PERCEPTIONS OF THE FORMS AND EFFECTS OF DOMESTIC VIOLENCE ON WOMEN'S HEALTH IN ZARIA, KADUNA STATE

BY

YOGO HELEN NOHGWE

DECEMBER, 2012.

DECLARATION

I hereby declare that this thesis titled “Perceptions of the Forms and Effects of Domestic Violence on Women’s Health in Zaria, Kaduna State” has been undertaken by me in the Department of Sociology, under the supervision of Dr.B.F. Okeshola and Dr. A.S. Maliki. All information used in this work that was derived from the literature has been acknowledged and presented as references. No part of this work has been previously presented for another degree in any institution.

Signature……………………………. Date ……………………..

YOGO HELEN NOHGWE

CERTIFICATION

This is to certify that, this research work entitled "**The Perceptions of the Forms and Effects of Domestic Violence on Women's Health**: A Study carried out in Zaria, Kaduna State, Nigeria" was conducted by YOGO HELEN NOHGWE (M.Sc/SOC-SCIEN/04841), in the Department of Sociology, Faculty of Social Sciences, Ahmadu Bello University Zaria, was read, corrected and approved for its contribution towards scientific knowledge and literary presentation.

Signature………………………… Date…………………………

Dr. B.F. Okeshola

Chairman, Supervisory Committee

Signature……………………….. Date ………………………….

Dr. A.S. Maliki

Member, Supervisory Committee

Signature…………………….. Date……………………………

Dr. A. Labo

Head of Department

Signature…………………… Date……………………………..

Prof. A.A. Joshua

Dean, School of Postgraduate Studies

DEDICATION

This piece of work is dedicated to my God of Surprises- the Great I AM THAT I AM, for His divine healing upon my life, continual strength and wisdom. It is also dedicated to all women, children, girls across the globe who have been victims of domestic violence in one way or the other and who have suffered from poor health as a result, to them I share their plight and say there is hope.

ACKNOWLEDGMENTS

I humbly wish to express my profound gratitude to my parents; Chief(Tita) Yogo Simon Peter Tapinye, Princess/Mrs.(Muertoh) Ndrenah Yogo Suefeu and Mrs. Yogo Modika Julie. My siblings Larry, Fuegare, Justina, Chris, Roger, Tata, Benedict, Madalene, Dube, Yari, Edmond, Leni, Nde, Melen. And to my wonderful nieces and nephews Hope,Pamela,Stephen and Yogo Junior.

I wish to thank my supervisors Dr. B.F. Okeshola and Dr. A.S. Maliki for their full encouragements and support.To all the staff in the Department of Sociology: Dr. Hellendendu, Dr. Oluwabamide, Dr. Gyong, Dr. Godswill, Mr. Gazama, Mrs. Mudiare, Professor Nkom, Mr. Abubakar, Mr Abel, Mr Ojo, Mr Rufai, thank you all.

I acknowledge the love and immeasurable support from Ahj. Adama Bouba at the Cameroon High Commission Abuja, General Abayomi Dominic Zamba, his Household Staff and Directing Staff for providing food, security and transportation throughout my field work and beyond and to mention Mr. Williams Yomi, Auntie Brenda, Amaka, Cecilia, Mr. Rasaq, Mr. Sharp-sharp, P.A, Bayo, Faruq, Bello, St Luke's Anglican Hospital Wusasa, Sabon gari Universal Board of Education.

I cannot end this piece without mentioning my spiritual mentors, His Lordship Bishop Bushu Emmanuel, Rev. Fr. Gabriel K, Uncle Paul Agbih, Sis. Justina Bello,Apostle Andreas Imoh and family, Brother Moses Adetunji, Sis. Rachel Ahmed.

Mention must also be made of Ene Adakole my hostel mummy who cared for me while in Shikka, my numerous friends and colleagues who made my stay in Nigeria memorable though challenging at some point: Dr. H.K. Tata, Engr. G. Attah, Dr.C. Awasum, Adams Idakwo, Mustapha Baffa, Ahj Sani Liti, Dijah, Martha, Esther, Bilikisu, Ahmed, Sam Joe, Chinapi, Oshodi, Lange Chris, Agem Chris, Divine Tata, Lola, Mama Lola(PG Hostel Cleaner), Andortahs, Harrison, Gennie E,Mabel, Prince O. Paul, Yinka Mustapha ,Charity typist.

TABLE OF CONTENTS

	Page
Title Page …………………………………………………………	i
Declaration…………………………………………………………	ii
Certification………………………………………………………..	iii
Dedication………………………………………………………….	iv
Acknowledgments…………………………………………………	v
Table of Contents………………………………………………..	vi
List of Tables…………………………………………………….	ix
Abstract…………………………………………………………….	xi

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study………………………………………..	1
1.2 Statement of the Research Problem……………………………..	4
1.3 Research Questions………………………………………………	10
1.4 Objectives of the Study…………………………………………..	11
1.5 Significance of the Study…………………………………………	12
1.6 Scope of the Study………………………………………………..	14
1.7 Definition of Terms………………………………………………	15
1.8. Synopsis of Later Chapters ……………………………………	19

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction…………………………………………………….	21
2.2 Review of Related Literature………………………………………	22
2.3 Forms of Domestic Violence………………………………………	33

2.4 Impact of Domestic Violence on Women's' Health……………. 36
2.5 Effects of Domestic Violence ……………………………………….. 43
2.6 Strategies Adopted by Victims of Domestic Violence…………… 46
2.7 Theoretical Framework…………………………………………… 51

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction……………………………………………………… 56
3.2 Location of the Study…………………………………………… 56
3.3 Type and Sources of Data………………………………………… 59
3.4 Research Population and Sampling Method……………………… 59
3.5 Method of Data Collection………………………………………… 62
3.6 Techniques of Data Analysis……………………………………… 63
3.7 Problem Encountered in the Field……………………………….. 64

CHAPTER FOUR: FINDINGS ON DOMESTIC VIOLENCE

4.1 Introduction…………………………………………………….. 65
4.2 Socio-demographic Attributes of Respondents……………………… 66
4.3 Forms of Domestic Violence in Zaria Communities………….. 69
4.4 Reasons for the Existence of Domestic Violence on Women's Health by Respondents……………. ……… 80
4.5 Behavioral Pattern of Victims of Domestic Violence and their Effects on Women's Health………………………………………………… 83
4.6 Impacts of Domestic Violence on Victim's Physical Health………….. 89
4.7 Strategies that could be Adopted to Curb Domestic Violence in the Community……………………………… ……………………. 101
4.8 Recommendations on Ways of Mitigating, the Incidence of Domestic Violence on Women's Health……………………………….. 102

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1Introduction…………………………………………………………… 104

5.2 Summary of Major Findings………………………………………………… 104

5.3 Conclusion………………………………………………………………… 108

5.4 Recommendations………………………………………………………… 111

5.5 Suggestions for Further Research………………………………………… 112

References……………………………………………………………………. 114

Appendix I: Questionnaire on the Perceptions of the Forms and Effects of Domestic Violence on Women's Health………………… 123

Appendix II: In-depth Interview Guide…………………………………… 128

Appendix III: Focus Group Discussion Guide…………………………… 130

LISTS OF TABLES

Table 4.2.1: Socio-Demographic Attributes of Respondents…………… 66

Table 4.3.1: Most Common Forms of Violence against Women's Health by Respondents ……………………………………………… 69
Table 4.3.2: Views of Respondents on Domestic Violence……………… 70
Table 4.3.3: Views of Respondents on Spouse Battering………………….. 71
Table 4.3.4: Views of Respondents on Forceful Marriage………………… 72
Table 4.3.5: Views of Respondents on Female Genital Mutilation……….. 73
Table 4.3.6: Views of Respondents on Ill-treatment from In-laws………… 74
Table 4.3.7: Views of Respondents on Isolation from Active Participation in all Decision Making at Home……………………………. 75
Table 4.3.8: Views of Respondents on Verbal Assault…………………… 75
Table 4.3.9: Views of Respondents on Refusing Wife Sexual Satisfaction……………………………………………………. 76
Table 4.3.10: Views of Respondents on Refusing Wife's Food…………… 77
Table 4.3.11: Views of Respondents on Forbidden Married to sit in the midst of Men……………………………………………… 77
Table 4.3.12: Views of Respondents on Forbidden Married Women to seek Competent Health Care Alone………………………… 78
Table 4.3.13: Views of Respondents on Other Forms of Violence against Women. …………………………………………… 79
Table 4.4.1: Views of Respondents on Lack of Dialogue with Spouse…………………………………………………… 80
Table 4.5.1: Views of Respondents on whether They Are Afraid of their Husbands……………………………………………… 83
Table 4.5.2: Views of Respondents on Reasons why they maybe Afraid of their Husbands…………………………………………… 84
Table 4.5.3: Views of Respondents on Relationship with Husbands……….. 85
Table 4.5.4: Views of Respondents on Relationship with Children………… 86
Table 4.5.5: Views of Respondents on how Traumatized they felt………….. 87
Table 4.5.6: Intimidation felt by Respondents………………………….. 87
Table 4.5.7: Isolation felt by Respondents …………………… 88
Table 4.5.8: Views of Respondents on Other Behaviors adopted…………………………………………………… 88
Table 4.6.1: Views of Respondents on Bruises/Injuries……………………. 93
Table 4.6.2: Swollen Body Parts and Stress Related Injuries by Respondents.. 94
Table 4.6.3: Miscarriage in their Relationship by Respondents …………..…… 95
Table 4.6.4: Views of Respondents on Loss of Blood ……………………… 96
Table 4.6.5: Views of Respondents on Cutting/Mutilation of the

Female External Genitalia…………………………………… 96
Table 4.6.6: Painful Intercourse experienced by Respondents……………… 97
Table 4.6.7: Views of Respondents on Other Effects of
Domestic Violence against Women and their Health……… 100

ABSTRACT

This study focused on investigating the Perceptions of the Forms and Effects of domestic violence on women's health in Zaria Communities of Kaduna State, Nigeria. The study was conducted in four communities within Zaria. The objectives were to identify and describe the forms of domestic violence on women's health; explore the nature and prevalence of domestic violence on women's health; examine factors that enhances domestic violence on women's health; identify the effects of domestic violence on women's health; strategies adopted by victims to cope with domestic violence and recommending ways of mitigating the incidence of domestic violence on women's health. Liberal Feminist Theory served as the theoretical framework for this study with its basic assumptions that: as the dominant class, men have differential access to material and symbolic resources thus women are devalued as secondary and inferior; intimate partner abuse is a predictable and common dimension of normal family life; women's experiences are often defined as inferior because male dominance influences all aspects of life. Information was derived from a sample of 186 respondents of age 10- 30 years and above, four in-depth interviews and three focus group discussions were conducted. The findings revealed that, domestic violence exist in the community with the most common forms as Sexual Assault 30 %(55) and Spouse Battering 22 %(41). As a consequence, its victims suffer effects like bruises/injuries 54 %(100), swollen body parts and stress related injuries 52 %(96). Findings also show that, factors that enhance domestic violence include age of marriage, how marriages are concluded and socioeconomic status. In addition, findings showed that reasons for the existence of domestic violence leading to poor health status of women were attributed to poverty, non-challant attitudes of spouse, and disobedience among couple. As a coping mechanism, the findings revealed some respondents tend to have very interactive relationships with their children, isolate themselves, become depressed, others accepted their situations and turn to God in prayers. The respondents recommended that: perpetrators must face the law; prayers should be implored; counseling and dialogue should be implemented; cases of domestic violence should be reported on time to parents and community leaders.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The welfare and status of women reflect the conditions of their countries. The objective of this study is to provide information about ways and means available to improve the social well-being and health status of women and the girl-child.

Domestic violence is a term that covers a range of violent or abusive behaviors perpetrated within the context of the family or intimate relationship which could be physical or verbal. For example, marital abuse is a form of domestic violence perpetrated within the context of an intimate relationship by one's partner over one, at the detriment of one's happiness and good health. It has synonyms like wife beating and intimate partner abuse. Although, this is a serious issue plaguing the health status of women, there is paucity of data on domestic violence, principally because it is underreported. As a matter of fact, most popular and academic literature have focused extensively on issues connected with the women's liberation movement; the fight for equality and freedom of speech, and neglected domestic violence, sexual violence perpetrated against women and their health status. In Nigeria, marital abuse has become a scourge and there is a report that 50% of Nigerian women have been battered by their husbands at one time or the other (NaijaGist.com, 2012).

From a sociological point of view, domestic violence could be defined as a pattern of abusive behaviors used by one individual intended to exert power and control over another individual in the context of an intimate relationship such as marriage, dating, family, friends or co-habitation. Domestic violence is maintained by societal and cultural attitudes, institution, and laws that are not consistent in regarding this violence as wrong. Moreover, awareness, perception and documentation of forms of domestic violence differ from country to country, and from era to era, since domestic violence may or may not constitute a crime, depending on local status, severity, and duration of specific acts. Other variables such as alcohol consumption" substance intake and mental illness are also frequently associated with abuse (Abama and Kwaja, 2009).

The Inter-African Committee on traditional practices affecting the health of women and children (1995) stated that most women accept violence against themselves because of social prejudice and their low self-esteem. The perpetuation of Domestic Violence against Women has continued due to women's economic dependence on men, patriarchy and the differential socialization process women pass through (Pallitio and Ocampo, 2004, Heise et al., 1999, Nhloyi, 1996; Kurta, 1989).

As a matter of fact, domestic violence against women by their male partners is widely accepted by many African societies because of their beliefs that men are superior, the women under them are regarded as their possessions, and can be treated as the men considered appropriate (Kerige, 1995, VAWA, 2011). In Nigeria where

this study is been carried out, it has been observed that domestic violence against women is not only widespread; it is also socially acceptable as in the case of the whole Africa (Stawarth, 1995). In addition, in Nigeria as in the Filipino culture, the main perceived domain of women is the home, where women are viewed mainly as mothers, wives, care-givers or daughters and this has eaten deep into some cultures in Nigeria (Carths, 1994). And the fact that there is usually no-intervention of, or coming up of most witnesses and victims present when such violence is committed against women, to testify against such incidence, demonstrates a clear social permissibility of domestic violence against women.

Irrespective of the fact that, there has been explicit acknowledgement of the state's responsibility for human rights' violation by private actors in both public and private spheres in several international conventions, in particular the Vienna Accord of 1993 and the Beijing platform of 1995, domestic violence against women remains highly prevalent and is still a major cultural blind sport (Aderinto, 2003). This study, therefore aims at investigating the prevalence, forms and effects of domestic violence on women's health in Zaria communities of Kaduna State, Nigeria.

1.2 Statement of the Research Problem

In Zaria, what is commonly observed as far as domestic violence is concerned is spousal battering. Among the Hausas, who form the majority of the ethnic groups, the girls are married at very tender ages. These girls are not free to talk about their

marriage lives and experiences. They are not allowed to go to the hospital without their husbands' permission. Even when they are not being well treated at home, their culture and tradition does not encourage them to speak about it. Women here are more or less treated as domestic servants especially those who have never gone to school. Interestingly, in a conversation between two men and the researcher, these men shared similar opinions by saying that, their wives are meant to do just whatever they ordered them to do, and these women do not have any rights whatsoever to dispute. Also, some house helps suffer violence at home either from their masters and madams or from their children.

In the typical indigenous Zaria Communities, many husbands do not seek their wives' opinions in decision making even in matters pertaining to home affairs or the wives themselves. In the Zaria Communities, there is a lot of silence as far as domestic violence against women is concerned. Domestic violence is yet to be properly addressed in developing countries. Violence at home is regarded as nothing. Those in polygamous families have no rights to refuse having sexual intercourse with their husbands. The standard for this is that, the husband is expected to understand either when she says she is sick or she is in her menstrual period. Yet some husbands will not want to understand even when she happens not to be in the right physical state for sex. Sexual intercourse is a routine, where every woman has a week to perform her sexual duties. Even when the man could be ill, the woman is expected to mate with him because she could be punished according

to tradition if she refuses. A woman who violates the rules, is regarded disrespectful and will be punished accordingly (Naseehah-An, 2008).

Apart from the physical dangers, the psychosocial consequences of violence are also grave. Victims are more likely to adopt other mechanisms in order to cope. They cannot leave or complain because if they do, their community will see them as failures and they will not be respected. Secondly, victims lack the courage and support from very close relatives to better address the issue. For women within the Zaria Communities, they turn to adopt strategies for dealing with violence they face, ranging from leaving the aggressor, accepting the violence or resorting to self-defense or staying quiet about it. Within the Zaria Communities, it was observed by the researcher that, some women did not acquired formal education; are tired from repeated childbearing and economical dependency (Fawole et al, 2005).

Research suggests that, physical violence in intimate relationships like the case we are investigating is often accompanied by other types of violence. Zimmerman and Watts (2002) reported that, perpetrators or the beneficiaries of domestic violence against women were largely 30-40 years old men whom have been married for over 5 years. Other researchers observed that, some men use violence against their wives, especially when such men want their wives to leave or divorce the marriage. This is a frequent occurrence especially when such men are seeing other women outside their matrimonial homes. And this is very true in our contemporary African society

where the women in tend to protect their homes condone and accept all forms of maltreatments from their partners to the detriment of their health status and self-esteem.

Domestic violence against women's health causes human suffering, impediments to personal development and reduction in the contribution women can make to the lives of others if they were free of such ill treatments and health hazards. There is no way a victim of domestic violence will properly take care of her home, children, work and all that concerns her. Some victims of domestic violence face varying degree of trauma and psychological torture that goes a long way to destroy her health physically and mentally. And as a result domestic violence against women hinders them to protect themselves from sexually transmitted diseases (STDs). Domestic violence against women's health has negative effect on women as a whole because it is somewhat related to their reproductive health since it occurs in connection with transmission of deadly diseases including HIV/AIDS, syphilis (that prohibits fertility), pregnancy and delivery or with fertility and sexuality. And as the researcher earlier observed, Heise (1993) added that, the fear of violence keeps women submissive to male decision-making. He continued that, quite a lot of women in their efforts to avoid violence accepts insults and misery or flee from the marriage, relationship, affair or intimacy.

