Statistical modelling of intimate partner violence in Nigeria magnitude, risk factors and costs implications

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Statistical Modelling of Intimate Partner Violence in Nigeria: Magnitude, Risk Factors and Costs Implications

By

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Abstract

Violence against women is a major human rights and public health problem that is pervasive in virtually all societies in the world. A common form of such violence is Intimate Partner Violence (IPV), which occurs in intimate relationships and affects about one in every three women. In addition to being a widespread disorder, IPV also profoundly damages the physical, sexual, reproductive, emotional, mental and social well-being of individuals and families.

In developing countries, especially in Africa where societies are already ravaged by a host of social and health issues, IPV is more likely to impose an additional burden, with research showing prevalence of IPV against women that is as high as 80%. Besides, there is indication of it confining victims, their families and the larger society within which they live to poverty, as it comes with immense financial burden. Despite this fact, developing countries in Africa (such as Nigeria) still lack effective means of protecting women against IPV. This is most likely due to the inadequate exploration of the issue in terms of the complex risk factors, socio-economic costs, attitudes towards gender roles among others.

This study investigates the complex nature of IPV in Nigeria, using a cross-sectional population-based study design to generate new set of results pertaining to the likely risk factors and socio-economic costs among others. It also explores the design of a novel preventive framework to address the IPV issue.

Data for the study were collected using a pretested questionnaire based on the World Health Organisation (WHO) Standards and administered by healthcare professionals (mostly nurses and midwives) to solicit relevant information from women across Kwara state, Nigeria. The critical inclusion criterion was: women aged 18 years and above who were previously or currently involved in a cohabiting or non-cohabiting relationship. A multistage sampling procedure which reflected the rural and urban locations of the respondents was adopted and used to gather 719 complete face-to-face interviews.

The collected data were analysed using descriptive and inferential statistical procedures (e.g., cross-tabulations and simple bivariate- as well as sequential-logistic regression) carried out via IBM SPSS®20. The novel results generated show that IPV, as hypothesized, is a serious issue in the country, with results indicating that 1 out of every 4 women has experienced IPV at least once in her life-time. Results also show that the experience of IPV for most women is not a one-off occurrence, but rather a recurrent one. There is also an indication of widespread acceptance of IPV across Urban and Rural areas. Results from the logistic regression analysis conducted show that factors such as women's and partner's educational attainments, controlling behaviours, partnership discord and choice of spouse among others are likely predictors of IPV occurrence. The results also give an indication of a slightly complex association between the likely risk factors and IPV – one involving interactions and partial mediations amongst these factors in their prediction of IPV. Costs

estimation results show that IPV is a major drain on households finances and also a potential hindrance on the Nigerian economy as a whole.

Drawing greatly on these findings as guides, relevant preventive strategies around the world with proven effectiveness were adopted in the research to propose a three-tier validated preventive framework to tackle the issue of IPV in Nigeria and other similar developing countries. Important recommendations are also made to address this issue.

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Glossary of Abbreviations

Acronym	Meaning
AIDS	Acquired Immune Deficiency Syndrome
AUS$	Australian Dollars
BIDS	Bangladesh Institute of Development Studies
CAN$	Canadian Dollars
CDC	Centre for Disease Control and Prevention
CEDAW	Convention on the Elimination of All forms of Violence Against Women
EPRC	Economic Policy Research Centre
GBV	Gender Based Violence
GDP	Gross Domestic Product
HIC	High Income Countries
HIV	Human Immunodeficiency Virus
ICRW	International Centre for Research on Women
IPV	Intimate Partner Violence
LMIC	Low- and Middle-Income Countries
NCIPC	National Centre of Injury Prevention and Control
PTSD	Post-Traumatic Stress Disorder
SIGI	Social Institution and Gender Index
STI	Sexually Transmitted Infection
UNFPA	United Nations' Population Fund
UNICEF	United Nations Children's Fund
US$	United States Dollars
VAW	Violence Against Women
WHO	World Health Organisation
WILDAF	Women in Law and Development in Africa

Dedication

I would like to dedicate this work to almighty Allah for his beneficence and mercy he has always bestowed upon me.

I would also like to dedicate the work to my late Grandmother – Alhaja Seliah Afolabi. *Maami,* I will forever cherish your love towards me. Your kind words of encouragement spurring me on to persevere and never give up whilst I was toiling to collect my research data in Nigeria have worked, and they will remain forever indelibly etched in my memory and consciousness.

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List of Publications

This research has been documented, in part, within the following publications:

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L. Olayanju, R.N.G. Naguib, Q.T. Nguyen, R.K. Bali and O.O. Kayode (2013) 'Violence Against Women in Nigeria: Prevalence and help-seeking behaviour', *Proc of the European Congress on Violence in Clinical Psychiatry*, 'Advances in epidemiology, nature and cross-cultural aspects.' 23 – 26 October 2013, Ghent, Belgium, pp. 56 – 60.

L. Olayanju, R.N.G. Naguib, Q.T. Nguyen, R.K. Bali and O.O. Kayode (2013) 'Assessment of the risk factors affecting intimate partner violence in Nigeria', *Proc of the European Congress on Violence in Clinical Psychiatry*, 'Advances in epidemiology, nature and cross-cultural aspects.' 23 – 26 October 2013, Ghent, Belgium, pp. 61 – 65.

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L. Olayanju, S.A. Amin, R.N.G. Naguib and Q.T. Nguyen (2014) 'Attitudes, Perceptions and Intimate Partner Violence: A Study of the Nigerian Context', *Proc of the 7th International Conference on Humanoid, Nanotechnology, Information Technology, Communication and Control Environment and Management*, November 2014, Puerto Princesa, The Philippines.

Chapter 1 Introduction

1.1 Overview

Violence comes in different forms and under varying circumstances. One such circumstance within which violence is common and pervasive is in an intimate relationship, and it is therefore befitting to consider what defines violence in these relationships – Intimate Partner Violence (IPV) – in order to help guide further exploration of the occurrence, magnitude, cost, and other facets of the malice. According to a widely used definition, by Heise and Garcia-Moreno (2002), IPV is '*any behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of Physical aggression, Sexual coercion, Psychological abuse and Controlling behaviours'*. This form of violence and behaviour may affect everyone – that is to say, it may be perpetrated by men against women, women against men or in a same-sex relationship context – but there is a strong gender pattern with overwhelming burden of IPV borne by women and the major perpetrators being men (WHO, 2010). In other words, as compared with IPV perpetrated by women, men-to-women partner violence is a more frequent event that has greater likelihood of resulting into injuries and other adverse consequences (Rennison and Welchans, 2000).

Intimate partner violence is a serious and widespread problem worldwide. Apart from being violation of human rights, it profoundly damages the physical, sexual, reproductive, emotional, mental and social well-being of individuals and families. The immediate and long-term health outcomes that have been linked to these types of violence include physical injury, unwanted pregnancy, abortion, adverse gynaecological outcomes, sexually transmitted infections (including HIV/AIDS), posttraumatic stress disorder (PTSD) and depression, among others. There are also a number of pregnancy-related complications such as miscarriage, premature labour and low birth weight associated with violence during pregnancy. In addition, high-risk behaviours such as smoking, harmful use of alcohol and drugs and unsafe sex are significantly more frequent among victims of intimate partner violence (WHO, 2010). Besides, this form of violence comes with great financial burden on the victims, their families and the larger society within which they live. These financial burdens that underscore the significant consequences of inaction are in the form of direct and indirect cost on households that can include expenditures on goods and fees for services (e.g.

medical or judicial), lost earnings and low productivity resulting from IPV; as well as cost at the community level that includes human resources expended on IPV cases and also cost regarding supplies and infrastructure involved in service provision (such as medical, social service, police or criminal justice services) (Duvvury et al., 2012; ICRW, 2009).

As stated earlier, the overwhelming burden of IPV is borne by women at the hands of men, with nearly one in every three women having experienced violence at the hands of their husbands or intimate partners (WHO, 2010; Krug et al., 2002; Ellsberg et al., 1999). Globally, the lifetime prevalence rates of IPV among ever partnered women range from 15 – 71% (Garcia-Moreno et al., 2005). According to the CDC's National Centre of Injury Prevention and Control (NCIPC), approximately 5.4 million episodes of IPV occur in the United States annually among women over the age of 18 (CDC, 2007). Moreover, in a research carried out by Fox and Zawitz (2007), using data collected by the FBI, it was noted that in 2005 alone about 1,500 people were murdered by an intimate partner. Based on the statistics above, the magnitude of IPV seems very high but the actual occurrence of the violence is even likely to be higher as some cases of IPV may go unreported.

Nonetheless, more research studies, mostly in developed countries, are emerging in this realm of violence shedding further light on the magnitude and nature of the violence, likely risk factors, its links to adverse health outcomes, its economic cost, as well as its intergenerational effects. Despite these remarkable contributions from the developed world, there has been barely little progress in terms of exploring the issues of IPV in developing countries, especially in Africa. More research is needed in these countries to provide information showing the extent of the issue and supporting programmes for the reduction and prevention of the malice. The need for more research in the developing world is absolutely imperative considering the fact that the governments of most of these countries, though signatories to international conventions protecting the rights of women, are yet to have specific legislation addressing IPV issues. In addition, most of the developing countries still have socio-cultural norms that favour gender inequality and discrimination against women, and therefore there is a need for elaborate research into these issues to generate information that can be used to support advocacy for cultural change. Such research results can also be used by service providers as empirical evidence to advocate for necessary resources to meet likely demand

for services as a result of IPV. As expressed by Duvvury et al. (2012), proper baseline information – especially that pertaining to costs across institutions providing services to address IPV – is essential to assess whether current funds/budget allocations are sufficient and also to forecast the resources that may be needed as demand for services increases as a result of effective awareness campaigns.

1.2 Intimate partner Violence in Africa

The African continent has witnessed fewer research studies in the area of IPV in comparison with the rest of the world, especially in developed countries. Nonetheless, research carried out in African countries shows IPV to be pervasive. Findings from a combination of studies – mainly population-based – show that current prevalence of IPV against women varies from 12% in Morocco (Hassan II University, 2009) to about 54% in Ethiopia (Garcia-Moreno et al., 2005). While the results also show that lifetime prevalence of violence from an intimate partner ranges from 31% in Nigeria (NPC and ICF Macro, 2008) to as high as 80% in Uganda (EPRC, 2009).

According to Lawoko (2008) the African continent harbours some peculiar risk factors for IPV that are culture-induced. As an illustration, wife-beating is widely justified by both men and women as a normal part of an intimate relationship, with women even more likely to justify such grievous acts (Uthman et al., 2010). Besides, patriarchal relations are the order of the day in most African countries and these expose a lot of women to partner violence as well as diseases (such as HIV) that could result from the abusive behaviour (Olayanju et al. 2013; WHO, 2010).

Widespread poverty in the African continent can also be presumed to have great influence on the occurrence of IPV. As pointed out by Jewkes (2002), IPV should not just be viewed as an expression of male dominance over women but also as male vulnerability stemming from social expectations of manhood that are unattainable due to factors such as poverty experienced by men.

Nonetheless, as shown by Olayanju et al. (2013), there is a dearth of specific programmes targeted at addressing IPV issues in many countries in Africa, and this is a major factor stifling the fight against violence in the continent.

1.3 The Nigerian context and Intimate Partner Violence in the country

Nigeria is a multi-ethnic nation with over 250 different ethnic groups, although 3 dominant groups account for nearly 60% of the country's total population of over 150 million people. The dominant ethnic groups are the Yorubas, who are predominantly in the southwest, the Igbos in the southeast and the Hausas in the north. Nigeria is a federation, which runs three tiers of government: the federal, state, and local. As the country is a federal republic, each state has the authority to draft its own legislation. Moreover, the Nigerian Legal System is made up of the Common Law and Statutory Law (Civil Law), Customary Law and Islamic Law.

Regarding discrimination against women, the Nigerian Constitution prohibits discrimination on the grounds of gender, but customary and religious laws continue to restrict women's rights, as the combination of federation and a tripartite system of civil, customary and religious laws makes it very difficult to harmonise legislation and remove discriminatory measures (SIGI, 2010). Besides, in Nigeria, as in some other African countries and developing countries elsewhere, traditional customs, deep-rooted cultural mores and religious beliefs tend to compete with, and in many cases overshadow, the civil laws with regard to some issues – particularly issues relating to women's rights and role of women in the society. Such issues result in the discrimination and violence against women in the country, with the highest incidence of such violence occurring in the home and the bosom of the closely knitted family (Bamgbose, 2002). Furthermore, in Nigeria and some other developing countries, even though domestic violence is widespread, societal norms discourage women from speaking out and disclosing being victims of such abusive behaviour (Uffah et al., 1995). The abused women are often afraid of reprisals from the perpetrator, his family, and the community. To make matters worse, women are often dependent on the abuser for economic support and cultural identity (Eme and Olaolorun, 2006).

In Nigeria, women and girls are subjected to multiple forms of violence in the homes or relationships, but the most common form of such violence is abuse at the hands of a partner (intimate partner violence) ranging from slapping, kicking, verbal abuse, denial of financial resources, rape and even death (Project Alert, 2005). Although there is limited baseline data in Nigeria that can be used to calculate representative prevalence rates for the different forms of Gender Based Violence (GBV), a study conducted in the country found that 45% of females aged 12–21 years reported having had forced sexual intercourse (Slap, 2003), while another research shows that 31% of women 15-49 years of age have ever experienced physical, sexual and/or emotional violence at the hands of their partners (NPC Nigeria and ICF Macro, 2008). Moreover, as highlighted by the executive director of UNFPA, 'many girls in Nigeria fall prey to sexual violence and coercion; with many others married off very young, long before they are psychologically and physically ready'. For such girls, negotiating with their partners for the use of condoms during sexual intimacy is not an option, which presumably accounts for the reason why 58% of Nigerians with HIV are female (Osotimehin, 2005). This only leaves one wondering why or how such a magnitude of social violence can exist in a democratic and egalitarian society like Nigerian's. Having said this, one can just imagine the number of children who will be affected, as IPV not only affects the women abused but may also damage the health and well-being of children in the family – in the case of women with children. This children mal-development is in part due to increased rates of depression and traumatic stress in the abused mothers, and the destructive effects of IPV on the quality of their attachment and parenting capacities (WHO, 2010). Probably this could be part of the major reasons why the rate of vaccine preventable morbidity and mortality is high in the country (Odunsanya et al., 2008; UNICEF, 2007), with research confirming that the children of abused mothers tend to have lower rates of immunisation and higher rates of diseases like diarrhoeal, and are more likely to die before the tender age of five years (Sabarwal et al., 2012; Silverman et al., 2009; Asling-Monemi et al., 2008).

1.4 Statement of the problem

As research on IPV shows that it is a violation of human right (Frye et al., 2008) and affects reproductive health (Bonomi et al., 2007; Shane and Ellsberg, 2002), maternal mortality (ICRW, 2009), level of child health and educational attainment (WHO, 2010), as well as increasing the risk of contracting sexually transmitted infections such as HIV (Cohen et al.,

2000), one could assume that IPV occurrence in Nigeria is not just an individual issue but one that poses a great threat to the society at large by preventing the achievement of general economic good – such as the achievement of the Millennium Development Goals (MDGs) that aim to promote gender equality and empower women, achieve universal basic education, reduce child mortality, improve maternal health, combat HIV/AIDS and other diseases and eradicate extreme poverty and hunger.

According to WILDAF (Women in Law and Development in Africa) (2002) Domestic violence/IPV is pervasive in Nigeria and it is so tolerated by the Nigerian society that it cuts across every social strata, it is irrelevant whether the parties are poor or rich, educated or illiterate, urban or rural dwellers, Christians or Muslims or traditional religionist or from a particular ethnic background. The societal tolerance makes men get away justifying this violation of women's rights with sometimes very flimsy excuses. Such excuses range from 'disrespect to husband or husband's family members', to 'lateness in preparing food', 'refusal to have sex even where the woman is ill', 'refusal to bear more children' and 'failure to take preventive measures for birth control' (Uffah et al., 1995).

Nonetheless, in recent years, the international community has increased efforts to protect women's right by the enactment of international laws and policies, which include the United Nation's Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) (UN, 2009). In addition, it is widely acknowledged that legislation and policies that address wider socioeconomic inequalities can make a vital contribution to empowering women and improving their status in society and that a first step towards this is the readiness of governments to honour their commitments in implementing international legislation and human right instruments (WHO, 2010; UN, 2011). Despite these ongoing efforts to protect women and vulnerable populations against violence, there is still much to be done in Nigeria in terms of policies/legislation and strategies to prevent such violence from occurring, protect victims of the violence and to further inform and educate the population about the issues of IPV. Although Nigeria is a signatory to the United Nation's CEDAW, it is yet to be adopted into Nigeria's legal code and this shows the level of work that is still needed to be undertaken to ensure gender equality and protection of women against all forms of violence in the country. As with CEDAW, in order for any international convention to be part of Nigeria's

legal code, the National Assembly and State Houses of Assembly are required to pass legislation and put the convention into effect within the national laws. After the law is passed at the federal level, for it to become a nationally binding legislation across the country, it must be passed by at least two-thirds of the 36 State Houses of Assembly (NPC Nigeria and ICF Macro, 2008). Considering this bureaucratic bottleneck, it is apparent that there is an urgent need for research on violence (especially on IPV) against women and other vulnerable groups nationally and at the state level, to provide evidence that can be used in advocating for comprehensive and rapid legislation on IPV and other forms of violence.

Moreover, currently around the world, evidence on the effectiveness of primary prevention strategies for IPV is limited, with the overwhelming majority of data derived from High Income Countries (HIC) – primarily the United States, Canada and the United Kingdom (WHO, 2010). Therefore, present high priorities in the area of IPV prevention in the developing world – of which Nigeria is no exception – emanate from the direct adoption of effective programmes from HIC. Although the proposition of adopting effective programmes directly from HIC to Low and Middle Income Countries (LMIC) seems great, new research findings underscore the complexities of IPV issues and how application of knowledge gained from one site to another without understanding the broader cultural context could be fraught with great peril (Koenig et al., 2003a; Ellsberg and Heise, 2005). With this fact, it becomes important to explore the local risk factors as well as deterrents of IPV in the developing world (where applicable, using the findings from developed countries as a guide) in order to come up with a new set of highly effective preventive measures more suitable for the immediate environment. Besides, as stated by the WHO (2010: 34), '*most of the evaluated strategies aimed at preventing intimate partner and sexual violence have targeted proximal risk factors – primarily at the individual and relationship levels*'. Therefore, it is imperative for more research to be carried out in developing countries (including Nigeria) to identify feasible primary prevention strategies or deterrents for IPV, especially those at the community or larger societal levels.

1.5 Rationale for the study

Despite close to 40 years of ground breaking research in the field of violence against women (VAW)/ GBV that has greatly expanded our awareness of the dimensions and dynamics of

violence, many developing countries still lag behind their developed counterparts in this realm of research. Although evidence exists on some aspects of IPV in Nigeria such as its prevalence, some determinants, and adverse health outcomes, most of this research is in the form of service-based studies – in other words, studies that rely mainly on data from hospital records or interviews with women attending or making use of a particular service to draw conclusions about the patterns of IPV in the larger Nigerian population (John et al., 2011; Mapayi et al., 2011; Okenwa et al., 2009a; Okenwa et al., 2009b; Fawole et al., 2005; Ezechi et al., 2004; Slap et al., 2003). One could assume that this category of research would invariably misestimate parameters such as the prevalence of IPV. This assumption is most likely to be true as research has found that the use of such services by IPV victims in developing countries is quite low (BIDS, 2009; EPRC, 2009), thereby making people attending such services atypical of the larger population. Nonetheless, there are a few more representative population-based studies on IPV in the country – such as the Nigeria Demographic and Health Survey 2008 that includes a module on partner violence against women (NPC Nigeria and ICF Macro, 2008). But again, as stated by the WHO (2010) as well as by Ellsberg and Heise (2005), the issue with these studies is that integrating such modules on IPV into very broad health surveys may result into misestimation of the actual IPV problem, which could ultimately prevent IPV intervention programmes from receiving the priority they deserve in terms of resources. Therefore more focused population-based studies on IPV amongst women in Nigeria would be more useful in the fight against violence. Even though a handful of such 'focused population-based studies' exist (Odujinrin, 1993), for the most part, they view IPV as a unitary construct rather than a phenomenon that can take different forms – including physical, sexual and psychological violence. These studies, despite being focused, would only provide representative information for tackling a particular form of IPV but not the phenomenon as a whole. Based on the foregoing, an important question to ask is, what is the actual magnitude and nature of IPV in Nigeria?

Therefore, this population-based research is partly aimed at opening up the issue of IPV in Nigeria by taking a holistic view of the violence (i.e., considering the physical, sexual and psychological forms and ramifications of the violence), so as to help bridge the gap in the current state of knowledge between the developing and developed worlds.

In addition to the above identified gaps in research on the magnitude of IPV in Nigeria, there is also one in the area of economic costs of IPV in the country, as there has not been any comprehensive study on the direct, as well as indirect, cost of IPV in Nigeria. Thus, it is obvious that a lacuna of knowledge still exists in this area of IPV against women in the country, and research needs to be carried out to fill this chasm in knowledge in order to help answer key questions pertaining to the impact of such costs: (1) what direct financial impact does it have on Nigerian households, (2) what indirect economic impact does it impose on the households? and (3) what is the macro-estimate of these impacts to the Nigerian economy?

At the moment there are no clearly designed strategy in place to address IPV issue in Nigeria, and this weakness in solving IPV problem is not just limited to the Nigerian society it is one that is synonymous with societies across Africa (Olayanju et al., 2013; WHO, 2010; EPRC, 2009). Most of these societies mainly adapt prevention programmes from developed countries (High-Income countries) and apply it directly to their own context (Developing/Low-Income settings), ignoring the fact that a programme being effective in developed countries does not necessarily imply that it will be the same in the developing world. In fact, research has shown inconsistency in the way certain risk factors influence IPV occurrence in different societies (i.e., some factors have been known to predispose women to IPV in a particular context, while they serve as protective factors in other contexts) (Lawoko, 2008; Jewkes, 2002). Thus, it becomes imperative to embark on more rigorous exploration of data using highly robust multivariable analytical procedures that allow for the exploration of phenomena such as moderation and mediation effects between variables that could give rise to inconsistency in results. This will facilitate the development of new evidence-based prevention framework built on careful consideration of context specific factors, whilst at the same time affording the chance to successfully adopt programmes from one society to the other.

Towards these voids in knowledge, this research aims to shed some light on the IPV problem in Nigeria by considering the magnitude and likely risk factors of IPV using a focused population-based study. Besides, the research also considers the estimation of cost of IPV on households (individuals) and community at large. These estimates of financial burden are important for apportioning resources to aid service provision for abused women. More

importantly, such estimates could be used to support the design and operations of different prevention programmes, and to facilitate costs-benefit analysis of programmes designed to reduce the impacts of IPV, as well as for highlighting the nature of violence.

Furthermore, this research draws together the different pockets of information mentioned earlier and proposes a novel preventive framework that would help prevent and reduce IPV occurrence and at the same time provide a reasonable strategy to ameliorate the impacts of violence on women and children. Besides, this framework would outline ways in which data/records pertaining to IPV experiences could be more efficiently collected and managed in order to facilitate the execution of future research work and the enhancement of whatever structure is put in place to address IPV issues.

1.6 Aim and Objectives

The aim of the research is to explore the issues of IPV against women in Nigeria and to generate novel results that would facilitate the design of policies and programmes to address violence in the country. Figure 1.1 shows the scope of the research.

To achieve the above aim, the following are the objectives of the research:

- Review related research in IPV in developing countries;
- Estimate the prevalence and distribution of IPV amongst women;
- Identify likely risk factors of IPV and generate predictive models for its occurrence;
- Investigate the help seeking behaviour of IPV victims and attitudes towards gender roles;
- Estimate the costs of IPV to households, and calculate macro-estimates of IPV costs to the Nigerian economy;
- Design and evaluate a novel framework for tackling the problem and make recommendations based on the findings of the study.

1.7 Research Hypotheses

- The prevalence of IPV against women in Nigeria is high, and also varies considerably with the demographic and social characteristics of the women.
- Most of the abused women seek help from informal sources (especially family members), as opposed to help from formal services (e.g., health, police and judicial services).
- Women are supportive of male dominance in relationships.
- Exposure to IPV amongst women is significantly associated with certain individual characteristics (e.g., age, educational attainment, among others), relationship characteristics (e.g., partnership discord, educational disparity, among others), and community characteristics (e.g., proportion of women with higher education, level of alcohol usage and illicit drug use in the community).
    - The earlier mentioned individual, relationship and community characteristics are predictive of violence if put in some form of predictive model (e.g., logistic regression model).
    - Some interactions among these predictors are also crucial to the robustness of the predictive model.
- The socio-economic cost of IPV in Nigeria is immense.
    - Women incur a high cost in the event of IPV victimisation, and the costs have grave impacts on them and their children.
    - The costs of IPV to the Nigerian economy are immense and large enough to be a hindrance to the economic prosperity of the nation.

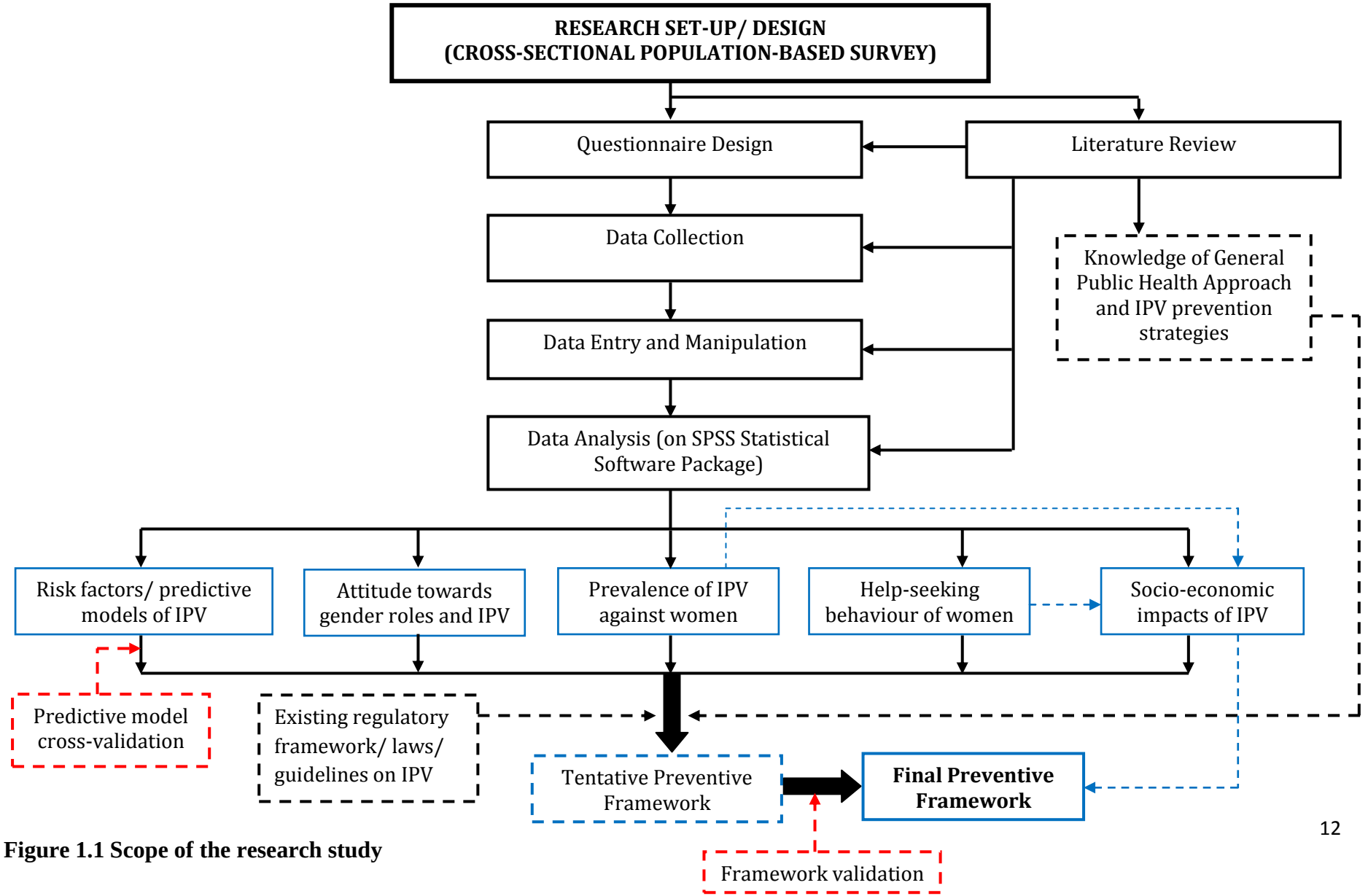

Figure 1.1 Scope of the research study

1.8 Summary of Research Significant Contributions

This research considers the issue of IPV in Nigeria from a more holistic population point of view and provides new set of important information pertaining to different ramifications of IPV (i.e., prevalence, risk factors, attitudes towards gender role and IPV, as well as help-seeking behaviour of abused women). These pieces of information are significant considering the fact that most of the pockets of evidence available at the moment are less representative as they are derived using mostly service-based studies, while this research employs a cross-sectional population-based design to capture more representative data analysed using a highly robust analytical procedure (e.g., multivariable sequential logistic regression used in modelling the risk factors of IPV and the likely moderation effects existing between risk factors).

As far as it could be ascertained, this research is the first to provide reliable estimates of the socio-economic costs of IPV in Nigeria. These estimates are absolutely of significant importance in terms of highlighting the resources required for effective public response to IPV, and also in assessing the cost effectiveness of any programme embarked on by the government. Additionally, the estimates also help provide useful evidence in educating the public on the seriousness of the issue and in advocating for change in attitude towards violence.

Most importantly, this research also developed a novel validated framework to prevent IPV in Nigeria, one that will also be useful in addressing the issues of IPV in other African countries, as they have socio-cultural attributes similar to that of Nigeria. This framework is of significant contribution as it is built on rigorous data analyses as well as proven effective prevention programmes. Unlike other approaches aimed at tackling IPV issues in Africa that involve the adaption of programmes from the developed world without thorough consideration of the variability in the likely risk factors of IPV amongst different societies, this framework is developed from careful and robust exploration of factors pertinent to the immediate Nigerian socio-cultural context. It also gives thorough consideration to the widely accepted theoretical model of IPV occurrence (the ecological model), by considering factors at the different levels of the ecological construct (i.e., individual-, relationship-, community- and societal-level), thus, affording the chance for easy replication or adoption of the

framework in other similar African countries. Another important aspect of this framework is that it recognises the fact that primary prevention of IPV in Nigeria (i.e., preventing IPV from occurring in the first place) is highly desirable in addition to policies focused solely on treating or providing support to already abused women, as this will help relief the already stretched healthcare systems in the country. Moreover, the framework creates a link for collaborative working amongst different relevant stakeholders in addressing IPV in Nigeria, and also proposes the usage of Information Technology in facilitating the activities of these stakeholders.

1.9 Structure of the Thesis

This thesis is structured into seven chapters, each focusing on different aspects of the research study. The following is a summary of the contents of each chapter.

Chapter 1: this introductory chapter begins by giving an overview of the issues of Intimate Partner Violence (IPV) and how these problems impact on the health and socio-economic wellbeing of people around the world. This is followed by a more specific exploration of the issues in Africa and Nigeria in particular. The rationale for the study is then provided and the research aim and objectives are also presented. These objectives include: the review of related research on IPV in the developing countries, estimation of the prevalence and distribution of IPV amongst women, identification of likely risk factors of IPV and generation of predictive models for its occurrence, investigation of the help-seeking behaviour of IPV victims and attitudes towards gender roles, estimation of the costs of IPV to households and to the Nigerian economy at large. Exploration of results emerging from the earlier mentioned objectives to design a validated preventive framework targeted at addressing IPV issue.

Chapter 2: provides a comprehensive review of pertinent literature in this field of research. It provides information on the typology of violence and also a concise definition of IPV widely adopted in research around the world. It then provides a review of relevant literature on IPV in developing countries. It explores the risk and protective factors of IPV, stating the different theories available in understanding the IPV issue. It also explores up-to-date literature on the

monetary as well as non-monetary impacts of IPV and the prevention efforts designed to address the problem.

Chapter 3: describes the methodology used in the execution of the research. It begins by discussing the research design that entails the use of a cross-sectional population-based survey aimed at exploring IPV issues in Nigeria. The chapter then proceeds to a summary on the study area and study sample. The chapter also discusses the sampling strategy used in the study, one that involves a multi-stage probability sampling procedure. It then discusses the survey instrument (questionnaire) and the data collection process. It gives an overview of key definitions that are germane to the study. Finally, the chapter provides detailed information on the data analysis procedures adopted in the research to explore the data collected.

Chapter 4: presents the results derived from the different data analyses carried out, which include: descriptive statistical analyses (i.e., counts, percentages and cross-tabulations), unit cost analysis and inferential statistical analyses (i.e., bivariate logistic regression and sequential logistic regression). Amongst the results presented include: the prevalence of IPV, predictors (likely risk factors) of IPV in Nigeria, help-seeking behaviour of abused women, attitudes towards gender roles and IPV, and socio-economic costs of IPV.

Chapter 5: describes the preventive framework proposed to address the issues of IPV in Nigeria. It presents the different components of the framework that were derived by drawing upon the results of this research study and also on available information pertaining to the effectiveness of existing preventive interventions/activities. The chapter also gives a schematic representation depicting how the components fit together. In addition, it provides information pertaining to the framework validation.

Chapter 6: this chapter discusses the meaning and implications of the results. It first provides an overview of the research findings and then continues with detailed explanation of the research results. This discussion on results meaning and implications involved juxtaposition and comparison of results from this study with those provided elsewhere. Discussion of the results also involved using existing theoretical understanding to discern emerging patterns in

the results, as well as drawing on anecdotal information where more robust forms of evidence are not available.

Chapter 7: this concluding chapter summarises the accomplishments of the research by providing an overview of its novel contributions to knowledge. It also provides information regarding the research constraints and limitations and highlights future research work.

Chapter 2 Review of relevant literature

2.1 Overview

Most of the literature on IPV, especially that pertaining to the risk and protective factors of violence, comes from high-income countries (HIC). But as stated by the WHO (2010), it is still not very clear whether factors identified in the HIC also apply to low- and middle-income countries (LMIC) due to differences in economies, ecologies, histories, politics and cultures. Therefore, it is important to have more research performed in this area in the LMIC. Nonetheless, a little body of knowledge exists on the risk factors, magnitude and adverse outcomes of IPV in LMIC.

This section of the thesis considers the available information on IPV, focusing on the typology of violence generally, the definition, nature and types of IPV specifically, as well as the epidemiology of IPV – covering information available on risk factors, health consequences and cost implications from both HIC and LMIC.

2.2 Typology of Violence

Although the research is focused on IPV, it is beneficial to characterise the different forms of violence, as this will facilitate clarity in the nature, scope and, more specifically, the definition of IPV.

Over the years, researchers have used many criteria to define violence. Some classify violence according to the type of act (i.e., physical, sexual, emotional or psychological), while other typologies focus on defining violence based on the nature of relationship between the victims and the perpetrators. Nonetheless, one typology that is comprehensive enough to perfectly characterise the different types of violence as well as the links between them is the one designed by the WHO (Krug et al., 2002). It divides violence into three broad categories based mainly on the characteristics of those committing the violent act. This division includes: self-inflicted, interpersonal, and collective violence. The categorisation helps differentiate the violence inflicted on oneself from that inflicted by another individual, or by a small group of individuals, as well as that inflicted by larger groups such as the states,

organised establishments, or terrorist organisations (Krug et al., 2002). Moreover, this typology reflects the WHO's conceptualisation of violence, which defines violence as *'the intentional use of physical force or power, threatened or actual, **against oneself**, **another person**, or **against a group or community**, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation'* (WHO, 1996).

As shown in Figure 2.1, each of the broad categories of violence is subdivided to show more specific types of violence. The first category – self-directed violence – as the name implies is one directed against oneself. This is sub-divided into suicidal behaviour (including suicidal thoughts, attempted suicides and complete suicides); and self-abuse (including self-maltreatment and self-mutilation).

The second category – interpersonal violence – is one directed against another person. This is sub-divided into two divisions: (1) family and intimate partner violence (including violence mainly between family members – e.g., child abuse and abuse of the elderly – and intimate partners – i.e., intimate partner violence); (2) community violence (including that occurring between individuals who are unrelated/ mere aquaintances, and strangers).

The third category – collective violence – is one that is committed by groups of individuals or establishments/states and directed towards groups of people or an individual. This type of violence is sub-divided, based on the likely motives for committing the violence, into social, political and economic fractions. As examples, social violence may be terrorist acts and crimes of hate perpetrated by organised groups to push for a particular social agenda, whilst political violence may include war and similar conflicts. Economic violence may include attacks perpetrated by larger groups for the sole purpose of economic gains (Dahlberg and Krug, 2002).

Furthermore, in terms of the nature of violence, as shown in Figure 2.1, all the sub-divisions of both the interpersonal violence and collective violence have physical, sexual, psychological and deprivational dimensions to them, whilst the two sub-divisions of self-directed violence lack the sexual facets.

Figure 2.1 Typology of Violence (Source: Krug et al., 2002)

2.3 Definition of IPV

As stated by Krug et al. (2002), any comprehensive analysis of violence should start by firstly defining the forms of violence in such a way that their scientific measurement is facilitated. With this in mind, and having explored the various types of violence, this section of the thesis specifically considers the definition of IPV.

Part of the reasons why the scope of IPV has been difficult to measure in both LMIC and HIC is as a result of lack of consensus about the definition of the violence. Over the years, researchers have not been able to agree on a particular definition of IPV. Some studies consider IPV as only including the behaviours that result into physical violence, ignoring acts that can result into psychological abuse – such as humiliation, verbal abuse and imprisonment (NCIPC, 2003); while others focus on married individuals without considering cohabiting and dating partners (Ayinmode and Tunde-Ayinmode, 2008). These variations in definition have grave implications on the estimation of number of women affected by IPV – as an example, a researcher that narrowly considers IPV as behaviours that result into physical violence is more likely to come up with a lower estimate of victims than one who broadly defines IPV.

Based on the above mentioned lack of universally agreed-upon conceptualisation of IPV against women and because it is a form Violence Against Women (VAW) or Gender-Based Violence (GBV), this thesis considers the myriad terminologies associated with VAW and GBV, so as to distinguish IPV from other forms of violence and to afford a clearer understanding of the concept of IPV.

Considering violence generally, both men and women can be victims as well as perpetrators of violence, but, based on available literature, men are more likely to be the perpetrators of violence (regardless of the gender of the victim); while, in contrast, women are more likely to be abused by someone they know (especially, a family member or intimate partner) (Ellsberg and Heise, 2005; Rennison and Welchans, 2000). With particular focus on VAW, women are exposed to different types of violence at different stages of their lives as outlined in Figure 2.2.

Figure 2.2 Life Cycle of Violence Against Women (Source: Ellsberg and Heise, 2005)

Having shown the wide scope of violence women could be exposed to, the term 'violence against women', according the United Nations (1993), could be described as any behaviour or act of gender-based violence that can either result, or is likely to result, in physical, sexual, or psychological harm, deprivation or mal-development of women, including the threat or actualisation of such acts, whether occurring in public or private life.

Despite this reasonable conceptualisation of VAW, it is important to state that there is still no universally agreed-upon terminology for referring to VAW (Ellsberg and Heise, 2005). This inconsistency has given rise to different terms in describing VAW, mostly based on diverse theoretical perspectives as well as disciplines, and having different meanings in different regions around the world.

As pointed out by Ellsberg and Heise (2005), a frequently used model for capturing VAW is the family violence (FV) framework that emanated mainly from the fields of sociology and psychology. FV refers to any form of abuse within the family regardless of the age and gender of the victim or the perpetrator (Gelles, 1997). Although this concept captures some of the ramifications of VAW, it does not encompass many of forms of violence women are exposed to outside the home. Besides, it has also been greatly argued, especially by feminist researchers, that the concept assumes gender neutrality and fails to highlight that violence within the family is mostly perpetrated by men against women and children (Ellsberg and Heise, 2005).

Despite the general lack of a major concept for describing VAW, there has been increased momentum for international consensus on the description of the violence. One such effort is the 1993 United Nations General Assembly Declaration on the Elimination of all forms of Violence Against Women, which officially defined the abuse of women and girls, regardless of the place of occurrence of the violent act, as Gender-Based Violence (GBV) (United Nations, 1993). Even with this official conceptualisation of abuse of women and girls – GBV – terms used in describing this type of violence are yet to be consistent. In some, perhaps many, parts of the world terms such as Domestic Violence (DV) are used to imply abuse of women by current or previous male intimate partners, while in other regions, such as Latin America, DV connotes violence that takes place in the home – including child abuse and that of the elderly (Ellsberg and Heise, 2005).

Other terms that are used interchangeably to describe GBV include: Spousal Abuse, Wife Abuse, Wife Assault, Sexualised Violence, and Intimate Partner Violence (IPV). Just as with other concepts such as DV, these concepts also have weaknesses, as they are not completely robust in their description of GBV. For example, IPV and Spousal Abuse do not show explicitly that the victims are generally, or more often, women; while Wife Abuse and Wife Assault implicitly exclude abusive behaviour in common law unions as well as dating relationships.

Based on the foregoing, it is apparent that there are different terms used to describe VAW/ GBV, and these terms have different meanings in different settings or regions around the world. However, for the purpose of this thesis, IPV, as opposed to other terms, is used to refer to the range of abusive acts used against women by their current or former male partners.

Having considered the differences and similarities between the various terms used in describing VAW, the next paragraph provides more detailed information about IPV.

Just as there has been a lack of agreement in the description of VAW or GBV, there has also been some lack of consensus regarding the definition of IPV as well. Nonetheless, greater overlap now exists in the conceptualisation of the phenomenon, with three major terms – 'physical', 'sexual' and 'psychological' – at the heart of the different overlapping definitions. The WHO defines IPV as *'behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours'* (WHO, 2010). On the other hand, the CDC defines IPV as abuse that occurs between two people in a close relationship, with such abuse including physical, sexual, threats, and emotional abuse. The CDC also considers IPV as *'occurring along a continuum from single episode of violence to ongoing battering'* between current and formal spouses and dating partners (CDC, 2007).

2.4 Component Types of IPV

Based on the above stated definitions of IPV and the common terms at the core of the different definitions, it can be deduced that there are three major types or categorisations of IPV – physical assault, sexual abuse and psychological harm.

2.4.1 Physical violence

The physical form of IPV encompasses any behaviour that inflicts physical harm, threatening or intending to cause injury. Such violence may include: throwing dangerous objects at the victim; pushing, grabbing, or shoving; pulling hair; slapping, punching, kicking, or biting; choking or trying to drown; hitting with an object; beating up the victim; threatening with a

gun, knife or other harmful weapon; and shooting or stabbing the victim (NCIPC, 2003; Saltzman et al., 2002).

2.4.2 Sexual violence

There are three categories of sexual form of IPV: (1) use of force, without the victim's consent, to engage in a sexual act (whether the act is attempted or completed); (2) attempted or completed sex act involving a victim who is unable to understand the nature or condition of the act, refuse to participate, or to communicate unwillingness to engage in the sexual act – due to illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure; and (3) abusive sexual contact (Saltzman et al., 2002).

2.4.3 Psychological violence

The psychological form of IPV often developmentally precedes the physical form and it involves trauma to victims as a result of cruel acts, threat of acts or coercive tactics. This form of IPV may include: humiliating the victim, controlling what the victim can or cannot do, isolating the victim from friends and/or family, denying the victim access to money or other basic resources, acting in a way that could result in hurt feelings and lower self-esteem, as well as stalking (Saltzman et al., 2002; Schumacher et al., 2001).

2.5 Epidemiology of IPV

2.5.1 Review of Relevant Evidence on IPV in Developing Countries

Evidence suggests that IPV is pervasive worldwide (WHO, 2010; Garcia-Moreno et al., 2005; Heise et al., 1999). Despite IPV being a global issue, studies pertinent to the developing countries indicate that these regions face the heaviest scourge of the malice, with research showing that more than 90% of violence-related deaths occur in such countries (Matzopoulos et al., 2008; Dahlberg and Krug, 2002). Moreover, available studies also show that the magnitude of this pervasive malice varies from one region to the other in the developing world. Research shows that the current prevalence of IPV against women on the African continent varies from 12% in Morocco to about 54% in Ethiopia, while the life-time violence experience ranges from 31% in Nigeria to as high as 80% in Uganda (EPRC, 2009;

Hassan II University, 2009; NPC and ICF Macro, 2008; Garcia-Moreno et al., 2005). On the Asian continent, life-time prevalence of IPV ranges from approximately 10% in the Philippines to 62% in Bangladesh province. In the Americas, the life-time prevalence varies from 17% in the Dominican Republic to as high as 69% in Peru (Devries et al., 2010; Garcia-Moreno et al., 2006). These variations in the level of IPV occurrence might be as a result of differences in the socio-cultural fabric of the different countries, and may also allude to the possibility of IPV prevention.

Furthermore, according to Lawoko (2008) the developing countries in the African continent harbour some peculiar risk factors for IPV that are culture-induced. As an illustration, wife-beating is widely justified by both men and women as a normal part of an intimate relationship, with women even more likely to justify such grievous acts (Uthman et al., 2010). Besides, patriarchal relations are the order of the day in most African countries and these expose a lot of women to partner violence as well as diseases (such as HIV) that could result from the abusive behaviour (Olayanju et al. 2013; WHO, 2010). For example, regarding discrimination against women, the Nigerian Constitution prohibits discrimination on the grounds of gender, but customary and religious laws continue to restrict women's rights, as the combination of federation and a tripartite system of civil, customary and religious laws makes it very difficult to harmonise legislation and remove discriminatory measures (SIGI, 2010). Besides, in Nigeria, as in some other African countries and developing countries elsewhere, traditional customs, deep-rooted cultural mores and religious beliefs tend to compete with, and in many cases overshadow, the civil laws with regard to some issues – particularly issues relating to women's rights and role of women in the society. Such issues result in the discrimination and violence against women in the country, with the highest incidence of such violence occurring in the home and the bosom of the closely knitted family (Bamgbose, 2002). Furthermore, in Nigeria and some other developing countries, even though domestic violence is widespread, societal norms discourage women from speaking out and disclosing being victims of such abusive behaviour (Uffah et al., 1995). The abused women are often afraid of reprisals from the perpetrator, his family, and the community. To make matters worse, women are often dependent on the abuser for economic support and cultural identity (Eme and Olaolorun, 2006). Nonetheless, widespread poverty in the African continent and elsewhere in the developing world can also be presumed to have

great influence on the occurrence of IPV and also dictate part of the dynamics of attitudes towards gender roles. As pointed out by Jewkes (2002), IPV should not just be viewed as an expression of male dominance over women but also as male vulnerability stemming from social expectations of manhood that are unattainable due to factors such as poverty experienced by men. Moreover, as shown by Olayanju et al. (2013), there is widespread poverty across the African continent and there is a dearth of specific programmes targeted at addressing IPV issues by empowering women and promoting gender equality in many countries in the developing world (especially in Africa). Thus, this could be a major factor stifling the fight against violence in this region.

Considering the health impact of the issues, research indicates that IPV impacts negatively on the health and wellbeing of women and children (CDC, 2011; Asling-Monemi et al., 2008; Ahmed et al., 2006). Among these health impacts include: gynaecological disorders, depression and anxiety, sexually transmitted diseases, chronic pain syndromes among others (WHO, 2010; Asling-Monemi et al., 2008; Bott et al., 2004; WILDAF, 2002). Studies show that women are also predisposed to IPV during certain critical periods in their lives (i.e., during pregnancy). Research results indicate that 28.7% of women attending antenatal clinic in Nigeria have experienced IPV during pregnancy (Ezechi et al., 2004), while 29% attending obstetrics and gynaecology clinics in Nigeria have a current experience of IPV (Okenwa et al., 2009). Results elsewhere in the developing world show that 7.2% of women screened for IPV in an antenatal care clinic in South Africa experienced violence during pregnancy (Matseke and Peltzer, 2013). Besides, Okenwa and colleagues (2011) also show that as compared with women without any IPV experience, those with such experience have a higher tendency of pregnancy miscarriages, induced abortion and still births. These pieces of evidence further point to the devastating impact of IPV in the developing world, especially on the health of women and children in the region. Nevertheless, it should be noted that most of these studies are service-based (i.e., based on women attending certain hospital service or other specialist services) and might not be a true representation of what is happening amongst the general population. As a matter of fact, the proportion of women experiencing IPV is likely to be higher considering that limited number of women has access to such service, and with research indicating that majority of abuse remains unreported to the relevant or appropriate authorities (Tabachnick, 2013).

Regarding the costs of IPV in the developing countries, there are limited studies available detailing the socio-economic costs of violence, but those available indicate a substantial impact on economic buoyancy of certain developing countries (Duvvury et al., 2012; EPRC, 2009; Waters et al., 2005; Buvinic et al., 1999; Morrison and Biehl, 1999). Specifically, a study on health expenditures related to violence shows that 0.3% of GDP in Venezuela is expanded, 1.3% in Mexico, and 1.5% in Peru (Buvinic et al., 1999). Moreover, in Uganda the annual costs to health and police service provision in response to IPV was estimated to be approximately 3.4 billion shillings (approximately 0.01% of Ugandan GDP) (EPRC, 2009). In Morocco, costs estimate of IPV based on economic data that include household income and expenditure as well as information pertaining to work and schooling of household members indicate that 0.45% of the GDP is lost as a result of IPV (Belghazi, 2006). A study in South Africa also indicate that the cost of gender-based violence (GBV) (i.e., IPV, sexual harassment, rape and sexual assault by stranger) is equivalent to approximately 0.9% of the country's GDP (Khumalo et al., 2014). Additionally, a study conducted in Vietnam shows that out-of-pocket expenditures and lost earnings as a result of IPV are approximately 1.41% of the GDP (Duvvury et al., 2012).

The limited number of studies available on the exploration of costs of IPV, especially in the developing countries, as shown in this review of relevant literature and categorically expressed by Matzopoulos and colleagues (2008), is partly an indication of the rudimentary surveillance and reporting systems in developing countries and a vivid reminder of the need for more comprehensive exploration of the socio-economic costs of violence in the developing regions. Besides, there are variations in the costs components covered in the different estimates provided by the available studies, possibly making the estimated costs across the different regions highly inconsistent. Thus, there is also a need for more robust costing framework that will help ensure comparability of results across regions.

In terms of the risk factors of IPV, considering that violence is a complex and multifaceted phenomenon, many research studies have used the social-ecological model that facilitates the exploration of IPV risk factors at the individual, relationship, community and societal levels (Heise et al., 1999). Part of the results derived from using this form of conceptualisation of

risk factors of IPV show that the follow factors at the individual level predispose women in developing countries to IPV: young age (Ntaganira et al., 2009; Fawole et al., 2008; Kaye et al., 2002), low level of educational attainment (Uthman et al., 2009; Ackerson and Subramanian, 2008; Fawole et al., 2008; Umeora et al., 2008; Koenig et al., 2006; Kishor and Johnson, 2004), partner's use of alcohol (Umana et al., 2014; Ntaganira et al., 2009; Fawole et al., 2008; Flake, 2005; Hindin and Adair, 2002), childhood exposure to violence (Gil-Gonzalez et al., 2007), socio-economic status of woman (Lawoko, 2006; Flake, 2005; Chakwana, 2004; Koenig et al., 2003a), antisocial personality (WHO, 2010), and large number of children (Mapayi et al., 2011; McCloskey et al., 2005). At the relationship level, the following factors have been identified: spousal/partnership educational difference (Flake, 2005; Kishor and Johnson, 2004), decision-making power (Flake, 2005), partnership discord (Flake, 2005; Jewkes, 2002; Jewkes et al., 2002), and infidelity (WHO, 2010). Besides, at the community level, the following are the predisposing factors identified: mean education level in community (Antai and Adaji, 2012), and justifying wife-beating/ weak community sanctions against abuse (Antai and Adaji, 2012; WHO, 2010). Lastly, at the societal level, traditional gender and social norms have been shown to relate with IPV occurrence (Ghosh, 2013).

Nonetheless, it should be noted that some of these factors identified act as protective factors against IPV in certain societies, while they predispose women to violence in other societies in the developing world. An example of this contradiction in evidence is apparent in the exploration of the association between socio-economic status (SES) and the occurrence of IPV. Certain studies have indicated that high SES protects women against IPV (Lawoko, 2006), while others have suggested otherwise (Chakwana, 2004). As opined by Okenwa and colleagues (2009a), this contradiction may be due to differences in normative roles women play in different societies. More importantly, the evidence highlights the complexity surrounding the exploration of IPV issues. Thus, more careful and rigorous exploration of risk factors of IPV that goes beyond superficial study of these factors is required. Though the study of how factors at the different level of influence interact with one another or mediate the effect of each other could afford one a more detailed understanding of IPV risk factors, such explorations of risk factors are still rudimentary in the developing world. The need for more rigorous exploration of risk factors is clearly spelled out in the work of Koenig and

colleagues (2003a), where their research results show that women with greater personal decision making power and residing in a highly conservative area in Bangladesh (i.e., patriarchal community where conservative norms pertaining to the roles of women prevail), as well as participating in a savings/micro-credit scheme experienced greater occurrence of IPV than other women in the same society with less decision making power (i.e., less autonomy). This piece of evidence further indicate the complexity of the host of IPV risk factors that could be at play and the interactions that may exist between them in predisposing women to IPV. Thus, at this juncture, it is important to reiterate the need for more robust exploration of risk factors of IPV in developing countries, with greater consideration for interactions or mediation effects that may exist between the different risk factors.

Regarding interventions in place to address IPV in the developing world, many countries in this region still rely mainly on legal instruments (i.e., judicial means) alone in resolving IPV issues, but paradoxically most of these developing countries have penal and civil law codes that fail to criminalise certain forms of violence against women (Olayanju et al., 2013; Bott et al., 2004). Nonetheless, in some regions in the developing world where these civil law codes recognise and criminalise such violence, the law enforcement institutions are often not well funded, inaccessible to abuse victims or even corrupt (EPRC, 2009; Bott et al., 2004). In addition to legal instruments/legal reforms, in recent years there have been some other promising strategies used in addressing IPV in developing countries. These promising strategies include: those used in the SHARE project and RAISING VOICES in Uganda that comprise mainly of comprehensive community based advocacy actions on women's rights and negative consequences of IPV in changing community attitudes towards gender norms and acceptability of IPV (Wagman et al., 2013; Michau, 2007). *Comisarias* (All-women police stations) in Nicaragua designed to specifically cater for the needs of women and children as well as support for the fight against IPV in the country. In a similar vein, special police cells in Zambia targeted at resolving or dealing with cases of IPV (Bott et al., 2004). Moreover, *Puntos de Encuentro* also in Nicaragua, and Soul City in South Africa use a combination of entertainment and education (edutainment) to promote a model of gender equality, and thereby addressing IPV issues in the society (Solorzano et al., 2008; Singhal, 2002).

Furthermore, the Rakai programme in Uganda is another intervention designed to link the prevention of IPV with HIV mitigation programme (e.g., integrating IPV services and referral into HIV Voluntary Counselling and Testing). This linked-action strategy is premised on the idea of using the well established resources of the HIV prevention programme to facilitate IPV prevention (Wagman et al., 2015; Koenig et al., 2003b). Additionally, the IMAGE intervention in South Africa on the other hand involves the usage of microfinance scheme and skills building actions to empower women so as to reduce the risk of IPV occurrence (Kim et al., 2007). Another programme in the developing world that uses the same microfinance and training actions is the BRAC programme in Bangladesh (Bott et al., 2004; Hashemi, 1996).

All these programmes have produced some tangible help in addressing the issue of IPV in various locations in the developing world, but as opined by WHO (2010), to significantly address or prevent the issue of IPV there is a need for broad-based approach that integrates multiple promising/effective strategies with already existing institutional structures in a well-articulated and coherent manner. Besides, WHO (2010) also emphasizes the need for the incorporation of outcome evaluation and cost effectiveness in such IPV primary prevention efforts. Additionally, Garcia-Moreno and colleagues (2014) as well as Michau and colleagues (2014) also reiterated the need for multi-sectoral actions against IPV, with the need for governments to address factors (i.e., economic, social and political structures) subordinating women in various societies. They stress the fact that the most successful interventions will require multiple approaches, engage with many stakeholders, and seek to address underlying risk factors of IPV.

2.5.2 Further Exploration of Risk and Protective Factors of IPV: General Theory and Overview of Empirical Evidence

To explain and tackle the issue of IPV in any society, especially to place in context efforts aimed at estimating the economic ramifications of violence, it is important to have a good grasp of the risks and protective factors that may influence its occurrence. In the quest for this understanding, many theoretical models have been developed and used – some with biological, psychological, cultural, or gender equality underpinnings (WHO, 2010; Gil-Gonzalez et al., 2007), while others adopt a more holistic approach (such as the ecological

model that combines the biological, psychological, cultural and gender equality concepts) to permit the assessment of risk and protective factors of IPV from multiple levels (Dahlberg and Krug, 2002; Heise, 1998).

To provide a better understanding of the risks and protective factors of IPV, this section of the thesis will adopt the usage of the ecological model (Figure 2.3) in discussing the information available on the factors influencing IPV occurrence. But before that, the section provides an overview of other theories – *microlevel theories* – available about the risk factors of IPV.

Figure 2.3 Ecological model for understanding IPV (Source: Dahlberg and Krug, 2002)

Presently, there is a dearth of empirical evidence positing that IPV cuts across all socio-economic classes. Information is also available on the fact that a degree of unevenness exists in the broad path cut by the violence – for example, women with lower socio-economic status experiencing IPV more often than those with higher status (Resko, 2010). This unevenness has given rise to different theories that serve as guides and underlying frameworks for understanding IPV over the years – theories such as: feminist, social exchange/social learning, resource/power, stress, biological and psychological theories, amongst others. The sheer size of theories available explaining IPV occurrence is a testament to the fact that the issue has a great array of factors that increases the likelihood of its occurrence.

Feminist theory: this theory considers IPV as a result of a deeply embedded social problem (e.g., patriarchy) that promotes male coercive power and domination over female (Dobash and Dobash, 1997; O'Leary, 1999). Partner abuse is considered as a consequence of a culture that favours men dominating women and, as such, has to be addressed by social change in terms of patriarchal norms (Yick, 2001). The theory focuses on gender inequality of power and invariably incorporates the notion of economic inequalities between men and women as a factor legitimising male dominance and abuse of women (Schneider, 2000). In other words, IPV is a product of male and female sex roles that are inherently imbalanced (Resko, 2010).

In addition to positing that patriarchy is the main cause of IPV, this perspective offers other explanations that include cycle of violence, learned helplessness, as well as the power and control wheel (Ali and Naylor, 2013a). Under the cycle of violence theory, it is posited that violence occurs in a cyclical manner that involves the building up of tension then explosion (occurrence of violence) and a phase of remorse/forgiveness, before the whole cycle starts all over again. This theory has over the years been met with great opposition as different researchers opined that if violence were at all as a result of tension and frustration, then abusers would have invariably vented this frustration on colleagues at work and other acquaintances as well; but most often this is not the case (Ali and Naylor, 2013a; Walker, 2006). On the other hand the phenomenon of learned helplessness argues that IPV mainly ensues from incessant, non-contingent and seemingly inescapable control by men which creates in their female partners a feeling of inability to change whatever unpleasant experience they suffer in the hands of such men (Peterson et al., 1993). Another perspective under the feminist theory is the power and control, which posits that male intimate partners use violence as a means of gaining control over their female partners. In other words, IPV results from men's desire to hold absolute power over women and to keep them in a totally submissive situation (Ali and Naylor, 2013a).

Social exchange theory: the theory has its root in utilitarian economics as well as classic anthropology, and focuses on the structure of social relationships and flow of goods or benefits through social interaction. The central theoretical argument of the social exchange theory is that human behaviour is in essence an exchange and one that is guided by the

pursuit of rewards as well as the avoidance of punishments. In other words, IPV is likely to occur when a partner (most often the male) expects that the costs of being violent are less than the rewards (Gelles, 1983). Owing to the foregoing reasons, this perspective gives greater consideration to factors such as societal norms and the attitude of people towards violence in understanding and explaining its occurrence (Erchak and Rosenfield, 1994).

Resource theory: is one that is closely related to the social exchange theory, and it has often been described as 'conceptually equivalent' to the exchange theory (McCloskey, 1996). Nonetheless, it is a social psychological framework built with a central premise that individuals who possess certain resources or attributes (economic resources, prestige and likeability or love) will not feel the need, or perhaps compulsion, to use threats/force. As a result, violence becomes a resource of last resort, which could be effective with the lack of other resources mentioned earlier or when they have proved to be ineffective (Resko, 2010). In other words, IPV occurs when a man loses his 'power' or 'symbolic role' as a breadwinner within the relationship, because he completely lacks the resources to attain this status or lacks the resources relative to his wife (Atkinson et al., 2005).

Stress theories: over the years stress has been considered a major risk factor of IPV by different researchers (Jasinski, 2001; Farrington, 1986) and these researchers or theorists generally approach the 'stress phenomenon' from two major perspectives: the family stress and environmental stress perspectives (Resko, 2010). The family stress perspective, as the name implies, focuses on individuals within the family and the attributes or characteristics that make families especially predisposed to stress (Farrington, 1986). While the environmental stress perspective studies the structural characteristics of the general society that result in a varying distribution of opportunities, and thereby making certain individuals in the society more exposed to stress than others (Resko, 2010; Jasinski, 2001). In other words, IPV arises from institutionalised inequalities between people of different races, gender, and social class lines (Gill, 1986).

