth interviews and FGD showed that violence exists and affects pregnancy. One of the health workers said:

"*You know when they are beating them, they normally avoid the stomach, the most serious one was the one we had to stitch her right eye. The man really dealt the blow to her eye* ..." (IDI with a health worker).

"*like the place wey I live, the man when the wife is pregnant is always beating his wife almost every time* ..." *(Speaker 7 pregnant women group 1 AMAC)*

However, the married men group did not see the reason for the existence of violence in pregnancy, speaking from their own view; they claimed men treat their wives with dignity in pregnancy:

"*When my wife is pregnant or double-decker, I usually take care of her differently, because I know she needs my support more at* this time" (speaker 7 married men group in AMAC)

"...... *we give them that respect more especially when they are in pregnancy. In African belief, we believe that no matter what, even if the woman is not the loving type; when she is pregnant, she deserves that respect, we accord her that love and other things. If she is troublesome, you ignore her. That is all" (speaker 1 married men group in Gwagwalada)*

Of the 47 who had experienced physical violence, 14(30.0%) had been hit by husband/partners' relative. This was corroborated by the FGD participants who were

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However, the married men group did not see the reason for the existence of violence in pregnancy, speaking from their own view; they claimed men treat their wives with dignity in pregnancy:

"When my wife is pregnant or double-decker, I usually take care of her differently, because I know she needs my support more at this time" (speaker 7 married men group in AMAC)

"....... we give them that respect more especially when they are in pregnancy. In African belief, we believe that no matter what, even if the woman is not the loving type, when she is pregnant, she deserves that respect, we accord her that love and other things. If she is troublesome, you ignore her. That is all" (speaker 1 married men group in Gwagwalada)

Of the 47 who had experienced physical violence, 14(30.0%) had been hit by husband/partners' relative. This was corroborated by the FGD participants who were

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unanimous in their opinion that men are the usual perpetrators of violence in intimate partner relationship, while the women are usually at the receiving end, that is, the victims, though an IDI conducted with a legal practitioner showed that in some few cases women are the perpetrators while men were the victims;

"..... *the husband comes in and says my wife is a beater, she beats the hell out of me, ... as a basis for divorce*" (IDI with a legal practitioner)

Six (12.8%) were not pregnant when hit by their husbands' relatives, while 7 (14.9%) were pregnant. One of them (2.1%) said she was hit by the partner's mother, 8 (17.0%) said it was his sister, 1 (2.1%) said the father, 1 (2.1%) said the brother while 3 (6.4%) said it was the cousin.

Majority of the participants in the FGD mentioned characters in women that can trigger violence in men. These are nagging, an overbearing woman, women who bring public disgrace, dirty women and women having extra marital affairs while on the other hand drunkenness, extra marital affairs and in some cases a man not meeting up with his financial responsibilities to his family are characters in men that can trigger off violence. However all the participants in the two groups of the FGD were quick to mention lack of economic independence, refusal of sex by the woman and effects of pregnancy itself as reasons for GBV occurring in pregnancy.

Majority also believe that contraceptive use can sometimes cause violence in the home;

"..... *yes if a family where the man come from or the woman come is big or may be his elder brother or sister or junior ones have 6 or 7 children and he has 4, if the wife say no, himself will say yes and the fight will start*" (*Speaker1 married men group in AMAC*)

Reported experiences of violence by the 300 respondents showed that 40(13.3%) had suffered threats of been hit by their partners, 251(83.7%) indicated "No" to such threat, while 9(3.0%) cannot remember. Twenty four (8.0%) indicated "Yes" to having been beaten while pregnant, 275(91.7%) said "No" and 1(0.3%) cannot remember. (Table 4.4.1)

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Table 4.4.1: a) Reported Experience of Violence among respondents.

Statement *	'Yes'	%	'No'	%	'Can't remember'	%
My husband has threatened to hit me	40	13.3	251	83.7	9	3.0
My husband has dragged, pushed,....me while pregnant	16	5.3	279	93.0	5	1.7
My husband has hit me with his hand while pregnant	20	6.7	275	91.7	5	1.7
My husband has hit me with hard object while pregnant	8	2.7	287	95.7	5	1.7
My husband has beaten me while pregnant	24	8.0	275	91.7	1	0.3
My husband has choked me while pregnant	22	7.3	278	92.7	-	-
My husband has kicked me while pregnant	18	6.0	282	94.0	-	-

*mutually exclusive statements

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Table 4.4.1: b) Reported Experience of Violence among respondents.

statement*	"Yes"	%	"No"	%	"Can't remember"	%
My husband has slapped me while pregnant	32	10.7	264	88.0	4	1.3
My husband has threatened me with a knife while pregnant	5	1.7	295	98.3	-	-
My husband has forced me to have sex while pregnant	17	5.7	280	93.3	3	1.0
My husband has been hard on me while pregnant	36	12.0	259	86.3	5	1.7
My husband's relative has hit me	14	4.7	278	92.7	8	2.6

* mutually exclusive statements

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4.5. Outcome of violence experience

Twelve (25.5%) out of the 47 respondents who had suffered physical violence claimed they had to seek help after been hit. Of these, 1 (8.3%) had to be hospitalized, 5 (41.7%) had to go to the clinic for treatment, 5 (41.7%) had to seek the neighbours help while 1(8.3%) had to run to relatives. One hundred and forty (46.7%) respondents resolved issues of violence with their partners through dialogue, 91 (30.3%) just forgot about it, 50 (16.7%) make up with sex, while 4 (1.3%) called a family meeting.

However report from the in-depth interview showed that women would rather remain silent about their experience of violence because of fear of losing their marriage, but those who talk about it, do so in their husband's absence while those who talk in their husbands' presence had reached breaking point

4.6. Attitude towards Risk Factors for GBV

Respondents attitude towards risk factors for GBV showed that majority 272(90.7%) disagreed with the notion that parents should not encourage daughters to aspire for professional qualification, 14(4.7%) agreed with the statement while 14(4.7%) were undecided. Two hundred and fifty three (84.3%) agreed disagreed with the statement that a male child was preferable to a female child. 16(5.3%) agreed with the statement and 31(10.3) were undecided. (Table 4.6.1)

The mean attitudinal score was 23.9(±5.1) out of a total obtainable score of 28. The median score was 26.0. The minimum and maximum scores were 5 and 28.0 respectively. Those aged 30-34years had the highest mean score of 24.8 (±4.9) while those aged <25years had the lowest mean score of 17.3 (±5.4). Respondents' who were professionals had the highest mean score of 27.6 (±1.1) while respondents who were house wives had the lowest mean score of 20.3 (±6.1), also respondents' married to professionals had the highest mean score of 24.8 (±4.6) while those married to farmers had the lowest mean score of 15.9 (±7.5). Based on ethnicity, Ibos had the highest mean score of 25.8 (±4.3) while Hausas had the lowest mean score of 20.5 (±5.2) (table 4.6.2)

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Table 4.6.1: Respondents' attitudes towards risk factors for GBV

SN	Statement	Disagreed		Agreed		Undecided	
		No	%	No	%	No	%
1	Parents should not encourage daughters to aspire professional qualification	272	90.7	14	4.7	14	4.7
2	The wife should not have equal say on important decisions	234	78.0	40	13.3	26	8.7
3.	Males and females should not have equal right	239	79.7	29	9.7	32	10.7
4.	Boys should not help with housework the way girls do	259	86.3	30	10.0	11	3.7
5.	A male child is preferable to a female child	253	84.3	16	5.3	31	10.3
6.	When resources are scarce, only male child should go to school	249	83.0	13	4.3	38	12.7
7.	It is okay for a man to beat his wife as a sign of discipline	240	80.0	19	6.3	41	13.7
8.	A woman should not question the authority of a man	209	69.7	55	18.3	36	12.0
9.	Women should not have the same leadership opportunity as men	222	74.0	19	6.3	59	19.7
10.	Women cannot make good decisions like men	260	86.7	14	4.7	26	8.7
11.	A woman should leave her husband if he does not provide for her	244	81.3	28	9.3	28	9.3
12.	A man can have girlfriends outside matrimony	277	92.3	7	2.3	16	5.3
13	It is acceptable for parents to choose a husband/wife for their daughter/son	258	86.0	16	5.3	26	8.7
14.	Men should be the ones in control during sex while women should just agree and cooperate	167	55.7	100	33.3	33	11.0

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Table 4.6.2: a) The mean attitude scores across levels of respondents' socio demographic characteristics.