The concept of the perceptions of the forms and effects of domestic violence on women's health refers to a phenomenon related to biological

reproduction and processes, inducing not only health problem related to reproduction itself, but also those related to the exercise of sexuality, physical assaults, prevention of undesired pregnancy and others (Stem, 1993). No doubt violence against women has been generally accepted as "understandable behavior" with patriarchy leading credence to it through the continuous perpetuation of male dominance (Dickstein, 1988).

Beside the determinants, forms and effects of domestic violence against women in Nigeria, Zaria, and women in particular, its consequences on health, are yet to be established. There is much that remains to be understood about the total set of possible health outcomes associated with domestic violence against women especially in developing countries.

Though studies have been conducted in developed countries on violence against women to highlight its implications for development in these developed countries, it has become a major tropical issue in modern development for developing countries (Oyediran and Isiugo-Abanihe, 2005).

Domestic violence against women is a universal issue and differs only in scope from one society to another. Available statistics from around the globe indicate that one out of every three women have experienced violence in an intimate relationship at some point in her life (Che and Cleland, 2004).

On the same note, domestic violence against women and all forms of violence against women is recognized as a violation against human rights. As early as 1984,

the universal declaration of human rights adopted by the United Nation General Assembly identified domestic violence against women as an abuse that threatens the security of women and their fundamental rights to life and liberty, as well as freedom from fear and want (Che and Cleland, 2004). The fact that, domestic violence against women and girls has long been considered a "private affair," has contributed to the serious gap in public health policy making and the lack of appropriate programs. Women for fear of inability to refuse sex or negotiate for safe sexual practices, are thus, probably exposed to agents of infections including the Human Immune-Deficiency virus/Acquired Immuno Deficiency Syndrome HIV/AIDS, hepatitis, gonorrhea. It is now clear from literature that the nature and incidence of violence against women, as well as its forms and effects on women's health is a global issue, but differing in scope. The present study focused on this, using the Zaria women of Kaduna State, Nigeria as a case study.

Though, violence against women is a major threat to social and economic development and it is the most pervasive violations of human rights existing in all societies on a continuum from violence perpetrated by an intimate partner to violence as a weapon of war. The Millennium Declaration of September 2000, in which the General Assembly of the United Nations resolved to combat all forms of violence against women and to implement the convention on the Elimination of all forms of Discrimination against women, has pledged recognition (United Nations, 2005: 12). This violence is intimately associated with complex social condition

such as poverty, lack of education, gender inequality, child mortality, and maternal ill-health.

However, violence against women is not highlighted in either the targets or the indicators in the goals set up to guide the implementation of the Millennium Declaration. And violence against women takes many forms, from the overt to the subtle.

1.3 Research Questions

The observed problem of domestic violence on women's health makes us ask the following questions, which the researcher is investigating:

1. Are there cases of domestic violence within the Zaria Communities?
2. What are the reasons for the occurrences of domestic violence within the Zaria Communities?
3. What impact does domestic violence have on women's health?
4. What are the manifestations of victims of domestic violence?
5. Will appropriate sanctions on men, husbands by the state, stop them from wife beating and maltreating women?
6. What measures should be put in place to educate, husbands who mistreat their wives?

1.4 Objectives of the Study

The aim of this study is to improve on the understanding of the nature and prevalence of domestic violence against women, identifying the acts, forms and effects on their health, while the Specific Objectives are:

1. To Identify and describe the forms of domestic violence found within the Zaria Communities.
2. To explore the nature and prevalence of domestic violence on women’s health.
3. To examine causal factors of domestic violence on women’s health.
4. To examine the effects of domestic violence on victims' physical health.
5. To find out the strategies adopted by victims to avoid or cope with domestic violence on women’s health.
6. To make recommendations on ways of mitigating, the incidence of domestic violence on women’s health.

1.5 Significance of the Study

The issue of domestic violence is rooted in the socio-cultural complexes of various societies in the world. As a result, it is not limited to only the women in Zaria and Nigeria. And base on the nurture-nature debate, women are somewhat regarded as the weaker sex while men the most powerful sex having total control over the women. Though there are exceptions based on biological features in both genders. On the same note, while religion encourages both sexes to see themselves as equals with guidelines of women being a support to the men, ethnicity defines specific roles for each sex. For example while the women are regarded as care-givers, the men are seen

as resource providers. Thus, this study is worth conducting, as the effects of domestic violence on women's health based on the relationship that exists within the family-may reveal greater knowledge as regards patterns of domestic violence as against some past studies on domestic violence.

This study is significant, as it goes beyond just the existence of domestic violence to investigate how it affects women's health. This study differs from previous studies in that, in contrast to previous studies like the work by Kantor. P. 1996, "The Impact of Domestic Violence against Women", it would rely on primary data got from the respondents themselves. This is in line with one of the basic tenets of the uses and gratification theory which states that "secondary analysis of survey data does not usually permit the researcher to understand the motives of respondents directly unless specific open-ended probes or checklists of motivations (in form of questions) are included in the questionnaire".

The issue of domestic violence and its forms and effects on women's health is one that has occupied the front burner in both circles of academic and the health care professionals in the public health sector. Thus, the findings from this study have provided more information on tackling domestic violence and improving on the health status of women. In the same light, contribute to scientific literature and will assist those working in other government sectors such as education, child welfare, social care, criminal justice, department of gender equality; advocates for the prevention of domestic violence on women’s health, for example nongovernmental organizations;

local authorities; environmental and urban planners and researchers.

1.6 Scope of the Study

This study was limited to identifying the forms and effects of domestic violence on women's health, circumstances around violent episodes and how it impact negatively on the women's health, and coping mechanisms used by victims. The study was conducted among the women in Zaria communities. For fast, correct and easy data collection, housewives, petite-traders, career women, female children, within the Zaria communities were targeted. It is important to keep in mind that, this study has reported data of perceived abuse by the respondents only. No information was obtained from other sources except from husbands, neighbors, family members and community members who confirmed being aware of the discord and were opened to help the research team identified victims for the research.

Worthy of note is the fact that, Zaria Community is a patriarchal community, where the men are in position of decision making both at home and at the work places. There is the paramount need for the women to be effectively and efficiently consulted, before enacting or drawing conclusions on issues that will affect them.

A researcher observed that, men and women alike are creatures with equal rights and obligations as well as same brain size. Most women in developing countries go tired after few deliveries, some even at forty still bear children when they can hardly care for them adequately (Giddens, 2005). All these impact negatively on the

physical well-being of the woman; many have been warned by doctors not to go in again for children because of one complication or the other. But due to the polygamous nature of men, they turn to go for as many women as possible, thus an unhealthy woman is not really an issue to some men since they can always go for as many women as possible provided they can afford them (Ngeve, 2007).

1.7 Definition of Terms

Abusive behavior: These behaviors may include: verbal assaults, threats, intimidation, physical assaults, the use of weapons, destruction of property, abuse of pets and violence toward significant people like children.

Community: A community is made up of a group of people living within a well defined geographical region, sharing a great feeling of social solidarity, equality, and togetherness within a given period of time and space. For example, the community we studied is the Zaria community.

Domestic violence: It describes the violence that takes place in the home between family members, especially adults. It could be very interactive, passive, jovial, relaxed or quarrelsome.

Family: A group of individuals related to one another by blood ties, marriage, or adoption, which forms an economic unit, of which the adult members are responsible for the upbringing of children. All known societies involve some form of family system, although the nature of family relationships varies widely. While

in modern societies the main family forms are the nuclear family, and the extended family.

Family abuse: This means any act of violence, including any forceful detention, which results in physical injury or places one in reasonable apprehension of serious bodily injury and which is committed by a person against such person's family or household member; or any act which causes a family or household member to engage involuntarily in sexual activity by force, threat of force or duress.

Intimate relationship: This means a relationship between two adults intended to provide emotional and/or physical intimacy. Domestic violence does not discriminate; men and women can be the abuser or the abused though in this study our focus is on men as the perpetrators and women the victims of domestic violence. Abuse can and does occur in both heterosexual and homosexual relationships, yet our objective in this study is to investigate how, why, what forms and effects of abuse on women's health occur in heterosexual relationships.

Pattern: In domestic violence, patterns are referred to more than one isolated incident of violence. These incidents can include a wide variety of abusive behaviors that often increase in frequency and intensity.

Physical health/Health: This is relative to physical fitness. Physically healthy or healthy refers to the ability of the human body to function with vigor and alertness, without undue fatigue, and with ample energy to engage in leisure activities, and to meet physical stresses. This is usually measured in relation to functional

expectations – that is, endurance, strength, agility, coordination, and flexibility and how the individual can accommodate stressors. The physical health of an individual can be influenced resulting to either positive results or negative consequences as we shall study in this research.

Physical violence: According to World Health Organization(2010), "Physical violence means a woman has been: slapped, or had something thrown at her; pushed, and had her hair pulled; bit with a fist or something else that could hurt; choked or burnt; threatened with or had a weapon used against her." Sexual violence means a woman has been: physically forced to have sexual intercourse; had sexual intercourse because she was afraid of what her partner might do; or forced to do something sexual she found degrading or humiliating.

Emotional violence: Though recognized as a serious and pervasive problem "emotional violence" does not yet have a widely accepted definition, but includes, for example, being humiliated, or belittled; scared or intimidated purposefully. Finally "intimate partner violence (also called "domestic" violence which is the area of concern for this study) means a woman has encountered any of the above types of violence, at the hands of an intimate partner or ex-partner; this is one of the most common and universal forms of violence experienced by women.

Women: In this study, woman or women referred to female adult (an adult female human being); women as groups (women collectively or in general); femininity (feminine qualities or feelings); domestic employee (a woman who is a domestic

employee, though this term sometimes sounds very offensive); wife or girl-friend (a wife, female lover, or girl-friend (informal term). The women under study are married, widows, into relationships or have been betrothed, and should fall under ages of twenty and above except otherwise with respect to age range.

1.8. Synopsis of Later Chapters

This document once again, aims to provide sufficient information for researchers, social workers, community project managers, policy-makers and planners to develop data-driven and evidence-based programmes for preventing the forms and effects of domestic violence on women's health. It is divided into the following chapters:

- Chapter 1 outlines the nature, magnitude and consequences of the forms and effects of domestic violence on women's health in Zaria communities within the broader typology of violence.
- Chapter 2 identifies the risk and protective factors for such violence, the importance of addressing both the risk and protective factors in prevention efforts and the theoretical framework adopted for the study.
- Chapter 3 summarizes the scientific evidence base on which the research was conducted dealing with methodology employed during the study.
- Chapter 4 presents the findings on the perceptions and views of respondents on the forms and effects of domestic violence on women's health, framework for

taking action, generating evidence and sharing result based on findings from the objectives of the study.

In the closing section, several future research priorities are outlined and a number of key conclusions drawn.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

Violence perpetrated by Men against Women is found in many societies in different forms and have varying effects on the health of women. According to WHO (2012), indicate that, women suffer a great deal of health problems, varying factors of which domestic violence against women is not left out. It stems from violating the rights of spouses; abusing women and their physical health; mistreating women based on power relationship and control; gender and health; domestic violence in pregnancy; pattern of domestic violence among pregnant women; female genital mutilation, forms of violence against women and their health. This Chapter has Seven Sections: review on related literature; forms of domestic violence; patterns of domestic violence on women's health; factors that enhances domestic violence; strategies adopted by victims of domestic violence; effects of domestic violence on women's health and the theoretical framework. The theoretical framework adopted for the study is the Liberal Feminist theory which is the model used for the study.

2.2 Review of Related Literature

According to the Islamic custom, before a woman becomes a wife, dowry (Mahr) must be paid. The payment of the dowry to the wife is an obligation and a debt upon the husband until he pays it. There is no escaping it unless the wife freely and willingly gives up her right to it. In the Qu'ran (Koran), Allah says "And gives women their dowries as a gift. Then, if they are pleased to give some of it with good health and enjoyment." (Q4 [Nisaa]:4).

Hirsi (2004), an Islamic Feminist argued that, Muslim women are deprived of freedom, suffer suppression and abuse, and they are often subjected to traditional legitimized abuse such as female circumcision, forced marriage, repudiation, and domestic violence. She further explained that, these go even for well-educated Muslim girls and women. She added that, there are high rates of domestic violence in Muslim families and the disproportionate number of Muslim woman in women's shelters; serving as petty trader, sales women, cooks etc. She directly links violence against Muslim women to traditional marriage patterns. Besides, the extreme violence against Muslim women, such as circumcision, 'arranged rape' (is an act performed by a man to a girl he intends marrying, in which he and his friends kidnapped the girl in question sometimes with the knowledge of the girl's parents and after the rape, marriage is being discussed between both the girl's parents and the rapist parents. This is practiced in Morocco and some of the victims of such rape cases end up committing

suicide)' , and domestic violence, there is also less excessive, daily violence that affects both women and their children that could be linked to psychological problems and personality disorders and poor self-esteem (Hirsi, 2003:49). She argues that, in marriage within the Islamic family, the suspicion of wife continues. As soon as the bride has been deflowered, the husband's anxiety assumes grave dimensions in protecting his wife. The only remaining way to prevent her deceiving him is by denying her access to the outside world as much as possible. Every step outside requires his approval or companionship (Hirsi, 2004:14).

In human society, men exhibit very strong power and control over their wives, and other sex partners (Isyaku, 1989). Fawoles (2005) observed that, some men still want to make babies irrespective of their wives delicate conditions after a medical diagnosis. To them, a woman has no rights whatsoever to deny her husband sex even when her life is at stake. This situation arises in most cases, as a result of power relations that exist between men over women.

In a study carried out in Nigeria by Maqsud (2005) on power relationships and control, men held that, women have no rights to stop their husbands from having sexual intercourse with their wives or even allow them to use a contraceptive. When the women are aware that, their husbands are not faithful and that they are liable to contract some venerable diseases, they are still required to mate. All these treatments impact negatively on the physical, social and psychological health of women (Gravrilescu, 2005).

Taking a critical look at the payment of dowry or bride-price, it goes a long way to better buttress this issue of power relationship and control. In Africa and other parts of Africa, payments can occur on marriage either to the bride's family by the husband (Nigeria, Cameroon) or by the bride's family to the husband or his family (South Asia and elsewhere). For some victims, their problems begin as soon as their husband pay this fee, especially if he paid too much or went through tough times to do so. The supposed failings of the wife can also result in her having no saying at all in family matters. Most time the husband always remind her of how much money he paid in order to have her as a wife. The husband by so doing assumes power and control over the woman to himself (Facts About Violence, 2010).

Bride wealth custom can place women's health at risk, for example, weakening her capacity to negotiate sexual relations or to agree on the number of children the couple will have. Bride wealth become a purchase when the parents give out their daughter for an outrageous sum in cash or kind as has been in the case of some Igbo customs in Nigeria or because the parents can no longer shoulder some social responsibilities due to family size and they decide to give them out for marriage to men whom they believe will be able to support them financially as in the case of some Northern customs in Nigeria. Most times, the parents do so, with the hope of equally benefiting from their in-laws. In some cultures, the brother of a deceased man can "inherit" his wife as this has been very common within our African settings. Wife inheritance is alright if it follows the appropriate culture whereby, both the widow and

her children are well cared for and supported but it is not alright when the inherited husband mistreat the widow and deprive her or her children from his brother's property. Customs such as these are believed to place women at higher risk of HIV infection, according to women's rights advocates (Amnesty International, 2004).

Abama and Kwaja (2009) conducted a study on Violence against Women in Nigeria. It was found that, Nigerian women like most women worldwide, confront a male dominated power structure that upholds male's authority in the home. Therefore, customs such as payment of "bride wealth," whereby men essentially purchase their wives' sexual favors and reproductive capacity, underscore men's entitlement to dictate the terms of sex. In the normal African customs depending on the society, there is supposed to be dowry paid by the man and this is a symbol of acceptance, love and unity but unfortunately, it has been over exaggerated among some tribes where some parents and relatives demand far more than what the husband can afford normally. And so practices such as widow inheritance by a man of his brother's widow can expose women to unprotected and unwanted sex with HIV-positive partners. When women in polygamous marriages are coerced into unprotected sex, they are exposed to a higher risk of HIV transmission as a result of the man having multiple partners. We live in a world in which women do not have basic control over what happens to their bodies as far as cultural practices are concerned. Women are unable to depend on the government to protect them from physical violence in the home, with sometimes fatal consequences, including increases risk of HIV/AIDS infection (NACA, 2011).

It has been observed by Kantor (1996) that, domestic violence is a pressing global issue. Violence experienced by women results in significant morbidity and mortality that has both short term and long term effects. Like the experience of domestic violence in pregnancy, sexual abuse as a child, can be linked to later development of psychological disorders. Furthermore, domestic violence has health effects beyond the acute injuries. Battered women are more likely to suffer from anxiety and depression, pelvic pain, and sexual and gynecological problems. In the United States and Canada, for example, domestic violence is often related to a woman's isolation from supportive kin ties (Kantor, 1996). This phenomenon has also been noticed in Yanomami in India, Muslims Afghanistan, Pakistan, North Africa and Central Asia. In Canada, 62% of women murdered are killed by either their husbands or domestic partners (Kantor, 1996). In Africa as a whole, spousal battering, sexual abuse, verbal assaults, inhumane treatments, inhumane customs and traditions are common (Kantor, 1996). For instance in South Africa, Zimbabwe and Morocco, what is observed is sexual violence most especially rape by intimate partners and marriage by abduction where the girl to be married is being carried away and raped and the rapist eventually becomes the husband as marriage will be discussed later between the two families (Newman et al, 2011). In some parts of Cameroon, like among the Betis, of the Central Province, wife battering is common, while female genital mutilation is practiced among the Bayangis of the Mamfe-Kumba (Ngeve, 2007). Moving to the North West Province in Cameroon, and the

Northern part of Nigeria, what prevails are early marriages, which at times could be negotiated, imposed or forced. Some parents also sell their female children for baby-sitting, sales girls or bar tenders (Kantor, 1996).