Biological perspective: based on this perspective, the exploration of the occurrence of IPV is centred on genetic, congenital and organic causes of behaviour. The central premise is that in order to understand the root cause of IPV one needs to assess/check for genetic defects, brain

injuries, brain infection, medical illnesses affecting the brain, and other neuropathological conditions (Ali and Naylor, 2013b). Under the biological perspective it has also been opined that aggression facilitates the male's reproductive advantage by controlling female sexuality, and in order to understand aggression and aggressive behaviour one needs to study the role of sex hormones such as testosterone (Wingfield et al., 2006; Daly and Wilson, 1997).

Psychological (trait) theory: the central theoretical argument of this perspective is that IPV against women or men is related to individual variation in personality traits. That is, individuals with hostile disposition are predisposed to being violent (Dutton, 2007). Moreover, under this perspective, the role of factors such as personality disorder, attachment needs, substance and alcohol abuse, low self-esteem and other psychopathological characteristics are often explored to glean an understanding of the occurrence of IPV (Ali and Naylor, 2013b).

Ecological model: provides a framework for understanding the many factors that result into violence. The model assumes that behavioural development emanates from the interactions at various levels of social organisation (Krug et al., 2002). To be more precise, the model posits that IPV is caused by the interaction of factors at four different levels: individual, relationship, community and societal (WHO and CDC, 2007). The model can be best visualised as four concentric circles (Figure 2.3), whose innermost circle or ring represents the biological and personal histories each individual brings to a relationship. At the individual level, many results regarding risk factors are emerging from research carried out in different parts of the world and some major risk factors have been consistently identified at this level. The next circle represents the immediate context where the abuse takes place. In other words, this level includes the proximal social relationships (such as those with peers, partners and family members) that increase the risk or protection for victimisation and perpetration of IPV. The third circle represents the formal and informal institution, as well as social structures, in which relationships are embedded. That is to say this level of the model examines how the community contexts (such as schools, workplaces, and neighbourhoods) in which social relationships are embedded can act as risk or protective factors in becoming victims or perpetrators of IPV. The outermost circle represents the economic and social environment the relationship resides in. This fourth level of the ecological model includes the larger societal

factors that influence the occurrence of IPV, and these factors may include, but are not limited to, gender inequality, religious or cultural belief systems, societal norms and economic or social policies that create or sustain gaps and tensions between groups of people (WHO, 2010; Ellsberg and Heise, 2005). It should also be noted that the overlapping circles in the model represent the interrelationship and interdependence that exist between the various factors; and therefore it suggests that in order to tackle the issue of IPV, the various factors at the different levels need to be explored and addressed simultaneously (Ali and Naylor, 2013a).

Furthermore, different research over the years has shed light on some of the wide range of factors at each level of the ecological model that are likely to increase the occurrence of IPV in a population, and these factors include:

Individual level risk factors

Young age

Based on available literature, age not only stands as a risk factor for IPV in terms of victimisation, but also as a risk factor for the perpetration of such violence (Brakman and Gold, 2011; Black et al., 2001). Young age has been consistently reported to be a risk factor for women experiencing IPV as well as for men being perpetrators of the violence (Abramsky et al., 2011; Romans et al., 2007; Hindin and Adair, 2002; Black et al., 2001). Research has shown that young women tend to be more at risk of rape than older women, with data from rape-crisis centres in some countries (e.g., the United States, Mexico and Malaysia) indicating that a higher number of victims of sexual assault are women aged around 15 years – in fact as high as two thirds of all sexual assault cases come from this age bracket (WHO, 2010; Rennison, 2001). Nonetheless, other research studies – such as the one carried out in South Africa by Jewkes and colleagues (2002) – also show that in certain contexts age (especially that of the male partner) is not always related to the occurrence of IPV.

Low level of education

Low level of education is a consistent, perhaps the most consistent, factor associated with IPV perpetration and victimisation (Boyle et al., 2009; Johnson and Das, 2009; Ackerson et al., 2008). Nonetheless, as pointed out by Hindin et al. (2008), the relationship between

educational status and IPV occurrence is mixed. Some studies show that women who report lower levels of education (primary), or no education at all, have approximately 2- to 5-fold increase in the risk of IPV compared to women with higher levels of education (Ackerson et al., 2008; Tang and Lai, 2008; Koenig et al., 2006), while other research results show no association between IPV and educational attainment (Clark et al., 2008; Hindin and Adair, 2002). Research pertaining to male perpetration of IPV shows that men having lower educational attainment are about 4 times more likely to be perpetrators of IPV than those with higher levels of education (Dalal et al., 2009).

Intra-Parental violence/ exposure to child maltreatment

Research shows that exposure to violence during childhood increases the likelihood of men being perpetrators of IPV by about 3- to 5-folds (Gil-Gonzalez et al., 2007; Koenig et al., 2006). Studies also show that childhood exposure to violence, especially intra-parental violence, is positively associated with women being victims of IPV (Vung and Krantz, 2009; Martin et al., 2007). The results from the research by Jewkes et al. (2002) show that childhood exposure to violence may increase the likelihood of a woman to be a victim of IPV by approximately 2- to 3-folds.

Harmful use of Alcohol and Illicit drug use

Alcohol consumption as a direct cause of IPV has often been challenged (Leonard, 2005), but evidence is available to support a relationship between alcohol and IPV, with research showing that excessive use of alcohol directly affects cognitive and physical functions, thereby reducing self control and rendering individuals less capable of amicably resolving conflicts within relationships without violence (Room et al., 2005). Harmful use of alcohol have been found to be strongly associated with the perpetration of IPV (Abramsky et al., 2011; Dalal et al., 2009; Johnson and Das, 2009, Fife et al., 2008), and research also shows that harmful use of alcohol may result in a 4.6-fold increase in the risk of exposure to IPV, compared to mild or no alcohol use (Gil-Gonzalez et al., 2006).

Acceptance of violence

Research conducted on risk factors of IPV shows that attitudes of people towards violence (acceptance of violence) are strongly correlated with the occurrence of IPV. The attitude of

women towards IPV can predispose them to being victims, whilst men's perception of violence can have great influence on them being perpetrators (WHO, 2010; Johnson and Das, 2009). Studies found that the risk of IPV increases as acceptance of violence increases, with men who believe it is always acceptable to beat their wives having a 4-fold increase in risk of perpetrating IPV, while men who believe that it is at times acceptable to beat their wives have a 2-fold increase in risk (Johnson and Das, 2009). Besides, women who commonly embrace violence have also been identified to have a higher likelihood of experiencing IPV (Uthman et al., 2010).

Antisocial personality

Research has shown that men displaying antisocial personality disorders are more predisposed to perpetrating IPV, as they often disregard generally accepted social norms and have a likelier tendency to become aggressive (Marshall et al., 2005).

Relationship level risk factors

Multiple partners and infidelity

Studies show that men with more than one sexual partner tend to perpetrate IPV more than those with a single partner, with a magnitude of risk ranging from 1.5- to 17.1-folds (Boyle et al., 2009; Jewkes et al., 2006). Moreover, men with multiple partners not only have the tendency to perpetrate IPV, but are also more likely to engage in risky sexual behaviours, such as refusing to use condoms, thereby exposing themselves and their partners to increased risk of sexually transmitted infections (STIs) (WHO, 2010).

Educational disparity

Disparity in the level of education between male and female partners may result into increased occurrence of IPV, as studies show that men in a relationship with women of higher educational attainment are more likely to use violence in order to gain power within the relationship (Abramsky et al., 2011; Ackerson et al., 2008; Xu et al., 2005). Further support of this assertion is provided by a research by Flake (2005) which shows that women with higher educational attainment than their partners are about 1.5-folds more predisposed to experiencing IPV as compared with those having the same attainment as their partners.

Community level risk factors

Porverty

Research has shown that women living in poverty are disproportionately affected by IPV, even though the violence is pervasive and cuts across all socioeconomic groups (Heise and Garcia-Moreno, 2002). The reason for this relationship may be due to the fact that poverty comes with factors such as hopelessness, stress and frustration, or because it provides the substrates for marital disagreements and it makes it difficult for women to leave unsatisfactory relationships; the actual reason is still not very clear (WHO, 2010).

Weak community sanctions

It has been noted that the way a community responds to IPV affects the overall levels or rates of abuse in the community (Heise and Garcia-Moreno, 2002). Research has found that communities with sanctions against IPV – such as formal legal sanctions or moral pressures from neighbours or family members – tend to have the lowest levels of IPV, while the opposite seems to be the case in communities that lack sanctions (WHO, 2010).

Societal level risk factors

Traditional gender and social norms

Studies across different cultures have highlighted some societal and cultural factors that are likely to give rise to increased levels of violence. Factors such as patriarchy or male dominance in a society and women's lack of easy access to divorce and legal protection have been revealed to have positive influence on the occurrence of IPV (Ghosh, 2013; Taft, 2009; Russo and Pirlott, 2006). On the other hand, the presence of female workgroups in a society has been suggested by research to offer protection against some forms of IPV; they serve as a source of income and social support for women (WHO, 2010).

2.5.3 Health consequences of IPV (Non-monetary impact)

Although there are gaps in information available on IPV, different studies have repeatedly shown that this abusive behaviour affects a distressingly high percentage of the world's population and comes with great toll on people's health in varied ways (CDC, 2011). A

growing body of epidemiological research shows the consequences of IPV for women's health and wellbeing, including fatal outcomes such as suicide, femicide (Frye et al., 2008) and sexually transmitted diseases related deaths (Heise et al., 1999); non-fatal outcomes such as physical injuries (Coker et al., 2002; Campbell et al., 2002), gynaecological disorders and pregnancy complications (Ahmed et al., 2006; Asling-Monemi et al., 2008), unintended pregnancies (Gazmararian et al., 1995), chronic pain syndromes (Tolman and Rosen, 2001), depression and anxiety (WILDAF, 2002), as well as drug and alcohol abuse (WHO, 2010).

The above-stated health outcomes of IPV are by no means exhaustive, as there are many more likely health consequences of the violence. Table 2.1 shows a more comprehensive, but not exhaustive, list of health consequences of IPV.

Table 2.1 Health consequences of IPV (Adapted from Bott et al., 2004)

Fatal outcomes	**Non-fatal outcomes**		
	Physical injuries and chronic conditions	**Adverse sexual and reproductive effects**	**Psychological and behavioural outcomes**
Femicide	Fractures	Gynaecological disorders	Depression and anxiety
Suicide	Abdominal and thoracic injuries	Pelvic inflammatory disease	Eating and sleep disorders
Homicide	Chronic pain syndromes	Sexually-transmitted infections, including HIV, Syphilis, Chlamydia and Gonorrhoea	Drug and alcohol abuse
AIDS-related mortality	Fibromyalgia	Unwanted pregnancies	Phobias and panel disorders
Maternal mortality	Permanent disability	Pregnancy complications	Poor self-esteem
	Gastrointestinal disorders	Miscarriage/ Low birth weight/ Prematurity	Post-traumatic stress disorders
	Irritable bowel syndrome	Sexual dysfunction	Self harm
	Lacerations and abrasions	Unsafe abortion	Unsafe sexual behaviours
	Cardiovascular diseases and Hypertension		
	Ocular damage		

As expressed by the WHO (2013), the likely causal pathways linking IPV exposure to adverse health outcomes are complex. These pathways harbour context-specific physiologic, behavioural and other factors that increase the likelihood of disease outcomes. Figure 2.4 is a schematic outline or representation of some of the various pathways and health effects of IPV exposure. The figure shows three main mechanisms (physical trauma, psychological trauma/stress as well as fear and control) and pathways via which different adverse health outcomes may occur.

Figure 2.4 Pathways and health effects of Intimate Partner Violence (Source: WHO, 2013)

2.5.4 Costs of IPV (Monetary impact)

Overview

IPV is a pervasive form of violence that has not just significant health and social consequences but also enormous economic impact on victims, their families and communities at large. The economic consequences are in the forms of direct and indirect cost, which include out-of-pocket spending for individuals seeking treatments for IPV injuries, the cost of providing healthcare and other services, reduction in productivity and decreased earnings, as well as increased absenteeism that comes with financial repercussions. Considering the massive toll IPV puts on societal and individual finances, it is imperative to address the issue by having an in-depth understanding of it and exploring ways to prevent its occurrence. One such way is to estimate its economic burden, which may go a long way in addressing the issue by providing reference points for the allocation of resources and for setting priorities in tackling the problem. Estimating cost can also help ensure that violence prevention is ranked equitably in terms of investment. Besides, certain estimates of the cost of IPV, such as cost per case of violent events, can be used in economic evaluations such as cost-benefit and cost-effectiveness analyses – which can ultimately be the first step in the process of exploring the benefit of potential interventions targeted at preventing IPV and ensuring that the most effective and cost-effective interventions are being deployed in the prevention of such violence (WHO, 2008). Above all, estimating the total/overall cost of IPV is extremely crucial in advocating for the prevention of violence.

Over the past decade there has been a growth in the body of work focused on understanding the monetary cost of IPV, with most such studies emerging from the high income countries or the industrialised world. The cost of annual medical care, mental health services, and lost employment productivity due to IPV has been estimated at more than $8.3 billion in just the United States alone, in the year 2003 (National Centre for Injury Prevention and Control, 2003). This alone goes a long way to demonstrate the huge financial burden such violence could exert on any economy.

2.5.4.1 Typology of costs

Just as stated earlier, most studies in the area of economic cost (monetary cost) of IPV use the broad terms of **direct** and **indirect** to conceptualise such cost. Direct cost includes the cost incurred by individuals or institutions in the use or provision of goods and services for preventing and responding to the occurrence of IPV. Such cost can be further divided into medical and non-medical cost, emphasizing the importance of documenting the cost of medical treatment associated with violence related injuries (WHO, 2008). Some of the well documented direct costs as a result of IPV include medical cost (such as Hospital treatment, psychological care and counselling expenditures for IPV victims, as well as cost of therapy for the perpetrators), and also non-medical cost (such as legal and criminal justice expenditure, police and social welfare, as well as transport cost related to accessing the different services) (Duvvury et al., 2004). As a result, most studies available on the direct cost of IPV estimate the cost across different sectors that normally include health, social service, the police and judicial. On the other hand, indirect costs are the value of goods and services lost due to IPV occurrence. Such costs include, but are not limited to, value of goods and services lost as a result of absenteeism, job loss and reduction in productivity from both paid and household chores; cost of disability-adjusted life years as a result of IPV; cost of increased mortality and morbidity; cost of drug and alcohol abuse; as well as cost of intergenerational transmission of violence. By virtue of the difficulty in calculating the indirect costs of IPV, few studies have attempted to design methods for estimating such costs. Most studies tend to focus on tangible costs such as reduced productivity by victims of the violence, which is most often calculated from average gross earnings and the amount of work time lost as a result of violence (Duvvury et al., 2012; WHO, 2008). Nonetheless, studies have suggested that indirect costs of IPV may be a lot more than the direct costs incurred as a result of the violence (Duvvury et al., 2004).

Table 2.2 Typology for costing Violence (Adapted from WHO, 2008)

Cost category	Type of cost	Components
Direct	Medical	Hospital inpatient
		Hospital outpatient
		Transport/ Abulance
		Physician
		Drugs/ Laboratory tests
		Counselling
	Non-medical	Policing and imprisonment
		Legal services
		Foster care
		Private security
		Transport (to and from services)
Indirect	Tangible	Loss of productivity (earnings and time)
		Lost investments in social capital
		Life insurance
		Indirect protection
		Macroeconomic costs
	Intangible	Health-related quality of life (pain and suffering , psychological)
		Other quality of life (reduced job opportunities, access to schools and public services, participatrion in community life)

2.5.4.2 Costs assessment methods

Based on the the available literature, most of the studies performed in the realm of economic cost of IPV focus on direct cost, though, a few studies estimate some forms of indirect cost. These studies mainly use three major methodologies to capture elements of direct and indirect cost. Two of the approaches – 'Proportional' and 'Unit' Cost – are accounting methodologies, while the third involves an econometric approach (Duvvury et al., 2012; BIDS, 2009; Duvvury et al., 2004).

The Proportional Cost approach involves proportioning operational budgets of different service providers based on the extent the service provided is for treating or addressing IPV (Duvvury et al., 2004). In other words, it is assumed that the total cost of IPV to a particular service provider is proportional to the number of IPV cases received within a 12-month period. This method is also commonly refered to as the 'top-down' or prevalence approach, as it focuses on estimating IPV victimisations costs for a given period, typically a year, regardless of when the victimisations first occurred.

The Unit Cost approach, at times also referred to as 'bottom-up approach', is an accounting approach in which costs incurred in different sectors (such as healthcare, police, judicial sector and social welfare) are estimated based on incidence and utilisation data regarding IPV and then aggregated across sectors (Brown et al., 2008; Duvvury et al., 2004). In other words, costs are broken down into specific categories and total costs from these categories are summed up to form the overall cost.

The econometric approach is mostly used in estimating indirect cost (e.g., income foregone and productivity loss) (Duvvury et al., 2004). Nonetheless, it could also be used to estimate direct cost. Its usage in estimating direct cost is similar to that of the unit cost approach in that it uses the estimated number of women's IPV victimisations over a given period, as well as the resulting increase in annual services costs in calculating the economic cost of IPV. The only difference is that the econometric approach uses regression analysis in estimating the increase in annual services costs (Brown et al., 2008).

Nonetheless, most of the above stated methods for calculating or estimating the cost of IPV have been vastly used and well established in the developed world, but as pointed out by Duvvury et al. (2004) very few of these methods are applicable to developing countries due to the fact that different social norms exist in relation to what act or behaviour is considered violence against women, as well as a lack of policy framework and information systems. Therefore, to address this and make information regarding the cost of IPV more available in developing countries for policy development, more research needs to be channelled to this area of IPV consequences.

2.5.4.3 IPV Cost Estimates around the world

As stated above, most studies on the costs of IPV are mainly conducted in developed countries, with just a handful of studies carried out in the developing world. A cost estimation study conducted in the UK estimated the total costs of IPV – that included costs of service provision, lost economic output as well as human and emotional costs – to be approximately £23 billion per year or 1.91% of the UK GDP (Walby, 2004). Another study conducted by Morrison and Orlando (1999) found that the costs of productivity lost as a result of IPV in Nicaragua and Chile were $29.5 million (1.6% of the GDP) and $1.56 billion (2.0% of the GDP), respectively. A study carried out by the WHO (2008) estimated productivity lost due to IPV in Brazil in 2004 to be 12% of the health budget that year (1.2% of the GDP). Besides, in the US approximately US$858 million is lost annually due to losts days of paid work and household work resulting from IPV (National Centre for Injury Prevention and Control, 2003). In Australia the total annual costs of service provision and economic costs as a result of IPV occurrence in 2002-2003 was estimated to be AUS$8.1 billion – 1.2% of the GDP (Access Economics, 2004). In Canada, the total annual costs of social service/education, criminal justice and health/medical services provided to address IPV as well as labour losses were estimated to be approximately CAN$4.3 billion (Greaves, 1995). Moreover, as expressed earlier in section 2.5.1, a study conducted by EPRC in Uganda shows the annual costs of health and police service provision in response to IPV to be approximately 3.4 billion Ugandan Shillings (EPRC, 2009). Another study in South Africa indicates the costs of GBV to be approximately 0.9% of GDP in the country (Khumalo et al., 2014). Based on a study conducted in Vietnam, the out-of-pocket expenditures and lost earnings as a result of IPV in 2010 were estimated to be approximately 2,536,000 billion Vietnamese Dong – 1.41% of the GDP (Duvvury et al., 2012).

2.6 IPV Prevention

2.6.1 Overview of Global Efforts

As expressed by the WHO (2010), IPV occurrence is not inevitable and it is absolutely amenable to prevention. Research evidence shows that levels of IPV vary considerably

between locations due to a variant of factors that include social, cultural and economic conditions, and these variations give an indication that the malaise could be prevented through well-designed programmes and policies.

Over the years, there has been a number of innovative prevention programmes designed to address IPV issues, although most of these efforts are concentrated in the developed or high-income countries.

Nonetheless, international responses to the prevention of IPV have been channelled mainly via different international instruments. These instruments are not preventive in their own right, but are rather international conventions that call for the prevention of IPV by various national governments. Some of these conventions include:

- Convention on the Elimination of all Forms of Discrimination against Women (CEDAW);
- The United Nations Declaration on the Elimination of Violence against Women;
- The Beijing Declaration and Platform for Action to Prevent and Eliminate Violence against Women;
- The United Nations General Assembly Resolution 61/143, enjoining States to take necessary measures in addressing structural causes of violence and to strengthen prevention efforts that address discriminatory practices predisposing women to abuse.

As a response to these declarations and conventions, countries around the world have embarked on the application of different policies and actions to address IPV issues, most of which focusing mainly on legal and judicial reforms applied to improve the situation of abused women, as opposed to addressing the underlying factors responsible for abuse in the first place (Harvey et al., 2007).

In addition to these policies (i.e., judicial reforms), there has also been research into ways of addressing the actual root cause of IPV and the development of prevention approaches. It is

important to note that these efforts, as regards prevention of IPV, are mostly made in developed countries.

The following include some of the developed prevention approaches that emerged from research carried out mostly in the High Income Countries:

Early Childhood and Family-Based Approaches

Home visits and parent training programmes in preventing child maltreatment: the premise of this approach is that having child maltreatment history predisposes an individual to be either a victim or perpetrator of violence and, therefore, a reduction in the level of maltreatment will also lead into a reduction in the occurrence of IPV (Foshee et al., 2009).

Home visits and parent training programmes covering positive reinforcement, non-violent disciplinary techniques, problem-solving and behavioural management skills: just as in the case of addressing child maltreatment, the idea behind the usage of this means of IPV prevention is that inculcating a culture of non-violence from childhood will prevent individuals from becoming perpetrators of IPV later in life (Harvey et al., 2007; WHO, 2010). Other examples of programmes that fall under a similar approach include: *Cognitive-behavioural skills training for children* and *Social development programmes to reduce antisocial and aggressive behaviour.*

Multi-component programmes with some combination of training for parents, children and teachers: this is also built on the premise of addressing IPV through emotional management skills in children (Mercy et al., 2002).

School-based approaches

Educating children about self-esteem and self-protection, as well as about how to recognise and avoid potential abusive situations: this approach is aimed at developing protective

behaviours against abuse by working with children at a younger age before gender-biased attitudes and behaviour are deeply ingrained in them (WHO, 2009a).

Pre-adolescent and Adolescent safe date programme: this programme is also designed to address norms and attitudes that influence violent acts in a relationship (Foshee et al., 2004).

Interventions to reduce Alcohol and Substance misuse

As harmful use of alcohol is often related to the occurrence of IPV, it is suggested that the reduction of availability of alcohol will also lead to a reduction in the level of IPV. This premise of IPV causation has led to the development of strategies such as: *The regulation of alcohol pricing and taxation* (Markowitz, 2000), and *regulation of alcohol availability and modifying the context of drinking* (Room et al., 2002).

Public Information and Awareness Campaigns

The idea behind this means of IPV prevention revolves round the dissemination of messages through mass media to influence attitudes and social norms about acceptability of violence (Donovan and Vlais, 2005). It also involves the provision of accurate information to dispel myths and stereotypes about IPV (WHO, 2010).

Community-Based Prevention

This involves mainly community level activism and leadership programmes on effecting social change through the means of influencing individual attitudes and behaviours. Other programmes within this category of IPV prevention strategy include *Group education sessions for individuals predisposed to IPV and equipping bystanders to be proactive in the prevention of IPV* (WHO, 2009a; Harvey et al., 2007).

Foster Gender Equality and Women Empowerment

Structural policy on gender equality: this empowerment approach is designed to aid social change by creating an enabling environment for changing attitudes and behaviours that predispose women to IPV (WHO, 2010).

Policies to improve women's access to paid and safe employment (Microfinance Schemes): the premise of this empowerment approach is to increase the economic and social power of women, especially through the provision of small loans to women to help them establish income-generating projects/ businesses (WHO, 2010; Kim et al., 2007). Another programme with a similar purpose is the *Gender equality training scheme.*

Integration of IPV Prevention into a range of Programme Areas

The idea behind this approach to IPV prevention is the fact that IPV interacts with other health, social and developmental issues. Therefore, combining the prevention of IPV with programmes in these other areas affords a chance to reach a greater number of people and at the same time save the limited resources available to execute the programmes. Some examples of these integrations are: the combination of IPV prevention with HIV/AIDS prevention and the combination of IPV prevention with programmes on reproductive health (Colombini et al., 2008; Harvey et al., 2007)

2.6.2 Overview of Current State of IPV Prevention in Nigeria and Relevant Legal Guidelines Protecting the Rights of Women in the Country

Generally speaking, Nigeria is greatly deficient in specific strategies targeted mainly at the prevention of IPV against women.

Although Nigeria is a signatory to the international Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the country is still yet to integrate this into its legal code. Besides, other relevant conventions or bills that advocate for the protection of women against violence and abuse, such as: Violence Against Persons (Prohibition) Bill,

the Gender and Equal Opportunity Bill and the National Gender Policy are also yet to be passed into law, even though they have been deliberated upon at the country's National Assembly for a couple of years now.

Nonetheless, there are couple of efforts being made, especially at the state level, to protect the rights of women in the country. Some of the States in Nigeria have legally domesticated CEDAW provisions and they currently have local laws that protect the rights of women. An example of some of these laws is the Lagos State Law against Domestic Violence (Ogundare, 2012). In addition, the federal government has established Human Rights and Gender Desks including Family Support Units in a few police stations in the country (Maina, 2013).

2.7 Summary

This chapter of the thesis provides an overview of the typology of violence to characterise different forms of violence. This exploration of typology of violence facilitates the clarity in the nature and scope of IPV. From this exploration, it could be deduced that IPV is a form of Interpersonal violence, and one that is closely related to other forms of violence.

Afterwards, a definition and component types of IPV was discussed. Based on this discussion, it is clear that the main forms of IPV are the physical, sexual and psychological abuse.

This review of relevant literature also discussed related research on the prevalence and extent of IPV, with greater emphasis on developing countries. Based on this review of relevant literature, it could be concluded that there has been little progress in the study or exploration of IPV in the developing world, most especially in Africa. These limitations in the exploration of the issue are more profound in the area of costs estimation and rigorous exploration of risk factors of IPV as well as prevention of the malice. This need for more research is imperative given the fact that most government in the developing countries are yet to put in place necessary steps to address IPV issues, and the limited evidence available suggests that IPV prevalence is as high as 80% in certain regions of the developing world.

Chapter 3 Methodology

3.1 Research design (overview)

To achieve the purpose of this research, a cross-sectional population-based household survey is conducted. This design has been chosen to provide a better insight into the issues of IPV in Nigeria, as most of the studies available in the country are service-based studies – studies that mainly rely on data from hospital records or interviews with women attending a particular service (e.g., women attending crisis services) to draw conclusions about the patterns of IPV in the larger Nigerian population. These types of service-based studies may provide relevant information about cost of service provision or utilisation (provided that there are efficient and accurate record keeping practices in place), but they are weak at estimating the magnitude of the violence as service utilisation data only apply to women in that particular setting or those who seek such formal services. These individuals, although are part of the general population, they are substantially different from the typical members of the general population – in other words, they are atypical as research has shown that very few women victimised by their intimate partners seek formal help (WHO, 2010).

The household survey has been conducted in three sites in Kwara state Nigeria: the capital city of Kwara state (Ilorin a major urban area), and two rural areas (Offa and Erin-Ile). In both the urban and rural locations a representative sample of around 1,020 women aged 18 years or older has been selected to participate in face-to-face interviews. This sample size was selected based on a statistical sample size calculation model (precision-based sample size calculation), which applies the formular $n = (1.96)^2 pq/ d^2$; where p is the proportion at risk of IPV, taken to be 0.277 (based on the reported life-time prevalence of IPV of 27.7% from previous studies (NPC and ICF Macro, 2008)); d is the margin of error that was selected to be at 0.05 with a 95% confidence interval and q is 1 – p. With this calculation, a sample size of approximately 250 in each of the two broad locations (urban and rural) was deemed appropriate to give sufficient power to meet the research objectives, but a final sample size of 1,020 women in both locations (approximately 500 each) was adopted to give enough room for likely drop-outs from the study and women who could not be interviewed completely due to other reasons.

As only one woman is selected from each household visited, 1,020 households have been surveyed in the sites; and a uniform questionnaire has been used to ask women about experiences of violence from intimate partners.

3.2 Study area

The study area, Kwara State, is one of the 36 member States constituting Nigeria. It is located in the middle-belt geo-political region and serves as a gateway between the northern and southern parts of Nigeria. The sociodemographic profile of the State is diverse in terms of ethnicity, religion, socioeconomic, as well as sociocultural practices, thereby making it suitable for the research. Besides, very few studies in the area of gender-based violence have been carried out in Kwara State, with most focusing on family violence without particular consideration of IPV against women. Therefore it was further deemed appropriate to embark on a study on IPV against women in the State, so as to cover the knowledge gap existing on the dynamics of violence in the State and also to provide benchmark estimates that can allow appropriate tailoring and targeting of interventions and services to effectively prevent and manage IPV occurrence nationally.

3.3 Study sample: coverage and scope

As briefly stated above, the critical inclusion criteria for the selection of the study sample was: women aged 18 years and above who were previously or are currently involved in a cohabiting or non-cohabiting relationship, and who reside in the urban area of Kwara State (specifically Ilorin, the State capital) or the rural area of the State (Erin-Ile and Offa) at the time of the research. These locations were carefully selected to facilitate the canvassing of both urban and rural areas; and the broader study sampling frame of women ages 18 years and older who have ever had an intimate partner was chosen as opposed to just formally married women, because research in this area has shown that risk of partner abuse is not restricted or confined to women who are currently in formal marriages (Garcia-Moreno et al., 2005). Besides, in order to facilitate the comparison of the results of the study with those that are available internationally, keeping to an internationally recognised definition of IPV that encompasses this broad group (study population) was deemed important.

3.4 Sampling strategy

HOUSEHOLDS

Having decided on the sample size (1,020 women), as explained earlier, the research sample frame has been designed to capture all ever-partnered women between the age of 18 years and above present at the study site during the execution of the research fieldwork – in other words, the design was put together to be representative, as much as possible, at the state and the national levels. The sample plan used in selecting eligible women from the frame involves a multistage probability sampling procedure that entails three levels of selection: Wards, Enumeration Areas, and then Households.

First stage:

The primary sampling units are the wards. These are selected based on simple random sampling of the total number of wards in Ilorin (the urban location) and those of Offa and Erin-Ile (the rural locations). A total of 15 wards are selected (8 in Ilorin [urban] and 7 in Offa and Erin-Ile [rural]) using this technique.

Second stage:

This stage is for the selection of Enumerated Areas of smaller clusters of people. The selection of Enumeration Areas (EAs) is also made using random sampling of such clusters of people in each of the earlier chosen wards. A total of 102 enumeration areas are selected in total. On average, 6 – 7 enumeration areas are selected from each of the wards chosen in the first stage.

Third stage:

The third stage is the selection of households. This involves randomly selecting households with a systematic selection of 10 households per enumeration area. The interval of selection (sampling interval) is arrived at by dividing the approximate total number of households in the enumeration areas by the number of household to be selected. This is performed separately for the urban area (Ilorin) and the rural area (Offa and Erin-Ile), as the household density tends to vary between these two locations. Afterwards, the starting point on the list of households is determined randomly – any household is selected as the starting point – and

subsequent households are picked from the list going from this starting point. In other words, after the selection of the random starting point, consecutive selection of households is obtained by adding the sampling interval to the random point.

In summary, 15 wards and 102 enumeration areas are chosen and 1,020 households/ women are targeted for interview. Although 1,020 households were pencilled down for interview, the final number of households interviews conducted was slightly less. This is due to the fact that households were selected without replacement and some of the households did not contain women, while some of the women in other households were not willing to be interviewed. The final number of households completely interviewed is 947 for a non-response rate of 7.2%. It should also be noted that not all the women interviewed were or have ever been in a relationship (with a partner), leaving the overall number of ever-partnered women in the study to **719** which is what all of the analysis pertaining to this research is based on. Table 3.1 provides more detail on the final distribution of the sample based on the 719 ever-partnered women.

Table 3.1 The distribution of sample

Area		Wards	Households
Urban	*Ilorin*	8	373
Rural	*Offa*	5	204
	Erin-Ile	2	142
TOTAL		**15**	**719**

3.5 Survey instrument (Questionnaire)

The survey as stated earlier consists of a major questionnaire (the women's questionnaire) administered to all women in the randomly selected sample. The designed questionnaire has been adapted from the questionnaires of the WHO-Multicountry study on domestic violence against women (Garcia-Moreno et al., 2005) and the ICRW study on the cost of domestic violence (ICRW, 2009). It is an eight-section questionnaire including an individual consent form used across all the selected sites in the research. The questionnaire primarily contains structured questions with closed responses that solicit information about the respondent and

her community, her general state of health, her reproductive health and children (if applicable), her current or most recent partner, her employment and time use as well as those of her partner (current or previous), her attitude towards gender roles, her experiences of partner violence and the consequences of such violence (financial and health).

The initial sections collect information on less sensitive factors/issues, while questions pertaining to more sensitive factors – including the experience of partner violence (rate and nature of such violence) – are introduced in later sections, after a rapport has been necessarily established between the interviewer and respondent.

Estimates of the prevalence of different forms of IPV are obtained by asking the respondents behavioural-specific questions related to their experiences of the acts of physical, sexual and emotional (psychological) abuse from their present or previous partners. This approach commonly referred to as 'etic' in social science parlance has been used widely in similar studies conducted in the United states, Canada and other regions, and has been seen to encourage better disclosure of violence than other approaches such as the 'emic' approaches which exclusively give women the total control over the definition of IPV and thereby risking the possibility of not being able to draw meaningful conclusions from the final results (Ellsberg and Heise, 2005; Garcia-Moreno et al., 2005). Nonetheless, considering the fact that the definition or conceptualisation of IPV may vary from one woman to another or between cultures, a conservative conceptualisation of IPV, similar to the one used in the WHO multi-country study (Garcia-Moreno et al., 2005), has been adopted. And in this way, the prevalence estimates are more likely to give underestimates rather than overestimates of the true prevalence rates of IPV.

As expressed earlier, this concept of IPV against women in its different natures/forms (physical, sexual, psychological) has been operationalised using questions pertaining to acts that were considered to constitute the different forms of violence (in other words, 'behaviour-specific' questions). The list includes acts that are commonly occurring in violent relationships, and is compiled drawing on the experience of the WHO multi-country study (Garcia-Moreno et al., 2005) among other studies (EPRC, 2009; ICRW, 2009). This list (shown in Table 3.2) is intended to be comprehensive, but by no means exhaustive.

Table 3.2 Operational definition of component types of IPV used in the research study

Physical violence	**Psychological violence**
Has he or any other partner ever:	Has he or any other partner ever:
Slapped you or thrown something at you that could hurt you?	Insulted you or made you feel bad about yourself?
Pushed you or shoved you?	Belittled or humiliated you in front of other people?
Hit you with his fist or with something else that could hurt you?	Did things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling or smashing things)?
Kicked, dragged or beaten you up?	Threatened to hurt you or someone you care about?
Chocked or burnt you on purpose?	
Threatened to use or actually used a gun, knife or other weapon against you?	
Sexual violence	**Controlling behaviours**
Has he or any other partner ever physically forced you to have sexual intercourse when you did not want to?	He tries to keep you from seeing your friends?
Did you ever have sexual intercourse that was not physically forced on you, but because you were afraid of what he might do?	He tries to restrict contact with your family?
Did he ever force you to perform a sex act that you found degrading or humiliating?	Insists on knowing where you are at all times?
Did he ever deny you from any sexual activity when you particularly wanted it?	Ignores you and treats you indifferently?
	Gets angry if you speak with another man?
	He is often suspicious that you are unfaithful?
	He expects you to ask his permission before seeking health care for yourself?

After asking the respondents each of the above listed questions pertaining to physical, sexual and psychological violence, subsequent follow-up questions are also asked regarding the timing (whether it had happened ever or in the past 12 months prior to the research) and frequency (once or twice, a few times, or many times) of such form of abuse/violence. This design makes it possible to assess the levels of life-time or current exposures of women to IPV.

The Questionnaire also includes further questions on the occurrence of likely injuries. The questionnaire is designed in such a way that only individuals that reported IPV victimisations are asked this type of questions. And based on the report of injuries as a result of IPV, respondents/interviewees are asked additional questions on different forms of costs likely to be incurred in response to the violent incident.

In summary, the survey questionnaire seeks to detail the type of violence, the circumstances surrounding the violence, the attitude of women towards gender roles, and consequences to the victims, including injuries sustained, use of formal medical and mental health care services, as well as traditional medicine, contact with the criminal justice system (police and the judicial system), and time lost from usual activities (work and household chores).

The questionnaire is designed in both English and Yoruba (the major local language spoken in the study area). A copy of both versions of the women's questionnaire can be accessed/found in Appendices 1 and 2 of the thesis.

3.6 Data Collection

3.6.1 Training of field staff and pre-testing

The training of interviewers took 3 days with the first two days for the theory part of the training (getting acquainted with the research data collection materials, learning interview techniques, learning ethical requirements of the research and also the likely support that should be provided to the interviewees/respondents). The final day was for field practice and review. Field practice involved actual interviews in the field with women, and the first 20 practices were used as the bases for the research pilot study, from which further refinements to the research set-up were made. The pilot study was conducted on a convenient sample of women in an area of Kwara State not included in the study sample frame.

The initially trained fieldworkers included highly experienced Midwives and Nurses with over 10 years of professional experience and had conducted epidemiological research fieldwork with international organisations such as the WHO. Although this group of individuals have extensive experience, they were still briefed on what the fieldwork entails as

well as the ethical requirements. Other fieldworkers who were later recruited included a member of the Kwara State house of assembly (who volunteered to be part of the study), secondary school teachers and university students who were trained in the conduct of the research fieldwork and equally tutored about the ethical requirements of the research. The later recruited and trained individuals were made to spend some time shadowing the more experienced fieldworkers to get the grasp of the survey before they were sent to the field themselves. This group was also supervised continuously by at least a Midwife or a Nurse throughout the data collection process.

3.6.2 Organisation of fieldwork

Data regarding the women's experience of IPV (the women questionnaire/ household survey) has been collected by teams consisting of a supervisor, 2 to 3 interviewers and a data assessor/entry operator. The team moved in a roving manner and data collection lasted for about 90 days (from the 3rd of March till the 3rd of June 2012).

As it was understood that the topic of the research was a bit sensitive, each of the participants/interviewees was assured of anonymity to ensure full participation in the research and to facilitate the validity of research findings. The consent of each participant was recorded at the beginning of the interview and signed for by each interviewer.

3.6.3 Field monitoring and evaluation

In order to ensure better quality of data, extensive monitoring and evaluation has been carried out throughout the entire research fieldwork. Examples of such monitoring processes include: data cleaning (i.e., going through the collected data to check for inaccuracies, anomalies, incompleteness and inconsistencies that may affect the validity of the colleceted data). Feedback was also given to data collectors for improvements, and this involved weekly meetings for appraisal on the work carried out/completed and to discuss issues that the fieldworkers have been facing, as well as the correction of errors that might have been made during previous rounds of data collection (interviews). Ideas about the way forward with some of the pressing issues were also shared during such meetings.

3.6.4 Ethical considerations

Research within the realm of IPV, just as in other areas of violence against women/gender-based violence, is sensitive and it comes with issues of confidentiality, problems of disclosure and issues surrounding the need to ensure adequate and informed consent. To address these issues, this research adopted some ethical guidelines or considerations, not just to protect the safety of the respondents and researchers involved in the study, but also to ensure the quality of data collected.

The following are the steps taken to achieve the above stated goal of standard ethical practice in the research. These steps are in line with the WHO (2001) ethical and safety recommendations for research on domestic violence against women:

Prior to the start of the survey and in addition to the highlighted steps taken to meet standard ethical practice, the study sought local approval for the research and was granted by the Kwara State Government through the Ministry of Women's Affairs. A copy of the letter detailing the approaval is provided in Appendix 3 of the thesis.

Fieldworkers or research assistants were trained in the area of survey methodology, interviewing techniques and how to refer women requesting assistance to available sources of support. As few of these resources exist in the study area (Kwara State), this research tried to gather information about institutions in Kwara State that support women with such victimisations and make arrangements with the institutions to provide support for the likely victims of IPV requesting support. A list of the institutions providing this kind of support and willing to support abused women was compiled and given to the respondents at the end of the interviews, in case they require assistance or know of anyone who might need such help.

Informed consent forms were given to the participants in the research to ensure that they or the respondents understand the purpose of the research and that their participation in it is voluntary. Besides, the participants were advised that they can opt out of the study at any stage or skip any question they do not wish to answer.

Participant safety was ensured by (1) interviewing one woman per household, in order to prevent or avoid alerting other women who may communicate the nature of the research back to the potential perpetrator of violence; (2) not informing the wider community that the survey includes questions regarding violence against women (this was achieved by introducing the survey as one on women's health and life experiences); (3) not conducting **any** research on violence with men in the same population clusters where women samples have been taken; and (4) conducting the violence related interview in complete privacy. Where privacy cannot be ensured, participants were encouraged to reschedule the interview for another time or place.

To minimise participants' distress interviewers were trained to be aware of the effects some of the questions asked may have on them and the best way to respond – especially based on the woman's level of distress. Such training, as recommended by the WHO (2001), included basic introduction to IPV issues and general orientation to the concept of inequality in relationships. In addition, with the pervasiveness of IPV worldwide, there is a possibility of having one or more data collectors that have experienced IPV or know someone close to them that has experienced it. Therefore, we had open discussions about IPV in the training sessions, and also during the weekly meetings/debriefing we had further discussions about what the data collectors have been hearing from the participants and their feelings about this. This set of arrangements was put in place to afford emotional support for the fieldworker or research assistants during the training and briefing sessions, so as to help them withstand the demands of the fieldwork and also to improve their ability to gather quality data.

3.6.5 Data management and data set description

Data entry and manipulation:

At the end of each week of fieldwork, the completed questionnaires were submitted to the supervisor for assessment. Valid completed questionnaires were immediately entered by the data entry operator into the computer system with the aid of the IBM SPSS 20 statistical software. After every 20 entries into the computer system, the data entry operator screens the data for errors, which included out of range values and other inconsistencies in the collected data. In the advent of any error, the supervisor makes any necessary corrections if possible,

otherwise a revisit is recommended to the fieldworkers to obtain the missing information. Due to this laborious, but necessary, approach to data handling and the limited resources available for the fieldwork, there was a considerably large backlog of data entry work. But at the end of the whole process there was no need for revisiting as most of the data where properly collected. This gave the research team some respite.

Data coding:

Coding and analysis of data are two major aspects of the research that have been given reasonable consideration during the design of the questionnaires. As stated earlier, the questionnaire primarily contains structured questions with closed responses. With this kind of design, the coding of the collected data for entry into the IBM SPSS 20 application was straightforward as similar codes to those used in the questionnaire were adopted.

3.6.6 Recapitulation of steps taken to ensure data validity and reliability

Firstly, the data collection instrument (questionnaire) used is a standardised questionnaire that was adapted from from an internationally used questionnaire designed by the WHO (and was used in the WHO Multi-country study by Garcia-Moreno et al., 2005). The design also drew on the experience of the questionnaire designed by the ICRW (ICRW, 2009). This triangulation of ideas/questions in the two internationally used questionnaires (i.e., those of the WHO and ICRW) was aimed at improving the validity of the collected data. As the design of the questionnaire for this study was adapted as explained earlier, after the completion of its design the questionnaire was pre-tested in Nigeria to check its suitability for the research context (i.e., the Nigerian society), and ultimately to ensure measurement validity. In addition, the questionnaire was also translated and made available in a Nigerian local dialect (Yoruba) format to facilitate accurate data capture from likely participants that are not literate in the English language. Morover, data collectors involved in the research fieldwork were also given briefings (i.e., trained) in the use of the questionnaire to prevent differences or disparities in the responses of the participants across data collectors. As explained earlier, a precision-based sample size calculation was used to ensure adequate sample size is selected, that will facilitate the collection of valid amount of data to accurately answer the research questions. Besides, multisatege probability sampling procedure was also used in the selection of samples, facilitating the collection of data that is more representative

of the study population. To further enhance the validity of the data collected and ensure ethical compliance, approval was sought from the Kwara state government for the execution of the study. Moreover, informed consent was provided to each woman (participant) at the beginning of the data collection. Also during the face-to-face interviews, at the beginning of each section of the questionnaire, participants were given further opportunity to decline answering any question they are not comfortable with. Additionally, to improve the quality of the collected data and keeping in line with standard ethical practice, one woman was interviewed per household and in privacy with the assurance of anonymity and confidentiality.

3.7 Key definitions

Throughout this thesis, terminologies such as intimate partner violence (IPV), ever-partnered women, incidence, prevalence, and victimisation rates of IPV are used; and just as stated earlier regarding the definition of IPV, lack of consensus still exists about these types of IPV-related terminologies. Due to this fact, definitions of such terms as they were used in the execution of this research are given below in order to ensure that people reading the thesis have a consistent understanding of what the terminologies stand for, as well as to facilitate the comparison of the findings of this study to those of other similar research.

It is important to state that most of the definitions adopted are those of recognised international institutions such as the WHO, ICRW and CDC (WHO, 2010; ICRW, 2009 and NCIPC, 2003).

Ever-partnered woman denotes any woman who is currently or previously in an intimate relationship (whether marital, common-law, or dating relationship) with a male partner. This is used as a criterion in defining the population of the study, in that it describes the population of women that could possibly be at risk of IPV.

Intimate Partner Violence (IPV) is any behaviour carried out by male partners within an intimate relationship that causes physical, sexual and psychological harm to their female counterparts, including acts of physical aggression, sexual coercion and psychological/emotional abuse.

Prevalence is the number of ever-partnered women aged 18 and older who have been victimised by an intimate partner at some point during their lifetime (lifetime prevalence) or during the 12 months preceding the research fieldwork of this study (current prevalence).

Incidence is the number of separate episodes of IPV that occurred to women aged 18 and older during the 12 months preceding the survey (fieldwork of this study). For IPV, incidence frequently exceeds prevalence because IPV is often repeated. In other words, one victim (who is counted once under the prevalence definition) may experience several victimisations over the course of 12 months (each of which contributes to the incidence count).

Victimisation rate is the number of IPV victimisations involving women aged 18 years and older per 1,000 women of the same age bracket in the population. The population estimates used in this report are those of the 2006 Nigerian Census population count (NPC, 2010), which estimated the total population of women/females aged 18 and above in Kwara State to be 599,406 and the national estimate to be 36,436,730.

3.8 Data analysis procedures and measures calculated in the study

3.8.1 Overview

This section provides a detailed account of the data analysis procedures used in the course of the research. The next sub-section (3.8.2) provides information pertaining to the procedures used in the calculations of IPV prevalence as well as those involved in exploring the help-seeking behaviour of abused women and attitudes of women generally towards gender roles. The subsequent sub-sections consider the procedures used in the analysis of likely risk factors (3.8.3) and estimation of cost of IPV (3.8.4).

As regards the estimation of prevalence, exploration of help-seeking behaviour and risk factor analysis aspects of this research, the data collected are first examined using descriptive statistics (e.g. percentages, frequency distribution and cross-tabulations) and then inferential statistics are conducted to further explore the data (e.g., logistic regression). In the case of economic cost analysis aspect, accounting methods such as unit cost analysis and human

capital approach are used to estimate the costs to individuals or households. The estimates generated are then used to extrapolate the costs at the national level in terms of indices such as the Gross Domestic Product (GDP). All the statistical analyses in the research have been carried out using the IBM SPSS 20 Statistical software package.

3.8.2 Magnitude of IPV: Prevalence and Help-seeking behaviour

3.8.2.1 Prevalence

IBM SPSS 20 statistical software is used to automatically estimate the life-time and current prevalence of any form of IPV (i.e., physical, psychological and/or sexual violence), and also for each of the specific forms of IPV covered in the study. The process involved in the calculation is the division of the number of women aged 18 years and above victimised by their partners by the total number of women in the sample, to arrive at a fraction that can be expressed in terms of percentage of women experiencing a particular form(s) of violence. This descriptive analysis process also generates frequency tables to examine how socio-demographic and behavioural factors – age, area of residence, employment status, educational attainment, literacy, marital status, choice of spouse, parenthood status, partners' controlling behaviour, among others – affect the estimated (observed) prevalence of IPV against women. In other words, disaggregation of prevalence estimates by the factors. Besides, to enhance the presentation of results, frequency distribution charts and cross-tabulations are used to depict the prevalence estimate of specific/separate acts of abused (i.e., prevalence of acts that are considered as physical abuse; such as slapping, pushing and shoving). The number of separate episodes of IPV that occurred to each woman in the survey during the last 12 months prior to the study (**incidence rate**) are equally measured.

3.8.2.2 Help-seeking behaviour

In analysing the help-seeking behaviour of the IPV victims in the study, descriptive statistics such as counts and percentages are used to explore service usage in relation to the incidents reported by current IPV victims (e.g., the number and percentage of victims who sought help from hospitals, family members, police, the judicial system and those who sought no help were all covered in the analysis). Charts and Tables are used to depict the distribution of formal services usage and other different forms of help sought by the women.

3.8.2.3 Attitudes towards gender roles

To study attitudes towards gender roles, this research explores the perceptions of women towards certain questions related to their role in relationships and in the society. Just as adopted by the WHO in its Multi-country study (Garcia-Moreno et al., 2005), the key questions explored include whether women agree or disagree with the notion that:

(1) A good wife obeys her husband even if she disagrees;
(2) It is important for a man to show his wife/ partner who is the boss;
(3) A woman should be able to choose her own friend even if her husband disapproves;
(4) It is the wife's obligation to have sex with her husband even if she does not feel like it;
(5) Investing in a male child's education is far more valuable than that of a female;
(6) If a man mistreats his wife, outside agencies should intervene.

To study the women's perceptions towards these questions (i.e., their attitudes towards gender roles), descriptive statistics such as counts and percentage are used to explore the data collected. The results are then cross-tabulated against women's age groups, place of residence and educational attainment to gain a greater insight into the distribution of the various perceptions towards gender roles as studied in the research.

3.8.3 Analysis of likely risk factors of IPV in Nigeria

3.8.3.1 Overview of risk factors analysis

This section of the thesis presents procedures/steps taken in the research to explore, as likely risk factors, the effects of individual, relationship and general societal and community characteristics (independent variables) on IPV experienced by women (dependent variable).

Bivariate logistic regression analysis is first performed to study the crude association between each of the independent variables and occurrence of IPV (Simple logistic regression). The set of bivariate analyses is then followed by multivariable analyses (Sequential/hierarchical logistic regression). The independent variables explored at the individual, relationship and community levels include: woman's characteristics (age, literacy, educational attainment,

employment, partnership status, categorical number of children, rural-urban residence, and frequency of communication with her family), partner's characteristics (age, literacy, educational attainment, employment, general history of physical aggression, affairs with other women, alcohol use, history of drug use - substance taken for its narcotic effects, and controlling behaviours), as well as relationship characteristics (age difference, employment and educational disparity, payment of dowry/bride price, discord, and choice of partner). Moreover, community-level characteristics are also explored, and these include: level of female literacy in the community, level of male literacy in the community, level of female unemployment in the community, among other factors. Appendix 4 provides the list of variables.

Overall, the aim of these sets of analyses is to (1) explore the crude associations between IPV experience and different independent variables (likely risk factors), (2) explore the interactions between the independent variables that may be of significant importance in predicting IPV occurrence, (3) study how subsets of the independent variables may serve as likely mediators for one another, as regards their association with IPV occurrence, and (4) study, as a whole, the predictive capability of independent variables in order to have a more refined idea of the associations between the independent variables and the experience of IPV.

3.8.3.2 Simple Bivariate Logistic Regression

In this stage of the analytical procedure, a series of simple logistic regression analysis is conducted to study the association between each independent/predictor variable (which may be categorical or countinuos) and the experience of IPV. This means of exploring associations between two variables is selected as it works perfectly well when the outcome variable is categorical – in this case 'yes' or 'no' experience of IPV by women. Besides the fact that logistic regression is highly suited to a scenario where the outcome variable is categorical, this form of analysis has also been found to produce roboust and very accurate results just as other forms of analyses that are amenable to the same categorical outcome variable scenario (i.e., Chi-Squared test when the independent variable is also categorical).

At the core of the simple logistic regression analysis conducted in this study via SPSS is the regression equation 3.1:

$$\textbf{Log (P/1 - P)} = \beta_o + \beta_i X_i. \qquad \textbf{(3.1)}$$

Where $\mathbf{X_i}$ is each of the independent/predictor variables, **P** the probability of dependent variable (Y) = 1 (which signifies exposure to IPV), $\boldsymbol{\beta_o}$ the intercept or a constant, and $\boldsymbol{\beta_i}$ is the slope coefficient (which in the case of a categorical predictor is the change in log odds of a particular case belonging to a particular outcome category as opposed to another; while in the case of a continuous predictor variable $\boldsymbol{\beta_i}$ signifies the change in log odds for an increase of one unit in $\mathbf{X_i}$).

Results are expressed in the form of Odds Ratios (ORs) – which are derived by exponentiating the slope coefficients ($\boldsymbol{\beta_i}$) in an operation that involves the natural logarithm of $\boldsymbol{\beta_i}$. Moreover, it should also be noted that the statistically significant level is set at $p<0.05$ which is the conventional value adopted in most scientific analyses.

3.8.3.3 Multivariable Logistic Regression

Although the series of separate simple bivariate logistic regression analyses provide informative results, they fail to take into account the likely correlation that may exist among the various independent variables tested – in other words, the simple bivariate logistic analysis ignores the possibility that a collection of independent variables, that are individually feebly associated with the outcome variable, can become important predictors of the outcome when taken together. Besides, it is quite possible that the conclusions drawn based on the results of the simple bivariate analyses are distorted by a phenonmenon known as confounding, which is described by epidemiologist as a situation in which an independent variable is associated with both the outcome variable of interest and another independent variable that is also associated with the outcome variable (Hosmer et al., 2013).

Based on the foregoing, this research also conducts another set of analyses (the multivariable logistic regression analyses) to adjust or control the results for likely confounding, and also to model for other complex relationships that may exist between the independent variables and the experience of IPV (e.g., interaction/moderation).

Under the multivariable logistic regression analysis which followed the completion of the simple bivariate logistic regression, any variable whose simple logistic regression test result has a *p*-value of <0.05 is selected as a candidate alongside other variables whose *p*-values do not meet the significant criterion ($p<0.05$) but have been identified in previous research/literature to have significant impact on the occurrence of IPV. The selected variables are then partitioned into subsets/sub-categories and tested as separate multivariable logistic regression models (i.e., Model 1 – Basic Demographic Factors, Model 2 – Individual Educational Factors, Model 3 – Individual Employment Factors, Model 4 – Individual Social Factors, Model 5 – Attitudinal and Behavioural Factors, Model 6 – Sexual and Reproductive Health Factors, Model 7 – Relationship-level Factors, and Model 8 – General Societal and Community Factors).

This partitioning is conducted to see how each of the subsets of variables associates with IPV occurrence. Moreover, the rationale behind the partitioning is to minimise the number of variables in the fitted predictive model, as this will facilitate the generation of a more numerically stable model, one that is more easily generalised (extended to other contexts). Research has shown that the more variables included in a model, the higher the estimated standard error and the more dependent the generated model is to the observed data – i.e., the model becomes more difficult to generalise to other contexts (Tabachnick and Fidell, 2006; Hosmer et al., 2013).

Figure 3.1 shows the processes/steps involved in the development of the models. Basically, all variables relevant to a particular model are entered into a multivariable logistic regression analysis procedure in SPSS, and one of the test statistical results (the Wald test statistic *p*-value, to be precise) is then examined to identify variables that are statistically significant ($p<0.05$). Besides, the logistic regression coeffients of the variables in the model are also compared with those in the simple regression analyses. Those variables whose Wald *p*-values are not significant and also show similar coefficients as they did in the simple logistic regression analyses are eliminated from the model. A new model is fitted excluding the eliminated variables and the old (initial) model is then compared with the newly fitted one using test statistics known as maximum likelihood ratio tests (Omnibus Chi-Square test, and

Hosmer and Lemeshow test are the two used). In cases where the newly fitted model is showing marked changes from the old one (which implies that one or more of the removed variables provide needed adjustment to the model), the removed variables are returned one by one to examine which are causing the discrepancies. At this stage, the model is described as 'preliminary main effect model'. The preliminary main effect model is then assessed for variable interaction/moderation. This extra exploration of the data (inclusion of interaction variables/effect modifiers in the logistic regression model) aims at addressing one of the major issues that has eluded researchers in the field of gender-based violence in the past. As expressed by the WHO (2010), there are variations in risk factors identified from one country or society to the other, making the adoption of programmes between these societies difficult to achieve. Besides, as noted by O'Campo (2003), factors at different levels of the ecological framework are likely to have indirect meditational and moderational effects that may be important in the generation of health risks, protective factors and outcomes.

Therefore, by further exploring the collected data for interaction variables/effect modifiers, this study attempts to improve the paucity of information and facilitate the adoption, as well as development, of programmes in combating IPV not just in the developing world but also in developed ones.

To undertake this, an interaction variable is introduced to the model, one at a time, via an option available for this in SPSS. As stated earlier, the inclusion of the interaction variable (in other words, assessment of interactions or moderation amongst variables) is important as the likely existence of such interactions provides better understanding of the occurrence of IPV (for example, the interaction between a woman's employment status and that of her partner can provide better explanation of the occurrence of IPV than that afforded by just the woman's or partner's status only).

Nonetheless, the significant contribution of any interaction is checked in this research by first assessing the Wald *p*-value ($p<0.05$ was considered significant) and then the preliminary model including the interactions is compared to that without the interactions using likelihood ratio tests, and the emerging result is termed the final model for the subset of variables.

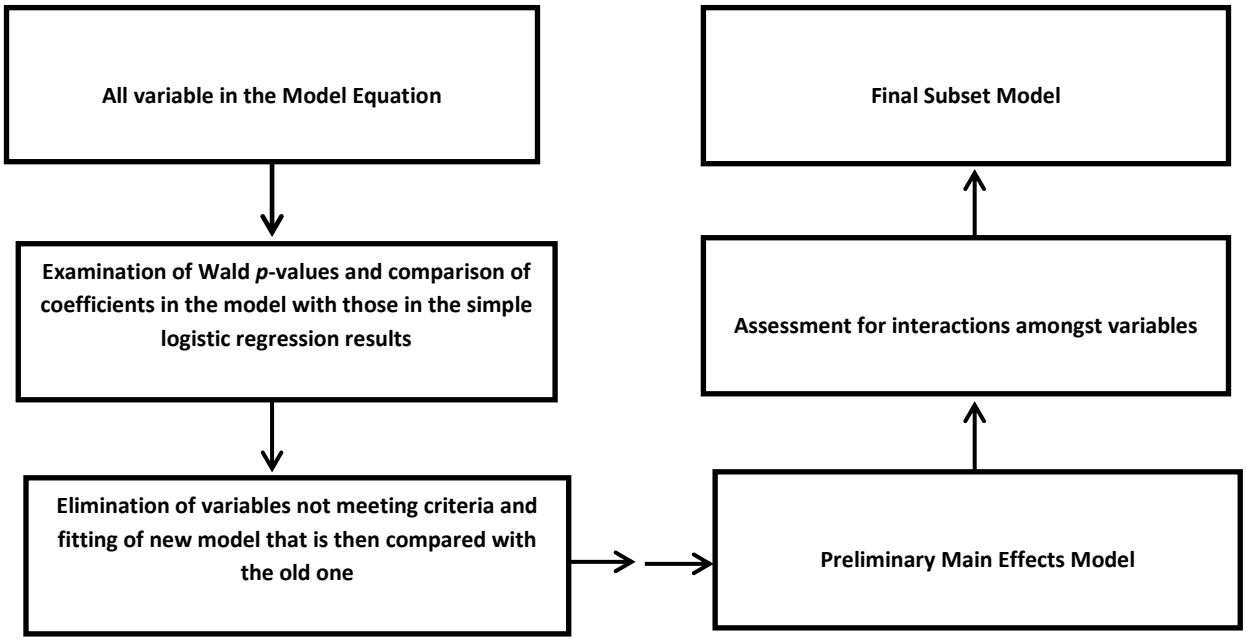

Figure 3.1 Steps in the development of subset models

Following the construction of the series of separate subset models, the next step in the multivariable analytic strategy is building a Sequential/hierarchical logistic regression model – 'Final Overall Model' – where the 'subset models' (blocks of variables) are entered in eight cumulative steps. This process leads to the generation of the best fitting, most parsimonious and scientifically reasonable model to describe the association between the sets of individual-, relationship- and general societal/community-level variables and women's experience of IPV. At the same time the sequential logistic regression analysis affords the opportunity to check whether there is any form of mediation between the subset models. Figures 3.2 and 3.3 show how the sequential logistic regression analysis is modelled. Figure 3.2 offers a schematic representation that entails the use of an ecological theoretical framework to demonstrate the complex relationships that may exist between IPV and factors/variables at the different levels of the theoretical framework, while Figure 3.3 affords a more detailed

breakdown of the steps involved in capturing the likely complexities (i.e., cumulative contributions of the subset models) with the use of sequential logistic regression analysis.

