SOURCES AND CONSEQUENCES OF DOMESTIC VIOLENCE AGAINST WOMEN IN ANAMBRA STATE, NIGERIA.

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Abstract

The study examined the consequences of violence against women in Anambra State, Nigeria. The theoretical thrust of the paper is frustration-aggression theory. Quantitative and qualitative methods of data collection such as questionnaires, focus group discussions and in-depth interviews were used for the study. One thousand, two hundred (1,200) questionnaires were administered to respondents selected for the study but only one thousand, one hundred and sixty five (1,165) questionnaires were validly completed and returned and these formed the base figure for the analysis. Also, 32 participants took part in the focus group discussions conducted in the urban and rural areas. Eight in-depth interviews were conducted in the study. The mean age of respondents is 35.51 approximately 36 years. The findings of the study show that psychological harm (insults, humiliation, restriction on freedom) is the major consequence of violence against women and also depression is the major problem associated with violence against women. Therefore, the study recommends that there should be institutional mechanisms where women and girls who are victims of violence can feel free to report acts of violence against them in a safe and confidential environment. Also, non-governmental organizations should make wider their sensitization projects to the rural areas through electronic and print media.

Keywords: consequences, domestic violence, violence against women.

Introduction

Violence against women is a worldwide public health and human rights concern. According to World Health Organization (WHO) multi-country study performed in 10 countries using a standardized methodology, the prevalence of different types of violence against women varies between 15% and 71% among women aged 15 – 49 years (Garcia, Jansen, Ellsberg, Heise and Watts, 2006; Jansen, Heise, Watts and Garcia–Moreno, 2008). Studies from developing countries that were not involved in the WHO study such as Haiti, Nigeria and Uganda have estimates with a similar variation, 11 – 52% (Okenwa, Lawoko and Janson, 2009; Koenig, Lutalo, Zhao, Nalugoda, Wabwire – Mangen and Kiwanuka, 2003).

Violence against women is any act of gender-based violence that results in physical, sexual or psychological harm or suffering to women, it includes threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (UN, 1993). United Nations (1995) report that acts or threats of violence, whether occurring within the home or in the community or perpetrated or conducted by the state, instill fear and insecurity in women's lives. According to United Nations report, high social, health and economic costs to the individual and society are associated with violence against women. The Global Commission on Women's Health (UNO, 1996) report that in addition to morbidity and mortality, violence against women leads to psychological trauma, depression, substance abuse, injuries, Sexually Transmitted Diseases (STDs), Human Immuno Deficiency Virus (HIV) infection, suicide and murder.

Adebayo (2003) maintained that the blacklash of violence or its threat from males has many negative outcomes that may tend to hinder the involvement of women in economic activities, thus reducing their tendency to improve on their level of economic independence, which may likely afford some protection against violence. The issues involved in violence against women have attained an international significance in the debates about sustainable development and quality of life. There have been many international conferences and declarations on violence against women, some of which include the following: The International Conference on Population and Development (ICPD); Fourth World Conference on Women (WCW); The Beijing Platform for Action (BPA) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). In spite of the fact that there have been series of conferences and campaigns against violence against women, the phenomenon still persists in Nigeria and other countries of the world.

However, as Ahmad, Riaz, Barata and Stewart (2004) have noted, women from patriarchal societies may themselves accept and adhere to patriarchal norms and values. They observed that South Asian women who adhered to more patriarchal values were less likely to judge spousal physical abuse as domestic violence compared with those women who disagreed with patriarchal social norms. In view of the above, it should be expected that women who accept patriarchal norms and values, are less likely to define behaviours as violence against women, less likely to judge such behaviours as serious, less likely to report such behaviour to others and indeed less likely to define themselves as victims.