According to Cupta et al. (1996), between 25 to 50% of women in many countries reported physical abuse by a present or former partner. They further affirmed that, many women are powerless to negotiate certain relevant strategies like the use of condom, birth control, and other available protective measures to protect themselves from partners who consume alcohol, beat them, insult them, isolate them or deprived them from active participation in affairs that concerns them. The prevalence of domestic violence and other forms of violence against women, in sub-Saharan African ranks high in comparison with levels elsewhere (McCholskey et al., 2005). This can be explained as a result of lack of adequate knowledge about one's rights as most women within the Sub-Saharan Africa are yet to understand that they have rights and privileges as mothers, wives, friends and co-workers. To some of them the fear of their husbands, male acquaintances or colleagues is the beginning of wisdom. They are still not ready to break the silence and take measures that will help them come out of this ill.

In India, studies have found that more than 40% of married women reported being kicked, slapped or sexually abused for reasons such as their husbands' dissatisfaction with their cooking or cleaning, jealousy, and a variety of other motives such as disputes over dairies. At least two women were killed in domestic

violence in Kenya in 1998-1999, and 35% of women in Egypt reported being beaten by their husbands. In North Africa, 6,000 women are generally mutilated each day. In 2001, more than 15, 000 women were sold into sexual slavery in china, 200 women in Bangladesh would also have been humbly disfigured when their spume husbands or suitors burned them with acid. For millions of women the home is, therefore not a heaven but a place of terme (a place like prison). There is also the concern that the media has been perpetuating this problem. In South Africa, for example, the report on the media-training workshop for South African media covering gender violence shows the skewed nature of how domestic violence is captured in the media (Gender link, 2001). Stories on violence against women also tend to be reported as summaries in crime round up and not as features. In many instances, women continue to be represented as helpless victims. In addition, women's rights to dignity and privacy are often ignored in these presentations. Similarly, the entertainment industry has been extremely irresponsible in perpetuating and stereo typing the violent attitudes of men to women (Jeremy Lovell, 2004).

Shivdas (2004) in her study of genders portray in the media in India, observed that, violence against women in films takes the shape of rapes, spousal abuse and sometimes, public humiliation of fallen women. These portrays convey some sense of reality but the construction of the message leaves many questions unanswered. Star actor, Patrick Stewart supports this view point when he asserted that the film

industry is partly to blame for a global culture, which glamorizes violence, especially against women while it has been problematic proving the direct causal effects of media violence and violence against women. Baron and Strauss (1987), Weaver (1987) including the report of the United States Attorney General Commission on Pornography (section 5.2.1 sexually violent material cited by Jennifer Nash 2002) supported this view. The Knegal Commission, set up by the French government to look into the broadcasting standards of violent or pornographic images, also came to the same conclusion (IOL, 14 November 2002).

WHO (2011), held that, the gender roles and behavior of men and women in a given culture, dictated by that culture's gender norms and values, give rise to gender differences. Not all such differences between men and women imply inequality. For example, the fact that, in many western societies, men generally wear trousers while women often wear skirts and dresses in a gender difference which does not itself, favor either group. Some gender norms and values, however give rise to gender inequality-that is, differences between men and women which systematically empower one group to the detriment of the other. The fact that, throughout the world, women on average have lower cash incomes than men is an example of gender inequality.

Combating violence against women's health based on gender should be a central goal, aimed at promoting gender equality; at the same time, achieving gender equality and women's empowerment. By so doing we shall be eliminating all forms and effects

of violence on women and their health in all its vice. Mindful of the fact that, such violence has serious impacts on women's lives and their health, productivity and well-being. The issue of gender with respect to women's health must be addressed cutting across religious affiliations, customs, traditional practices, background and others. A comprehensive approach will be appropriate to overcome not only violence against women's health, but also gender-based discrimination in laws and policies, and deeply embedded social and cultural norms that perpetuate gender inequality (Gender Link, 2001).

To sum it all, violence against women's health and gender inequality result from a complex of interwoven factors. These include harmful gender norms and traditions, and social acceptance of violence as an accepted means of conflict resolution like in the case of South African women, where the women's social and health statuses are also being blighted by the very high rates of intimate partner violence and sexual assault, paving way for women to be sexually assaulted every 17seconds yet the women cannot routinely implement their sexual and reproductive decisions in a safe manner, even when they attend State Health Facilities and worse more, young South African girls are being raped by HIV positive men on the believe that, they will get healed(Mandisa & Sethembiso, 2012). Violence against women's health is often embedded in social customs that allow it to be perpetrated with impunity-even, in many cases, without being considered as violence, let alone a crime. In many parts of the world, women have no social or legal recourse against violence by their husband

or partner. Harmful gender roles can be reinforced by traditional practices such as widow-cleansing, wife inheritance, child marriage and female genital mutilation. Therefore, there is the need to empower women and to address current norms and traditional social customs that legitimize violence against them (VAWA, 2011).

2.3 Forms of Domestic Violence

It is worth noting that violence against women and their health can take various forms. These include: physical violence, sexual violence (rape, psychological or emotional violence, economic or other forms of deprivation), domestic violence, and violence in the community, violence in conflict and post-conflict situations, trafficking and enforced prostitution, sexual violence in the military, forced marriage, dowry-or bride-price-related violence, coercive measures relating to reproductive health, virginity tests, and genital mutilation (GHC,2012).

a) Physical violence: Physical violence is a type of gender-based physical violence to which women are subjected. This includes slaps, punches, choking and kicks, to beating with sticks, clubs or whips, the use of fire or acid to inflict pain and long term harm, through homicide (Zubairu et al, 2011).

Rape, sexual harassment, varies from jurisdiction to jurisdiction. But once the concern of the woman was not taken into consideration then it is reviewed as a criminal act according to International Criminal Court (ICC) status. In such cases, rape has posed problem with no adequate solution and the woman's identity and integrity remains label with the act and thus rape perpetrated by non-state actors can

also constitute torture, since in most countries, women are not been protected from rape within marriages. In some cases, the crime of rape is being resolved by the rapist marrying the victim. Yet the question to ask is how many of such reality emerge true and practical?

b) Psychological or emotional violence: Here the features are always threats, demeaning comments, non-sexist language and humiliating behavior. All physical and sexual violence also have an effect on the mental state of the victim(s) (WHO, 2012).

c) Economic violence: With respect to economic or other forms of deprivation, millions of women around the world are sole dependent upon men for economic support and security. By so doing, these men exhibit a direct impact on the women's well-being by granting or withholding the means for food, clothing and other daily needs. Furthermore, the impact can be even more pervasive than that, in situations where a divorce wife is left impoverished and stigmatized, others when the husband dies, the widow is forced to marry her husband's brother (wife inheritance) or she will be left in worst circumstances as she became vulnerable to exploitation or abuse and violence by others in her husband's family or clan group. According to the UN Task Force on Women, Girls and HIV/AIDS in South Africa, they described this unfortunate realities as "without the enforcement right to own or inherit land and property, women and girls face destitution after the death of their husbands, partners or parents, while poverty and economic dependence leave them exposed to increase sexual exploitation, disguised prostitution and violence" (Antai, 2011).

d) Domestic violence: It refers to abuse at the hands of a partner and ranges from verbal and physical aggression, to sexual violence and marital rape, through homicide, domestic violence can include an economic component where the perpetrator is male and the victim female in most cases. In some countries and cultures where particularly young women are forced to marry men who have been chosen for them by their parents or guardians and whom they do not wish to marry, put these women at risk to suffer violence from the husband or his relatives whom may feel dishonored by the woman's behavior to quit the union.

e) Female Genital Mutilation: Is known as the clitoral excision, clitoridectomy; in which much of the tissue of a female's clitoris is removed. Women who have undergone the procedure, seems not to enjoy nor have full sexual satisfaction and are always likely to face difficulties during childbirth because their clitoris have been cut off (Ngeve, 2007).

2.4 Impact of Domestic Violence on Women's Health

The impact of Domestic Violence on Women's Health (DVWH); has considerable impact on women's health and well-being. The direct and immediate physical effects of domestic violence include injuries such as bruises, cuts, broken bones, lost teeth, and hair, miscarriage, stillbirth and other complications of pregnancy (NaijaGist.com, 2012). The results of domestic violence can also be long-term and

may cause or worsen, chronic health problems of various kinds including asthma, epilepsy, digestive problems, migraine, hypertension and skin disorders (WHO, 2010). Domestic violence may lead to increased use of alcohol, drugs, and other substances (Miller, 1991).

Sharma (2007) held that, women carry a high burden of chronic ailments. This situation is mainly due to women's health needs getting the least priority in the family. Gender discrimination in nutrition and health care in childhood, early marriage and conception, lack of voluntary check on family size and poor state of pre-natal and maternal health care services only intensify women's health problems. It would have been better if the victims of domestic violence have access to competent health care services on time. Yet, poverty, illiteracy and lack of awareness are a constraint and intend results in the worsening health conditions of women. As some women will prefer to use the little resources they have to care for their children other than seeking appropriate medical care on the grounds that, children are considered as economic assets.

However, the intentional use of physical force or power, threatened or actual, against oneself or another person, that either results in or has a likelihood of resulting in injury, death, psychological harm, mal- development or deprivation should be avoided as much as possible. Reflecting on this, violence on women and their health encompasses, but is not limited to, physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the

household, dowry related violence, married rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation are factual of what Hirsi (2004) and Sharma (2007) et al investigations was all about.

In addition, violence on women's physical health does not only stop at the individual level. It goes beyond into group and the community. Thus physical, sexual and psychological violence occurring with the general community, include rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and these are perpetrated and condoned by the state, wherever it occurs. Worthy to note is the fact that, violence on women's health give rise to a cluster of physical and psychological consequences (including those touching on emotional and sexual health) reflecting not only the mechanism of the violence but also the interconnectedness of the human response to violence. Hence, physical violence against the individual woman or girl-child, may give rise to serious psychological reactions such as fear, anxiety or depression, while emotional and sexual abuse may give rise to physical symptoms such as chest pain and tachycardia (an excessive rapid heartbeat, typically regarded as a heart rate exceeding 100 beats per minute in a resting adult), as well as behavioral changes such as substance abuse.

A Brisbane study of antennal patients in Australia found that 18% of women were abused during the first time pregnancy (Taft ,2001).Women exposed to abuse

during pregnancy had an increased risk of miscarriage and abortion when compared to non-abused women, as found in a study conducted at the Royal Women's Hospital, Brisbane (Webster, 1996).This study also found that, the proportion of women having had multiple miscarriages increased with severity of abuse. This is consistent with the idea that, physical impacts are those-dependent and increased with severe and frequent abuse. On the same note, Webster (1996) explained further that, poor obstetric or medical history combined with admission to hospital during pregnancy for conditions which are unrelated to pregnancy were found as possible indicators of domestic violence.

Abdominal trauma during pregnancy was also reported as an effect of domestic violence (Pak, 1998). Likewise, women experiencing domestic violence were more likely to have peri partum complications in comparison with those who experienced other forms of abdominal trauma. Peri partum complications include rupture of membranes, preterm (born before completion of a pregnancy of normal length) labor. This study also found that, 75% of women in the study who were hospitalized twice during the same pregnancy reported domestic abuse as the cause of the trauma (Pak, 1998). Possible risks that pregnant women experiencing violence may face include preterm labor, foetal- material haemorrhage, uterine rupture and stillbirth (Pearlman, 1990; Rose, 1995).

During pregnancy, every doctor or health practitioner working with a victim of domestic violence stands the better chance to diagnose what could be the cause of the

violence faced by the woman. This is because at this stage some facts about her health cannot be so hidden irrespective of the fact that domestic violence has been referred to as “The Hidden Burden”. Nonetheless, Kurz & Stark, 1988 suggest that few doctors or health workers identify injuries as being caused by male partners and that this failure is itself psychologically damaging for pregnant women. But doctors treat the physical injuries and thereby satisfy their medical obligation and fail to acknowledge or address the underlying cause of the pregnant women’s injuries. At this state, the secondary health problems that women develop are individualized and psychiatric labels such as ‘evasive’ or ‘repeaters’, shifting the blame for the lack of an effective outcome onto the woman; so it is the woman who needs to take steps to change her situation- she is seen as the problem, rather than as having problems created by her assailant (an attacker; somebody who violently attacks somebody else, usually causing physical injury).

Domestic violence is a major cause of injury and death for women in all cultures. On the same token, pregnant women are not spared from sexual violence and several studies document the scale and outcome of partner violence during pregnancy (WGNRR, 2012). And apart from the physical and mental suffering arising from abuse, victims may also feel silenced- unable to talk about their experiences to other family members or caregivers- through fear or because they may blame themselves for the violence; or may feel constrained in their ability to change their situation because of financial dependence, social stigma and powerlessness(Gyuse,2009).

Pregnancy-related violence is a serious public health issue. Although there is a growing body of research on this subject, there are still many unanswered questions regarding the prevalence of this type of victimization, the risk factors, and the consequences. Domestic violence in pregnancy is on the increase and may involve overlapping variables at group and personal levels (Antai, 2011).

A study carried out to investigate the pattern of violence among pregnant women attending antenatal clinic at ECWA Hospital, Jos, Nigeria, showed that, women who were screened using the modified Abuse Assessment Screen (AAS) survey instrument (developed by McFarlane) had experienced domestic violence and the results showed that, verbal, physical, sexual and emotional violence at prevalence rates of 38%, 27%, 11% and 1%, respectively. A total of 14% had experienced a combination of physical and verbal abuse while 7% had experienced a combination of physical and sexual violence. Full time house wives and self-employed women were most abused, 83% had no definite timing pattern. Hence the results suggest that, the major forms of domestic violence are verbal, physical, sexual and emotional, and the violence has poor timing specificity (Gyuse, 2009).

Physical injuries can include bruises, cuts, burns and scalds, concussion, broken bones, penetrative injuries from knives and other objects, as well as miscarriages, permanent injuries such as damage to joints, partial loss of hearing or vision and physical disfigurement from burns, bites or knife wounds. Women in violent relationships also frequently experience depression and somatic complaints such as

migraine and non-specific pains in the stomach and joints. Women living in violent relationships have significantly poorer health than women who do not live in such relationships (Anu, 2011). The psychological impact of domestic violence can be more debilitating than physical injuries. Women who live with violent men tend, then, to develop serious health problems as a consequence of the repeated violence and fear they experience (Gyuse, 2009).

Stark&Flitcraft (1996) have identified this as 'Battered Woman Syndrome', characterized by recurrent assaultative injuries, stress-related injuries, isolation, substance abuse and mental illness. (It is essential to note that the syndrome has been defined more around white than Black or Hispanic (relating to Spanish/Latin American) women's responses to violence). Thus, pregnant victims of domestic violence seek medical help for health problems that are consequent on being assaulted by their partners.

There are varying factors that enhances domestic violence: age of marriage, socioeconomic status, fear, isolation, guilt and shame, hope, individual belief system, emotional and physical impairment and cultural hurdles (Heise et al, 1998).

Most especially, there is a lack of cultural sensitive appropriate services for victims of domestic violence. And there are cultural values and customs that can influence individual's belief system about the role of men and women, husband and wife. In addition, some victims keep hopes alive that some day they would be free from abuses by their partners and for the fear of being isolated; they feel guilty of

leaving their partner and what their society will make of them. All these add up to the factors that increases domestic violence on women's health (Zubairu et al, 2011).

2.5 Effects of Domestic Violence

Violence against women is associated with, physical, mental, sexual and reproductive health. This has been regarded as a consequence of gender inequality that has led victims of domestic violence to suffer from physical, mental or emotional and sexual effects.

a) **Physical effects:** The victim was slapped, kicked, had something thrown on her that hurts, dragged, pushed etc which might led to injuries, bruises, swollen parts of the body, lost of blood, cicatrix(permanent mark) on the body. Most times, suffer lost of body parts like eyes, nose or teeth which are most important for the holistic functioning of every individual (Jewkes et al, 1998).

b) **Mental or emotional effects:** The victims are been humiliated, isolated, assaulted and insulted in the midst of others, made to feel bad about herself. Perpetrators even go further to scare her by yelling at her at any given opportunity, threaten to hurt someone that she cared so much about, and even intimidated her on purpose. All these may result in very severe mental problems whereby the victims risk suffering psychiatric health problems or traumatism (Mandisa& Sethembiso, 2012).

c) **Sexual effects:** Forceful sexual intercourse at a very tender age or when she founds it degrading or humiliating or when she does not want, has resulted to the transmission of diseases like STD, now HIV/AIDS which are lethal health issues. In most cases, the victims suffer lost of blood and some bleed to death, others end up facing problems at child birth, some live and die with the trauma (Uchenna,2010).

Million of girls and women have been affected by the cultural practice of cutting/mutilating the external genitalia. This has gotten its roots in the long existing traditional practices which explain variously as a product of culture, religion, aesthetic values or patriarchy. This is increasingly being seen as breaching the human rights of those upon whom it is imposed. This practice has both acute and long-term consequences on the health and well-being of women, including during the woman's sexual and reproductive life. In the immediate period after the procedure the wound can hemorrhage or become infected and lead to generalized sepsis (presence of micro organisms or their toxins in the tissue or blood stream of a human). Death can follow in either event. So the woman or girl may also experience problems with urination. The effects of FGM can be damaging for the woman later in her life when intercourse, pregnancy and childbirth can be painful and, in the case of childbirth, life threatening (Newman et al, 2011).

In addition, WHO (2012) has categorized FGM into:

Type I: excision of the prepuce [or clitoral hood] with or without excision of part or the entire clitoris.

Type II: excision of the clitoris together with partial or total excision of the labia minora.

Type III: excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulations).

Type IV: unclassified: include pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissues; scraping of the virginal orifice (opening) or cutting of the vaginal; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure which falls under the [WHO] definition of FGM.

Consequences and complications of FGM have short-term, long-term and obstetric phases. Immediate and short-term include hemorrhage, infection, urinary dysfunction, shock and death. Long-term: Urinary complications, scarring, pain, infection, infertility, painful intercourse. Obstetric: tearing, wound infections, postpartum hemorrhage, sepsis, death (Cook & Dickens, 2011).