The first stage in the Sequential process involves the entry of the subset model 1 (Basic demographic factors) that was constructed in the initial round of the multivariable logistic regression analysis. In subsequent stages, each of the other constructed subset models are entered sequentially in the fashion depicted in Figure 3.3. To decide which subset models (i.e., variables) to include in the 'Final Overall Model', the extent to which each subset model associates with IPV or attenuates the association of other subsets is assessed at every level/stage of the sequential development process via Goodness-of-fit tests – Omnibus Chi-square test as well as Hosmer and Lemeshow test, with $p<0.05$ and $p>0.05$, respectively indicating good fit. In other words, when subset model 1 is entered into the sequential logistic regression process the Goodness-of-fit tests are used to check how well the subset predicts the experience of IPV. Then when subset model 2 enters the process, the tests are used to check wether the subset model provides a better prediction over and above that afforded by just subset model 1. Having included two subset models in the process, the inclusion of subset model 3 is used to explore the issue of wether the inclusion of this subset significantly add to the prediction of IPV after differences among subsets 1 and 2 have been statistically eliminated. This process is repeated for the other subset models to get the final detailed picture of what is going on. At the final step, which is the culmination of the development of the 'Final Overall Model', it is possible to answer two key questions: (1) what is the level of predictability of IPV using all the significant subsets of variables (subset models)? Or how well does the Final Overall Model fit to the predction of IPV? (2) How much does each variable or interaction amongst variables contribute to the prediction?

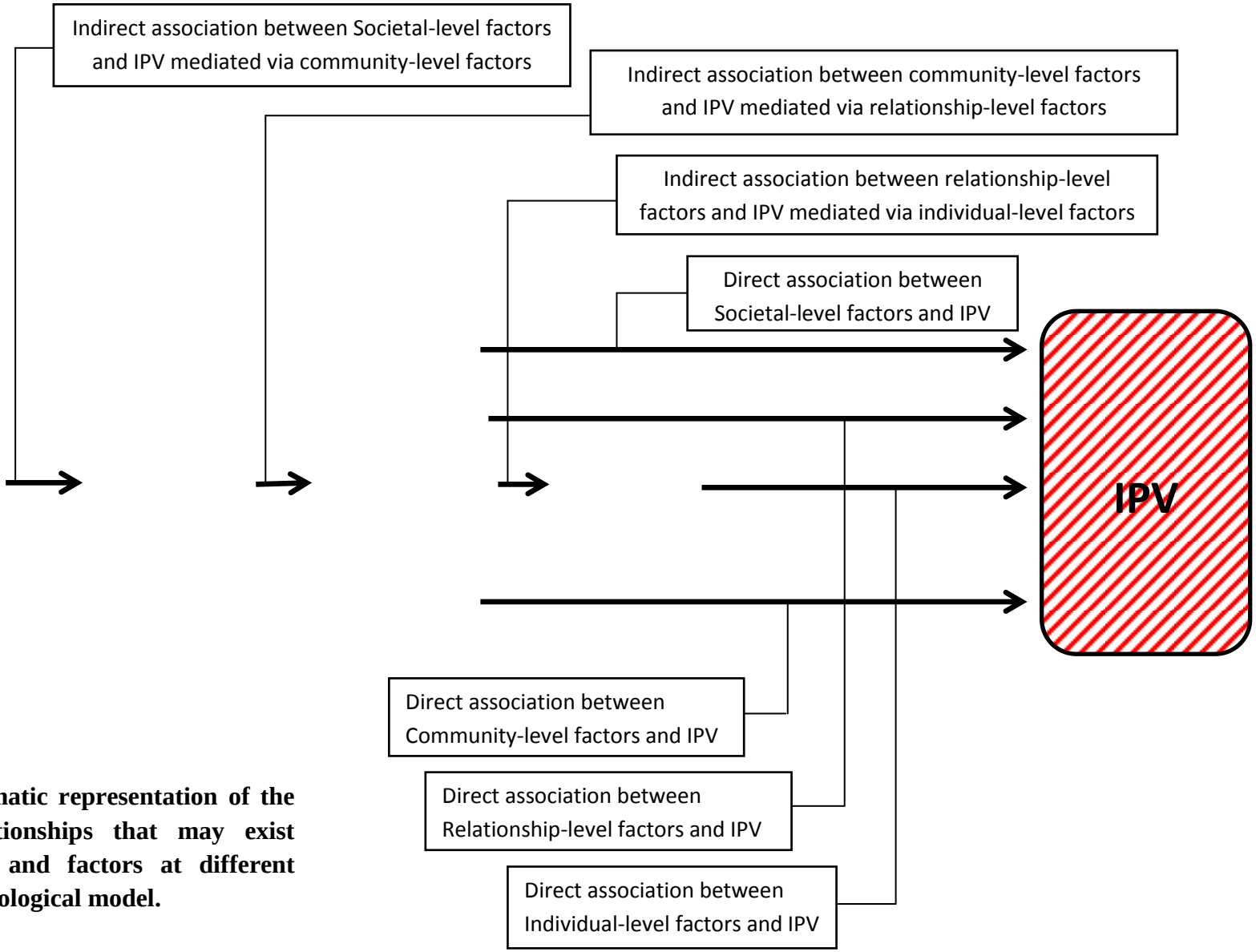

Figure 3.2 Schematic representation of the complex relationships that may exist between IPV and factors at different levels of the ecological model.

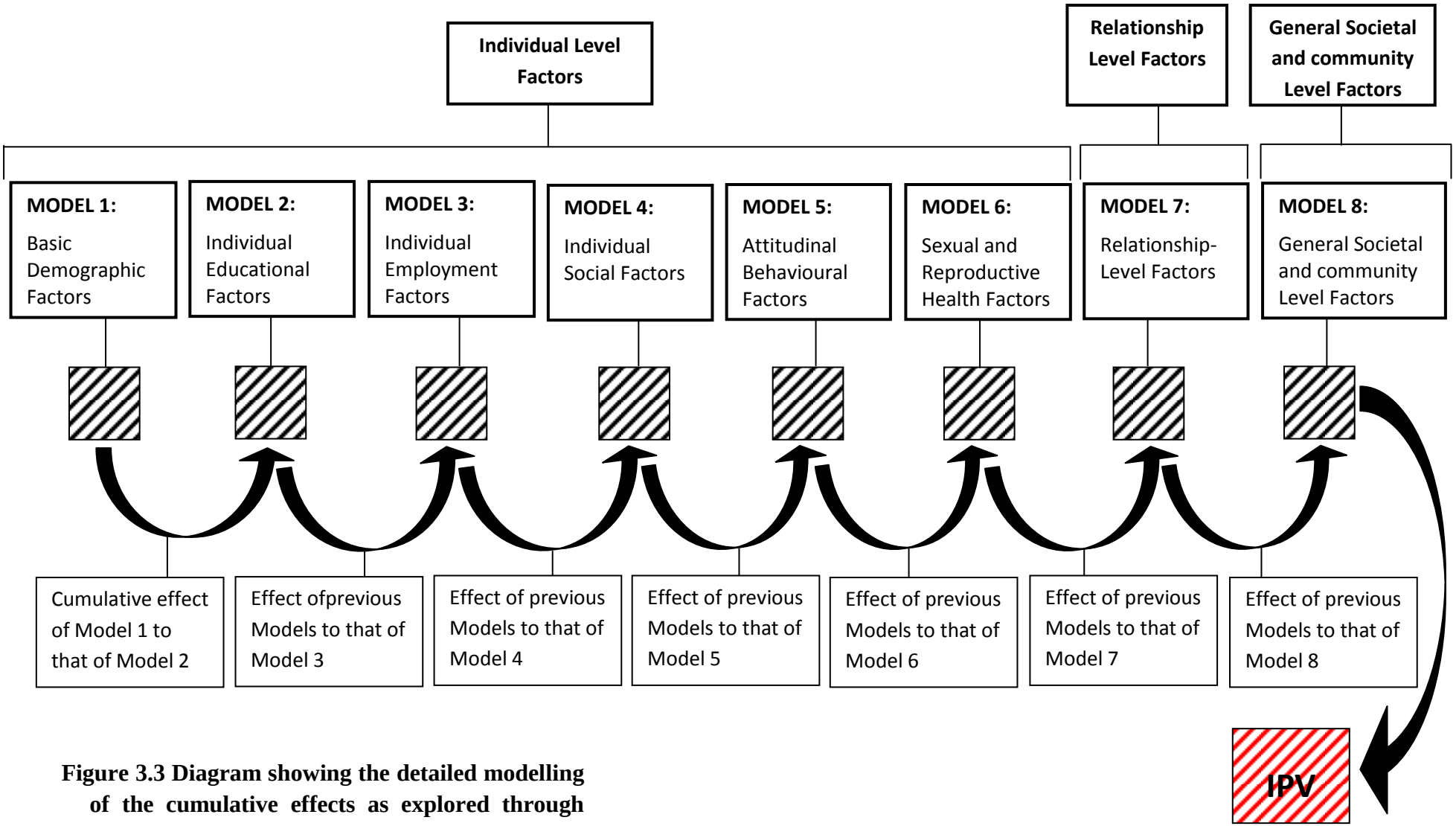

Figure 3.3 Diagram showing the detailed modelling of the cumulative effects as explored through Squential logistic regression in the research.

3.8.4 Socio-Economic Impacts: Costs Estimations of IPV

3.8.4.1 Costs estimation framework

As it is true for most developing countries, estimating the cost of IPV in Nigeria comes with some great challenges. These challenges range from economic to social ones, as a larger part of the economy is informal – in other words, a large percentage of the workforce is employed in the informal sector of the economy – and socio-cultural norms as well as patriarchal attitudes that encourage silence or non-disclosure of IPV occurrence are still the order of the day in the country (Olayanju et al., 2013).

Moreover, other issues such as inadequate services to cater for the needs of women, minimal utilisation of some available services, and service providers' inadequate information systems to capture the help-seeking behaviour of abused women are also probable factors that could hamper execution of costs estimation.

Nonetheless, to achieve the aim of getting a reliable estimate of the costs of IPV, this research draws from the experience of similar research conducted in other countries (Duvvury et al., 2012; BIDS, 2009; EPRC 2009; Hassan II University, 2009; Duvvury et al., 2004; Morrison and Orlando, 2004) and comes up with an operational costs estimation framework suited to the Nigerian context, keeping the earlier mentioned issues in perspective.

In the costs estimation framework adopted, the costs of IPV to the households start at the point of occurrence of the violence. It is assumed that Nigeria does not really have well-established preventive mechanisms in place to tackle IPV occurrence, and as a result the conceptualisation does not include the costs of prevention to the household or to the service provider.

As shown in Figure 3.4, although for households the occurrence of IPV may result in reduction in available income through out-of-pocket expenses, it may also result in loss of human capital, reduced income and loss of productivity. Therefore this research does not only focus on the economic costs of IPV in the form of out-of-pocket expenses (direct medical and non-medical costs), but also considers the reduced income as well as loss of productivity as a

result of IPV victimisations, even though achieving this is difficult due to the earlier stated fact that Nigeria is a developing nation and economic information emerging from the country shows that there is a predominance of household economies, which has great impact on the estimation of loss of human capital and loss of productivity. In other words, it means that there is an extensive informal and unpaid household production in this part of the world, which makes it difficult to assign correct and accurate values to lost and reduced productivity as a result of IPV.

From the conceptual framework, in Figure 3.4, it can also be deduced that, whether help was sought or not, there will be post-violence impacts on households, in the form of out-of-pocket costs, loss of productivity and others.

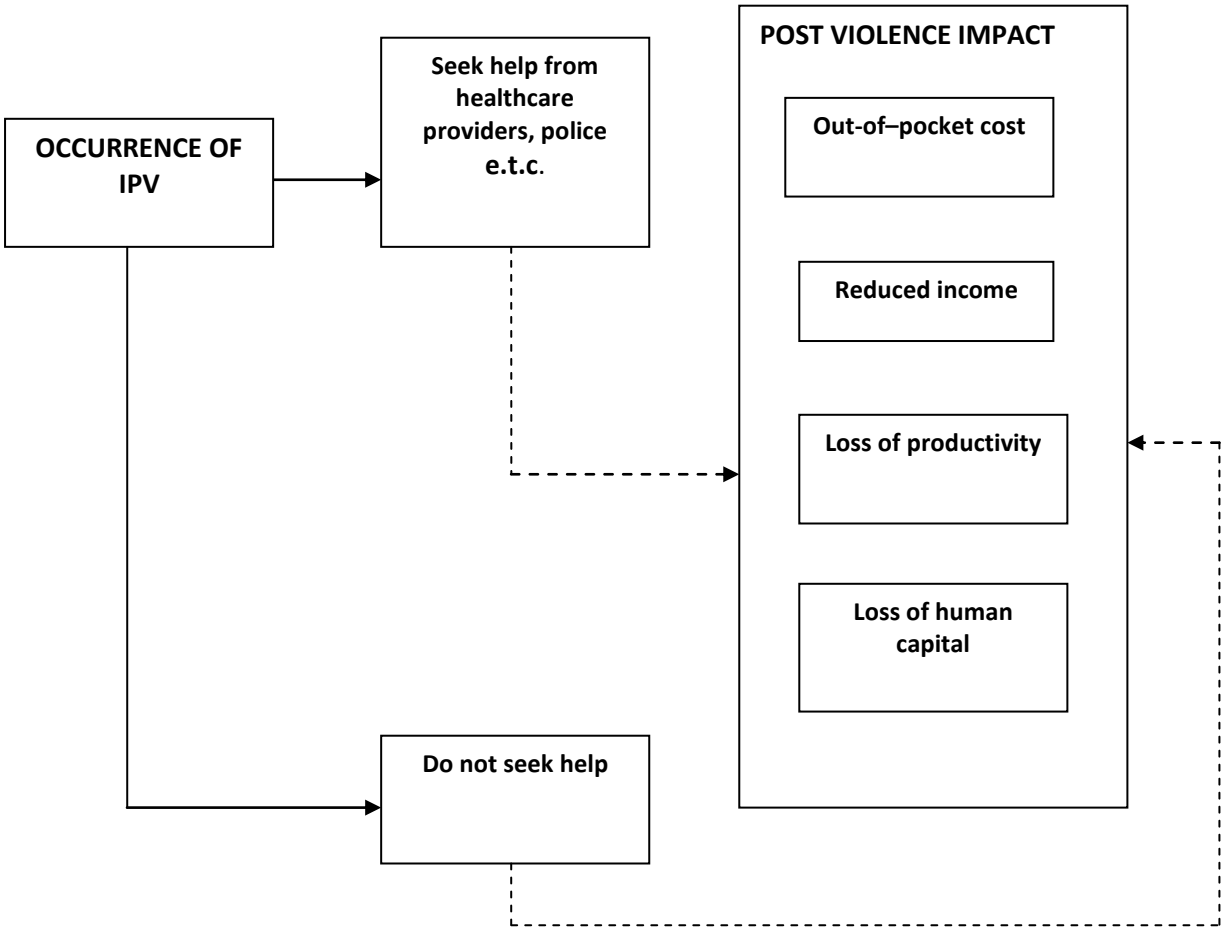

Figure 3.4 IPV costs conceptual framework – from occurrence to post violence economic impact on households (adapted from EPRC, 2009)

Table 3.3 captures the key components of the overall costs estimation framework that will be used in this research and it shows the different categories of costs for the various services and also shows the data requirement for the estimation of the categories of costs. In terms of the conceptual underpinning of the adopted framework, it is important to reiterate that the concept "costs" covers direct (out-of-pocket) expenditures incurred by households for the usage of services and indirect (imputed) value of goods and services – which includes lost income emanating from missed paid work and household work and school days lost for children in the household.

Table 3.3 Costs estimation framework (Adapted from Duvvury et al., 2004)

Level of Analysis	**Category of Costs**	**Type of Costs**	**Data/Infomation Requirement**
Direct household-level costs	Out-of-pocket expenditures		Actual spending on transportation and all fees paid for each service per each incident
	Formal Healthcare services	Emergency room care Hospitalisation Outpatient visits Nursing home care Mental healthcare Medication Dental care Ambulance/Transportation Surgery Psychological care	
	Traditional Healer	Consultation Traditional herbs Transport	
	Legal services	Mediation Divorce Legal counsel Temporary restraining order (TRO)	

	Police and social services	Police intervention Counselling Rehabilitation Transport	
	Housing and refuge	Hotel Shelters Rental housing Transition homes	
	Seeking help from Community leaders	Advice and consultation Transport	
Indirect household-level costs	*Reduced income*	Lost days of paid work immediately following incident (for victim and perpetrator) Lost days of paid work in order to access services (for victim and perpetrator)	Number of days (paid and unpaid) lost per each incident by woman and husband/partner Number of days lost in accessing services per each incident by woman and husband/partner Weighted average wage rate for women and men
	Loss of household services/ work	Lost days of household work immediately following incident for victim Lost day of household work due to accessing services (for victim)	Number of lost days of household work by woman per each incident Number of lost days in order to access services
	Impact on children	Missed schooling	Number of missed school days for each incident Annual school fees paid Annual number of school days
Macro-level costs	*Costs to the Nigerian Economy*	Direct costs (out-of-pocket expenditures) Lost Household earnings from missed paid work (total for both women and partners) Lost Household work (total for both women and partners) Costs of Missed Schooling	Results from the earlier mentioned household-level costs estimates (i.e., average unit costs per incident for each costs category) IPV victimisation rate Current Prevalence of IPV Total population of women aged 18 years and above Nigerian GDP estimate Nigerian annual appropriated Budget

3.8.4.2 Direct Costs

As stated earlier, the direct household-level costs considered in the study are out-of-pocket expenditures incurred as a result of IPV victims seeking support from different service providers (such as healthcare providers, police and court or legal services) as well as from friends and local community leaders. This direct costs category includes the actual amount paid for services, transport to access the different services/support and, in the case of healthcare costs, for example, includes the costs for medications. This can be written formally as a mathematical expression:

$$\textbf{Direct Cost} = \sum_{i=1}^{n}\sum_{x=1}^{m} C_{ix}S_{ix} \qquad (3.2)$$

Where:

$\mathbf{C_{ix}}$ = cost of each item *x* (that includes, but not limited to, transport costs or fees up to n items) used after incident *i*.

$\mathbf{S_{ix}}$ = number of usage of item *x* under service provider/support S (that includes, healthcare, police, legal services, community leaders up to m providers/support givers) after incident *i*.

Equation 3.2 simply implies that the total out-of-pocket expenditure for households as a result of IPV is the sum of the cost for each item ***x*** (that includes transport costs and/or service fees up to n items) used in accessing services/support provided by service provider (that includes healthcare, police, legal services up to m providers) in response to IPV occurrence. In succinct terms, total out-of-pocket costs are derived by multiplying average costs per incident by the number of incidents. It is important to note that the total out-of-pocket expenditure for households is estimated for one year (the past 12 months prior to the survey).

Nonetheless, not all women (victims) who reported out-of-pocket expenditures as a result of IPV incidents were likely to use all the services/support available, and as a result, the **average costs** for the different categories of services/support considered in this study are

weighted in order to adjust for variations in services/support usage prior to calculating the total direct (out-of-pocket) costs.

3.8.4.3 Indirect Costs

These costs feature: 1) **Reduced income** as a result of the days of paid work lost immediately after the incident, as well as days lost in the aftermath of violence to seek resolution. As these lost days not only affect the victims but also the perpetrators, this research study considers the lost days incurred by both parties. 2) **Loss of household work/chores** – includes the time lost to provide household services such as washing, cooking, shopping for household needs and running other errands. This indirect costs sub-category is also considered for both the abused women/victims and their partners/perpetrators. 3) **Impact on children** – this is a form of social cost of IPV, whereby children in the family are affected, most often by missing school despite the fact that the school fees have been paid.

To calculate the **reduced income** for a particular household member ***f*** (which may either be the woman/victim or the partner/perpetrator) following incident ***i***, the number of days of paid work missed by the household member due to IPV incidence is multiplied by the average market wage rate for the household member (in other words, average daily earnings for the household member). The calculation is performed separately for the woman (victim) and her partner (perpetrator). Finally, the summation of these income losses across different households represents the total reduced income at the household-level.

$$\textbf{Reduced income from lost days of paid work} = \sum_{i=1}\sum_{f=1} W_f L_{if} \qquad \textbf{(3.3)}$$

Where:

$\mathbf{W_f}$ = Market wage rate for household member *f* (i.e., average daily earning)

$\mathbf{L_{if}}$ = Days lost from market (paid) work by household member *f* following incident *i*

It should be noted that the calculation of market wage rate (average daily earnings) for each household member has been carried out based on the actual reported income.

To expand further, information used to derive the daily earnings included those solicited from the respondents (women) in the research – such as total amount earned in the last 12months (previous year), number of months worked and frequency of payment (whether hourly, daily, weekly, monthly or yearly). As recommended by Duvvury et al. (2012), in order to standardise as well as normalise the earnings figure across respondents, earnings reported (total amount earned in the last 12 months) are divided by the number of months worked, and then multiplied by 12 to derive what the individuals' earnings would be for working the year round. The standardised and normalised annual earnings are then divided by 248 (total number of work days in a year) to get daily earnings. These daily earnings are subsequently summed across the sample and divided by the number of individuals in the sample to get the average daily earnings.

$$\textbf{Average Daily Earning} = \frac{\sum_{i=1}^{n} \left(\left[\left(ER_i / MW_i \right) \times 12 \right] / 248 \right)}{n} \qquad \textbf{(3.4)}$$

Where:
ER*i* = Earnings reported by individual *i*/respondent *i*
MW*i* = Months worked by individual *i*/respondent *i*
n = total number of individuals in the sample

It should be noted that instead of a normal 260 work days in a year, this study opted for 248 work days, as this is typical for the Nigerian society. In other words, 248 days is more representative of the normal annual work days in Nigeria after accounting for the public holidays.

Moreover, another important aspect of the daily earnings calculation that should be carefully noted is that the sample in this study consists of individuals who are either salaried or self-

employed. Due to this fact, it is likely that the 248 work days adopted, although representative of those with salaried employment/jobs, may not necessarily be the typical number of work days for those who are self-employed. As such, there is a possibility of bias in terms of the daily earnings of those in the self-employed sector (i.e., a likelihood of overestimating the daily earnings of self-employeds).

Nonetheless, this procedure for the calculation of daily earnings is selected as opposed to other means of deriving such values, as studies have shown that it affords more robust results (Duvvury et al., 2012; Duvvury et al., 2004; Morrison and Orlando, 2004). An example of other means that have been used for the estimation of the average daily earning is a calculation based on mean age group of individuals, where mean annual earnings of the mean age group is divided by the number of paid working days per year to get the average/mean daily earnings (NCIPC, 2003).

The cost of **loss of household work/chores** is also calculated using a unit cost analysis procedure, where the estimated total number of household work hours lost by household member *f* (that may either be the woman/victim or her partner/ perpetrator) following IPV incident *i* is multiplied by an imputed market wage rate. It should be noted that the calculation is performed separately for women (victims) and their partners (perpetrators). Finally, the summation of these costs of lost household work hours across different households represents the total costs of lost household work hours in the study sample. Equation 3.5 is a mathematical expression of how these costs were estimated in the research.

$$\textbf{Cost of Loss of Household Work} = \sum_{i=1}^{} \sum_{f=1}^{} W^*_f L^*_{if} \qquad \textbf{(3.5)}$$

Where:

$\mathbf{W^*_f}$ = Imputed wage rate for household member *f*

$\mathbf{L^*_{if}}$ = Days lost from missed household work/chores by household member *f* following incident *i*

To initially derive the estimated number of missed household work hours by household member *f,* an approach known as Human Capital Approach is used. This method of analysing or extracting missed household work hours due to an IPV incident involves estimating the number of hours spent by the household member carrying out household activities following an IPV incident as a proportion of the total number of hours used by the household member on a 'normal day' carrying out such activities. The calculated proportion is subsequently multiplied by the number of household work days lost to get the total number of hours lost.

The imputed market wage (i.e., wage imputed for unpaid productive labour in the household – such as carrying out household chores) is derived from the minimum wage for casual labour in Nigeria which is ₦1500.00 per day for a workday that lasts for 9 hours. Therefore the imputed market wage used in this study is approximately ₦167.00 per hour.

The cost of IPV in terms of **school days lost for children in the family** is basically calculated by dividing number of missed school days for each child in the year by 195 days (the total number of school days in a year), and then multiplying the derived value by the total amount of school fees paid for the year for each child, before summing up across all the children involved.

$$\textbf{Costs of school days missed by children} = \sum_{i=1}\sum_{c=1}(\mathrm{MD}_{ic}/\mathrm{TD})\ \mathrm{SF} \qquad \textbf{(3.6)}$$

Where:

$\mathbf{MD}_{ic}$ = Number of missed school days by child *c* following incident *i* in the previous 12 months prior the study (i.e., average number of school days missed by a child per incident in a year)

TD = Total number of school days in the year

SF = Total amount of school fees paid for the year

The 195 days taken as the total number of school days in a year has been derived by first multiplying 5 school days per week by 52 weeks per year to get 260 school days in a year. As there are approximately 13 weeks of holidays per annum in the Nigerian educational system, 65 days were subtracted from the derived 260 days to adjust for the holidays and get the actual total number of school days in a year (195 days). In terms of the total amount of school fees paid per annum, information pertaining to school fees in Nigeria provided by Ali-Akpajiak et al. (2003), Theobald et al. (2008), and United States Diplomatic Mission to Nigeria (2014) were gleaned to derive the estimated amount of ₦16,500 that is used in this study.

Therefore the total household costs (THC) for the study sample are derived by summing all the different costs:

$$\mathbf{THC} = \sum_{i=1}^{n}\sum_{c=1}^{m} C_{ix}S_{ix} + \sum_{i=1}^{}\sum_{f=1}^{} W_f L_{if} + \sum_{i=1}^{}\sum_{f=1}^{} W^*_f L^*_{if} + \sum_{i=1}^{}\sum_{x=1}^{} (MD_{ic}/TD)\ SF \qquad \textbf{(3.7)}$$

3.8.4.4 Macro-estimates of costs to the Nigerian economy

To derive the macro-estimates of IPV costs to the Nigerian economy (in other words, the amount of resourses/money lost per annum as a result of IPV incidents in the country), the household-level costs estimates from the study sample are extrapolated to the Nigerian population (i.e., population of women aged 18 years and above).

The extrapolation process involves the use of the average (unit) costs of IPV from the different costs categories (i.e., out-of-pocket expenditure and the others stated earlier), victimisation/incident rate, current prevalence of IPV and a population parameter – the total

number of women aged 18 years and above in Nigeria (36,436,730 women). Initially, the current prevalence is multiplied by the total number of women (36,436,730) to get the estimated number of women experiencing IPV in Nigeria in the past 12 months prior to the study. The derived estimate is then multiplied by the victimisation (incident) rate of IPV to get the total number of incidents of IPV in Nigeria per year. Subsequently, the total number of incidents is multiplied by the average (unit) costs per incident estimated for each cost category to derive the total costs for the categories and the total costs to the Nigerian economy.

To provide a clear picture of the magnitude of these lost resources, the estimated costs to the Nigerian economy were also described using two different bases of reference – (1) the Nigerian GDP (Gross Domestic Product) in 2013 and (2) the National Budget for the year 2013.

It should be noted that the total number of women in Nigeria aged 18 years and above – 36,436,730 – has been derived from the most recent Nigerian Census Population Data collected in 2006 (NPC, 2010), while the prevalence and victimisation (incident) rates used are the ones derived from this research study.

3.9 Summary

This chapter commenced with an overview of the research design adopted in the study – the cross-sectional population-based household survey. In comparison with the suitability of other research designs, this design was deemed most suitable to address the research question and to provide better insight into IPV issues in Nigeria.

The chapter also provides justification for the sample size and expresses the critical inclusion criterion for the selection of participants in the research (women age 18 years and above who were previously or are currently involved in a cohabiting or non-cohabiting relationship). Additionally, the chapter gives an explanation of how the 719 data size used in the research was derived via a multistage sampling procedure.

The data collection instrument which is a questionnaire was also discussed in terms of its design and administration during the data collection process. The questionnaire was designed and pretested to capture data about sociodemographic identity, attitudinal and behavioural characteristics of the respondents and their partners as well as experiences and consequences of violence in their relationships.

The chapter also provides information on the ethical considerations involved in the research and definitions pertinent to key concepts explored in the research. The data analysis procedures adopted in the research were also discussed in this chapter. Specifically, the nature of the IBM SPSS statistical software package usage in the research was discussed. The estimation of prevalence, exploration of help-seeking behaviour and risk factor analysis areas of this research were examined via the use of descriptive means (frequency distribution and cross-tabulations) and inferential statistical (e.g., logistic regression) capability of the software package. The economic costs estimation aspects of the research were explored using accounting methods and human capital approach, based on the prevailing socio-economic conditions in Nigeria and other similar developing countries. The cost estimation processes were also facilitated using the SPSS software package.

Chapter 4 Results

4.1 Overview

This chapter of the thesis presents the results derived from the research, following the application of the different analytical procedures explained in the previous methodology section. It first presents the results pertaining to the prevalence of IPV experienced by the abused women, and then provides the results on the determinants/ likely risk factors of IPV in Nigeria. In addition, the chapter presents the results on the help-seeking behaviour of abused women, and then the results related to the attitudes towards gender roles and IPV. Finally, the chapter presents the results pertaining to the socio-economic costs of IPV, detailing both the costs to households and to the Nigerian economy.

4.2 Prevalence of IPV

As stated in detail earlier in the methodology section of this thesis, respondents in the research were asked whether any of their current or recent intimate partners had ever physically, psychologically, or sexually abused them. This was undertaken in order to explore the occurrence of violence. Tables 4.1, 4.2, 4.3 and 4.4, as well as Figures 4.1, 4.2 and 4.3 are the schematic presentations of the research results derived from the data analyses. The results in Table 4.1 are presented by different socio-demographic, attitudinal and behavioural characteristics of the women (respondents) and those of their partners. In other words, the results show the distribution of IPV prevalence with the different characteristics of the respondents and their partners. Besides, the results in Tables 4.2, 4.3 and 4.4 are those pertaining to specific forms of IPV (e.g., physical violence), and are presented according to the separate acts that constitute each form of violence as described in the methodology section of this thesis (i.e., prevalence of acts that are considered as physical abuse, such as slapping, pushing, shoving among others). Results regarding the overlap between the different forms of IPV are also presented in the form of Venn diagrams (Figure 4.2 for the life-time prevalence, and Figure 4.3 for the current prevalence). Furthermore, additional exploration of the data (i.e., assessment of IPV severity in terms of frequency of occurrence and number of incidents) was also conducted and figures 4.5 through to 4.9 present the results of these additional descriptive analyses.

It should be noted that in this presentation of the results, any statement of **life-time or current prevalence of IPV** implies the prevalence of any form of life-time or current violence, unless otherwise stated to mean just a specific form of violence in particular (e.g., physical abuse).

4.2.1 Life-time prevalence and current prevalence of IPV

The results in Figure 4.1 show that the life-time and current prevalence of IPV are 25.5% and 16.7%, respectively, with psychological abuse being the dominant form of IPV; this is closely followed by physical aggression (overall, 24.3% and 18.6% of women suffered from these forms of abuse over a life-time or currently, respectively). The results in Table 4.1 further show that there is not much difference in the prevalence of IPV between the urban and rural areas (with the urban and rural areas having a life-time prevalence of IPV of 26.3% and 24.6%, and a current prevalence of 16.6% and 16.8%, respectively). As regards age, women within the age category of 50 – 59 years show higher exposure to IPV (having a life-time prevalence of approximately 34.0% and a current prevalence of 22.9%); when the partner's age group is considered, women whose partners are between the ages of 30 – 39 show the highest level of life-time IPV prevalence (28.8%), while those with partners in the age group of 40 – 49 years have the highest current IPV prevalence (21.0%). These distributions of IPV occurrence are further explored in terms of frequency and incidents in section 4.2.6.

In terms of partnership age difference, women who are 1 – 4 years younger than their partners show the highest level of life-time IPV victimisation (approximately 29%), while those who are 5 – 9 years younger than their partners are more predisposed to current IPV experience (19.1%). When compared with women having higher educational attainment, those with lower or no attainment at all show greater prevalence of IPV (those with primary or no attainment at all having a life-time prevalence of 48.9% and 43.0%, respectively). They also show similarly higher levels for current prevalence (42.2% and 35.5%, respectively). Just as in the case of the women, the results pertaining to partner's attainment indicate higher cases of IPV victimisation amongst women with partners having lower educational

attainments (life-time prevalence of 35.5% amongst those whose partners have no attainments at all, as compared with 19.8% amongst those having partners with tertiary/higher educational attainments). When partnership educational difference is considered, the results show that relationships with educational disparities tend to be fraught with cases of IPV. Situations where women are better educated indicate life-time IPV prevalence levels of 26.1% and a current prevalence of 21.7%, while cases where male partners are better educated show a life-time prevalence of approximately 33.0% and a current prevalence of 24.6%. In terms of literacy amongst the women, those who are not literate show a higher level of both current and life-time experience of IPV (36.0% and 43.2%, respectively). The results also show a similar outcome when the partner's literacy is considered – a current and life-time prevalence of 33.3% and 36.5%, respectively.

Regarding employment, women who are in employment tend to be more exposed to IPV experience (those in employment having a life-time and current prevalence of 25.9% and 18.0%, respectively, as compared with 24.0% and 12.6% for those that are not working, respectively). In terms of partner's employment status, women who are in partnership with men in employment show higher prevalence of IPV (a life-time prevalence of 26.0% and current prevalence of 17.1%). When partnership employment (i.e., whether both or one of the couple is employed) is considered, there is no significant difference in IPV prevalence between cases where both the woman and her partner are employed (current prevalence 18.7%) and those where both are unemployed (current prevalence of 18.5%). Nonetheless, these two situations show greater IPV prevalence as compared with circumstances where only one of the two is employed – current prevalence of 3.6% when only the woman is employed, and 10.1% when only the partner is employed. When the data is further explored in terms of the nature of employment, the results show that those women in unpaid family work are more exposed to IPV experience (with a current and life-time prevalence of 42.0% and 41.7%, respectively). Women whose partners are also in unpaid family work are also more predisposed to IPV experience (a current prevalence of 30.8% and life-time prevalence of 38.5%).

As regards partnership/relationship status, women who are currently living with a man (partner), but not yet married show the highest life-time IPV prevalence (31.8%), while those

who are currently married show the highest current exposure to IPV (current IPV prevalence of 19.4%).

Moreover, situations where other people choose a partner (spouse) for the women without their consent show extremely high levels of IPV (a current and life-time prevalence of 62.2% and 70.3%, respectively). Cases where partnerships involve financial commitments – with both dowry and bride price paid – show the highest prevalence of IPV (current and life-time prevalence of 33.3% and 37.0%, respectively).

Considering a partner's history of physical aggression, women with partners who have such history show higher prevalence of IPV (current prevalence of 37.2% and life-time prevalence of 45.9%). Women who accept the use of violence within an intimate relationship (i.e., agree with a reason for a man to beat up his partner), surprisingly, show slightly lower prevalence of IPV (a current and life-time IPV prevalence of 16.5% and 24.8% respectively, as compared with 16.8% and 25.8%, respectively, for those who disagree with beating of partner/spouse). Moreover, women who categorically stated that their partners have never engaged in sexual affairs with other women, whilst they are still with them, show far less experience of IPV than those who expressed that their partners have, may have or even stated that they do not know whether they have such affairs.

As regards contraception refusal by partners, there is no significant difference between cases with such refusal and those without. With respect to history of miscarriages, stillbirths, and abortions, women with such history and those without show only slight difference in life-time experience of violence (25.1% and 25.5%, respectively); but when current prevalence is considered, those with such history show higher prevalence (21.1%) as compared with those without (15.3%).

In terms of parenthood status, there is no significant difference in the life-time experience of IPV between those women who have children and those who do not (25.8% and 24.3%, respectively); although, those with children show slightly higher current IPV prevalence

(18.2% as compared with 12.4% amongst those without children). Besides, women with five or more children tend to show higher prevalence of IPV (current prevalence of 24.4% and life-time prevalence of 30.4%); although, those with only one or two children also show equally high life-time prevalence of violence (30.5%). Considering the gender of children, the results show that women with only female children tend to experience higher prevalence of IPV (current prevalence of 19.0% and life-time prevalence of 28.6%).

The results also show that male partners having 4 or more controlling behaviours tend to be greater perpetrators of IPV – with women in a partnership with such men displaying a life-time prevalence that is as high as 46.8% and a current prevalence of 30.3%. With regard to alcohol use by partners, women with partners who use alcohol on a daily basis tend to be more predisposed to experiencing IPV (a life-time prevalence of 39%). The results also show that intimate partners who are physically, psychologically or sexually violent tend to have a history of drug use (substance abuse). Women with partners who use drugs on a daily basis or twice a month have a life-time IPV prevalence that ranges from 81.5% - 90% and a current prevalence that ranges from 63% - 80%, making them highly predisposed to experiencing all forms of IPV. Women who reported frequent occurrence of discord in their relationships show a remarkably higher experience of IPV (with a life-time IPV prevalence that is as high as 61.7% and a current prevalence of 47.3%).

Regarding the frequency of communication with family members, women who hardly ever communicate with their family tend to experience IPV more. The same applies in terms of proximity to family members – women who live further away from their family have a higher prevalence of IPV than those who live near by (current and life-time prevalence for those who live further away are 27.6% and 38.6%, respectively).

Furthermore, these results support the hypothesis made regarding the prevalence of IPV in Nigeria at the inception of the study. Particularly, the 25.5% prevalence of life-time experience of IPV recorded supports the hypothesis that the prevalence of IPV against women in Nigeria is high, while other results regarding the distribution of prevalence based

on social and demographic attributes support the hypothesis that there is considerable variability in the prevalence of IPV based on these factors.

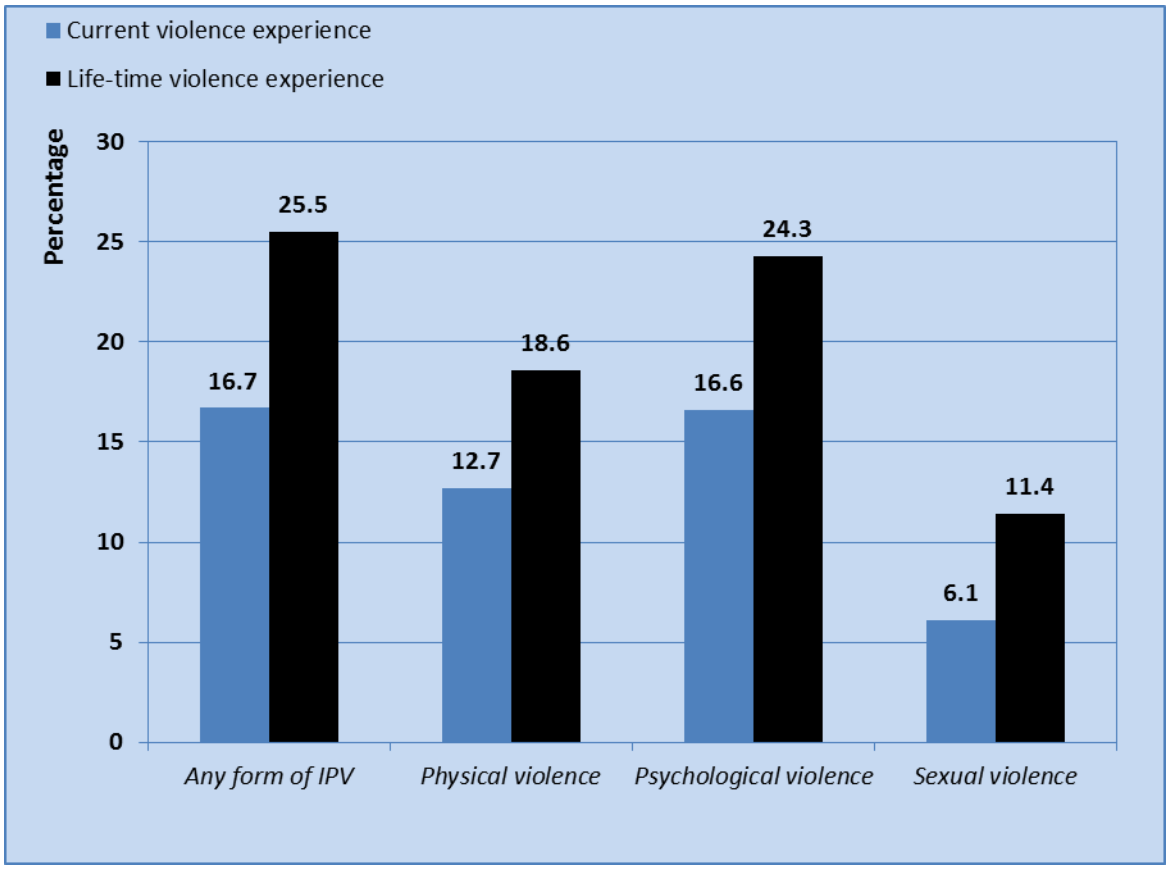

Figure 4.1 Current and life-time prevalence of any form of IPV, physical aggression, psychological abuse and sexual coercion

Table 4.1 Prevalence of Physical, Psychological, Sexual and any form of violence (Physical, Psychological and/or Sexual) by various demographic and attitudinal characteristics of the respondents and their partners, and attributes of their relationships)

		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
Variable		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Site	*Rural*	18.8	13.9	23.4	16.8	10.7	5.5	24.6	16.8	346
	Urban	18.5	11.5	25.2	16.4	12.1	6.7	26.3	16.6	373
Location	*Ilorin*	18.5	11.5	25.2	16.4	12.1	6.7	26.3	16.6	373
	Offa	18.1	14.2	23.0	16.7	13.2	6.9	25.0	16.7	204
	Erin-Ile	19.7	13.4	23.9	16.9	7.0	3.5	23.9	16.9	142
Respondent's age group	*18 – 29*	15.3	8.4	24.5	11.2	12.0	4.0	27.3	11.6	249
	30 – 39	21.5	18.1	23.0	20.4	11.3	8.3	23.0	20.4	265
	40 – 49	18.0	10.0	24.0	18.0	9.3	5.3	24.7	18.0	150
	50 – 59	28.6	17.1	34.3	22.9	17.1	5.7	34.3	22.9	35
	60 and above	10.0	5.0	25.0	10.0	10.0	10.0	25.0	10.0	20
Respondent literate	*No*	40.8	33.6	43.2	36.0	18.4	14.4	43.2	36.0	125
	Yes	14.0	8.2	20.4	12.5	9.9	4.4	21.7	12.6	594

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Respondent's educational attainment	*None*	40.5	33.1	43.0	35.5	18.2	14.0	43.0	35.5	121
	Primary	35.6	28.9	48.9	42.2	20.0	15.6	48.9	42.2	45
	Secondary	16.4	10.2	22.3	14.8	12.1	5.9	23.0	14.8	256
	Higher	9.1	4.0	14.8	6.4	6.7	1.7	16.8	6.7	297
Marital/ relationship status	*Currently married*	21.3	15.8	26.2	19.4	11.0	7.2	26.4	19.4	545
	Currently living with a man, but not married	13.6	0.0	31.8	13.6	9.1	4.5	31.8	13.6	22
	Currently having a regular partner who lives apart	9.4	3.6	16.5	6.5	13.7	2.9	21.6	7.2	139
	Divorced, broken up with partner or widowed	15.4	0.0	15.4	7.7	7.7	0.0	15.4	7.7	13
Choice of spouse/partner	*Both chose*	17.2	11.1	22.4	14.9	10.7	5.3	23.8	15.0	606
	Respondent chose	0.0	0.0	10.0	0.0	0.0	0.0	10.0	0.0	20

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
	Others chose with respondent's consent	10.7	7.1	19.6	10.7	8.9	3.6	19.6	10.7	56
	Others chose without respondent's consent	64.9	54.1	70.3	62.2	32.4	27.0	70.3	62.2	56
Partnership involves financial commitments	*No payments*	12.2	5.3	20.2	9.6	14.4	4.8	23.9	10.1	188
	Dowry	17.1	13.6	22.3	17.3	9.5	6.4	22.3	17.3	346
	Bride price	26.9	15.4	32.3	20.8	9.2	6.2	33.1	20.8	130
	Both dowry and bride price	37.0	33.3	37.0	33.3	18.5	11.1	37.0	33.3	27
	Respondent does not know	25.0	17.9	28.6	17.9	17.9	7.1	28.6	17.9	28
Respondent has ever been pregnant	*No*	11.8	8.1	20.5	11.2	12.4	3.7	23.6	11.2	161
	Yes	20.7	14.1	25.4	18.1	11.2	6.9	25.9	18.3	552
	May be	16.7	0.0	33.3	16.7	0.0	0.0	33.3	16.7	6

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Parenthood status	*No*	13.0	8.6	21.6	12.4	11.9	4.3	24.3	12.4	185
	Yes	20.6	14.0	25.3	18.0	11.2	6.7	25.8	18.2	534
Contraception refusal by partner	*No*	18.8	13.9	25.6	17.1	11.7	6.6	26.9	17.3	532
	Yes	21.1	10.6	23.6	16.8	12.4	5.6	24.2	16.8	161
Partner's age group	*18 – 29*	11.1	4.2	18.8	6.9	12.5	2.1	22.9	6.9	144
	30 – 39	22.4	18.8	28.2	20.0	10.0	7.6	28.8	20.6	170
	40 – 49	21.5	14.9	26.2	21.0	9.2	6.2	26.2	21.0	195
	50 – 59	22.8	13.8	26.2	19.3	17.2	9.0	26.9	19.3	145
	60 and above	7.7	6.2	16.9	9.2	6.2	4.6	16.9	9.2	65
Partner literate	*No*	34.4	30.2	36.5	33.3	18.8	17.7	36.5	33.3	96
	Yes	16.2	10.0	22.5	14.0	10.3	4.3	23.8	14.1	623
Partner's educational attainment	*None*	34.4	30.1	35.5	32.3	17.2	16.1	35.5	32.3	93
	Primary	28.6	21.4	32.1	25.0	17.9	14.3	32.1	25.0	28
	Secondary	29.4	19.6	34.0	24.2	15.0	6.5	34.6	24.2	153
	Higher	11.0	6.1	18.2	10.1	8.5	3.4	19.8	10.3	445

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Partner's use of alcohol	*Never*	12.0	8.1	17.7	10.8	4.7	1.5	18.7	10.8	407
	Everyday	35.0	25.2	39.0	30.9	22.0	14.6	39.0	30.9	123
	Once a week	29.0	24.7	34.4	31.2	23.7	17.2	35.5	31.2	93
	1 – 3 times a month	16.7	0.0	25.0	0.0	8.3	0.0	25.0	0.0	36
	Less than once a month	13.0	8.7	17.4	13.0	17.4	13.0	21.7	17.4	23
	Respondent does not know	16.2	5.4	27.0	13.5	18.9	2.7	32.4	13.5	37
Partner's history of drug use	*Never*	12.8	7.3	18.1	10.4	8.5	3.4	19.3	10.5	626
	Every day	74.1	55.6	81.5	63.0	37.0	25.9	81.5	63.0	27
	1 – 4 times a month	80.0	60.0	90.0	80.0	40.0	30.0	90.0	80.0	10
	Respondent does not know	46.4	42.9	55.4	51.8	26.8	23.2	55.4	51.8	56
Partner engaged in affairs with other women	*No*	7.6	4.7	13.3	5.7	4.3	0.9	15.2	6.2	211
	Yes	18.8	10.2	24.4	17.8	13.7	8.1	24.4	17.8	197
	May have	31.1	21.6	37.8	24.3	18.9	9.5	39.2	24.3	74
	Respondent does not know	24.5	19.0	30.0	22.8	13.5	8.0	31.2	22.8	237

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Partner's general history of physical aggression	*No*	12.3	6.8	17.9	10.2	8.1	3.0	19.4	10.4	530
	Yes	41.2	32.4	45.9	37.2	23.6	18.2	45.9	37.2	148
	Respondent does not know	19.5	17.1	29.3	24.4	9.8	2.4	29.3	24.4	41
Respondent in employment	*No*	12.6	7.4	21.1	12.6	12.0	3.4	24.0	12.6	175
	Yes	20.6	14.3	25.4	17.8	11.2	7.0	25.9	18.0	544
Nature of respondent's work	*Salaried*	15.5	8.9	22.5	13.7	10.0	4.4	23.6	14.0	271
	Self-employed	24.9	18.8	27.6	21.1	12.3	9.2	27.6	21.1	261
	Unpaid family worker	41.7	41.7	41.7	41.7	16.7	16.7	41.7	41.7	12
Partner in employment	*No*	12.5	11.2	20.0	13.8	6.2	3.8	21.2	13.8	80
	Yes	19.4	12.8	24.9	16.9	12.1	6.4	26.0	17.1	639
Nature of partner's work	*Salaried*	16.0	9.0	21.8	14.1	10.6	4.5	23.4	14.4	376
	Self-employed	24.0	18.0	28.8	20.4	14.4	9.2	29.2	20.4	250
	Unpaid family worker	30.8	23.1	38.5	30.8	7.7	7.7	38.5	30.8	13

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Respondent's proximity to her family	*Live with family of birth*	14.3	9.5	19.0	11.1	9.5	1.6	22.2	11.1	63
	Live near	15.7	10.6	21.3	14.1	9.8	5.3	22.1	14.3	511
	Live further away	31.0	21.4	37.2	27.6	17.9	11.0	38.6	27.6	145
Respondent's frequency of communication with family members	*Corresponds at least once a week*	15.7	10.2	20.0	14.0	9.7	4.8	20.9	14.3	421
	Corresponds at least once a month	19.9	12.2	29.5	16.7	10.9	6.4	30.8	16.7	156
	Corresponds at least once a year	36.6	31.0	42.3	36.6	21.1	16.9	42.3	36.6	76
	Never or hardly corresponds	33.3	22.2	44.4	22.2	33.3	11.1	44.4	22.2	9
Partnership employment	*Both employed*	21.6	15.1	26.3	18.5	11.6	7.3	26.8	18.7	518
	Only partner employed	9.2	3.4	18.5	10.1	13.4	2.5	21.8	10.1	119

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
	Only woman/ respondent employed	3.6	0.0	10.7	3.6	7.1	0.0	10.7	3.6	28
	Both unemployed	18.5	16.7	25.9	18.5	7.4	5.6	27.8	18.5	54
Partnership age difference	*Woman older*	15.4	15.4	15.4	15.4	15.4	7.7	15.4	15.4	13
	Woman is same age	21.7	17.4	26.1	17.4	13.0	4.3	26.1	17.4	23
	Woman is 1-4 years younger	21.8	13.1	27.3	16.7	9.5	4.7	28.7	16.7	275
	Woman is 5-9 years younger	18.2	13.3	24.4	18.7	14.7	7.6	26.2	19.1	225
	Woman is 10+ years younger	14.2	10.4	20.2	13.7	9.8	6.6	20.2	13.7	183
Partnership educational difference	*Partner better educated*	24.1	18.0	32.5	24.6	14.0	8.3	32.9	24.6	228
	Woman/ Respondent better educated	23.9	15.2	26.1	21.7	17.4	10.9	26.1	21.7	46
	Same level	15.3	9.7	20.0	11.9	9.4	4.5	21.6	12.1	445

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Partner's controlling behaviour	*None*	3.5	0.9	3.5	1.8	0.0	0.0	3.5	1.8	113
	One	7.3	3.6	10.0	8.2	2.7	0.9	11.8	8.2	110
	Two or Three	15.5	11.2	22.3	15.1	8.3	4.7	23.0	15.5	278
	Four or more	36.2	25.2	45.0	30.3	25.7	13.8	46.8	30.3	218
Categorical number of children	*None*	13.0	8.6	21.6	12.4	11.9	4.3	24.3	12.4	185
	One or Two	24.8	17.0	29.1	18.4	11.3	7.8	30.5	19.1	141
	Three or Four	17.1	11.6	20.5	14.3	8.5	4.3	20.9	14.3	258
	Five or more	23.0	15.6	30.4	24.4	16.3	10.4	30.4	24.4	135
History of miscarriages, stillbirths and abortion	*No*	18.8	12.2	24.1	15.1	10.9	5.5	25.5	15.3	548
	Yes	18.1	14.0	25.1	21.1	12.9	8.2	25.1	21.1	171
Partnership discord	*Never*	1.8	1.8	3.5	2.7	1.8	0.9	4.4	2.7	113
	Rarely	11.2	5.7	15.7	8.4	6.6	1.6	17.1	8.7	439
	Often/ Sometimes	49.7	38.3	61.1	47.3	30.5	21.6	61.7	47.3	167

(continued)

Table 4.1 continued

Variable		Physical violence		Psychological violence		Sexual violence		Any form of violence		Total number of respondents
		Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Sex(es) of child(ren)	*Only male*	25.0	16.1	25.0	17.9	12.5	8.9	25.0	17.9	56
	Only female	23.8	17.5	28.6	19.0	14.3	9.5	28.6	19.0	63
	Both male and female	19.5	13.3	24.8	17.8	10.6	6.0	25.5	18.1	415
	No children at all	13.0	8.6	21.6	12.4	11.9	4.3	24.3	12.4	185
Respondent's acceptance of violence	*Disagrees with all of the reasons to beat wife*	19.7	13.4	24.5	16.6	10.7	6.1	25.8	16.8	477
	Agrees with one or more of the reasons to beat wife	16.5	11.2	24.0	16.5	12.8	6.2	24.8	16.5	242
Total		**18.6**	**12.7**	**24.3**	**16.6**	**11.4**	**6.1**	**25.5**	**16.7**	**719**

4.2.2 Prevalence of Acts of Physical violence

As stated earlier, overall, the results show that the life-time prevalence for the physical form of IPV is 18.6%, and the current prevalence is 12.7%. As this form of IPV is constituted by different acts of violence, Table 4.2 shows the percentage distribution of women's experience of the various acts covered in this study, which is also stratified by place of residence (i.e., Rural or Urban).

The physical violence acts covered in this study are: Being slapped or thrown at by objects that could hurt, pushed or shoved, hit with the fist or something else that could hurt, kicked, dragged or beaten up, chocked or burnt on purpose, and threatened or hurt with a gun, knife or other weapon.

As shown in Table 4.2 the most common act of physical violence experienced over a life-time is pushing and shoving, with 17% of women experiencing it. This act of violence is also the most experienced in terms of current prevalence (11.6%). The results also show that women residing in rural areas suffer more of the severe acts of violence (i.e., being hit with fist or something that could hurt; kicked, dragged or beaten up; chocked or burnt on purpose; and threatened or hurt with gun, knife or other weapon) as compared with their urban counterparts. For example, all the reported cases of being chocked or burnt on purpose, as well as cases of being threatened or hurt with a weapon, came from the rural areas. In addition, the current prevalence recorded in terms of women being kicked, dragged or beaten up was 4.6% in the rural areas as compared with 3.1% in the urban.

Table 4.2 Distribution of the different acts of physical violence

Acts of Physical Violence	Rural		Urban		Both Sites	
	Life-time n (%)	Current n (%)	Life-time n (%)	Current n (%)	Life-time n (%)	Current n (%)
Slapped or thrown things that could hurt	57 (7.9)	42 (5.8)	60 (8.3)	37 (5.1)	117 (16.3)	79 (11.0)
Pushed or Shoved	59 (8.2)	43 (6.0)	63 (8.8)	40 (5.6)	122 (17.0)	83 (11.6)
Hit with fist or something else that could hurt	50 (7.0)	39 (5.4)	41 (5.7)	26 (3.6)	91 (12.7)	65 (9.0)
Kicked, Dragged or Beaten up	52 (7.2)	33 (4.6)	41 (5.7)	22 (3.1)	93 (12.9)	55 (7.6)
Chocked or Burnt on purpose	2 (0.3)	1 (0.1)	-	-	2 (0.3)	1 (0.1)
Threatened or hurt with a Gun, Knife or other Weapon	2 (0.3)	-	-	-	2 (0.3)	-
Overall	65 (9.0)	48 (6.7)	69 (9.6)	43 (6.0)	134 (18.6)	91 (12.7)

4.2.3 Prevalence of Acts of Psychological violence

As shown in Table 4.3, overall, the life-time prevalence of psychological abuse is 24.3%, while the current prevalence of this form of abuse is 16.6%. Regarding the different acts constituting psychological abuse (i.e., being insulted or made to feel bad about oneself; belittled or humiliated in front of other individuals; scared or intimidated on purpose; and threatened to be hurt or someone else she cares about to be hurt) the results show that the most common act of psychological abuse is that of women being insulted by their partners and made to feel bad about themselves (life-time prevalence of 24.2% and a current prevalence of 16.7%). Besides, the results show that women who are urban dwellers tend to experience all the acts of psychological abuse more than those residing in rural areas. The only exception to this is in the case of women reporting being scared or intimidated on purpose, where, for example, rural dwellers have a slightly higher life-time prevalence of this form of abuse (8.8%) as compared with those living in urban areas (8.1%).

Table 4.3 Distribution of the different acts of psychological violence

Acts of Psychological Violence	Rural		Urban		Both Sites	
	Life-time n (%)	Current n (%)	Life-time n (%)	Current n (%)	Life-time n (%)	Current n (%)
Insulted or made to feel bad	81 (11.3)	58 (8.1)	93 (12.9)	62 (8.6)	174 (24.2)	120 (16.7)
Belittled or Humiliated in front of other individuals	72 (10.0)	55 (7.6)	77 (10.7)	54 (7.5)	149 (20.7)	109 (15.2)
Scared or Intimidated on purpose	63 (8.8)	48 (6.7)	58 (8.1)	41 (5.7)	121 (16.8)	89 (12.4)
Threatened to be hurt or someone else she cares about to be hurt	42 (5.8)	29 (4.0)	36 (5.0)	12 (1.7)	78 (10.8)	41 (5.7)
Overall	81 (11.3)	58 (8.1)	94 (13.1)	61 (8.5)	175 (24.3)	119 (16.6)

4.2.4 Prevalence of Acts of Sexual violence

As shown in Table 4.4, the overall life-time prevalence of sexual violence is 11.4% and the current prevalence is 6.1%. As regards the acts constituting this form of violence (i.e., being physically forced to have sexual intercourse that is not solicited; having sexual intercourse that is not physically forced, but had under duress; having a sexual act that is degrading or humiliating; and being denied sexual pleasures), the results show that the most common form of sexual violence act is 'having sexual intercourse that is not physically forced but was had under duress' (life-time prevalence of 8.9% and current prevalence of 4.7%). The results also show that there is no significant difference between the distributions of IPV prevalence in urban and rural areas, although the results pertaining to the sexual violence experiences of urban dwellers show slightly higher levels – for example, results regarding women's experience of sexual act that was not through physical force, but was had under duress show a life-time prevalence of 5% for urban dwellers and 3.9% for those residing in rural areas.

Table 4.4 Distribution of the different acts of sexual violence

Acts of Sexual Violence	Rural		Urban		Both sites	
	Life-time n (%)	Current n (%)	Life-time n (%)	Current n (%)	Life-time n (%)	Current n (%)
Physically forced to have sexual act that is not solicited	10 (1.4)	4 (0.6)	10 (1.4)	7 (1.0)	20 (2.8)	11 (1.5)
Sexual act that was not physically forced, but had under duress	28 (3.9)	14 (1.9)	36 (5.0)	20 (2.8)	64 (8.9)	34 (4.7)
Sexual act that is degrading or humiliating	6 (0.8)	1 (0.1)	6 (0.8)	4 (0.6)	12 (1.7)	5 (0.7)
Denied sexual pleasures	16 (2.2)	8 (1.1)	21 (2.9)	10 (1.4)	37 (5.1)	18 (2.5)
Overall	37 (5.1)	19 (2.6)	45 (6.3)	25 (3.5)	82 (11.4)	44 (6.1)

4.2.5 Overlaps between the prevalence rates of the different forms of IPV

The overlaps between the different forms of IPV are shown in the Venn diagrams in figures 4.2 and 4.3.

In terms of life-time experience of IPV, Figure 4.2 shows that there are extensive overlaps between the different forms of IPV experienced by abused women. With the exception of only psychological violence, all forms of IPV do not mostly occur in isolation. In other words, women tend to experience multiple forms of IPV as opposed to just one single form. For example, the results show that out of the 18.6% of women who have at least once experienced a physical form of IPV in their life-time, 9.6% have concomitantly suffered psychological abuse, while 8.8% have at the same time suffered psychological and sexual abuse in addition to being physically abused. Therefore, both these overlaps account for 18.4% out of the 18.6% of women reporting physical violence; a clear indication that physical violence rarely occurs alone. Besides, the Venn diagram also shows that psychological abuse tends to be a constant feature of IPV experienced by abused women, as it is the main form of IPV mostly experienced by such women and one that has extensive overlap with the experience of other forms of IPV.

Regarding the current prevalence of IPV, the Venn diagram in Figure 4.3 shows a similar pattern as that in Figure 4.2 (representing life-time experience of IPV). Results presented in Figure 4.3 give the indication that the physical form of IPV invariably occurs alongside other forms – especially psychological violence. The results also show that all current experience of a physical form of IPV experienced by women overlaps with other forms; out of the 12.7% of women who experienced physical abuse in the past 12 months prior to the study, 7.4% have at the same time experienced psychological abuse, while the remaining constituent 5.3% have experienced both psychological and sexual abuse in addition to physical violence. Overall, the results show that the major areas of overlap in the different experiences of IPV by women lie in the area of overlap between physical and psychological violence, and the area of overlap between the three major forms of IPV. Moreover, the results show that just as in the case of life-time experience of IPV, current occurrence of each case of physical and sexual abuses against women is mostly not an isolate event, but one that comes with other forms of abuse.