Oyediran and Isiugo-Abanihe (2005) identified different forms of violence against women to include verbal and physical abuse, rape and sexual assault, early and forced marriages, incest and female genital cutting. Ezeilo and Ohia (2006) conducted a study in Nigeria and they identified different forms of violence against women to include flogging, beating, need denial, suppression, sexual harassment, rape, widowhood practice, abusive speech, destruction of property, deprivation, maltreatment, threats, child abuse, intimidation and humiliation. In a study conducted in Ghana, Ardayfio–Schandorf (2005), identified different forms of violence against women which include wife beating, early and forced marriages, rape (both within and outside marriage), defilement, sexual harassment, psychological abuse, economic abuse and physical abuse. In a study conducted in South Africa, Lawrence (1984) found that wife beating accounted for more than 15% of reported crime. According to him, it was estimated that violence is present in 50% to 60% of marital relationships, often leading to problems of depression, suicide, drug and alcohol abuse. Kameri-Mbote (2001) observed that physical violation of the women's body through acts as kicking, pushing, burning, pulling hair, punching, rape, verbal abuse, harassments, deprivation of resource or denial of access to various facilities are forms of violence against women.

Several studies conducted on violence against women have indicated that it is high in male-dominated, patriarchal societies especially where gender attitudes and perceptions support marked inequality between men and women and where rigid gender roles may lead to justification and acceptance of violence against women (Okenwa, Lawoko and Jansson, 2009; Okenwa and Lawoko, 2010; Lawoko, Dalal, Jiayou and Jansson, 2007). Other factors that may contribute to violence against women are women's economic dependence, poverty, low level of education and unemployment (Negussie, Berhane, Ellsberg, Emmelin, Kullgren and Hugberg, 2010; Lawoko, 2008). Antai and Antai (2009) argued that the

traditional Nigerian society is patriarchal and tends to encourage violence against women in communities where women are assigned an inferior role, subordinate to the male head of the family and regarded as the property of their husbands. According to Ondicho (2000), traditional practices and beliefs regarding the subordination of women also encourage violence against women.

Violence against women is usually associated with an increased risk for health problems (Campbell, 2002). Several studies have been conducted on violence against women in Nigeria. Antai (2011) and Ushie (2011) have done studies on the health implications of violence against women. The indirect consequence of violence against women is that it affects the economy since women's productivity is reduced. In a study conducted by WHO, more than 25% of the women suffered severe injuries such as fractures and broken teeth. Also, psychological problems such as depression, anxiety and post traumatic stress disorders are other common health problems. Women who are victims of violence may experience gynaecological and other reproductive health problems, adverse pregnancy outcomes, chronic pain and changes in endocrine and immune functions (Sutherland, Bybee and Sullivan, 2002; Vos, Astbury and Piers, 2006). According to Ezeilo and Ohia (2006), consequences of violence against women include disrespect, psycho-instability and mental instability, dehumanization, physical pains and harm, embarrassment, deformation, diseases and sickness, death, depression and emotional harm, severe pains and injury, shame and disgrace, stress, divorce, poverty, unwanted pregnancy and abortion.

In view of the aforementioned problems, this present study was designed to examine the consequences of violence against women. Also, the study examined some problems that are associated with violence against women in Anambra State, Nigeria.

Theoretical Orientation

The study is anchored on frustration-aggression theory. According to Anderson and Dill (1995), frustration-aggression theory states that frustration caused by interference in goal- directed activity, does not automatically result in aggression but produces a readiness for aggression which if triggered can result in aggression responses. The trigger may be an insignificant element of behaviour such as a casual joke, gesture or mild criticism which would normally be overlooked but to the frustrated individual may be enough to provoke an aggressive response. Berkowitz (1989) and Anderson and Dill (1995) defined frustration as an interference blocking someone from obtaining a goal and they also defined aggression as a behaviour in response