2.6 Strategies Adopted by Victims of Domestic Violence

Victims of domestic violence do not possess a set of universal characteristics or personality traits, but they do share the common experience of being abused by

someone close to them. One remarkable difficulty in recognizing victims of domestic violence is that, they are not usually covered in marks or bruises though it often occurs. And if there are injuries, victims have often learned to conceal them to avoid detection, suspicion, and shame (Hajiya Bilikisu, 2010).

Unfortunately, there have emerge a set of misconceptions over time about victims of domestic violence and as a consequence, there have arise harmful stereotypes and myths (Ex: victims of domestic violence suffer from low self-esteem and psychological disorders; victims provoke and deserve the violence they get; victims of domestic violence are weak and always want help etc) about who the victims are and the realities of their abuse and its effects on their health. As a result, victims of domestic violence often feel stigmatized and misunderstood by the people in their lives. These people may be well-intended family members and friends or persons trained to help them, such as social workers, police officers, or doctors. Thus some victims adopt strategies like: escaping the violence as quickly as possible (which is an obvious choice); accepting their situation because leaving on a short time frame might be as bad as staying since the partners have differential control and access to material and symbolic resources. Some victims tend to live isolated lifestyles, grow angry and become very aggressive (Yusuf et al, 2011).

Within the Zaria communities, issues concerning families and intimate relationships are regarded as ‘private matter’ which should not be discussed outside the roofs of the house. As a consequence, the extent of violence at home against

women and even men has been over looked. However, the woman is expected to complaint to family/kin right on time if she perceives any form of violence at home. Once a complaint is sent to the family/kin, solutions are sorted to resolve the issue and in cases where the man persists in abusing his wife physically, verbally or sexually, the case is further reported to religious leaders and the elites. And in worst cases, the woman is free to leave the man till the issue is resolved before she can return to her husband's house. Worthy to note is the fact that, for Muslims within the Zaria communities and others in the Northern Nigeria, the religious leaders or elites have the right to dissolve any marriage when there is problem and the woman keep complaining yet the man refuses to make amend. But the question probing the researcher's mind after this revelation during her interactive section with a religious leader in Sabon gari is, are the women aware of this right? If yes, how many of them take upon themselves to make complaints to their religious elites on time to save them from further problems? Nonetheless, some women ignorantly and out of fear of losing their marriage, keep quiet about their situation which gradually get worse till someone else attempts to intervene like the case of a woman in Tudun wada which was narrated during this study had intervention from her neighbors who could no longer support the woman's predicaments anymore.

The respondent said, *my pregnant neighbor who had words with her husband recently in a fit of anger, he not only beat the wife but kicked her in the belly containing a foetus of 6 months. And he left the house leaving the woman on the floor crying. When*

we heard her crying we thought it was one of those their usual quarrels but this time around some neighbors and myself decided to go and see what was happening this time. Lo and behold, we got there and rushed her to the hospital. While there, it was discovered that the baby she was carrying had died and an emergency operation was to be performed on her in order to remove the dead child and save the woman's life. The husband refused to pay for her medical fee and this made the issue to be reported to the police so that, he will be compelled to settle the hospital bills (woman).

On the same note, strategies should be put in place involving the government and all major stakeholders to curb this phenomenon. The strategies may include: Public awareness, use of the Media and or encouraging victims in initiating lawsuits, laws and policies that will adequately protect women should be enacted and awareness of these laws should be made. Another strategy will be for the women within Zaria communities and the northern Nigeria to embrace education, even adult education like has been the case in Sabo gari community organized by the Local Government Basic Education Board. Where the women will be empowered, enlighten and learn about their rights as well as other useful skills to make them less independent which will save them and their children from finding themselves in similar situations in the future thereby improving on the status of the women within these communities.

The findings of this study also provide additional information for those working or campaigning against gender based violence in Nigeria as it will enable them make adequate and better informed decisions.

From the above related literature reviews, the scholars based their investigations on inhuman practices, traditions and customs that impart negatively on the women's health. Looking at what the State is supposed to do that it has not done leaving rooms for more women to become possible victims of domestic violence in the nearest future. Thus, the gap here identified is the fact that, these scholars have failed to critically looked into the roles that can be played by the victims of domestic violence themselves to help them come out of this plight. Most especially, the relationship existing between educated women and less educated women, rural women and urban women within out societies. Unfortunately within the Zaria communities, the researcher observed that, some of the so-called educated women do not share the plight of their fellows since they come to them for some material and symbolic support where the educated women end up employing them in their business centers, or as nannies and wash women. Since they are supposed to be well informed and enlighten.

2.7 Theoretical Framework

This study is hinged upon the ideology of the Liberal Feminist Theory. This brand of feminism is chosen because it most preferably addresses the issue the researcher is investigating and its basic assumptions gives a good debate for understanding the issue under investigation, which provides an appropriate framework for analysis. The Liberal theory is a collaborative effort of a group of scholars such

Maria Mies, Hirsi Ali, Miller Barbara, Rebecca Walker, Nancy Cott and Christine de Pizan, Firestone. Based on their ideologies, a society can be viewed from a woman-centered perspective about social life and human experiences. This means that, every society is made up of a positive institution called the family which serves as the first agent of socialization and comprises of father (mostly regarded as breadwinner and Head), and dependant mother and children, where the mother is often being oppressed.

One of the assumptions for this theory is that, the family is supposed to be a social, positive, mutual and beneficiary institution where its members get nurturing, care and unconditional love irrespective of who is the head or bread winner of the home. And on the contrary, another brand of feminism called the Radical Feminist theory has looked at the family as a place where potential wives are being treated like mere slaves and strictly domestic worker as a result of the fact that we live in a patriarchy society and the women seem totally depended upon the men for power, control, social, economical, financially, educational, political, cultural and even religious benefits since it's a man's world (Miller, 1997).

Based on the theoretical framework that feminists have used regarding the (I believe false dichotomy) of nature versus nurture, the feminist theory blatantly refuse to acknowledge that something do in fact have a biological component to them, that gender might conceivably, just possibly have some biological basis. According to Mies (1986), the problems of women are not the issue of gender differences, there is

obviously a dominance relationship, based on a long history of exploitation, deprivation, discrimination, power control and oppression, which had to be taken into account on a very serious, conscious note. And this was how the concept of patriarchy became relevant to the woman. The feminist theory assumes that,

1- as the dominant class, men have differential access to material and symbolic resources and women are devalued as secondary and inferior;
2- intimate partner abuse is a predictable and common dimension of normal family life;
3- Women's experiences are often defined as inferior because male dominance influences all aspects of life.

In addition, there are other theoretical frameworks that redress domestic violence, integrate more psychological, sociological and biological at the individual and couple level. These are cultures of violence theory, ecological theory, biopsychosocial theory, marital power theory.

Men create and maintain patriarchy not only because they have the resources to do so, but because, they have real interests in making women serve as compliant tools, by mustering their basic power resources, through physical force, to establish control, of which among others are; economic, ideological, legal can be marshaled and sustained. Nonetheless, physical violence always remains its base, and in both interpersonal and intergroup relations, violence is used to protect patriarchy from

women's individual and collective resistance (Fawole, 2005). The feminist theory postulates that:

1- It is strictly grounded in ideology and philosophy based on what empirical academic research/academic literature have asserted over the years.
2- Human development is not based on characterized or explainable by a parochial distinction but between what is "nature' and what is 'nurture'
3- The social can influence the biological and vice versa, that they are not distinct and compartmentalized.

Regarding the assertion that feminist theory lacks any empirical base, it is important to remember that theory is a systematic explanation of observation that relate to a particular aspect of life, and that feminist theory has been made in explaining the mechanics of domestic violence, rape and sexual assault, gender division of labor etc. Hence, theory informs research and vice versa. This explains why feminists engaged in both quantitative and qualitative research to justify the theoretical premises they produce. As a matter of relevance, the researcher is out to give a critical and empirical analysis on the perceptions of the effects and forms of domestic violence on women's health within Sabon Gari and Zaria local government areas in Kaduna State Nigeria.

On the one hand, some African Feminists like Hannah Pool from South Africa, Minna Salami from Nigeria and Ngeve Rebecca from Cameroon, have shaped their own ideologies to view African women's issues stemming from domestic imbalance

and gender roles, bread and butter issues like poverty reduction, violence prevention, health and reproductive rights that affects African women worse than men. Thus, stating that, African Feminism is interested in appreciating cultures and patriarchal systems that does not negatively affect the welfare of women but rather advocate for harmful practices to be revised yet still maintaining the prestige of the African cultures (MsAfropolitan, 2010). And based on the basic assumptions and ideologies of the Liberal Feminist Theory as stated above, it best addresses the issue under study and as such gives a clearer perspectives of understanding the interrelationship between the actors of domestic violence and their victims which is the interest of investigation for this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes and focuses on the method and procedures that was used in carrying out the study. It will also outline the target population, research design, and sources of data, sample size and samplings, methods of data collection, methods of data analysis and problems encountered in the field.

3.2 Location of the Study

Zaria is a community situated within Kaduna State in the Northern part of Nigeria, West of Africa. The Zaria community covers an area of 7,627.20sqk, with a total population of about 4,652,989(National Population Census, 2006).

Zaria is a major old city in Kaduna State as well as a Local Government Area. Formerly, Zaria was known as Zazzau (with its indigenous inhabitants known as the Zazzau people), one of the original seven Hausa City-States. And also, it was initially the capital of the Hausa Kingdom of Zazzau. Furthermore, the main languages spoken within this community are Hausa, Gbagi and sometimes English Language for official purpose when necessary. The people here resides typically in traditional adobe compounds and has neighbors; Tudu Wada, Samaru, Muchia ,Jushin, Waje, Chikaji, Sabon Gari etc, where these neighboring communities are predominantly occupied by the indigenous Hausas though there are other ethnic groups like Yoruba, Igbo, Nupe, Ijaws etc, who are peasant farmers, traders, commercial motor cycle riders, commercial bus drivers, provision sellers, restaurants owners/waiters/waitresses and civil servants. Interesting enough, most of the women within these Local Government Areas are petty traders, with others into textile selling with very few as educators or career women. However those

women involve in commercial food selling do so in three phase namely; morning, after, evening. In the morning, they begin with frying of stuffs like beans cake with pad (known by the people as ‘koko’), ‘Massa’ and ‘Waina’; then in the afternoon, they make ‘Fura da nunu’, ‘Dambu’, ‘Gurasa’ or ‘Danwake’ and finally in the evening, the women sell ‘Tuwo’, ‘Shikafah da mia’, ‘Yakwua’ and ‘Kuka’. The Zaria community has been in existence before it was curved out as a Local Government Area in 1967. The largest market place is in Sabon Gari. It is important to note here that, Sabon gari community is a community in Sabon Gari Local Government Area of Kaduna State, one of the communities where this study was conducted.

With respect to education, there are several higher institutions of learning, professional schools as well as churches, mosques, hospitals and clinics which are either privately owned or by the State. Zaria is home of the famous and prestigious Ahmadu Bello University, the second largest university in West Africa, Federal Polytechnic of Leather Research Centre, Zaria Academy among others. Present are herbalists and other traditional health practitioners or doctors. The population of women within these areas dominates that of men (Isyaku, 1989). In as much as these facilities are meant to enable the women to get access to western education and curb illiteracy, majority of them still lack the opportunity to go to school.

Nonetheless, the Zaria communities are some of the most historic and oldest within the Northern Nigeria, which in fact the history of the North cannot be completed without the mention of Zaria and some of its heroes and heroines like Queen Amina of Zaria, Sir Ahmadu Bello(the Premier of the Northern Region) and the list continues, yet the area has been neglected by successive Federal and State governments leaving the people suffering from the lack of basic fundamental needs like potable water, functional public health care facilities, proper hygienic control facilities, and proper waste disposal system which exposes the people to some health and environmental hazards.

The Zaria community was chosen as the location for this study because of the existence of the social issue the researcher set out to investigate. This study was aimed at examining the manifestations of the various forms and effects of domestic violence on the poor health or wellbeing of some women and the girl child. This was observed as a result of lack of adequate awareness, sensitization, education, valuable information, techniques, strategies, motivational devices and skills. Furthermore, the locations of study was also chosen because of the researcher's familiarity with the areas, mindful of the fact that, she has done some survey research and has asked one or many questions about the areas before considering these areas as suitable for her research. This allowed easy access to the information needed that enabled her to undertake this research successfully.

3.3 Types and Sources of Data

a. **Primary Source:** Primary data on the perceptions of the forms and effects of domestic violence on women's health in Zaria were collected from this source through questionnaire, focus group discussions and In-depth interviews got from specific key informants.
b. **Secondary Source:** Secondary data were obtained from some victims of domestic Violence at the St. Luke's Anglican hospital Wusasa - a community in Zaria with the consent of both the participants and the Medical Director In charge.

3.4 Research Population and Sampling Method

The study was descriptive and cross-sectional in design. The research's target population for this study was the women folk and the girl children in Zaria communities. A reasonable sample size was selected from the population, as a case study of the entire population of the women and girl children in Zaria, since the total population of women could not be undertaken due to time factor, resource

constraints and other natural factors. For appropriate balanced of views, data were collected from some members of the communities as well which of course included men. The assumptions were on a 95% confidence limit, a 5% margin of error and allowance made.

The major communities within Zaria include: Zaria city, Sabon Gari new town, Tundu wada, Gyallesu, Kongo, Muchia, Waje, Samaru, Jushin, Gaskiya, Gworgwoji, and Wusasa, each with its distinct characters. The Sabon Gari (New Town) area is where most southern Nigerian residents reside and it has the town's largest market. The Kongo area simply refers to the university community while the community is known as Gyallesu community which on the other hand, has a mixed population that includes professionals and non professional, more educated women and less educated women, some teaching at a branch of Ahmadu Bello University while others are support staffs in varying domain based on their qualifications. Zaria city has distinct settlements like the old walled area of Zaria known as Birnin Zaria, Old Zaria. There are no specific streets or house numbers but they have different quarters. Mindful of the demographic and geographical characteristics of these Study areas, stratified sampling techniques was adopted as most appropriate for the collection of relevant and objective data from the women while quota sampling technique was used to get data from other members in Zaria communities.

For the purpose of objectivity, stratified sampling techniques were adopted in other to facilitate proximity to members of the communities in Zaria and four communities within Zaria were stratified namely: Sabon gari community, Gyallesu community, Tundu wada community and Wusasa community. A successful sample size of 186 respondents was what the researcher worked with, out of the 200 that was intended. Everything being equal, it was not an easy task getting across to the entire population of women within these communities. Thus, out of an equal proportion of 50 respondents that were intended to work with; the researcher only

got Gyallesu =48respondents, Wusasa= 46respondents, Sabon gari =46respondents and Tundu wada 46 respondents from which gave a total of the 186 respondents for this study. This went a long way for the rightful selection of those who were willing to share their experiences and gave information about the subject under examination.

In-depth interviews and focus group discussions of key informants were conducted to add more flavor to the quantitative techniques used already. A stratified sampling procedure was employed. Four communities in Zaria were identified as strata. Stage 1: There was the random selection of 2(two) closely related communities within Zaria. This resulted in Sabo gari and Gyallesu communities. Stage 2: This invloved the random selection of 2(two) more communities where well utilized hospitals and clinics were found given rise to Tundu wada and Wusasa communities. At each selected stage, one adult woman or the girl child was randomly selected from each household in the selected communities. The adult woman or girl child is one who must have been or is in an intimate relationship. For the In-depth interviews, five (5) were intended to be distributed as follows : One (1) Religious Leader, One(1) Women Leader), One(1) Youth Leader, One(1) Traditional Leader and One(1) Social Worker interviewed in study area. But only four (4) were successfully conducted. On the same note, these four (4) served as key informants for the study since they work, live and interact within members of the communities. Also, four (4) Focus Groups Discussions (FGDs) were to be conducted in the four stratified study areas: Religious Group, Community Leaders, and Women, Social Workers and Youth but only three (3) were successful. Both the four (4) In-depth interviews and three (3) Focus Groups Discussions were conducted in Gyallesu, Wusasa, Tundu wada and Sabon gari communities respectively. Questionnaires were distributed with a total of 32 questions on 200 respondents but 186 were completely filled and returned, and this reflects 93% response rate. After dividing the Communities into four strata; namely

Gyallesu Community, Wusasa Community, Sabon Gari Community and Tundu wada community, four In-depth Interviews (4 IDIs), were successfully conducted

3.5 Methods of Data Collection

The research instruments that facilitated this study is the Survey research techniques, which involved the use of a structure self administered open-ended and close- ended questions in a form of questionnaires. To elicit information (data) from both the members of the communities, the women and the girl children using stratified sampling techniques.

The Survey research technique was considered by the researcher as most suitable for this study. And the researcher used quantitative (the instrument used is (questionnaire) and qualitative methods (instruments used; in-depth interviews and focus group discussion guides).The questionnaire was divided into seven sections:

Section A: Socio-Demographic Attributes of the Respondents.

Section B: Quality of the Health Status of Women within this Community

Section C: Reasons for the Existence of Domestic Violence on Women's Health

Section D: Forms and Effects of Domestic Violence on Women

Section E: Manifestations of Domestic Violence on Women's Health

Section F: Consequences of Domestic Violence on Women's Health

Section G: Strategies towards educating perpetrators of Domestic Violence on Women's Health.

On the other hand, simple well prepared In-depth interviews in form of interview guides and focus group discussions in form of brief interactive sections between the interviewees and discussants were used to collect data from key informants such as older women, long time residents of the communities, some women group leaders and heads, social workers, within the communities health care centers to find out if they have identified any form of the problem under investigations

and how they have been able to manage the situation and the victim(s). At the beginning of each section, a brief introduction was done to assure anonymity and confidentiality of responses. And here, the researcher was given the opportunity to interact with some victims in the hospital who were identified by the social workers to be members of the communities under study.

3.6 Techniques of Data Analysis

In analyzing the data, Social Science Statistical Package (S.P.S.S) now known as P.A.S.W software was used for quantitative data (95% confidence interval). Descriptive statistics including frequency distribution and percentages were used for analysis. Cross tabulation of variables were used for accurate correlation of the results as the case demanded.