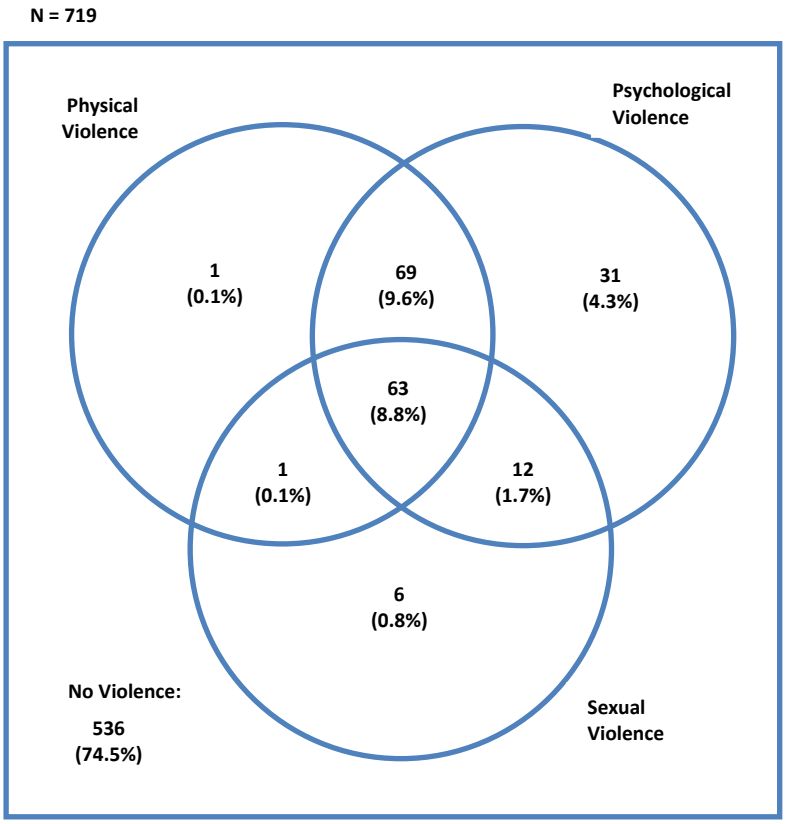

Figure 4.2 Overlaps between the prevalence of different forms of life-time IPV

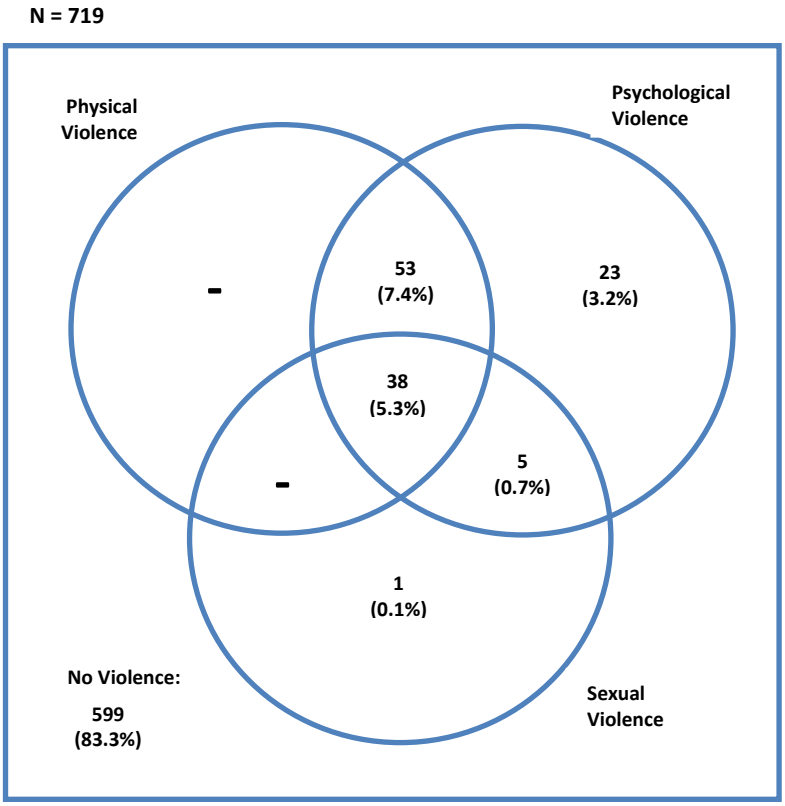

Figure 4.3 Overlaps between the prevalence of different forms of current IPV

4.2.6 Further exploration of IPV occurrence: IPV frequency and incidents

Although the prevalence results in section 4.2.1 show that life-time prevalence of IPV is as high as 25.5%, it was considered important to further explore these occurrences in terms of severity (i.e., whether the experience of IPV by the women is a one-off occurrence or a multiple/repeated incident across their lifetimes).

Figure 4.4 shows that out of the 25.5% of women with IPV experience over their lifetimes 25.1% have experienced IPV more than once, while only a meagre 0.4% reported a single experience over a lifetime. As regards the different forms of violence, the results in figure 4.5 show that out of the 18.6% of women reporting physical violence, only 2.5% have experienced abuse just once over their lifetimes, while 13.3% have a few number of experiences and 2.8% with several/many experiences. In terms of psychological abuse, the

results in figure 4.6 show that out of the 24.3% reporting this form of abuse only a meagre 0.8% reported experiencing abuse just once, while 18.3% reported a few number of times and 5.2% reported experiencing such abuse several/many times. Considering sexual violence, as shown in figure 4.7, out of the 11.4% reporting this form of abuse over a lifetime, only a meagre 0.7% reported several/many occurrence of such experience, while 1.2% reported experiencing sexual abuse just once and a 9.5% majority reported such experience a few number of times.

Overall, the results show that the experience of IPV is mostly a repeated occurrence in the lifetime of abused women, and also attest to the severity of the malice as experienced by women in the Nigerian society.

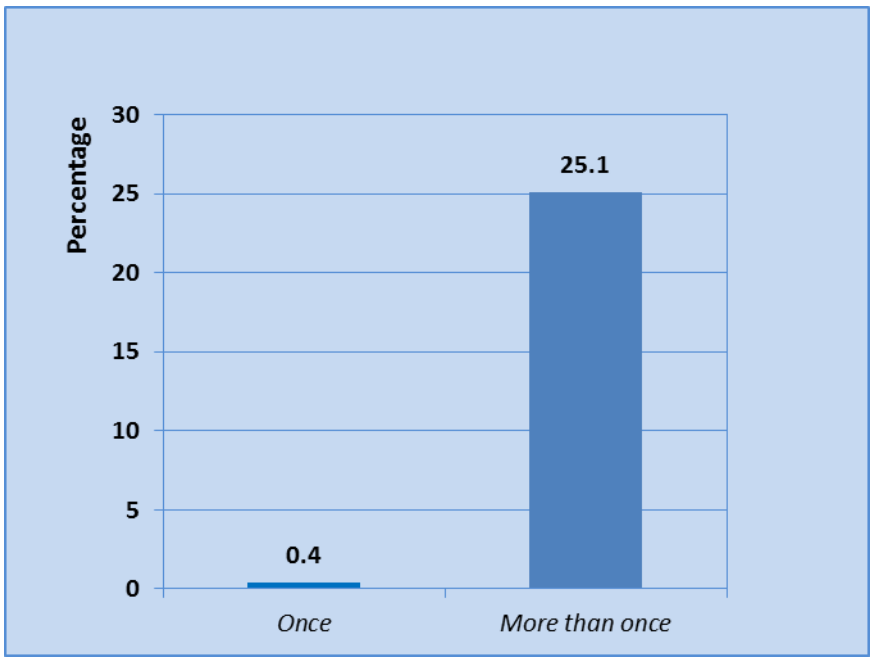

Figure 4.4 Frequency of IPV experiences over lifetime

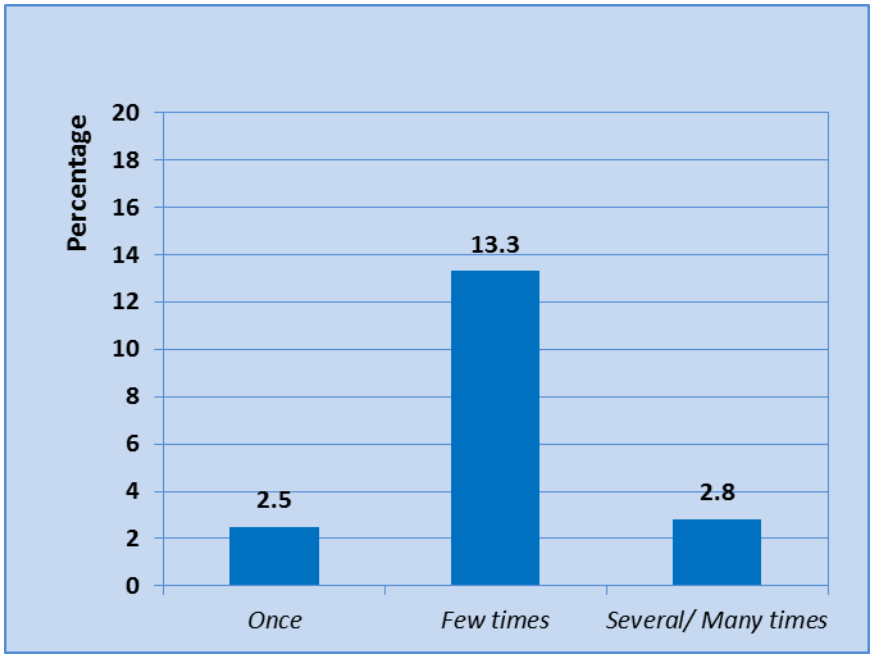

Figure 4.5 Frequency of the experience of physical form of IPV over lifetime

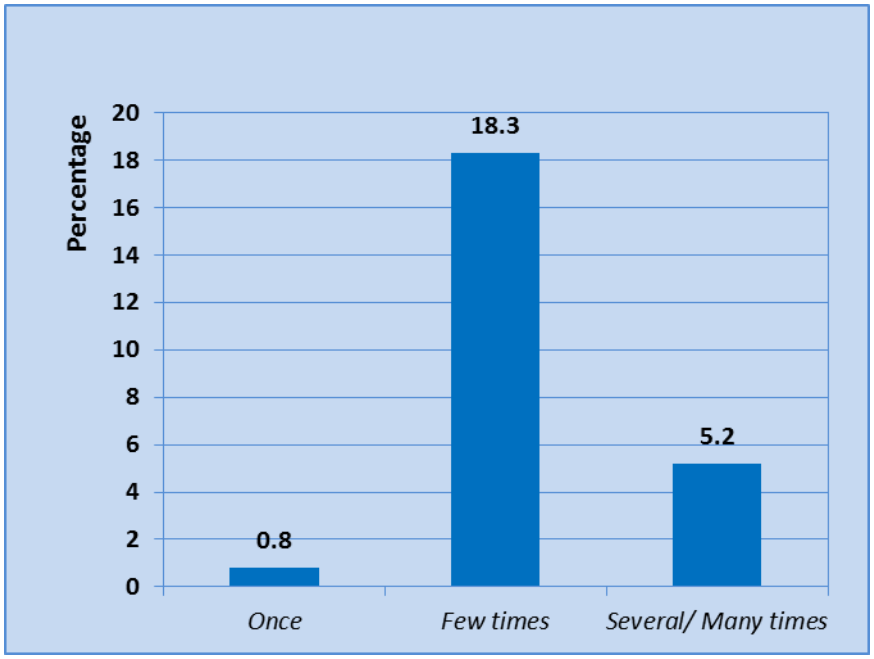

Figure 4.6 Frequency of the experience of psychological form of IPV over lifetime

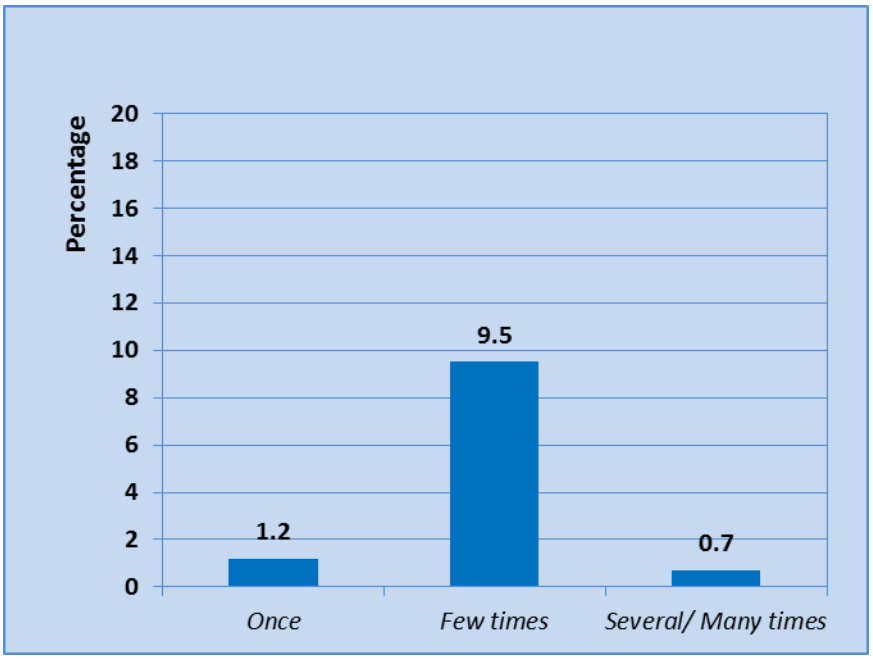

Figure 4.7 Frequency of the experience of sexual form of IPV over lifetime

In addition to the exploration of IPV severity in terms of frequency of occurrence over a lifetime, women were also asked to provide an approximate number of incidents of IPV they have had in the 12 months prior to the study.

In total, approximately 890 cases were reported by the women to have occurred. The highest number of incidents reported being 24 (this number was reported by 3 women) and the lowest being a single incident in the last 12 months prior to the study (this was reported by 2 women). As such, on average there were approximately 7 incidents per woman. Furthermore, the results as shown in figure 4.8 indicate that there are more incidents of IPV in the rural areas as compared with the urban (480 and 410, respectively). These results in addition to those presented earlier in section 4.2.1 further show that in the prior 12 months slightly more women experienced IPV in the rural areas as compared with the urban.

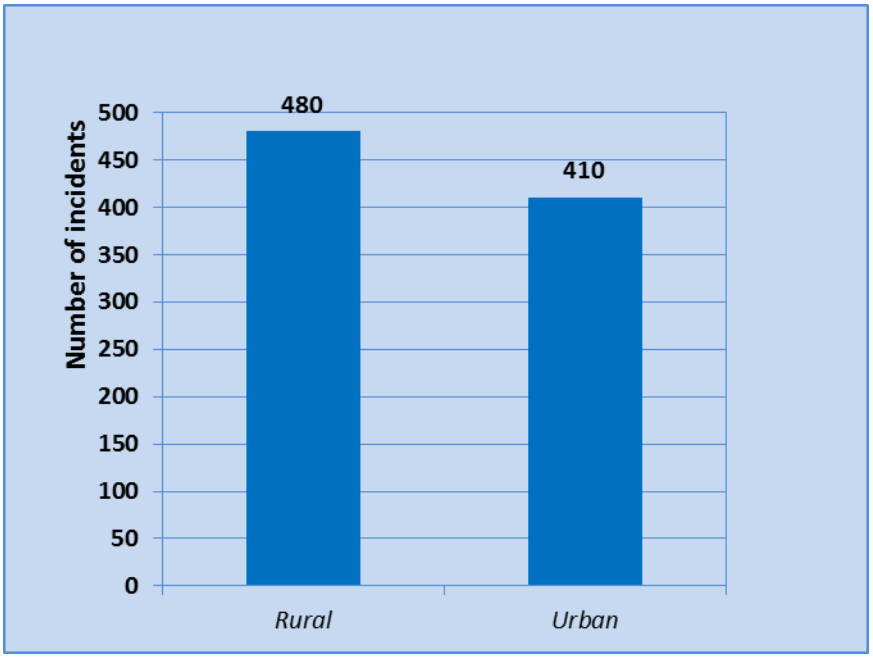

Figure 4.8 Number of current IPV incidents by site

Moreover, in terms of the age group of women, the results in figure 4.9 show that women in the age group of 30 – 39 reported the highest number of IPV incidents (376 incidents) while those in the age groups 50 – 59 as well as 60 and above indicated the lowest incidents (66 and 24, respectively). These results with those presented in section 4.2.1 show that although women in the age group of 50 – 59 may have the highest prevalence of IPV, those in the younger age group of 30 – 39 actually experience far more incidents of current IPV abuse.

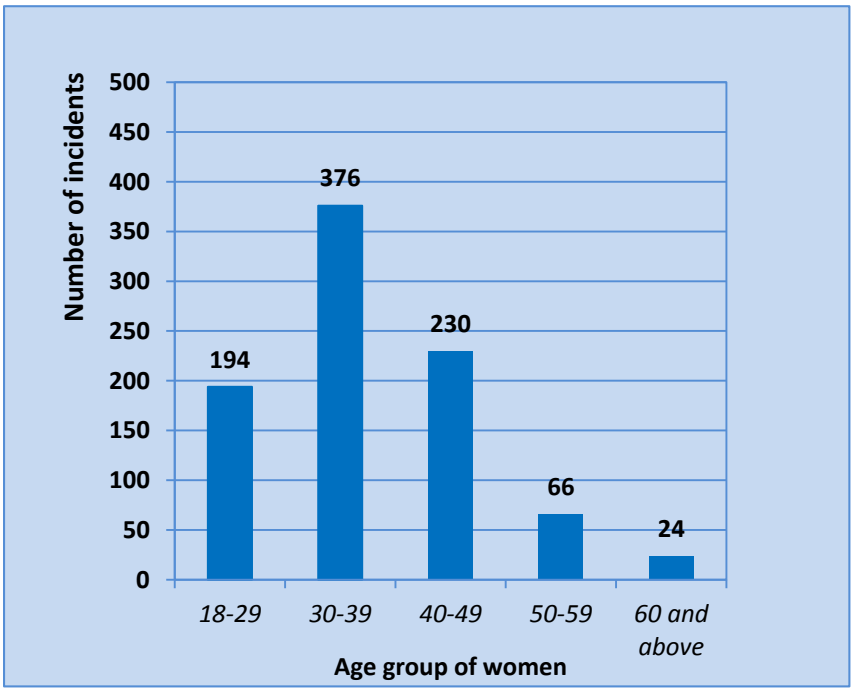

Figure 4.9 Number of current IPV incidents by age group

4.3 Predictors/Likely risk factors of IPV in Nigeria

4.3.1 Bivariate Logistic Regression Analyses

As explained in the methodology section of this thesis, a simple bivariate logistic regression analysis has first been performed to study the crude association between each of the independent variables and occurrence of IPV. This section presents the results of the series of analyses conducted by considering the predictors of both the current and life-time experience of IPV.

4.3.1.1 Predictors of Current Intimate Partner Violence

When the simple bivariate logistic regression analyses are conducted, the results (Table 4.2) show significant association (p<0.05) between **current experience of IPV** and some **individual-level variables** that include: woman's age group, partner's age group, marital/partnership status, woman's literacy and educational attainment, partner's literacy and

educational attainment, nature of woman's work, nature of partner's work, woman's frequency of communication with family, woman's proximity to family members, partner's general history of physical aggression, partner's affairs outside of the relationship, partner's illicit drug use, partner's controlling behaviour, categorical number of children; and **partnership level variables** such as: partnership discord, use of dowry/bride price, woman's say in the choice of spouse, partnership educational disparity, partnership employment disparity; as well as **community level factor**: general trust in the community.

In terms of the nature and degree of association, the results show that women within the age range of 30 – 39 years were approximately twice as likely to experience current IPV (p=0.008) as compared with those in the younger age group of 18 – 29 years. As regards partners' age group, women whose partners fall within the older age groups were more likely to experience IPV as compared with those with partners in the age group of 18 – 29 years – those with partners in the age group of 30 – 39 have an increase likelihood of 3.5-folds (p=0.001); 40 – 49, 3.6-folds (p=0.001); 50 – 59, 3.2-folds (0.003). Considering marital/partnership status, women who are currently having a regular partner who lives away from them (in other words, women in non-cohabiting relationships) are over 3 times less likely to experience IPV as compared with those who are currently married and are in cohabiting relationships (p=0.001). The result pertaining to women's literacy levels shows that those who are illiterate are approximately 4 times more likely to experience current IPV as compared with those who are literate (p<0.001). In terms of partner's literacy level, women whose partners are illiterate are 3 times more likely to experience current IPV as compared with women with literate partners (p<0.001). As regards women's educational attainment, women with lower or no educational attainment at all are more predisposed to current experience of IPV – with women having just primary or no educational attainment all showing an 8-fold increase in the likelihood of such experience as compared with those having higher educational attainment (p<0.001). Besides, even those with a secondary level educational attainment show a 3-fold increase in predisposition to experiencing IPV when compared with those having higher education (p=0.002). In terms of partner's educational attainment, women whose partners have just primary or no educational attainment at all have an approximately 3-fold increase in likelihood of experiencing current IPV as compared with those with higher educational attainment (p<0.001). Moreover, women whose partners have

secondary educational attainment show an increase in likelihood of approximately 4-folds (p<0.001). As regards the disparity in the educational attainment of couples (women and their partners), the results show that women with better educated partners are over two times more likely to experience current IPV as compared with couples with the same educational attainment (p<0.001). In terms of the nature of work a woman performs, the results show that earning a steady salary confers some protection against current experience of IPV – with women who are self-employed and those who are in unpaid family work being more prone to experiencing IPV as compared with those earning salaries, an approximate increase of 2-folds (p=0.033) and 4-folds (p=0.016), respectively. As regards the nature of partner's work, women whose partners are self-employed show a significant increase in experience of current IPV – approximately 2-folds (p=0.049). In terms of disparity in employment status of couples, women who are unemployed but have employed partners are 2 times less likely to experience current IPV as compared with those who are employed and have partners who are also employed (p=0.027). Regarding women's frequency of communication with family members, those who hardly ever communicate are over 3 times more likely to experience IPV as compared with those who communicate at least once a week (p<0.001). Considering a woman's proximity to her family, as compared with a woman who lives with her family, one who lives further away has a 3-fold increase in likelihood of experiencing current IPV (p=0.012). As regards, choice of spouse/partner, women who have their partners chosen for them without their consent are more predisposed to experiencing current IPV as compared with those in a relationship were they and their partners made the choice of their own volition (p<0.001) – with such women showing an increase in excess of 9-folds.

In terms of partner's history of physical aggression, women whose partners have such history are 5 times more likely to experience current IPV as compared with those whose partners do not (p<0.001). What is more, women who reported that they are not aware of their partner having such aggressive history also show an increase of approximately 3-folds when compared with those who categorically stated that their partners do not have such history (p=0.009). Regarding partner's affairs outside of the relationship (infidelity), women who reported the existence of such affairs by their partners show a 3-fold increase in the experience of current IPV as compared with those who reported otherwise (p<0.001). Besides, women who stated that such affairs may exist or might have existed (but are not

certain) and those who are absolutely unaware of the existence of any affairs also show significant likelihood of experiencing current IPV when compared with those who expressed absolute inexistence of such affairs – having an approximately 5-fold increase in likelihood (p<0.001).

In terms of partner's use of alcohol, women whose partners indulge in daily or weekly usage of alcohol are approximately 4 times more likely to experience current IPV as compared with those whose partners have never taken alcohol (p<0.001). Regarding partner's history of illicit drug use, women who reported that their partners use such drugs show an increase in likelihood of experiencing current IPV as compared with those who expressed their partners' avoidance of the drugs (p<0.001). Precisely, partners who use drugs on a daily basis have a 14-fold increase and those using it weekly having a 34-fold increase. These differences in magnitude of the likelihood between daily usage of drug as well as alcohol and their weekly usage may be due to the fact that excessive substance abusers (i.e., more frequent users of such substance/ daily users) are less likely to be in intimate relationships, as research shows that excessive use of such substances weakens companionship (e.g., marital companionship) (Abrahams et al., 2004; Hoffman et al., 1994). Therefore, the less the number of frequent substance abusers in partnerships the relatively less the magnitude of the relationship between IPV and frequent substance abuse (e.g., daily usage of drugs), as compared with the relationship between weekly usage of such substance and IPV occurrence.

Considering partner's controlling behaviour, women with partners showing some form of controlling behaviour are more prone to experiencing current IPV (p<0.001); with women reporting partner as having one, two or three, and four or more controlling behaviours showing increased likelihood of approximately 5-, 10- and 24-fold respectively.

In terms of categorical number of children, women having 3 – 4 children are approximately 2 times less likely to experience current IPV as compared with those that having 5 or more (p=0.014), while those who have no children at all are also twice less likely to experience current IPV when compared with those that have 5 or more children (p=0.006).

As regards the payment of dowry or bride-price, the results show that women in partnerships involving such financial commitments are predisposed to experiencing current IPV as compared with women in partnerships without such payments – with women in partnerships involving the payment of dowry or bride-price having a 2-fold increase in likelihood, while those in partnerships involving the payment of both dowry and bride-price are approximately 5 times more likely to experience current IPV (p=0.002).

Considering partnership discord, women in relationships that involve some form of discord are predisposed to experiencing current IPV, with frequent experience of such discord exposing women to a staggering 33-fold increase in likelihood of experiencing current IPV (p<0.001).

4.3.1.2 Predictors of Life-time intimate Partner Violence

With regard to life-time IPV, when the simple bivariate logistic regression analyses to estimate the crude associations between each of the independent variables (as listed in Table 3.3) and the experience of IPV are conducted, the results (Table 4.2) show significant associations with factors at the **individual-level** such as: woman's literacy and educational attainment, partner's literacy and educational attainment, woman's frequency of communication with family, woman's proximity to family members, partner's general history of physical aggression, partner's affairs outside of the relationship, partner's use of alcohol, partner's illicit drug use, partner's controlling behaviour, categorical number of children; and **relationship-level characteristics** such as: partnership educational disparity, woman's say in the choice of spouse, partnership discord; as well as **community-level factors** such as: proportion of men using alcohol daily in the community and level of illicit drug use by men in the community.

Considering the direction and degree of association, the results show that women that are illitrate are approximately 3 times more likely to experience IPV as compared with those who are literate (p<0.001). In terms of partner's literacy status, women whose partners are illitrate

are approximately 2 times more likely to experience IPV as compared with those whose partners are literate (p=0.008). When a woman's educational attainment is considered, women with only primary or no educational attainment at all are more predisposed to experiencing IPV as compared with those with higher education (p<0.001) – with results showng an increased likelihood of IPV experience of 4-folds. Regarding partner's educational attainment, women whose partners have only primary or no educational attainment are over 2 times more likely to experience IPV (p=0.001), while those with partners having secondary education also show a similar 2-fold increase in the likelihood of experiencing IPV (p<0.001), as compared with those having higher educational attainment.

Pertaining to women's frequency of communicating with family members, those who hardly communicate are approximately 3 times more likely to experience IPV (p<0.001), while those who communicate once a month or there about are 2 times more likely to experience IPV (p=0.012) when compared with those who communicate at least once a week.

In terms of proximity to family members, women who live further away from their families are over 2 times more likely to experience IPV as compared with those who live with family members (p=0.023).

Regarding the history of partner's physical aggression, women whose partners have such history are approximately 4 times more likely to experience IPV as compared with women whose partners do not have a history of physical aggression (p<0.001). Moreover, results pertaining to partner's affairs outside of the relationship (infidelity) show that women who reported the perpetration of this act by their spouses have a 2-fold increase in likelihood of experiencing IPV as compared with those who reported the lack of such act (p=0.020). In addition, women who reported that their partners may have had affairs outside a relationship and those who reported that they are not so certain of the perpertration of such act have approximately a 4- and 3-fold increased likelihood of experiencing IPV, respectively, when compared with women who reported absolute lack of such act (p<0.001).

In terms of partner's use of alcohol, women whose partners use alcohol on a daily basis and once a week both have increased likelihood of experiencing IPV (3- and 2-fold increase, respectively) when compared with those whose partners do not use alcohol at all. Considering partner's usage of illicit drugs, women who reported that their partners use such drugs are more likely to experience IPV as compared with those who reported that their partners do not – results show that women with a partner who uses drugs on a daily basis have over 18-fold increased likelihood of experiencing IPV (p<0.001), while those whose partners use such drug 1 - 4 times a month have a staggering 38-fold increased likelihood (p=0.001). Besides, women who reported that they are not aware of their partners' usage of such drug (i.e., that there might be a posiblity of usage) show a 5-fold increased likelihood (p<0.001). Again, these differences in the magnitude of the likelihood of IPV (i.e., 18-fold for daily users and 38-fold for the weekly users) may be due to the weakness in companionship associated with excessive substance abuse (i.e., daily usage of such substace) as suggested by studies (Abrahams et al., 2004; Hoffman et al., 1994).

With respect to the controlling behaviour of partners, women whose partners have some form of such behaviour are more predisposed to IPV as compared to those having partners without any form of controlling behaviour – with partners having one controlling behaviour the likelihood of experiencing IPV increases approximately 4 times (p=0.028), for two or three controlling behaviours it increases by over 8 times (p<0.001), and with four or more controlling behaviours, the increase is approximately 24 times (p<0.001).

In terms of categorical number of children, results show that women having 3 or 4 children are approximately two times less likely to experience IPV as compared with those having 5 or more (p=0.039).

In relation to partnership discord, women who reported some form of discord in their relationship with their partners are more predisposed to experiencing IPV as compared with those who reported the lack of such discord, with frequent experience of partnership discord exposing women to a staggering 35-fold increase in likelihood of experiencing IPV

(p<0.001), while even rare experience of such discord exposing women to a 5-fold increase in likelihood of IPV experience (p=0.002).

In terms of the decision women have in choosing their spouses/partners, women who have no say in the choice of their spouses/partners are 8 times more likely to experience IPV as compared with those who are in a relationship were they and their partners chose one another (p<0.001).

Lastly, the results show that there is a slight increase in women's likelihood of experiencing IPV (a 1.03-fold increase, p=0.005) with every unit increase in the propotion of men using alcohol daily in the community. Besides, there is also a slight increase in the likelihood of women experiencing IPV (a 1.1-fold increase, p=0.002) with every unit increase in the proportion of men using illicit drug in the community.

4.3.1.3 Recapitulation of the Bivariate Logistic Regression Analyses

In summary, the results of the series of bivariate logistic regression analyses conducted show that life-time experience of IPV is associated with factors that include: woman's literacy and educational attainment, partner's literacy and educational attainment, woman's frequency of communication with family, woman's proximity to family members, partner's general history of physical aggression, partner's affairs outside of the relationship, partner's use of alcohol, partner's illicit drug use, partner's controlling behaviour, categorical number of children, partnership educational disparity, woman's say in the choice of spouse, partnership discord, proportion of men using alcohol daily in the community and level of illicit drug use by men in the community. Although this set of results affords a tangible opportunity to understand the relationship between the set of independent variables (predictors) tested against the experience of IPV, it is still imperative to follow up the analyses with multivariable logistic regression procedure in order to obtain clearer and more informative results pertaining to the relationships. As expressed by Hosmer and colleagues (2013), fitting a series of univariate models (in this case, separate simple bivariate logistic regression models) rarely provides an adequate analysis of the data in a study since the independent variables (predictors) are

usually associated with one another and perhaps have different distributions within levels of the outcome variable. As a result, one generally considers a multivariable analysis (Multivariable logistic regression) for a more comprehensive modelling of the data to – (1) statistically adjust the estimated effect of each of the variables in the model for differences in the distributions of other independent variables, (2) capture complex relationships amongst the independent variables (such as moderation or interaction).

Nonetheless, these results support the research hypothesis pertaining to the significant association between IPV and some of the different variables explored. Although, studying via a multivariable analytical procedure will be required to ascertain whether the variables are actually predictive of violence.

Table 4.5 Results of Bivariate logistic regression analysis showing the coefficients, odds- ratios (ORs), 95% Confidence Intervals and *P*-values for the variables tested in association with current and life-time Intimate Partner Violence experience

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	OR (95% CI)	*P*-value	Coefficient	OR (95% CI)	*P*-value
Woman's age group			0.068			0.601
18 – 29	0.00	1		0.00	1	
30 – 39	0.66	1.94 (1.19 – 3.17)	0.008	-0.23	0.80 (0.53 – 1.19)	0.263
40 – 49	0.51	1.67 (0.94 – 2.94)	0.079	-0.14	0.87 (0.55 – 1.39)	0.562
50 – 59	0.81	2.25 (0.93 – 5.41)	0.071	0.33	1.39 (0.66 – 2.95)	0.392
60 and above	-0.17	0.84 (0.19 – 3.82)	0.825	-0.12	0.89 (0.31 – 2.54)	0.823
Partner's age group			0.003			0.387
18 – 29	0.00	1		0.00	1	
30 – 39	1.25	3.47 (1.65 – 7.30)	0.001	0.31	1.36 (0.82 – 2.27)	0.236
40 – 49	1.27	3.57 (1.72 – 7.40)	0.001	0.18	1.19 (0.72 – 1.97)	0.495
50 – 59	1.17	3.21 (1.50 – 6.88)	0.003	0.21	1.24 (0.73 – 2.11)	0.435
60 and above	0.31	1.36 (0.47 – 3.92)	0.566	-0.38	0.69 (0.32 – 1.46)	0.327
Parenthood status			0.073			0.683
No	0.00	1		0.00	1	
Yes	0.45	1.56 (0.96 – 2.55)	0.073	0.08	1.08 (0.74 – 1.60)	0.683

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	**OR (95% CI)**	***P*-value**	**Coefficient**	**OR (95% CI)**	***P*-value**
Marital/ relationship status			0.008			0.476
Currently married	0.00	1		0.00	1	
Currently living with a man, but not married	-0.43	0.65 (0.19 – 2.25)	0.501	0.26	1.30 (0.52 – 3.25)	0.576
Currently having a regular partner who lives apart	-1.14	0.32 (0.16 – 0.63)	0.001	-0.27	0.77 (0.49 – 1.20)	0.243
Divorced/ broken up with partner/ widowed	-1.06	0.35 (0.04 – 2.68)	0.309	-0.68	0.51 (0.11 – 2.31)	0.380
Location			0.997			0.850
Ilorin	0.00	1		0.00	1	
Offa	0.00	1.0 (0.63 – 1.59)	0.989	-0.07	0.94 (0.63 – 1.38)	0.738
Erin-Ile	0.02	1.0 (0.61 – 1.71)	0.939	-0.12	0.88 (0.56 – 1.38)	0.589
Woman literate			0.000			0.000
Yes	0.00	1		0.00	1	
No	1.36	3.89 (2.51 – 6.03)	0.000	1.01	2.74 (1.83 – 4.11)	0.000
Partner literate			0.000			0.008
Yes	0.00	1		0.00	1	
No	1.11	3.04 (1.88 – 4.92)	0.000	0.61	1.84 (1.17 – 2.90)	0.008

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	OR (95% CI)	*P*-value	Coefficient	OR (95% CI)	*P*-value
Woman's educational attainment			0.000			0.000
Higher	0.00	1		0.00	1	
Secondary	0.88	2.41 (1.37 – 4.27)	0.002	0.39	1.48 (0.97 – 2.25)	0.068
Primary or none	2.11	8.26 (4.75 – 14.34)	0.000	1.38	3.97 (2.58 – 6.12)	0.000
Partner's educational attainment			0.000			0.000
Higher	0.00	1		0.00	1	
Secondary	1.02	2.77 (1.71 – 4.47)	0.000	0.77	2.15 (1.43 – 3.32)	0.000
Primary or none	1.34	3.82 (2.33 – 6.25)	0.000	0.77	2.16 (1.39 – 3.35)	0.001
Partnership educational difference			0.000			0.006
Same level	0.00	1		0.00	1	
Partner better educated	0.86	2.36 (1.56 – 3.57)	0.000	0.58	1.78 (1.25 – 2.55)	0.002
Woman better educated	0.70	2.01 (0.94 – 4.28)	0.070	0.25	1.28 (0.64 – 2.57)	0.483
Woman in employment			0.095			0.612
Yes	0.00	1		0.00	1	
No	-0.42	0.65 (0.39 – 1.07)	0.095	-0.10	0.90 (0.61 – 1.34)	0.612

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	OR (95% CI)	*P*-value	Coefficient	OR (95% CI)	*P*-value
Partner in employment			0.455			0.361
Yes	0.00	1		0.00	1	
No	-0.26	0.78 (0.40 – 1.51)	0.455	-0.26	0.77 (0.44 – 1.35)	0.361
Nature of woman's work			0.008			0.409
Salaried	0.00	1		0.00	1	
Self-employed	0.49	1.64 (1.04 – 2.58)	0.033	0.21	1.23 (0.83 – 1.82)	0.294
Unpaid family worker	1.48	4.38 (1.32 – 14.51)	0.016	0.84	2.31 (0.71 – 7.53)	0.165
Nature of partner's work			0.105			0.209
Salaried	0.00	1		0.00	1	
Self-employed	0.42	1.53 (1.00 – 2.33)	0.049	0.30	1.35 (0.94 – 1.94)	0.105
Unpaid family worker	0.98	2.65 (0.79 – 8.91)	0.115	0.72	2.05 (0.65 – 6.41)	0.220
Partnership employment			0.049			0.222
Both employed	0.00	1		0.00	1	
Only woman employed	-1.83	0.16 (0.02 – 1.20)	0.074	-1.12	0.33 (0.10 – 1.10)	0.071
Only partner employed	-0.72	0.49 (0.26 – 0.92)	0.027	-0.27	0.76 (0.47 – 1.23)	0.264
Both unemployed	-0.01	0.99 (0.48 – 2.03)	0.970	0.05	1.05 (0.56 – 1.96)	0.882

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	OR (95% CI)	*P*-value	Coefficient	OR (95% CI)	*P*-value
Woman's frequency of communication with family			0.000			0.000
Corresponds at least once a week	0.00	1		0.00	1	
Corresponds at least once a month	0.23	1.26 (0.77 – 2.07)	0.354	0.52	1.68 (1.12 – 2.52)	0.012
Corresponds like once a year or hardly ever	1.22	3.40 (2.01 – 5.77)	0.000	1.03	2.80 (1.71 – 4.58)	0.000
Woman's proximity to her family			0.000			0.000
Lives with family of birth	0.00	1		0.00	1	
Lives near	0.29	1.33 (0.59 – 3.04)	0.494	-0.01	0.99 (0.53 – 1.87)	0.984
Lives further away	1.11	3.05 (1.28 – 7.25)	0.012	0.79	2.20 (1.11 – 4.35)	0.023
Choice of spouse/partner			0.000			0.000
Both chose	0.00	1		0.00	1	
Woman chose	N/A			-1.03	0.36 (0.08 – 1.56)	0.170
Others chose with woman's consent	-0.39	0.68 (0.28 – 1.63)	0.386	-0.24	0.78 (0.40 – 1.56)	0.487
Others chose without woman's consent	2.23	9.30 (4.61 – 18.74)	0.000	2.03	7.58 (3.66 – 15.73)	0.000
Partner's general history of physical aggression			0.000			0.000
No	0.00	1		0.00	1	
Yes	1.63	5.11 (3.31 – 7.89)	0.000	1.26	3.52 (2.39 – 5.20)	0.000
Woman unaware	1.03	2.79 (1.30 – 5.99)	0.009	0.54	1.72 (0.85 – 3.48)	0.134

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	OR (95% CI)	*P*-value	Coefficient	OR (95% CI)	*P*-value
Partner's affairs outside of relationship			0.000			0.000
No	0.00	1		0.00	1	
Yes	1.19	3.29 (1.68 – 6.43)	0.000	0.59	1.80 (1.10 – 2.96)	0.020
May have	1.59	4.90 (2.26 – 10.60)	0.000	1.28	3.61 (1.98 – 6.57)	0.000
Woman unaware	1.50	4.49 (2.38 – 8.51)	0.000	0.93	2.54 (1.59 – 4.05)	0.000
Partner's use of alcohol			0.000			0.000
Never	0.00	1		0.00	1	
Everyday	1.31	3.69 (2.25 – 6.05)	0.000	1.03	2.79 (1.80 – 4.33)	0.000
Once a week	1.32	3.74 (2.18 – 6.41)	0.000	0.87	2.40 (1.46 – 3.92)	0.001
1 – 3 times a month	N/A			0.37	1.45 (0.66 – 3.21)	0.358
Less than once a month	0.55	1.74 (0.57 – 5.34)	0.335	0.19	1.21 (0.44 – 3.36)	0.715
Woman unaware	0.25	1.29 (0.48 – 3.48)	0.616	0.74	2.09 (1.01 – 4.35)	0.048
Partner's history of drug use			0.000			0.000
Never	0.00	1		0.00	1	
Every day	2.67	14.42 (6.34 – 32.81)	0.000	2.91	18.36 (6.82 – 49.48)	0.000
1-4 times a month	3.53	33.94 (7.06 – 163.19)	0.000	3.63	37.56 (4.71 – 299.31)	0.001
Woman unaware	2.21	9.11 (5.09 – 16.33)	0.000	1.64	5.18 (2.95 – 9.09)	0.000

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	**OR (95% CI)**	***P*-value**	**Coefficient**	**OR (95% CI)**	***P*-value**
Partner's controlling Behaviour			0.000			0.000
None	0.00	1		0.00	1	
One	1.60	4.95 (1.04 – 23.43)	0.044	1.30	3.65 (1.15 - 11.58)	0.028
Two or Three	2.32	10.16 (2.42 – 42.68)	0.002	2.10	8.15 (2.89 – 22.97)	0.000
Four or more	3.18	24.10 (5.78 – 100.49)	0.000	3.18	23.96 (8.53 - 67.30)	0.000
Woman's acceptance of violence (wife beating)			0.934			0.773
Disagrees with all of the reasons to bit wife	0.00	1		0.00	1	
Agrees with one or more reasons to bit wife	-0.02	0.98 (0.65 – 1.49)	0.934	-0.05	0.95 (0.66 – 1.36)	0.773
Contraception refusal by partner			0.877			0.502
No	0.00	1		0.00	1	
Yes	-0.04	0.96 (0.60 – 1.54)	0.877	-0.14	0.87 (0.58 – 1.31)	0.502
Woman has ever been pregnant			0.108			0.762
No	0.00	1		0.00	1	
Yes	0.58	1.78 (1.04 – 3.04)	0.035	0.12	1.13 (0.75 – 1.71)	0.555
May be	0.46	1.59 (0.18 – 14.37)	0.680	0.48	1.62 (0.29 – 9.18)	0.587

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	**OR (95% CI)**	***P*-value**	**Coefficient**	**OR (95% CI)**	***P*-value**
Categorical number of children			0.022			0.091
5 or more	0.00	1		0.00	1	
3 – 4	-0.66	0.52 (0.31 – 0.87)	0.014	-0.50	0.61 (0.38 – 0.98)	0.039
1 – 2	-0.31	0.73 (0.41 – 1.30)	0.287	0.01	1.01 (0.60 – 1.68)	0.982
None	-0.82	0.44 (0.24 – 0.79)	0.006	-0.31	0.74 (0.45 – 1.21)	0.229
History of miscarriages, stillbirths and abortions			0.081			0.916
No	0.00	1		0.00	1	
Yes	0.39	1.47 (0.95 – 2.28)	0.081	-0.02	0.98 (0.66 – 1.45)	0.916
Sex of child(ren)			0.355			0.929
Only male	0.00	1		0.00	1	
Only female	0.08	1.08 (0.43 – 2.74)	0.867	0.18	1.20 (0.53 – 2.71)	0.661
Both male and female	0.02	1.02 (0.49 – 2.10)	0.969	0.03	1.03 (0.54 – 1.96)	0.930
No children at all	-0.43	0.65 (0.29 – 1.47)	0.303	-0.04	0.96 (0.48 – 1.93)	0.918

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	OR (95% CI)	*P*-value	Coefficient	OR (95% CI)	*P*-value
Partnership involves financial commitments			0.016			0.091
No payments	0.00	1		0.00	1	
Dowry	0.62	1.87 (1.08 – 3.23)	0.026	-0.10	0.91 (0.60 – 1.38)	0.658
Bride price	0.85	2.33 (1.23 – 4.40)	0.009	0.45	1.57 (0.96 – 2.58)	0.074
Both dowry and bride price	1.49	4.45 (1.75 – 11.27)	0.002	0.63	1.87 (0.80 – 4.37)	0.149
Woman unaware	0.66	1.93 (0.66 – 5.68)	0.230	0.24	1.27 (0.52 – 3.08)	0.596
Partnership age difference			0.705			0.297
Woman is same age	0.00	1		0.00	1	
Woman older	-0.15	0.86 (0.14 – 5.51)	0.877	-0.66	0.52 (0.09 – 3.03)	0.463
Woman is 1-4 years younger	-0.05	0.95 (0.31 – 2.94)	0.935	0.13	1.14 (0.43 – 3.00)	0.788
Woman is 5-9 years younger	0.12	1.12 (0.36 – 3.47)	0.841	0.01	1.01 (0.38 – 2.68)	0.989
Woman is 10 or more years younger	-0.29	0.75 (0.24 – 2.39)	0.629	-0.33	0.72 (0.27 – 1.95)	0.515
Partnership discord			0.000			0.000
Never	0.00	1		0.00	1	
Rarely	1.25	3.48 (1.05 – 11.47)	0.041	1.49	4.45 (1.76 – 11.28)	0.002
Often/ Sometimes	3.49	32.92 (10.05 – 107.82)	0.000	3.55	34.76 (13.45 – 89.82)	0.000

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	OR (95% CI)	*P*-value	Coefficient	OR (95% CI)	*P*-value
Level of female illiteracy in community	-0.01	1.00 (0.97 – 1.02)	0.699	0.00	1.00 (0.98 – 1.02)	0.995
Level of male illiteracy in community	-0.01	1.00 (0.97 – 1.02)	0.700	0.01	1.01 (0.99 – 1.03)	0.521
Proportion of women with higher education in community	-0.02	0.99 (0.96 – 1.01)	0.172	-0.01	0.99 (0.97 – 1.01)	0.319
Proportion of men with higher education in community	0.01	1.01 (0.99 – 1.03)	0.593	0.01	1.01 (0.99 – 1.03)	0.247
Level of female unemployment in community	-0.01	0.99 (0.97 – 1.01)	0.357	0.00	1.00 (0.98 – 1.02)	0.975
Level of male unemployment in community	0.02	1.02 (0.98 – 1.05)	0.379	0.03	1.03 (1.00 – 1.06)	0.098
Proportion of couples without employment in community	0.01	1.01 (0.97 – 1.05)	0.560	0.03	1.03 (1.00 – 1.07)	0.088
Level of women's acceptance of violence (wife beating) in community	0.01	1.01 (0.99 – 1.03)	0.192	0.01	1.01 (1.00 – 1.03)	0.088

Continued

Table 4.5 continued

Variable	Current Intimate Partner Violence			Life-time Intimate Partner Violence		
	Coefficient	**OR (95% CI)**	***P*-value**	**Coefficient**	**OR (95% CI)**	***P*-value**
Proportion of men using alcohol daily in community	0.02	1.02 (1.00 – 1.04)	0.102	0.03	1.03 (1.01 – 1.05)	0.005
Level of iilicit drug use by men in the community	0.05	1.05 (0.99 – 1.13)	0.127	0.09	1.10 (1.03 – 1.16)	0.002
Level of general trust in the community	0.03	1.03 (1.01 – 1.05)	0.007	0.00	1.00 (0.99 – 1.02)	0.694
Level of social cohesion and reciprocated exchange in community	0.03	1.03 (0.98 – 1.08)	0.227	0.03	1.03 (0.99 – 1.07)	0.184

4.3.2 Mulitivariable Logistic Regression Analyses

Having conducted a series of bivariate analyses to explore the different crude associations, sets of multivariable analyses (sequential/hierarchical logistic regression) are also carried out. As explained in a greater depth in the methodology section of this thesis, the overall aim of these extra sets of analyses is to get a clearer picture of the patterns of associations between IPV and the independent variables by (1) exploring separate groups of independent variables (subset models) that are effective at predicting IPV occurrence and studying the interactions between the independent variables in each separate group that could be of significant importance in the prediction, (2) studying the cumulative contribution of the subsets models towards the prediction of IPV occurrence when put into an overall predictive model, and (3) studying the changes in predictive capability of each independent variable along the series of analyses conducted in order to ascertain their strength and stability in predicting IPV occurrence (i.e., comparison of changes in results from the simple bivariate to the separate subset model, then to the overall model).

4.3.2.1 Subset Predictive Models

This section presents the results of the fitted subset models. It should be noted that not all variables tested for statistical significance within each subset made it into the final fitted subset model. Each fitted subset model only consists of the variables that are statistically significant and those found to provide needed adjustments (confounding).

Subset Model 1 explores the relationship between the life-time experience of IPV against women and basic demographic variables (women's age, partner's age, marital status, place of residence and parenthood status). Table 4.6 shows the details of the variables in the final fitted subset model for the basic demographic factors [χ^2 (10, N=719) = 15.07, p=0.130; Hosmer and Lemeshow: p=0.652]. As shown in this Table, the two variables that are statistically significant in the model are women's age (p=0.042) and partner's age (p=0.034), indicating that women's age and partner's age both contribute to the prediction of IPV occurrence.

Table 4.6 Coefficients, *adjusted odds ratios, 95% confidence interval and *p*-value of the best fitting logistic regression model for the basic demographic variables (Subset Model 1)

Variable	Coefficient	OR (95% CI)	*p*-value
Woman's age group			0.042
18 – 29	0.00	1	
30 – 39	-0.46	0.63 (0.37 – 1.10)	0.103
40 – 49	-0.31	0.73 (0.37 – 1.47)	0.381
50 – 59	0.82	2.27 (0.78 – 6.61)	0.134
60 and above	0.87	2.39 (0.54 – 10.60)	0.251
Partner's age group			0.034
18 – 29	0.00	1	
30 – 39	0.55	1.73 (0.97 – 3.07)	0.062
40 – 49	0.52	1.68 (0.83 – 3.39)	0.152
50 – 59	0.44	1.55 (0.70 – 3.43)	0.276
60 and above	-0.85	0.43 (0.13 – 1.42)	0.165
Place of residence			0.000
Ilorin (Urban)	0.00	1	
Offa (Rural)	-0.08	0.92 (0.62 – 1.37)	0.692
Erin-Ile (Rural)	-0.19	0.83 (0.52 – 1.31)	0.413

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

Subset Model 2 explores the relationship between life-time experience of IPV against women and educational factors (woman's educational attainment, partner's educational attainment, woman's literacy and partner's literacy). Table 4.7 shows the details of variables in the final fitted subset of model for the educational factors [χ^2 (4, N=719) = 46.81, p<0.001; Hosmer and Lemeshow: p=0.816]. The only variable found to be statistically significant and having a main effect in predicting IPV occurrence in this model is woman's educational attainment. After adjusting for the effect of partner's educational attainment, the results show that lower or no educational attainments expose women to IPV, with women having only primary or no attainments showing approximately a 4.4-fold increase in likelihood of experiencing IPV as compared with those having higher attainments (p<0.001).

Table 4.7 Coefficients, *adjusted odds ratios, 95% confidence interval and *p*-value of the best fitting logistic regression model for the educational factors (Subset Model 2)

Variable	Coefficient	OR (95% CI)	*p*-value
Woman's educational attainment			0.000
Tertiary/ Higher	0.00	1	
Secondary	0.31	1.36 (0.87 – 2.14)	0.178
None or Primary	1.48	4.40 (2.45 – 7.90)	0.000
Partner's educational attainment			0.087
Tertiary/ Higher	0.00	1	
Secondary	0.33	1.38 (0.87 – 2.21)	0.175
None or Primary	-0.30	0.74 (0.40 – 1.37)	0.339

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

Subset Model 3 explores the relationship between life-time experience of IPV against women and employment factors (woman's employment status, partner's employment status, nature of woman's employment and nature of partner's employment). Table 4.8 shows the details of variables in the final fitted subset model for the employment factors [χ^2 (6, N=719) = 5.73, p=0.455; Hosmer and Lemeshow: p=0.663]. The results show that none of the variables in the constructed model is significantly related to the occurrence of IPV.

Table 4.8 Coefficients, *adjusted odds ratios, 95% confidence interval and *p*-value of the best fitting logistic regression model for the employment factors (Subset Model 3)

Variable	Coefficient	OR (95% CI)	*p*-value
Woman in employment			0.786
Yes	0.00	1	
No	0.07	1.07 (0.67 – 1.71)	0.786
Partner in employment			0.616
Yes	0.00	1	
No	-0.16	0.85 (0.46 – 1.59)	0.616
Nature of Woman's employment			0.526
Salaried	0.00	1	
Self-employed	0.12	1.13 (0.75 – 1.70)	0.573
Unpaid family worker	0.68	1.98 (0.57 – 6.82)	0.280
Nature of Partner's employment			0.344
Salaried	0.00	1	
Self-employed	0.26	1.29 (0.88 – 1.90)	0.187
Unpaid family worker	0.52	1.69 (0.51 – 5.61)	0.392

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

Subset Model 4 explores the relationship between life-time experience of IPV and the set of variables labelled as individual social factors (woman's say in the choice of spouse/partner, woman's frequency of communication with family and woman's proximity to her family). Table 4.9 shows the details of variables in the final fitted subset model for the individual social factors [χ^2 (7, N=719) = 54.18, p<0.001; Hosmer and Lemeshow: p=0.899].

Again, the results show that the only two variables that are statistically significant and having main effects in predicting IPV occurrence in the final fitted subset model 4 are the woman's choice of spouse/partner (p<0.001) and her frequency of communication with family (p=0.001). Women who had no say in selecting their partners (i.e., having other people choosing their partners for them without necessarily seeking their consent) show approximately a 7-fold increase in IPV experience when compared with women who had a say in the choice and their partners also consented to the selection (p<0.001). Regarding communication with family, the results show that women who rarely communicate with the family are more predisposed to experiencing IPV as compared with those who communicate at least once a week. Results show that women who communicate just once a month are approximately 1.6 times more likely to experience IPV (p=0.031), while women who only communicate once a year or hardly ever are 2.4 time more likely to experience IPV (p=0.001).

Table 4.9 Coefficients, *adjusted odds ratios, 95% confidence interval and *p*-value of the best fitting logistic regression model for the individual social factors (Subset Model 4)

Variable	Coefficient	OR (95% CI)	*p*-value
Choice of spouse or partner			0.000
Both chose	0.00	1	
Woman (respondent) chose	-1.06	0.35 (0.08 – 1.52)	0.161
Others chose with woman's consent	-0.23	0.80 (0.40 – 1.59)	0.524
Others chose without woman's consent	1.89	6.62 (3.16 – 13.87)	0.000
Woman's frequency of communication with family			0.001
Corresponds at least once a week	0.00	1	
Corresponds at least once a month	0.46	1.58 (1.04 – 2.40)	0.031
Corresponds like once a year or hardly ever	0.89	2.44 (1.46 – 4.09)	0.001

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

Subset Model 5 explores the relationship between life-time experience of IPV and attitudinal and behavioural factors (partner's level of alcohol use, partner's drug use, partner's controlling behaviours, partner's general history of physical aggression, partner's affairs outside of relationship and woman's acceptance of violence [wife-beating]). Table 4.10 shows the details of variables in the final fitted subset model for the attitudinal and behavioural factors [χ^2 (16, N=719) = 189.05, p<0.001; Hosmer and Lemeshow: p=0.531].

The results show that variables that include a partner's history of physical aggression, partner's controlling behaviour, partner's affairs outside the relationship and partner's drugs use are all statistically significant in predicting IPV occurrence in this model. The results in Table 4.10 indicate that women who expressed that their partners have a history of physical aggression show approximately a 2-fold increase in the likelihood of experiencing IPV as compared with those who expressed otherwise (p=0.020). As regards partner's controlling behaviour, women with partners having/showing one or more controlling behaviour(s) are more predisposed to experiencing IPV as compared with those whose partners do not have any form of controlling behaviour. Women whose partners have 1, 2 or 3, and 4 or more controlling behaviours show approximately 5-, 9- and 25-fold increase in IPV exposure, respectively. In terms of partner's affairs outside of the relationship, women reporting that their partners may have been involved in affairs outside the relationship are 2.4 times more likely to experience IPV as compared with those reporting no such affairs (p=0.011). Concerning partner's drugs use, women whose partners use drugs are predisposed to experiencing IPV (p<0.001). In comparison with women whose partners have never used drugs, those whose partners have indulged in daily usage or a usage of 1 to 4 times a month are approximately 11 to 24 times more predisposed to experiencing IPV. Besides, those women who reported that they are unaware of such drug use by their partners also show a relatively slight increase in the likelihood of experiencing IPV (approximately a 4-fold increase) as compared with those who categorically reported that their partners have never used drugs.

Table 4.10 Coefficients, *adjusted odds ratios, 95% confidence interval and *p*-value of the best fitting logistic regression model for the attitudinal and behavioural factors (Subset Model 5)

Variable	Coefficient	OR (95% CI)	*p*-value
Partner's general history of physical aggression			0.067
No	0.00	1	
Yes	0.62	1.86 (1.10 – 3.14)	0.020
Woman (Respondent) do not know	0.17	1.18 (0.52 – 2.68)	0.692
Partner's controlling behaviour			0.000
None	0.00	1	
One	1.64	5.14 (1.51 – 17.47)	0.009
2 or 3	2.18	8.88 (2.97 – 26.52)	0.000
4 or more	3.20	24.50 (8.24 – 72.86)	0.000
Partner's affairs outside of relationship			0.075
No	0.00	1	
Yes	0.16	1.17 (0.64 – 2.14)	0.610
May have	0.88	2.40 (1.22 – 4.72)	0.011
Woman (Respondent) do not know	0.29	1.34 (0.79 – 2.26)	0.277
Partner's history of drugs use (substance abuse)			0.000
Never	0.00	1	
1 – 4 times	3.17	23.77 (2.73 – 206.73)	0.004
Everyday	2.36	10.56 (3.23 – 34.49)	0.000
Woman (Respondent) do not know	1.33	3.78 (1.96 – 7.29)	0.000
Partner's use of alcohol			0.978
Never	0.00	1	
Less than once a month	-0.33	0.72 (0.24 – 2.16)	0.558
1 – 3 times a month	-0.04	0.96 (0.39 – 2.36)	0.933
Once a week	0.15	1.17 (0.62 – 2.20)	0.635
Every day	0.08	1.08 (0.57 – 2.04)	0.808
Woman (Respondent) do not know	0.14	1.15 (0.52 – 2.54)	0.732

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

Subset Model 6 explores the impact of a set of variables labelled as sexual and reproductive health factors on the likelihood of women reporting life-time experience of IPV. The model explores the predictive capability of four independent variables (number of children, gender of child, contraception refusal by partner, and history of miscarriages, stillbirths or abortions). Table 4.11 shows the details of the variables in the final fitted model 6. The model was found to be statistically significant [χ^2 (7, N=719) = 21.59, p=0.003; Hosmer and Lemeshow:

p=0.100], expressing that the model was effective/able in distinguishing between women reporting life-time experience of IPV and those that did not. Model 6 as a whole is able to correctly classify 74.5% of cases.

Nonetheless, the results contained in the Table show that only the number of children have a main effect contribution to the model (*p*=0.004), while the interaction variable (number of children by history of miscarriages, stillbirths or abortions) is the only significant interaction variable (*p*=0.016) in the final fitted model 6. Furthermore, the results indicate that women with 3 – 4 children are approximately 2 times less predisposed to IPV experience as compared with those having 5 or more children, provided that they have no history of miscarriages, stillbirths or abortions (*p*=0.035). In addition, the results pertaining to the significant interaction variable show that women with 1 – 2 children, despite having a history of miscarriages, stillbirths or abortions, are significantly less likely to experience IPV as compared with those having 5 or more children and without any history of miscarriages, stillbirths or abortion (*p*=0.010). In fact they are 9 times less likely to experience IPV.

Table 4.11 Coefficients, *adjusted odds ratios, 95% confidence interval and p-value of the best fitting logistic regression model for the sexual and reproductive health factors (Subset Model 6)

Variable	Coefficient	OR (95% CI)	*p*-value
Categorical number of children			0.004
5 or more	0.00	1	
3 – 4	-0.64	0.53 (0.29 – 0.96)	0.035
1 – 2	0.34	1.40 (0.77 – 2.54)	0.270
None	-0.25	0.78 (0.44 – 1.39)	0.404
History of miscarriages, stillbirths or abortions			0.684
No	0.00	1	
Yes	0.16	1.17 (0.54 – 2.53)	0.684
Categorical number of children **by** History of miscarriages, stillbirths or abortions			0.016
5 or more × No History of …	0.00	1	
3 – 4 × Yes History of …	0.41	1.51 (0.56 – 4.06)	0.412
1 – 2 × Yes History of …	-2.21	0.11 (0.02 – 0.58)	0.010
None × Yes History of …	-0.21	0.81 (0.20 – 3.31)	0.772

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

Subset Model 7 explores the impact of a set of variables labelled as relationship characteristics on the likelihood of women reporting life-time experience of IPV. The model explores the predictive capability of five independent variables (partnership involves financial commitments, partnership age difference, partnership educational disparity, partnership employment and partnership discord). The model is found to be statistically significant [χ^2 (8, N=719) = 173.86, p<0.001; Hosmer and Lemeshow: p=0.993], indicating that the model is effective/able in distinguishing between women reporting life-time experience of IPV and those who did not. Model 7 as a whole is able to correctly classify 80.4% of cases.

Table 4.12 shows the details of variables in the final fitted model 7. The results contained in the Table indicate that three of the independent variables in the model make unique significant contributions. These variables are: partnership discord (p<0.001), partnership age difference (p=0.005), and partnership educational disparity (p=0.004). In terms of partnership discord, women with rare, and those with frequent occurrence/experience of discord in their relationships, have approximately 5- and 4-fold increase in likelihood of experiencing IPV, respectively, as compared with women without any report of partnership discord. Regarding partnership age difference, women who are 10 or more years younger than their partners show significant reduction in IPV experience when compared with couples of equal age (p=0.033). Age difference confers a 3.6-fold reduction in the likelihood of experiencing IPV. In terms of partnership educational disparity, women having partners with better education than themselves are approximately 2 times more likely to experience IPV as compared with those having the same level of education as their partners (p=0.001).