to frustration intended to harm the person blocking the goal. According to them, the feelings of frustration lead to aggressive behaviours emitted by humans in extremely traumatic situations. They went further to state that frustration-aggression theory was proposed to link frustrating scenarios to acts of aggression towards people. There have been two basic theories on frustration-aggression in relation to humans (Anderson and Dill, 1995). The theories agree that there is a relationship between frustration and aggression. The original theory posits that all acts of aggression are the result of previous frustration and all frustration leads to aggression. However, research found that this theory contradicted itself in human application. Berkowitz (1989) argued that the revised theory stresses the fact that only certain frustrating situations such as unsupportable drug addiction produce aggressive behaviour. He went further to say that the frustration-aggression theory now recognizes that the obstruction of a goal is not enough to frustrate any person to the point of an aggressive act. Frustration that causes acts of aggression are instigated by an implicit or explicit drive to reach the goal.

An example of frustration-aggression theory is an article written by Taki and Tam (2007) where they compared female bullying in Hong Kong to female bullying in Japan. Their research revealed that factors like home life, academic activities, societal expectations and stress level contributed greatly to the level of frustration and type of aggression they demonstrated. They reported that although all the different factors identified contributed to the subjects' frustration and aggression, it was societal expectations and stress level that accounted for most of the subjects' frustration. It was observed that girls from Hong Kong expressed aggression through the frustrations of academic activities and social behaviour, while the girls from Japan expressed aggression because of societal expectations. Taki and Tam (2007) maintained that stress is a major factor in the frustration-aggression theory.

In relating this theory to the study, there is an assumption that some perpetrators of violence against women do so as a result of frustration. Certain factors that may lead to frustration are income disparity between husband and wife, cheating by wives and gender of children. For some males who perpetrate violence against women, this theory may be applicable to them.

Study Area and Population

The cross sectional survey design was adopted in this study. The study was conducted in Anambra State. Anambra State was created on 27th August, 1991. It was part of the former Eastern region, part of the former East Central State and part of

the former old Anambra State. It is one of the thirty-six states of the Federal Republic of Nigeria and one of the five states in the South-East geo-political zone. It shares boundaries with Delta State to the West, Imo State to the South, Enugu State to the East and Kogi State to the North. The State has three senatorial zones – Anambra North, Anambra South and Anambra Central.

The capital of Anambra State is Awka which has a territorial area of 4,887 square kilometers. The predominant language is Igbo with minor dialectical differences. The predominant religion in Anambra State is Christianity. There are twenty-one local government areas and one hundred and seventy-seven autonomous communities.

The 2004 estimated population of 4,055,048 for Anambra State (projected from the 1991 National Population Census) was used for the study. It was impossible to get the exact population of those 18 years and above from 2006 census conducted in Anambra State and so the researcher relied on the 2004 population estimate of adults which is 1,910,834 persons representing 47.0% of the total population. Therefore, this figure formed the study population. The target population for this study comprises males and females aged 18 years and above. The age range of the respondents falls within the adult age.

Sample Size and Sampling Procedure

A sample size of 1,200 was used for the study. This number was considered adequate in view of the statistical requirements, time frame and available resources. The multi-stage sampling method that involves successive random sampling was employed in selecting: Senatorial districts, towns, wards, households and respondents in the study. All the local government areas were first categorized into urban and rural LGAs. From each category, two LGAs were selected using purposive sampling method. Consequently, Anaocha and Aguata LGAs were selected from the rural LGAs while Onitsha North and Onitsha South LGAs were also selected from the urban LGAs using purposive sampling method. The researcher used simple random sampling method (balloting) in selecting the desired number of respondents. One respondent above 18 years was chosen from each selected household. The researcher alternatively chose one sex from a selected house and another sex from the next. This was to ensure gender balance.

Instrument

The major instrument used for collecting data in this study is the questionnaire. The first part deals with the socio-demographic characteristics of the respondents while the second

part consists of general questions to ascertain the consequences and problems associated with violence against women. The other complementary instruments used in the study are Focus Group Discussion (FGD) Guide and In-depth Interview (IDI) Guide. Five research assistants were recruited and trained on the methods and objectives of the study. The field assistants were postgraduate students in the Department of Sociology/Anthropology, Nnamdi Azikwe University, Awka. The questionnaires were administered on a one-on-one (other administered) basis with all the respondents to ensure uniformity in the interpretation of concepts and recording of responses.