For in-depth interviews and the focus group discussions, the data collected were transcribed and summarized manually based on findings with respect to the objectives of the study taken into cognizant the fact that, there were some similarities and disparities in the patterns of experiences and responses of the respondents under study.

Furthermore, the method of triangulation was relevant as a means of data analysis and it ensured accurate synergizing and strengthening of the evidence on ground and those found on the field as was the case, but were based totally on the research findings.

3.7 Problems Encountered during the Fieldwork

The major challenged the researcher encountered during her research, arose mainly from the nature of the subject. Forms and effects of domestic violence is a sensitive social issue as regarded by most respondents. As a matter of emphasis, the reaction from the respondents were encouraging though some were still shy to share their experiences on the subject, none was forced or

compel to respond to the questions and interviews. Nonetheless, efforts were made through questionnaires, in-depth interviews and focus group discussions, with special assistance from the St Luke’s Anglican Hospital in Wusasa, Basic Education Board in Sabon Gari, Private Clinics in Gyallesu and Tudu wada Communities, where the researcher was able to dialogue with some victims of domestic violence and the social workers involved. Unfortunately the researcher was not allowed to take live specimens like snap shots. However, although the researcher could not fluently communicate in the local language which is Hausa, she worked closely with two fluent interpreters who were adequately prepared weeks before embarking to the field. In addition, the research team got valuable contributions from the above mentioned bodies that were willing and interested in the study and to give their best of support the research needed. Thus, the validity and reliability of this research is not undermined or the quality degraded.

CHAPTER FOUR

FINDINGS ON THE EFFECTS OF DOMESTIC VIOLENCE ON WOMEN'S HEALTH

4.1 Introduction

The analysis in this chapter is based on questionnaires, In-depth Interviews and Focus Group Discussions conducted. There are seven sections in this chapter: Socio-demographic attributes of respondents; Forms of domestic violence in Zaria communities; Reasons for the existence of domestic violence on women's health; Behavioral patterns of victims of domestic violence and their effects on women's health; Impacts of domestic violence on victim's physical health; Effects of domestic violence on women's health; Strategies that could be adopted to curb domestic violence in the community; Recommendations on ways of mitigating the incidence of domestic violence on women's health. On the other hand, three Focus Group Discussions were conducted successfully out of the four (4) that were intended to be conducted. Quantitative and qualitative methods were used to analyze data collected from the field and presented in frequency Tables. The later part of the chapter presents the summary and findings of the research which were based on deductions and inferences made from each analysis objectively.

4.2 Socio-Demographic Attributes of Respondents

This section represents the socio-demographic attributes of respondents: This includes sex of respondents, age, marital status, educational attainment, ethnic group, religion and occupation.

Table 4.2.1: Socio-Demographic Attributes of Respondents

1) Sex of Respondents	**Frequency**	**Percentage (%)**
Male	-	-
Female	186	100.0
Total	**186**	**100.0**
2) Age	**Frequency**	**Percentage (%)**
10 – 15 Years	2	1.1
15 – 20 Years	4	2.2
20 – 30 Years	22	11.8
30 Years and above	103	55.4
No response	55	29.6
Total	**186**	**100.0**
3) Marital Status	**Frequency**	**Percentage (%)**
Married	163	87.6
Betrothed	11	5.9
divorced	5	2.7
Widow	3	1.6
No response	4	2.2
Total	**186**	**100.0**
4) Education of Respondents	**Frequency**	**Percentage (%)**
No education	27	14.5
Primary education	39	21.0
Secondary education	48	25.8
Tertiary education	65	34.9
No response	7	3.8
Total	**186**	**100.0**

5) Ethnic Groupings of Respondents	Frequency	Percentage (%)
Hausa Igbo Yoruba Others No Response	65 31 36 47 7	34.9 16.7 19.4 25.3 3.8
Total	**186**	**100.0**
6) Religion Affiliation	**Frequency**	**Percentage (%)**
Islam Christianity Others	98 84 4	52.7 45.2 2.2
Total	**186**	**100.0**
7) Occupation	**Frequency**	**Percentage (%)**
Causal laborer Strictly Housewife Petite trader Working class Others No response	25 23 41 37 52 8	13.4 12.4 22.0 19.0 28.0s 4.3
Total	**186**	**100.0**

According to the findings as presented in Table 4.2.1, all the respondents 100% were females. The respondents had varying ages with the majority (55%) falling under the age range of 20 – 30 years and above. This implies that issues concerning domestic violence are much more conversance among women than men that the study carried out targeted mostly the young women of the communities who are at the peak of their fecundity rate; good reproductive age; child bearing age and matured enough for marriage. Similarly, out of the total respondents, 35% had

acquired tertiary education 26% secondary education 21.0% primary education. This shows that illiteracy is still a problem within these communities and something has to be done if we are of the opinion to help these communities.

Interestingly 35% indicates that majority of the women are women who have been empowered academically with great potentials, knowledgeable and career oriented who must have undergone one formal training or the other to be able to help the less privilege women of these communities. Also 88% are married while 6% were widows who were once married but lost their spouses to nature called death. This clearly states that marriage is a culture of these communities that must not be joked with as majority of the women are either married or betrothed. A break down per occupation which is not included in our list of categories like tailoring and farming 20% are working class ladies or finally called “pajero women”, 22% are into petite trading, frying and selling of provisions locally made snack like 7060, kunu, fura etc, 14% are casual laborers within the city and other institutions within the communities 13% are strictly house services depending solely on what the husband bring home.

4.3 Forms of Domestic Violence in Zaria Communities

This section represents views and perceptions of respondents on the most common forms of domestic violence against women within the Zaria Communities.

Table 4.3.1: Most Common Forms of Violence Against Women's Health by Respondents

Forms of Violence	Frequency	Percentage (%)
Domestic Violence	54	29.0
Incest	8	4.3
Sexual assault	55	29.6
Spouse battering	41	22.0
Others	10	5.4
No response	18	9.7
Total	**186**	**100.0**

Table 4.3.1 showed that, the most common form of domestic violence existing within the Zaria communities is sexual assault with 30% testifying to this claim and 29% confirming that domestic violence occurs very often. The next most common is spouse battering 22% while the least which might be inexistence or insignificant is incest with 4% of the respondents attesting to the fact.

On the same token the In-depth interviews conducted on four (4) knowledgeable people: Social worker, Religious leader, Youth leader and Women leader revealed that, sexual assault, forceful marriage and early child-bearing, verbal assault, spouse battering are the most common identified forms of domestic violence on women's health within the communities as opposed to others.

Similarly, the Focus group discussions conducted with respondents in the study area attested that most women suffer from too much domestic work, given birth to

many children without being properly taken care of, given out for marriages at a very tender age among others.

Table 4.3.2: Views of Respondents on Domestic Violence: Very Often= highest degree of occurrence (six times in a week); **Often=** many times of occurrence (four times in a week)**; rarely=** not occurring many times (one time in a week) and **Never=** at no time did it occurs (zero time in a week).

Views	Frequency	Percentage (%)
Very often	91	48.9
Often	59	31.7
Rarely	14	7.5
Never	6	3.2
No response	16	8.6
Total	**186**	**100.0**

This Table showed that 49% of the respondents accepted that, Domestic Violence occurs very often, while 32% of the respondents said it occurs often, but 9% of the respondents were those with little or no knowledge on the occurrence of the Domestic Violence within the communities, and 8% of the respondents were those who said domestic violence rarely occurred. From this data collected, it is a fact that, some women from these communities have been victims of domestic violence in one way or the other.

From the responses based on in-depth interview and focus group discussion, the key informants observed that, domestic violence occurs most often within the Zaria communities. And they gave examples of spouse battering, verbal assault, forceful marriages, and sexual assault.

Table 4.3.3: Views of Respondents on Spouse Battering

Spouse Battering	Frequency	Percentage (%)
Very often	77	41.4
Often	67	36.0
Rarely	17	9.1
Never	8	4.3
No response	17	9.1
Total	**186**	**100.0**

This Table showed that, 41% of the respondents accepted that spouse battering occurred very often within their communities. While 4% said that spouse battering never occurred within the community. But 36% added that spouse battering often occurs as opposed to 9% who said it rarely occurs. Thus, most women within these communities experience spouse battering which of course put them at risk with respect to their health status.

Information from in-depth interviews and focus group discussions revealed that spouse battering occurs within the communities with the men having one or two reasons for taking such an action. Which the informants said it could be based on factors like; adultery, disobedience, lies telling, deception, poor manners and poor attitude or sexual immorality on the side of women. Here are testimonies of some women:

1% of the respondents confessed; my husband broke my head in a fight we had accusing me of adultery…. (Women).

3% of the respondents explained; my husband got me beaten severally because I complaint about his late outings and the way he treats me…. (Women).

9% of the respondents grieved that; it is not a thing to remember...(Women).

Table 4.3.4: Views of Respondents on Forced Marriage

Forced Marriage	Frequency	Percentage (%)
Very often	41	22.0
Often	70	37.6
Rarely	39	21.0
Never	17	9.1
No response	19	10.2
Total	**186**	**100.0**

This Table indicated that, 38% of the respondents were of the opinion that forceful marriage often occurs, 22% related to it that its occurs very often while 21% held that it rarely occurs and 10% shared no views on this issue. However, forceful marriages sometime do take place within these communities as observed in the data presented. The focus group discussions stipulated that forceful marriage exists and is still in existence within the communities. For instance one of the informants narrated: *A respondent narrated that, as we speak there is a little girl in my compound from Samaru who got married at the age 11 years old and she is already pregnant……….(woman).*

In addition, information from the in-depth interviews supported that marriages are being concluded between parents or forcefully.

Table 4.3.5: Views of Respondents on Female Genital Mutilation

Female Genital Mutilation	Frequency	Percentage (%)
Very often	21	11.3
Often	52	28.0
Rarely	45	24.2
Never	36	19.4
No response	32	17.2
Total	**186**	**100.0**

From this Table, 28% of the respondents were of the views that female genitals mutilation often occurs in as much as 24% said it rarely occurs in their communities. In addition 19% attested that female genital mutilation has never occurred, leaving us with 17% who shared no views on the occurrence of female genital mutilations within the Zaria communities. Nonetheless, 11% still strongly held the view that female genital mutilation exists very often within the Zaria communities.

The response from the in –depth interviews and focus group discussions revealed that female genital mutilation is a very sensitive issue, which has some cultural values. And it is significant as well as insignificant within the communities since very few families still hold on to these practices.

Table 4.3.6: Views of Respondents on Ill- Treatment from In-laws

Ill-treatment from In-laws	Frequency	Percentage
Very often	53	28.5
Often	69	37.1
Rarely	31	16.7
Never	15	8.1
No response	18	9.7
Total	**186**	**100.0**

Table 4.3.6 presented that, 37% of the respondents were of the views that some women are being ill- treated by their in-laws, while 8% confessed that, they are ignorant of the fact that some women within their communities are being ill-treated by their in-laws.

Table 4.3.7: Views of Respondents on Isolation from Active Participation in All Decision Making At Home

Isolation fun decision making	Frequency	Percentage(%)
Very often	53	28.5
Often rarely	69	37.1
Never	31	16.7
No response	15	8.1
	18	9.7
Total	**186**	**100.0**

The above Table indicated that 37% of the respondents said the women suffer from alienation of active participation in all decision making at home, while 29% said women are very often isolated from full participation in all decision making at home. However, 10% said they are ignorant of the subject matter, 17% of the respondents shared their views saying that women are rarely kept in isolation from decision making at home. While 8% of the respondents said this never happens. In-depth interviews and focus group discussions attested that some women have not been fully involved in decision making at home because men have proven over time to always have their ways of doing things. Thus, it is at their discretion to either seek the women's opinion or not.

Table 4.3.8: Views of Respondents on Verbal Assault

Verbal Assault	Frequency	Percentage (%)
Very often	68	18.6
Often	70	37.6
Rarely	28	15.1
Never	7	3.8
No response	13	7.0
Total	**186**	**100.0**

About 38% of the respondents shared their views that, verbal assaults often occur within their communities. While 37% of the respondents confirmed that verbal assault occurs very often. The responses from the in-depth interviews and focus group discussions supported that verbal assault is very common within the communities. This is an indication that, most women within these communities are victims of verbal assaults either from their husbands, in-laws or those they have related with, within the communities.

Table 4.3.9: Views of Respondents of Refusing Wife Sexual Satisfaction.

Refusing wife sexual satisfaction	Frequency	Percentage (%)
Very often	35	18.8
Often	74	39.8
Rarely	37	19.9
Never	15	8.1
No response	25	13.4
Total	**186**	**100.0**

About 40% of the respondents observed that most husband refuse their wives sexual satisfaction, while only 8% said husbands never refuse their wives sexual satisfaction. The in-depth interviews and focus group discussions explained that, this

issue is a two sided thing. Meaning the men will put the blame on the women and the women will put the blame on the men.

Table 4.3.10: Views of Respondents on Refusing Wife's Food

Refusing wife's food	Frequency	Percentage (%)
Very often	40	21.5
Often	69	37.1
Rarely	41	22.0
Never	14	7.5
No response	22	11.8
Total	**186**	**100.0**

The majority of the respondents of 37% agreed that it is possible for husbands to refuse their wives' food, 78% argued that husbands will never refuse their wives' food. Information gathered from the in-depth interviews and focus group discussions explained that husbands have every right to either accept or refuse their wives' food depending on how they are being treated at home by their wives.

Table 4.3.11: Views of Respondents on Forbidden Married Women from Sitting in the Midst of Men

Forbidden	Frequency	Percentage (%)
Very often	61	32.8
Often	52	28.0
Rarely	37	19.9
Never	17	9.1
No response	19	10.2

Total	186	100.0

From the views of these respondents, 33% confirmed that married women are very often forbidden from sitting in the midst of men, while 9% argued that married women are never forbidden from sitting in the midst of men within the communities. It is cleared here that, married women within these communities are advised not to be always found in the midst of men.

The in-depth interviews and focus group discussions explained that married women are discouraged from sitting in the midst of men. This is due to the fact that, women are supposed to be treated with due respect and their responsibility is to take care of the home

Table 4.3.12: Views of Respondents on Forbidden Married Women to Seek Competent Health Care Alone

Forbidden to seek	Frequency	Percentage (%)
Very often	29	15.6
Often	65	34.9
Rarely	36	19.4
Never	29	15.6
No response	27	14.5
Total	**186**	**100.0**

About 35% of the respondents were of the views that some married women within the communities are forbidden from seeking competent health care alone, while 16% shared views that such never happen.

The in-depth interviews and focus group discussions explained that, it has been observed that, some men forbid their wives from seeking competent health care alone on less they are being accompanied by their husbands or other relatives.

Table 4.3.13: Views of Respondents on Other Forms of Violence against Women

Other forms of violence	Frequency	Percentage (%)
Rejection	20	10.8
Slap	21	11.3
Ignoring	21	11.3
Neglected in bed	12	6.5
Malice	8	4.3
Rape	19	10.2
No response	85	45.7
Total	**186**	**100.0**

The above Table indicated that there are forms of domestic violence against women which was not included in our category of responses. And these include rejection 11%, slapping of spouse 11%, ignoring spouse 11%, neglecting spouse in bed 7%, keeping malice with spouse 4%, and rape(force sexual relationship on spouse)10%. According to the in-depth interviews and focus group discussions, some other forms of violence against women include over burden with family chores, argument over money, leaving her with not enough time to rest, interference of in-laws, dispute over number of children and given birth to many children at the detriment of their health status.

4.4. Reasons for the Existence of Domestic Violence on Women's Health

The analysis in this section is based on the views of respondents on the possible rationale behind the existence of domestic violence within the Zaria communities and its effects on women's health.

Table 4.4.1: Views of Respondents on Lack of Dialogue with Spouse

Lack of dialogue	Frequency	Percentage (%)
Yes	111	59.7
No	2	1.1
No response	73	39.2
Total	**186**	**100.0**

From the Table above, 60% of women live in families where there is lack of dialogue and mutual understanding between partners. On the other hand, information elicited from the in-depth interviews and focus group discussions accepted that lack of dialogue in any family is a possible cause for domestic violence.

Here, the views of respondents on non-challant attitude of spouse, showed that 62%(115) of the respondents live in families within the communities where men exhibit non-challant attitude towards their wives, children and families. Only 1%(2) said no while 37%(69) did not respond. The qualitative data gathered observed that, some men are very irresponsible and carefree when it has to do with the health status of their wives. And it will only take proper action when their wives health status gets

to critical condition. And as such most women end up losing their lives as a result of minor health issues not appropriately addressed on time.

With respect to the views of respondents on poverty as gathered from the survey, 69 %(128) of the respondents accepted that poverty is the major factor of domestic violence and the poor health of women. About 2 %(3) said no, while 30 %(55) did not respond. Based on this information, it is likely that poverty can be a root cause to domestic violence. In addition, the qualitative data collected explained that without money a home cannot be properly managed. And if married to an uncompromised woman, there is bound to be trouble at home. To better appreciate these views, we look at the operational definition of poverty which refers to the denial of choices and opportunities, a violation of human dignity. It means lack of basic capacity to participate effectively in society: not having enough to feed and clothe a family; not having a school or a clinic to go to; it means susceptibility to violence- like having women who did not receive treatment for recent serious illness on time or who did not receive any antennal care or who did not receive any assistance during child birth from a trained midwife, or who did not receive a tetanus inoculation during pregnancy, women or girl children who never attended school, have no access to information, no access to proper sanitation facilities and depend totally on their partners or husbands who intend could not provide as a result of poverty(Gordon, 2006).

In addition, views of respondents on disobedience within the family show that, 60%(112) of the respondents accepted that disobedience is a possible factor of domestic violence at home; 1%(2) said no, while 38 % (72) did not respond. Meaning, that it is for a fact that disobedience between partners in an intimate relationship can cause domestic violence. The responses from the qualitative data

revealed that disobedience could be from either partners and it is a factor for domestic violence.

From the views of respondents on infidelity between the wife and husband, 55 %(103) of the respondents argued that infidelity is a cause of domestic violence, while 2% argues against and 43%(80) did not respond. Here, it is clearly explained that, infidelity in marriage is a cause for some domestic violence. On the same note, qualitative data collected revealed that infidelity is a suitable cause of domestic violence against the health of women. And as a result both partners are vulnerable to sexually transmitted diseases.