Variables	Mean attitude score (SD)	p-value	significance
Age group		0.001	S
>25years	17.3 (5.4)		
25-29years	24.5 (4.4)		
30-34years	24.8 (4.9)		
35+years	24.0 (4.2)		
Marital status		0.685	NS
Married	23.8 (5.1)		
Single	25.2 (5.3)		
Divorced/separated	23.0 (6.5)		
Living together	24.4 (5.8)		
Ethnic group		0.001	S
Hausa	20.5 (5.2)		
Ibo	25.8 (4.3)		
Yoruba	24.4 (5.1)		
Others (Ebira, Nupes, Igalas, e.t.c.)	23.9 (4.2)		
Religion		0.001	S
Islam	22.1 (5.3)		
Christianity	25.1 (4.5)		
Traditional	22.7 (7.6)		

Note: S = Significant. NS= Not Significant

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Table 4.6.2: b) The mean attitude scores across levels of respondents' socio demographic characteristics.

Variables	Mean attitude score (SD)	p-value	significance
Partner's occupation		0.001	S
Professional	24.8 (4.6)		
Civil servants	24.6 (4.7)		
Farmers	15.9 (7.5)		
Self employed	23.3 (5.0)		
Unemployed	19.1(4.8)		
Respondents' occupation		0.001	S
Professional	27.6 (1.1)		
Civil servant	26.0 (3.0)		
Self employed	24.3 (5.0)		
Unemployed	23.2(4.9)		
House wife	20.3 (6.1)		

Note: S = Significant, NS = Not Significant

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4.7. Respondents' perception about marital relationship

The study assessed respondents' perception about marital relationship by looking at issues bordering around happiness, depression, healthiness and fulfilment. Two hundred and thirty four (78.0%) of the respondent claimed to be happy in their relationship, 6 (2.0%) said they are unhappy, 57 (19.0%) are relatively happy while 3 (1.0%) can't say if they are happy or not. Two hundred (66.7%) are fulfilled in their relationship, 13 (4.3%) are unfulfilled, 81(27.0%) are relatively fulfilled, while 6 (2.0%) cannot say if they are fulfilled or not in their relationship. When asked if they are sometimes depressed, 99 (33.0%) said "Yes" while 201 (67.0%) said "No". Twenty seven respondents (42.2%) claimed unemployment was their source of depression, 19 (29.7%) said it was lack of financial independence, 7 (10.9%) said it was due to negligence, 6 (9.4%) claimed it was due to their marital status, 1 (1.6%) said it was due to nagging nature of their partner, 2 (3.1%) claimed it was due to the communication gap between them and their partners, while 2 (3.2%) said it was due to their mood (Table 4.7.1)

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Table 4.7.1: Respondents' perception about marital relationship

SN	Statement*	Yes		No		Relatively		Can't say	
		No	%	No	%	No	%	No	%
1.	I can describe myself as a happy person	234	78.0	6	2.0	57	19.0	3	1.0
2.	I am fulfilled in my relationship	200	66.7	13	4.3	81	27.0	6	2.0
3.	I am sometimes depressed	99	33.0	201	67.0	-	-	-	-
4.	I am a healthy person	271	90.3	9	3.0	20	6.7	-	-
5.	I get tired often	27	9.0	252	84.0	21	7.0	-	-
6.	I have a house help	150	50.0	150	50.0	-	-	-	-

*mutually exclusive statement

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Table 4.7.1: Respondents' perception about marital relationship

SN	Statement*	Yes		No		Relatively		Can't say	
		No	%	No	%	No	%	No	%
1.	I can describe myself as a happy person	234	78.0	6	2.0	57	19.0	3	1.0
2.	I am fulfilled in my relationship	200	66.7	13	4.3	81	27.0	6	2.0
3.	I am sometimes depressed	99	33.0	201	67.0	-	-	-	-
4.	I am a healthy person	271	90.3	9	3.0	20	6.7	-	-
5.	I get tired often	27	9.0	252	84.0	21	7.0	-	-
6.	I have a house help	150	50.0	150	50.0	-	-	-	-

*mutually exclusive statement

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4.8. Respondents' health and lifestyle

Two hundred and seventy one (90.3%) respondents could boast of being healthy, 9 (3.0%) could not boast of good health while 20 (6.7%) were just relatively healthy. Twenty seven (9.0%) get tired often while 21 (7.0%) get tired relatively. Half of the respondents 150 (50%) had house helps while the remaining half do not. When asked the reason why they do not have helps, 70 (46.7%) claimed they do not need one, 4 (2.7%) said they were not allowed to have one, 14 (9.3%) said they were unable to get one while 62 (41.3%) said they have relations staying with them who help out. When asked how they would cope when they are delivered of the current pregnancy, 170 (56.7%) of the respondents said their mothers would come to help with the baby, 86 (28.7) of them will have their partners' mothers come in to help, 30 (10.7) will have their relations come in to help, 5 (1.7%) will have their partners' relations come in to help, 5 (1.7%) will have other people come in to help while 1 (0.3%) will have both mothers come in to help. As to the decision of who would come to help out with the baby, 76 (25.3%) of the respondents claimed it would be their self decision, 108 (36.0%) said it would be their partners' decision, 58 (19.8%) claimed it would be a joint decision while 58 (19.8%) said it is tradition that dictates who comes.

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4.9. Results of hypotheses testing

4.9.1. Hypothesis one

The first hypothesis stated that there would be no significant relationship between experience of violence and respondents' socio-demographic profile. Majority of the respondents aged between 30-34 years 56(43.4%), had ever experienced one form of violence or the other while only 12(9.3%) aged below 25years had ever experienced violence. Based on ethnicity, majority of those who had ever experienced violence were Yorubas 47(36.4%) while those represented as 'others' had the least experience of violence 23(17.8%). Out of 262 respondents who were married. 109(84.5%) of them had ever experienced violence while those who were living together suffered the least form of violence 5(3.9%). Seventy two (55.8%) of the respondents who were Christians had ever experience violence. 50(38.8%) of respondents who were Muslims had ever suffered violence while those 3(2.3%) who were traditionalist had ever experience violence. Forty five (34.9%) married to civil servants had ever suffered violence. 35(27.1%) married to professionals had ever experienced violence while all the 7 married to farmers i.e. 100% had ever experienced violence. Partners' occupation was statistically significant with experience of violence ($p<0.05$) so also were respondents' profession and occupation with experience of violence ($p<0.05$) (Table 4.9.1).

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Table 4.9.1 a) Relationship between respondents' socio demographic characteristics and experience of violence

Variables	Experience of violence		p-value	X^2	df	Level of sig.
	No	%				
Age group			0.180	4.892	3	NS
>25yrs	12	9.3				
25-29yrs	44	34.1				
30-34yrs	56	43.4				
35+yrs	17	13.2				
Ethnic group			0.039	8.393	3	S
Hausa	29	22.5				
Ibo	30	23.3				
Yoruba	47	36.4				
Others	23	17.8	0.039	8.393	3	S
Marital status			0.093	6.408	3	NS
Married	109	84.5				
Single	9	7.0				
Divorce/separated	6	4.7				
Living together	5	3.9				
Religion			0.837	0.851	3	NS
Islam	50	38.8				
Christianity	72	55.8				
Traditional	3	2.3				
Others	4	3.1				

Note: S = Significant, NS= Not Significant

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Table 4.9.1 b) Relationship between respondents' socio demographic characteristics and experience of violence

Variables	Experience of violence		p-value	X^2	df	Level of sig.
	No	%				
Partners occupation			0.000	22.834	4	S
Professional	35	27.1				
Civil servant	45	34.9				
Farmer	7	5.4				
Self employed	29	22.5				
Unemployed	13	10.1	0.000	22.834	4	S
Respondents' occupation			0.000	21.773	4	S
Professional	6	4.7				
Civil servant	26	20.2				
Self employed	27	20.9				
Unemployed	39	30.2				
House wife	31	24.0				