For the in-depth interviews, two male legal practitioners and two female school principals were interviewed in the urban area while two males and two female opinion leaders were interviewed in the rural area. Therefore, eight in-depth interviews were conducted in the study. This choice limitation became necessary because of the fact that not everybody was willing and disposed to be interviewed and so the researcher relied on only those who were willing.

For the focus group discussions, one FGD was conducted in each of the LGAs. These FGDs are as follows: eight (8) adult females and eight (8) adult males in the urban area, eight (8) adult males and eight (8) adult females in the rural area. In view of this, a total of four FGD sessions were conducted in all. This FGD helped the researcher in collecting some vital and relevant information that were not revealed in other instruments used in the study.

The researcher used Igbo as the language of administration since most of the communities are Igbo communities. English language was used where the respondents preferred to use it. The instrument was translated into Igbo language and re-translated into English language. Discussions were held with homogenous groups and the moderator was of the same sex with each group. These FGDs were conducted at locations, time and days chosen by the participants. Tape recorders and note books were used in taking down responses from the participants.

Data Analysis

The data were analyzed with the help of Statistical Package for Social Sciences (SPSS). The analysis involved the use of descriptive statistics such as frequencies, percentages and graphic illustrations which include bar charts and pie charts to present the characteristics of the research subjects. The transcripts derived from the FGD sessions and in-depth interviews were subjected to content analysis. However, illustrative quotes and expressions were identified and organized under distinct themes.

Results

The socio-demographic characteristics

The socio-demographic information of the respondents is presented in Table 1 below.

Table 1: *Distribution of respondents by socio-demographic characteristics*

	Place of Residence		
	Rural Area	**Urban Area**	**Total**
Sex			
Male	290 (57.5)	214 (42.5)	504 (100.0)
Female	317 (48.0)	344 (52.0)	661 (100.0)
Total	**607 (52.1)**	**558 (47.9)**	**1165(100.0)**
Age			
18 – 27	205 (58.4)	146 (41.6)	351 (100.0)
28 – 37	166 (43.2)	218 (56.8)	384 (100.0)
38 – 47	98 (43.8)	126 (56.2)	224 (100.0)
48 – 57	74 (56.1)	58 (43.9)	132 (100.0)
58 – 67	41 (83.7)	8 (16.3)	49 (100.0)
68 yrs and above	23 (92.0)	2 (8.0)	25 (100.0)
Total	**607 (52.1)**	**558 (47.9)**	**1165(100.0)**
Marital Status			
Married	315 (48.8)	330 (51.2)	645 (100.0)
Single	251 (55.2)	204 (44.8)	455 (100.0)
Divorced	10 (58.8)	7 (41.2)	17 (100.0)
Separated	3 (50.0)	3 (50.0)	6 (100.0)
Widowed	28 (66.7)	14 (33.3)	42 (100.0)
Total	**607 (52.1)**	**558 (47.9)**	**1165(100.0)**
Level of Education			
No Formal Education	28 (90.3)	3 (9.7)	31 (100.0)
FSLC	123 (79.4)	32 (20.6)	155 (100.0)
WASC/SSCE/GCE	232 (65.4)	123 (34.6)	355 (100.0)
NCE/OND	78 (41.5)	110 (58.5)	188 (100.0)
B.Sc/HND	126 (33.6)	249 (66.4)	375 (100.0)
M.Sc/Ph.D	20 (32.8)	41 (67.2)	61 (100.0)
Total	**607 (52.1)**	**558 (47.9)**	**1165(100.0)**
Occupation			
Unemployed	55 (59.1)	38 (40.9)	93 (100.0)
Student	175 (74.2)	61 (25.8)	236 (100.0)
Apprentice	20 (62.5)	12 (37.5)	32 (100.0)
Farmer	36 (75.0)	12 (25.0)	48 (100.0)
Civil Servant	130 (29.8)	306 (70.2)	436 (100.0)
Business/Trader	130 (52.4)	118 (47.6)	248 (100.0)
Artisan	58 (85.3)	10 (14.7)	68 (100.0)
Retired Civil Servant	3 (75.0)	1 (25.0)	4 (100.0)
Total	**607 (52.1)**	**558 (47.9)**	**1165(100.0)**