Table 4.12 Coefficients, *adjusted odds ratios, 95% confidence interval and p-value of the best fitting logistic regression model for the relationship characteristics (Subset Model 7)

Variable	Coefficient	OR (95% CI)	*p*-value
Partnership age difference			0.005
Woman is same age as partner	0.00	1	
Woman is older	-0.89	0.41 (0.06 – 3.06)	0.385
Woman is 1 – 4 years younger	-0.29	0.75 (0.25 – 2.28)	0.612
Woman is 5 – 9 years younger	-0.71	0.49 (0.16 – 1.52)	0.216
Woman is 10 or more years younger	-1.27	0.28 (0.09 – 0.90)	0.033
Partnership educational difference			0.004
Same level	0.00	1	
Partner better educated	0.70	2.02 (1.33 – 3.08)	0.001
Woman better educated	0.09	1.10 (0.49 – 2.48)	0.822
Partnership discord			0.000
Never	0.00	1	
Rarely	1.60	4.96 (1.94 – 12.71)	0.001
Often/ sometimes	3.75	42.64 (16.15 – 112.55)	0.000

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

Subset Model 8 explores the impact of a set of variables labelled as general societal and community factors on the likelihood of women experiencing IPV. The model explores the predictive capability of 7 independent variables and 3 interaction variables – **Independent Variables**: proportion of couples without employment in the community, proportion of women with higher education in the community, proportion of men with higher education in the community, proportion of men using alcohol daily in the community, level of illicit drug use by men in the community, level of women's acceptance of violence (wife-beating) in the community, and societal cohesion and reciprocated exchange; **Interaction Variables**: proportion of men using alcohol daily in the community by proportion of men with higher education in the community, proportion of men using alcohol daily in the community by level of women's acceptance of violence (wife-beating) in the community, and level of illicit drug use by men in the community by level of women's acceptance of violence (wife-beating) in the community. Table 4.13 shows the details of variables in the final fitted model 8. This model is found to be statistically significant [χ^2 (6, N=719) = 23.17, p=0.001; Hosmer and Lemeshow: p=0.724], indicating that the model is able in distinguishing between women

reporting life-time experience of IPV and those who did not. Model 8 is able to correctly classify 74.5% of cases.

The results displayed in Table 4.13 show that only two main effect variables (proportion of men using alcohol daily in the community and proportion of men with higher education in the community) and one interaction variable (proportion of men using alcohol daily in the community by proportion of men with higher education in the community) has statistically significant contributions. Furthermore, these results give an indication that the higher the proportion of men with further (higher) education in the community, the more likely women are to experience IPV in communities with zero or no daily alcohol consumption by men. Nonetheless, it is important to note that this increase in likelihood is only a slight 1.1-fold increase (p=0.002). Regarding the proportion of men using alcohol daily in the community, the higher the proportion of men consuming alcohol, the more likely women are to experience IPV in communities lacking men with higher education (i.e., with every 1% increase in such proportion, there is approximately 1.3-fold increase in the likelihood of IPV occurrence is such communities, p=0.006).

Despite the results of the two significant main effect variables explained above, and based on the significant interaction between them, the results of the main effects are not really considered to be of significant importance. This is because there will very likely to be a fraction of men in every community who will use/drink alcohol daily and there will also very likely be a fraction of men with higher education in every community. Therefore, the more important result to focus on is that of the significant interaction effect. Pertaining to the significant interaction effect, the result shows that even if there is a high proportion of men using alcohol daily in a community, with a larger proportion of men in such community having higher education, there is likely going to be a very slight decrease in IPV against women in the community, as compared with a community with lower proportion of men using alcohol daily and with a lower fraction of men having higher education. It is important to note that this decrease in likelihood is only a minute 1.003-fold decrease in the likelihood of experiencing IPV (p=0.027).

Table 4.13 Coefficients, *adjusted odds ratios, 95% confidence interval and *p*-value of the best fitting logistic regression model for the general societal and community factors (Subset Model 8)

Variable	Coefficient	OR (95% CI)	*p*-value
Proportion of men with higher education in the community	0.077	1.080 (1.029 – 1.134)	0.002
Proportion of men using alcohol daily in community	0.233	1.263 (1.070 – 1.491)	0.006
Level of illicit drug use by men in the community	0.092	1.096 (0.984 – 1.220)	0.094
Level of women's acceptance of violence (wife beating) in community	-0.020	0.980 (0.943 – 1.019)	0.311
Societal cohesion and reciprocated exchange	0.005	1.005 (0.951 – 1.061)	0.861
Proportion of men using alcohol daily in the community by Proportion of men with higher education in the community	-0.003	0.997 (0.994 – 1.000)	0.027

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

4.3.2.2 Block Modelling of Subset Predictors (Cumulative contribution of the subset models)

As explained in the methodology, sequential logistic regression is used to explore the cumulative contributions of the subset models towards the prediction of IPV occurrence. In other words, the subset models fitted earlier are entered sequentially to study whether the insertion of additional variables (subset models) produces an increase in the capability of predicting IPV occurrence.

Table 4.14 is the summary of the contribution of each subset model to the prediction of IPV at the different steps of the block modelling procedure. A subset model for the basic demographic variables is first included in the process. It should be noted that the subset

model for employment factors has been excluded from the block modelling procedure as the results pertaining to variables in this subset model are all not statistically significant, as shown in section 4.3.2.1.

The block modelling procedure shows contrasting results at level 1, where the subset model for basic demographic variables is introduced. Result from one of the statistical assessment tests indicates a non-significant association, while the other shows that the subset model significantly contributes towards the prediction of IPV (Chi-Square: p=0.130, Hosmer and Lemeshow: p=0.652). This incongruity in results is most likely due to a weak association, or contribution, towards IPV prediction. Nonetheless, with the inclusion of the subset model for educational variables at level 2 the model becomes more predictive of IPV, meaning that the educational variables contribute significantly to the prediction of IPV (Chi-Square: p<0.001, Hosmer and Lemeshow: p=0.454). At level 3, the results after the inclusion of the subset model for individual social factors also show significant prediction, indicating that the subset model contributes over and above that where the educational variables contributed (Chi-Square: p<0.001, Hosmer and Lemeshow: p=0.538). Moreover, at level 4, the introduction of the subset model for attitudinal and behavioural factors also contributes further to the prediction of IPV (Chi-Square: p<0.001, Hosmer and Lemeshow: p=0.530). The addition of the subset model for sexual and reproductive factors at level 5 also adds to the predictive strength over and above what other subset models have contributed (Chi-Square: p=0.003, Hosmer and Lemeshow: p=0.315). Furthermore, at level 6, the inclusion of the subset model for relationship characteristics also contributes significantly to the prediction (Chi-Square: p<0.001, Hosmer and Lemeshow: p=0.500). Just as with most other subset models included earlier in the block modelling procedure, the subset model for general societal and community factors also contributes significantly to the prediction (Chi-Square: p<0.001, Hosmer and Lemeshow: p=0.585).

Table 4.14 The contribution of each subset model to the prediction of IPV at the different level/step of the block modelling procedure

	Omnibus Chi-Square Test			Hosmer and Lemeshow Test
Level (Model)	χ^2	***p*-value**	**df**	***p*-value**
Level 1 (Basic Demographic variables)	15.07	0.130	10	0.652
Level 2 (Educational variables)	51.32	0.000	4	0.454
Level 3 (Individual social factors)	35.61	0.000	5	0.538
Level 4 (Attitudinal and behavioural factors)	151.16	0.000	16	0.530
Level 5 (Sexual and reproductive health factors)	21.85	0.003	7	0.315
Level 6 (Relationship characteristics)	71.45	0.000	8	0.500
Level 7(General societal and community factors)	30.59	0.000	6	0.585

Note: a *p*-value <0.05 under the omnibus Chi-Square Test indicate significant result or contribution, while a *p*-value >0.05 under the Hosmer and Lemeshow Test show a statistically significant contribution towards predicting IPV occurrence.

4.3.2.3 Summary of the predictive capability of the independent variables

Woman's Educational Attainment: The bivariate logistic regression results show that women's educational attainment is related to IPV occurrence, even after multivariable adjustments, as shown in Table 4.15, the educational attainment is still significantly associated with IPV occurrence in similar fashion – i.e., women with just primary or no educational attainment having a much higher likelihood of experiencing IPV as compared with those having higher educational attainment. This consistency in association is an indication that educational attainment is a strong predictor of IPV against women.

Partner's Educational Attainment: just as in the case of woman's educational attainment, partner's attainment is also consistently associated with IPV, even after multivariable adjustments. But as opposed to the woman's educational attainment, the results show that

women having partners with only primary or no educational attainment at all are less likely to experience IPV as compared with those having partners with higher education. This peculiar finding lends credence to the resource theory, and a further explanation or reflection as to why this is plausible is provided in chapter 6 (i.e., the discussion chapter).

Woman's frequency of Communication with family members: although the bivariate logistic regression results and those of the subset model fitted for individual social factors show that women's frequency of communication with family members is statistically significant in predicting IPV occurrence, under the block modelling procedure (the overall predictive model) the significance of the variable diminishes. This indicates that the variable is a weak predictor of IPV.

Choice of spouse/partner: this variable is consistently associated with IPV across the different set of analytical tests applied, even after multivariable adjustment, implying that women's choice of spouse/partner is highly predictive of IPV occurrence. Women who have no say in the choice of their spouse/partner are more predisposed to experiencing IPV as compared with those who have a say.

Partner's history of physical aggression: despite the fact that bivariate logistic regression analysis results indicate that partner's history of physical aggression is significantly predictive of the occurrence of IPV against women, the results of the block modelling (the overall predictive model) show less consistency in the prediction along the levels of the overall model. This indicates a likely weak association between partner's history of physical aggression and IPV occurrence.

Partner's affairs outside of relationship: just as in the case of partner's history of physical aggression, the results show that, along the levels of the overall model, a partner's affairs outside of the relationship is not consistently associated with IPV. As such, this independent variable is most likely to be a weak predictor of IPV.

Partner's alcohol use: although the simple bivariate logistic regression results show that women whose partners use alcohol daily or once a week have increased likelihood of experiencing IPV, in the multivariable analyses this is not the case – the results show that partner's alcohol use is not statistically significant in predicting IPV.

Partner's illicit drug use: after adjusting the effects of this variable through multivariable logistic regression analysis, the results show that partner's illicit drug use is consistently significant in predicting the occurrence of IPV (i.e., women whose partners use such drugs are more likely to experience IPV as compared with those whose partners do not use drugs). This is an indication that illicit drug use by male partners is a stable and strong predictor of IPV occurrence.

Partner's controlling behaviour: the bivariate logistic regression results indicate that partner's controlling behaviour is related to IPV occurrence (i.e., women whose partners have some controlling behaviours are predisposed to IPV as compared to those whose partners do not possess such behaviours). The association is still maintained even after multivariable adjustments, as shown in Table 4.15; this indicates that partner's controlling behaviour is strongly related to the occurrence of IPV.

Categorical number of children: the bivariate logistic regression results show that women having 3 to 4 children are less likely to experience IPV as compared with those having 5 or more. This model of association between IPV and number of children has been consistently noted across all the steps of multivariable logistic regression analyses conducted. This implies that the categorical number of children is an important factor in predicting IPV occurrence.

Partnership discord: association has been found between partnership discord and IPV occurrence in the simple bivariate logistic regression results, thus indicating that women reporting some form of discord in their relationship are more predisposed to IPV experience as compared with those who reported absence of such discord. After multivariable

adjustments, the association between partnership discord and IPV is still present/maintained in a similar fashion, indicating the partnership discord variable to be a strong predictor of IPV occurrence.

Proportion of men consuming alcohol daily in the community: as shown in section 4.3.1.2, the bivariate results indicate an increase in the likelihood of women experiencing IPV with a higher proportion of men consuming alcohol daily in communities. After multivariable adjustments, the association is still maintained, but a more complex relationship between the proportion of men consuming alcohol in the community and IPV occurrence is unravelled with the multivariable analyses. This complex relationship involves the interaction between the proportion of men consuming alcohol daily in the community and proportion of men with higher education in the community. In other words, it is likely that the proportion of men using alcohol daily in the community interacts with another variable (i.e., proportion of men with higher education in the community) in predisposing women to IPV occurrence.

Level of illicit drug use by men in the community: the bivariate logistic regression results show that the level of illicit drug use by men in communities is related to the experience of IPV by women in such communities. Following multivariable adjustment, this relationship or association is no longer present. This indicates that the level of illicit drug use by men in the community is likely to be a confounder rather than a variable with main effect in predicting women's experience of IPV.

Finally, these results support the hypothesis regarding the predictive capability of some variables tested in the research to be effective in predicting IPV occurrence. The results additionally suggest the plausibility of the hypothesis regarding the existence of interaction variable that is also predictive of IPV occurrence.

Table 4.15 Coefficients, *adjusted odds ratios, 95% confidence interval and p-value of the regression model at the final step of the block modelling procedure (overall model)

Model	Variable	Coefficient	OR (95% CI)	*p*-value
Model composed of basic demographic variables	***Woman's age group***			0.100
	18 – 29	0.00	1	
	30 – 39	-0.62	0.54 (0.21 – 1.37)	0.194
	40 – 49	-0.63	0.53 (0.15 – 1.93)	0.338
	50 – 59	1.16	3.20 (0.48 – 21.21)	0.228
	60 and above	0.02	1.02 (0.07 – 14.45)	0.989
	Partner's age group			0.512
	18 – 29	0.00	1	
	30 – 39	0.43	1.54 (0.59 – 3.97)	0.376
	40 – 49	0.77	2.16 (0.55 – 8.44)	0.270
	50 – 59	0.87	2.38 (0.41 – 13.67)	0.331
	60 and above	-0.14	0.87 (0.09 – 8.68)	0.904
	Place of residence			0.066
	Ilorin (Urban)	0.00	1	
	Offa (Rural)	-0.95	0.39 (0.17 – 0.89)	0.025
	Erin-Ile (Rural)	-0.76	0.47 (0.10 – 2.11)	0.324

Continued

Table 4.15 continued

Model	Variable	Coefficient	OR (95% CI)	*p*-value
Model composed of educational factors	***Woman's educational attainment***			0.027
	Tertiary/ Higher	0.00	1	
	Secondary	0.71	2.03 (0.61 – 6.78)	0.248
	None or Primary	2.21	9.07 (1.33 – 62.03)	0.025
	Partner's educational attainment			0.002
	Tertiary/ Higher	0.00	1	
	Secondary	-0.19	0.82 (0.27 – 2.53)	0.734
	None or Primary	-2.43	0.09 (0.01 – 0.60)	0.013
Model composed of individual social factors	***Choice of spouse or partner***			0.074
	Both chose	0.00	1	
	Woman (respondent) chose	-1.27	0.28 (0.04 – 1.83)	0.184
	Others chose with woman's consent	-0.46	0.63 (0.21 – 1.88)	0.410
	Others chose without woman's consent	1.45	4.25 (1.07 – 16.92)	0.040
	Woman's frequency of communication with family			0.853
	Corresponds at least once a week	0.00	1	
	Corresponds at least once a month	-0.003	0.997 (0.52 – 1.90)	0.993
	Corresponds like once a year or hardly ever	0.22	1.25 (0.56 – 2.82)	0.590

Continued

Table 4.15 continued

Model	Variable	Coefficient	OR (95% CI)	*p*-value
Model composed of attitudinal and behavioural factors	***Partner's general history of physical aggression***			0.173
	No	0.00	1	
	Yes	0.69	2.00 (0.97 – 4.13)	0.061
	Woman (Respondent) do not know	0.20	1.22 (0.39 – 3.79)	0.735
	Partner's controlling behaviour			0.000
	None	0.00	1	
	One	2.09	8.08 (1.97 – 33.09)	0.004
	2 or 3	2.34	10.37 (2.92 – 36.88)	0.000
	4 or more	3.40	29.82 (8.32 – 106.88)	0.000
	Partner's affairs outside of relationship			0.252
	No	0.00	1	
	Yes	-0.18	0.84 (0.35 – 2.00)	0.688
	May have	0.74	2.09 (0.87 – 5.00)	0.097
	Woman (Respondent) do not know	0.02	1.02 (0.51 – 2.02)	0.961

Continued

Table 4.15 continued

Model	Variable	Coefficient	OR (95% CI)	*p*-value
	Partner's history of drugs use (substance abuse)			0.000
	Never	0.00	1	
	1 – 4 times	5.32	203.80 (6.42 – 6471.18)	0.003
	Everyday	2.68	14.55 (2.33 – 90.74)	0.004
	Woman (Respondent) do not know	1.91	6.74 (2.76 – 16.46)	0.000
	Partner's use of alcohol			0.846
	Never	0.00	1	
	Less than once a month	-0.70	0.50 (0.11 – 2.17)	0.353
	1 – 3 times a month	-0.14	0.87 (0.26 – 2.86)	0.817
	Once a week	0.06	1.06 (0.47 – 2.38)	0.889
	Every day	-0.41	0.66 (0.26 – 1.69)	0.391
	Woman (Respondent) do not know	0.17	1.18 (0.42 – 3.35)	0.754
Model composed of sexual and reproductive health factors	***Categorical number of children***			0.028
	5 or more	0.00	1	
	3 – 4	-1.09	0.34 (0.13 – 0.85)	0.021
	1 – 2	0.11	1.11 (0.39 – 3.15)	0.843
	None	-0.16	0.85 (0.25 – 2.83)	0.789

Continued

Table 4.15 continued

Model	Variable	Coefficient	OR (95% CI)	*p*-value
	History of miscarriages, stillbirths or abortions			
	No	0.00	1	
	Yes	-0.45	0.64 (0.20 – 2.02)	0.443
	Categorical number of children by History of miscarriages, stillbirths or abortions			0.007
	5 or more × No History…	0.00	1	
	3 – 4 × Yes History …	1.32	3.74 (0.78 – 17.95)	0.100
	1 – 2 × Yes History …	-3.15	0.04 (0.003 – 0.62)	0.021
	None × Yes History …	-0.51	0.60 (0.06 – 6.54)	0.675
Model composed of relationship characteristics	***Partnership age difference***			0.013
	Woman is same age as partner	0.00	1	
	Woman is older	-1.18	0.31 (0.22 – 4.31)	0.381
	Woman is 1 – 4 years younger	0.93	2.54 (0.61 – 10.54)	0.201
	Woman is 5 – 9 years younger	-0.003	0.997 (0.23 – 4.40)	0.997
	Woman is 10 or more years younger	-0.24	0.79 (0.15 – 4.28)	0.782
	Partnership educational difference			0.247
	Same level	0.00	1	
	Partner better educated	-0.02	0.99 (0.31 – 3.15)	0.980
	Woman better educated	1.14	3.12 (0.75 – 13.04)	0.118

Continued

Table 4.15 continued

Model	Variable	Coefficient	OR (95% CI)	*p*-value
	Partnership discord			0.000
	Never	0.00	1	
	Rarely	1.80	6.03 (2.01 – 18.14)	0.001
	Often/ sometimes	3.50	33.05 (10.16 – 107.53)	0.000
Model composed of general societal and community factors	***Proportion of men with higher education in the community***	0.16	1.17 (1.09 – 1.26)	0.000
	Proportion of men using alcohol daily in community	0.51	1.17 (1.09 – 1.26)	0.000
	Level of illicit drug use by men in the community	0.14	1.14 (0.96 – 1.36)	0.128
	Level of women's acceptance of violence (wife beating) in community	-0.05	0.95 (0.90 – 1.01)	0.116
	Societal cohesion and reciprocated exchange	-0.06	0.94 (0.83 – 1.07)	0.370
	Proportion of men using alcohol daily in the community × Proportion of men with higher education in the community	-0.01	0.993 (0.989 – 0.998)	0.003

*Odds ratio adjusted for all the variables in the table (model)
OR = Odds ratio, CI = Confidence Interval

4.4 Help-seeking behaviour of abused women

Table 4.16 shows the help-seeking behaviour of women who reported current IPV in the study (120 women). It covers 185 incidents reported in detail by those women.

The results show that help-seeking in response to an IPV incident is a common practice amongst abused women in the study (with 68.0% reporting that they sought at least one form of help). Most of the women used formal services (59.5%), while a similarly high number of women sought informal help as well (53.0%). Health/medical services rank highest amongst the formal services used, with every woman who reported a contact with formal services in relation to an IPV incident reporting contact with the health services. The other three formal services considered were poorly utilised (police, 5.4%; judicial service, 0.5%; shelter, 0%). In terms of the informal services, usage of traditional healers was the highest (33.0%), with a fair number of women also seeking help from local community leaders (29.2%). Besides, the results show that abused women do not often leave the abusive environment (home) after incidents of IPV – only 14.0% of women reporting they left home in the 12 months prior to the study. Nonetheless, when women do choose to leave home, they mostly turn to family members for help (92.3%).

These results partly refute the research hypothesis pertaining to the help-seeking behaviour of abused women. Contrary to the research hypothesis, the overall results show that larger proportion of women used formal services as compared with informal services. Nevertheless, when one considers certain formal services such as the police, judicial and shelter service, the results absolutely support the research hypothesis as these services are poorly utilised by abused women in comparison with informal services.

Table 4.16 Help-seeking behaviour of women and monetary implications

Variables	Options	Incidents of IPV	
		Number	Percentage (%)
Woman sought help	*No*	60	32.0
	Yes	125	68.0
Formal services*	*No*	75	40.5
	Yes	110	59.5
Informal Services#	*No*	87	47.0
	Yes	98	53.0
Health/ Medical care	*No*	75	40.5
	Yes	110	59.5
Police	*No*	175	94.6
	Yes	10	5.4
Judicial service	*No*	184	99.5
	Yes	1	0.5
Traditional Healer	*No*	124	67.0
	Yes	61	33.0
Local/ community authority	*No*	131	70.8
	Yes	54	29.2
Left Home after IPV incident	*No*	159	86.0
	Yes, stayed with family	24	13.0
	Yes, stayed with friends	2	1.0
	Yes, stayed at shelter	0	0

*Formal services include: police, shelter, health and judicial services.
#Informal services include: traditional healers, support from community leaders, family and friends.

4.5 Attitudes towards Gender Roles

The results in Table 4.17 indicate that a large proportion of women in Nigeria, approximately 86%, agree to the notion that part of the attributes of a good wife is to obey her husband regardless of what her opinions might be. Regarding the man stamping his authority as the boss of the house, approximately 51% of women were of the same opinion that a man should show his wife or partner who the boss is, while 45% of women show a contrary view. As regards women's liberty in choosing their own friends (i.e., women should be able to choose their friends even if their husbands/partners disapprove), the larger proportion of women (72.3%) disagreed with such idea. Concerning a wife's sexual obligation to her partner, the results show that approximately 53% of women agreed to the notion that a wife should be obliged to have sex with her husband even if she is averse to having sex at that particular

moment, while 43% of women expressed that a wife should not be tied to such obligations. In terms of investing in the education of a male child as opposed to that of a female child, the majority of women (92.1%) expressed their disagreement to this idea. Nonetheless, 6% of women still support the idea of investment in male child's education being more advantageous than that of a female. As regards external agencies intervening in the mistreatment of a wife by her husband, approximately 64% of women concurred with the involvement of outside agencies, while 33% of women disagreed with agencies intervening.

Table 4.17 Women's perception/attitudes towards gender roles in relationships

Question on attitude towards gender role	Agree		Disagree		Woman does not know	
	n	(%)	n	(%)	n	(%)
A good wife obeys her husband even if she disagrees	621	86.4	85	11.8	13	1.8
It is important for a man to show his wife/partner who is the boss	365	50.8	326	45.3	28	3.9
A woman should be able to choose her own friends even if her husband/ partner disapproves	182	25.3	520	72.3	17	2.4
It is the wife's obligation to have sex with her husband even if she does not feel like it	382	53.1	311	43.3	26	3.6
Investing in a male child's education is far more valuable than that of a female	43	6.0	662	92.1	14	1.9
If a man mistreats his wife, outside agencies should intervene	463	64.4	237	33.0	19	2.6

Furthermore, to explore the distribution of the women's various attitudes towards gender roles based on their demographic attributes, cross-tabulation of such attitudes and some basic demographic variables has been generated. Table 4.18 contains the results of the cross-tabulation. Overall, the results show that the distributions of the various attitudes towards gender roles are somewhat similar across place of residence (whether urban or rural),

educational attainment (whether the woman has higher, secondary, primary or no education at all), and age groups. For example, the results indicate that women living in urban areas and rural areas all have a similar level of agreement in terms of a good wife being obedient to her husband even if she disagrees (in other words, subservient to the man's wishes) – with 83.9% of women in the urban areas agreeing to this notion, while a similarly high proportion of women (89.2%) concurred with the idea in the rural areas. The same uniformity was observed in the case of women's educational attainment, with results pertaining to women being subservient to men's wishes indicating that 85.9% of those with higher/tertiary education, 82.4% with secondary education and 93.4% with primary or no education agreeing with the idea. In terms of age groups, there is also identical distribution of proportions of women agreeing to the idea that women should be subservient to their male partners across the different age groups – 18-29 (87.6%), 30-39 (85.3%), 40-49 (83.3%), 50-59 (97.1%), 60 and above (90%).

These results lend credence to the research hypothesis regarding women's support for male dominance in relationships within the Nigerian society.

Table 4.18 The distribution of attitudes towards gender roles by demographic variables

	Question on attitudes towards gender role								
	A good wife obeys her husband even if she disagrees			*It is important for a man to show his wife/partner who is the boss*			*A woman should be able to choose her own friends even if her husband/ partner disapproves*		
Demographic variable	Agree (%)	Disagree (%)	Do not know (%)	Agree (%)	Disagree (%)	Do not know (%)	Agree (%)	Disagree (%)	Do not know (%)
Place of residence									
Ilorin (Urban)	83.9	13.7	2.4	49.1	46.4	4.6	25.5	71.6	2.9
Offa (Rural)	89.2	8.8	2.0	51.5	46.1	2.5	27.9	70.6	1.5
Erin-Ile (Rural)	88.7	11.3	0.0	54.2	41.5	4.2	21.1	76.8	2.1
Woman's educational attainment									
Tertiary/ Higher	85.9	11.1	3.0	46.1	50.5	3.4	24.6	72.1	3.4
Secondary	82.4	16.0	1.6	48.8	47.3	3.9	30.1	68.4	1.6
None or Primary	93.4	6.6	0.0	62.0	33.1	4.8	19.3	78.9	1.8
Woman's age group									
18 – 29	87.6	10.4	2.0	47.4	49.4	3.2	22.5	74.3	3.2
30 – 39	85.3	13.6	1.1	51.7	43.8	4.5	27.2	70.2	2.6
40 – 49	83.3	14.7	2.0	52.0	46.0	2.0	29.3	70.0	0.7
50 – 59	97.1	0.0	2.9	57.1	34.3	8.6	5.7	91.4	2.9
60 and above	90.0	5.0	5.0	60.0	30.0	10.0	40.0	60.0	0.0

Continued

Table 4.18 continued

Demographic variable	Question on attitudes towards gender role								
	It is the wife's obligation to have sex with her husband even if she does not feel like it			*Investing in a male child's education is far more valuable than that of a female*			*If a man mistreats his wife, outside agencies should intervene*		
	Agree (%)	Disagree (%)	Do not know (%)	Agree (%)	Disagree (%)	Do not know (%)	Agree (%)	Disagree (%)	Do not know (%)
Place of residence									
Ilorin (Urban)	48.5	47.7	3.8	5.1	93.3	1.6	61.7	35.1	3.2
Offa (Rural)	53.4	42.6	3.9	9.3	89.2	1.5	64.7	33.8	1.5
Erin-Ile (Rural)	64.8	32.4	2.8	3.5	93.0	3.5	71.1	26.1	2.8
Woman's educational attainment									
Tertiary/ Higher	54.2	41.1	4.7	5.1	92.9	2.0	66.0	31.3	2.7
Secondary	48.0	48.0	3.9	6.2	92.2	1.6	59.0	38.7	2.3
None or Primary	59.0	39.8	1.2	7.2	90.4	2.4	69.9	27.1	3.0
Woman's age group									
18 – 29	53.0	41.8	5.2	4.0	94.4	1.6	59.0	38.6	2.4
30 – 39	49.8	46.8	3.4	6.4	91.3	2.3	67.5	29.4	3.0
40 – 49	56.7	41.3	2.0	6.0	93.3	0.7	65.3	32.0	2.7
50 – 59	51.4	48.6	0.0	8.6	88.6	2.9	71.4	25.7	2.9
60 and above	75.0	20.0	5.0	20.0	70.0	10.0	70.0	30.0	0.0

4.6 Attitudes towards IPV

The distribution of attitudes of women towards IPV in terms of their acceptance of wife-beating in the study sample is given in Table 4.19. The results presented in the table show that 33.5% of women agree with the acceptability of wife-beating for at least one of the reasons stated earlier in the methodology chapter. Support for wife-beating is slightly higher in the urban areas than in the rural areas, with women in both regions showing acceptance levels of 35.4% and 31.5%, respectively. In terms of educational attainment, women with primary and secondary attainments tend to be more supportive of wife-beating (60.0% and 41.8%, respectively), as compared with those without any attainment (24.0%) and those with higher educational attainment (26.3%). As regards age group of women, those in the age bracket of 18 – 29 years show the least acceptance of wife-beating (24.1%), while those in the age group of 40 – 49 years show the highest level of acceptance (50.7%) as compared with other age groups. This result may be a reflection of the coping strategy used by women or the reason why women in Nigeria stay in an abusive relationship, as research shows that women with children in an abusive relationship tend to adopt a coping strategy of seeing their abusive experiences as normal occurrences mainly as a way of protecting their children or as a means of sustenance in a patriarchal society (Decker et al., 2013; Abeya et al., 2012). This statement is plausible as other results in this research show that there is a relationship between IPV and the number of children. This assertion becomes even clearer when one considers the likely fact that women within the age of 40 – 49 are most likely to have children from their partnerships and as such more compelled to stay in the relationship even if it is abusive, as this will afford their children some protection. On the other hand, women in the younger age groups are less likely to have such commitments, as they are mostly in non-marital (i.e., dating) relationships and child bearing outside of wedlock is widely considered as immoral within the Nigerian society (Bamgbose, 2002). Besides, women within older age groups (i.e., 50 and above) are also likely to have children from their partnership, but their children are likely to be older and more independent and, as such they are less likely than those in the age group of 40 – 49 to support or adopt a compliance to abuse coping mechanism.

Considering women's literacy, those who are literate tend to show a greater acceptance of wife-beating (35.4%) in comparison with those who are not literate (24.8%). Again, this result may be an indication of patriarchy and cultural approval of IPV within the Nigerian

society. The results could also suggest the plausibility of exchange theory as expressed by Gibson-Davis et al. (2005) – decrease in violence as women's economic resource/power increases. These two notions (i.e., cultural approval of violence and exchange theory) are likely to be pertinent as literacy could confer some form of economic power on literate women (e.g., greater likelihood of getting better paid jobs) and as a result have less IPV victimisation, but with the influence of dominant societal norms of patriarchy they may accept wife-beating under certain 'socially justified' conditions. On the other hand, illiterate women may be exposed to greater IPV victimisations due to limited economic leverage and, as a result, develop an aversion towards wife-beating despite cultural approval of such violence as a normative practice in asserting male authority.

Table 4.19 The distribution of women's attitudes towards IPV (wife-beating)

	Women's Acceptance of Wife-beating		**Total no. of women**
Variable	*Non-acceptance (%)*	*Acceptance (%)*	*(n)*
Area			
Rural	68.5	31.5	346
Urban	64.6	35.4	373
Woman's educational attainment			
None	76.0	24.0	121
Primary	40.0	60.0	45
Secondary	58.2	41.8	256
Higher	73.7	26.3	297
Woman's age			
18 – 29	75.9	24.1	249
30 – 39	68.3	31.7	265
40 – 49	49.3	50.7	150
50 – 59	60.0	40.0	35
60 and above	65.0	35.0	20
Woman literate			
No	75.2	24.8	125
Yes	64.6	35.4	594
Total	66.5	33.5	719

4.7 Socio-Economic Costs of IPV

4.7.1 Household-level Estimates

4.7.1.1 Overview

As expressed in the methodology chapter, the economic costs of Intimate Partner Violence (IPV) at the household level included in this research study are: (1) the direct/actual out-of-pocket expenditures that women incurred in the process of accessing formal health care/medical treatments or services, traditional healing services, police support, legal counselling/judicial redress and support from local authorities/community leaders; (2) reduced household income or income foregone as a result of missed paid work; (3) costs of lost household work; and lastly, (4) additional indirect expenditures/amount lost in the form of children missing school days due to IPV experienced by their mothers.

Although elaborately explained in the methodology chapter, it is important to reiterate here that the way this survey gathered information used for costs estimation was by asking each woman about the number of incidents of violence she had experienced in the previous 12 months prior to the study. This was subsequently followed by soliciting detailed information on the most recent incident, and this required each woman to recall and give specific account of injuries that might have occurred, the help/support sought, expenditures incurred as well as number of days of paid work missed by her and her partner, hours of household work missed by her and her partner, and number of school days missed by the children. These questions were repeated to gather extra information on additional incidents each woman could recall up to a maximum of three (i.e., detailed information was solicited for the three most recent incident categories).

As stated in sub-section 4.4 for results on women's help-seeking behaviour, a total of 120 women reported experiencing IPV in the last 12 months. These women provided detailed information about 120 victimisations in the incident-one (latest incident) category for which such information was solicited. Information pertaining to 49 victimisations was provided for the incident-two category, while information about 16 victimisations was given in the third incident cases, thus making a total incident cases/victimisations of 185. Across these

incidents women experienced in the hands of their partners a varied combination of the different forms of abuse – physical, psychological and sexual. These are the cases explored in the quest for estimating the different costs incurred by the abused women and their various households in this study.

Nonetheless, it is also important to state that, in addition to the multiple forms of abuse experienced by the women, they also reported a wide range of injuries across the incident cases. As shown in Table 4.20, in most of the incidents women reported that they suffered scratches, abrasions and bruises (63.8%) as well as cuts, punctures and bites (53.5%). Women also suffered more serious injuries in some incidents such as sprains and dislocations (16.8%). In smaller proportions of incidents, women reported very serious injuries such as burns (0.5%), fracture/broken bones (1.1%) and vagina discomfort among others (0.5%). The varied range of injuries reported, some really serious and could lead to permanent disabilities, provides a base for exploring some of the health care/medical costs incurred by abused women in this study sample.

Table 4.20 Distribution of Injuries sustained by abused women during incidents of IPV

n=185

Category of injuries	Percentage across incidents
Cuts, Punctures and Bites	53.5
Scratches, Abrasions and Bruises	63.8
Sprains and Dislocations	16.8
Burns	0.5
Penetrating Injuries, Deep cuts and Gashes	23.8
Broken eardrum and Eye injury	0
Fractured/ Broken bones	1.1
Broken teeth	0
Vagina pain or discomfort and Others	0.5

n is the total number of incidents

4.7.1.2 Out-of-pocket Costs/Direct Expenditures

4.7.1.2.1 Formal Healthcare Costs

As shown in Table 4.20, women suffered multiple injuries across the incident cases reported, which is a testament to the brutality of the abuse experienced by these women. Highlighting further the seriousness of the cases, in as high as 110 incidents women reported incurring healthcare/medical costs such as the costs for service provision, transport costs and costs pertaining to medicines among others. The average service costs incurred for formal healthcare services per incident was ₦3,189.05. As stated earlier, transport was also required by the women to access the necessary healthcare treatments, and on average the costs of transport incurred by the women was ₦455.95 per incident. In terms of medicines prescribed for the women, they paid on average about ₦1,534.66 for each incident. Thus, costs of accessing formal healthcare services amount to a total average of ₦5,179.66 per incident. Based on this average, the total formal healthcare costs incurred by abused women across the incidents recorded in the sample is ₦569,762.60.

4.7.1.2.2 Costs Incurred Through Consulting Traditional Healers

Sixty one (61) incident cases required traditional healing, and on average the women expended ₦2,664.82 per incident. As such, the total costs incurred by abused women in consulting traditional healers in the sample amount to ₦162,554.02.

4.7.1.2.3 PoliceInvolvement Costs

Ten (10) incident cases involved police services. In the process, the women paid on average ₦1,975.00 per incident for such services. They also incurred transport costs which on average were about ₦219.00 per incident case. Thus, the costs of involving the police amount to a total average of ₦2,194.00 per incident. As such, the police involvement costs incurred by abused women across the incidents in the sample yield a sum total of ₦21,940.00.

4.7.1.2.4 Costs Incurred in Seeking Court/Judicial Redress

Amongst the incident cases, only one woman sought judicial redress. In the process, costs of: court fee of ₦5,000.00, Lawyer of approximately ₦10,000.00 and Transport amounting to approximately ₦1,000.00 were incurred. These costs yield a total of ₦16,000.00.

4.7.1.2.5 Costs Incurred by Reporting to Community Leaders

Fifty four (54) incident cases were reported to local authorities/community leaders. One case reported a payment of ₦2,000.00 in the form of community consultation fee, while 40 cases reported the payment of transport fees in seeking local authority's/community leader's support/mediation – these transport fees on average were approximately ₦434.50. Thus, the estimation of the total average costs involved in reporting to the authorities/leaders per incident amount to ₦2,434.50. Based on these estimates, the local authority/community leader involvement costs incurred by abused women across incidents in the study sample yield a sum total of ₦131,463.

4.7.1.2.6 Costs Incurred in the Process of Leaving Home after IPV Incident

Twenty six (26) incidents warranted some of the women to leave their homes after an IPV victimisation. Two (2) incidents required the women to stay with a friend, while 24 incidents required women to leave home and stay with family members. The average length of their stay away from home was 7 nights per incident. Five (5) women incurred costs in the course of staying away from home. The average cost for such expenditures by the women was ₦3,500 per incident (in other words, ₦3,500 per stay). As such, the estimated total costs incurred by abused women in the process of leaving home after IPV incident to stay elsewhere amount to ₦91,000 across the incidents reported in the sample.

4.7.1.2.7 Overall Out-of-Pocket Costs (Direct Expenditures)

As shown in Table 4.21, for each category of service/support (e.g., formal healthcare costs and costs of police services) the comprehensive expenditures information pertaining to accessing the service/support by abused women generated in the previous sub-sections has

been used in calculating weighted average costs per incident of IPV. The weighted average costs are then summed across the categories of services/support to derive the overall average cost per incident. In other words, the proportion of incidents reporting specific costs as a result of a particular service usage in the total of 262 occurrences involving some form of costs has been used to develop the weighted average costs. Based on these calculations, the overall average weighted out-of-pocket costs for an incident sum up to ₦3,795.24. Therefore, within the research sample the total out-of-pocket costs/expenditures for the 262 occurrences involving payments for accessing services/support amount to ₦994,352.88.

Table 4.21 Weighted Averages of Out-of-Pocket Costs (in Naira) per service/support category and Overall Weighted Average Costs across the categories

Service/ Support category	Incidents with number of service usages	Weight	Average Unit Costs (₦)	Weighted Average Costs (₦)
Formal Healthcare	110	0.420	5,179.66	2,175.46
Police	10	0.038	2,194.00	83.37
Judicial/ Court	1	0.004	16,000.00	64.00
Traditional Healer	61	0.233	2,664.82	620.90
Community Leader/ Local Authority	54	0.206	2,434.50	501.51
Leaving Home to stay elsewhere	26	0.100	3,500.00	350.00
			Total	**3,795.24**

4.7.1.3 Indirect Costs

As expressed by Duvvury et al. (2012) as well as by Morrison and Orlando (2004), IPV impacts gravely not just on the existence of the abuse women but it also comes with immense disruption in the daily life of their family (i.e., partners and children). As such, to estimate the total impact – in terms of indirect cost – of IPV, this study does not just focus on the impact of IPV on the women but also considers the impacts on men and children in the families affected. To address this, the research explores the detailed information provided by the women on the impacts of IPV on their paid work and that of their partners, as well as how

IPV hampers both their execution of household chores. Besides, the effects of IPV on school attendance by children in the family are also considered.

4.7.1.3.1 Costs of Lost Earnings: Reduced Income from Missed Days of Paid Work – Women/Respondents

Out of the total number of incidents reported, 88 required women to take time off paid work. The highest number of days taken off work was 17 days; this number was recorded by four women. The average number of days taken off work across all reported incidents was approximately 6 days. As explained in detail in the methodology chapter, average daily earnings are calculated for women reporting missed work due to IPV incidents on the basis of actual reported income and these average daily earnings are subsequently used to derive the costs of losing a day of paid work due to an IPV incident.

The average cost per incident calculated across the sub-sample of women reporting loss of earnings due to missed work days ensuing from an IPV incident in the sample is ₦5,868.78. Applying the calculated average costs per incident, the total costs for the sampled women across the 88 incidents reporting missed paid work amount to ₦516,452.64.

Having estimated the costs of lost productivity in terms of total loss of earnings due to missed work days following IPV incidents, to get a further idea about how IPV impacts negatively on the earning power of abused women (in other words, how IPV reduces their productivity in the labour market), a comparison is performed by juxtaposing the earlier calculated total earnings lost (one based on the sub-sample of abused women) with the total earnings lost, calculated based on all the women in the sample as opposed to including just the abused women. As shown in Table 4.22, the newly calculated total earnings lost give a value of ₦767,400.48. Therefore, the value of the costs based on the average market wages of abused women is 67% of the costs based on the average market wage of the entire sample. This technically means that the average daily earnings of IPV abused women are 23% less than those of the average Nigerian women.

Table 4.22 Estimates of costs of earning lost from missed work days due to IPV incidents

Proportion of the sample used in estimating daily earnings	Average Costs per Incident (₦)*	Total Costs of lost Days (₦)
Sub-sample of only abused women	5,868.78	516,452.64
Entire sample of women in the study	8,720.46	767,400.48

*₦=Naira – Nigerian currency

4.7.1.3.2 Costs of Lost Housework Hours – Women/Respondents

Overall, 74 incidents resulted in women missing housework: 45 from women reporting first (latest) incident, 22 from the second and 7 from the third incident categories. On average, women expressed that they missed 16.24 hours of housework following the first incident of IPV they reported. The total number of hours of missed housework for the first incident was 731 hours. Pertaining to the second incident reported by some of the women, an average of 12.90 hours of housework was missed. The total number of hours of household chores missed by women reporting the second incident was 284 hours. Regarding the third incident, for which information was solicited from the abused women, 23.43 hours of housework were missed as a result of IPV. In total, 164 hours of housework were missed by these women reporting missed housework in the third incident category. Therefore, overall, the total number of housework hours missed by women as a result of IPV incidents in this study sample equals to 1,179 across the 74 incidents reported to involve such missed housework, and on average approximately 15.93 hours of housework were missed per incident.

In terms of the number of hours missed in each specific household chore category, Table 4.23 shows the breakdown of imputed costs for the different types of housework missed as a result of IPV and the overall costs, as well as depicting the distribution of the costs in terms of rural-urban classification. Besides, Table 4.24 also shows the costs estimates of missed housework as a result of IPV victimisations, but this time the results are grouped based on the incidents as opposed to the household chores missed. As expressed in the methodology chapter, the average costs per incident is calculated using the hourly wage of manual (unskilled) labour - ₦167.00 - derived from the average daily income of unskilled labour -

₦1,500.00 - divided by the number of hours stipulated for such labour – 9 hours. Therefore, on the basis of this hourly wage, the imputed average costs of missing housework as a result of IPV per incident in this study is approximately ₦2,660.72, amounting to an overall imputed cost of ₦196,893.00 across all incidents reporting missed housework by women.

Table 4.23 Breakdown of Imputed Costs for Lost Housework - Women

	Urban		Rural		Overall (Both sites)	
Household Chore	No. of hours missed	Imputed foregone earnings (₦)*	No. of hours missed	Imputed foregone earnings (₦)	No. of hours missed	Imputed foregone earnings (₦)
Fetching water	80	13360.00	105	17535.00	185	30895.00
Fetching firewood	42	7014.00	57	9519.00	99	16533.00
Washing clothes	80	13360.00	86	14362.00	166	27722.00
Sweeping	39	6513.00	30	5010.00	69	11523.00
Washing dishes	45	7515.00	25	4175.00	70	11690.00
Ironing	12	2004.00	5	835.00	17	2839.00
Disposing garbage	15	2505.00	18	3006.00	33	5511.00
Cooking	182	30394.00	179	29893.00	361	60287.00
Shopping for household	66	11022.00	75	12525.00	141	23547.00
Running errands	21	3507.00	17	2839.00	38	6346.00
Total	***582***	***97194.00***	***597***	***99699.00***	***1179***	***196893.00***

*₦=Naira – Nigerian currency

#167 is the approximate hourly wage for manual (unskilled) labour, calculated by dividing ₦1500 (which is the average daily wage for unskilled labour in Nigeria) by 9 (the number of hours per day stipulated for such labour)

Table 4.24 Incident Grouped Costs of Lost Housework

Incident category	Average cost per incident (₦)*	Total imputed costs per category of incidents reported (₦)*
First Incident	(16x167#)= 2672.00	(731x167)= 122077.00
Second Incident	(13x167)= 2171.00	(284x167)= 47428
Third Incident	(23x167)= 3841.00	(164x167)= 27388
Overall	***2660.72***	***196893.00***

*₦=Naira – Nigerian currency

#167 is the approximate hourly wage for manual (unskilled) labour, calculated by dividing ₦1500 (which is the average daily wage for unskilled labour in Nigeria) by 9 (the number of hours per day stipulated for such labour)

4.7.1.3.3 Costs of Lost Earnings: Reduced Income from Missed Days of Paid Work – Men/Partners

Out of the total perpetrated incidents of IPV reported, only 8 required male partners to take time off paid work. The average number of days taken off work across all these reported incidents was approximately 3 days. Just as in the case of women, the average daily earnings is calculated for partners/men with missed work days ensuing from IPV incidents on the basis of actual reported income and the average daily earnings is used to derive the average costs of losing a day of paid work due to an IPV incident. The average costs per incident calculated across the sub-sample of partners with missed work days due to IPV incidents in the sample is ₦3,232.02. Applying the derived average costs per incident, the total costs incurred by the perpetrators of IPV with missed days of paid work ensuing from IPV abuse amount to ₦25,856.16.

4.7.1.3.4 Costs of Lost Housework Hours – Men/Partners

Overall 11 incidents resulted in partners missing housework as a result of IPV. On average, the perpetrators (partners of abused women) missed 2.91 hours of housework following an incident of IPV. Therefore, in the sample the total number of hours of housework missed by the perpetrators of IPV amount to 32 hours. Just as in the case of the abused women, the average cost per incident for the perpetrators is calculated using the hourly wage of manual (unskilled) labour - ₦167.00. On the basis of this hourly wage, the imputed average costs of

missing housework by perpetrators of IPV per incident in this study sample is approximately ₦485.82 and, as shown in Table 4.25, amounting to an overall imputed cost of ₦5,344.00 across all incidents with perpetrators of IPV missing housework.

Table 4.25. Breakdown of Imputed Costs for Lost Housework - Partners

	Urban		Rural		Overall (Both sites)	
Household Chore	No. of hours missed	Imputed foregone earning[#] (₦)[*]	No. of hours missed	Imputed foregone earning (₦)	No. of hours missed	Imputed foregone earning (₦)
Fetching water	-	-	-	-	-	-
Fetching firewood	2	334.00	3	501.00	5	835.00
Washing clothes	2	334.00	-	-	2	334.00
Sweeping	-	-	-	-	-	-
Washing dishes	-	-	-	-	-	-
Ironing	4	668.00	4	668.00	8	1336.00
Disposing garbage	-	-	-	-	-	-
Cooking	-	-	-	-	-	-
Shopping for household	9	1503.00	8	1336.00	17	2839.00
Running errands	-	-	-	-	-	-
Total	***17***	***2839.00***	***15***	***2505.00***	***32***	***5344.00***

*₦=Naira – Nigerian currency

#167 an approximate hourly wage for manual (unskilled) labour – calculated by dividing ₦1500 (which is the average daily wage for unskilled labour in Nigeria) by 9 (the number of hours per day stipulated for such labour) – was multiplied by the number of hours missed in each house chore category to derive the imputed foregone earning for the different household chores.

4.7.1.3.5 Costs of Missed School Days Ensuing from IPV Incidents

Overall, the number of incidents with women reporting that their children missed school days due to an occurrence of IPV is 13. Across these incidents, women reported that their children missed 65 school days due to IPV incidents. On average, the number of school days missed by children due to an IPV incident is approximately 5 days. Therefore, using the estimated average number of school days missed (5 days) and applying a total number of school days in a year of 195 days as well as an average total amount of school fees paid per year of

₦16,500.00, an average of ₦423.08 is lost per incident of IPV. Therefore, a total estimate of ₦5,500.00 is lost across the entire sample in this study as a result of missed schools due to IPV incidents.

4.7.1.4 Total Household Costs (THC) of IPV in the Study Sample

To derive the total household costs (THC) of IPV, as expressed in Equation 3.7 in the methodology chapter, the total costs in the different categories of costs are summed up. The summation gives a grand THC of ₦1,744,398.68. Table 4.26 shows the breakdown of the total costs in the different costs categories as well as the average unit costs in the categories.

It is important to express at this juncture that these cost estimates support one of the hypothesis of the research, that IPV impacts significant costs on women and also have grave impact on their children.

Table 4.26 Total Household Costs (THC) of IPV in the research study sample

Cost Category	Average (Unit) Costs per Incident (₦)	Total Costs (₦)
Indirect Costs		
Missed Work Days – Women	5,868.78	516,452.64
Missed Work Days – Partners (Men)	3,232.02	25,856.16
Loss of Household Work – Women	2,660.72	196,893.00
Loss of Household Work – Partner (Men)	485.82	5,344.00
Missed School Days by Children	423.08	5,500.00
Direct Costs (Out-of-Pocket Expenditures)	3,795.24	994,352.88
	Grand Total	1,744,398.68

4.7.2 Macro-Estimates of the Costs of IPV: Costs to the Nigerian Economy

As discussed in the methodology chapter, the costs estimates derived from the study sample are extrapolated to the Nigerian Census Population Data to get approximate values of amount of resources (money) lost per annum as a result of IPV incidents in the country. The values of

resources lost are viewed in terms of actual amount lost in Naira, percentage of the country's GDP (Gross Domestic Product) for the year 2013, as well as a proportion of the Nigerian Budget appropriated for the year 2013. Table 4.27 shows the key variables and parameters used in the calculation of macro estimates in Nigeria.

Table 4.27 Key variables/ parameter used in the calculation of the Macro-Estimates of IPV in Nigeria

Variable/ Parameter	Value
Total Population of Women Aged 18 years and above in Nigeria#	36,436,730
Prevalence of Current IPV (IPV in the previous 12 month prior to the study) in Nigeria	16.7%
Estimated Aggregate Number of Women Experiencing IPV in Nigeria	6,084,934
Victimisation (Incident) Rate	1540 per 1000 women
Total Number of Incidents	9,370,798

The latest (2006) Nigerian Population Census values are used (NPC, 2010)

As shown in Table 4.28, the results of the extrapolation to the Nigerian economy indicate that the total costs in terms of lost earnings from missed paid work is approximately ₦85.3 billion, while direct (out-of-pocket) expenditures is approximately ₦35.6 billion. The approximate value of missed household work amounts to ₦29.5 billion, and costs due to missed school days by children is approximately ₦4.0 billion. The summation of these costs, which is the annual costs of IPV (i.e., potential lost opportunity costs), is approximately **₦154.4 billion** equivalent to 0.20% of the total GDP of Nigeria that stood at ₦80.22 trillion in 2013. Considered in another dimension, the annual costs are approximately 9.64% of the Nigerian budget appropriated for the year 2013, which was approximately ₦1.6 trillion.

These macro-estimates of IPV costs on the Nigerian economy support the research hypothesis that the costs of IPV to the economy are significant and large enough to be a hindrance to the economic prosperity of the Nation.

Table 4.28 Macro-Estimates of the Costs of IPV in Nigeria

Cost Category	Average (Unit) Costs per Incident (₦)	Total Costs (₦)*	Percentage of GDP#	Proportion of the Nigerian Budget^
Lost Household Earnings from Missed Paid work days (Total of both women and partners)	9,100.80	85,281,758,438.40	0.106	5.330
Missed Household Chores (Total for both women and partners)	3,146.54	29,485,590,738.92	0.037	1.843
Missed School Days	423.08	3,964,597,217.84	0.005	0.248
Direct Costs (Out-of-Pocket Expenditures)	3,795.24	35,564,427,401.52	0.044	2.223

*Total Costs were calculated by multiplying average costs per incident with total number of incidents (9,370,798 as given in table 4.27)
#The GDP used is the one estimated for the year 2013, which stood at approximately ₦80.22 Trillion (NBS, 2014).
^The Nigerian Budget considered is the one appropriated for the year 2013, which is approximately ₦1.60 Trillion (FMF-Nigeria, 2014).

4.8 Summary

This chapter of the thesis presents the different results derived from the various descriptive and inferential statistical analyses conducted in the study. It commences by providing results pertaining to the prevalence of IPV in Nigeria. These results show that the level of life-time experience of IPV by women in the country is as high as 25.5% (i.e., 1 out of every 4 women in the country has experienced IPV in her life-time). Besides, the results show that IPV occurrence is not just a one-off experience by victims, but rather a continuous occurrence that transpires across multiple incidents.

Results pertaining to the modelling of predictors of IPV were also presented, and they show that factors such as educational attainments of women and those of their partners, women's frequency of communication with family members, choice of spouse/partner, partner's history of physical aggression, partner's affairs outside of relationship, partner's illicit drug use, partner's alcohol consumption, partner's controlling behaviour, categorical number of children and partnership discord are also related to the occurrence of IPV against women in Nigeria.

The chapter subsequently presents results on help-seeking behaviour of abused women, and these indicate that larger proportion of such women used formal services (especially the health/medical service) as compared to informal service. But the usage of some formal services such as the police, judicial and shelter service are poorly utilised by abused women. Results on attitudes towards gender roles show that women are more supportive of male dominance in relationships and women being subservient to their husband/partner within the Nigerian society. Additionally, results on attitudes towards IPV (wife-beating) show that there is a relatively high acceptance of such act, which is evenly spread across both urban and rural areas in Nigeria. Nonetheless, the results show differences in the distribution of such acceptance based on age, educational attainment and literacy.

This chapter concludes with results on socio-economic costs of IPV, and the results indicate that there are significant costs to households as well as to the Nigerian economy as a whole.

Chapter 5 IPV Preventive Framework

5.1 Overview

As stated by Hartmann et al. (1997), considering the breadth of the impact of IPV on societies – through its effects on health, employment, homelessness, among others – it is likely that a significant reduction in abuse and its corresponding costs will only be achieved via a comprehensive intervention that addresses the problem from many directions, and includes strategies involving a variety of players/stakeholders (e.g., government, businesses, healthcare and other service providers, community groups and individuals).

Based mainly on the results of this research, a Three-Tier preventive framework is proposed to tackle issues of IPV in Nigeria and other similar developing countries. The framework is carefully developed by splitting the preventive efforts against IPV into three layers (Primary-, Secondary-, and Tertiary-Preventive layers). Besides, with each layer of prevention, the framework integrates individual-, relationship-, community-, and societal-level interventions which reflects the ecological model used in understating the risk factors of IPV in the research. Moreover, the framework outlines the roles and responsibilities of different stakeholders (organisations), and also indicates the links (in terms of referrals and feedbacks) amongst the relevant stakeholders. In addition, the framework also reflects the characteristics of pre-existing institutions and programmes in Nigeria. These layers of prevention are uniquely designed to serve as self-improving systems, as the tertiary layer provides a feedback to the secondary, while the secondary relays similar feedback to the primary preventive layer and vice versa, thereby providing a means of improving and providing better control of the IPV issues, while at the same time offering maximum support services to abused women and optimum use of scarce resources. Furthermore, this framework captures the quintessence of the fact that the key to short-term reduction in the level of IPV is via the successful reduction in likely risk factors of violence (e.g., low educational attainment, illiteracy, alcohol and substance abuse, controlling behaviours among others). It is also an embodiment of the facts gleaned from this research that sustainable long-term reduction in IPV occurrence requires far-reaching and broad-based interventions covering not just individual factors but also relationship, community and societal factors that predispose

women to IPV and encourage men to be perpetrators. The framework also recognises the need for collaborative working and information sharing amongst the relevant stakeholders.

As would be explained in a greater detail in the next couple of sub-sections, the primary prevention layer of the framework is built on five key/broad approaches including: structural and policy approach, school-based approach, media intervention/public awareness campaigns, interventions to reduce alcohol and substance misuse, as well as community-based prevention/community strengthening. The secondary layer is built on changing organisational practice, fostering coalition and networks, educating providers and influencing policy and legislation. On the other hand, the tertiary preventive layer is composed of service for long-term needs such as trauma counselling, police and criminal justice reforms, shelter service/transitional housing schemes, employment and training schemes (empowerment of abused women), and empowerment of people to be proactive in the advent of IPV.

Nonetheless, since the proposed framework is a multi-pronged prevention strategy, there is an utmost need for intermittently testing its effectiveness and refinement of the individual components. Based on this important requirement, this framework also includes a built-in impact evaluation and costs assessment facet that ensures that the different programmes/ activities continue to meet its major objectives. Moreover, to make these assessment and refinement processes seamless and efficient, the framework also proposes the usage of appropriate information technology (IT) in the implementation and day-to-day running of the preventive framework. In other words, IT serves as a backbone for the preventive framework. The numerous advantageous usages of IT include: affording a joint referral platform for the different stakeholders, providing an information storage system that can help provide necessary information/data for important research (e.g., costs assessments and service utilisation and needs assessment), rendering a means of documenting and sharing information across the different organisations/relevant stakeholders.

Figure 5.1 is a schematic representation of the proposed framework showing the three different leyers of prevention and separate components that make up the framework.

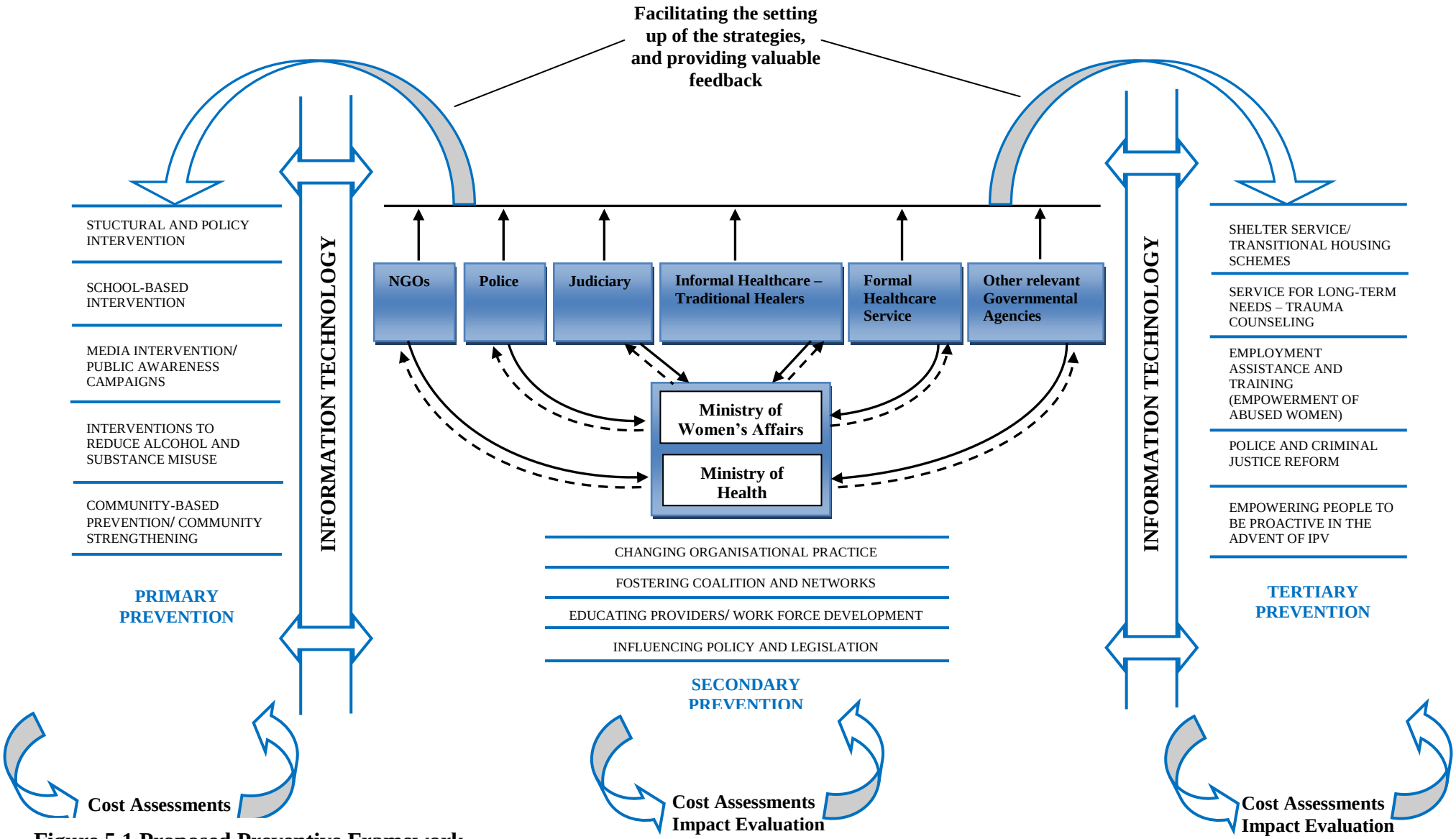

Figure 5.1 Proposed Preventive Framework

5.2 Design of the Preventive Framework

Public health approach was used in the design of the proposed preventive framework. This design approach was executed in three phases and involved the usage of a blend of three well-established public health models – social ecological model (a model that draws on social-ecological levels of influence in the exploration of likely risk factors of IPV and in the selection of preventive interventions), the spectrum of prevention (a model that helps in coordinating different prevention activities – programmes and policies – into more manageable strategies that facilitate the development of a viable preventive framework), and the three-tier prevention design (a design that channels intervention strategies into three levels of prevention or remediation).