Note: S = Significant, NS= Not Significant

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4.9.2. Hypothesis two

The second hypothesis stated that there would be no significant difference between forms of violence and respondents' socio-demographic profile. The distribution showed that 23(48.9%) respondents aged between 30-35yrs suffered physical violence, 13 respondents (81.3%) in the same age bracket suffered financial violence, 53(43.4%) in the same age suffered psychological/emotional violence while 8(47.1) suffered sexual violence. Nineteen (40.4%) Yorubas suffered physical violence, 5(31.3%) of them suffered financial violence, 46(37.7%) had suffered psychological/emotional violence while 9(52.9%) had suffered sexual violence. Psychological/emotional violence was the highest form of violence suffered in all the socio demographic characteristics distribution. It was statistically significant with respondents' occupation and partner's occupation ($p<0.05$). Age group was statistically significant with financial violence ($p<0.05$) (Tables 4.9.2)

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Table 4.9.2 Relationship between respondents' socio demographic characteristics and types of violence

[illegible]	Physical violence				Financial violence				Psychological/emotional Violence				Sexual violence			
	%	P value	X^2	df	%	P value	X^2	df	%	P value	X^2	df	%	P value	X^2	df
group		0.342	3.340	3		0.004	13.1[illegible]	3		0.235	[illegible]	3		0.191	4.060	3
[illegible]	4(8.5)				0(0.0)				11(9.0)				1(5.9)			
[illegible]	14(29.8)				3(18.8)				[illegible]				4(23.5)			
[illegible]	23(48.9)				13(81.3)				[illegible]				[illegible]			
[illegible]	6(12.8)				0(0.0)				16(13.1)				[illegible]			
[illegible] group		0.149	3.353	3		0.027	0.095	3		0.623	[illegible]	3		0.060	[illegible]	3
[illegible]	12(25.5)				4(25.0)				25(20.5)				1(5.9)			
[illegible]	19(40.4)				5(31.3)				46(37.7)				6(35.3)			
[illegible]	9(19.1)				3(18.8)				30(24.6)				3(17.6)			
[illegible]	7(14.9)				4(25.0)				21(17.2)				4(23.5)			
[illegible] status		0.059	[illegible]	3		[illegible]	[illegible]	3		[illegible]	[illegible]	3		[illegible]	[illegible]	3
[illegible]ried	43(87.2)				13(81.3)				[illegible]				[illegible]			
[illegible]le	0(0.0)				[illegible]				[illegible]				1(5.9)			
[illegible]orced/separated	3(6.4)				1(6.3)				[illegible]				0(0.0)			
[illegible]ng together	3(6.4)				2(12.5)				[illegible]				1(5.9)			
[illegible]igion		0.011	11.043	3		[illegible]	[illegible]	3		0.739	[illegible]	3		0.005	12.70	3
[illegible]	22(46.8)				5(31.3)				[illegible]				4(23.5)			
[illegible]	22(46.8)				9(56.3)				70(57.4)				11(64.7)			
[illegible]	3(6.4)				2(12.5)				[illegible]				2(11.8)			
[illegible]	0(0.0)				[illegible]				[illegible]				[illegible]			
[illegible] Husband's occupation		0.000	[illegible]	4		[illegible]	[illegible]	4		0.000	[illegible]	4		[illegible]	[illegible]	4
[illegible]fessional	12(25.5)				4(25.0)				[illegible]				[illegible]			
[illegible] servant	10(21.3)				5(31.3)				[illegible]				[illegible]			
[illegible]	[illegible]				2(12.5)				[illegible]				[illegible]			
[illegible] employed	[illegible]				[illegible]				[illegible]				[illegible]			
[illegible]employed	[illegible]				2(12.5)				[illegible]				[illegible]			
Respondents' occupation		[illegible]	[illegible]	4		[illegible]	[illegible]	4		[illegible]	[illegible]	4		[illegible]	[illegible]	4
[illegible]	2(4.3)				1(6.3)				[illegible]				[illegible]			
Civil servant	[illegible]				2(12.5)				[illegible]				[illegible]			
Self employed	12(25.5)				2(12.5)				[illegible]				[illegible]			
[illegible]employed	14(29.8)				[illegible]				[illegible]				[illegible]			
[illegible]	[illegible]				2(12.5)				[illegible]				[illegible]			

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Table 4.9.2 Relationship between respondents' socio demographic characteristics and types of violence

Variable	Physical violence %	P value	X^2	df	Emotional violence %	P value	X^2	df	Psychological/emotional Violence %	P value	X^2	df	Sexual violence %	P value	X^2	df
Age group		0.342	3.340	3		0.004	13.1[illegible]	3		0.235	4.255	3		[illegible]	[illegible]	3
[illegible]25	4(8.5)				0(0.0)				11(9.0)				1(3.9)			
25-29	14(29.8)				3(18.8)				62(34.9)				4(21.1)			
30-35	23(48.9)				13(81.3)				53(41.4)				[illegible]			
35+	6(12.8)				0(0.0)				14(33.3)				4(23.5)			
Ethnic group		0.149	5.333	3		0.827	0.893	3		0.022	9.638	3		0.060	7.415	3
Hausa	12(25.5)				4(25.0)				23(20.3)				1(3.9)			
Yoruba	19(40.4)				5(31.3)				46(37.7)				8(32.0)			
Ibo	9(19.1)				3(18.8)				30(24.6)				3(17.6)			
Others	7(14.9)				4(25.0)				21(17.2)				4(23.5)			
Marital status		0.059	7.427	3		0.225	4.363	3		0.0[illegible]	[illegible]	3		0.023	[illegible]	3
Married	41(87.2)				13(81.3)				102(83.6)				15(88.2)			
Single	0(0.0)				0(0.0)				9(7.4)				1(5.9)			
Divorced/separated	3(6.4)				1(6.3)				6(4.9)				0(0.0)			
Living together	3(6.4)				2(12.5)				5(4.1)				1(5.9)			
Religion		0.011	11.043	3		0.108	12.3[illegible]	3		0.750	1.1[illegible]	3		0.005	12.70[illegible]	3
Islam	22(46.8)				5(31.3)				45(36.9)				4(23.5)			
Christianity	22(46.8)				9(56.3)				70(57.4)				11(64.7)			
Traditional	3(6.4)				2(12.5)				3(2.5)				2(11.8)			
Others	0(0.0)				0(0.0)				4(3.3)				0(0.0)			
Husband's occupation		0.000	33.145	4		0.053	9.351	4		0.000	22.47[illegible]	4		0.000	30.0[illegible]	4
Professional	12(25.5)				[illegible]				33(27.0)				0(0.0)			
Civil servant	10(21.3)				3(18.8)				41(33.6)				1(5.9)			
Farmer	5(10.6)				2(12.5)				9(7.4)				8(47.1)			
Self employed	13(27.7)				3(18.8)				26(21.3)				8(47.1)			
Unemployed	7(14.9)				2(12.5)				13(10.7)				6(35.3)			
Respondents' occupation		0.030	10.740	4		0.004	19.[illegible]	6		[illegible]	23.43[illegible]	6		0.162	[illegible]	4
Professional	3(6.3)				1(6.3)				6(4.9)				0(0.0)			
Civil servant	5(10.3)				2(12.5)				24(19.7)				1(5.9)			
Self employed	13(28.6)				2(12.5)				24(19.7)				6(35.3)			
Unemployed	14(29.8)				9(56.3)				39(32.0)				8(47.1)			
Housewife	14(29.8)				2(12.5)				29(23.8)				2(11.8)			

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4.9.3. Hypothesis three

The third hypothesis stated that there would be no significant difference between years of marriage and experience of violence. Seven (5.8%) of those whose marriage were in the first year had experienced violence and 39((32.5%) who had been married for six years and above experienced violence. Years of marriage was however not significant with experience of violence (p>0.05). (Table 4.9.3)

4.9.4. Hypothesis four

The fourth hypothesis stated that there would be no significant difference between years of marriage and the forms of violence experienced. None of those (0.0%) whose marriage was within the first year had suffered financial violence, 15(93.8%) of those whose marriage were between 2 to 5 yrs had suffered financial violence. Majority of those who suffered physical violence 29(61.7%) were those whose marriages were between 2 to 5 years. Years of marriage was significant with financial violence (p<0.05) (table 4.9.4)