Religion			
Catholic	349 (53.3)	306 (46.7)	655 (100.0)
Anglican	231 (50.2)	229 (49.8)	460 (100.0)
Moslem	7 (43.8)	9 (56.2)	16 (100.0)
African Traditional Religion	14 (77.8)	4 (22.2)	18 (100.0)
Atheist	2 (66.7)	1 (33.3)	3 (100.0)
Pentecostal	4 (30.8)	9 (69.2)	13 (100.0)
Total	**607 (100.0)**	**558 (100.0)**	**1165(100.0)**

Table 1 clearly indicates that majority of the respondents (52.0%) are females. In terms of age, majority of the respondents (56.8 %) are in the age group of 28 - 37 years while the least number of respondents are in the age group of 68 years and above. The mean age of respondents is 35.51 approximately 36 years with a minimum age of 18 years and maximum age of 82 years. A look at the marital status of the respondents' shows that majority of the respondents (51.2%) are married while the least number of respondents are separated. In terms of level of education majority of the respondents (66.4%) have B.Sc/HND while the least number of respondents have no formal education. A look at the occupation indicates that majority of the respondents (70.2%) are civil servants while the least number of respondents are retired civil servants. The religion of the respondents shows that majority of the respondents (53.3%) are Catholics while the least number of respondents are atheists. In terms of place of residence, 52.1% are rural respondents while 47.9% are urban respondents.

Respondents views on the major consequences of violence against women

In this study, problems associated with violence against women were identified. To ascertain the consequences of violence by the respondents, they were asked. "What is the major consequence of violence against women?"

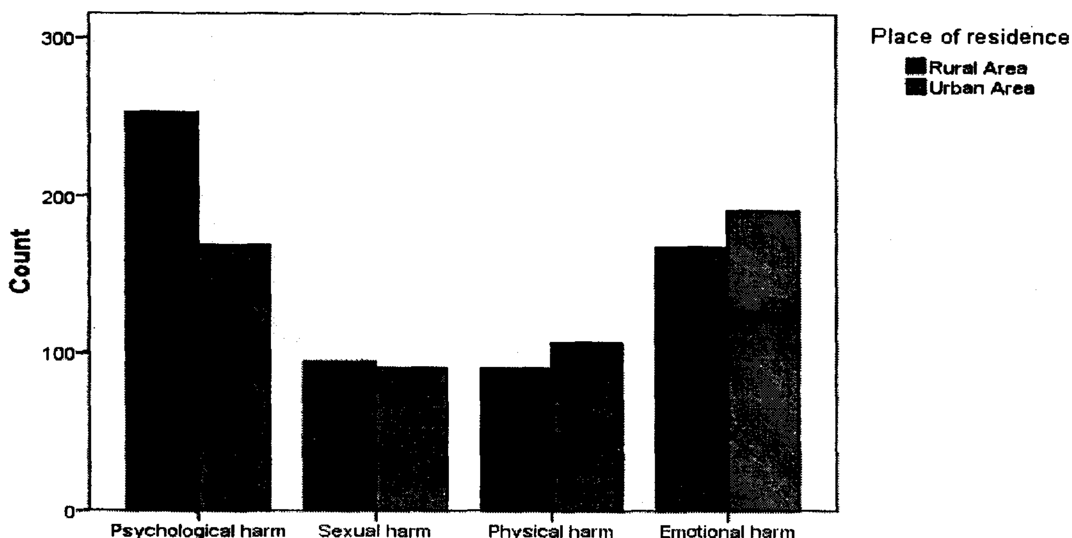

Figure 1: *Respondents' views on the major consequence of violence against women.*