This design approach was chosen as it recognises the importance of primary prevention, and facilitates the extraction of knowledge from different disciplines to address social and health issues. Besides, it is an approach that applies intersectoral mechanisms to provide the maximum benefit for the largest proportion of people. This approach was even deemed to be more suitable as it resonates with the results of this study (for example, the results indicate that IPV issues affect a significant proportion of women in the Nigerian society and the attitudes, likely risk factors as well as costs estimates all point to a multi-sectoral response to addressing the IPV issues – a strong attribute of the public health approach).

Figure 5.2 is a schematic representation of the different factors taken into consideration in the design of the proposed preventive framework.

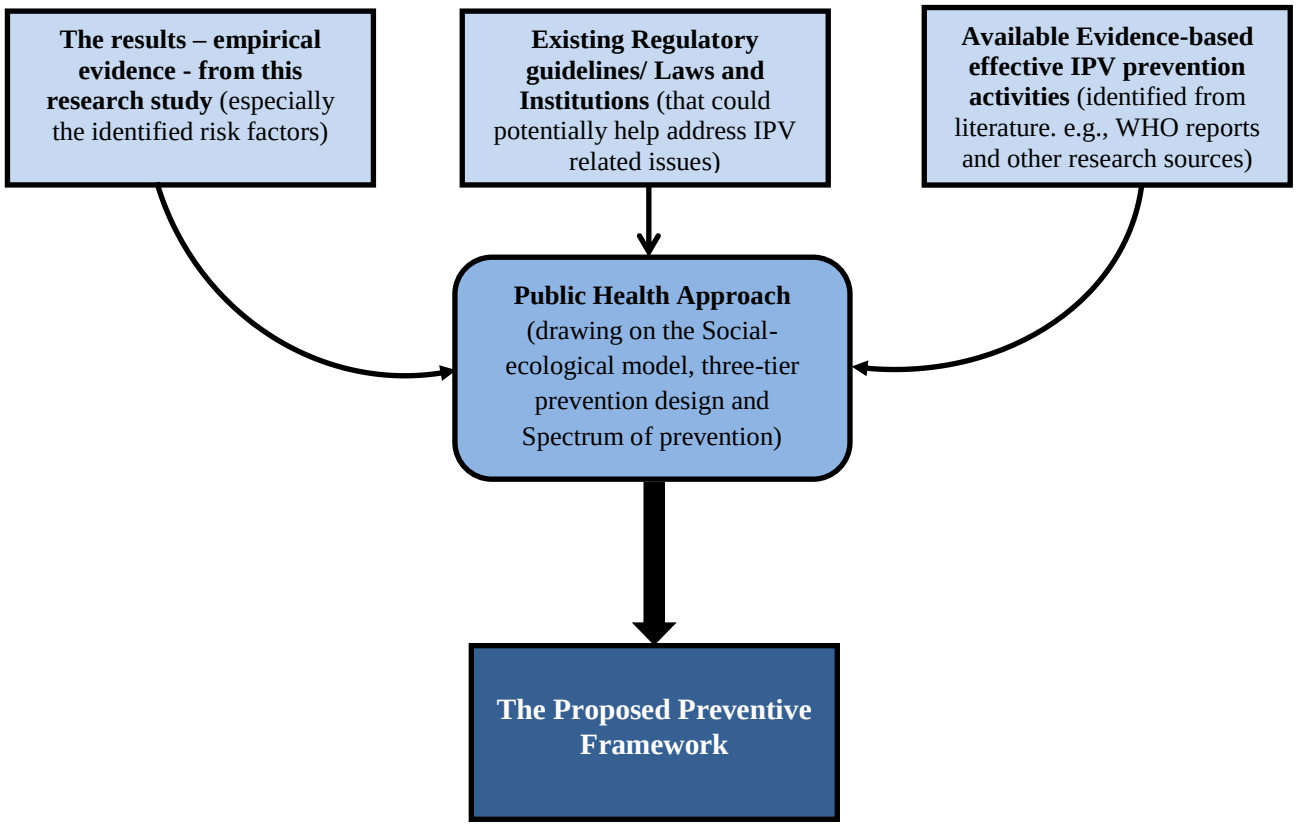

Figure 5.2 Schematic Representation of the Design of Proposed Preventive Framework

The three phases involved in the development of the proposed preventive framework, which will be discussed in the subsequent paragraphs complement the earlier mentioned public health models.

Phase 1: **Exploration of results/empirical evidence and theoretical principle that will inform the choice of interventions**

The first phase of the design of the preventive framework involved the extraction of empirical evidence from the results of this research study. Most importantly, the risk factors identified in the study were extracted to facilitate the identification of potential preventive activities that could help support the IPV preventive effort in Nigeria and other similar developing

countries. These risk factors were organised along the individual, relationship and societal-community levels (i.e., social-ecological model) that underpinned their exploration in this study in the first place. Figure 5.3 shows some of the identified factors along the different social-ecological levels. The aim of the exploration of these results/empirical evidence is to facilitate the identification of the right intervention to adapt to the Nigerian context (i.e., to facilitate the optimisation of the chosen programmes to the Nigerian context).

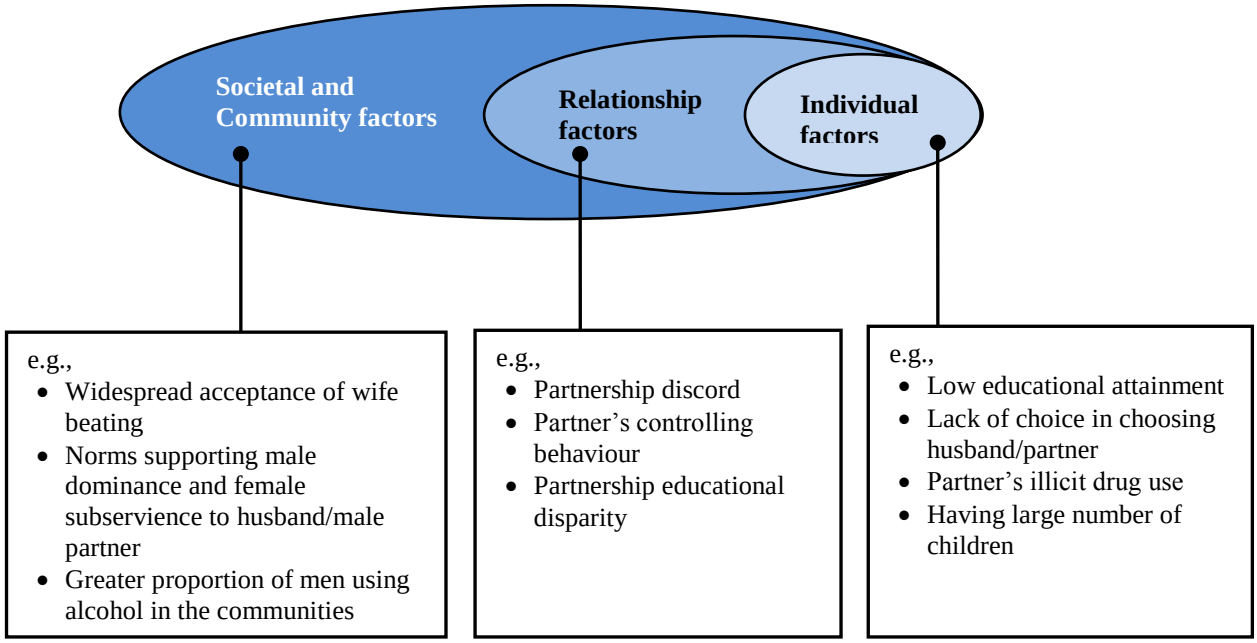

Figure 5.3 Likely Factors Predisposing Women to IPV Identified at Different Levels of the Ecological Model

Phase 2: Identification of prevention strategies and activities

This phase of the preventive framework development involved the identification of evidence-based IPV prevention actions. This process mainly drew on the available literature to identify potential actions/activities that will be relevant to the Nigerian context, and then juxtaposed the identified programmes against the empirical evidence on risk factors derived from this research (phase 1). A list of identified potential actions (programmes and policies) is

provided in appendix 5 of this thesis. Part of the criteria for the selection of these programmes is that they must have been subjected to rigorous scientific evaluations and the results of such evaluations should indicate that: (1) they provide significant preventive effects against IPV (2) the effect provided is a sustained one and (3) there is evidence supporting the replication of outcomes of the preventive activity. Nonetheless, due to the limited number of activities (programmes and policies) meeting these stringent selection conditions, other promising programmes, as identified by the WHO (2010), were also considered.

The spectrum of prevention, a well-established public health model used in developing multifaceted approach to prevention, was also employed in this phase of the framework development. Basically, the spectrum of prevention is a tool for comprehensive action targeted at a public health issue. It is comprised of six related strategies for preventing public health issues: (1) Strengthening individual knowledge and skills, (2) promoting community education, (3) educating service providers, (4) fostering coalitions and networks, (5) changing organisational practices and (6) influencing policies and legislation (Davis et al., 2006; Rattray et al., 2002; Cohen and Swift, 1999). Basically, its application in this research is to help classify identified evidence-based IPV prevention actions into broader categories of strategies.

Phase 3: Organisation/channelling of empirical evidence, theory and evidence-based strategies and activities into a coherent preventive framework

A three-tier public health prevention design was used in this phase to channel the different identified strategies and activities into three major levels of influence (i.e., primary-, secondary- and tertiary prevention). These levels indicate when the preventive intervention will occur. Activities under the primary prevention are those that will prevent IPV victimisation or perpetration from occurring in the first place, while secondary prevention activities are those that serve as intermediate responses to IPV occurrence in the short-term to ameliorate the negative impact of the malice. Besides, the tertiary prevention activities are the long-term response aimed at dealing with the lasting implications of IPV.

Also at this stage of the framework development considerations were given to the existing regulatory guidelines and systems relevant to addressing IPV issues. Thus, key ministries, parastatals and other relevant stakeholders were identified and integrated into the design of the framework. Moreover, to facilitate the seamless operation of the framework considerations were also given to the inclusion of an Information Technology (IT) backbone in the framework.

Additionally, drawing on the results and knowledge gleaned from the costs estimation aspect of this research, a cost assessment and impact evaluation consideration was also integrated into the preventive framework design.

Finally, as stated by Bradley and colleagues (1999), despite the fact that a particular approach/technology is visibly grounded in theory and evidence, there is still a need for it to be evaluated amongst relevant practitioners or stakeholders. As such, after the initial design of the proposed framework, as explained in the preceding paragraphs, a validation of the framework was carried out by conferring with relevant stakeholders. Details of the validation process are provided in section 5.4.

5.3 Components of the Preventive Framework

5.3.1 Primary Prevention Components of the Framework

The framework lays great emphasis on the need for a more robust primary prevention, as this layer functions as the first line of defence against IPV – i.e., stopping IPV before it occurs by addressing the factors that make its perpetration more likely to occur and reducing the number of new instances of violence. As stated by the WHO (2010), given the magnitude of lifetime prevalence of IPV recorded across the globe, the hundreds of millions of women worldwide in need of service would outstrip the capacity of even the best-resourced countries. And therefore a problem of this magnitude requires a major focus on primary prevention.

As broadly explained in the methodology chapter and section 5.2 of this chapter, the primary prevention strategy developed as part of this research framework draws on the experience of previous research (in terms of primary prevention programmes that have been proven to be effective) and combines this experience with the results of this research study (especially those pertaining to 'upstream' determinants of IPV, help-seeking behaviour and attitude towards IPV and gender roles) to come up with the most likely effective primary prevention barrier against IPV in Nigeria, which most likely should also be applicable to other similar developing countries. Based on this plan, and as shown in Figure 5.1, the five key/broad strategies identified were: school-based intervention, structural and policy intervention, media intervention/public awareness campaign, interventions to reduce alcohol and substance misuse as well as community-based prevention/community strengthening.

School-based Interventions: as the name implies, these programmes are integrated into formal school curricula as single-lesson activities or intensive long-term tutoring. They are designed to change individuals' (especially younger people's) knowledge, attitude and general perception of IPV and related issues, and by so doing reduce IPV victimisation rates (as these individuals would have developed an aversion towards IPV, having gone through the school-based programmes) (Harvey et al., 2007).

The results of this study show that there is a male-biased attitude towards gender roles in Nigeria, one that poses great threat to the well-being of women and children in the country. In addition, the results also show that there is an evenly spread acceptance of wife-beating across urban and rural areas. Based on these and the fact that studies have shown school-based initiatives to be highly efficient in addressing IPV issues (Gibson and Leitenberg, 2000; Foshee et al., 2004; Guttman et al., 2006; WHO, 2009a), this research has included in the proposed framework school-based interventions as viable options in tackling IPV issues in Nigeria. This strategy is deemed even more suited for the Nigerian society considering the results of the present study suggesting that young women are less likely to accept the acts of wife-beating, as this offers a glimmer of hope in breaking the chain of IPV incidents in the country if appropriate programmes that denounce wife-beating are introduced to people

within this age bracket on time to nurture them. As expressed by the WHO (2009b), school-based programmes can help address attitudes and gender norms before they become deeply rooted and ingrained in children and youths.

Appendix 5 provides a list of evidence-based effective programmes that fall under the broad category of school-based interventions.

Community-based Prevention: the framework also includes community-based prevention initiatives as such programmes have been shown to have a far-reaching capability to empower women and engage with men in the prevention of IPV (Wolfe et al., 2003; WHO, 2009a; WHO, 2009b). This strategy is selected as it is more likely to have profound impact on IPV prevention in Nigeria, given that the results in this research show that women who are deprived of critical resources – such as education and freedom to make personal decisions – are more predisposed to IPV. Besides, the results also show that men with high level of controlling behaviours are more likely to perpetrate IPV. Therefore, community-based programmes on IPV prevention in Nigeria can be used to help empower women to be less susceptible to IPV victimisation and dissuade men from IPV perpetration, as programmes that fall under this category are specifically designed to deal with the whole community or particular subgroups in the population and are targeted towards the creation of an environment that would facilitate desired changes in individual attitudes and behaviour, as well as promoting equitable gender norms and respect for rights (Harvey et al., 2007; WHO, 2010).

Appendix 5 provides a list of evidence-based effective programmes that fall under the broad category of community-based prevention.

Structural and Policy Interventions: programmes that fall under this umbrella of prevention strategy, as described by Harvey (2007), are of three main types: those targeted at fostering gender equality and women's empowerment, those aimed at reforming the legal system and strengthening the criminal justice responses, and those geared towards integrating

IPV prevention into other existing programmes. The overarching objective of these different programmes is mainly to stop IPV from occurring in the fisrt place by addressing attitudes towards violence and factors found to be associated with violence as well as making more efficient the operations of relevant stakeholders in primary IPV prevention.

With the existence of rigid and biased attitudes towards gender roles, as shown in this study, the proposed preventive framework also includes the usage of structural and policy interventions as means of primary prevention of IPV in Nigeria. This strategy is deemed appropriate as research studies show that government interventions – such as laws and policies – that promote gender equality and women empowerment have potent capability of preventing violence (Pronyk et al., 2006; Harvey et al., 2007). Besides, with the results derived from this study showing underutilisation of police services and judicial redress by abused women, legal reform and strengthening of the criminal justice system which falls under the broad umbrella of 'structural and policy interventions' can also contribute greatly towards prevention of IPV in Nigeria. In addition, the idea gained from this study in terms of how health programmes (especially family planning programme) could help reduce IPV, further stresses the importance of adopting appropriate 'structural and policy interventions' in tackling IPV issues in Nigeria. The adoption of such interventions by integrating IPV prevention with ongoing health programmes will be beneficial and cost-effective, considering the fact that there are already existing outreach programmes on health among others in Nigeria (e.g., Nigeria Midwives Service Scheme, Roll-back Malaria Programme and HIV/AIDS Programmes).

Appendix 5 provides a list of evidence-based programmes on primary prevention of IPV involving fostering gender equality and women empowerment, legal reform and strengthening of criminal justice system and integrating IPV prevention into other initiatives.

Media Interventions/Public Awareness Campaigns: this kind of strategy is used to inform and attempt to influence individuals' attitudes as regards acceptability of IPV. Moreover, awareness campaigns are also used to break the silence surrounding IPV issues and to build

political interest in addressing these issues by designing persuasive messages delivered to wide audiences via the media and other means (Harvey et al., 2007).

With results from the present study showing that IPV is pervasive in the Nigerian society and that the malice is a hindrance on economic development, it is proposed in this framework that public awareness campaigns can be effective in addressing IPV issues in Nigeria, with research showing that mass media can be highly effective in altering attitudes towards gender roles and norms (Boehm and Itzhaky, 2004; Usdin et al., 2005). This primary prevention means is highly desirable as the results of this research further suggest that there is a high level of acceptance of IPV in Nigeria and there is also a rigid attitude towards gender roles that undermines women's rights.

Examples of media interventions that have been hugely successful and evaluated in other contexts are provided in Appendix 5.

Interventions to Reduce Alcohol and Substance Misuse: the premise of this strategy is that substantial gains in preventing IPV can be achieved by using general measures to reduce alcohol- and drug-related harm (WHO, 2006). Such general measures include regulating alcohol availability and strictly prohibiting illicit drug use.

This framework proposes the introduction of interventions that would help reduce alcohol and substance misuse, as the results derived from this study show that such substance abuses are strong predictors of IPV against women in Nigeria. Besides, other studies (e.g., Markowitz, 2000; PIRE, 2004) have also shown that regulating the usage or access to such substances can greatly reduce violence occurrence.

Appendix 5 provides a list of evidence-based effective programmes that fall under the broad category of Interventions to Reduce Alcohol and Substance Misuse.

5.3.2 Secondary Prevention Components of the Framework

The Secondary layer is aimed at the immediate response to IPV occurrence. As this research shows, there are large proportions of women currently experiencing IPV and that these experiences are more or less continuous. It thus becomes imperative to create a structure to cater for the needs of women and at the same time create a barrier to break the chain of IPV abuse against them. As such, the second tier of prevention in this framework is targeted towards addressing this.

The secondary prevention layer as designed in the proposed framework is built on four (4) key foundations or fundamental principle/targets – changing organisational practice, fostering coalition and networks, educating providers, and influencing policy and legislation. In addition, the secondary prevention process, as shown in Figure 5.1, includes key stakeholders that will need to undertake or undergo the four earlier mentioned fundamental targets. It should also be noted that although the key stakeholders are included in the secondary prevention portion of the framework, they also have crucial roles to play in both primary and tertiary prevention activities, especially by facilitating the setting up of the strategies (activities) and providing valuable feedback to those two other tiers of the preventive framework.

In terms of **changing organisational practice**, results of this study show that there are major inadequacies in the way most of the stakeholders currently handle IPV cases. For example, results show that certain formal services such as the police and judicial services are poorly utilised by abused women, and as explained in the discussion section of this thesis, this could be due to inaccessibility of such services or lack of awareness regarding the existence of services or, perhaps, lack of trust in the service providers. Therefore, there is a need for changes in organisational practices. These changes could be operational or structural. For example, setting up police stations to afford abused women emergency shelter, guidance, legal advice and support in terms of referral, as well as carrying out necessary follow-up actions to ensure that cases are justly dealt with. By embarking on these adjustments, the system of policing in the country could be strategically placed to make IPV issues against women more widely seen as public and punishable acts. Moreover, the police system could

also provide women the opportunity to have their rights upheld by serving as a deterrent to likely male perpetrations of IPV. On the other hand, screening women for IPV in healthcare settings, as suggested by John et al. (2011), Koziol-McLain et al. (2008), as well as Stenson et al. (2001), could help in the early identification of likely victims and in providing them with necessary support in terms of referral to the right authorities/services that could cater for their needs.

As regards **fostering coalition and networks**, the need for joint working/coalition is critical in addressing IPV in Nigeria as the results in this research, which corroborate results from other studies elsewhere, show that abused women present varied and multiple needs or service requirements. Besides, as pointed out by the WHO (2009b), components of a successful system for preventing IPV and any other form of violence should include a broad partnership between agencies, joint training and integrated systems of referral. As such, the proposed framework is made up of a coalition of relevant stakeholders that are linked together by a chain of update and referral mechanisms. This network, as shown in Figure 5.1, is designed in such a way that the Ministries of Women's Affairs and Health would jointly maintain this coalition by convening a regular stakeholders meeting, conducting regular case reviews to monitor the quality and effectiveness of services and make recommendations for service improvement, as well as serving as the hub in the referral processes that are likely to take place amongst the relevant stakeholders. Nonetheless, the framework recognises all the stakeholders as equal partners, having a say and responsibility in the process of ensuring the prevention of IPV against women.

In terms of **educating providers**, it is deemed important in the proposed framework that more specialised training is needed to provide the different stakeholders with the skills required to handle IPV cases and prevent their occurrence. This is highly important given that the results in this study show very low utilisation of certain services, which may be due to lack of confidence in the current system emanating from improper handling of IPV and other related cases. For example, healthcare providers (e.g., Doctors, Nurses, Midwives, and Psychologists) could be trained to provide risk assessments, safety planning and counselling services. As stated by the WHO (2009b), this type of training is more effective than even

setting up specialised counselling services that are known to be related to IPV, as such services can be stigmatising and can be a barrier to the utilisation of the services by abused women.

As regards **policy and legislation**, the results of this study show a relatively high level of IPV and wide spread acceptance of wife beating across Urban and Rural areas, as well as poor utilisation of certain supportive services (e.g., judicial services) by abused women. These are a vivid testament to the need for changes in local, state and national laws as regards women's right and empowerment in Nigeria. Therefore, this preventive framework has included the need for influencing policy and legislation. For example, as stated in section 2.6.2, Nigeria is a signatory to some international conventions that provide a mandate for executing actions to end violence against women (e.g., the UN Declaration on the Elimination of Violence against Women). But the country is still yet to integrate these conventions into its legal code. Besides, there are also laws, though highly limited, enacted at the State level that are tuned towards elimination of violence (e.g., Lagos State Law against domestic violence that came into being in 2007) but these laws are poorly implemented, with Magistrates and Lawyers in Lagos State attesting to the dismal implementation of such laws (Gbenga-Ogundare, 2012; Onanuga and Jibueze, 2012). Therefore, enhancing and ensuring proper implementation of these laws could facilitate the limiting of IPV issues in the country.

5.3.3 Tertiary Prevention Components of the Framework

Tertiary prevention as designed in this preventive framework is very closely related to the secondary prevention, but unlike the secondary prevention that seeks to identify issues of IPV before they become greatly manifested and intervene to prevent the issues from recurring or progressing, the tertiary prevention aims to provide protection for abused women by reducing the short-term impacts and long-term consequences of the abuse.

Within the purview of this framework, five key areas of tertiary prevention are important in the fight against IPV issues in Nigeria. These strategies include: Shelter services/Transitional housing schemes, service for long-term needs – Trauma counselling, Employment

Assistance, Police and Criminal Justice reforms, and empowering people to be proactive in the advent of IPV against women.

In terms of **shelter/transitional housing schemes**, the results from this research show that none of the abused women reported the usage of such services/scheme. As opined in the discussion chapter, the lack of usage may be due to the fact that these services are non-existent or, perhaps, that they are poorly structured and inaccessible to their intended users (abused women). Therefore, the proposed preventive framework includes, as part of the tertiary prevention layer, the need for proper shelter/transitional housing schemes to supported IPV victims. The need for such schemes is even more important with studies indicating that finding a safe, stable as well as affordable housing is one of the greatest impediments women who leave abusive male partners face (Menard, 2001). Besides, there is evidence supporting the effectiveness of these programmes at providing a critical service in addressing issues pertaining to IPV against women (Melbin et al., 2003).

Regarding **services for long-term needs – Trauma counselling/Psychological Intervention**, there is reasonable evidence suggesting the profound effectiveness of these kind of interventions in meeting the long-term needs of IPV victims, especially in terms of reduction in the likelihood of depression and Post Traumatic Stress Disorder as well as improved birth outcomes (Gilbert et al., 2006; Kiely et al., 2010; Zlotnick et al., 2011). Besides, with the results of this study showing how women at child bearing age in Nigeria are predisposed to IPV victimisations, it becomes important to provide long-term support to the abused women in order to avert other adverse health outcomes or complications likely to ensue from the experience of IPV – complications such as miscarriages, premature birth and other gynaecological problems. Based on this evidence or fragments of information, the proposed framework includes the usage of long-term strategies such as trauma counselling or psychological intervention to help support the needs of abused women.

In terms of **Police and Criminal Justice reforms**, the results of this study show poor utilisation of the police and judicial services by victims of IPV. This aspect demonstrates an

imperative need to have a reform of these sectors in order to cater adequately, in the long run, for the requirements of abused women. This type of reform can include the implementation of legal advocacy programmes in the activities of the legal sectors in Nigeria, which could help guide abused women in navigating the judicial system without any hindrance in the pursuit of redress, and by so doing improve the usage of these important services. Besides, there is evidence backing the effectiveness of these kinds of programmes (Bell and Goodman, 2001), and it would be a wise choice to have such interventions in place to address IPV issues in Nigeria.

With evidence pointing to women's subordination to their male partners in Nigeria, as demonstrated by the results on attitudes towards gender roles in this study, **employment assistance and training (empowerment of abused women)** is included as one of the strategies proposed in the IPV preventive framework. The need for the inclusion becomes even more pressing when one considers other results from this study showing partner's controlling behaviour as a likely risk factor of IPV in Nigeria. In addition, what makes this strategy more desirable is that its viability has been rigorously assessed by research studies, and results indicate that such programmes are capable of reducing the risk of IPV by over 50% within a short period of time and perhaps achieve a better result in the long-term (Kim et al., 2007). Examples of evidence based programmes that fall under this category are provided in Appendix 5.

Furthermore, the results from this study, as stated earlier, show that there is widespread acceptance of IPV against women in the country and thus indicating a lack of sensitivity and a likely unwillingness of individuals (bystanders) to intervene in abuse against women. Therefore, the proposed framework also includes the need for **empowering people to be proactive in the advent of IPV**. This is likely to be effective in reducing the occurrence of IPV as studies have shown that equipping bystanders in speaking out and acting in preventing IPV, as well as challenging adverse social norms, is a viable means of controlling victimisation (Harvey et al., 2007; McMahon and Dick, 2011; Erin and Ohler, 2012).

5.4 Framework Validation

As expressed by Davis et al. (2006), data is not just numbers. The experience and wisdom of advocates, educators, practitioners and other relevant stakeholders count and should be honoured in the development of an effective prevention strategy. Based on the foregoing, the proposed preventive framework has been validated by conferring with different relevant stakeholders on the possibility of introducing it to address IPV issues in Nigeria. The validation process involved relevant stakeholders from 6 different organisations/ establishments that include: Government Ministries (e.g., Health and Women's Affairs), the Criminal Justice System (i.e., the Judiciary), a Non-governmental organisation (NGO), the Media, and a Hospital. The rationale behind the selection of these stakeholders is mainly due to the scope of their work and their relevance to IPV prevention and case handling in Nigeria, as identified in the research study.

5.4.1 Profiles of Stakeholders involved in the validation process

Tables 5.1 – 5.6 describe the profiles of the relevant stakeholders conferred with regarding the framework validation. The profile description includes details such as establishment type, staff size or number, area of work and the purview of responsibility.

Table 5.1. Profile of Stakeholder 1

Establishment Type	Ministry of Health
Number of Staff	2,160
Main Area of Work	Providing health services, drafting health related policies and management of health institutions
Purview of Responsibility	General population (including women, men and children)

Table 5.2. Profile of Stakeholder 2

Establishment Type	Ministry of Women's Affairs
Number of Staff	37 (Core Ministry Staff)
Main Area of Work	Ensuring the welfare of women and children, promoting gender equality and formulating policies relating to the uplift of women (especially in terms of socio-economic status)
Purview of Responsibility	Mainly women and children

Table 5.3. Profile of Stakeholder 3

Establishment Type	Judiciary
Number of Staff	Over 1000 personnel
Main Area of Work	Administration of justice and related activities
Purview of Responsibility	General population (including women, men and children)

Table 5.4. Profile of Stakeholder 4

Establishment Type	NGO
Number of Staff	15
Main Area of Work	Improving health outcomes for Nigerians through advocacy, social mobilisation and community engagement
Purview of Responsibility	All Nigerians

Table 5.5. Profile of Stakeholder 5

Establishment Type	Hospital
Number of Staff	23
Main Area of Work	General medical practice
Purview of Responsibility	General population (including women, men and children)

Table 5.6. Profile of Stakeholder 6

Establishment Type	Media
Number of Staff	About 100
Main Area of Work	Entertainment, News and General Social Affairs
Purview of Responsibility	General population (including women, men and children)

5.4.2 Stakeholders' comments and suggestions on the proposed IPV prevention framework

The comments and suggestions of the stakeholders are summarised in this section in a serial manner based on the sequence of questions asked in the validation process. Detailed responses of the stakeholders can be found in Appendix 6 of the thesis.

What is your view on the three-tier IPV prevention framework proposed in this research? Do you believe it is comprehensive enough?

Stakeholder	Comment and Recommendation
1	The Ministry of Health opined that the framework is comprehensive and that it gives accurate consideration to the appropriate factors needed to be addressed to prevent IPV issues.
2	The stakeholder stated that the framework is comprehensive, and that it appropriately gives oversight of running the different prevention programmes to the right establishment (i.e., the Ministry of Women Affairs and the Ministry of Health).
3	The stakeholder expressed that the framework covers the major activities and relevant stakeholders needed to address IPV in Nigeria, and deemed the framework comprehensive.
4	The NGO believes that the framework is comprehensive and that it will provide strong foundation in addressing the issues of IPV against women in Nigeria. The stakeholder pointed out that the different blends of strategies will provide government and other relevant stakeholders the chance to comprehensively tackle IPV in the country.
5	The hospital conferred with stated that the framework is comprehensive and well rounded.
6	The stakeholder believes that the framework is highly comprehensive and would be very helpful in addressing IPV issues in Nigeria. The stakeholder further added that the framework will help address other forms of violence as well, as there is overlap between IPV and forms of abuse (e.g., child labour, human trafficking and terrorism).

Discussion of the stakeholders' views: the stakeholders conferred with unanimously expressed that the framework is comprehensive, and generally believe that it will afford the country an opportunity of addressing IPV issues.

Usage of Information Technology was proposed as part of the framework to make the whole host of IPV prevention activities seamless and provide information storage backbone for the proposed preventive framework, what do you think about this and how effective do you think its implementation would be?

Stakeholder	Comment and Recommendation
1	Ministry of Health believe that it is an added advantage to include the usage of IT, and that it will be very effective in addressing IPV issues in the country
2	The stakeholder stated that when one considers the number of organisations or agencies identified in the framework, the application of IT becomes really important in managing the activities of the agencies. But further expressed that the implementation of such technologies in Nigeria may be slow to get off the ground, as they are expensive and require the support of specialist – factors that might not be readily available.
3	The stakeholder believes that IT is inextricably linked to the success of programmes and running of establishment in the modern era, and therefore considered the inclusion of the IT backbone in the proposed framework immensely important.
4	The NGO expressed that it is an excellent idea to introduce the use of IT in addressing IPV issues in Nigeria, as it will help in managing the different programmes proposed and also serve as a means of record keeping. But the NGO also stated that the implementation of IT will be very expensive and that many of the identified stakeholders do not really have the required resources to implement such technologies.
5	The stakeholder expressed that IT is widely used to support different activities by various organisations nowadays, and the stakeholder believes that it is really important to use IT in supporting the activities proposed in the framework.
6	The stakeholder expressed that it is a very good idea to deploy IT in tackling IPV, as the introduction of such technologies will make prevention programmes more manageable and also provide a means of information storage. The stakeholder also stated that factors that might affect the smooth implementation of the technology will be the availability of skilled individuals and erratic electricity power supply in the country. But the stakeholder expressed that the implementation can still be highly effective if it receives the strong backing of the government.

Discussion of the stakeholders' views: all the stakeholders agree that the adoption of appropriate Information Technology would be advantageous in facilitating the activities identified in the proposed IPV prevention framework. Nonetheless, some stakeholders deem the IT adoption or implementation expensive in terms of the resources that will likely be required for such projects. They also expressed that the success of the adoption will greatly require the full support of the government.

Do you believe Information Technology has a role to play in preventing IPV, whether through awareness raising or other means?

Stakeholder	Comment and Recommendation
1	The Ministry of Health believe that the usage of IT is important in the area of Health Information Campaign, as the usage of IT in such campaign could help reach a wider audience.
2	The stakeholder believes IT has a role to play in preventing IPV.
3	The stakeholder believes that IT has a very important role to play in the prevention of IPV and all other forms of violence, as the technology can be used to 'manage programmes, raise awareness, store information and monitor the progress of interventions.'
4	The NGO expressed that IT has a role to play in preventing IPV, as such technologies can help provide a way of efficiently storing information and help in health campaigns to inform women on the availability of support services.
5	The stakeholder stated that in the modern age a lot of people get their information from the internet, and due to this it is believed that using IT in awareness campaigns on IPV would help reach greater number of people.
6	The stakeholder believes that IT has an important role to play in the prevention of IPV.

Discussion of the stakeholders' views: the stakeholders, again, unanimously believe that Information Technology has a role to play in IPV prevention, especially in terms of campaigns and raising awareness.

Can you kindly provide your perception of how IPV could be prevented in Nigeria?

Stakeholder	Comment and Recommendation
1	The Ministry of Health opined that IPV could be prevented by the means of health information campaigns targeted at changing community norms that expose women to IPV, and also by training healthcare staff on handling IPV issues.
2	The stakeholder believes that the most important way of preventing IPV in Nigeria is by empowering women and advocating against practices that are likely to resort to IPV in the society.
3	The stakeholder stated that IPV could be prevented in Nigeria by creating an ambience of non-tolerance of violence using punitive measures against perpetrators of abuse, and also by informing women of their rights as well as empowering them through microfinance schemes.
4	The NGO believes that IPV could be prevented in Nigeria by mainly empowering women and improving their status in the society.
5	The stakeholder expressed that IPV could be prevented in the country by creating a greater partnership between law enforcement agencies, criminal justice

	establishments and health agencies. In other words, just as proposed in the framework, the stakeholders could help solve the IPV problem by sharing 'a common violence prevention agenda and having a single vision on the problem.'
6	The stakeholder stated that 'IPV can be prevented in Nigeria by promoting gender equality and giving female children the opportunity to go to school just like their male peers.'

Discussion of the stakeholders' views: the stakeholders have a somewhat varied perception of how IPV could be prevented. But most of the stakeholders believe that women's empowerment is very important in preventing violence. Other views include the training of healthcare staff to support women, creating an ambience of non-tolerance of violence by using punitive measures against perpetrators and mass advocacy.

Do you think implementation of the proposed framework will be feasible in Nigeria? If not, why do you believe it would not and what do you think could be done to make it work?

Stakeholder	Comment and Recommendation
1	The Ministry of Health is of the opinion that the implementation of the proposed framework is feasible in the country.
2	The stakeholder believes the framework is perfect and will work in the Nigeria society.
3	The stakeholder believes that the framework is feasible.
4	The stakeholder believes the implementation of the proposed framework is feasible, but will require a lot of government support.
5	The stakeholder really believes the framework will be feasible in Nigeria.
6	The stakeholder believes that the implementation of the proposed framework is feasible in Nigeria, but will require the strong backing of the government for it to be really effective.

Discussion of the stakeholders' views: all stakeholders believe that the implementation of the framework is feasible in Nigeria. But some of the stakeholders expressed that the effectiveness of the framework will be dependent on the backing of the government.

What are your views as to the effectiveness of the framework in terms of the primary prevention strategies proposed to address IPV?

Stakeholder	Comment and Recommendation
1	The Ministry of Health believe that the framework's primary prevention strategies will be effective in preventing IPV in Nigeria, especially because they consider the 'likely root causes of the problem.'
2	The stakeholder expressed that the primary prevention strategies are properly structured and believe that 'they will go a long way in helping to prevent IPV within the society, if implemented.'
3	The stakeholder stated that the primary prevention strategies are elegantly structured and believes that the strategies 'will be very effective in preventing IPV and its concomitant issues.'
4	The NGO expressed that the primary prevention layer of the framework is well designed and contains critical strategies that will help prevent violence, but there is still need for the layer to include the allocation of funds for further research into the general issues of violence against women (e.g., allocation of funds to support social-science or epidemiological research on developing new interventions).
5	The stakeholder believes that the primary prevention strategies are well rounded and provide important opportunity to stop IPV from occurring in the first place.
6	The stakeholder expressed that the primary prevention strategies are broad-based, and that the design of the primary prevention truly considered the underlying issues that are likely to give rise to IPV. Therefore, the stakeholder believes that the prevention plan will make great contribution to addressing IPV in Nigeria.

Discussion of the stakeholders' views: the stakeholders are all of the opinion that the primary prevention strategies are properly structured, and they believe that the strategies would be effective in preventing IPV in Nigeria.

Do you think the secondary prevention plan proposed in the framework is robust enough to support abused women and prevent recurrence of abuse?

Stakeholder	Comment and Recommendation
1	The secondary prevention plan is considered robust by the Ministry of Health. The Ministry also believe that the prevention plan would be effective in supporting abused women.
2	The stakeholder believes that the secondary prevention plan is robust, and that 'it includes the important organisations or agencies that handle IPV cases and are relevant to the prevention of violence.'

3	The stakeholder expressed that the secondary prevention plan is robust and adequate to cater for the needs of women, but stated that the framework should include agencies such as the Citizens Mediation & Conciliation Centre and The Centre for Alternative Dispute Resolution in the secondary prevention plan, as these agencies provide important avenue for settling interpersonal injustice related issues in an amicable way.
4	The NGO believes that the secondary prevention plan is robust, and that the inclusion of wide range of relevant stakeholders will be highly advantageous in responding appropriately to IPV incidents.
5	The stakeholder stated that the secondary prevention plan is perfect, and believes that the plan is exactly what is needed to address IPV issues in the country.
6	The stakeholder expressed that the secondary prevention plan is highly robust, and that the network of different stakeholders in the design will help provide needed support to abused women.

Discussion of the stakeholders' views: The stakeholders unanimously believe that the secondary prevention plan is robust. But one of the stakeholders expressed that it will be important to include certain agencies (e.g., the Citizens Mediation & Conciliation Centre and The Centre for Alternative Dispute Resolution) as part of the plan, because the agencies in Nigeria provide an important avenue for settling interpersonal grievance-related issues in an amicable way.

What do you think about the structure and likely effectiveness of the proposed tertiary prevention of IPV in the framework?

Stakeholder	Comment and Recommendation
1	The Ministry of Health expressed that the structure of the tertiary prevention tier of the framework is simple and well designed. But believe that the layer of prevention should include as part of the hosts of plans/ policies 'the addition of specialised curricula on violence against women into health worker training.'
2	The stakeholder stated that the structure of the tertiary tier of prevention is good.
3	The stakeholder stated that the tertiary prevention tier of the framework should effective in providing long-term support for women.
4	The NGO expressed that the introduction of transitional housing scheme as part of the tertiary prevention plan is vital, and believes that once implemented it will save a lot of lives, as it will provide an important option for abuse women to escape brutal abuse.
5	The stakeholder expressed that the structure of the tertiary prevention plan is okay, but further stated that it would be beneficial if a special segment on treatment for

	abusers is included in the plan.
6	The stakeholder believes that the tertiary prevention plan is adequate and well designed.

Discussion of the stakeholders' views: the stakeholders believe the structure of the tertiary prevention plan is good, and one of the stakeholders expressed great admiration for the inclusion of transitional housing scheme for IPV victims as part of the plan. Nonetheless, a stakeholder stated the need for further expansion of the proposed tertiary prevention plan, by the addition of specialised curricula on violence against women into health worker training.

As highlighted in the framework, networking and close co-operation between the relevant stakeholders is crucial to the success of the proposed plan, do you believe such co-operation is achievable, if not what could be the restraining factors/ inhibitors?

Stakeholder	Comment and Recommendation
1	The Ministry of Health believes that this kind of close co-operation between different stakeholders is achievable. The Ministry also stated that it has always being active in multi-sectoral initiatives and most of the time such close working or co-operations have resulted in achievement of desired goals.
2	The stakeholder believes that the close co-operation required is achievable and, if planned properly, would work very well.
3	The stakeholder believes that the networking and close co-operation between the relevant stakeholders is achievable, but also expressed that the success will require the serious oversight by the government.
4	The NGO stated that the co-operation is achievable, but will require a lot of planning and that the government will need to take responsibility to ensure that all relevant stakeholders have equal say in the prevention effort.
5	The stakeholder believes that the close co-operation amongst the different sectors or stakeholders is what is needed to tackle the IPV issue in the country, and that such co-operation is achievable.
6	The stakeholder stated that the co-operation is achievable, but there is a serious need for all stakeholders to have 'equal desire' in ensuring that IPV is reduced in the country. Besides, the stakeholder expressed that the government will need to co-ordinate the network to achieve desire results by bringing the different stakeholders together regularly through the means of meeting and joint trainings.

Discussion of the stakeholders' views: the stakeholders believe that the required co-operation amongst the different agencies or organisations identified in the proposed

framework is achievable. But some of the stakeholders expressed that the true effectiveness of such co-operation is largely dependent on the amount of effort put into the implementation of the plan by the government.

If the framework is adopted by the Nigerian Government (State/ Federal) will you be willing to be part of its implementation?

Stakeholder	Comment and Recommendation
1	The Ministry of Health stated that 'as the custodians of health and well-being in the state we will be happy to be part of a health improvement plan like the one proposed in the framework.'
2	The stakeholder expressed that the Ministry is willing to be part of the implementation, and will support the activities of the proposed framework.
3	The stakeholder stated that the judiciary will be willing to be part of the implementation of the framework, if called upon.
4	The NGO expressed that it 'will be more than willing to be part of this great plan to solve a major public health problem.'
5	The stakeholder expressed that the health sector has an important role to play in preventing IPV, and if the framework is implemented in the country, the hospital would like to be part of it.
6	The stakeholder stated that it will like to be part of the implementation of the 'extraordinary framework designed to prevent IPV against women, especially in terms of public awareness campaigns.'

Discussion of the stakeholders' views: the stakeholders view the proposed framework as important and ideal, and they are all willing to be part of its implementation.

In addition to the covered areas in the previous questions, do you have further comments about the proposed framework?

Stakeholder	Comment and Recommendation
1	-
2	-
3	The stakeholder believe that there are varied ways in which information technology could be used to support the IPV prevention plan in the country, and there is a great need for further research into how the full capability of technology could be fully

	harnessed in solving IPV issues.
4	The NGO expressed the need for more funding to support further research on violence against women.
5	The stakeholder believes that the health system is the first point of contact for women who are victims of IPV, and it will be very important to give greater focus on how health policies could be designed to help support abused women and reduce IPV occurrence.
6	The stakeholder believes that it will be advantageous if the strategies outlined in the framework are implemented in stages as opposed to running all the strategies all together from the beginning. The stakeholder stated that this would help save costs and provide adequate time for relevant stakeholders to fully understand and implement the required activities.

Discussion of the stakeholders' views: some of the stakeholders further commented that there is a need for: (1) further research into how the full capability of IT could be fully harnessed to support IPV prevention; (2) more funding to support further research on violence against women; and (3) the implementation of the proposed plan in stages, as opposed to running or implementing all the programmes or policies at a single go.

5.4.3 Summary of the stakeholders' views, refinement of the prevention framework and recommendations for its implementation

Having discussed the perceptions of the stakeholders gleaned from the framework validation process, in this sub-section a brief summary of the views of the stakeholders as regards the suitability and implementation of the proposed framework is provided. In the light of these views, the refinement of the framework and recommendations for its implementation are discussed.

Overall, the proposed preventive framework was deemed comprehensive by the different stakeholders conferred with, and all three tiers of the prevention introduced in the framework were considered appropriate and useful in addressing IPV in Nigeria. The need for a network of co-operation amongst the relevant stakeholders identified in the framework and the application of appropriate Information Technology (IT) to facilitate the work of the service

providers, as proposed in the framework, were also validated to be needed and critical in tackling IPV issues in Nigeria.

Nonetheless, the stakeholders opined that to make the proposed framework more effective and the IPV prevention in Nigeria achievable, there is further need:

- To include pertinent agencies such as the Citizens Mediation & Conciliation Centre and The Centre for Alternative Dispute Resolution as part of the plan.
- To further expand the proposed tertiary prevention plan, by adding the requirement for specialised curricula on violence against women into the health worker training.
- To implement the plan outlined in the framework in stages and sequential manner, in order not to over burden the relevant service providers and to ensure cost effectiveness.
- For the government to be really proactive in implementing the plan outlined in the framework and to be in the driving seat in ensuring its success.

In light of these comments and suggestions made by the stakeholders during the validation process, the following are the key recommendations proposed by this research to further improve the IPV prevention framework and to facilitate its successful implementation:

- Plans and actions in the proposed framework should be implemented in a stepwise fashion. In this stepwise implementation process, the government should initially be in the driving seat by creating a conducive mean for the entire plan proposed in the framework to thrive. The government could achieve this by putting in place national policies and laws that criminalise IPV perpetration, just as expressed in the framework, to create a climate for non-tolerance of IPV. In addition, the government could go a step further by financially supporting relevant service providers/ stakeholders identified in the framework to facilitate subsequent steps in the prevention plan.
- In the framework validation process, the need for further investment in research and training of healthcare professionals in identifying and helping IPV victims was

emphasised by the stakeholders. Based on this, it is recommended that the government should support further research into IPV issues and adopt programmes on the identification of likely victims of IPV in the healthcare setting in Nigeria. This programme adoption process could include the training of staff and adjusting health training curricula to afford healthcare professionals better knowledge and understanding of IPV issues and how to address them. Nonetheless, if the government chooses to go down the route of victim identification, an approach that would be preferable will be one involving the 'identification of symptoms' as opposed to screening of women routinely. It would be more expensive to embark on routine screening of all women having contact with the healthcare service. Besides, there is no evidence suggesting that routine screening is more effective in identifying abused women than the approach based on symptoms identification. Moreover, for example, the Malaysian One-Stop centre, widely known to be successful at identifying and supporting abused women, is based on the symptoms identification approach (Colombini et al., 2011).

- It is also recommended that the government should fully harness the capability of the currently available institutions and infrastructure in addressing IPV issues in the country. Examples of such services and programmes include those identified in the preventive framework. Additionally, capabilities of agencies such as the Citizens Mediation & Conciliation Centre and The Centre for Alternative Dispute Resolution, as suggested by one of the stakeholders in the validation process, should be given serious consideration as well.

5.5 Summary

This chapter provides a detailed account of the preventive framework proposed in this research to address IPV issues in Nigeria and other similar developing countries. The chapter starts off with an overview of the preventive framework, giving a brief description of it and also providing a schematic representation of the framework showing its different components as they are spread across a three-tier prevention design.

Additionally, information about the design of the preventive framework is also afforded by this chapter. The details of the three phases involved in the development of the framework were all discussed – the phases include: phase 1 (exploration of the results/empirical evidence and theoretical principle that will inform the choice of interventions), phase 2 (identification of prevention strategies and activities), and phase 3 (organisation/channelling of empirical evidence, theory and evidence-based strategies into a coherent preventive framework). Besides, the public health models (i.e., ecological model, the spectrum of prevention and the three-tier prevention design) that underpinned/anchored the development of the framework were also presented.

The product of these phases of development, which is the proposed preventive framework shown in figure 5.1, includes 5 strategies at the primary prevention level, 4 strategies and a coalition of agencies/stakeholders at the secondary prevention level, as well as 5 strategies targeted towards tertiary prevention of IPV. It incorporates the use of IT and recognition for cost assessments and impact evaluations.

As validation is a pivotal part of the development of any system or intervention, the concluding section of this chapter presents an account of the validation of the proposed framework. The results of the validation indicate the suitability of the framework to the targeted context, and also provide clarification on steps to take in ensuring optimum effectiveness of the framework. The information gleaned from the validation also gave rise to certain recommendations that include: the pertinent inclusion of agencies such as the Citizens Mediation and Conciliation Centre and the Centre for Alternative Dispute Resolution as part of the plan, as well as the sequential implementation of the plan outlined in the proposed framework to ensure cost effectiveness among other relevant considerations.

Chapter 6 Discussion

This study explored the magnitude and nature, likely risk factors/predictors, as well as socioeconomic costs of IPV in Nigeria. The research findings show that:

1) IPV level is relatively high in the country, with life-time prevalence standing at 25.5%,
2) Women are not passive victims of IPV, they seek help in response to violence incidents,
3) Attitudes towards gender roles is highly biased towards the male gender, with a large proportion of women of the opinion that women should be subservient to their husband/partner,
4) Overall, women somewhat believe that IPV (wife beating) is justified, with 33.5% of women agreeing to the acceptability of such acts,
5) A host of factors are predictive of IPV, and these factors include a woman's and her partner's educational attainment, partner's controlling behaviour, choice of spouse/partner, partner's illicit drug use, categorical number of children, as well as the interaction between the proportion of men consuming alcohol daily in the community and proportion of men with higher education in the community,
6) IPV comes at a great cost to households, and abused women face a greater brunt of the cost. Violence is also a major drag on the Nigerian economy, with IPV costing the country approximately ₦154.4 billion per annum – equivalent to 0.2% of its current Gross Domestic Product (GDP).

The findings of this study pertaining to the prevalence of IPV, as expressed above, indicate that about 1 out of every 4 women has experienced IPV at least once in her life-time. This is consistent with the pervasiveness reported by other research (Heise and Garcia-Moreno, 2002; Garcia-Moreno et al., 2005; WHO, 2010). This study also suggests that psychological abuse is the highest form of IPV experienced by women (life-time and current prevalence of

24.3% and 16.6%, respectively), lending further credence to observations of prior studies (NPC and ICF Macro, 2008; Okenwa et al., 2009). The high level of IPV victimisation indicates how imperative it is for the government and other relevant stakeholders to act swiftly in providing support for abused women and, most importantly, develop policies to prevent the occurrence of violence. This urgent need for appropriate intervention is echoed further by the results showing that IPV against women in Nigeria is not a one-off experience, but an occurrence that is repeated over time.

The results regarding help-seeking behaviour suggest that women often seek help in response to IPV and that they are not passive victims of abuse (68.0% sought help after IPV incidents), corroborating the findings of studies such as those of Barrett and St. Pierre (2011). Regarding preference of support, most of the abused women (59.5%) used formal services, although this is only slightly higher than the usage of informal services (53.0%). Considering this fact, it becomes important for the Nigerian government to enhance services provided by the formal sector for abused women, whilst at the same time support the informal sources (e.g., by promoting and encouraging families, friends and likely bystanders to be more proactive and support abused women, or by considering informal care givers, such as traditional healers, as relevant stakeholders in the design of policies to address IPV issues). Besides, given the high utilisation of healthcare services by abused women, adoption of a screening protocol that is sensitive in detecting IPV within the health sector would assist in identifying abused women and afford a chance of supporting them in terms of referral to other relevant agencies or provision of specialised support. This type of screening protocol has been proposed by researchers from different countries (Waalen et al., 2000; John et al., 2011).

Nonetheless, additional evidence from this study also shows that despite the high usage of formal healthcare services, there is still low utilisation of some particular formal services such as the police (5.4%), judicial service (0.5%), and shelter (0%). This poor usage begs the questions of whether such service providers are part of the IPV problem in the country due to their inability or unwillingness to meet the needs of abused women, or may be the dismal service usage is due to inaccessibility of such services or, perhaps, lack of trust in service providers. Research findings in other countries with similar patriarchal structures as Nigeria

have shown that abused women do not make use of certain services that could have helped them in addressing their issues because service providers often show antagonistic attitudes (i.e., indifference, mocking and even attempt to instil guilt) towards reporting this kind of abuse. And even when the service providers respond, they rarely carry out a proper follow-up on cases (Hassan II University, 2009). Based on the foregoing, one could assume that the poor utilisation of some services, as observed in this study, is due to the inadequacies in the system of operations of the service providers. Lack of awareness regarding the existence of services may also be a barrier to usage. Therefore, it will be highly beneficial if the government could embark on policy reforms of service providers and also increase the awareness of people of the existence of the different services available to support women and address IPV issues. The overhaul and reform of the judicial system and police service, in particular, could go a long way in preventing IPV occurrence as these two important services could help create a climate of non-tolerance of violence. In addition, the results show that there were no usage of shelter services by the abused women and, again, this may be an indication of lack of awareness regarding the existence of such services or a stark reflection of the absence of such services emanating from inadequate policies on gender issues to cater for women's needs.

Furthermore, another major objective of this study is the exploration of women's attitudes towards the roles of women and men in relationships, by documenting their perceptions towards gender roles (i.e., clustering their attitudes towards gender role by demographic factors). The results suggest that women's attitudes towards gender roles in Nigeria are more supportive of male dominance and women being subservient to their husband/partner. This widespread acceptance might be partly responsible for the high IPV burden in the country, as results from other parts of the world with equally high IPV prevalence have shown similar patterns of women's attitudes towards gender roles (Heise et al., 1999, Rani et al., 2004, Jayatilleke et al., 2011). Besides, as pointed out by the WHO (2009b), this acceptance of gender inequality may be the inhibiting factor preventing women from seeking protection through available formal services.

Results pertaining to the cross-tabulation of women's attitudes towards gender roles in the country by demographic variables show that there is a somewhat uniform pattern to the distribution of attitudes, making it important to implement broad-based prevention programmes in changing the widespread gender-biased norms that assist in exposing women to IPV, as this variant of programmes will have a greater coverage and go a long way in promoting gender equality and addressing IPV issues in Nigeria.

Nonetheless, Fanslow et al. (2010) noted that Asian women in their study show low agreement with outside intervention as a response to a man mistreating his wife, and they also opined that this might be a factor limiting the usage of available services to address IPV issues. Contrary to this finding, the results of this study pertaining to the acceptance of outside intervention show a greater agreement amongst women to outside intervention when a man mistreats his wife. As such, this important discovery in this study opens up the possibility that IPV prevention strategies, especially those involving social or criminal justice intervention, will most likely be effectively used by abused women if adopted in the country.

In addition, another facet of the objectives of this research is the documentation of attitudes towards IPV. The results show an evenly spread acceptance of IPV (wife-beating) across urban and rural areas; which is, again, an indication of the need for greater IPV preventive measures. This need becomes even more pressing when one considers the fact that the level of acceptability of wife beating recorded in this study is as high as those recorded in violence prone regions of the world, and even higher than the levels seen especially in Latin American countries – some of whom have deemed this issue very serious and have taken certain steps to address the issue (Morrison & Biehl, 1999; Morrison et al., 2007; Fanslow et al., 2010; Speizer, 2010; Bott et al., 2012). Additionally, the results in this study show that, as compared with rural women, slightly higher proportions of women in the urban areas believe that wife beating is justified. The results also indicate that women within the young age group (18–29 years) show the least acceptance for IPV. These findings are contrary to those of Hindin (2003), that indicated that women living in rural areas are more accepting of wife beating than their urban counterparts and that young women are more likely to accept that wife beating is justified. The major advantage of the findings of this study is that the younger

(next) generation of women is less likely to be supportive of abuse and, if nurtured by appropriate social policies that denounce wife beating, could help to some extent to break the chain of IPV incidents in the country. Nonetheless, other results showing literate women to be more supportive of wife-beating are a further testament to the need for more robust policies and actions, preferably those built on school-based enlightenment schemes/ interventions or based on community mobilisation and mass communication for social change, as these strategies have been shown to have effective impact on reducing IPV occurrence (Foshee et al., 2005; WHO, 2009a; WHO, 2010; Bott et al., 2012).

Moreover, the results from the multivariable logistic regression analyses to identify likely risk factors of IPV show that different factors at the individual level, relationship level as well as community level are predictive of IPV occurrence. The results indicate that women with lower educational attainment are more predisposed to experiencing IPV. This is consistent with findings from other studies (Koenig et al., 2006; Ackerson et al., 2008; Abramsky et al., 2011). On the contrary, results pertaining to partner educational attainment show that higher educational attainment increases the likelihood of IPV perpetration. Nevertheless, it could be suggested that this particular finding lends credence to resource theory that posits male violence to be a resource of last resort when other forms of resources are out of reach or unavailable (McCloskey, 1996; Atkinson et al., 2005). This assertion is plausible as a lot of graduates of higher learning in Nigeria are unemployed and struggle to make ends meet, making them a likely user of the 'last resort' (violence) when other resources that can support standard living are out of reach or not available. The practicality of resource theory in this situation is germane, despite the fact that other analyses pertaining to employment status (bivariate logistic regression analysis of male partner employment in particular) show that there is no significant difference in the likelihood of IPV perpetration between partners that are employed and those without employment. This is so because being employed in Nigeria does not necessarily guarantee access to resources needed in making ends meet, especially with recent studies indicating that most jobs in the country simply pay too little (Teal, 2014).

In terms of choice of spouse/partner, the results show that women who have no say in the choice of their spouse/partner are more likely to experience IPV. This corroborates the

findings of Abramsky et al. (2011). Regarding the use of drugs by male partners, studies have shown strong positive association between drug use and IPV perpetration (Coker et al., 2000; Jewkes, 2002). The results of this present research are also consistent with these prior findings. Considering controlling behaviour of male partners, the results show that men imposing control, whether great or minute, on their partners are more likely to perpetrate IPV. This finding is in line with those of other studies (Abramsky et al., 2011). In terms of number of children, the results show that women having 3 to 4 children are less likely to experience IPV as compared with those having more. This could be an indication of how limited resources to take care of more children could lead to the occurrence of IPV. Besides, this important finding shows how programmes on family planning and sexual health could also help in addressing IPV in addition to affording families/couples reproductive control. Therefore, linking IPV prevention to such programmes would be beneficial in the Nigerian context, and most likely in the context of other similar developing countries. Moreover, descriptive statistical analysis results show that women having only female children from their partnerships are more predisposed to IPV as compared with other women having male children and those without children at all. This could be due to the patriarchal nature of the Nigerian society, as research has shown cases of female infanticide in patriarchal societies (Elangovan, 2013; Ellsberg and Heise, 2005; Khosla, 1980). Therefore, some consideration should be given to this disparity in the design of intervention. Nonetheless, it should be noted that the bivariate and sequential logistic regression results in this study indicate that sex of child is not significantly related to the mother's experience of IPV.

In addition, other complex associations (such as interaction or effect moderation) were also explored in this study, and results regarding this indicate that the interaction between the proportions of men consuming alcohol daily in communities and proportions of men with higher education in such communities is important in the prediction of IPV victimisation. This extra exploration of data for complex associations gives one the opportunity to have a more detailed understanding of the dynamics of abuse occurrence and, as such, affords one the edge of making sound judgment in the adoption of preventive programmes from other societies (e.g., adoption of programmes designed and effectively used in developed countries). Based on the finding pertaining to the interaction variable, it would be an auspicious step for IPV prevention in Nigeria if the government could implement policies

that would help regulate alcohol availability. The effectiveness of such regulations has been noted in other countries such as the United States and Brazil (Markowitz, 2000; PIRE, 2004).

Furthermore, the results of the block modelling procedure carried out on the series of subset models generated in the research indicate that virtually all the subset models make an individual contribution that is significant towards the prediction of IPV. This means that they are all key levels of influence that need to be explored or considered to address IPV issues in the country. Therefore, this provides further evidence for the need to adopt a broad-based prevention approach in tackling IPV in Nigeria – programmes or policies that will address issues at each of the separate levels of influence, as opposed to one that is channeled towards just a particular level.

This research also considered the socio-economic costs of IPV to households and to the Nigerian economy at large. Results regarding such costs indicate that a higher proportion of women sought help from the healthcare establishments, most likely due to the severity of the injuries or harm inflicted on them, and this actually came at a very significant cost. The results in this study show that women pay as high as ₦5,179.66 in the form of out-of-pocket spending per incident to access health services. Amongst the different costs categories explored in this study, the healthcare services cost was the second highest out-of-pocket expenditure incurred, after the judicial service costs estimated at ₦16,000 per incident. Despite these relatively exorbitant costs, many women and their households still had to make such payments, indicating how IPV could be a significant drain on the resources available to households. Besides, results pertaining to the indirect costs estimates show that women significantly incur greater loss of income due to missed work days ensuing from IPV incidents than men do (women on average losing ₦5,868.78, while in the case of men it was ₦3,232.02 per incident). Similar results were found regarding the costs of missed household chores (women losing ₦2,660.72, while men only lost ₦485.82 per incident). This great difference in the amount of resources lost is another testament to the fact that women bear an immense burden due to IPV, while men only feel a meagre proportion of that burden. Therefore, this might be the reason why abusive men find the perpetration of IPV as an easy means of controlling women. In spite of these facts, additional results pertaining to how IPV

impacts negatively on the earning power of abused women further indicate that such women earn 23% less than average Nigerian women, which leaves them at a very disadvantaged position in terms of socio-economic standing.

Moreover, giving the patriarchal context of the Nigerian society, with women being the main carer of children within families, this huge loss of resources is likely to have grave impact on the development of children in households witnessing IPV incidents, as such there is urgent need for women's empowerment and a greater push for gender equality within the Nigerian society. This need to address gender-based issues is even more important when one considers the costs of IPV against women to the Nigerian economy. Results on macro-estimates of IPV costs indicate that ₦154.4 billion (0.2%) of the country's GDP is lost annually to violence incidents.