Finally, based on the views of respondents on other reasons for the existence of domestic violence on women's health, presents that, 60%(112) from the survey indicated that there are some other reasons for domestic violence within the Zaria communities which are not included in our category of response. The in-depth interviews revealed similar responses as of the survey, adding that lack of communication, illiteracy, customs and traditions are the major reasons why such a problem may arise within the communities. The focus group discussions explained that husbands have unique ways of treating their wives, and wives must obey their husband's instructions without any objection. And as a result quarreling steps in.

4.5. Behavioral Pattern of Victims of Domestic Violence and their Effects on Women's Health

This section presents how victims of domestic violence respond to abuses and violence and its negative impact(s) on their health status.

4.5.1: Views of Respondents on whether they are Afraid of their Husbands

Afraid of husband	Frequency	Percentage (%)
Yes	42	22.6
No	97	52.2
No response	47	25.3
Total	**186**	**100.0**

Table 4.5.1 showed that, among the respondents, 52% stated boldly that they are not afraid of their husbands despise all odds, 23% accepted calmly that they are afraid of their husbands based on some reasons like;

9% of the respondents said; if I offend him, he will beat me (women)
5% of the respondents stated that; I am afraid of my husband, because I do not want to be assaulted by him (women) and 3% of the respondents added that; I am afraid of my husband because he is harsh on me (women).

On the other hand, information gathered from the qualitative data revealed that all the informants were afraid of their husbands for one reason or the other not just being respectful to them.

Table 4.5.2: Views of Respondents on Reasons why they may be afraid of their Husbands

Reasons	Frequency	Percentage (%)
If I offend him, he will beat me	17	9.1
Because he is harsh to me	6	3.2
Because I do not want to be assaulted by him	10	5.4

Because we are married as friends	3	1.6
Because of the painful intercourse	4	2.2
Because every-wife must fear and respect the husband	3	1.6
Because he is the head of the family	3	1.6
No response	140	75.3
Total	**186**	**100.0**

From the Survey, majority of respondents 75% did not shared any view on this issue, while 9% of the respondents clearly stated that they are afraid of their husbands because if they offend them, they will beat them, and because they want to avoid being beaten, they tend to be afraid of their husbands and not just respecting them as the case should be. Responses elicited from the qualitative data supported every claim of the survey.

Table 4.5.3: Views of Respondents on Their Relationship with Husband

Relationship with Husband	Frequency	Percentage (%)
Passive	19	10.2
Interactive	35	18.8
Very passive	7	3.8

Very interactive No response	81 44	43.5 23.7
Total	**186**	**100.0**

Based on the data collected, 44% of the respondents accepted that the women have very interactive relationship with their husbands; while 13% indicated some other married women have very passive relationships with their husbands. Majority of the key informants from the in-depth interviews and focus group discussions stated that, the relationship between husbands and wives within the communities is not so cordial and mutual. These clearly explain some of the basis of queries at home. For where there is lack of mutual understanding, there is bound to be some sort of problems at home.

Table 4.5.4: Views of Respondents on their Relationship with their Children

Relationship with Children	Frequency	Percentage (%)
Passive Interactive Very passive Very interactive No response	12 26 5 91 52	6.5 14.0 2.7 48.9 28.0
Total	**186**	**100.0**

The Table above showed that, 49% of the respondents confirmed that, most women has very interactive relationship with their children, while 9% indicated that other married women have very passive relationships with their children. Majority of the key informants from the in-depth interviews and focus group discussions stated that, the relationship between wives and children within the communities is so cordial and mutual. This explained that, most women turn to their children to comfort and console themselves when they are facing one or more domestic issues.

Table 4.5.5: Views of Respondents on how Traumatized they felt when being violated

Traumatized	Frequency	Percentage(%)
Very often	35	18.8
Often	45	24.2
Rarely	39	21.0
never	19	10.2
No response	48	25.8
Total	**186**	**100.0**

It was found that 43% of the respondents have been traumatized, while 21% said they were rarely traumatized. From this analysis, it is observed that women within

these communities are being traumatized due to the way they are being treated either by their husbands or in-laws.

Table 4.5.6: Intimidation Felt by Respondents

Intimidated	Frequency	Percentage (%)
Very often	24	12.9
Often	62	33.3
Rarely	30	16.1
Never	24	12.9
No response	46	24.7
Total	**186**	**100.0**

From the above Table, about 46% of the respondents accepted that they have been intimidated in one way or the other.While 16% of the respondents have never been intimated. This shows that, majority of the women within these communities have been often intimidated either for one reason or the other by their spouses.

Table 4.5.7: Isolation Felt by Respondents

Isolated	Frequency	Percentage (%)
Very often	21	11.3
Often	61	32.8
Rarely	33	17.7
Never	24	13.4
No response	46	24.7
Total	**186**	**100.0**

Findings on this Table revealed that, 44% of the respondents accepted that they have been isolated. From this data, it is an indication that, some women within these communities are not being fully involved in the matters at home and therefore they are

being isolated from decision making as well as matters at the domestic levels that also concerns them directly or indirectly.

Table 4.5.8: Views of Respondents on Others Behaviors Adopted

Behaviors Adopted	Frequency	Percentage (%)
Very often	10	5.4
Often	24	12.9
Rarely	22	11.8
Never	18	9.7
No response	94	50.5
Depressed	18	9.7
Total	**186**	**100.0**

This Table showed that, there are other behaviors adopted by women as about 10% of the respondents confessed they feel depressed base on the manner in which they are being treated, but majority of the respondents did not respond.

4.6 Impacts of Domestic Violence on Victim's Physical Health

This section includes the consequences of the effects of domestic violence on women's health based on the views of the respondents studied. Sadly enough, women stand the most chance to suffer the consequences of domestic violence and this has contributed seriously to the poor health status of the women within our communities.

In the course of my investigation at St Luke's Anglican Hospital Wusasa-Zaria, there were women patients with deteriorating health lying helpless all as a result of domestic violence. Though very few were willing to open up, here is one patient's experience:

< I was married to my husband as the last wife without my full consent. I did not want to go but I had no one to support me. My parents have already concluded that my husband should come and take me from Sokoto to Wusasa where we are now. I came to marry him when I was 11years old and I got pregnant for him not too long. I was

given some traditional bath to make the baby healthy because I was told that, this will help me not to face some difficulties during child birth. Finally I went into labor and could not deliver naturally, so after nothing could be done at home and for fear that the baby and I may lost our lives, I was rushed to the hospital where I was operated upon and bore the child but under severe pains and injuries. Since then, I have just been pretending all is well and still had other children with the wound in my private part. One day, I discovered that, there was a kind of wetness in my underwear. I cleaned up and complained to my husband who paid less attention and so I kept feeling this pain. Before, I could know what was happening, I was told that, I am suffering from a disease that has been as a result of tender child birth and immature of my private organ and the numerous incision to open me up and remove my children and the fact that over the years, this wound has not been properly treated. The doctor called it VVF- Vesico- Virginal Fistula. But she assures me that I will be fine over a period of appropriate medical attention and medication. So that is why I am here in this hospital, I am dying my sister…> (Anonymous, 2012).

Nonetheless, this is just one out of the many victims within the Zaria Communities who was willing to share her story. As she narrated her story, the researcher observed that, most of the women within the communities were either pregnant or nursing a baby. Thus, the point is, at an age of 11years, are young girls matured enough for marriage emotionally and physiologically? Mindful of what it takes from getting pregnant to delivery to coping with family affairs. Interestingly, some of these women have managed to escape, others have accepted their fate since not even their parents could sustain them if they were to run back home.

The physical, social and psychological trauma VVF victims undergo are enormous. The case of VVF in a woman is usually the end result of a long journey on a road beset with poverty, multiple deprivation, injustice, ignorance and neglect and this is most common within the northern regions of Nigeria like Kano and Kaduna

(Tahzib, 1989). In addition, this is one of the prime causes of the high maternal mortality within these regions.

Motherhood in Zaria communities has been accepted as the only route to status and self respect for a woman. Thus, girls are therefore married off as soon as they reach the local marriageable age with little or no skills and become solely dependent upon their husbands for every support. Soon pregnancy follows of course with undefined health consequences because reproduction starts at an immature stage. Once these problems begin, the girls are divorced by their husbands. As a way to cope, the family may accept the victim and support her, often times keeping her in segregated quarters but later too reject her. Then with no education and no skills to compete in the labor market, many of these women take into begging or disguised prostitution. Ironically, the very men that rejected them because of their predicament and smell shamelessly turn to them as sources of cheap sexual gratification (Ejembi, 1980). In Zaria, it is observed that, prostitution is one of the main sources of income for helpless women, as most of the women end up taking jobs of plates washing, nannies, petite traders, cleaners or restaurants helpers.

So far so good, the elites of Kano, Katsina, Sokoto and Kaduna have seen reasons in increasing the age of marriage to 18years which is in line with the National Population Policy of Nigeria. And unlike when some victims were abandoned in the ABUTH, Zaria, family members are doing their best to understand the situation and accepting that, the predicament is not as a result of infidelity at the part of the woman in marriage or some sexually transmitted disease but a result of unhealthy decisions taken because of customary and traditional practices.

The current interest in VVF has been a result of the work of non-governmental organization notably the National Council of Women's Societies (Kano State) and Women in Nigeria (Kaduna State). They have been working in the area of advocacy, community mobilization, public enlightenment, treatment and rehabilitation of VVF victims. Also the social welfare sector is not let out including religious bodies in the

fight to better address this issue and serve many girls from becoming future victims of VVF.

In the light of the law, court and state of violence, the Universal Declaration of Human Rights condemns such violence in Article1, 4 and 5. The African Charter of Human Rights also has provisions to such effects (Article 4, 5 and 6). Many African countries including Nigeria are signatories to such declarations and charters. Citizens are however generally unable to enforce their rights under these laws because of the lack of appropriate fora and the weaknesses in the laws, especially the African Charter. Theoretically, it should have been possible for the court both customary and Sharia courts to take legal proceedings against individual members for violence but religion and ethnicity comes into place making this an uphill task (Edzodzinam, 1990). For example in customary law, while cruelty on the part of the husband is considered a ground for divorce, moderate wife beating is allowed and the practice of female circumcision continues in the Sahel belt right across Africa.

Looking at the role of religion and ethnicity, it should be noted that, religion deals with beliefs while ethnicity deals with customs. It has been a custom over times that, a man can marry as many wives as he desires though Christianity frowns on this custom and practice, Islamism supports it stating that, as long as the man can equally provide un conditional love and support to all his wives which of course based on social reality has not been achieved in most families within the Zaria communities. Thus, leaving the women poor, wanting, sick and suffering all in a bit to cope with the situation they find themselves in.

Though it is expected that, those women within Zaria who had the opportunity to embrace western education to empower themselves and know their right should not be victims of domestic violence rather to be a light for their counterparts, it is shocking that, they too are victims of domestic violence because they find it difficult to kick against their religion and customs and to do the right thing which will not jeopardize their health status and wellbeing as women, mothers, workers and care givers.

4.6.1 Effects of domestic Violence Against women's Health

From the responses elicited from the survey, the respondents identified that: Bruises and injuries, Swollen Body Parts and Stress related Injuries, Miscarriages, Lost of Blood, Cutting and Multination of the Female External Genitalia, Painful Intercourse, Painful Child-Birth, sexually transmitted Diseases, Non-specific pains in the Stomach and joints, Mental illness and others like committing suicide, rejection, ignoring, slaps, sleeplessness, depression are the effects of domestic violence on women's health.

Table 4.6.1: Views Respondents on Bruises/Injuries on Women's Health

Injuries on women Health	Frequency	Percentage (%)
Very often	55	29.6
Often	100	53.8
Rarely	14	7.5
Never	8	4.3
No response	9	4.8
Total	**186**	**100.0**

This Table categorically showed how women who have often been physically violated by their partners, with 54% confessing they have suffered from bruises/injuries. Others, making 30% attested they have very often, been bruised and injured by their husbands like-wise. From the data, it is worthy to know that, not every victim will like to talk about such issue and that most women 83% suffer from bruises/injuries as a result of spouse battering.

Table 4.6.2: Swollen Body Parts and Stress Related Injuries by Respondents

Stress	Frequency	Percentage (%)
Very often	54	29.6
Often	96	51.6
Rarely	14	7.5
Never	13	7.0
No response	9	4.8
Total	**186**	**100.0**

This Table indicated, 52% of the women were victims of swollen body parts and stress related injuries committed by their husbands, while 30% said this happens to them often in their communities. Based on the normal day to day routine of human life, it is a fact that, everyone undergoes one form of stress or the other. But here, we are much concerned with the stresses that women faced at home that are detrimental to their health. And as shown on this Table, women most often suffer from varying kinds of stress that could be caused by different factors like; too much work at home, non-challant attitude from the husband or children, the husband over staying out of the home for too long without any explanation to the wife and many others.

Table 4.6.3: Miscarriages in their Relationship by Respondents

Miscarriages	Frequency	Percentage (%)
Very often	46	24.7
Often	86	46.2

Rarely	34	18.3
Never	13	7.0
No response	7	3.8
Total	**186**	**100.0**

This Table showed that, 71% of the women in Zaria attested that, they have had miscarriage sometimes in their relationship due to both spouse battering, and sexual assault. Once a pregnant woman at such delicate state of her life is subdued under certain unfavorable conditions by her husband and the people around her, there is likelihood for miscarriages. Like in this study, majority of the respondents (71%) agreed that, violence on a woman could lead to poor health status of women and of course if she is an expectant mother, it might seriously affect her condition, possibly leading to miscarriage.

Table 4.6.4: Views of Respondents on Loss Blood Sometimes

Lost Blood	**Frequency**	**Percentage (%)**
Very often	47	25.3
Often	77	41.4
Rarely	45	24.2
Never	10	5.4
No response	7	3.6
Total	**186**	**100.0**

This Table showed that 67% of the women in Zaria attested that, they have had loss of blood due to either spouse battering or sexual assault. However, there is a tendency for a battered woman to suffer some lost of blood as a result and there is a

need for immediate medical attention because there could occurred internal bleeding, only medical professionals stand at the best chance to diagnose and save the victim's life on time.

Table 4.6.5: Views of Respondents on Genital Mutilation

Mutilation	Frequency	Percentage (%)
Very often	31	16.7
Often	56	30.1
Rarely	56	30.1
Never	26	14.0
No response	17	9.1
Total	**186**	**100.0**

This Table showed that 44% of the women in Zaria attested that they been mutilated of their female external genitalia either by their parent while they were still young or by their relatives. This result confirmed the point that, practices, traditions, values or beliefs within each community apart from the normal society norms, varies from family to family and groups to groups. Thus, what might not be a practice to a particular family may be for the other though, they all live within the same communities and share certain communal norms and benefits like same routes, paths, markets, language etc.

Table 4.6.6: Painful Intercourse Experienced by Respondents

Painful Intercourse	Frequency	Percentage (%)
Very often	45	24.2

Often	77	41.4
Rarely	28	15.1
Never	19	10.2
No response	17	9.1
Total	**186**	**100.0**

This Table showed that, 66%of the respondents have experienced or are still experiencing painful intercourse because they were given to marriage in a very tender age, forcefully, out of ignorance by their parents and relatives. Therefore, it could be concluded that, painful intercourse though medically and psychologically can be explained from the conception of age of marriage and the maturity of the human reproductive organs, it can as well be explained from a realistic point of view which simply attests that, it depends on individuals. As well as placing the young married woman at the demise of suffering from likely cases of Vesico-Virginal Fistula (V.V.F) in the nearest future.

From the qualitative data, some respondents explained that, one of the prime reason for some women experiencing painful sexual intercourse sometimes could be as a result of the utilization of 'yaji' by the husband on the woman. At this point the researcher asked a probing question to better understand what 'yaji' is all about. The respondents further explained that, 'yaji' is a Hausa word well known and utilized by most northerners locally, which is a mixture of some gingering substances like onions, roots of herbs, spices like curry, garlic. And it is known as 'yaji' when pepper is added into this mixture. 'Yaji' acts as a stimulant and appetizer when consume. The preparation and mixture to make 'yaji' varies from one livelihood to another. It can be used domestically in cooking of food and even by those people who sell 'suya' (roasted meat). 'Yaji' can be also used by a man or woman to increase sexual libido during sexual intercourse between the husband and wife. Equally, 'yaji' can be used as a weapon to enhance traditional child punishment or wife punishment. In the light

that, when a child does something wrong, pepper can be put in his eyes to prevent him from further doing such act and this is true for young boys and girls who were caught practicing premature sex or reported to have been involved in such an act. The punishment with pepper depends on the gravity of the crime committed. Also, if a wife refuses her husband sexual intercourse, the man can beat her up and as well use 'yaji' on her during sexual intercourse which will inflict her with severe pains.

Based on the socio-demographic attributes of the respondents studied, 35% were Hausa, 25% were others like Nupe, Ijaws, Tiv etc, 19% were Yoruba and 17% were Igbo all residing within the Zaria communities as the time of this study. And a breakdown of their religious affiliation stated that, 53% practice Islam, 45% were Christians from different denomination while others were just 2%. Thus, the respondents revealed that, Marital Sexuality (meaning sexual intercourse strictly between a married husband and wife or wives) in Islam is religiously a form of worship (ibada- an Arabic word for worship). Mindful of the fact that religion in brief refers to beliefs and ways of worship, whereby one is expected to do what God says one should do and do not do what God says one should not do.

Furthermore, for the fact that some Muslim husbands may marry more than one wife, and it is their duty to render their full sexual satisfaction to their wives, 'yaji' can be used to assist the husband achieve this gladly. Since he has a routine to satisfy all his wives and make them happy and fulfill in their marriage. On the other hand, most Christian husbands marry one wife and the use of 'yaji' does not really come into play. Though it is equally a fact that, some Christian husbands too make use of 'yaji' and sometimes more than even their counterparts. There is a need for enough calories, physical fitness and mental uprightness to achieve all these; hence 'yaji' is used as tool to promote sexuality in a home.