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Table 4.9.3 years of marriage and experience of violence

Variables	Experience of violence		P value	X^2	df
	N	%			
Years of marriage			0.193	3.289	2
0-1yr	7	5.8			
2-5yrs	74	61.7			
6+yrs	39	32.5			

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Table 4.9.4. Years of marriage and types of violence

Variable	Physical violence				Financial violence				Psychological Emotional violence				Sexual violence			
	%	P value	X^2	df	%	P value	X^2	df	%	P value	X^2	df	%	P value	X^2	df
Years of marriage		0.720	0.657	2		0.040	[illegible]	4		0.157	3.523	4		0.925	0.155	2
[illegible]	3(5.4)				0(0.0)				6(5.3)				1(6.7)			
[illegible]	29(61.7)				15(73.8)				58(51.5)				1(62.5)			
[illegible]	15(31.9)				1(6.3)				39(32.7)				[illegible]			

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4.9.5. Hypothesis five

The fifth hypothesis stated that there would be no significant difference between experience of violence and unintended pregnancy. Fifty five (42.6%) of the respondents who were pregnant without planning for it had ever experienced violence while 44 (34.1%) of the respondents who were currently pregnant had ever suffered violence. Unintended pregnancy was significant with experience of violence ($p<0.05$) (Table 4.9.5)

From the report on FGDs conducted, majority of the participants were of the view that settlement after violence can lead to unplanned pregnancy resulting from the joy of re-union. One participant said, "*And again because they have stayed apart, it's like the love is now new; they want to show affection, before you know it can lead to pregnancy*" (Speaker 7, Pregnant women's group 2 in AMAC). Another women said "*When you come together, there is a lot of happiness and you over enjoy yourself and it can lead to pregnancy*" (Speaker 6, pregnant women's group, Gwagwalada)

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Table 4.9.5 Unintended pregnancy and experience of violence

Variables	Experience of violence				p-value	X^2	df	Level of sig
	Yes	%	No	%				
Ever pregnant without plan for it	55	42.6	74	57.4	0.00	31.005	1	S
Currently pregnant without plan for it	44	34.1	85	65.9	0.00	22.009	1	S

Note: S = Significant, NS= Not Significant

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4.9.6 Hypothesis 6

The sixth hypothesis stated that there would be no significant difference between unintended pregnancy and forms of violence. Twenty three (48.9%) of the respondents who were pregnant without planning for it suffered physical violence, 8(50.0%) suffered financial violence, 51(41.8%) suffered psychological/emotional violence while 13(76.5%) suffered sexual violence. Nineteen (40.4%) of respondents who were currently pregnant had suffered physical violence, 7(43.8%) suffered financial violence while 12(70.6%) suffered sexual violence. Unintended pregnancy was significant with all the four forms of violence (P<0.05 in all the four types of violence tested) (table 4.9.6)

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Table 4.9.6. Unintended pregnancy and types of violence

Variable	Physical violence				Financial violence				Psychological/emotional Violence				Sexual violence			
	%	P value	X^2	df	%	P value	X^2	df	%	P value	X^2	df	%	P Value	X^2	df
[illegible] pregnant [illegible] plan for	23 (48.9)	0.000	14.677	1	8 (50.0)	0.027	4.800	1	51 (41.8)	0.00	23.367	1	13 (76.5)	0.000	23.352	1
[illegible] pregnant [illegible] plan for	19 (40.4)	0.001	12.165	1	7 (43.8)	0.024	5.061	1	41 (33.6)	[illegible]	18.456	1	12 (70.6)	[illegible]	[illegible]	1

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4.9.7. Hypothesis 7

The seventh hypothesis stated that there would be no significant difference between experience of violence and alcohol consumption of partners. Nineteen (95%) out of the twenty respondents married to partners who take alcohol had ever experienced violence. Eleven (23.4%) suffered Physical violence, 4 (25.0%) suffered financial violence while 14(82.4%) had suffered sexual violence. Alcohol consumption was significant with all forms of violence ($p<0.05$). Alcohol consumption by partners of respondents was also found to be significant with experience of violence ($p<0.05$). (Table 4.9.7)

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Table 4.9.7 Relationship between respondents whose partners take alcohol and experience of violence

Variables	Experience of violence				P value	X^2	df	Level of sig
	Yes	%	No	%				
Husband takes alcohol	19	95.0	1	5.0	0.000	23.640	1	S

Note: S = Significant, NS= Not Significant

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4.9.8. Hypothesis eight

The eight hypotheses stated that there would be no significant relationship between forms of violence experienced and alcohol consumption by partners. Eleven (23.4%) of respondents whose partners take alcohol suffered physical violence. This was significant with a P-value of 0.000. Alcohol consumption was significant with all forms of violence experienced ($P<0.05$)(table 4.9.8)

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Table 4.9.8 Relationship between respondents whose partners that take alcohol and types of violence

[illegible]	Physical violence				Financial violence				Psychological/emotional violence				Sexual violence			
	%	p-value	X^2	df	%	p-value	X^2	Df	%	p-value	X^2	df	%	p-value	X^2	df
[illegible]	11 (23.4)	0.000	25.093	1	4 (25.0)	0.000	9.130	1	19 (15.6)	0.000	26.217	1	14 (82.[illegible])	0.[illegible]	165.91	1

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4.10. Respondents' view on ways to eliminate violence

All participants of both the FGD and the IDI were of the opinion that Gender-based violence can only be curbed but cannot be stopped. Among the suggestions on how to control GBV was, enlightenment, exercise of patience by couples, going for counselling before and during marriage, having the fear of God within

The married men group emphasized creation of awareness which can be attained by involving men in issues concerning women's health.

"It can be controlled by creating awareness …some of those things that we pointed out were wrong that we practice to be sin during women pregnancy- not even only during pregnancy- should be highlighted. They should know that these things are wrong through awareness" (Speaker 1 married men group in Bwari)

" It cannot be stopped … characters are not the same. I might stop my own in my house but my second might not stop her own because of bad behaviour or something that you planted in your body by not being respectful to your husband. A man might just be coming from office, meets some of his friends at the bar, when he gets home, that problem will start again. So I don't think it can stop finally" (speaker 8, pregnant women group in AMAC)

" It is still counselling because some women and men went into marriage without counselling…. So when they are in matrimonial home, most of them will behave how their father and mother used to behave in those days….. love, if there is love between couples, I don't think one will like to stop the other" (IDI with a nurse)

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CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter discusses the findings from the research and looks at the reproductive health education Implication of Gender Based Violence among pregnant women. It also includes conclusions and recommendations.

5.1 DISCUSSION

5.1.1 Demographic Characteristics of respondents

Majority of the respondents (79.9%) were between the ages 25-34 years. This is consistent with a similar study carried out at Nnewi among 300 women of childbearing age. by Ilika, Okonkwo and Adogu, (2002) where majority (75%) of the respondents were between ages 21-35years. This could be attributed to this age bracket being in the active reproductive period. The three major ethnic groups were almost equally represented (Hausa-24.3%; Igbos-28.3%; Yorubas-28.0%), this is due to the fact that Abuja is a centre of unity that gives equal accommodation to all Nigerians being the country's headquarters. The finding that 87.3% of respondents were married could be attributed to the fact that the culture of Nigeria expects pregnancy to occur in marital relationships, a trend that is changing as a result of westernization. The finding that most of the respondents and their spouses are civil servants is not surprising as Abuja is a civil servant settlement, as it is the seat of government and where federal industries are located.

5.1.2 Violence

GBV is a recognized entity all over the world. In Mexico for example, a survey of 234 randomly sampled women revealed that (20%) reported blows to stomach during pregnancy, the figure was 49% in Costa Rica leading to (7.5%) having miscarriages (Pro-Hope International, 2005). This is almost consistent with (38.9%) from this study who reported kicks directed at their stomachs while pregnant.