As compared with other available results elsewhere in the developing world, this estimate is smaller than the 1.41% of GDP recorded in a study carried out in Asia – Vietnam (Duvvury et al., 2012). The estimate is also smaller than those recorded in Mexico (1.3% of GDP) and Peru (1.5% of GDP) (Buvinic et al., 1999). Nonetheless, the estimate in this study is significantly higher than the approximately 0.01% of GDP (3.4 billion Ugandan Shillings) that was recorded in another study in Africa – Uganda (EPRC, 2009) – though it should also be noted that the Ugandan study only considered annual costs of health and police service provision in response to IPV. Additionally, the estimate in this study is relatively similar to those recorded in Venezuela (0.3% of GDP) (Buvinic et al., 1999), Morocco (0.45% of GDP) (Belghazi, 2006) and South Africa (0.9% of GDP) (Khumalo et al., 2014).

Moreover, the macro-estimate of this study may seem lower in comparison to what has been recorded in developed countries – 1.9% of GDP in the United Kingdom (Walby, 2004), 1.2% in Australia (Access Economics, 2004), and 1.2% in Brazil (WHO, 2008) – yet, it is still absolutely large enough to be a hindrance on the economic development of Nigeria considering the fact that the country is a developing one, and also the fact that this estimate equals approximately 10% of Nigeria's budget for the year 2013. In other words, this

estimate is larger than the combined total amount of funds appropriated in that fiscal year for agencies/ministries in charge of trade and investment, youth development, women affairs, information as well as police affairs.

Besides, the relatively smaller macro-estimate recorded in this study may be due to the fact that some of the stated estimates in other countries, especially in the developed countries, included elements that were not covered within the purview of this current study; costs elements such as human and emotional costs and those due to self-directed violence. Additionally, as opposed to the bottom-up approach used in this study, most of these studies used a top-down approach in calculating the costs (i.e., they estimated the costs of IPV as a proportion of the healthcare and judiciary budget, as well as budgets of other relevant agencies/ ministries). Thus, this is also likely to account for the sizeable differences in the macro-estimates of IPV costs.

Chapter 7 Conclusion

7.1 Overview

This concluding chapter of the thesis provides a recapitulation or summary of the research, discusses the research contribution to knowledge, considers the limitations of the research and provides directions for future research in this realm of study.

7.2 Research Summary

The main aim of this research was to study the issues of IPV against women in Nigeria and to generate novel results that would facilitate the design of policies and programmes to address violence in the country. To achieve this, the study explored the magnitude of violence in Nigeria, its nature, likely risk factors and socioeconomic costs. The research also drew on prior knowledge and combined it with the novel results generated from this study to design a prevention framework for addressing IPV issues in Nigeria – a framework that is most likely applicable to other similar developing countries.

The introductory chapter of the thesis highlighted the issues of IPV in Nigeria and other developing countries and provided the rationale for undertaking this study. That chapter also provided a list of objectives to meet in order to achieve the research aim. Based on these objectives, the following were the accomplishments of this research:

- The research provided estimates of the current- and lifetime-prevalence of IPV
- It provided detailed information on the likely risk factors of IPV
- It also provided information on the help-seeking behaviour of abused women
- It gave a concise documentation of the attitudes towards Gender Roles and IPV
- The research provided estimates of the costs of IPV to households and also to the Nigerian economy at large

- Based on the derived evidence, the research designed a preventive framework to address the issues of IPV.

7.3 Research Contribution to Knowledge

As state in chapter 1, most studies on the prevalence of IPV in Nigeria are service-based studies (e.g., those conducted in a hospital environment). Considering this fact, the present research being a population-based study makes a tangible contribution to the expansion of knowledge on the dynamics of violence by exploring the prevalence of IPV from the vantage point of the general population, as opposed to just from the perspective of a sample of women attending a particular clinic or making use of just a specialist service.

Moreover, in terms of the exploration for likely risk factors and the design of a preventive plan, this research did not just apply results from simple bivariate logistic regression analysis to design an IPV prevention plan/approach, as often seen in research within this area of study. It goes extra steps further by using a more rigorous analytical regime – multivariable sequential logistic regression – to generate more precise and accurate results suitable for designing smarter plans to tackle IPV issues. In other words, by exploring complex associations that may exist amongst variables (e.g., moderation or interaction effects) using multivariable analysis the research affords the opportunity to gain better understanding of the likely risk factors of IPV and as such provides a chance to generate more reliable plans to address IPV issues.

In Nigeria, as far as it can be ascertained, there are no studies estimating the national or state-level direct costs estimates of IPV against women. Neither is there any study looking into the indirect costs of IPV. Besides, there are no baseline figures to guide the exploration of services cost-effectiveness in reducing the level of IPV victimisation or perpetration. These are all significant gaps in knowledge that this research addressed. Without these very important pieces of information, it becomes extremely difficult for policymakers and advocates of IPV prevention to argue that a particular intervention or programme provides immense benefits that outweigh its costs. Similarly, without these sets of information, it

becomes difficult for the government to appropriate required funds for the provision of services to tackle or alleviate IPV against women. Therefore, the costs estimates generated in this study help to highlight the resources needed for an effective public response to IPV and also facilitate cost-effectiveness analysis of future interventions. Furthermore, the household costs estimates provided a medium to demonstrate the drain of resources that IPV imposes on families, thus lending important evidence in educating the public on the seriousness of the issue and to champion the need for change in behaviour/attitudes towards gender roles and IPV.

Moreover, this research makes further significant contribution to knowledge by designing a novel IPV prevention framework that provides a practical means of preventing IPV and affording women in Nigeria and other similar developing countries the help they need to avoid such abuse. The importance of this framework cannot be over emphasised, considering the fact that thousands of women are currently experiencing IPV in Nigeria and, perhaps, millions might experience abuse in the country in the future if no actions are taken to address the issue.

This preventive framework outlines the required means to avert IPV from occurring in the first place by channelling appropriate strategies to tackle likely risk factors of the malice (i.e., primary prevention). It also takes into consideration the need to provide barriers to break the chain of IPV victimisations and to ameliorate the scourge faced by victims (i.e., secondary prevention). Besides, the framework recognises that to achieve sustainable reduction in IPV occurrence there is a need for broad-based interventions that afford abused women protection over the long run. Furthermore, the framework also draws on the knowledge gleaned from the costs estimation aspect of this research and, thus, integrates a cost assessment and impact evaluation facet that will ensure efficiency and sustainability of the different actions in the framework.

7.4 Research Constraints and Limitations

Given the cross-sectional nature of the data used in this research study, additional exploration of the issues of Intimate Partner Violence (IPV) in Nigeria, especially the study of the intergenerational transmission of IPV, was not feasible.

This research documented the help-seeking behaviour of women and also identified the utilisation of services by women in Nigeria, providing a clear view of how social norms guide the choice women make in terms of support seeking in the advent of IPV. But the research did not cover how the culture of Institutions or Service Providers influences the service utilisation and help-seeking behaviour of abused women.

Despite the fact that the results of this study showed that IPV is a major burden on household across Nigeria and a potential hindrance on the Nigerian economy, it is equally important to state that the actual total costs of violence would definitely be higher than the value estimated in this study as the estimates in the present study did not include certain costs components such as the proportionate costs to service providers. The exclusion of these costs was as a result of unavailable or inadequate and robust data, primarily due to the fact that service providers (e.g., hospitals) generally do not have or keep accurate records of service usage by IPV victims. These costs will likely have additional impact on the Nigerian economy, as the government subsidises the costs of using public services such as healthcare, and therefore, even though individuals pay for such services, the government also makes some payments towards the usage. Furthermore, other costs categories such as the costs to businesses were also not included in this study, obviously due to lack of business establishments having accurate recorded reports of absenteeism or sick-leave due to IPV incidents. Nonetheless, some of these limitations formed part of the issues addressed with the proposed framework, as it included the recommendation for appropriate record keeping by service providers, which could be used to facilitate future IPV costs analysis processes.

Furthermore, there are two sides to any successful public health intervention (i.e., internal effectiveness of the intervention and acceptability of the intervention by intended users).

Even though there was evidence from this research study that guided the choice of the varied prevention programmes/interventions proposed in the framework design, and this evidence suggested the likely effectiveness of the programmes, some of these IPV prevention programmes/interventions proposed were designed and are used in developed countries and are mostly yet to be used in developing ones (e.g., Nigeria). Therefore, one cannot completely ascertain the level of acceptability of these programmes in the developing world. Nonetheless, the proposed framework was subjected to a validation process that indicated its suitability and likely effectiveness in the Nigerian society.

7.5 Future Work

Although this cross-sectional population-based study provided novel and invaluable information on the dynamics of IPV in Nigeria, there is still need for further exploration of IPV issues in the country and other similar developing countries using longitudinal studies. These forms of research will not just provide information on current IPV issues, they will also afford the opportunity to fully study causation and the inter-generational effects of IPV in a society.

As highlighted in earlier section, this research has estimated the potential drain IPV imposes on households in terms of direct and indirect costs and also provided the macro-estimates of costs to the Nigerian economy. Nonetheless, there is still great need for further assessment of economic impacts of IPV in terms of costs to service providers, costs to local businesses and how these costs add up to the costs on the national economy as well as how inter-generational economic costs could also hamper the future economic growth of the country.

As part of the novel framework designed in this study, it was proposed that screening for IPV should be implemented to help identify IPV victims early enough to prevent adverse health outcome or complications. But the acceptability of such screenings by healthcare professionals is still not fully certain. Therefore, it is important to assess the acceptability of partner violence screening among healthcare professionals in Nigeria.

As stated by the WHO (2009b), prevention programmes or interventions for men who perpetrate IPV only work if they want to change. Therefore, there is also a need for research into the identification of men who are willing and need help to desist from IPV perpetration.

It was identified in the present study that certain institutions/service providers are poorly utilised by IPV victims, but it was not ascertained whether institutional cultures have contributed towards the poor utilisation. Therefore, of paramount importance are studies into the contribution of institutional culture as regards IPV occurrence, and also how changing institutional cultures could facilitate tangible gains in IPV prevention.

A feature of the proposed framework is the networking amongst different stakeholders or multisectoral co-operation, but a basic fact about this is that multisectoral working comes with challenges in terms of documentation and sharing of information across a multitude of organisations. Nigeria, being a developing country, could struggle a little more with this challenge, making imperative the need for systems that would go a long way in facilitating the success of this type of multisectoral co-operation in Nigeria. Therefore, there is a necessity of further research and investment into completely bespoke seamless information sharing platforms for IPV prevention purposes.

Furthermore, the proposed framework recommends the screening of women in healthcare centres, but this kind of screening could be a daunting exercise, especially when one considers the number of women that are likely predisposed to IPV experience. Therefore, to facilitate this exercise, the usage of appropriate tool for such screening will be highly preferable. Thus, there is a need for research into decision support systems (DSS) that would provide prompts/pop-ups to alert medical/health personnel attending to women that are likely to be at the risk of IPV, as this kind of system will help save time, as well as other resources, in addition to helping to meet with the screening requirements.

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Appendix1

Survey on Women's Health, Partner Relations, and Life Events in Kwara State, Nigeria

WOMEN'S QUESTIONNAIRE

Study Conducted by
Lateef Olayanju
BIOCORE Applied Research Group, Coventry University, UK

INDIVIDUAL CONSENT FORM

Hello, my name is [*]. I am working with [*]. We are conducting a survey in Kwara State to learn about women's health and life experiences. You have been randomly selected (as in a lottery/raffle), and we would very much appreciate your participation in this survey.

This study has been approved by the Kwara State Ministry of Women's Affairs (show copy of letter) and I want to assure you that all of your answers will be kept strictly confidential. All paper records of your name and address will be destroyed once the data has been anonymously transferred into digital format. You have the right to stop the interview at any time, or to skip any questions that you do not want to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk.

Your participation is completely voluntary but your experiences could be very helpful to other women in Nigeria.

Do you have any questions?
(The interview takes approximately 20 to 30 minutes to complete). Do you agree to be interviewed?

NOTE WHETHER RESPONDENT AGREES TO INTERVIEW OR NOT

[ ] DOES NOT AGREE TO BE INTERVIEWED → THANK PARTICIPANT FOR HER TIME AND END INTERACTION

[ ] AGREES TO BE INTERVIEWED

↓

Is now a good time to talk?
[ ] Yes [ ] No → THANK PARTICIPANT AND SCHEDULE THE PREFERED TIME
(NEW INTERVIEW DATE AND TIME:)

↓

It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

TO BE COMPLETED BY INTERVIEWER

I CERTIFY THAT I HAVE READ THE ABOVE CONSENT PROCEDURE TO THE PARTICIPANT.

NAME: _____ SIGNATURE: _____

PRE-INTERVIEW IDENTIFICATION	
PLACE NAME (Ilorin = 1; Offa = 2; Erin-Ile = 3):	
SITE (Rural = 1; Urban = 2):	
WARD NUMBER:	
HOUSEHOLD NUMBER:	
NAME OF HOUSEHOLD'S HEAD:	
NAME OF SELECTED WOMAN:	
LINE NUMBER OF SELECTED WOMAN (HH SELECTION FORM, Q3):	

INTERVIEWER'S VISIT(S)	1	2	3	FINAL VISIT
DATE				DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐
INTEVIEWER'S NAME				
INTERVIEW RESULT: 1. TEMPORARY VISITOR → Stop Interview 2. COMPLETED 3. NOT AT HOME 4. POSTPONED 5. REFUSED 6. PARTLY COMPLETED 7. INCAPACITATED 8. OTHER (SPECIFY)				INTERVIEW NUMBER ☐☐☐
NEXT VISIT: DATE				TOTAL NUMBER OF VISITS ☐
TIME				

SECTION 1	INFORMATION ON RESPONDENT AND HER COMMUNITY		
Question no.	**Questions and Filters**	**Coding categories**	**Skip to**
If you do not mind, I would like to start by asking you a little about (community name)			
101	Do neighbours in (Community name) generally tend to know each other well?	Yes……1 No……2 Don't know……77	
102	If there were a street fight in (Community name) would people generally do something to stop it?	Yes……1 No……2 Don't know……77	
103	In this neighbourhood do most people generally trust one another in matters of lending and borrowing things?	Yes……1 No……2 Don't know……77	
104	If someone in your family suddenly fell ill or had accident, would your neighbours offer to help?	Yes……1 No……2 Don't know……77	
105	I would like to ask you some questions about yourself. What is your date of birth (month, and year that you were born)?	Month……☐☐ Year ……☐☐☐☐ Don't know month……77 Don't know year……88	
106	How old were you on your last birthday? (MORE OR LESS)	Age (years) ……☐☐	
107	How long have you been living continuously in (Community name)?	Number of years……☐☐ Under one year……77 Lived all her life……88	
108	Can you read and write?	Yes……1 No……2	
109	Have you ever attended school?	Yes……1 No……2 →	111
110	What is the highest level of education that you achieved?	Primary……1 Secondary……2 Higher……3	
111	Do any of your family of birth live close enough by that you can easily see/visit them?	Yes……1 No……2 Living with family of birth……3 →	113
112	How often do you see or talk to a member of your family of birth? Would you say at least once a week, once a month, once a year, or never?	At least once a week……1 At least once a month……2 At least once a year……3 Never (hardly ever)……4	
113	When you need help or have a problem, can you usually count on family members for support?	Yes……1 No……2	

114	**Currently:** Are you married Do you have a partner? IF RESPONDENT HAS A PARTNER ASK	Currently married……1 Currently have a partner.....2 Living with a man , but not married…….....A Currently having a regular partner (sexual relationship) who lives apart…….....B Not currently married nor living with a man (not involved in a sexual relationship)…….. C	→118 →118 →118
115	Have you ever been married or lived with a male partner or had a regular male partner you did not live with?	Yes……1 No…….....2	→ S2
116	Did the **last partnership** end in divorce or separation, or were you widowed?	Divorced……1 Separated/broken up…….....2 Widowed……3	→118
117	Was the divorce/separation initiated by your husband/partner, or did you both decide that you should separate?	Respondent……1 Husband/partner……..2 Both (respondent & partner)…..3 Other:_____.....77	
118	Is this your first marriage/ relationship?	Yes……1 No…….. 2	
119	Does/Did your husband/partner have any other wives while being married (having a relationship) with you?	Yes……1 No…….. 2 Don't know……..77	→122 →122
120	How many wives does/did he have?	Number of wives…… ☐☐ Don't know……..77	→122
121	Are/were you the first, second….. wife?	Position…….....☐☐	
122	Did you choose your current husband/partner, did someone else choose him for you, or did he choose you? **(MARK ALL THAT APPLY)** IF SHE DID NOT CHOOSE HERSELF, PROBE: Did you have a say in the choice of your husband/partner?	Both chose..... A Respondent chose……B Respondent's family chose... C Partner chose.....D Partner's family chose.....E Other:_____..... X Yes……1 No……..2	

123	Did your marriage involve dowry/bride price payment?	Yes/Dowry……...……1 Yes/Bride price……2 No……...……..3 Don't know……77	

SECTION 2 GENERAL HEALTH			
I would like to ask you a few questions about your general health and wellbeing.			
Question no.	**Questions and Filters**	**Coding categories**	**Skip to**
201	In general, would you describe your health as excellent, good, fair, poor or very poor?	Excellent……..……...1 Good……..…….. 2 Fair……..…….. 3 Poor……..…….. 4 Very poor……..……...5	
202	Now I would like to ask you about your health in the **past 4 weeks**. How would you describe your ability to walk around? Would you say that you have no problems, very few problems, some problems, many problems or unable to perform usual activities?	No problems……..……..1 Very few problems……..…….. 2 Some problems…….. 3 Many problems……..…… 4 Unable to walk at all……...5	
203	In the **past 4 weeks** did you have problems with performing usual activities, such as work, study, household, family or social activities?	No problems……..……..1 Very few problems……..……. 2 Some problems……..…... 3 Many problems…….... 4 Unable to perform usual activities……..…… 5	
204	In the **past 4 weeks** have you been in pain or discomfort? Would you say not at all, slight pain or discomfort, moderate, severe or extreme pain or discomfort?	No pain or discomfort……..……1 Slight pain or discomfort…….. 2 Moderate pain or discomfort….3 Severe pain or discomfort..... 4 Extreme pain or discomfort..... 5	
205	In the **past 4 weeks** have you had problems with your memory or concentration? Would you say no problems, very few problems, many problems or extreme memory or concentration problems?	No problems……...1 Very few problems…… 2 Some problems…….. 3 Many problems……... 4 Extreme memory problems….. 5	
206	In the **past 4 weeks**, have you taken medication: a) To help you calm down or sleep? b) To relieve pain? c) To help you not feel sad or depressed?	Yes No a) Calm down/sleep 1 2 b) Relieve pain 1 2 c) For sadness 1 2	
207	In the **past 4 weeks**, did you consult a doctor or other professional or traditional health worker because you were sick? IF YES: whom did you consult? PROBE: Did you also see anyone else?	No one consulted…….. A Doctor…….. B Nurse (Auxiliary)…… C Midwife…… D Counsellor……..E Pharmacist…….. F Traditional healer…….. G Traditional birth attendant…… H Other:_____.....X	

208	The next questions are related to other common problems that may have bothered you in the **past 4 weeks**. If you had the problem in the past 4 weeks, answer YES; if you have not, answer NO. a) Do you often have headaches? b) Is your appetite poor? c) Do you sleep badly? d) Are you easily frightened? e) Do your hands shake? f) Do you feel nervous, tense, stressed or worried? g) Do you have trouble thinking clearly? h) Do you find it difficult to make decisions? i) Do you feel unhappy? j) Do you cry more than usual? k) Do you find it difficult to enjoy daily activities? l) Has your daily work suffered due to any health problems? m) Have you lost interest in things? n) Is your digestion poor? o) Do you have uncomfortable feelings in your stomach? p) Are you easily tired?	 a) Headaches 1 2 b) Appetite 1 2 c) Sleep badly 1 2 d) Frightened 1 2 e) Hands shake 1 2 f) Nervous 1 2 g) Thinking 1 2 h) Decision 1 2 i) Unhappy 1 2 j) Cry more 1 2 k) Not enjoy 1 2 l) Work suffered 1 2 m) Lost interest 1 2 n) Indigestion 1 2 o) Stomach 1 2 p) Easily tired 1 2	Yes No
209	Just now we talked about problems that may have bothered you in the past 4 weeks. I would like to ask you now if, in your life you ever **thought** of ending your life?	Yes……1 No…… 2 → S3	
210	Have you ever **tried** to take your life?	Yes…….. 1 No…… 2	

SECTION 3	INFORMATION ON REPRODUCTIVE HEALTH AND CHILDREN		
Question no.	**Questions and Filters**	**Coding categories**	**Skip to**
301	Now I would like to ask you about all the births that you have had during your life. Have you ever been pregnant?	Yes……1 No……2 Maybe/Not sure……3	 → 309 → 309
302	Have you ever given birth? If yes, PROBE: How many times?	Yes……1 No……2 Number of births……☐☐	 → 307
303	How many of your NATURAL children are living here with you?	Number of children living with respondent……☐☐	
304	How many of your NATURAL children are living elsewhere?	Number of children living elsewhere……☐☐	
305	How many girls and boys do you have? NATURAL CHILDREN	No. of girls……☐☐ No. of boys……☐☐	
306	Have you ever given birth to a boy or a girl who was born alive but later died? This could be at any age?	Boy……1 Girl……2 None……77	
307	How many times have you been pregnant – including pregnancies that did not end in a live birth?	**Total no.** of pregnancies: ☐☐	
308	Have you ever had a pregnancy that miscarried, or ended in a stillbirth? PROBE: How many times did you miscarry, how many times did you have a stillbirth, and how many times did you abort?	Miscarriages……☐☐ Stillbirths……☐☐ Abortions……☐☐ None……77	
309	Are you pregnant now?	Yes……1 No……2 Maybe……3	
310	Have you **ever** used anything, or tried in any way to delay or avoid getting pregnant? IF YES why (are there any particular reasons)?	Yes……1 No……2 Never had intercourse……3 Reason for pregnancy prevention: ……	 → 313 → S4
311	Are you **<u>currently</u>** doing something, or using any method to avoid getting pregnant? IF YES, why do you not want to get pregnant?	Yes……1 No……2	 → 313

312	Does your **current** husband/partner know that you are using a method of family planning?	Yes……..... 1 No..... 2 N/A (No current partner)..... 77	
313	Has/did your **current**/ **most recent** husband/ partner ever refused to use a method or tried to stop you from using a method to avoid getting pregnant?	Yes……..... 1 No..... 2	→ 315
314	In what ways did he let you know that he disapproved of using methods to avoid getting pregnant? **(MARK ALL THAT APPLY)**	Told me he did not approve...A Shouted/got angry…….. B Threatened to beat me.....C Threatened to leave/ throw me out of the home……..... D Beat me/physically assaulted.....E Took or destroyed method….F Other_____..... X	
315	Have you ever used a condom with your current/ most recent partner to prevent disease?	Yes……..... 1 No..... 2	→ S4
316	Have you ever asked your **current**/ **most recent** partner to use a condom?	Yes..... 1 No..... 2	→ S4
317	Has/ did your **current**/**most recent** husband/ partner ever refuse to use a condom to prevent disease?	Yes..... 1 No..... 2	→ S4
318	In what way did he let you know that he disapproved of using a condom? **(MARK ALL THAT APPLY)**	Told me he did not approve...A Shouted/ Got angry…..... B Threatened to beat me…….. C Threatened to leave/ throw me out of the home..... D Beat me/Physically assaulted.....E Took or destroyed method….F Accused me of being unfaithful/ not a good woman……..G Laughed at me/did not take serious……H Said it is not necessary……I Other_____ ……X	

SECTION 4	INFORMATION ON CURRENT OR MOST RECENT PARTNER			
Check questions 114&115, mark what the response is in the appropriate box provided in the adjacent cells to the right and follow the skip pattern	Currently married/Living with a man/Have a partner ☐	Previously married/Previously living with a man/ Previously had a partner ☐	Never married/Never had a partner ☐ → S5	**SKIP TO**

I would like you to tell me a little about your current/most recent husband/partner.

Question no.	Questions and Filters	Coding categories	Skip to
401	How old was your husband/partner on his last birthday?	Age (Years)…….. ☐☐	
402	In what year was he born?	Year…….…… ☐☐☐☐ Don't know…….....77	
403	Can he read and write?	Yes…….....1 No…….……....2	
404	Did he ever attend school?	Yes.....1 No..... 2	→ 406
405	What is the highest level of education that he achieved? What was the highest grade he completed at that level?	Level…….... ☐ Grade……..…..... ☐☐ **Level** 1=Primary 2=Secondary 3=Higher 4=Don't know **Grade** 00=less than 1 year/ not completed 10=Completed 98=Don't know	
406	How often does/did your husband/partner drink alcohol? 1 = Every day or nearly every day 2 = Once or twice a week 3 = 1 – 3 times a month 4 = Occasionally, less than once a month 5 = Never	Every day or nearly every day……1 Once or twice a week..... 2 1 – 3 times in a month..... 3 Less than once a month……4 Never..... 5 Don't know..... 77	→ 409

407	In the past 12 months (In your last relationship), how often have you seen (did you see) your husband/partner drunk? Would you say most days, weekly, once a month, less than once a month, or never?	Most days..... 1 Weekly..... 2 Once a month..... 3 Less than once a month..... 4 Never..... 5	
408	In the past 12 months, or during the last 12 months of your relationship, did you experience any of the following problems in relation to your husband/partner's drinking? a) Money issues b) Family issues c) Any other problems, specify	Yes No a) Money issues 1 2 b) Family issues 1 2 c) Others: _____	
409	How often does/did your husband/partner use drugs (like Heroin, weed, etc.)? 1 = Every day or nearly every day 2 = Once or twice a week 3 = 1-3 times a month 4 = Occasionally, less than once a month 5 = Never	Every day or nearly every day.....1 Once or twice a week..... 2 1-3 times in a month..... 3 Less than once a month..... 4 Never..... 5 Don't know..... 77	
410	Since you have known him, has he ever been involved in a physical fight with another man? The reason for the fight?	Yes.....1 No..... 2 → 412 Don't know.....77 → 412 He initiated the fight..... 1 He was angered by someone..... 2 Other reasons_____ ...88	
411	In the **past 12 months** (in **the last 12 month of the relationship**), has this happened never, once or twice, a few times or many times?	Never.....1 Once or twice.....2 A few (3 – 5) times..... 3 Many (more than 5) times.....4 Don't know..... 77	
412	Has your **current/most recent** husband/partner had a relationship with any other women while being with you?	Yes.....1 No..... 2 May have..... 3 Don't know.....77	

SECTION 5 EMPLOYMENT AND TIME USE			
Question no.	**Questions and Filters**	**Coding categories**	**Skip to**
501	As you know, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. Are you currently involved in any such activity?	Yes……..……...1 No.....2	→ 507
502	Which of these is your MAIN activity? Agriculture/ Farming…….....1 Non-Agriculture.....2		
503	Which of the following best describes the work you do: PROBE ALL ACTIVITIES Salaried? Self employed? Unpaid family worker? Other?	Salaried……A Self employed…….....B Unpaid family worker..... C Other _____ ..... X (Specify)	
504	In your MAIN work, do you work: Throughout the year? Seasonally/Part of the year? Whenever you can find a job?	Throughout the year..... 1 Seasonally/Part of the year.....2 Whenever find a job.....3	
505	In the past 12 months, how many months did you work in your MAIN job? What was your total earning from the work you performed (Amount in Naira)?	Months worked…….. ☐☐ Amount earned _____	
506	What control did you have over the money you earned?	Self/own control……1 Give part to husband/partner at own will…….. 2 Give part to husband/partner against will.....3 Give all to husband/partner at own will.....4 Give all to husband/partner against own will.....5	

507	As a woman, you must be responsible for many of the household activities. Can you please tell me which of these household chores you have done in the past 7 days? Can you tell me how much time you spent, on average, on each one of these activities in the **last** 7 days? How about on average, in **any** 7 days?		**1 = Yes** **2 = No**	Hours spent on average in the **last 7days**	Hours spent on average in **any 7days**	
		Fetching water				
		Fetching firewood				
		Caring for children				
		Ironing				
		Washing				
		Sweeping				
		Washing dishes				
		Washing vehicles				
		Dispose garbage				
		Cooking				
		Shopping for household needs				
		Running errands				
		Other housekeeping activities				

Check questions 114&115, mark what the response is in the appropriate box provided in the adjacent cells to the right and follow the skip pattern	Currently married/Living with a man/Have a partner ☐	Previously married/Previously living with a man/Previously had a partner ☐	Never married/Never had a partner ☐ → S6	**SKIP TO**
508	Does your current or former husband/partner work?	Yes……1 No……2		→ 514
509	Which of these is his MAIN activity? Agriculture/ Farming…..1 Non-Agriculture.....2			
510	Which of the following best describes the work he does: PROBE ALL ACTIVITIES Salaried? Self employed? Unpaid family worker? Other?	Salaried……A Self employed……B Unpaid family worker.....C Other _____ .....X (Specify)		
511	In his MAIN work, does he work: Throughout the year? Seasonally/Part of the year? Whenever he can find a job?	Throughout the year……1 Seasonally/Part of the year……2 Whenever find a job……3		
512	In the past 12 months, how many months did he work in his MAIN job? What was his total earning from the work he has performed (Amount in Naira)?	Months worked…… ☐ Amount earned _____		

513	Does/did your husband/partner give part of these earnings to use for household expenses?		None …….....…….. 1 Part……..... 2 All…….....3			
514	Does/did your husband or partner help you with any of the household chores? Which of the following chores did he help you with in the **last** 7 days? Can you tell me how much time he spent, on average, on each one of these activities in the **last** 7 days? How about on average, in **any** 7 days?		**1 = Yes** **2 = No**	Hours spent on average in the **last 7days**	Hours spent on average in **any 7days**	
		Fetching water				
		Fetching firewood				
		Caring for children				
		Ironing				
		Washing				
		Sweeping				
		Washing dishes				
		Washing vehicles				
		Dispose garbage				
		Cooking				
		Shopping for household needs				
		Running errands				
		Other housekeeping activities				

SECTION 6 ATTITUDE TOWARDS GENDER ROLES			
In this community and elsewhere, people have different ideas about families and what is an acceptable behaviour for men and women in the home. I am going to read you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statements. There are no right or wrong answers.			
Question no.	**Questions and Filters**	**Coding categories**	**Skip to**
601	A good wife obeys her husband even if she disagrees	Agree…… 1 Disagree……2 Don't know..... 77	
602	Family problems should only be discussed with people in the family	Agree……..……..1 Disagree……..2 Don't know……..……...77	
603	It is important for a man to show his wife/partner who is the boss	Agree……..……..1 Disagree……..2 Don't know..... 77	
604	A woman should be able to choose her own friends even if her husband disapproves	Agree……..……..1 Disagree……..2 Don't know……..... 77	
605	It is the wife's obligation to have sex with her husband even if she doesn't feel like it	Agree……..……..1 Disagree……..2 Don't know..... 77	
606	Investing in a male child's education is far more valuable than that of a female	Agree……..... 1 Disagree..... 2 Don't know……77	
607	If a man mistreats his wife, outside agencies should intervene	Agree…… 1 Disagree……...2 Don't know……..... 77	
608	In your opinion, does a man have a good reason to hit his wife if: a) She does not complete her household work to his satisfaction b) She disobeys him c) She refuses to have sexual relations with him d) She asks him whether he has other girlfriends e) He suspects that she is unfaithful f) He finds out that she has been unfaithful	Yes No DK a) Household 1 2 77 b) Disobeys 1 2 77 c) No sex 1 2 77 d) Girlfriends 1 2 77 e) Suspects 1 2 77 f) Unfaithful 1 2 77	
609	In your opinion, should a married woman refuse to have sex with her husband if: a) She doesn't want to b) He is drunk c) He is high on drugs (e.g. Heroin, weed, etc.) d) She is sick e) He mistreats her	Yes No DK a) Not want 1 2 77 b) Drunk 1 2 77 c) High 1 2 77 d) Sick 1 2 77 e) Mistreat 1 2 77	

SECTION 7 RESPONDENT AND HER PARTNER				
Check questions 114&115, mark what the response is in the appropriate box provided in the adjacent cells to the right and follow the skip pattern	Currently married/Living with a man/Have a partner 	Previously married/ Previously living with a man/ Previously had a partner 	Never married/Never had a partner 	**SKIP TO** S8

When two people marry, live together or are in a relationship, they usually share both good and bad moments. I would like to ask you some questions about your current and past relationships and how your husband/partner treats (treated) you. If anyone interrupts us I will change the topic of conversation. I would again like to assure you that your answers will be kept confidential, and that you do not have to answer any questions that you do not want to. May I continue?

701	In general, do (did) you and your (current or most recent) husband/partner discuss the following topics together: a) Things that happened to him in the day b) Things that happened to you in the day c) His worries or feelings d) Your worries or feelings		Yes / No a) His day 1 2 b) Your day 1 2 c) His worries 1 2 d) Your worries 1 2
702	In your relationship with your (current or most recent) husband/partner, how often would you say that you quarrel(ed)?		Never..... 1 Rarely..... 2 Sometimes..... 3 Often..... 4
703	I am now going to ask you about some situations that are true for many women. Thinking about your (current or most recent) husband/partner, would you say it is generally true that he: a) Tries to keep you from seeing your friends b) Tries to restrict contact with your family c) Insists on knowing where you are at all times d) Ignores you and treats you indifferently e) Gets angry if you speak with another man f) Is often suspicious that you are unfaithful g) Expects you to ask his permission before seeking health care for yourself		**Always / Some-times / Never** a) Seeing friends 1 2 3 b) Contact family 1 2 3 c) Wants to know 1 2 3 d) Ignores you 1 2 3 e) Gets angry 1 2 3 f) Suspicious 1 2 3 g) Health care 1 2 3

The next few questions are about things that happen to many women and that your current partner, or any other partner, may have done to you.											
704	Has your current husband/partner ever done any of the following things to you:	A) **(IF YES continue with B. If NO, skip to next item)**		B) Has this happened in the <u>past 12 months</u> **(IF YES, ask C only. If NO ask D only)**		C) <u>In the past 12 months</u> would you say that this has happened once, a few times or many times? **(After answering C, skip D)**			D) <u>Prior to the last 12 months</u> would you say that this has happened once, a few times or many times?		
		YES	NO	YES	NO	Once	Few times	Many times	Once	Few times	Many times
	i. Insulted you or made you feel bad about yourself?	1	2	1	2	1	2	3	1	2	3
	ii. Belittled or humiliated you in front of other people?	1	2	1	2	1	2	3	1	2	3
	iii. Did things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling or smashing things)?	1	2	1	2	1	2	3	1	2	3
	iv. Threatened to hurt you or someone you care about	1	2	1	2	1	2	3	1	2	3

705	Has he or any other partner ever:	A) **(IF YES continue with B. If NO, skip to next item)**		B) Has this happened in the <u>past 12 months</u> **(IF YES, ask C only. If NO ask D only)**		C) <u>In the past 12 months</u> would you say that this has happened once, a few times or many times? **(After answering C, skip D)**			D) <u>Prior to the last 12 months</u> would you say that this has happened once, a few times or many times?		
		YES	NO	YES	NO	Once	Few times	Many times	Once	Few times	Many times
	i. Slapped you or thrown something at you that could hurt you?	1	2	1	2	1	2	3	1	2	3
	ii. Pushed you or shoved you?	1	2	1	2	1	2	3	1	2	3
	iii. Hit you with his fist or with something else that could hurt you?	1	2	1	2	1	2	3	1	2	3
	iv. Kicked, dragged or beaten you up?	1	2	1	2	1	2	3	1	2	3
	v. Chocked or burnt you on purpose?	1	2	1	2	1	2	3	1	2	3
	vi. Threatened to use or actually used a gun, knife or other weapon against you?	1	2	1	2	1	2	3	1	2	3

706	Has he or any other partner ever:	A) **(IF YES continue with B. If NO, skip to next item)**		B) Has this happened in the past 12 months **(IF YES, ask C only. If NO ask D only)**		C) In the past 12 months would you say that this has happened once, a few times or many times? **(After answering C, skip D)**			D) Prior to the last 12 months would you say that this has happened once, a few times or many times?		
		YES	NO	YES	NO	Once	Few times	Many times	Once	Few times	Many times
	i. Physically forced you to have sexual intercourse when you did not want to?	1	2	1	2	1	2	3	1	2	3
	ii. Did you ever have sexual intercourse that was not physically forced on you, but because you were afraid of what he might do?	1	2	1	2	1	2	3	1	2	3
	iii. Did he ever force you to perform a sex act that you found degrading or humiliating?	1	2	1	2	1	2	3	1	2	3
	iv. Did he ever deny you from any sexual activity when you particularly wanted it?	1	2	1	2	1	2	3	1	2	3

Verify if respondent answered YES to any question in 704, 705 or 706 – Tick the appropriate box on the right.		YES, SOME FORM OF VIOLENCE ☐ ↓	NO VIOLENCE ☐ →	SKIP TO S8
No.	**Questions**			
707 I	You said there have been occasions where your husband / partner has hurt you or threatened to hurt you. How many incidents of this nature do you remember in the last 12 months? ☐☐			

707 II	What happened in the last (or if you can remember, the last three) of these incidents? **DO NOT READ FROM THE LIST, MATCH RESPONDENT'S ANSWER TO ALL OPTIONS THAT APPLY**	**INCIDENT 1** Insulted you or made you feel bad about yourself……..... A Belittled or humiliated you in front of other people……..... B Did things to scare or intimidate you on purpose……..... C Threatened to hurt you or someone you care about……..... D Slapped you ……..…….. E Thrown something that could hurt you…….....F Pushed or shoved you..…..... G Hit you with his fist or something else that could hurt..... H Kicked, dragged or beaten you up..... I Chocked or burned you on purpose….. J	**INCIDENT 2** Insulted you or made you feel bad about yourself……..... A Belittled or humiliated you in front of other people……..... B Did things to scare or intimidate you on purpose……..... C Threatened to hurt you or someone you care about……..... D Slapped you ……..…….. E Thrown something that could hurt you…….....F Pushed or shoved you..…..... G Hit you with his fist or something else that could hurt..... H Kicked, dragged or beaten you up..... I Chocked or burned you on purpose….. J	**INCIDENT 3** Insulted you or made you feel bad about yourself……..... A Belittled or humiliated you in front of other people……..... B Did things to scare or intimidate you on purpose……..... C Threatened to hurt you or someone you care about……..... D Slapped you ……..…….. E Thrown something that could hurt you…….....F Pushed or shoved you..…..... G Hit you with his fist or something else that could hurt..... H Kicked, dragged or beaten you up…….....I Chocked or burned you on purpose….. J

		Threatened to use, or actually used a gun, knife or other weapon on you ……..... K Forced you to do something sexual that you found degrading or humiliating..... L You had sexual intercourse because you were afraid of what he might do ……..M Physically forced you to have sexual intercourse when you did not want..... N			Threatened to use, or actually used a gun, knife or other weapon on you..... K Forced you to do something sexual that you found degrading or humiliating..... L You had sexual intercourse because you were afraid of what he might do.....M Physically forced you to have sexual intercourse when you did not want…... N			Threatened to use, or actually used a gun, knife or other weapon on you..... K Forced you to do something sexual that you found degrading or humiliating…... L You had sexual intercourse because you were afraid of what he might do…..... M Physically forced you to have sexual intercourse when you did not want.....N		
707 III	Did you have any physical or sexual injuries after this incident? **Any psychological issues will be dealt with later in the questionnaire**	**INCIDENT 1** Yes…….....1 No……..... 2 →	707V		**INCIDENT 2** Yes…….....1 No……..... 2 →	707V		**INCIDENT 3** Yes……..…….....1 No……..…….....2 →	707V	
707 IV	What was the nature of the injury you had?	**INCIDENT 1**	YES	NO	**INCIDENT 2**	YES	NO	**INCIDENT 3**	YES	NO
		a) Cuts, Punctures, Bites	1	2	a) Cuts, Punctures, Bites	1	2	a) Cuts, Punctures, Bites	1	2
		b) Scratches, Abrasions, Bruises	1	2	b) Scratches, Abrasions, Bruises	1	2	b) Scratches, Abrasions, Bruises	1	2
		c) Sprains, Dislocations	1	2	c) Sprains, Dislocations	1	2	c) Sprains, Dislocations	1	2
		d) Burns	1	2	d) Burns	1	2	d) Burns	1	2
		e) Penetrating injury, Deep cuts, Gashes	1	2	e) Penetrating injury, Deep cuts, Gashes	1	2	e) Penetrating injury, Deep cuts, Gashes	1	2
		f) Broken eardrum, eye injury	1	2	f) Broken eardrum, eye injury	1	2	f) Broken eardrum, eye injury	1	2

		g) Fractured/Broken bones h) Broken teeth i) Vaginal pain or discomfort j) Other _____....77	1 1 1	2 2 2	g) Fractured/Broken bones h) Broken teeth i) Vaginal pain or discomfort j) Other _____....77	1 1 1	2 2 2	g) Fractured/Broken bones h) Broken teeth i) Vaginal pain or discomfort j) Other _____.....77	1 1 1	2 2 2
707 V	Did you receive healthcare after this incident?	**INCIDENT 1** Yes…….....1 No……..…….....2 →	707VII		**INCIDENT 2** Yes……..…….....1 No……..…….....2 →	707VII		**INCIDENT 3** Yes……..... 1 No……..... 2 →	707VII	
707 VI	Did you go to: How much total money did you have to spend?	**INCIDENT 1** Hospital…….....	YES 1	NO 2	**INCIDENT 2** Hospital…….....	YES 1	NO 2	**INCIDENT 3** Hospital…….....	YES 1	NO 2
		Chemist.....	1	2	Chemist.....	1	2	Chemist.....	1	2
		Dentist……..……....	1	2	Dentist……..……....	1	2	Dentist……..……....	1	2
		Traditional healer….....	1	2	Traditional healer….....	1	2	Traditional healer….....	1	2
		Other: _____…...77 Amount spent on: a) Service: _____ b) Transport: _____ c) Medicine: _____			Other: _____…..77 Amount spent on: a) Service: _____ b) Transport: _____ c) Medicine: _____			Other: _____…..77 Amount spent on: a) Service: _____ b) Transport: _____ c) Medicine: _____		

707 VII	Did you have to take time off work after this incident?	**INCIDENT 1** Yes……..1 No……..2 →	707IX			**INCIDENT 2** Yes……..1 No……..2 →	707IX			**INCIDENT 3** Yes……..1 No……..2 →	707IX
707 VIII	How many days did you have to take off because of this incident? Did you still get paid during the days you had to take off work?	**INCIDENT 1** No. of days off…..☐☐ Yes……..1 No……..2				**INCIDENT 2** No. of days off…..☐☐ Yes……..1 No……..2				**INCIDENT 3** No. of days off…..☐☐ Yes……..1 No……..2	
707 IX	Did you have to stop housework after this incident?	**INCIDENT 1** Yes……..1 No……..2 →	707XIV			**INCIDENT 2** Yes……..1 No……..2 →	707XIV			**INCIDENT 3** Yes……..1 No……..2 →	707XIV
707 X	What are the types of work you had to forego?	**INCIDENT 1** Caring for children….. **YES** 1 **NO** 2 →	707-XIII			**INCIDENT 2** Caring for children….. **YES** 1 **NO** 2 →	707-XIII			**INCIDENT 3** Caring for children….. **YES** 1 **NO** 2 →	707-XIII

707 XI	You said you could not take care of the children, were they fed by someone else or fed themselves?	**INCIDENT 1** Fed by someone else…………..…..... 1 Fed themselves…..……....…………... 2 Fed by you, but food was of poor quality.. 3 Went hungry……..…………….…...... 4			**INCIDENT 2** Fed by someone else…………....…......1 Fed themselves…..……....……..…...... 2 Fed by you, but food was of poor quality...3 Went hungry……..……………….......... 4			**INCIDENT 3** Fed by someone else……………....…....1 Fed themselves…..……..……..…..........2 Fed by you, but food was of poor quality...3 Went hungry……..……………...…........4		
707 XII	Did any of your children have to miss school after this incident? IF YES how many school days did they miss?	**INCIDENT 1** Yes………...…........…………............1 No…………………..……….........…....... 2 IF YES, Number of school days missed………..........…..…..…. ☐☐			**INCIDENT 2** Yes………...…..........………...............1 No…………………..……...…................. 2 IF YES, Number of school days missed……….............…….......☐☐			**INCIDENT 3** Yes………....….......………...…………....1 No…………………..………............…......2 IF YES, Number of school days missed……….............……........☐☐		
707XIII	What are the other types of work you had to forego?	**INCIDENT 1**	**YES**	**NO**	**INCIDENT 2**	**YES**	**NO**	**INCIDENT 3**	**YES**	**NO**
		a) Fetching water…….............	1	2	a) Fetching water…….............	1	2	a) Fetching water…….............	1	2
		b) Fetching firewood…...........	1	2	b) Fetching firewood…............	1	2	b) Fetching firewood…............	1	2
		c) Ironing….............	1	2	c) Ironing…..….........	1	2	c) Ironing……...........	1	2
		d) Washing clothes….............	1	2	d) Washing clothes……............	1	2	d) Washing clothes…….........	1	2
		e) Sweeping….........	1	2	e) Sweeping….........	1	2	e) Sweeping…...........	1	2
		f) Washing dishes…….........	1	2	f) Washing dishes…….............	1	2	f) Washing dishes……...........	1	2

		g) Washing vehicle…….....	1	2	g) Washing vehicle…….....	1	2	g) Washing vehicle…….....	1	2
		h) Dispose garbage.....	1	2	h) Dispose garbage.....….....	1	2	h) Dispose garbage.....	1	2
		i) Cooking…..….....	1	2	i) Cooking….....	1	2	i) Cooking…..……	1	2
		j) Caring for sick……....	1	2	j) Caring for sick……....	1	2	j) Caring for sick……....	1	2
		k) Shopping/household needs.....	1	2	k) Shopping/ household needs...	1	2	k) Shopping/ household needs...	1	2
		l) Running errands.....	1	2	l) Running errands….....	1	2	l) Running errands…..….....	1	2
		Other housework:			Other housework:			Other housework:		
707 XIV	Did your husband/ partner have to take time off from work after this incident?	**INCIDENT 1** Yes……..……1 No……..…..…..…2 → 707XVI			**INCIDENT 2** Yes……..... 1 No…….....2 → 707XVI			**INCIDENT 3** Yes……....1 No……..…..… 2 → 707XVI		
707 XV	How many days did he (your husband/ partner) have to take off because of this incident? Did he get paid for the days he had to take off from work?	**INCIDENT 1** No. of days off…..…….…..…..... ☐☐ Yes…….....1 No…….....2			**INCIDENT 2** No. of days off…..…….…..…..... ☐☐ Yes…….....1 No…….....2			**INCIDENT 3** No. of days off…..…….…… ☐☐ Yes…….....1 No…….....2		

707 XVI	Did your husband/ partner have to stop or reduce the work he usually does around the house?	**INCIDENT 1** Yes……………..……..1 No…………..……….... 2 → 707XVIII			**INCIDENT 2** Yes………....……........1 No………...……….......2 → 707XVIII			**INCIDENT 3** Yes………....……....... 1 No…………...……...... 2 → 707XVIII		
707 XVII	What are the types of work he had to forego?	**INCIDENT 1**	YES	NO	**INCIDENT 2**	YES	NO	**INCIDENT 3**	YES	NO
		a) Fetching water…......	1	2	a) Fetching water…........	1	2	a) Fetching water….........	1	2
		b) Fetching firewood.....	1	2	b) Fetching firewood.......	1	2	b) Fetching firewood.......	1	2
		c) Caring for children....	1	2	c) Caring for children......	1	2	c) Caring for children.......	1	2
		d) Ironing……………........	1	2	d) Ironing……………..........	1	2	d) Ironing……………..........	1	2
		e) Washing clothes…...	1	2	e) Washing clothes…......	1	2	e) Washing clothes…......	1	2
		f) Sweeping………......	1	2	f) Sweeping………..........	1	2	f) Sweeping………..........	1	2
		g) Washing dishes….....	1	2	g) Washing dishes….......	1	2	g) Washing dishes….…...	1	2
		h) Washing vehicle…...	1	2	h) Washing vehicle…......	1	2	h) Washing vehicle…......	1	2
		i) Dispose garbage…...	1	2	i) Dispose garbage….....	1	2	i) Dispose garbage….....	1	2
		j) Cooking……..…….....	1	2	j) Cooking……..……........	1	2	j) Cooking……..…….....	1	2
		k) Caring for sick…..…	1	2	k) Caring for sick…..…...	1	2	k) Caring for sick…..…...	1	2
		l) Shopping/household needs…….............	1	2	l) Shopping/household needs….................…	1	2	l) Shopping/household needs…...................…	1	2
		m) Running errands…...	1	2	m) Running errands…......	1	2	m) Running errands…......	1	2
		n) Other housework…..	1	2	n) Other housework….....	1	2	n) Other housework….....	1	2
707 XVIII	Did you go to the police and/or file a formal complaint after this incident?	**INCIDENT 1** Yes…..………….......1 No…………...…..... 2 → 707XXII			**INCIDENT 2** Yes…..………………1 No……………...…......2 → 707XXII			**INCIDENT 3** Yes…..………….…... 1 No…………...……..... 2 → 707XXII		

707 XIX	Did you pay for transport to get to the police station? If YES how much did you pay?	**INCIDENT 1** Yes……1 How much was the transport cost: _____ No……2	**INCIDENT 2** Yes……1 How much was the transport cost: _____ No……2	**INCIDENT 3** Yes……1 How much was the transport cost: _____ No……2
707 XX	Did you have to pay the police any money? If YES how much did you pay them?	**INCIDENT 1** Yes……1 Amount paid: _____ No……2	**INCIDENT 2** Yes……1 Amount paid: _____ No……2	**INCIDENT 3** Yes……1 Amount paid: _____ No……2
707 XXI	Did the complaint go to court? If YES, did you pay any court, lawyer fees?	**INCIDENT 1** Yes……1 Amount paid? Court fees: _____ Lawyer: _____ Transport: _____ No……2	**INCIDENT 2** Yes……1 Amount paid? Court fees: _____ Lawyer: _____ Transport: _____ No……2	**INCIDENT 3** Yes……1 Amount paid? Court fees: _____ Lawyer: _____ Transport: _____ No……2

707 XXII	Did you leave the house after this incident?	**INCIDENT 1** Yes……..... 1 No……..... 2 →	707XXIV		**INCIDENT 2** Yes……..... 1 No……..... 2 →	707XXIV		**INCIDENT 3** Yes……..... 1 No……..... 2 →	707XXIV	
707 XXIII	Where did you go when you left the house? How many days did you spend there? Did you have to pay any money to stay there? If YES how much did you have to pay per day?	**INCIDENT 1** Shelter…..……..….. Family……..….. Friends…..……. Others : _____ ...77 No. of days away from home..... ☐☐☐ Yes…….....1 Daily rate: _____ No…….....2	YES 1 1 1	NO 2 2 2	**INCIDENT 2** Shelter…..……..….. Family……..….. Friends…..……..……. Others : _____ .....77 No. of days away from home……... ☐☐☐ Yes…….....1 Daily rate: _____ No…….....2	YES 1 1 1	NO 2 2 2	**INCIDENT 3** Shelter…..……..….. Family……..….. Friends…..……..……. Others : _____ .....77 No. of days away from home…..…..☐☐☐ Yes…..…..…….....1 Daily rate: _____ No…….....2	YES 1 1 1	NO 2 2 2
707 XXIV	Did you go to any other authorities in the community after this incident?	**INCIDENT 1** Yes…….....1 No……..…….....2 →	707XXVI		**INCIDENT 2** Yes…….....1 No……..…….....2 →	707XXVI		**INCIDENT 3** Yes…….....1 No……..…….....2 →	707XXVI	

707 XXV	Were there any costs related to this action? If YES, how much?	**INCIDENT 1** Some amount of money was paid? Yes…….....1 Fees: _____ Transport: _____ No…….....2			**INCIDENT 2** Some amount of money was paid? Yes…….....1 Fees: _____ Transport: _____ No…….....2			**INCIDENT 3** Some amount of money was paid? Yes…….....1 Fees: _____ Transport: _____ No…….....2		
707 XXVI	I know that these are difficult experiences to deal with. Did you feel any of the following because of this incident?	**INCIDENT 1**	YES	NO	**INCIDENT 2**	YES	NO	**INCIDENT 3**	YES	NO
		a) Your daily work suffered……....	1	2	a) Your daily work suffered……....	1	2	a) Your daily work suffered……....	1	2
		b) Felt unable to play a useful part in life….....	1	2	b) Felt unable to play a useful part in life….....	1	2	b) Felt unable to play a useful part in life….....	1	2
		c) Found it difficult to enjoy daily activities.....	1	2	c) Found it difficult to enjoy daily activities.....	1	2	c) Found it difficult to enjoy daily activities.....	1	2
		d) Had the thought of ending your life.....	1	2	d) Had the thought of ending your life.....	1	2	d) Had the thought of ending your life.....	1	2

707XXVII	IF YES to any of the questions above (707 XXVI), did you seek healthcare or other forms of support or therapy to soothe the difficulties?	**INCIDENT 1** a) Medical or psychological therapy..... b) Traditional healer... c) Others:	YES 1 1	NO 2 2	**INCIDENT 2** a) Medical or psychological therapy..... b) Traditional healer..... c) Others:	YES 1 1	NO 2 2	**INCIDENT 3** a) Medical or psychological therapy..... b) Traditional healer..... c) Others:	YES 1 1	NO 2 2
707XXVIII	Was any cost involved in the treatment or therapy? IF YES, how much?	**INCIDENT 1** Yes……..... 1 Amount paid: _____ No……..... 2			**INCIDENT 2** Yes……..... 1 Amount paid: _____ No……..... 2			**INCIDENT 3** Yes……..... 1 Amount paid: _____ No……..... 2		
707XXIX	We have talked about various fees and other costs you had to bear. Did you pay for all these fees out of your own pocket or did others pay for some of the fees?	**INCIDENT 1** Self……..... 1 Husband/ Partner……..... 2 Natal family……..... 3 Self and husband/ partner…..... 4 Self and natal..... 5 Husband/ Partner and natal..... 6			**INCIDENT 2** Self……..... 1 Husband/ Partner..... 2 Natal family……..... 3 Self and husband/ Partner…..... 4 Self and natal..... 5 Husband/ Partner and natal..... 6			**INCIDENT 3** Self……..... 1 Husband/ Partner..... 2 Natal family……..... 3 Self and husband/ Partner…..... 4 Self and natal..... 5 Husband/ Partner and natal..... 6		

SECTION 8 COMPLETION OF INTERVIEW		
801	We have now finished the interview. Do you have any comments, or is there anything else you would like to add? _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
802	I have asked you about many difficult things. How has talking about these things made you feel?	Good/Better……..... 1 Bad/Worse……..... 2 Same/No difference……..... 3

FINISH (A) – IF RESPONDENT HAS DISCLOSED PROBLEMS/VIOLENCE

Finally, I would like to thank you very much for helping with this research. I appreciate the time you have taken. I realise that these questions may have been difficult for you to answer, but it is only by hearing from women themselves that we can have a better understanding of their health and experiences of violence.

From what you have told me, I can tell that you have had some difficult times in your life. No one has the right to treat someone else in that way. However, from what you have told me I can see that you are strong, and have survived through some difficult circumstances.

Here is a list of organisations that provide support, legal advice and counselling services to women in Kwara State. Please do contact them if you would like to talk over your situation with anyone. Their services are free, and they will keep anything that you say private. You can go whenever you feel ready to, either soon or later on.

FINISH (B) – IF RESPONDENT HAS NOT DISCLOSED PROBLEMS/VIOLENCE

Finally, I would like to thank you very much for helping with this research. I appreciate the time that you have taken. I realise that these questions may have been difficult for you to answer, but it is only by hearing from women themselves that we can have a better understanding of their health and experiences in life.

In case you ever hear of another woman who needs help, here is a list of organisations that provide support, legal advice and counselling services to women in Kwara State. Please do contact them if you or any of your friends or relatives need help. Their services are free, and they will keep anything that anyone says to them private.

Appendix2

Survey on Women's Health, Partner Relations, and Life Events in Kwara State, Nigeria/ Ṣísẹ Ìwákiri Ìlera Àwọn Obìnrin Àgbàlagbà, Ìbágbépọ̀, àti ÌṢẹ̀lẹ̀ Ayé wọn ní Ìpílẹ̀ Kwárà, Nàìjíríà

WOMEN'S QUESTIONNAIRE/ Pépà ìbéèrè àwọn Obìnrin

Study Conducted by/ Ẹ̀kọ́ tí a darí rẹ̀ láti ọwọ́
Lateef Olayanju/ Latîifù Ọláyanjú
BIOCORE Applied Research Group, Coventry University, UK/ Ẹgbẹ́ Iṣàmúlò Ìwádìí BIOCORE, Yunifásítì Ti Kòfẹ́ntìrì, YÚKEÈ

INDIVIDUAL CONSENT FORM/ Fóòmù Ìmo Èrò enìkòòkan

Hello, my name is [*]. I am working with [*]. We are conducting a survey in Kwara State to learn about women's health and life experiences. You have been randomly selected (as in a lottery/raffle), and we would very much appreciate your participation in this survey. ẹ nlẹ́ o, orúkọ mi ni [*]. Mò n Ṣisẹ́ pẹ̀lú [*]. A ti fẹnu kò pé láti káàkiri Ìpínlẹ̀ Kwárà láti lè mọ̀ nípa èrò ìlera àti ìrírí ayé àwọn obìrin. A ti wá dijú Ṣà nínú yín (nípa ṢíṢe ìkówójọ onítíkẹ̀ẹ̀tì), àti pé ninú wa á dùn púpọ̀ sí ìkópa yín nínú iṢẹ́ ìṢàwákiri yìí.

This study has been approved by the Kwara State Ministry of Women's Affairs (show copy of letter) and I want to assure you that all of your answers will be kept strictly confidential. All paper records of your name and address will be destroyed once the data has been anonymously transferred into digital format. You have the right to stop the interview at any time, or to skip any questions that you do not want to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk. ẹ̀kọ́ yìí ni a ti fọ̀wọ́ sí láti ọ̀dọ̀ ẹ̀ka tí ó rí sí Èrò ọ̀rọ̀ Àwọn Obìnnrin ní ìjọba Ìpínlẹ̀ Kwárà (fi lẹ́tà ìdánilójú èyí hàn) mo sì fẹ́ mu dáa yín lójú pé gbogbo ìdáhùn yín ni a kò ní gbé fáráyé rí.Gbogbo pépà àkọsílẹ̀ orúkọ yín àti àpèjúwe ilé ìgbé yín ni a ó fàya ní kété tí a bá ti a bá ti fi sínú ẹ̀rọ ìgbàlódé wa ní kọ̀kọ̀. O ní ẹ̀tọ́ láti dá ìfọ̀rọ̀wánilẹ́nuwò yìí dúró ní ìgbàkigbà tí ó bá wù ọ́ tàbí kí o fo ìbéèrè tí o kò bá fẹ́ dáhùn. Díẹ̀ nínú àwọn ìbéèrè yìí lè le láti sọ̀rọ̀ bá Ṣùgbọ́n ọ̀pọ̀ àwọn obìnrin ti rí i gẹ́gẹ́ bí i ohun tí ó wúlò láti ní irú ànfàànì báyìí lá fi sọ̀rọ̀.

Your participation is completely voluntary but your experiences could be very helpful to other women in Nigeria. Ìkópa rẹ ni kò kúkú pọn dandan rárá bí ó bá wù ọ́ ni Ṣùgbọ́ àwọn ìrírí rẹ lè wúlò púpọ̀ fún àwọn obìnrin mìíràn ní Nàìjíríà.

Do you have any questions? Njẹ́ o tilẹ̀ ní ìbéèrè Kankan?
(The interview takes approximately 20 to 30 minutes to complete). Do you agree to be interviewed? (Ìfọ̀rọ̀wánilẹ́nuwò yìí tó bíi ogún sí ọgbọ̀n ìṢẹ́jú láti parí). Ṣé o fara mọ́ kí á fi ọ̀rọ̀ wá ẹ lẹ́nu wò?

NOTE WHETHER RESPONDENT AGREES TO INTERVIEW OR NOT Ṣe àkíyèsí bóyó ẹni tí ọ̀rọ̀ kàn gbà tàbí kò gbà

[ ] DOES NOT AGREE TO BE INTERVIEWED → THANK PARTICIPANT FOR HER TIME AND END INTERACTION
[] Kò gbà kí á fi ọ̀rọ̀ wá òun lẹ́nu wò → Dúpẹ́ Lọ́wọ́ akópa fún àkókó rẹ̀ kì o sì fi òpin sí ìbáraẹnisọ̀rọ̀ náá

[ ] AGREES TO BE INTERVIEWED

Is now a good time to talk?

[ ] Yes [ ] No → THANK PARTICIPANT AND SCHEDULE THE PREFERED TIME (NEW INTERVIEW DATE AND TIME:)

It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

[] GBà kí á fi ọ̀rọ̀ wá òun lénu wò

Asìkò ti tó láti sọ̀rọ̀ bí?

[] Bẹ́ẹ̀ni [] Bẹ́ẹ̀kọ́ → Dúpẹ́ lọ́wọ́ akópa kí ẹ wá àkókò mìíràn tí ó bá rọgbọ (ọjọ́ àti àkoókò tuntun fún ìfọ̀rọ̀wánilẹ́nuwò:)

Ó Ṣe kókó kí á wá kọ̀rọ̀ kan tí a ti lè sọ̀rọ̀. Ṣé ibí yìí náà dára fún ìfọ̀rọ̀wánilẹ́nuwò, àbí ibòmìíràn wà tí ó wù yín láti lọ?