Table 4.6.7: Views of Respondents on Other Effects of Domestic Violence against Women's Health

Other Effects	Frequency	Percentage (%)
Stressed	26	14.0
Depressed	34	18.3
Always thinking	22	11.8
Sleepless	14	7.5
Committing suicide	23	12.4
No response	67	36.0
Total	**186**	**100.0**

From the views of Respondents on other effects of domestic violence against Women's Health, 18% of the respondents complained of being depressed, 14% said they have been stressed, 12% always thinking, 8% having sleepless nights. Information from the qualitative data had it that, other effects is what is known as Vesico-Virginal Fistula (V.V.F) which they explained any woman is likely to suffer from in her latter days if she had engaged in procreation activities when her reproductive organs were not well developed enough to support the process, or had a Caesarian Section that did not healed appropriately before she engaged into further reproductive exercises. Finally, another common practice as a result of the ill-treatment women faced led them to think of committing suicide

4.7 Strategies that could be Adopted to Curb Domestic Violence in the Community

- More than (3/4) three quarter of the respondents advocated that, severe punishment and sanctions should be applied on men while 38 (20%) added that, perpetrators (men) must face the law as this is a very necessary way forward to solve this problem.
- Prayers should be encouraged at the level of the partners to be. Also, parent should often show love to their children and partners, as this inculcate the habit of reciprocity, within the family, in areas of sharing and expressing love in harmony.
- Counseling and Mutual dialogue should be introduced, and cases of domestic violence should be reported as early as possible to parents and community leader(s), the ancient customs of maltreating wives by in- laws, giving out for meager bride price which often turn out into modern slavery in the name of getting married should stop. Rather, any of such wicked practices, customs or traditions should be modified if possible or be wiped out completely, such that the girl-child can be as useful as the boy child.
- There should be acceptability between partners, giving children all the moral lessons they need, that will carry them through life, without any strings attached to gender discrimination or superiority.

4.8 Recommendations on Ways of Mitigating the Incidence of Domestic Violence on Women's Health

Educated people or parent should raise their children, at very early stages with the habits of equality, hard work, honesty, loyalty, charity, love and good morals. For the grown-up children, parents should monitor their activities (but should not imposed on them or force them to do or engage in what they do not like and do not want); including how they manage their resources. Women as a whole should be educated on health issues and others; jobs should be created for women; women should be treated as mothers and not as slaves nor domestic workers; marriage should not be forceful.

In Sociology of Deviance and criminally it is argued that, corrections must begin at an early stage so as not to mislead a child who keeps on doing wrong things yet he/she is not corrected. For he/she will grow up thinking, that is the right thing to do. Thus, sensitization and campaigns on women's health related issues should be carried out, orientation should be included and violators of women's health should not go unpunished as well as women too should endeavored and be encouraged to speak up on time, break the silence and take a chain of actions to seek solutions to their domestic problems.

The State, Human Right Activists, Feminist Movements and Associations, Women Advocacy Groups, Religious Organizations also play a major role in this fight. Nonetheless, scholarships, and many other education programs are being put in place, all in an attempt to tackle this women's plight. In addition,

other individuals and groups who have felt the cries of women's health issues, and who wish to become Advocates and Facilitators, encouraging the education and freedom of the young and future of Zaria Communities at heart should do their possible best on improving on this pressing issue and giving the women the quality and respect they deserve.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter is the final chapter of this work which summarizes the results obtained from the previous chapters and discusses the major findings, draw conclusion and proffer some recommendations based on the findings that could hopefully lead to improvement in the health status of women within the Zaria Communities. Also, suggestions for further research were documented.

5.2 Summary of Major Findings

This study set out to examine the perceptions of the forms and effects of domestic violence on women's health in Zaria communities of Kaduna State in Nigeria. There were six research questions and six objectives of the study captured. However, the overall objective was to investigate the prevalence, nature and scope of the forms and effects of domestic violence on women's health, thereby exploring into understanding the reasons for the existence and examining some behavioral patterns adopted by victims to cope in such situations.

Furthermore, the theory used for this study is the Liberal Feminist Theory with the basic assumptions that; as the dominant class, men have differential access to material and symbolic resources thus women are devalued as secondary and inferior; intimate partner abuse is a predictable and common dimension of normal family life; women's experiences are often defined as inferior because male dominance influences all aspects of life.

The methods of data collection for this study were through the use of survey research techniques; structured in open-ended and closed ended questions administered to respondents as questionnaires, In-depth Interviews and Focus Group

Discussions, which were conducted via stratified sampling, with a sample size of 186 respondents. The findings proceeded as follows:

Majority of the respondents (53%) confirmed that, marriages within their communities are concluded by parents. Meaning that, in some cases the partners to be married have no much saying and this of course explain that, this may pave way for possible causes of domestic violence, then 10% of the respondents, who declared that some marriages were forcefully imposed upon the partners, narrated that, married life has not been so easy for them, since they had neither the time nor opportunity to court with the man/woman that was going to be their partner. So they turn to study each other while already as couple which indeed makes things difficult for them thus making rooms for quarrels, assaults, fighting, humiliation, isolation and injuries. In addition, the tendency that, men who got their wives at a platter of gold tend not to respect them accordingly and as a result, there develop no mutual understanding between husband and wife.

In the researcher's opinion, marriage is a sure and gradual process. Marriage is also a culture which eventually leads into an institution or a social contract that is known as the family. Here, the family becomes the first agent of socialization which automatically becomes a secret institution sealed with absolute love, purity, peace, selflessness, honesty, free will and mutual benefits. Though there is a need for body chemistry and compatibility, the parties involved must be matured enough to know what they are getting themselves into. This is so because once a marriage is wrongly concluded, the consequences cannot be over emphasized. This will go a long way to prevent women from suffering and treated as slaves, domestic servants either in the hands of their husbands, boyfriends, intimate partners or in-laws, all because the women were cheaply given out into marriages.

Furthermore, from the reviewed work of other scholars on this issue, this study is here to throw more light in addition to what other scholars have done that, marriage comes first before a family. Marriage goes with courtship over a good duration and

not just co-habitation as the case has been. During this courtship, which is a process in time and in space; whereby adults of opposite sex (man/woman) decide to know each other intimately, to avoid unforeseen repercussions in the nearest future when they eventually become husband and wife. Within this period of courtship, a lot of checks are being carried out ranging from ancestral lineage, body chemistries, personal attitudes and characteristics, blood groups and other relevant, related issues. This bear fruits to the fact that, marriage is a social issue which must include a social contract to determine what the parties involve want and these two parties must be rational enough to decide on their own what they want. Thus, a child who is yet to be born or at five(5)years old should not be betrothed because it will be like a slavery and abomination to the Human Rights Act.

The researcher observed that, this issue of forceful and tender marriages was a very serious issue and a call for concern within the Zaria communities. Most women within these communities who have been victims were crying for help, to redress this issue while others are dying in silence. As a way out, some women have turned to God in prayers and others into petite trading, farming and selling of locally made products like (Fura de nunu, kunu, Masa etc as known in Hausa). This helps them to buy over the counter drugs and medication as the case may be as well as care for other needs.

On the same view, the data collected from these communities revealed that, there appears to be some agreement on some of the factors that are likely to bring about domestic violence which are not causal factors anyways. Some of these are age at marriage, social class, lack of courtship before marriage, duration of marriage and children.

However, the occurrences of sexual assault, forceful marriages and early child bearing, verbal assaults, spouse battering, subjecting of spouse to excessive hard work, showing preference for co-wives, treating spouse as hired domestic slave, has been a common practice in our communities as such, the aspect of tradition and

culture should not be misunderstood so as to help our modern communities know where to draw the line.

The reader(s) will bear with the researcher that, women and the girl-child are deeply suffering within our communities especially within the rural areas where this investigation was carried. The researcher observed worst things with respect to the poor health status of women. And funny enough, these women go about as though nothing is happening; one wonders what future grandmothers and mothers we aimed at having if this issue is not well addressed now.

On the whole, the pattern and nature of acts, forms and effects of domestic violence against women's health suffered by women within the Zaria communities as revealed in this research is realistic. Though more attention is given to the physical status of women, mental status is also a priority as this has to do with emotion and psychology. An emotionally balanced woman is a powerful tool for development at all levels. Thus women, who are subjected to many acts of violence, undergo untold hardship which often results in social, mental and psychological problems leaving scars for life like in the testimony of the victim above. As it has been the case, some of these abusive acts can be quite dehumanizing, so much so that, women tend to prefer being beaten and ill-treated to enduring emotional, physical, social and psychological stress. For example, refusing a woman's food or sexual satisfaction or staying away from home for longer hours can be worse oppression than physical violence. Like in a case where a man flirts openly to the knowledge of his wife, this is good enough to make the wife lost her self-confidence.

Furthermore, this is not in support of any forms, acts or effects of violence on women but the reality about the issue and advocating that, such should be ignored as much as possible. As can be deduced from the findings, human relationship and interaction must be based on mutual understanding, dialogue, tolerance, love, respect and social contract because humans are most complex and unpredictable irrespective

of whether we look alive, share similar characteristics like age, education, language or skin color.

5.3 Conclusion

From the background of the study to the findings of this study, this research was able to explain the conditions of women's health status within the Zaria communities, observing from one woman to many women, in understanding some of the laid down traditional practices, cultures and customs over the years and how it has negatively affected the health status of some women using well designed research techniques and reported findings based on objective observations. Thus, this qualifies the study to be a sociological analysis having invested a social issue to report the reality on ground starting from a micro to a macro level; from one woman to many women, aspect of harmful cultural practices like FGM, early marriage, forceful marriage.

Comparatively, findings from this study confirmed that the most common form of domestic violence on women within the Zaria communities is sexual assault 30% which together with factors as poverty 69%, among others are responsible for the poor health status of women. These findings were similar to that reported among women in Kano(28%) by Zubairu et al, 2011, but higher than that reported among women in Jos(13%) by Gyuse, 2009, Furthermore, the prevalence of this study is much more lower than those reported from selected communities in eastern(79%) by Uchenna,2010) and western(81%) Nigeria by NACA, 2011). In contrast, findings were comparable with reports from South Africa where there is a possibility for any South African woman to be rape in every 17seconds (89%) by Mandisa et al, 2012 and another report(22%) from Cameroon by Ministere des affairs de la femme, 2012. Thus, the lower or higher prevalence in this study population as compared to the general populace from the same region could be due to socio-cultural differences as

demonstrated by other studies carried out with higher figures for South South Nigeria (52%) and difference in methodology could also explain some of the variations.

It is not enough for these investigations to be carried out on domestic violence against women and how it affects their health status. What is most important is how we can join forces and resources to postulate feasible and practical ways to take them back into our communities to begin to work with those victims who have open up and those who will be willing to. In Nigeria, and in Africa as a whole, there is this lack between the formally educated and the less educated as well as the urban women and the rural women, so all what we study, investigate, and report and examine, is not taken back in practice to the communities that needs them.

In every research, there should be a feedback from both the researcher and the respondents in the community under study. If not, us as researchers risk facing a situation whereby the communities will refuse collaborating with us if nothing is done about this. Therefore, there is high need to increase the number of protective measures and legal measures to support and encourage victims of domestic violence and an evaluating team to monitor and scrutinized to ensure that, aids given to these victims by government, other partners should actually reach them on time without difficulties. This will help to determine the extent of violence against women and the effects on their health in our society and also help to provide the most effective means of curbing the problem.

Today, Nigeria is rated the worst nation with poor health status of women and the girl child(WHO,2012) yet aids from NGO and foreign bodies comes into the country for women and the girl-child every now and then. Some of the reasons we are stilling facing this problem is because, we lack the foresight to care for one another, reasoning why such researches are being carried out to know what is on ground and to do something about it. Not to keep them in the libraries or fold our hands and watch the situation getting deteriorating by the day.

To conclude, the time is now and we must have a fighting spirit to do something very fast about the health status of women within our communities.

5.4 Recommendations

As revealed in this research, the acts, forms and effects of violence on women's health are mostly perpetrated by men, the negligence of law forces, unrevised traditions and customs. Though many of the forms are less violent in nature like bruises/injuries, assault, the outcome is very serious and severe. Therefore, women must be prepared and well equipped to fight against such politely and diplomatically irrespective of whether the woman is formally educated or not as supported by the Liberal Feminist School of Thoughts.

Women should not shy away from sharing their problems with institutions and other bodies who are ready to help, as well as to God in prayers as was the case of some respondents in this study. By so sharing, it will inculcate that stamina to search for solution and of course lessening the burden. And as such, women groups, no matter how small should be swift in organizing responses when they are aware of such violent acts not that; they tend to start gossiping about their fellows situations. And I urge victims of domestic violence not to be silent about their situation and speak up on time as this will help in resolving the issue of domestic violence and its effects on their health.

Cases of abuse and other forms of domestic violence should be reported to parents, community leaders, social workers, police officers or doctors right on time so

as to prevent repeated occurrences as would be the case if the victim(s) keep silent about their predicaments.

Severe punishments, strict sanctions should be applied and an accurate evaluation should be implemented to ensure that perpetrators of domestic violence face the Law and do not go unpunished.

Early marriages at tender ages between 10-12years should be discouraged and if it must take place, counseling and dialogue should be implored so that the partners are aware of what they are getting into. In addition, it would be better if marriages are concluded between parents and partners not just parents alone.

Lastly, some violence cultures and customs should be revised so as to place the women as important as the men. Equally, women should be encouraged to work and earn salaries and should low self-esteem and total dependence upon their partners for material and symbolic resources. This will enable women to become supportive in care-giving as well as in material sources thereby letting the men realized their worth.

5.5 Suggestions for Further Research

This research was limited to the Zaria Communities. The study suggest that, further research be carried out in other Local Government Areas in Nigeria and beyond based on the health status of women or related issues affecting women and the girl-child to postulate what could be done and how beneficiary it would be to the women in the communities. Research can also be carried out in the following topics:

1) Impact of domestic violence on the fertility rate of women in the Zaria Communities.
2) Can there be a mutual feedback between the formally educated women and the less educated women within our communities? A case study of contemporary Nigeria and Africa as a whole.

3) What does the women of this generation needs most- Equality and Empowerment or Equity and Empowerment? The case of family management and politics in Zaria Communities.

REFERENCES

Abama,A., Kwaja,K. (2009), "Violence Against Women in Nigeria: How the Millennium Development Goals Addresses the Challenge." The Journal of Pan African Studies, vol.3, no.3, September 2009.

Aderinto,A. (2003), Public Concern of Private Affair: Social Construction of Domestic Violence against Women in post-colonial Nigeria. Paper presented at the Congress of the South African.

Amnesty International, (2001**)**, Broken Bodies, Shattered Minds: Torture And III Treatment of Women. March 2004.Website:http//www.amnesty.ca/stoptorture/womenreport.pdf.

Amnesty International, (2004), Lives blown apart: crimes against women in times of conflict. London, Zed Publishers**.**

Anu,K.(2011), Let Women Die Act in Nigeria.

Beijing Women's Conference, (1995), "Declaration and Platform for Action". Critical Areas of Concern no.43. Fourth World Conference on Women: Action for Equality, Development, and Peace, Beijing, September 15, 1995.

Baron, L., & Strauss, M.A. (1987), Four Theories of Rape in American Society: A State-Level Analysis. New Haven: Yale University Press**.**

Bograd,M.(1987), Battered women, cultural myth and clinical interventions: a feminist analysis, Women and Therapy, 5, pp. 69-77**.**

Che, Y., and Cleland, J. (2004), Unintended Pregnancy among Newly Married Couples in Shanghai. Int. Family Plann. Perspect., 30(1): 6-11**.**

Cited in Tahzib, F. VVF in Nigeria (1989), A Report submitted to Carnegie Cooperation.

Dickstein, L.J. (1988), Spouse Abuse and Other Domestic Violence. Paychiatr. Clin. North Am., 11(4): 611-608**.**

Edzodzinam, T. (1990), Doing Violence, Dealing with Violence: State Policy and Practice in Africa.

Ejembi, C.L. (1980), Reproductive Health Abuse: The case of Vesico-Vaginal Fistula.

Facts About Violence,(2010), - Feminist.com, www.feminist.com/ Antiviolence/facts.html-cached.

Fawole, O.I., Aderenmu, A.L., Fawole, A.O.(2005), Intimate partner Abuse: Wife beating among civil servants in Ibadan, Nigeria. Afr J Report Health : 9(2):54-64.

Gage, A.J. (2005), Women's Experience of Intimate Partner in Gambia. Soc.Sci.Med., 61:343-364.

Gavrilescu, N. (1976), Occupational Safety and Health series: Organization of Family Planning in Occupational Health Services.

Gender Link, (2001), Report on the Media Training Workshop for South African Media Practitioners, South Africa, May 2001. Website: http://www.genderlinks.org.za/images/documents/pdf%20files/ sa-gender-violence-report.pdf.

Gordon,D.(2006), Indicators of Poverty: eradication of poverty, Townsend Centre for international poverty research,University of Bristol, UN Headquarters, New York.

Global Health Council(GHC), (2012), Maternal, Newborn, Child and Reproductive Health Initiative.

Gyuse,A. (2009), Pattern of domestic violence among pregnant women in Jos, Department of Family Medicine, University of Calabar Teaching Hospital, Calabar, Cross River State, ECWA Evangel Hospital Plateau State, Nigeria.

Gupta, G.R., Heise, L., Weise, E., Whelan, P. (1996), Fostering Linkages between AIDs community and the violence against

women movement, Paper presented at the 11th international conference on AIDs, Vancouver, Canada, July, 7-12, p.7.

Hajiya,B.(2010), Ending Violence against Women in Nigeria, published in Furtune Newspaper, 9th September, 2010.

Heise, L., Elisberg, M., Gotte, M.M. (1999), Ending Violence Against Women Population Reports, series1,No. 11, Baltimore Maryland, John Hopkins University School of Public Health, Population Information Programme Available at: http://www.infoforhealth.org/pr/111/violence.pdf.

Hirsi, A.(2008), Debating Cultural Differences on Islam and Women: Published in: R. Grillo (ed), 'Immigrant Families in Multicultural Europe: Debating Cultural Difference.' Erik Snel (Erasmus University Rotterdam) & Femke Stock (University of Groningen), Amsterdam: Amsterdam University Pres.