According to a recent review of 50 studies from around the world, between 10% to 50% of women have experienced some act of physical violence by an intimate partner at some

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point in their lives (Heise, Ellsberg, and Gottemoeller 1999). This is in line with this study where 15.7% of the respondents had experienced physical violence from their partners. This and an earlier World Bank review (Heise, Pitanguy, and Germain 1994) highlighted some of the characteristics that often accompany violence in intimate relationships:

- The great majority of perpetrators of violence are men; women are at the greatest risk from men they know; this is also in line with this research, as 89.1% of respondents suffered violence perpetrated by their male partners
- Physical violence is almost always accompanied by psychological abuse and in many cases by sexual abuse; this is in line with this study, as a these types of violence were present among the respondents along with economic violence
- Violence against women cuts across socioeconomic class and religious and ethnic lines; this is also true for the pregnant respondents of this study, as results showed that violence among these pregnant women all religion, ethnic and occupational groups.

A review of studies from the United States found the prevalence of abuse during pregnancy to range from 0.9 to 20.0% with the majority of studies reporting a prevalence rate between 4.0% and 8.3% (Gazmararian et al., 1996). This study however reported a prevalence rate of 43.0%, which is rather on the high side. This high prevalence corroborates the report of a women rights Activists in Nigeria where she reported "One-third (33.3%) of Nigerian women in the country are believed to have experienced physically, sexual or psychological violence in the family, and also quoted Amnesty International as stating in its 2005 report on Violence Against Women in Nigeria that in some groups, the figure was as high as two-thirds (66.7%)". Reviewing harmful traditional practices and other forms of violence against women and girls in Nigeria, Mrs. Saudata Mahdi cited the 2008 Nigeria Demographic and Health Survey which stated that more than fifty percent of men and women justified the beating of a woman. (Daily Trust, 2005).

5.1.3 Violence and alcohol

Previous researches have consistently found heavy drinking patterns to be related to intimate partner and sexual violence. However, the exact relationship between alcohol and violence remains unclear (National Research Council, 1996). However some evidence exists that violent men who abuse alcohol are violent more frequently and inflict more serious injuries on their partners than do men without alcohol problems (Frieze and

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Browne, 1989 in Heise, 1998.). This study corroborates the above as (95%) respondents married to partners who take alcohol had experienced a form of violence or the other in their lifetime.

5.1.4. Reasons and Reactions to Violence

Majority of the participants in the FGD mentioned characters in women that can trigger violence in men as, nagging, an overbearing woman, women who bring public disgrace, dirty women and women having extra marital affairs while on the other hand drunkenness, extra marital affairs and in some cases a man not meeting up with his financial responsibilities to his family are characters in men that can trigger off violence, however all the participants in the two groups of the FGD were quick to mention lack of economic independence, refusal of sex by the woman and effects of pregnancy itself as reasons for GBV occurring in pregnancy. These were confirmed by the Nnewi study where economic demands among other factors were responsible for violence in the home (Ilika, Okonkwo and Adogu, 2002).

Official reporting of cases of gender based violence is almost inexistent as none of the victims in this study reported to the police. This low / underreporting was also documented by Ilika *et al* (2002) when only 1% of the respondent reported to the police.

In Nigeria, GBV is still widespread. The preliminary report of a study being conducted by Pro-Hope International, Port Harcourt, revealed that most women in Rivers state are not only routinely abused sexually, physically and verbally both at home at home as well as in the work place; most of these abuses are often taken meekly by the victims as the lot of women. Consequently an overwhelming majority of these abuses go unreported; and when reported, no action is usually taken against the offenders. This can be supported by the report from this study's In-depth interview which showed that women would rather remain silent about their experience of violence because of fear of losing their marriage, but those who talk about it, do so in their husbands' absence while those who talk in their husbands' presence had reached breaking point.

5.1.5. Resolution of violence

According to the study, the participants devised several ways of resolving the violence. Majority of them (46.7%) resolve the violence through dialogue with the spouse, few

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(1.3%) resolve the conflict through family mediation, some (5.0%) buy gifts or prepare special dishes for their husbands/partners, and some (16.7%) make up with sex while some (30.3%) just ignore the issue and continue with life.

5.1.6. Perpetrators of violence

Findings from this study showed that majority of the perpetrators of violence were men, however, some participants experienced violence from individuals apart from their partners. Such perpetrators included sisters-in-law (6.2%), partner's cousins (2.5%), mother-in-law (0.8%), father-in-law (0.8%) and brother-in-law (0.8%)

5.1.7. Utilization of Family Planning/Child Spacing Method

Slightly more than half of the respondents (51.7%) had ever used a method of family planning. Majority of them had ever discussed family planning with their husbands

In all societies, to a greater extent or lesser degree, women are subjected to physical, sexual, psychological and economic violence that cuts across lines of income, class and culture. GBV against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms (Pro-Hope International, 2005).

5.1.8. Sex Bargaining Power and Unintended Pregnancy.

Violence and/or fear of violence can also indirectly affect sexual and reproductive health, as they impact on women's ability to negotiate safer sex, including use of condoms, and their use of contraception (Holmes, 1996). Report from this study show that only 19.0% of the respondents were very confident they could refuse sex with their spouses, while only 26.7% are very confident they can initiate sex with their spouses. This is a source of concern for women's health.

5.1.9. Implications of Findings for Reproductive Health Education

This study attempted to document the prevalence of violence against pregnant women in selected hospitals in Abuja. It revealed a prevalence (43%), which is of public health importance i.e. more than 20%, however it is similar in prevalence with a study carried out at a primary health centre at Nnewi, Eastern Nigeria, which revealed a violence prevalence of (46.3%) among 300 women of childbearing age (Ilika et al, 2002).

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5.1.10. Participants' view on elimination of violence

The Canadian Panel on Violence against Women stated in the introduction to its report that: "it is abundantly and indisputably clear that women will not be free from violence until there is equality, and equality cannot be achieved until the violence is eliminated from women's lives" (Canadian Panel on Violence Against Women, 1993). This corroborates the findings from the FGDs discussants and IDI interviewees in this study who were of the opinion that Gender Based Violence cannot be eradicated but can only be controlled. Several suggestions were made but creation of awareness through men's education was emphasized.

5.2 CONCLUSION

Silence about violence against women and scarcity of data obscure the reality that this is a big problem. Therefore, the first and continuing task is to collect data and statistics, to make it impossible to shrug off GBV as an issue of personal and statistical irrelevance.

Gender Based Violence experienced by pregnant women with a prevalence of 43% in a city as Abuja is rather on the high side. This shows that civilization, literacy and exposure has little or no effect on it. However, the study revealed that 32% unemployed respondents and 23% who were housewives were the most affected. It is not a situation to be ignored, as the general believe is that pregnancy is supposed to protect against violence.

The study revealed that women who suffered violence usually do not report the occurrence as they see it as an issue unfit for public digestion. This is further heightened by the fact that if and when such reports are made, the women are first advised to be patient, which means they should bear it all the way on the other hand the report system see the issue as one that should be settled privately. There must be an effective legal response to Gender Based Violence. This can only be achieved if the law keepers do not see women as just women, and stop insinuating/advising such reporting women to go home to settle matters that might eventually lead to their disabilities or worst still their deaths. Victims of violence need to be supported. Only 10% of rapes and only about 5% of incidences of domestic violence are reported to the police (Theorin, 2000). Victims of gender-based violence need comprehensive support networks to provide them services such as psychological counselling, witness protection, shelters, help lines and legal services.

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It is also important to actively involve men in reproductive health issues like family planning, ante-natal services, e.t.c. for them to be able incur solutions from their informed view. Since it was also an issue of general consensus that GBV can only be controlled, then active community participation in GBV issues is of utmost importance.

5.3. RECOMMENDATIONS

These findings highlight the fact that there is an unmet need. There is no doubt that the results of this study will have a great and far reaching implication for the planning and development of more research and provide baseline data in the area of violence against pregnant women and against women in general.

Bilateral donors and multilateral institutions can play an important role in addressing gender based violence by:

- Funding research on the health and socio-economic costs of GBV,
- Encouraging science based evaluations of GBV programs,
- Disseminating evaluation results across the country.
- Promoting investment in effective prevention treatment initiatives [illegible]
- Encouraging public-private partnership.

There is an implied need for more, continuing community-based involvement, and the need for more extensive studies on violence.

There is the need to sensitize young people, men, women, the community and all stake holders on the magnitude of the problem and to open up dialogue that will break the social and cultural factors promoting GBV among pregnant women and among females generally in Nigeria.