Figure 1 shows the respondents' views on the consequences of violence against women. The data indicate that 60.0% of rural respondents and 40.0% of urban respondents identified psychological harm (insults, humiliation, restriction on freedom) as the major consequence of violence against women. Also, 51.1% of rural respondents and 49.0% of urban respondents mentioned sexual harm (rape, unwanted sexual touching, forced sex through the use of physical force, threats and intimidation, forced participation in degrading sexual acts and denial of the rights to use contraceptives), 46.0% of rural respondents and 54.0% of urban respondents identified physical harm (biting, beating, kicking, slapping, and strangling) while 46.8% of rural respondents and 53.2% of urban respondents identified emotional harm (bringing girlfriends home, not allowing a woman to visit family and friends, locking a woman out of the house and refusing to have sex with the woman) as the major consequence of violence against women. However, the findings indicate that majority of rural respondents and urban respondents believe that psychological harm is the major consequence though the number of

rural respondents seems to be higher than that of urban respondents.

In reaffirming these findings, an FGD participant in Onitsha South noted that, *Some women think of committing suicide after experiencing violence from their husbands or boyfriends (female, 55 years, trader, urban respondent).* Supporting this view, an IDI respondent from Aguata Local Government Area also said that, *Women feel psychologically defeated and again they tend to live in fear of further attack and further violence. When a woman continues to suffer attack and violence repeatedly, it naturally affects her health and mortality rate consequently, the woman might die quick (male, 55 years, school principal, rural respondent).*

Problems associated with violence against women

In order to examine the various problems which victims of violence face, the respondents were asked, "What is the major problem associated with violence against women in the society?" In this study, several problems were identified to be associated with violence against women.

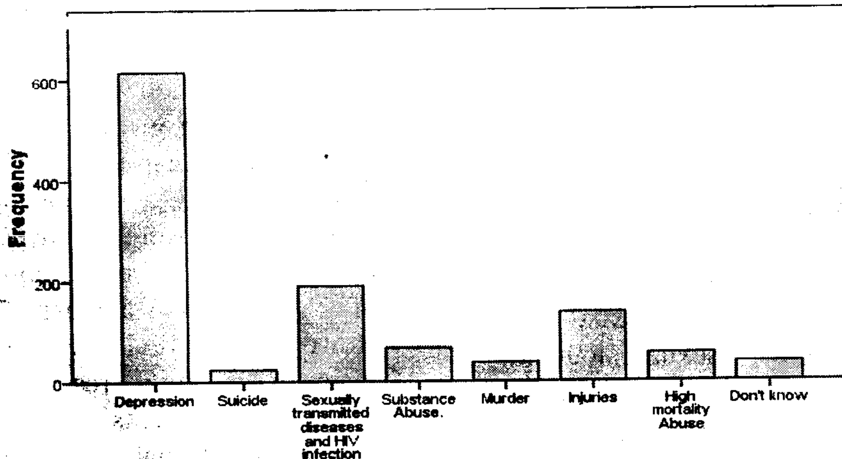

Figure 2: Respondents views on the major problems associated with violence against women.

The results of the study show that majority of the respondents (52.8%) mentioned depression, 2.1% identified suicide, 18.3% identified sexually transmitted diseases and HIV infection, 5.8% identified substance abuse. Other respondents identified murder (3.3%), physical injuries (11.8%) and high mortality (4.8%) respectively. However, only 3.3% of the respondents said that they did not know of any problem associated with violence against women. In reaffirming these findings, an FGD participant in Onitsha North noted that: *Violence against women may lead to sudden death, depression, high blood pressure and emotional problem (male, 40 years, school teacher, urban respondent).*

Figure 3 shows the views of respondents on whether violence against women is injurious to female's health.