Human Rights Watch, (2002), Nepal: Sexual Abuse Reports Highlight Plight of Bhutanese Refugees, AI Index: ASA 31/071/2002, 22 November,2002. Available at: http://web.amnesty.org/library/Index/ENGASA310712002.

Human Rights Watch, (1994), A Matter of Power: State Control of Women's Virginity in Turkey. New York, available at http://www.hrw.org/reports/1994/turkey/TURKEY.pdf

IOL ,France Proposes Times Bans for TV Porn**,** 14 November 2002. Website:http://www.iol.co.za/index.php?click id=3&art id=qw 1037289421450B216&set id=1

Isyaku, D. (1989), A study of financial coping scale of employed Housewives in ABU Zaria, under Austere condition pp56.

Inter-African Committee (1995), on traditional practices affecting the health of women and children Newsletter. Violence against women, April, (17)5.

Jewkes, R., Jonathan, L., Loveday, P., (1998), Social Science & Medicine, Volume 55, Issue 9, Pages 1603- 1617.

Kantor, P. (1996), Domestic Violence against Women: A Global Issue. http:/metalab.unc.edu/ucis/pubs/Carolina-papers/abuse/figure1.html.

Kurz, D. & Stark, E. (1988), Not-so-benign Neglect: the medical response to battering, in: K. YLLO & M.

Kerige, J. (1995), HIV prevention and women's rights: Working for one means working for both AIDs captions, Nov.,11, No.3.

Lovell, J. Movies Glamorize Violence. IOL, 5 March (2004), Website: http://www.itechnology.co.za/index.php?set id =1&click id=31&art id=qw1078494663691B262.

Mandisa,M.,& Sethembiso,M.(2012), The Politics of Women's Health in South Africa, first published 21st August,2012.

McCholskey, L.A., Williams, C., Larsen, U. (2005), "Gender inequality and Intimate partner violence among women in Moshi, Tanzania". Int. Family Plann. Perspect., 31(3):124-130.

Mies, M.(1986), Patriarchy and Feminism: Published by Zed Books Ltd, London and New York, and by Spinifex Press, USA.

Miller, B.D. (1997), The Endangered Sex: Neglect of Female Children in Rural North India. New York: Oxford University Press.

Millennium Declaration (2000), Declaration on the Elimination of Violence and Health. September 2000 in Geneva.

MsAfropolitan Bulletin,(2010), : African men, are you listening? Published By African Feminists, 29th November, 2010.

Maqsud,M. (2005), Relationships between Personal Control, Moral Reasoning, and Socio-economic Status of Nigerian Hausa Adolescents. Publisher: Springer Netherlands, Journal of Youths and Adolescents, pp. 281-288.

Nash, J. (2002), Making Women's Place Explicit: Pornography, Violence, and the Internet. Open Education Module II,

Harvard Law School. April, 2004. Website: http://eon.law.harvard.edu/vaw02/mod2-5.htm.

NaijaGists.com(2012), The State of Domestic Violence in Nigeria.

Newman,W., Symphorosa,R., & Owence, C.(2011), Violation of Women's Rights by Harmful Traditional Practices in South Africa.

Ngeve, E. R. (2007), Report On The Reproductive and Sexual Health And Rights Of Women In Cameroon: An Advocacy-Based Research. African Women's Development and Communication Network, December:14.

National Population Census of Nigeria (2006).

National Agency for the Control of AIDS (NACA), (2011), Factsheet: Women, Girls and HIV in Nigeria last updated Wednesday, 17 August, 2011.

Naseehah-An, (Dec.2007/Jan.2008**),** Religion is sincere advice, volume 6/Number 11, Dhul-Hijjah 1428 AH.

Nhloyi, M. (1996), Socio-Culture milieu, Women's status and Family Plannings in Family Planning, Health and Family well-being Bengalore, India, 26-30 October, 1992 (compiled by) United Nations. Department of Economic and Social Information and Policy Analysis Population Division New York. United Nations, 61-85t/ESA/SER.R/131.

Oyediran, K.A.,Isiugo-Abanihe,U.C.(2005**),**Perceptions of Nigerian Women on Domestic Violence: evidence from 2003 Nigeria Demographic and Health Survey. Afr. J. Reprod. Health Surv.,9(2005):38-53.

Okemgbo,C.N., Omideyi, A.K.,Odimegwu,C.O.(2002),Prevalence, patterns And correlates of domestic violence in selected Igbo communities in Imo State, Nigeria. Afr.J.Reprod. Health Surv.9(2005):38-53.

Pak, L.L., Reece, A.E., Chan, L. (1998), Is adverse pregnancy outcome predictable after blunt abdominal trauma? American Journal of Obstetrics and Gynecology, vol. 179, no.5, pp. 1140-1144.

Pallitio, C.C., Ocampo, P.(2004), The relationship between intimate partner violence and unintended pregnancy: analysis of a national sample from Colombia, Int. Family Planning Perspective., 30(4): 165-173**.**

Pearlman, M.D., Tintinalli, J.E., Lorenz, R. (1990), A prospective controlled study of trauma during pregnancy, American Journal of Obstetrics and Gynecology, vol. 162, no. 6, pp. 1502-10.

Rebecca,C., & Dickens,B.,(2011), Conscientious Commitment to Women's Health, Int.Journal of Gynecology & Obstetrics, 113.2(2011):163-166. http://papers.ssrn.com/abstract=1832549.

Sharma, N. (2007), Gender Inequality and Women's Health: An Empirical study of the factors affecting their health, Paper presentation at the annual meeting of the Southern Political Science Association, Hotel Inter-Continental, NewOrleans,LA.http://www.allacademic.com/meta/p143276_index.html.

Stawarth, S. (1995**),** Working with a radical agenda; The Musasa Project, Zimbabwe. Gender and Development: Women ND Culture, February. 3(1):30-35.

Stark, E., & Flitcraft, A. (1996), Women at Risk: domestic violence and women's health (London, Sage).

Stem,O. (1993), Why a program on Reproduction Health and Society? Salud Reproductive Y. Soivedad September- December, 1(1):111-112.

Shivdas, M. (2004), Women**:** Media Portrayal of Violence against Women. April, 2004. Website: http://www.wacc.org.uk/modules.php?

name=News&file=article&sid=1301

Taft, A. (2001), Intimate partner abuse in pregnancy, O&G, vol, 3, no. 4, pp. 250-253.

Tahzib, F. (1989), An Initiative on vesico-vaginal fistula. Lancet 1316-1317.

Uchenna,N.(2010), Violence against Women in the Nigerian Community: Issue of Power and Control.

United Nations, (2005), Resolution A/RES/55/2. The United Nations Millennium Declaration, New York, United Nations, 8 September.

Violence Against Women Act (VAWA), (2011), Ending violence against Women, remedying the laws and social practices that have fostered And justified the history of violence against women, published April,2011.

Warshaw, C. (1993), Limitations of the medical model in the care of battered women, in: P.BART & E. MORAN (Eds), Violence against Women: the bloody footprints (London, Sage).

Weaver, J. (1987), Effects of Portrayals of female Sexuality and Violence against Women on the Perceptions of Women. Diss. Indiana University, July 1987.

Webster, J., Chandler, J., & Battistutta, D. (1996), "Pregnancy outcomes and health care use: effects of abuse", American Journal of Obstetrics and Gynecology, vol.174, no. 2, pp. 760-767.

WOMEN IN NIGERIA (WIN), (1993). "Breaking The Silence: Women Against Violence; Edited Proceedings of the Tenth Anniversary Women in Nigeria Conference; Edited by Elsbeth Robson; WIN KADUNA STATE. Published by: el-rafiu prints and company 73a Zaria Road, Kano.

Women Global Network for Reproduction RightsWGNRR),(2012),: African Women's Health and Rights Day's statement, Feb. 4th,2012.

WHO, (2010), Preventing intimate partner &Sexual violence among women:Taking action and generating evidence,Genera, World Health Organization,2010**.**

WHO, (2011), Violence against women: an urgent public health priority: Editorial-WHO Bulletin, January,2011.

WHO.(2012),: Mental Health &Pyschological Support for conflict-related Sexual violence: principles and interventions: WHO/RHR/HRP/12.18

Yusuf,O.B., Arulogun,O.S.,Oladepo,O., & Olowokeere,F. (2011), Physical Violence among intimate partners in Nigeria: A multi level analysis.

Zimmerman, C.,&Watts,C., (2002), Violence Against Women:Global scope and Magnitude. Lancet, 359(9313): 1232-1237**.**

Zubairu,I., Isa,S.,Musa, B., Hadiza,S.,(2011), Domestic Violence among Women living with HIV/AIDS in Kano, Northern Nigeria.

APPENDIX I

QUESTIONNAIRE ON PERCEPTIONS OF THE FORMS AND EFFECTS OF DOMESTIC VIOLENCE ON WOMEN'S HEALTH

Dear Respondent,

I am a post graduate student of the Faculty of Social Sciences, Department of Sociology, Ahmadu Bello University, Zaria currently carrying out a research on "The Perceptions of the Forms and Effects of Domestic Violence on Women's Health." It is in partial fulfillment of the requirement for the award of M.Sc Degree in Sociology. Your sincerity in responding to the questions will be highly appreciated and all the information given will be treated most confidential. Thank you for your kind gesture.

INSTRUCTIONS: Please tick ( ) in the boxes or write in the spaces provided below.

Section A: Socio-Demographic Data of the Respondents

1. Sex a) Male ( ) b) Female ( )

2. Age a) 10-15yrs ( ) b) 15-20yrs ( ) c) 20-30yrs ( ) d) 30 and above ( )

3. Marital status a) Single ( ) b) Married ( ) c) Betrothed ( ) d) Divorced ( ) e) Widow ( ) f) Widower ( ).

4. Number of wives married to your husband?

a) Less than 3 ( ) b) 4 ( ) c) 5 ( ) d) above 6 ( )

5. What is your current position as a wife?

a) First ( ) b) Second ( ) c) Third ( ) d) others please specify……….

6. What is your highest level of formal education?

a) No formal education ( ) b) Primary School ( ) c) Secondary School ( )

d) Tertiary Institution ( )

7. Name of your Community…a)Sabon Gari…. b) Gyallesu…… c) Tundu Wada…… d) Wusasa….

8. Name of your Ethnic group a) Hausa…… b) Igbo…… c) Yoruba……… d) Others specify…………………………

9. Your Religious Affiliation a) Islam…… b) Christianity…… c) Others specify……………………….

10. What is your occupation? Please state

a) Casual laborer ( ) b) Strictly housewife ( ) c) Petite trader ( ) d) Working class ( ) e) others please specify…………………………………

11. What are your monthly earnings?

a) Less than #30,000 ( ) b) #30, 1000 - #60,000 ( ) c) #60, 1000- #90,000()

d) #90, 1000 and above ( )

Section B: Quality of the Health Status of Women within this Community

12. Have you ever suffered from stress?

a) Yes ( ) b) No ( )

13. If yes in question (10), what kind of stress did you suffered from?

a) Emotional ( ) b) Psychological ( ) c) Physical ( ) d) Social ( ) d) others please specify ………………………………………………......................

14.If yes in question (13) please could you described how you felt?..

15. Where did you go to for consultation or counseling?

a) Hospital ( ) b) Clinic ( ) c) Traditional herbalist ( ) d) others please specify………………………….

16. Were you properly treated and accommodated?

a) Yes ( ) b) No ( )

17. Would you mind sharing your experience with us?

……

………………………………………………………………………………..

Section C: Reasons for the Existence of Domestic Violence on Women's Health.

18. How are women being treated within your Community?

a) As mothers ( ) b) As servants ( ) c) As domestic workers ( ) d) Others please specify ……………………………………..

19. Are there any policies that permit domestic violence against women within your community?

a) Yes ( ) b) No ( )

20. If yes in question (19) could you kindly state such……………………….

……………………………………………………………………………….

21. Would you say that husband has right to beat his wife?

a) Yes ( ) b) No ( )

22. If yes in question (21) under what situation or crime committed could such be allowed ……………………………………………………………..

23. How are marriages concluded within your community?

a) Between parents ( ) b) Between partners ( ) c) Forcefully ( ) d) Others specify ……………………………………………………………….

Section D: Forms and Effects of Domestic Violence on Women

24. What types of violence against women could be reported within this community? a) Domestic violence.. b) Incest…c) Sexual assault…. d) Spouse Battering… e) Others specify……………………………………….

25. How often do you experience these forms of domestic violence?s

RATING

Form of Domestic Violence	Very often(highest degree of	Often(many times of occurrence=four	Rarely(not occurring many	Never(at no time did it

	occurrence= six times in a week)	times in a week)	times= one time in a week)	occurs= zero time in a week)
Spouse battering				
Forceful marriage				
Female Genital Mutilation				
Ill-treatment from in-laws				
Isolation from active participation in all decision making at home				
Verbal assault				
Refuses sexual satisfaction				
Refuses wife's food				
Forbidden to sit in the midst of men				
Forbidden to seek competent health care alone				
Other Forms of domestic violence (Specify)				

26. How often do you witness such complaints?

RATING

Effects of domestic violence	Very Often(	Often	Rarely	Never
Bruises/Injuries				
Swollen body parts/ stress related injuries				
Miscarriages sometimes				
Lost of blood				
Cutting/mutilating the external genitalia				
Painful intercourse				
Painful childbirth				
Sexually Transmitted Diseases				
Non specific pains in the stomach and joints				
Mental Illness				
Other Effects of domestic violence (Specify)				

Section E: Manifestations of Domestic Violence on Women's Health

27. Are you afraid of your husband?

a) Yes ( ) b) No ( )

28. If yes in question (27) could you briefly explain why? ………………

……………………………………………………………………………….

29. What is your relationship like between your children, your husband and yourself?

RATING

Relationship	Passive	Interactive	Very passive	Very interactive
Husband				
Children				

30. How do you feel when being ill-treated by your husband?

RATING

Type of Behavior	Very often	Often	Rarely	Never
Traumatized				
Intimidated				
Isolated				
Others(Specify)				

Section F: Consequences of Domestic violence on Women's Health

31. In your opinion what could be the cause of domestic violence that may result to the poor health condition of most women?

Causes of domestic violence	
Lack of mutual understanding	
Lack of dialogue	
Non challant attitude	
Poverty	
Disobedience	
Infidelity	
Others(Specify)	

Section G: Strategies towards educating perpetrators of Domestic Violence on Women's Health.

32. What is your stand on domestic violence on women's health? ……..
…………………………………………………………………………….
……………………………………………………………………………
33. In your opinion, what could be done to those who violate women?
………………………………………………………………………..
…………………………………………………………………………
………………………………………………………………………

34. Would you accept the establishment of a State Body to monitor evaluate and punish any perpetrator of domestic violence on women?

a) Yes ( ) b) No ( )

35. In your opinion, what can be done to mitigate the prevalence of domestic violence on women's health? …………………....................
…………………………………………………………………………….
……………………………………………………………………………
…………………………………………………………………………..
…………………………………………………………………………
…………………………………………………………………………..

Thank you.

APPENDIX II

IN-DEPTH INTERVIEW GUIDE (IDI)

Section A: Questions on the Awareness of Domestic Violence on Women's Health.

1. In your opinion, would you agree that there are some women within this community facing serious domestic challenges that are detrimental to their well-being as women?
2. Are you aware that some women are faced with varying kinds of violence within this community that is given them a poor state of health?
3. Are the women much free to discuss about some of the challenges they encounter at a) Home…… b) Family…… c) School…… d) Place of work…… within their community?
4. At what age are the women or girls qualified for marriage within this community? a) 0- 15… b) 15-30…. c) 30-45…. d) Others specify….

Section B: Questions on the Health Status of Women within this Community

5. In your opinion, what are the types of illnesses that most women within this community suffer from?
6. What types of Health Care Services are available within this community?
7. Would you agree that, in most time when a woman within this community needs medical attention, the best is being given to her?
8. What do you consider as the best type of health care services in respect to effectiveness and efficiency within this community?

Section C: Questions on the Reasons for the Existence of Domestic Violence on Women's Health.

9. In your opinion, would you say that, domestic violence is a normal family affair?
10. Are you aware of any custom/tradition that encourages domestic violence within this community?
11. Under what situation can a woman suffer violence within this community?

12. In your opinion, what do you think could be the main cause of domestic violence on women's health?

Section D: Questions on the Forms and Effects of Domestic Violence on Women's Health.

12. In your opinion, what are the forms of domestic violence experienced by women within this community?

13. Are women within this community aware of the prevalence of Vesico- Vaginal Fistula (VVF), as a result of marriages at very tender ages?

Section E: Questions on the Manifestations of Domestic Violence on Women's Health.

14. How would you describe the relationship existing between

a) Husband…. b) Wife…. c) Children….. within this community?

15. Would you conclude that, there exist a kind of mutual relationship between the husbands and wives of this community?

Section G: Questions on Measures to curb Domestic Violence on Women's Health.

17. In your opinion, could you suggest some possible and feasible strategies and initiatives that could be put in place to fight and conquer this ill practice called domestic violence?

APPENDIX III

FOCUS GROUP DISCUSSION GUIDE (FGD)

1. To whom do you think women can confide in, with respect to their well-being or domestic issues?
2. Who is responsible for attending to women who might need some kind of counseling, concerning such domestic challenges?
3. Would you agree that most of the women within this community do not know to what extend they need to take measures that will positively improve on their status as women?
4. Would you consider husbands knowledgeable enough, to provide first aid to their wives before medical attention?
5. From your understanding, are women the cause of their domestic challenges which might negatively affect their health status?
6. Who are those responsible for the ill-treatment of women and the girl-child within this community?
7. Have there been any efforts in this community to sensitize the women about their well-being and how to care for themselves?
8. Has government ever organized training programs for the women within this community on their rights?
9. Where do most of the women within this community put to birth?
10. In your opinion, have you been able to identify any particular health problem that is specific with the women within this community?
11. What do you think could be done to the perpetrators of domestic violence against women?
12. Who do you think should be responsible for the effective carrying out of major strategies to curb violence against women?