A combination of appropriate health education strategies such as advocacy, training, BCC/IEC, peer education, role modelling are needed to tackle this problem. The intervention programmes must stress not reproductive health aspect but also boost women's confidence and upgrade their skills on issues relating to GBV the adoption of abstinence and self efficacy such as education and skills acquisition that would go a long way to promote financial independence.

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APPENDIX I

LIST OF ALL REGISTERED HOSPITALS IN THE FEDERAL CAPITAL TERRITORY AS AT JANUARY, 2005.

S/N	Name of Hospital	Location	Area Council
1.	Abuja clinics limited	Maitama	AMAC
2.	Abuja Sheraton & Towers Clinic	Maitama	AMAC
3.	Abuja Unity clinic & Maternity	Lugbe-FHA	AMAC
4.	Alfad Specialist Hospital	Kuje	Kuje
5.	Alpha & Omega Clinic & Maternity	Karmo	AMAC
6.	Alpha-Zed Medical Clinic	Karu	AMAC
7.	Amana Medical Centre	Garki	AMAC
8.	Arewa Polyclinic Area	Garki	AMAC
9.	Arewa Specialist & Diagnostic Hospital	Wuse II	AMAC
10	Asher Hospital & Maternity	Kubwa	Bwari
11	Bethel Medical Centre	Nyanya	AMAC
12	Bioprevent Consult	Gwagwalada	Gwagwalada
13	Bismol Clinic & Maternity	Nyanya	AMAC
14	Bwari medical Centre	Bwari	Bwari
15	Capital Doctor's Clinic & Maternity	Idu-Karmo	AMAC
16	Care Hospital & Maternity	Wuse II	AMAC
17	Carmel Wood Medical Centre	Garki	AMAC
18	Centre Medics Clinic & Maternity	Gwagwa	AMAC
19	Choice Maternity & Nursing Home	Kwali	Kwali
20	Cream Medics Clinic	Gwagwa	AMAC
21	Crescent Clinic	Garki	AMAC
22	Crown Hospital	Gwagwa	AMAC
23	Danck Clinic & Maternity	Apo	AMAC
24	Dantata & Sawoe Life Camp Clinic	Maitama	AMAC
25	Dara Medical Clinic	Garki	AMAC

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26	Daughters of Charity-St Vincents	Kubwa	Bwari
27	Diff Hospital	Garki	AMAC
28	Divine Clinics & Maternity Centre	Bwari	Bwari
29	Divine Fortress Clinic	Kubwa	Bwari
30	Faith Medical Centre	Karmo	AMAC
31	First City Clinic & Maternity	Apo	AMAC
32	Folusho Clinic & Maternity	Jiwa	AMAC
33	Gethsemane Clinic & Maternity	Mpape	Bwari
34	Glory Maternity Home	Jikwoyi	AMAC
35	God Bless Medical Centre	Kubwa	Bwari
36	God Grace Clinic & Maternity Home	Apo	AMAC
37	Grace of God Specialist Medical Centre	Kubwa	Bwari
38	Gwagwalada Clinic & Maternity	Gwagwalada	Gwagwalada
39	Horizons Medical Centre	Wuse	AMAC
40	Hugo medical Centre	Maitama	AMAC
41	Hugo medical Centre	Karu	AMAC
42	Ideal Hospital	Garki	AMAC
43	Iduna Specialist Hospital	Wuse II	AMAC
44	Jalingo Medical Centre	Nyanya	AMAC
45	Jamad Clinic	Gwagwalada	Gwagwalada
46	Jerab clinics	Gwagwalada	Gwagwalada
47	Jerab Clinics	Kuje	Kuje
48	Jiff Hospital & Maternity	Kado Estate	AMAC
49	Julius Berger Clinic	Wuse	AMAC
50	Julius Berger Clinic	Life Camp	AMAC
51	Julius Berger Clinic	Maitama	AMAC
52	Julius Berger Clinic	Airport	AMAC
53	Kela Foundation Clinic & Maternity	Nyanya	AMAC
54	Life Clinic & maternity	Gwagwa	AMAC
55	Limi Hospital Ltd	Garki	AMAC
56	Living Stream Specialist Med Centre	Gwagwalada	Gwagwalada
57	Liviana Clinic	Maitama	AMAC

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No.	Name	Location	LGA
58	Lola-Femi Clinic & Maternity	Jikwoyi	AMAC
59	Lugard Clinic	Mpape	Bwari
60	Lugbe Clinic & Maternity	Lugbe	AMAC
61	Maraba Clinic & Maternity	Gwagwalada	Gwagwalada
62	Martina Bills Medical	Nyanya	AMAC
63	Mercy Specialist Hospital	Wuse II	AMAC
64	N Foundation Hospital	Kuje	Kuje
65	Nakowa Maternity Home	Mabuchi	AMAC
66	Nisa Premier Hospital	Jiwa	AMAC
67	Nissi Hospital Ltd	Kubwa	Bwari
68	Nufin Allah Maternity	Karu	AMAC
69	Omega Medical Centre	Mpape	AMAC
70	Our Lady's Clinic & Maternity	Gwarimpa	AMAC
71	Our Lord's Clinic	Gwagwalada	Gwagwalada
72	Peace Maternity Home	Gwagwa	AMAC
73	Pogma Clinic & Maternity	Jikwoyi	AMAC
74	Poly Clinic	Wuse	AMAC
75	Precious Nursing & Maternity Home	Karmo	AMAC
76	Prolfa Hospital Ltd	Garki II	AMAC
77	Rhema Foundation Hospital	Kwali	Kwali
78	Rouz Hospital & Maternity	Apo	AMAC
79	Royal diagnostic Centre	Karu	AMAC
80	Royal Lord's Hospital & Maternity	Dutse-Alhaji	Bwari
81	Saffron Hospital	Nyanya	AMAC
82	Salihu Memorial Hospital	Zuba	AMAC
83	Sami Wadata Clinic	Wuse	AMAC
84	Shammah Clinics	Nyanya	AMAC
85	Silver Fountain Med. Centre	Kubwa	Bwari
86	Standard Care hospital & Maternity	Lugbe	AMAC
87	St. Francois Medical Centre	Wuse II	AMAC
88	Suleja Clinics	Garki	AMAC
89	Suleiman Yawa Memorial Hospital	Jiwa	AMAC
90	Sumit Hospital	Bwari	Bwari

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91	Sybron Medical Centre	Asokoro	AMAC
92	Victory Maternity Home	Kubwa	Bwari
93	Wildot Clinic	Utako	AMAC
94	Yemi Clinic & Maternity	Kurudu	AMAC
95	Zankli Medical Centre	Utako	AMAC

Source: Federal Capital Development Authority (FCDA), Data office, Abuja.

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APPENDIX II

QUESTIONNAIRE

GENDER BASED VIOLENCE EXPERIENCED BY PREGNANT WOMEN ATTENDING ANTE-NATAL CLINICS IN SELECTED HOSPITALS IN ABUJA

QUESTIONAIRE NO:

Date of administration: ....

Identity of administrator: ....

Location ....

INTRODUCTION

Good day. My name is ADEOLA JIDDA. I am undertaking a research on gender based violence among pregnant women in Abuja. It has been seen that pregnant women suffer violence from people close to them. You have been selected to participate in this research and I believe you will cooperate with me in providing true answers to the questions that you will be asked. Your response will go a long way to enable us get the true picture of what pregnant women go through. This information will be treated strictly as confidential and your name will not in anyway be connected to the findings.

A. SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Ethnic group

Hausa	______	1
Ibo	______	2
Yoruba	______	3
Others (specify)	______	4

2 Age at last birthday (completed years) ______________

3 Marital status

Married 1

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Single 2

Divorce/separated 3

Living together 4

4. Religion

Islam 1

Christianity (Catholic) 2

Christianity (Protestants) 3

Traditional 4

Others (specify) 5

Family background

4. What is your husband/Partner's occupation?

Professional/specialist 1

Civil Servant 2

Farmer 3

Retired/pensioner 4

Unskilled Labourer 5

Self employed/ Artisans 6

Unemployed 7

5. What is your occupation?

Professional/specialist 1

Civil Servant 2

Farmer 3

Retired/pensioner 4

Unskilled Labourer 5

Self employed/ Artisans 6

Unemployed 7

6. How many wives does your husband/partner have?

7. How many children does your husband/partner have?

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8. How many children do you have?