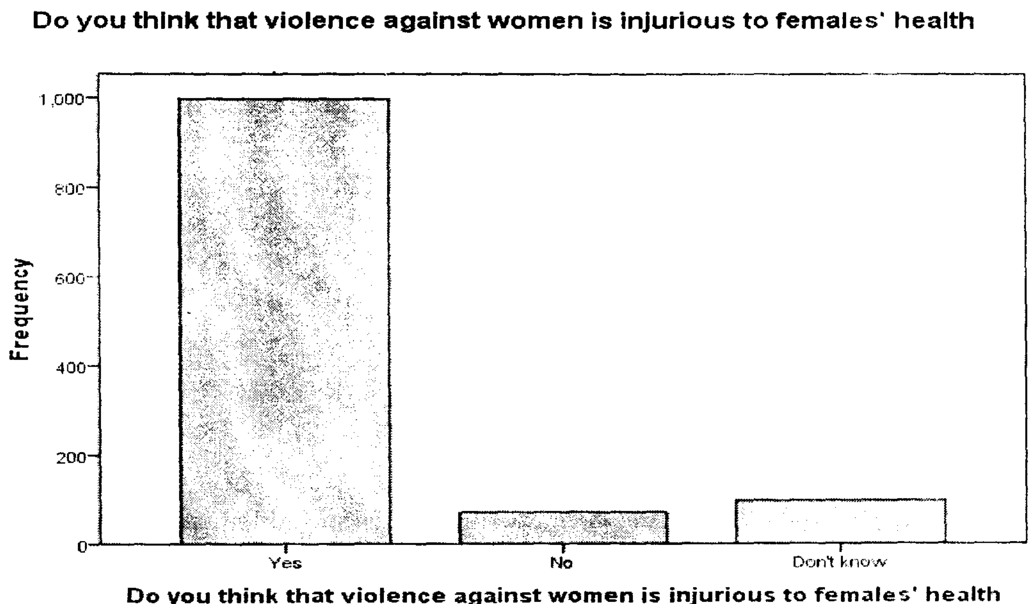

Figure 3: Respondents views on whether violence against women is injurious to females' health.

From the figure above, 85.6% of the respondents said that violence against women is injurious to females' health while 6.1% said that violence is not injurious to females' health. Only 8.3% said that they did not know whether violence against women is injurious to females' health.

Respondents' views on health problems associated with violence against women

Respondents who said that violence against women is injurious to females' health, were asked to identify the health problems that may arise from it in a follow up question. Figure 4 clearly shows their responses.