9. How many years have you been married?

B. UTILIZATION OF FAMILY PLANNING SERVICES

11. Have you ever used a method of family planning?

Yes 1

No 2

12. Whose decision was it?

Husband/partner 1

Respondent 2

Joint decision 3

Others (specify) 4

13. Who do you think should take the decision to use family planning?

Wife 1

Husband/partner 2

Both 3

Either of them 4

Neither of them 5

Others (specify) 6

Don't know 7

14. Have you ever discussed family planning with your husband/partner?

Yes 1

No 2

Don't know 3

15. If no, what prevented you?

Don't know how to start/embarrassed 1

Fear of husband/partner's reaction 2

Religious reasons 3

Others (specify) 4

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16. How confident are you that you can refuse sex with your husband/partner?

Very confident 1

Confident 2

Not confident 3

Don't know 4

C. BELIEVES AND ATTITUDES THAT ARE CONSIDERED RISK FACTORS FOR GENDER BASED VIOLENCE

	Disagree	Don't know	agree
17. Parents should encourage their daughters to aspire Professional qualification	1	2	3
18. Within the couple, both the wife and the husband should have equal say on important decisions	1	2	3
19. Males and females should have equal rights	1	2	3
20. Boys should help with housework the way Girls do	1	2	3
21. A male child is preferable to a female child	1	2	3
22. When resources are scarce, only boys should be sent To school	1	2	3
23. It is okay for a man to beat his wife as a sign of discipline, if she does something wrong	1	2	3
24. A woman should not question the authority of a man	1	2	3
25. Women should not have the same leadership opportunity as men	1	2	3

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26. Women cannot make good decisions on important issues like men

27. A woman should leave her husband if she does not provide for her — 1 2 3

28. A man should have girlfriends outside marriage — 1 2 3

29. It is acceptable for parents to choose a wife for their son — 1 2 3

30. It is acceptable for parents to choose a husband/wife for their daughter/son — 1 2 3

31. Men should be the ones in control during sex, while the women should Agree and be cooperative.

32. Does your husband/partner smoke?

Yes...1

No..2

33. Does your husband/partner drink alcohol?

Yes...1

No..2

D. GENDER BASED VIOLENCE EXPERIENCES

34. Has your husband/partner ever THREATEN to hit you with his fist or anything else that could hurt you?

Yes...1

No..2

Can't remember..........................3

35. Has your husband/partner ever pushed, grabbed or shoved you while pregnant?

Yes...1

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No 2

Can't remember 3

36. Has your husband/partner ever hit you with his hand while pregnant?

Yes 1

No 2

Can't remember 3

37. Has your husband/partner ever hit you with a hard object or any object that could hurt you, while pregnant?

Yes 1

No 2

Can't remember 3

38 Has your husband/partner ever bitten you while pregnant?

Yes 1

No 2

Can't remember 3

39. Has your husband/partner ever kicked you?

Yes 1

No 2

Can't remember 3

40. To which part of your body was it directed?

Head 1

Leg 2

Stomach 3

Others (specify) 4

41. Has he ever thrown anything at you that could hurt you, while pregnant?

Yes 1

No 2

Can't remember 3

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42. Did he ever slap you while you were pregnant?

Yes 1

No 2

Can't remember 3

43. Has your husband/partner ever dragged you?

Yes 1

No 2

Can't remember 3

44. Has your husband/partner ever threatened you with a knife?

Yes 1

No 2

Can't remember 3

45. Has your husband/partner ever threatened you with a gun?

Yes 1

No 2

Can't remember 3

46. Has your husband/partner ever tried to choke you?

Yes 1

No 2

Can't remember 3

47. Has your husband/partner ever forced you to have sex?

Frequently 1

Sometimes 2

Once 3

Can't remember 4

48. Was he ever hard on you in any other way while you were pregnant?

Yes 1

No 2

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49. If yes, what way?

Emotionally-Specify 1

Physically-specify 2

Financially-specify 3

Psychologically-specify 4

50. When did the most recent one happen?

Last month 1

Last 12 months 2

51. Did it begin, when you were pregnant?

Yes 1

No 2

52. Have you ever felt unsecured during any pregnancy?

Yes 1

No 2

Can't remember 3

53. Has any of your husband/partner's relative ever hit you?

Yes 1

No 2

54. If yes, in what state?

In non pregnant state 1

While pregnant 2

While nursing 3

55. If pregnant, what stage was the pregnancy?

First trimester 1

Second trimester 2

Third trimester 3

56. What is the relationship of the person that hit you, to your husband/partner?

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His mother 1
His sister 2
His father 3
His brother 4
His cousin 5
His aunty 6
His uncle 7
Others (specify) 8

57. Have you ever had to seek help after been hit?
Yes 1
No 2

58. If yes, where?
Hospital 1
Local clinic 2
Chemist 3
Friends 4
Relatives 5
Neighbours 6

59. When you and your husband/partner have a misunderstanding, how do you normally resolve it?
Through dialogue 1
Just forget about it 2
Call a family meeting 3
Make up with sex 4

E. PREGNANCY OUTCOME
60. Have you ever become pregnant without planning for it?
Yes 1
No 2
Can't remember 3

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61. Did you plan for this particular pregnancy?

Yes 1

No 2

Can't remember 3

62. Have any of your babies been underweight, less than 2.5kg?

Yes 1

No 2

Can't remember 3

63. Have you ever suffered any miscarriages?

Yes 1

No 2

64. At what stage of your pregnancy?

First trimester 1

Second trimester 2

Third trimester 3

65. What was the cause?

Stress 1

Sickness 2

Domestic accident 3

Spontaneous 4

Others (specify) 5

F. **Perception about marital relationship**

66. Have you ever felt unsecured in your relationship?

Yes 1

No2 2

67. Have you ever had any reason to feel jealous in your relationship?

Yes 1

No 2

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68. Can you describe yourself as a happy person?

Yes.....................................1

No.....................................2

Relatively.....................................3

Can't say.....................................4

69. Are you fulfilled in your relationship?

Yes.....................................1

No.....................................2

Relatively.....................................3

Can't say.....................................4

70. How can you describe your marriage/relationship (i.e. your husband/partner in relation to you)?

50-50.....................................1

60-40.....................................2

80-20.....................................3

100-0.....................................4

71. Are you sometimes depressed?

Yes.....................................1

No.....................................2

72. What is usually your source of depression?

73. Can you describe yourself as healthy?

Yes.....................................1

No.....................................2

Relatively.....................................3

74. Do you get tired often?

Yes.....................................1

No.....................................2

Relatively.....................................3

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75. Do you have a house help?

Yes...1

No..2

76. If no, why?

Don't need one 1

Not allowed to have one...................................2

Can't get one...3

Has a relation who helps 4

77. When you put to bed, who usually comes around to help?

My mother...1

His mother 2

My relation...3

His relation..4

Others (specify)..5

78. Whose decision is it to determine who comes around to help?

Mine..1

His...2

Others (specify)..3

79. Do you derive satisfaction, anytime you make love with your husband/partner?

Yes...1

No..2

Relatively..3

80. How confident are you that you can initiate sex with your husband/partner?

Very confident..1

Confident...2

Not confident...3

Don't know..4

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APPENDIX III

FGD GUIDE FOR PREGNANT WOMEN AND MARRIED MEN

Welcome participants

Describe what FGD is- a group discussion that allows you to discuss amongst yourselves the topic, rather than to us.

We will be discussing Gender based violence related issues. We are interested in your ideas, comments and suggestions. All comments both positive and negative are welcomed. Please feel free to disagree with one another. We would like to have many points of view. (WE WOULD WANT YOU TO DISCUSS ALL THE ISSUES YOURSELVES)

(We are going to record our discussion) All comments will be kept confidential and are for research purposes only. We will also want you to speak one at a time so that the tape recorder can pick up your voice appropriately.

1. Self introduction

(Ask each participant). Tell us your first name and something about yourself

2. Community Characteristics

Tell us about your community, what makes it unique and what the values it places on women are.

3. What are the common health problems faced by pregnant women

Probe for;

- What causes such problems that were mentioned
- What can be done to prevent such problem
- What can be done to cure such problem

<u>Gender</u> related issues

4. In your community, do men treat women differently when pregnant?

Is GBV a problem?

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Probe for:

- Why is it a problem
- Whose problem is it
- What type of violence exists
- Which type is most common

5. Some men beat their wives as a sign of discipline, if she does something wrong. What do you have to say about this?

Probe for:

- Why is it okay for a man to do so
- For what offence should discipline be considered

6. Does GBV has its roots in family background?
7. Do you think it is culturally instigated?

Probe for:

- What kind of upbringing can lead to violence in adult life
- What culture do you think is most affected
- What form of character triggers it most

8. What are the usual reasons for Gender Based Violence occurring in pregnancy?

Probe for:

- Role of financial handicap
- Lack of financial independence for the woman
- Is it pregnancy instigated
- Can refusal of sex by the woman lead to violence by the man

9. Does violence lead unintended pregnancy?

Probe for:

- Role of contraceptive bargaining power

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10. Can GBV be curbed?

Probe for;

- How the problem can be solved
- How long it might take
- If it can be curbed entirely

Summary and wrap up

We thank you for your time, we really appreciate your making out time to come.

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APPENDIX IV

IN-DEPTH INTERVIEW GUIDE FOR HEALTH WORKERS

INTRODUCTION

Thank you for agreeing to be interviewed. The purpose of the interview is to gather in-depth information from health workers about their experience in the cases concerning domestic violence against Pregnant women.

Please be assured that nothing you tell me will later be attributed by name to you. The information you provide today will be combined with information provided by other health providers we are interviewing to give an overall research result.

1. Self introduction: (Ask respondent)
- Tell me something about yourself
- How old were you at your last birthday
- How long have you been working as a health worker/legal practitioner/community leader

2. Tell me about your personal opinion on GBV issues
- Issues concerning domestic violence
- other issues you might like to share
- Who are the victims and the perpetrators
- Are there training for medical personnel to handle these cases

3. Have you ever handled cases of marital based violence?
- Who are the usual victims
- Have you handled cases concerning pregnant women, to which part of their body is the violence usually dealt
- In the case of pregnant women victims, does the violence affect their pregnancy outcome
- Share your experience about these women patients

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- Were they always willing to open up

4. There is the general believe that women are usually temperamental when pregnant

- What is your own opinion?
- Are there any medical explanations?
- What are the common health problems faced by pregnant women?

5. What do you think can be done to curb this problem of domestic violence?

- How long can it take?
- Do you think it can stop permanently?

6. Do you think violence has its root instilled in family backgrounds?

- Is it culturally instigated?
- Which culture is most affected?
- Does it have to do with upbringing
- What kind of character triggers it

CLOSURE

Those are all the questions I have for you. The information you have given has been very useful. Thank you very much for participating

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APPENDIX V

IN-DEPTH INTERVIEW GUIDE FOR COMMUNITY LEADERS

INTRODUCTION

Thank you for agreeing to be interviewed. The purpose of the interview is to gather in-depth information from health community leaders about their experience in the cases concerning domestic violence against pregnant women.

Please be assured that nothing you tell me will later be attributed by name to you. The information you provide today will be combined with information provided by other community leaders we are interviewing to give an overall research result.

1. Self introduction: (Ask respondent)
- Tell me something about yourself
- How old were you as your last birthday
- How long have you been working as a health worker/legal practitioner/community leader

2. Tell me about your personal opinion on GBV issues
- Issues concerning domestic violence
- other issues you might like to share
- Who are the victims and the perpetrators

3. Have you ever handled cases of marital based violence?
- Who are the usual victims
- Have you handled cases concerning pregnant women, to which part of their body is the violence usually dealt
- In the case of pregnant women victims, does the violence affect their pregnancy outcome
- Share your experience about these women victims
- Were they always willing to open up

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4. There is the general believe that women are usually temperamental when pregnant

- What is your own opinion?
- Are there any explanations for this?
- What are the common problems faced by pregnant women?

5. What do you think can be done to curb this problem of domestic violence?

- How long can it take?
- Do you think it can stop permanently?

6. Do you think violence has its root instilled in family backgrounds?

- Is it culturally instigated?
- Which culture is most affected?
- Does it have to do with upbringing
- What kind of character triggers it

CLOSURE

Those are all the questions I have for you. The information you have given has been very useful. Thank you very much for participating

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APPENDIX VI

IN-DEPTH INTERVIEW GUIDE FOR LEGAL PRACTITIONERS

INTRODUCTION

Thank you for agreeing to be interviewed. The purpose of the interview is to gather in-depth information from legal practitioners about their experience in the cases concerning domestic violence against pregnant women.

Please be assured that nothing you tell me will later be attributed by name to you. The information you provide today will be combined with information provided by other practitioners we are interviewing top give an overall research result.

1. Self introduction: (Ask respondent)

- Tell me something about yourself
- How old were you at your last birthday
- How long have you been working as a health worker/legal practitioner/community leader

2. Tell me about your personal opinion on GBV issues

- Issues concerning domestic violence
- other issues you might like to share
- Who are the victims and the perpetrators
- Are there training for legal practitioners to handle these cases

3. Have you ever handled cases of marital based violence?

- Who are the usual victims
- Have you handled cases concerning pregnant women, to which part of their body is the violence usually dealt
- In the case of pregnant women victims, does the violence affect their pregnancy outcome

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- Share your experience about these victims
- Were they always willing to open up

4. There is the general believe that women are usually temperamental when pregnant
- What is your own opinion?

5. What do you think can be done to curb this problem of domestic violence?
- How long can it take?
- Do you think it can stop permanently?

6. Do you think violence has its root instilled in family backgrounds?
- Is it culturally instigated?
- Which culture is most affected?
- Does it have to do with upbringing
- What kind of character triggers it

CLOSURE

Those are all the questions I have for you. The information you have given has been very useful. Thank you very much for participating.

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APPENDIX VII

INFORMED CONSENT FORM FOR PARTICIPANTS

GENDER BASED VIOLENCE EXPERIENCED BY PREGNANT WOMEN IN ABUJA, NIGERIA.

PURPOSE OF STUDY This research is being carried out to determine the prevalence and effects of gender based violence among pregnant women. We will ask pregnant women who have come to the antenatal care (ANC) clinics within this hospital some questions.

PROCEDURES

If you agree to take part in this research, we require you to fill a standardized questionnaire. There is also a chance that you might be verbally interviewed, if need be, and might be invited for a focus group discussion.

RISKS/DISCOMFORTS

There are two discomforts which you may experience, if you choose to partake in this research. First, the harm you have suffered from a partner is a personal matter and discussing it may make you feel sad or unhappy. If this happens, there are counselors around who will help deal with this problem.

Secondly, it is possible that your partner gets to know that you have taken part in this research and therefore cause you even more harm. To prevent this, all forms of data collection will take place in a safe place at the ANC centre. Also information collected will not be disclosed to anybody and the tapes for the FGDs will be kept in a locked cabinet.

BENEFITS

These are also of two types.

First, you may get some relief when you discuss your experience with a counsellor, who will help.

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Secondly, the information you share may help us understand why men harm their pregnant partners, hence enabling those who will get the results of this research know where to start addressing the problem.

ALTERNATIVES TO PARTICIPATION/VOLUNTARINESS

Your participation is voluntary, you may choose to participate or not. If you choose not to participate but still need help, counsellors are there to help.

CONFIDENTIALITY

This has been taken care of in five steps, by;

-ensuring your questionnaire is filled in a private place, where no one will hear the questions you ask the assistants.

-your name will not be written down, instead you will be given identification numbers, if subsequent contacts are warranted.

-tapes used will be kept in a safe place and will be destroyed five (5) years after the research is completed.

-you may talk to the leader of the team In case you have any concern or questions to ask

Do you have questions to ask about the research?

Do you want to participate in this research?

1. Yes______ 2. No________

________________________ Date

________________________ Signature of participant/ID no

QUESTIONS

If you want to talk to anyone about this research, because you have not been treated fairly, or have any question, please contact Dr. Oyedunni Arulogun, of the department of health promotions and education. Her address is stated below.

Contact information

Dr. Oyedunni Arulogun

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