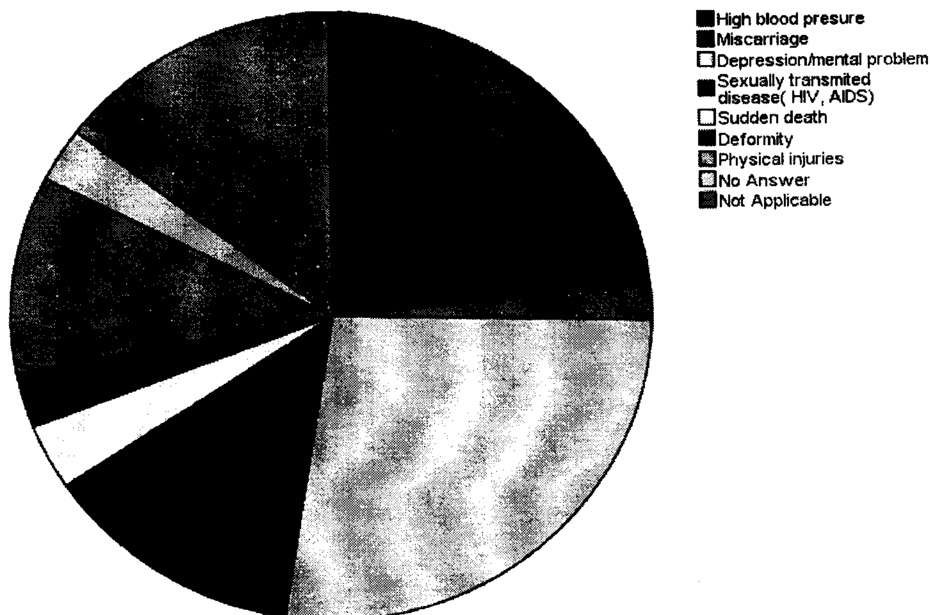

Figure 4: Respondents views on the major health problem associated with violence against women.

From the figure above, 27.2% mentioned depression/mental problem, 23.6% identified high blood pressure, 1.8% mentioned miscarriage, 13.1% of the respondents mentioned sexually transmitted diseases and HIV/AIDS, 3.5% of them identified sudden death, 2.9% mentioned deformity and 10.5% of the respondents identified physical injuries.

Supporting this view, an FGD participant in Onitsha South noted that, Violence results in health problems like high blood pressure, pelvic pain, depression, body pains, sexually transmitted diseases

and untimely death (female, 33 years, typist, urban respondent).

Discussion

Findings from the study show that violence against women has a lot of consequences on women. Women who are victims of violence suffer psychological, sexual, physical and emotional harm. Majority of the respondents in the study believe that psychological harm is the major consequence of violence against women. This is in agreement with United Nations (1996) report that in addition to morbidity and mortality, violence against women leads to psychological trauma, depression, substance abuse, injuries, Sexually Transmitted Diseases (STDs), Human Immuno Deficiency Virus (HIV) infection, suicide and murder.

Results from the study also show that problems that are associated with violence against women include depression, suicide, substance abuse, murder, injuries, high blood pressure, Sexually Transmitted Diseases (STDs) and HIV infection. However, results of studies conducted on violence against women indicate that psychological problems such as depression, anxiety, post traumatic stress disorders and other common health problems are consequences of violence against women (Campbell, 2002). Majority of the respondents in the study identified depression as the major problem that is associated with violence against women. This finding then suggests that most women who experience violence are usually depressed. Feelings of depression may become a serious problem for women because it may lead to other problems like drug addiction, suicide and murder. United Nations (1995) reports that acts or threats of violence, whether occurring within the home or in the community or perpetrated or condoned by the state, instill fear and insecurity in women's lives. According to this report, the fear of violence including harassment, is a permanent constraint on the mobility of women and limits their access to resources and basic activities. Another study notes that some of the health problems are violence related injuries, gynaecological problems, miscarriage, Sexually Transmitted Diseases (STDs) including HIV/AIDS, pelvic inflammatory disease, chronic pelvic pain, headaches, permanent disabilities, haemorrhage, and sterility resulting from female genital mutilation (Ikejiuba, 1997).

Findings of the study suggest that high blood pressure is the major health problem that is associated with violence against women. Other health problems identified are miscarriage, deformity, physical injuries and sudden death. Vos, Astbury and Piers (2006) also reported that women who are victims of violence may experience gynaecological and other reproductive health problems, adverse pregnancy

outcomes, chronic pain and changes in endocrine and immune functions.

Recommendations

Based on the findings of the study, the paper therefore recommends that counselling services should be provided for both men who are perpetrators of violence and women who are victims of violence. Men who are perpetrators of violence should also be counseled and enlightened on the dangers and health consequences of violence against women. There is need to create awareness in the society so that people who are involved in this act may have a change of attitude and resort to alternative methods of resolving conflicts rather than using different forms of violence against women. Existing laws on violence against women should be strengthened and made more effective. This will go a long way to serve as a deterrent to perpetrators of violence against women. In this way, the rate of violence can be reduced since men who engage in such act will desist from it knowing the implications or consequences of their actions.

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