TO BE COMPLETED BY INTERVIEWER/ Kí olùfọ̀rọ̀wálẹ́nuwò parí rẹ̀

I CERTIFY THAT I HAVE READ THE ABOVE CONSENT PROCEDURE TO THE PARTICIPANT. Mo gbà mo sì faramọ pé mo ti ka àkọ̀ọ̀lẹ̀ òkè fún akópa.

NAME/Orúkọ: _____

SIGNATURE/Ìfọwẹ́ọ́sÍ: _____

PRE-INTERVIEW IDENTIFICATION/Ìdánimọ̀ ìbẹ̀rẹ̀ ìfọ̀rọ̀wánilénuwò	
PLACE NAME/Orúkọ Ìlú (Ìlọrin = 1; Ọfà = 2; Ẹrìn-Ilé = 3):	
SITE/AGBÈGBÈ (Rural/Ìgbèríko = 1; Urban/Ìlú nlá = 2):	
WARD NUMBER/Nọ́mbà Wọ́ọ̀dù:	
HOUSEHOLD NUMBER/Nọ́mbà Ojúlé:	
NAME OF HOUSEHOLD'S HEAD/Orúkọ Báálé:	
NAME OF SELECTED WOMAN/Orúkọ Obìnrin tí a yàn:	
LINE NUMBER OF SELECTED WOMAN/ Nọ́mbà ojú-òpó Obìnrin tí a ti yàn (HH SELECTION FORM, Q3):	

INTERVIEWER'S VISIT(S)/ Àwọn ọjọ́ ìbẹ̀wò Olùfọ̀rọ̀wánilẹ́nuwò	1	2	3	FINAL VISIT/ Ìbẹ̀wo tí ó kẹ́yìn
DATE/Ọjọ́, Oṣù àti Ọdún				DAY/ọjọ́ ☐☐ MONTH/OṢù ☐☐ YEAR/ Ọdún ☐☐☐☐ INTERVIEW NUMBER/Nọ́mbà ìfọ̀wánilẹ́nuwò ☐☐☐
INTEVIEWER'S NAME/ Orúkọ Olùfọ̀rọ̀wánilẹ́nuwò				
INTERVIEW RESULT/ Àbájáde Ìfọ̀rọ̀wánilẹ́nuwò: 1. TEMPORARYVISITOR/ Olùbẹ̀wò igbà díẹ̀ → Stop Interview/ Dá Ìfọ̀rọ̀wánilẹ́nuwò Dúró 2. COMPLETED/ Parí 3. NOT AT HOME/ Kò sí ní Ilé 4. POSTPONED/ Sun síwájú 5. REFUSED/ Kọ̀ jálẹ̀ 6. PARTLY COMPLETED/ Parí apá kan 7. INCAPACITATED/ Kò lè Ṣé e tọ́ 8. OTHER (SPECIFY)/ Òmíràn (fi hàn ní pàtó)				
NEXT VISIT/ Ìbẹ̀wò tí ó tẹ̀le: DATE/ ọjọ́, oṢù, ọdún TIME/ Àkókò				TOTAL NUMBER OF VISITS/ Àròpọ̀ gbogbo ìbẹ̀wò ☐

SECTION/ ÌPÍN 1	INFORMATION ON RESPONDENT AND HER COMMUNITY/ Ìfitónilétí nípa Abẹ́nà ìmọ̀ àti Àdúgbò rẹ̀		
Question no / Nọ́mbà ìbéèrè	**Questions and Filters/ Ìbéèrè àti ÀṢàtúnṢà**	**Coding categories/ Ipele oníkóòdù**	**Skip to/ Fi sílẹ̀ lọ sí**
If you do not mind, I would like to start by asking you a little about (community name)/ Tí ẹ kò bá lòdì sí i, màá fẹ́ láti bẹ̀rẹ̀ nípa bíbi yín ní Ṣókí nípa (Orúkọ Àdúgbò)			
101	Do neighbours in (Community name) generally tend to know each other well? / Njẹ́ àwọn aládùúgbò ní (orúkọ Àdúgbò) máa n mọra dáradára?	Yes/ Bẹ́ẹ̀ni.....1 No/ Rárá..... 2 Don't know/ kò mò..... 77	
102	If there were a street fight in (Community name) would people generally do something to stop it? / Bí ìjà àdúgbò bá Ṣẹlẹ̀ ní (orúkọ Àdúgbò) Ṣé àwọn ènìyàn lápapọ̀ máa n Ṣe ohunkóhun láti dáwọ́ rẹ̀ dúrò?	Yes/ Bẹ́ẹ̀ni .....1 No/ Rárá .....2 Don't know/ kò mò 77	
103	In this neighbourhood do most people generally trust one another in matters of lending and borrowing things? / Ní àdúgbò yìí, ṣé àwọn ènìyàn lápapọ̀ máa n gbàbọ́ nínú ara wọn láti yá ara wọn ní nnkàn?	Yes/ Bẹ́ẹ̀ni .....1 No/ Rárá .....2 Don't know/ kò mò 77	
104	If someone in your family suddenly fell ill or had accident, would your neighbours offer to help? / Bí ẹnìkan nínú ìdílé yìn bá káàárẹ̀ tàbí ní ìjàmbá, Ṣé àwọn aládùúgbò máa n Ṣe ìrànlọ́wọ́?	Yes/ Bẹ́ẹ̀ni .....1 No/ Rárá .....2 Don't know/ kò mò 77	
105	I would like to ask you some questions about yourself. What is your date of birth (month, and year that you were born)? / Mà á fẹ́ láti bèèrè àwọn ìbéèrè kan lọ́wọ́ ọ yín nípa ara yín. Kín ni ọjọ́ orí yín (oṣù, àti ọdún tí wọn bíi yín)?	Month/ Oṣù.....☐☐ Year/ ọdún.....☐☐☐☐ Don't know month/ Kò mò oṣù... 77 Don't know year/ Kò mò ọdún.....88	
106	How old were you on your last birthday? (MORE OR LESS) / ọmọ ọdún mélòó ni yín ní ọjọ́-ìbí tí ẹ Ṣe kẹ́yìn? (tayọ ni àbí yọkù)	Age (years)/ọjọ́ orí (ọduún).. ☐☐	
107	How long have you been living continuously in (Community name)? / Ó ti tó ìgbà wo tí ẹ ti n gbé ní (Orúkọ Àdúgbò) yìí?	Number of years/Iye ọdú.....☐☐ Under one year / Lááárín ọdún kan.....77 Lived all her life/ Ti gbé gbogbo ayé re níbẹ̀..... 88	

108	Can you read and write? / Ṣé ẹ lè kọ̀wé tàbí kàwé?	Yes/ Bẹ́ẹ̀ni..... 1 No/ Rárá..... 2	
109	Have you ever attended school? / Njẹ́ ẹ tilẹ lọ sí ilé-ìwé rí?	Yes/ Bẹ́ẹ̀ni..... 1 No/ Rárá.....2 →	111
110	What is the highest level of education that you achieved? / Ipele ẹ̀kọ́ ilé-ìwé wo ló ga jù ẹ ti dé?	Primary/ Alákọ̀ọ́bẹ̀rẹ̀.....1 Secondary/ Girama.....2 Higher/ Ilé-ìwé gíga.....3	
111	Do any of your family of birth live close enough by that you can easily see/visit them? / Njẹ́ ọ̀kankan nínú àwọn ìdílé tilẹ n gbé ní àrọ́wọ́tó tí ẹ fi lè bẹ̀ wọ́n wò?	Yes/ Bẹ́ẹ̀ni..... 1 No/ Rárá..... 2 Living with family of birth/ Mò n gbé pẹ̀lú ìdílé mi ni..... 3 →	113
112	How often do you see or talk to a member of your family of birth? Would you say at least once a week, once a month, once a year, or never? / Ó máa n tó ìgbà mélòó tí ẹ fi n bá ọ̀kankan nínú ìdílé yín sọ̀rọ̀? Ṣé ẹ ma sọ pé ẹ̀ẹ̀kan lọ́ṣẹ̀, ẹ̀ẹ̀kan lóṣù, ẹ̀ẹ̀kan lọ́dún tàbí ẹ kò tilẹ kìí bá wọn sọ̀rọ̀ rárá?	At least once a week/ ẹ̀ẹ̀kan Lọ́ṣẹ̀.....1 At least once a month/ ẹ̀ẹ̀kan Lóṣù ..... 2 At least once a year/ ẹ̀ẹ̀kan Lọ́dún..... 3 Never (hardly ever)/ N kò tilẹ kí bá wọn sọ̀rọ̀ rárá.....4	
113	When you need help or have a problem, can you usually count on family members for support? /Tí ẹ bá nílò ìrànlọ́wọ́ tàbí ẹ ní ìṣòro, njẹ́ ẹ tilẹ máa n rò ó pé àwọn ìdílé yín wà níbẹ́ fún un yín?	Yes/ Bẹ́ẹ̀ni..... 1 No/ Rárá..... 2	
114	**Currently/ Lọ́wọ́lọ́lọ́ báyìí:** Are you married? / Njẹ́ ẹ ti ṣe ìgbáyàwó? Do you have a partner? / Ṣé ẹ ní àfẹ́ṣọ́nà? IF RESPONDENT HAS A PARTNER ASK/ tí olùfọ̀rọ̀wálénuwòbá ní ọkọ, ẹ bí i	Currently married / Wà nílé ọkọ..... 1 → Currently have a partner / Ní àfẹ́ṣọ́nà.....2 Living with a man, but not Married / N gbé pẹ̀lú ọkùnrin ṣùgbọ́n kò tíì ṣe ìgbéyàwó..... A → Currently having a regular partner (sexual relationship) who lives apart / Ní ẹnìkan tí (ó n bá sùn) à kò gbé papọ̀.....B → Not currently married nor living with a man (not involved in a sexual relationship) / Kò tí ì gbéyàwó kò sì gbé pẹ̀lú ọkùnrin (kò tilẹ ní alábàásùn).....3	118 118 118

115	Have you ever been married or lived with a male partner or had a regular male partner you did not live with? / Njé o tilè ti ṣe ìgbéyàwó rí tàbí gbé pèlú ọkùnrin kan tàbí ní ọ̀kùnrin kan bí i àfẹ́ṣọ́nà tí o kò gbé pèlú rẹ̀?	Yes/ Bẹ́ẹ̀ni..... 1 No/ Rárá..... 2 → S2	
116	Did the **last partnership** end in divorce or separation, or were you widowed? / Ṣé ìbágbépọ̀ yín parí sí ìjáwèé fún un àbí ìkọ̀sílẹ̀ ni tàbí opó?	Divorced/ Jáwèé fún un.....1 Separated/broken up / Ìkọ̀sílẹ̀/ ìyapa.....2 Widowed/ Opó..... 3 → 118	
117	Was the divorce/separation initiated by your husband/partner, or did you both decide that you should separate? / Ṣé ìkọra/ìyapa yín wáyé láti ọdọ̀ ọkọ àbí àjọmọ̀ èyin méjèèjì ni?	Respondent / Olùfọ̀rọ̀wálẹ́nuwò.....1 Husband/partner / ọkọ..... 2 Both (respondent & partner)/ èyin méjèèjì..... 3 Other:/Òmíràn _____ 77	
118	Is this your first marriage/ relationship? / Ṣé ìgbé-ayé lọ́kọ-láya àkọ́kọ́ yín nìyí?	Yes/ Bẹ́ẹ̀ni.....1 No/ Rárá.....2	
119	Does/Did your husband/partner have any other wives while being married (having a relationship) with you? / Ṣé ọkọ rẹ ní ìyàwó mìíràn léyìn rẹ nígbà tí ẹ fẹ́ ara yín tán?	Yes/ Bẹ́ẹ̀ni..... 1 No/ Rárá..... 2 → 122 Don't know/ Kò mọ̀..... 77 → 122	
120	How many wives does/did he have? / Ìyàwó mélòó ni ọkọ rẹ ní?	Number of wives/ Iye Ìyàwó..... ☐☐ Don't know/ Kò mọ̀..... 77 → 122	
121	Are/were you the first, second...wife? / Ṣé ìyàwó àkọ́fẹ́ ni yín ni àbí ìkejì...?	Position/ Ipò.....☐☐	

122	Did you choose your current husband/partner, did someone else choose him for you, or did he choose you? / Njẹ́ fúnrara à rẹ ni o yẹn ọkọ rẹ, Ṣé wọ́n yẹn ẹ́n fún ọ ni àbí òun gangan ló yẹn ọ́ ní àyò. **(MARK ALL THAT APPLY/Sàmì sí gbogbo èyí tí ó yẹ)** IF SHE DID NOT CHOOSE HERSELF, PROBE/Tí kò bá yẹn fúnrara rẹ, bi í síwájú: Did you have a say in the choice of your husband/partner? / Njẹ́ ìwọ gangan lẹ́nu nínú yíyẹn ọkọ rẹ.	Both chose/ èyin méjèèjì lẹ yẹn ara yín..... A Respondent chose/ Olùfọ̀rọ̀wálẹ́nuwò ló yẹn fúnrara rẹ..... B Respondent's family chose/ Ìdílé olùfọ̀rọ̀wálẹ́nu wò ló yẹn..... C Partner chose/ ọkọ ló yẹn ..... D Partner's family chose/ Ìdílé ọkọ ló yẹn..... E Other/Òmíràn:_____ ..... X Yes/ Bẹ́ẹ̀ni..... 1 No/ Rárá..... 2	
123	Did your marriage involve dowry/bride price payment? / Njẹ́ ìgbeyàwó yín la owó orí ìyàwó/nnkan ìdána lọ bí?	Yes/ Dowry Bẹ́ẹ̀ni/ Nnkan Ìdána..... 1 Yes/ Bride price Bẹ́ẹ̀ni/ owó orí ìyawo..... 2 No/ Rárá..... 3 → S2 Don't know/ Kò mọ̀..... 77 → S2	

SECTION/ ÌPÍN 2 GENERAL HEALTH/ Èto ilera lápapò			
I would like to ask you a few questions about your general health and wellbeing. Màá fẹ láti bi yín ní ìbéèrè díẹ nípa lápapò àti ìgbé-ayé ìrọ̀run.			
Question no / Nọ́mbà Ìbéèrè.	**Questions and Filters/ Ìbéèrè àti Àṣàtúnṣà**	**Coding categories/ Ipele oníkóòdù**	**Skip to /Fi sílẹ̀ lọ sí**
201	In general, would you describe your health as excellent, good, fair, poor or very poor? / Lápapò, njẹ́ wàá ṣe àpèjúwe ìlera rẹ gégé bíi èyí tí ó dára gidi, ó dára, ó ṣé faramọ́, ó burú tàbí ó burú jáì?	Excellent/ Ó dára gidi…..... 1 Good/ Ó dára…..…… 2 Fair/ Ó ṣé Fara mọ́…… 3 Poor/ Ó burú…..…….... 4 Very poor/ Ó burú jáì…..... 5	
202	Now I would like to ask you about your health in the **past 4 weeks** . How would you describe your ability to walk around? Would you say that you have no problems, very few problems, some problems, many problems or unable to perform usual activities? / Ní báyìí, màá fẹ́ bèèrè nípa ìlera yín láti **òsè mérin séyìn**. Báwo ni ẹ ṣe fẹ́ ṣe àpèjúwe bí ẹ Ṣe lè rìn kiri tó? Ṣé ẹ máa sọ wí pé kò sí ìṢòro, ní ìwọ̀nba ni, àwọn ìṢoro díẹ̀, ìṣòro tó pọ̀ ni àbí ẹ kò lè ṣe bí ẹ ṣe n ṣe tẹ́lẹ̀?	No problems/ Kò sí ìṣòro…….... 1 Very few problems/ Ìṣòro níwọ̀nba..... 2 Some problems/ Àwọn ìṣòro díẹ̀.....…….. 3 Many problems/ Ìṣòro púpọ̀…..…….. 4 Unable to walk at all/ ẹ kò tilẹ̀ lè rìn rárá…..... 5	
203	In the **past 4 weeks** did you have problems with performing usual activities, such as work, study, household, family or social activities? / Láti **òsè mérin séyìn,** Ṣé ẹ ní ìṣòro nínú ṣíṣe ohun tí o sábà máa n ṣe, bí i iṣẹ́, ẹ̀kọ́, iṣẹ́ ilé, iṣẹ́ ìdílé/ayeyẹ?	No problems/ Kò sí ìṣòro…….... 1 Very few problems/ Ìṣòro níwọ̀nba..... 2 Some problems/ Àwọn ìṣòro díẹ̀.....…… 3 Many problems/ Ìṣòro púpọ̀…….. 4 Unable to perform usual Activities / ẹ kò tilẹ̀ lè rìn rárá…….. 5	
204	In the **past 4 weeks** have you been in pain or discomfort? Would you say not at all, slight pain or discomfort, moderate, severe or extreme pain or discomfort? /Láti **òsè mérin séyìn,** Ṣé ẹ ti wà nínú ìrora tàbí ìnira? Ṣé ẹ ma sọ pé rárá, ìrora tàbí ìnira kékeré, kò pọ̀ ju ara lọ, ìrora àti ìnira yìí kọjá bẹ́ẹ̀?	No pain or discomfort/ Kò sí ìrora tàbí ìnira rárá…..…1 Slight pain or discomfort/ Ìrora tàbí ìnira kékeré…..... 2 Moderate pain or discomfort / ìrora àti ìnira kò kọjá ara…..3 Severe pain or discomfort/ Ìrora àti ìnira yìí pọ̀..... 4 Extreme pain or discomfort/ Ìrora àti ìnira yìí kọjá Àfẹnusọ...5	

205	In the **past 4 weeks** have you had problems with your memory or concentration? Would you say no problems, very few problems, many problems or extreme memory or concentration problems? /Láti **òsè mérin séyìn,** njé o ni ìṢòro pẹlú ìrántí àti ìfọkànsíbìkan rẹ? Ṣé wàá sọ pé kò sí ìṢòro, ìsòro níwọ̀nba, ìṢoro púpọ̀ tàbí ìṢòro nínú ìrántí àti ìfọkansí tí ó kọjá àfẹnusọ?	No problems/ Kò sí ìṢòro……..1 Very few problems/ ÌṢòro níwọ̀nba..... 2 Some problems/ Àwọn ìṢòro díẹ̀.....3 Many problems/ ÌṢòro púpò.....4 Extreme memory problems/ ÌṢòro nínú ìrántí àti ìfọkansí tí ó kọjá àfẹnuso…… 5	
206	In the **past 4 weeks**, have you taken medication: / Láti **òsè mérin séyìn**, njé ẹ ti lòògùn: d) To help you calm down or sleep? / Láti mú yín· wálẹ̀ tàbí sùn? e) To relieve pain? / Láti dẹ̀kun ìrora? f) To help you not feel sad or depressed? / Láti má mú inú yín bàjẹ́ tàbí mú u yín rẹ̀wèsì?	Yes/ Bẹ́ẹ̀ni / No/ Rárá a) Calm down/sleep Mún un wálẹ̀/sùn 1 2 b) Relieve pain Dẹ̀kun ìrora 1 2 c) For sadness/ Fún ìbànújẹ́ 1 2	
207	In the **past 4 weeks**, did you consult a doctor or other professional or traditional health worker because you were sick? /Láti **òsè mérin séyìn,** Njé ẹ lọ Ṣe àyẹ̀wò bóyá lọ́dọ̀ oníṢègùn òyìnbó tàbí onímọ̀ mìíràn tàbí oníṢègùn ìbílẹ̀ nítorí àìsàn yín? IF YES: whom did you consult? /**Tí ó bá jẹ́ bẹ́ẹ̀ni**: tani ẹ kàn sí? PROBE: Did you also see anyone else? / **Bi í síwájú**: Ṣé o rí ẹlòmìíràn	No one consulted/ Kò sí ẹnikẹ́ni tí a kàn sí.....A Doctor/ OníṢègùn òyìnbó…….. B Nurse (Auxiliary)/ Nọ́ọ̀sì (Amúgbálẹ́gbẹ́ẹ́) …….. C Midwife/ Àgbẹ̀bí òyìnbó…… D Counsellor/ Agbaninímọ̀ràn…..E Pharmacist/ Olóògùn òyìnbó.....….....F Traditional healer/ OníṣègùnÌbílẹ̀…….. G Traditional birth attendant/ Agbẹ̀bí ìbílẹ̀.....…… H Other:/Òmíràn _____ X	

208	The next questions are related to other common problems that may have bothered you in the **past 4 weeks**. If you had the problem in the past 4 weeks, answer YES; if you have not, answer NO. / Awọn ìbéèrè tí ó kàn ni àwọ tí ó jẹ mọ́ ìṣoro tí ó wópò tí ó sì ti n jẹ yín lọ́kàn **láti ọsè mérin séyìn.** Tí o bá ní àwọn ìṢòro yìí **láti ọsè mérin séyìn,** dáhùn **BẹẹNI**; tí ẹ kò bá sì ní, dáhùn **RÁRÁ** a) Do you often have headaches? / Ṣé ẹsábà máa ní èfọ́rí? b) Is your appetite poor? / Ṣé ìfẹ́ sí oúnjẹ yín burú? c) Do you sleep badly? / Ṣé ẹ máa n sun àsùnpinyè? d) Are you easily frightened? /Ṣé èrù máa n tètè é bà yín? e) Do your hands shake?/ Ṣé ọwọ́ rẹ máa n gbọ̀n f) Do you feel nervous, tense, stressed or worried? / Ṣé ẹ máa n gbọ̀n rìrì, pò, ní ìmò.lára rẹ jù tàbí ṣàníyàn ṣá? g) Do you have trouble thinking clearly? / Ṣé ẹ máa n ní ìṣòro nínú ríronú tààrà? h) Do you find it difficult to make decisions? / Njẹ́ ó máa n nira fún un yín láti pinnu? i) Do you feel unhappy? / Ṣé inú yín kìí dùn? j) Do you cry more than usual? / Ṣé ẹ máa n sunkún ju bó ṣe yẹ lọ? k) Do you find it difficult to enjoy daily activities? / Ṣé ó máa n nira fún un yín láti gbádùn àwọn áápọn ojúmọ́? l) Has your daily work suffered due to any health problems? / Ṣé iṣẹ́ ojúmọ́ yín tilẹ̀ máa n fara gba nítorí àìlera yín? m) Have you lost interest in things? / Ṣé ẹ ti sọ ìfẹ́ sí àwọn nnkan nù? n) Is your digestion poor? / Ṣé dídà oúnjẹ nínú yín burú? o) Do you have uncomfortable feelings in your stomach? / Ṣé ẹ tilẹ̀ máa n ní àwọn ìnira kan nínú ikùn yín? p) Are you easily tired? / Ṣé ó máa n tètè é rẹ̀ yín?	a) Headaches/ èfọ́rí b) Appetite/ Ìfẹ́ sí oúnjẹ c) Sleep badly/ Oorun àsùnpinyè d) Frightened/ Ìbẹ̀rù e) Hands shake / ọwọ́ máa n gbọ̀n f) Nervous/ Gbọ̀n rìrì g) Thinking/ Ìrònú h) Decision/ Ìpinnu i) Unhappy/ Ìbànújẹ́ j) Cry more/ Sunkun jù k) Not enjoy/ Kìí gbádùn l) Work suffered/ Isẹ́ máa n fara gba m) Lost interest/ Sọ ìfẹ́ sí nnkan nù n) Indigestion/ Oúje kìí dà o) Stomach/ ìnira ikùn p) Easily tired/ Títètè rẹ̀	Yes/ Bẹ́ẹ̀ni 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No/ Rárá 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	

209	Just now we talked about problems that may have bothered you in the past 4 weeks. I would like to ask you now if, in your life you ever **thought** of ending your life? / Ní ìsinsìí yìí ni a sọ̀rọ̀ nípa àwọn ìṢòro tí ó lè má jẹ yín lọ́kàn láti ọ̀ṣẹ̀ mẹ́rin sẹ́yìn. Màá fẹ́ bi yín báyìí bóyá ní ayé yín ẹ ti rò ó láti fòpin sí ayé yín?	Yes/ Bẹ́ẹ̀ni……..1 No/ Rárá…….. 2 → S3	
210	Have you ever **tried** to take your life? / Njẹ́ ẹ ti gbìyẹ̀njú àti gba ẹ̀mí ara yín rí?	Yes/ Bẹ́ẹ̀ni …….....1 No/ Rárá …….. 2	

SECTION/ÌPÍN 3	INFORMATION ON REPRODUCTIVE HEALTH AND CHILDREN/ Ìfitónilétí nípa ìlera ìbí-sí àti àwọn ọmọ		
Question no/ Nọ́mbà ìbéèrè.	**Questions and Filters/ Ìbéèrè àti Àṣàtúnṣà**	**Coding categories/ ipele oníkóòdù**	**Skip to/ Fi sílẹ̀ lọ sí**
301	Now I would like to ask you about all the births that you have had during your life. Have you ever been pregnant? / Níbáyìí, mà á fẹ́ láti bi yín àwọn ìbí yín ní ayé yín. Njẹ́ ẹ tilẹ̀ lóyún rí?	Yes/ Bẹ́ẹ̀ni.....1 No/ Rárá .....2 Maybe/Not sure Bóyá/Kò dájú..... 3	→ 309 → 309
302	Have you ever given birth? If yes, PROBE: How many times? / Tó bá jẹ́ bẹ́ẹ̀ni, **bi í síwájú**: ẹ̀ẹ̀melòó ni?	Yes/ Bẹ́ẹ̀ni.....1 No/ Rárá.....2 Number of births/ Iye ìbí..... ☐☐	→ 307
303	How many of your NATURAL children are living here with you? / Mélòó nínú àwọn ọmọ **àpilẹ̀** bí yín ló ṣì n gbé pẹ̀lú yín níbí?	Number of children living with respondent / Iye ọmọ tó n gbé pẹ̀lú olùfọ̀rọ̀wálẹ́nuwò..... ☐☐	
304	How many of your NATURAL children are living elsewhere? / Mélòó nínú àwọn ọmọ **àpilẹ̀** bí yín ló n gbé níbòmìíràn?	Number of children living elsewhere/Iye ọmọ tó n gbé níbòmìíràn ..... ☐☐	
305	How many girls and boys do you have? NATURAL CHILDREN/ọkùnrin àti obìnrin mélòó ni ẹ ní? **àwọn ọmọ àpilẹ̀ bí**	No. of girls / Iye ọmọbìrin..... ☐☐ No. of boys / Iye ọmọkùn ..... ☐☐	
306	Have you ever given birth to a boy or a girl who was born alive but later died? This could be at any age? /Ṣé ẹ tilẹ̀ bí ọmọbìnrin tàbí ọmọkùnrin rí. Èwo ni ẹ bí láàyè tí ó sì padà kú? Iye ọdún ìyówù tí ìbáà pé?	Boy / ọmọkùnrin .....1 Girl / ọmọbìnrin ..... 2 None / Kò sí.....77	
307	How many times have you been pregnant – including pregnancies that did not end in a live birth? /ẹ̀ẹ̀melòó ni ẹ lóyún rí-àti àwọn oyún tí ẹ kò bí?	**Total no.** of pregnancies / **Iye** oyún **lápapọ̀**: ☐☐	
308	Have you ever had a pregnancy that miscarried, or ended in a stillbirth? /Ṣé ẹ ti lóyún àkúndé rí, tàbí yọrí sí ìbílókùú? PROBE: How many times did you miscarry, how many times did you have a stillbirth, and how many times did you abort? / **Bi í síwájú**: ẹ̀ẹ̀melòó ni ẹ ti lóyún àkúndé rí, ẹ̀ẹ̀melòó ni ẹ ti bí ìbílókùú, àti pé ẹ̀ẹ̀melòó ni ẹ ti ṣẹ́ oyún?	Miscarriages / Oyún àkúndé..... ☐☐ Stillbirths / Ìbílókùú..... ☐☐ Abortions / Oyún ṣíṣẹ́..... ☐☐ None / Kò sí..... 77	

309	Are you pregnant now? / Ṣé ẹ lóyún báyìí?	Yes / Bẹ́ẹ̀ni ..... 1 No / Rárá..... 2 Maybe / Bóyá..... 3	
310	Have you **ever** used anything, or tried in any way to delay or avoid getting pregnant? / Ṣé ẹ ti lo nnkan rí, tàbí ẹ gbìyẹ̀njú lọ́nà kankan láti lè má tètè tàbí má lóyún? IF YES why (are there any particular reasons)? / **Tó bá jẹ́ bẹ́ẹ̀ni**, kí ló dé (Ṣé ìdí kan gbòógì wà)?	Yes / Bẹ́ẹ̀ni..... 1 No / Rárá..... 2 → 313 Never had intercourse / Kò sí ìbálòpọ̀ Kankan..... 3 → S4 Reason for pregnancy prevention/ Ìdí fún ìdènà oyún:	
311	Are you **currently** doing something, or using any method to avoid getting pregnant? / Njẹ́ **Lọ́wọ́lọ́wọ́ yìí,** ẹ n Ṣe nnkankan, tàbí lo ọ̀nà kan láti sá fún oyún? IF YES, why do you not want to get pregnant? / **Tó bá jẹ́ bẹ́ẹ̀ni**, kí ló dé ẹ kò fẹ́ lóyún	Yes / Bẹ́ẹ̀ni ..... 1 No / Rárá..... 2 → 313	
312	Does your **current** husband/partner know that you are using a method of family planning? /Ṣé ọkọ yín **báyìí** mọ̀ pé ẹ n lo ọ̀nà kan láti fi ètò sọ́mọ bíbí?	Yes / Bẹ́ẹ̀ni ..... 1 No / Rárá..... 2 N/A (No current partner) / Kò sí ọkọ kankan báyìí.....77	
313	Has/did your **current**/ **most recent** husband/ partner ever refused to use a method or tried to stop you from using a method to avoid getting pregnant? / Ṣé ọkọ yín **báyìí** tàbí èyí tí ẹ wà lọ́dọ̀ rẹ̀ **lọ́wọ́lọ́wọ́ yìí** kọ̀ tàbí má gbà fún un yín láti lo ọ̀nà láti yẹra fún oyún oyún níní?	Yes / Bẹ́ẹ̀ni ..... 1 No / Rárá..... 2 → 315	
314	In what ways did he let you know that he disapproved of using methods to avoid getting pregnant? /Ní ònà wo ni ó jẹ́ kẹ mọ̀ pé òun lòdì sí lílo ọ̀nà kan láti sá fún oyún níní? **(MARK ALL THAT APPLY / Sàmì sí gbogbo èyí tí ó yẹ)**	Told me he did not approve Sọ fún mi pé òun lòdì si..... A Shouted/got angry Jágbe/bínú..... B Threatened to beat me Halẹ̀ láti lù mí..... C Threatened to leave/throw me out of the home Halẹ̀ láti kúrò nílé tàbí lé mi jáde..... D Beat me/physically/ assaulted Lù mí/Kọlù lójúkojú..... E Took or destroyed method Mú ọ̀nà yìí tàbí bà á jé.....F Other / Òmíràn _____ X	

315	Have you ever used a condom with your current/ most recent partner to prevent disease? / Njé ẹ lo rọ́bà ìdáàbòbò rí pẹ̀lú ọkọ yín **báyìí** tàbí èyí tí ẹ wà lọ́dọ̀ rẹ̀ **lọ́wọ́lọ́wọ́ yìí** láti dènà àrùn?	Yes / Bẹ́ẹ̀ni ..... 1 No / Rárá..... 2	→ S4
316	Have you ever asked your **current**/ **most recent** partner to use a condom? /Njé ẹ rọ ọkọ yín **báyìí** tàbí èyí tí ẹ wà lọ́dọ̀ rẹ̀ **lọ́wọ́lọ́wọ́ yìí** láti lo rọ́bà ìdáàbòbò rí?	Yes / Bẹ́ẹ̀ni..... 1 No / Rárá..... 2	→ S4
317	Has/ did your **current**/**most recent** husband/ partner ever refuse to use a condom to prevent disease? / Njé ọkọ yín **báyìí** tàbí èyí tí ẹ wà lọ́dọ̀ rẹ̀ **lọ́wọ́lọ́wọ́** yìí ti kọ̀ láti lo rọ́bà ìdáàbòbò rí?	Yes / Bẹ́ẹ̀ni..... 1 No / Rárá..... 2	→ S4
318	In what way did he let you know that he disapproved of using a condom? /Báwo ni ó ṣe jẹ́ kí ẹ mọ̀ pé òun ṣe lòdì sí lílo rọ́bà ìdáàbòbò? **(MARK ALL THAT APPLY / Sàmì sí gbogbo èyí tí ó yẹ)**	Told me he did not approve Ṣọ fún mi pé òun lòdì si..... A Shouted/ Got angry Jágbe /bínú…..... B Threatened to beat me Halẹ̀ láti lù mí.....C Threatened to leave/ throw me out of the home Halẹ̀ láti kúrò nílé tàbí lé mi jáde…..... D Beat me/Physically assaulted Lù mí/Kọlù lójúkojú..... E Took or destroyed method Mú ọ̀nà yìí tàbí bà á jé…..F Accused me of being unfaithful/ not a good woman Fẹ̀sùn kàn mí pé n kò kìí olóòótọ́/kìí ṣe obìnrin dáradár……..G Laughed at me/did not take serious Fi mí ṣe yẹ̀yẹ́/kò mu lọ́kùn-únkúndùn.....…… H Said it is not necessary Ṣọ pé kòpọn dandan……..I Other / Òmíràn _____ X	

SECTION/ ÌPÍN 4	INFORMATION ON CURRENT OR MOST RECENT PARTNER/ Ìfitónilétí nípa ọkọ ìsisìí yìí.			
Check questions 114&115, mark what the response is in the appropriate box provided in the adjacent cells to the right and follow the skip pattern / Ẹ ìbéèrè 114&115 wò, sàmì sí èyí tí olùfọ̀rọ̀wálẹ́nuwò jẹ́ nínú kóló tí ó yẹ ní ọ̀wọ́ ìsàlẹ̀ apá ọ̀tún kí o sì tẹ̀lé liana fífò lọ sí.	Currently married/Living with a man/Have a partner/Wà nílé ọkọ/N gbé pẹ̀lú ọkùnrin/Ní àfẹ́ṣọ́nà ☐	Previously married/Previously living with a man/ Previously had a partner/ Wà nílé ọkọ tẹ́lẹ̀/N gbé pẹ̀lú ọkùnrin tẹ́lẹ̀ /Ní àfẹ́ṣọ́nà tẹ́lẹ̀ ☐	Never married/Never had a partner / Kò lọ́kọ rí/Kò ní àfẹ́ṣọ́nà rí ☐ → S5	**SKIP TO/ Fi sílẹ̀ lọ sí**

I would like you to tell me a little about your current/most recent husband/partner
Màá fẹ́ kí ẹ ṣọ díẹ̀ fún mi nípa ọkọ yín tí ẹ wà lọ́dọ̀ rẹ̀ báyìí/àfẹ́ṣọ́nà yín.

Question no/ Nọ́mbà ìbéèrè.	Questions and Filters/ Ìbéèrè àti Àṣàtúnṣà	Coding categories/ Ipele oníkóòdù	Skip to / Fi sílẹ̀ lọ sí
401	How old was your husband/partner on his last birthday? / Kín ni ọjọ́ orí ọkọ yín tàbí àfẹ́ṣọ́nà yín ní ọjọ́ ìbí rẹ̀ tó ṣe kẹ́yìn?	Age (Years) / ọjọ́-orí (ọdún)..... ☐☐	
402	In what year was he born? / Ní ọdún wo la bi?	Year / ọdún..... ☐☐☐☐ Don't know / Kò mọ̀..... 77	
403	Can he read and write? / Sé ó lè kàwé tàbí kọ̀wé?	Yes / Bẹ́ẹ̀ni ..... 1 No / Rárá 2	
404	Did he ever attend school? / Njẹ́ ó tilẹ̀ gba ilé-ìwé kọjá?	Yes / Bẹ́ẹ̀ni..... 1 No / Rárá..... 2 → 406	
405	What is the highest level of education that he achieved? / Kín ni ipele ẹ̀kọ́ tí ó ga jù tí ó dé? What was the highest grade he completed at that level? / Kín ni ipò tí ó ga jù tí ó parí ní ipele yẹn?	Leve / Ipele..... ☐ Grade / Ipò..... ☐☐ **Level / Ipele** 1=Primary / Alákọ̀ọ́bẹ̀rẹ̀ 2=Secondary / Sẹ́kọ́ndìrì 3=Higher / Ilé-ìwé gíga 4=Don't know / Kò mọ̀ **Grade / Ipò** 00=less than 1 year/ not completed / Kò pé ọdún kan/kò parí 10=Completed / Parí 98=Don't know / Kò mọ̀	

406	How often does/did your husband/partner drink alcohol? Báwo ni ọkọ/tàbí àfẹ́ṣọ́nà yín ṣe máa n mu ọtí líle tó? 1 = Every day or nearly every day Ojoojúmó tàbíó fẹ́rẹ̀ jẹ́ ojoojúmọ́ 2 = Once or twice a week ẹ̀ẹ̀kan tàbí ẹ̀ẹ̀mejì lọ́sẹ̀ 3 = 1 – 3 times a month 1 – 3 lọ́ṣù kan 4 = Occasionally, less than once a month ẹ̀ẹ̀kọ̀ọ̀kan, kò pé ẹ̀ẹ̀kan lọ́ṣù kan 5 = Never / Kò mú rí	Every day or nearly every day Ojoojúmọ́ tàbí ó fẹ́rẹ̀ jẹ́ ojoojúmọ́…….. 1 Once or twice a week ẹ̀ẹ̀kan tàbí ẹ̀ẹ̀mejì lọ́sẹ̀..... 2 1 – 3 times in a mont 1 – 3 lọ́ṣù kan..... 3 Less than once a month Kò pé ẹ̀ẹ̀kan lọ́ṣù kan…….... 4 Never / Kò mú rí..... 5 → 409 Don't know / Kò mọ̀..... 77	
407	In the past 12 months (In your last relationship), how often have you seen (did you see) your husband/partner drunk? / Láti bíi oṣù méjìlá sẹ́yìn, (nínu ìbáṢepọ̀ tó kéyìn yií), ẹ̀ẹ̀melòó ni ẹ rí tà ti rí ọkọ yín tí ó yó? Would you say most days, weekly, once a month, less than once a month, or never? / Ṣé ẹ ma sọ pé púpọ̀ ọjọ́, ọsọ̀ọ̀sè, kò pé ẹ̀ẹ̀kan lọ́ṣù kan, kò yó rí?	Most days/ Púpọ̀ ọjọ́…….. 1 Weekly / Ọsọ̀ọ̀sẹ̀..... 2 Once a month / Èẹ̀kan lọ́ṣù..... 3 Less than once a month/ Kò pé ẹ̀ẹ̀kan lọ́ṣù kan..... 4 Never / Kò yó rí..... 5	
408	In the past 12 months, or during the last 12 months of your relationship, did you experience any of the following problems in relation to your husband/partner's drinking? Láti bíi oṣù méjìlá sẹ́yìn tàbí lásìkò oṣù méjìlá sẹ́yìn, nẹ ẹ tin í ìrírí ọ̀kan nínú àwọn ìṣòro yìí rí èyí tí ọtí mímú fà nínú àyé ọkọ tàbí àfẹ́ṣọ́nà? a) Money issues / Ìṣòro owó b) Family issues / Ìṣòro ìdélé c) Any other problems, specify / Ìṣòro mìíràn, sọ ní pàtó	Yes/ Bẹ́ẹ̀ni / No/ Rárá a) Money issues/ Ìṣòro owó 1 2 b) Family issues/ Ìṣòro ìdélé 1 2 c) Others / Òmiràn: _____	

409	How often does/did your husband/partner use drugs (like Heroin, weed, etc.)? Báwo ni ọkọ yín /àfésọ́nà yín ṣe máa n lo/ lo òògùn líle (bi igbó) tó? 1 = Every day or nearly every day Ojoojúmọ́ tàbí ó fẹ́rẹ̀ jẹ́ ojoojúmó 2 = Once or twice a week ẹ̀ẹ̀kan tàbí ẹ̀ẹ̀mejì lọ́sẹ̀ 3 = 1 – 3 times a month 1 – 3 lọ́ṣù kan 4 =Occasionally, less than once a month ẹ̀ẹ̀kọ̀ọ̀kan, kò pé ẹ̀ẹ̀kan lọ́ṣù kan 5 = Never / Kò ló rí	Every day or nearly every day/ Ojoojúmọ́ tàbí ó fẹ́rẹ̀ jẹ́ ojoojúmó..... 1 Once or twice a week/ ẹ̀ẹ̀kan tàbí ẹ̀ẹ̀mejì lọ́sẹ̀..... 2 1 – 3 times in a month/ 1 – 3 lọ́ṣù kan..... 3 Less than once a month/ Kò pé ẹ̀ẹ̀kan lọ́ṣù kan.....4 Never / Kò ló rí..... 5 Don't know / Kò mọ̀.....77	
410	Since you have known him, has he ever been involved in a physical fight with another man? / Láti ìgba tí ẹ ti mọ ọ́, njẹ́ ó ti kópa nínú ìjà ojúkojú pẹ̀lú ẹlòmíràn rí? The reason for the fight? / Ìdí fún ìjà?	Yes / Bẹ́ẹ̀ni ..... 1 No / Rárá ..... 2 → 412 Don't know / Kò mọ̀.....77 → 412 He initiated the fight/ Ó dá ìjà náà silẹ̀..... 1 He was angered by someone / ẹnìkan bi nínú..... 2 Other reasons/ Ìdí mìíràn: _____ 88	
411	In the **past 12 months** (in **the last 12 month of the relationship**), has this happened never, once or twice, a few times or many times? **Láti bíi oṣù méjìlá sẹ́yìn, (nínu ìbáṣepọ̀ oṣù tó kéyìn yìí)** njẹ́ èyí kò ṣẹlẹ̀ rí, ẹ̀ẹ̀kan tàbí ẹ̀ẹ̀mejì, ṣẹlẹ ·fún ìgbà díẹ̀ tàbí lọ́pọ̀lọpọ̀ ìgbà?	Never / Kò ṣẹlẹ̀ rí..... 1 Once or twice/ ẹ̀ẹ̀kan tàbí ẹ̀ẹ̀mejì lọ́sẹ̀..... 2 A few (3 – 5) times/ Ìgbà díẹ̀ (3 – 5)..... 3 Many (more than 5) times/ ọ̀pọ̀lọpọ̀ ìgbà (ju ẹ̀ẹ̀marùn ún lọ)..... 4 Don't know / Kò mọ̀.....77	
412	Has your **current/most recent** husband/partner had a relationship with any other women while being with you? / Njẹ́ ọkọ/àfésọ́nà rẹ báyìí ti bá obìnrin mìíràn sùn rí nígbà tí ẹ ṣì tún wà papọ̀?	Yes / Bẹ́ẹ̀ni..... 1 No / Rárá..... 2 May have / Ó lè..... 3 Don't know / Kò mọ̀..... 77	

SECTION/ ÌPÍN 5 EMPLOYMENT AND TIME USE / Ìgbàsíṣẹ́ àti àkókò líló			
Question no/ Nọ́mbà ìbéèrè.	**Questions and Filters/ Ìbéèrè àti Àṣàtúnṣà**	**Coding categories/ Ipele oníkóòdù**	**Skip to/ Fi sílẹ̀ lọ sí**
501	As you know, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. Are you currently involved in any such activity? / Gẹ́gẹ́ bí ẹ ṣe mọ̀, àwọn obìnrin kan máa n gba iṣẹ́ tí a ti máa n san ọ̀yà wọn fún wọn. Àwọn ìyókù n tajà, n ṣiṣẹ́ òwò kékeré tàbí íṣẹ́ oko ìdílé tàbí iṣẹ́ òwò oko ìdílé. Njé ẹ n ṣe ọ̀kankan nínú àwọn iṣẹ́ yìí?	Yes / Bẹ́ẹ̀ni ..... 1 No / Rárá..... 2 → 507	
502	Which of these is your MAIN activity? Èwo nínú ìwọ̀nyìí gan ni **ojúlówó** iṣẹ́ yín gan Agriculture/ Farming / Àgbẹ̀..... 1 Non-Agriculture / Kò jẹ mọ́ iṣẹ́ àgbẹ̀..... 2		
503	Which of the following best describes the work you do / Èwo nínú àwọn wòn yìí ni ó sọ gangan irú iṣẹ́ tí ẹ n ṣe: PROBE ALL ACTIVITIES/ **Bí i síwájú, gbogbo iṣẹ́:** Salaried? / Olówó oṣù? Self employed? / Ìṣẹ́ àdáni? Unpaid family worker? / IṢẹ́ ìdílé tí kò yọwó? Other? / Òmíràn?	Salaried / Olówó oṣù..... A Self employed / Ìṣẹ́ àdáni..... B Unpaid family worker? / Iṣẹ́ ìdílé tí kò yọwó..... C Other / Òmíràn_____ …X (Specify/Ṣọ ní pàtó)	
504	In your MAIN work, do you work / Nínú **ojúlówó** iṣẹ́ yín, ṣé ẹ máa n ṣiṣẹ́: Throughout the year? / Jálẹ̀ ọdún? Seasonally/Part of the year? / Ó ní ìgbà/Apá kan ọdún? Whenever you can find a job? / Ìgbàkugbà tí ẹ bá le ríṣẹ́?	Throughout the year / Jálẹ̀ ọdún..... 1 Seasonally/Part of the year / Ó ní ìgbà/Apá kan ọdún..... 2 Whenever find a job / Ìgbàkugbà tí ẹ bá le ríṣẹ́..... 3	
505	In the past 12 months, how many months did you work in your MAIN job? / Láti bíi oṣù méjilá séyìn, oṣù mélòó ni ẹ fi n ṣiṣẹ́ gan nínú **ojúlówó** iṣẹ́ yín? What was your total earning from the work you performed (Amount in Naira)? / Èló ni àpapọ̀ owó tí ẹ gbà nínú iṣẹ́ tí ẹ ṣe (Iye owó ní náírà)?	Months worked/ Oṣù tí ẹ fi ṣiṣẹ́..... ☐☐ Amount earned / Iye owó tí ẹ gbà _____	

506	What control did you have over the money you earned? / Àṣẹ wo lo ní lórí owó tí o gbà?		Self/own control/ Àṣẹ ọwọ́ ara mi...1 Give part to husband/partnerat own will/ Fún ọkọ ní díẹ̀/alábàápín pẹ̀lú ìyọ̀nda ara mi……..…2 Give part to husband/partner against will/ Fún ọkọ ní díẹ̀/alábàápín lòdì sí ìyọ̀nda ara mi..... 3 Give all to husband/partner at own will/ Fún ọkọ ní gbogbo rẹ̀/alábàápín pẹ̀lú ìyọ̀nda ara mi..... 4 Give all to husband/partner against own will/ Fún ọkọ ní gbogbo rẹ̀/alábàápín lòdì sí ìyọ̀nda ara mi..... 5		
507	As a woman, you must be responsible for many of the household activities. Can you please tell me which of these household chores you have done in the past 7 days? / Gẹ́gẹ́ bí i obìnrin, ẹ ní àwọn ojúṣe kan gẹ́gẹ́ bí iṣẹ́ ilé. ẹ jọ̀wọ́, njẹ́ e lè sọ èwo nínú àwọn iṣẹ́ yìí ni ẹ n ṣe lójú méjèèjì láti ọjọ́ méje séyìn? Can you tell me how much time you spent, on average, on each one of these activities in the **last** 7 days? / Njẹ́ ẹ lè sọ nípa dídá, iye àsìkò tí ó máa n gbà yí láti Ṣe àwọn iṣẹ́ wọ̀yìí láti ọjọ́ méje **séyìn**? How about on average, in **any** 7 days? / Báwo ni nípa dídá, nínú ọjọ́ méje **ìyówù**?		**1 = Yes/ Bẹ́ẹ̀ni** **2 = No/ Rárá**	Hours spent on average in the **last 7days/** Wákàtí ìlò ní dídá **láti ọjọ́ méje séyìn**	Hours spent on average in **any 7days/** Wákàtí ìlò ní dídá **nínú ọjọ́ méje ìyówù**	
		Fetching water/ Omi pípọn				
		Fetching firewood/ Igi ṣíṣàjọ				
		Caring for children / Mímójútó ọmọ				
		Ironing/ Aṣọ lílọ̀				
		Washing/ Aṣọ Fífọ̀				
		Sweeping/ Ilẹ gbígbá				
		Washing dishes/ Abọ́ fífọ̀				
		Washing vehicles/ Fífọ ohun ìrìnnà				
		Dispose garbage/ Dídalẹ̀ nù				
		Cooking/ Oúnjẹ sísè				
		Shopping for household needs/ Rajà fún ilé				
		Running errands/ Iṣẹ́ jíjẹ́				
		Other housekeeping activities/ Iṣẹ́ ilé pípamọ́ mìíràn.				

Check questions 114&115, mark what the response is in the appropriate box provided in the adjacent cells to the right and follow the skip pattern/ Ye ìbéèrè 114&115 wò, sàmì sí èyí tí olùfọ̀rọ̀wálẹ́nuwò jẹ́ nínú kóló tí ó ye ní ọwọ́ ìsàlẹ̀ apá ọ̀tún kí o sì tẹ̀lé liana fífò lọ sí.		Currently married/Living with a man/Have a partner//Wà nílé ọkọ/N gbé pẹ̀lú ọkùnrin/Ní àfẹ́ṣọ́nà ☐	Previously married/Previously living with a man/Previously had a partner/ Wà nílé ọkọ tẹ́lẹ̀/N gbé pẹ̀lú ọkùnrin tẹ́lè /Ní àfẹ́ṣọ́nà tẹ́lè ☐	Never married/Never had a partner/ Kò lọ́kọ rí/Kò ní àfẹ́ṣọ́nà rí ☐ → S6	**SKIP TO/ Fi sílẹ̀ lọ sí**
508	Does your current or former husband/partner work? / Ṣé ọkọ/àfẹ́ṣọ́nà rẹ tẹ́lẹ̀ rí tàbí nísìn-ín yìí n ṣíṣẹ́?		Yes / Bẹ́ẹ̀ni .....1 No / Rárá .....2 →		514
509	Which of these is his MAIN activity? / Èwo nínú èyí ni ó jẹ́ **ojúlówó** iṣẹ́ rẹ̀ gan? Agriculture/ Farming / Àgbẹ̀.....1 Non-Agriculture / Kò jẹ mọ́ iṣẹ́ àgbè.....2				
510	Which of the following best describes the work he does: Èwo nínú àwọn wòn-yìí ni ó sọ gangan irú iṣẹ́ tí wọ́n n ṣe: PROBE ALL ACTIVITIES / Bí i síwájú gbogbo iṣẹ́ Salaried? / Olówó oṣù? Self employed? / Iṣẹ́ àdáni? Unpaid family worker? / Iṣẹ́ ìdílé tí kò yọwó? Other? / Òmíràn?		Salaried / Olówó oṣù..... A Self employed / Ìṣẹ́ àdáni..... B Unpaid family worker/ Iṣẹ́ ìdílé tí kò yọwó..... C Other / Òmíràn_____.... X (Specify/Ṣọ ní pàtó)		
511	In his MAIN work, does he work Nínú **ojúlówó** iṣẹ́ wọn, ṣé wọ́n- máa n ṣiṣẹ́: Throughout the year? / Jálẹ̀ ọdún? Seasonally/Part of the year? / Ó ní ìgbà/Apá kan ọdún? Whenever he can find a job? / Ìgbàkugbà tí wọn bá le ríṣé?		Throughout the year/ Jálẹ̀ ọdún..... 1 Seasonally/Part of the year / Ó ní ìgbà/Apá kan ọdún?.....2 Whenever find a job/ Ìgbàkugbà tí wọn bá le ríṣé..... 3		
512	In the past 12 months, how many months did he work in his MAIN job? / Láti bíi oṣù méjìlá sẹ́yìn, oṣù mélòó ni wọ́n fi ṣiṣẹ́ gan nínú **ojúlówó** iṣẹ́ wọn? What was his total earning from the work he has performed (Amount in Naira)? Èló ni àpapò owó tí wọ́n gbà nínú iṣẹ́ tí wọn ṣe (Iye owó ní náírà)?		Months worked / Oṣù tí wọn fi ṣiṣẹ́..... ☐ Amount earned/ Iye owó tí wọn gbà _____		

513	Does/did your husband/partner give part of these earnings to use for household expenses? Ṣé ọkọ/àfẹ́ṣọ́nà yín máa n fún un yín/fun yín ní díẹ̀ nínú owó tí wọ́n n gbà fún ìnáwó isẹ́ ilé?	None/ Kò ṣe ọ̀kankan……1 Part/ Díẹ̀……..….....2 All/ Gbogbo rẹ̀.....3	

514	Does/did your husband or partner help you with any of the household chores? Ṣé Ọkọ /àfẹ́ṣọ́nà yín máa n ràn yín lọ́wọ́ pẹ́lú ọkankan nínú isẹ́ ilé? Which of the following chores did he help you with in the **last** 7 days? / Èwo nínú wọn ni wọ́n ti máa n ṣe ìrànlọ́wọ́? Can you tell me how much time he spent, on average, on each one of these activities in the **last** 7 days? / Njẹ́ ẹ lè so nípa dídá, iye àsìkò tí wọ́n máa n lò nínú àwọn isẹ́ yìí **láti ọjọ́ méjé séyìn**? How about on average, in **any** 7 days? / Báwo ni nípa dídá, **nínú ọjọ́ méje ìyókù**?		**1 =Yes/ Bẹ́ẹ̀ni** **2 =No/ Rárá**	Hours spent on average in the **last 7days/**Wákàtí ìlò ní dídá **láti ọjọ́ méje séyìn**	Hours spent on average in **any 7days** Wákàtí ìlò ní dídá **nínú ọjọ́ méje ìyókù**	
	Fetching water/ Omi pípọn					
	Fetching firewood/ Igi ṣíṣàjọ					
	Caring for children / Mímójútó ọmọ					
	Ironing/ Aṣọ lílọ̀					
	Washing/ Aṣọ Fífọ̀					
	Sweeping/ Ilẹ gbígbá					
	Washing dishes/ Abọ́ fífọ̀					
	Washing vehicles/Fífọ ohun ìrìnnà					
	Dispose garbage/ Dídalẹ̀ nù					
	Cooking/ Oúnjẹ sísè					
	Shopping for household needs/ Rajà fún ilé					
	Running errands/ Isẹ́ jíjẹ́					
	Other housekeeping activities/ ISẹ́ ilé pípamọ́ mìíràn.					

SECTION/ ÌPÍN 6	ATTITUDE TOWARDS GENDER ROLES/ Ìhà sí ojúṣe ìmọ̀ ọ̀kùnrin àti obìnrin		
In this community and elsewhere, people have different ideas about families and what is an acceptable behaviour for men and women in the home. I am going to read you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statements. There are no right or wrong answers. Ní àdúgbò yìí àti níbìmìíràn, àwọn ènìyàn ní èrò oríṣiríṣi nípa àwọn ìdílé àti ìwà tí ọkùnrin àti obìnrin lè gbà nínú ilé. Màá ka àwọn ọ̀rọ̀ kan jade, màá fẹ́ kí ẹ ṣọ fún mi bóyà ẹ káàkiri, ẹ fara mọ́ àwọn ọ̀rọ̀ yìí tàbí ẹ kò fara mọ. Kò sí ìdáhùn tí ènìyàn lè gbà tàbí ṣì.			
Question no/ Nọ́mbà ìbéèrè.	**Questions and Filters/ Ìbéèrè àti Àṣàtúnṣà**	**Coding categories/ Ìbéèrè àti Àṣàtúnṣà**	**Skip to/ Fi sílẹ̀ lọ sí**
601	A good wife obeys her husband even if she disagrees/ Aya rere máa gbọ́ràn sí ọkọ rẹ lẹ́nu ni kódà bí kò bá fara mọ.	Agree / Fara mọ…..…… 1 Disagree / Kò fara mọ…..…… 2 Don't know / Kò mọ̀..... 77	
602	Family problems should only be discussed with people in the family/ Ìṣòro inú ìdílé gbọdọ̀ jẹ́ èyí tí wọ́n ó máa sọ nínú ìdílé	Agree / Fara mọ…..……..1 Disagree / Kò fara mọ…..……..2 Don't know / Kò mọ̀..... 77	
603	It is important for a man to show his wife/partner who is the boss/ Ó ṣe pàtàkì kí ọkùnrin fi han aya tàbí àfẹ́ṣọ́nà rẹ ẹni tí í ṣe ọ̀gá	Agree / Fara mọ…..……..1 Disagree / Kò fara mọ…..…… 2 Don't know / Kò mọ̀..... 77	
604	A woman should be able to choose her own friends even if her husband disapproves / Obìnrin yẹ kí ó lè yẹn àwọn ọ̀rẹ́ rẹ̀ kódà tí ọkọ rẹ̀ kò bá fọwọ́ si	Agree / Fara mọ…..…….. 1 Disagree / Kò fara mọ…..…… 2 Don't know / Kò mọ̀..... 77	
605	It is the wife's obligation to have sex with her husband even if she doesn't feel like it/ Ohun tó pọn dandan ní ṣíṣe fún obìnrin ni láti máa bá ọkọ rẹ̀ ní àjọ̀sepọ̀ kódà tí kò (obìnrin) bá fẹ́ ṣe.	Agree / Fara mọ…..……1 Disagree / Kò fara mọ…..…… 2 Don't know / Kò mọ̀..... 77	
606	Investing in a male child's education is far more valuable than that of a female/ Kíkówólé ẹ̀kọ́ ọmọkùnrin níye lórí gidi ju ti ọmọbìnrin lọ	Agree / Fara mọ…..……..1 Disagree / Kò fara mọ…..…… 2 Don't know / Kò mọ̀..... 77	
607	If a man mistreats his wife, outside agencies should intervene/ Tí ọkùnrin kàn bá n hùwà burúkú sí ìyàwó rẹ̀ tàbí ṣe sí i bí kò ṣe tọ́, ó yẹ kí àwọn ará ìta dá si.	Agree / Fara mọ…..……..1 Disagree / Kò fara mọ…..…… 2 Don't know / Kò mọ̀..... 77	

608	In your opinion, does a man have a good reason to hit his wife if/ Gẹ́gẹ́ bí èrò ti yín, ṣé ọkùnrin kan ní ìdí gidi kan láti lu ìyàwó rẹ̀ tí kò bá: a) She does not complete her household work to his satisfaction/ Tí kò bá parí iṣẹ́-ilé rẹ̀ tẹ́ ẹ lọ́rùn b) She disobeys him/ Bá ṣàìgbọràn sí i lénu c) She refuses to have sexual relations with him/ Bá kọ̀ láti báa lájọṣepọ̀ d) She asks him whether he has other girlfriends/ Bá bí ọkọ rẹ̀ léèrè pé ṣé ó ní ọ̀rẹ́bìnrin mìíràn e) He suspects that she is unfaithful/ Tí ó (ọkọ) bá fura pé (aya òun) kìí ṣe olóòótọ́ f) He finds out that she has been unfaithful/ Bá rí wí pé kì í ṣe olóòótọ́		Yes/ Bẹ́ẹ̀ni	No/ Rárá	DK Kò mọ̀	
		a) Household/ Iṣé ilé	1	2	77	
		b) Disobeys / Ṣàìgbọràn	1	2	77	
		c) No sex/ Kò sí àjọṣepọ̀	1	2	77	
		d) Girlfriends/ ọ̀rẹ́bìnrin	1	2	77	
		e) Suspects/ Fura sí i	1	2	77	
		f) Unfaithful/ Kò ṣe olóòótọ́	1	2	77	
609	In your opinion, should a married woman refuse to have sex with her husband if: Nínú èrò ti yín, ṣé ó yẹ kí obìnrin tó ti lọ́kọ kọ̀ jálẹ̀ pé òun kò ní áṣepọ̀ pẹ̀lú ọkọ òun tí: a) She doesn't want to/ Kò (obìnrin) bá fẹ́ ṣe b) He is drunk/ Tí (ọkùnrin) bá ti mutí yó c) He is high on drugs (e.g. Heroin, weed, etc.)/ Tí ojú rẹ̀(ọkùnrin) bá ti lé fún òògùn olóró d) She is sick/ Tí ara obìnrin kò bá yá e) He mistreats her/ Bá hùwà burúkú si		Yes/ Bẹ́ẹ̀ni	No/ Rárá	DK Kò mọ̀	
		a) Not want / Kò fẹ́	1	2	77	
		b) Drunk/ Yó fún ọtí	1	2	77	
		c) High/ Ojú le kokoko	1	2	77	
		d) Sick/ Ara rẹ̀ kò yá	1	2	77	
		e) Mistrea/ Hùwà burúkú	1	2	77	

SECTION/ ÌPÍN 7	RESPONDENT AND HER PARTNER / Olùfọ̀rọ̀wálẹ́nuwò ati ikejì rẹ̀			
Check questions 114&115, mark what the response is in the appropriate box provided in the adjacent cells to the right and follow the skip pattern/ Ẹ̀ ibéèrè 114&115 wò, sàmì sí èyí tí olùfọ̀rọ̀wálẹ́nuwò jẹ́ nínú kóló tí ó ẹ̀ ní ọ̀wọ́ ìsàlẹ̀ apá ọ̀tún kí o sì tẹ̀lé liana fífò lọ	Currently married/Living with a man/Have a partner//Wà nílé ọkọ/N gbé pẹ̀lú ọkùnrin/Ní àfẹ́sọ́nà	Previously married/ Previously living with a man/ Previously had a partner/ Wà nílé ọkọ tẹ́lẹ̀/N gbé pẹ̀lú ọkùnrin tẹ́lè /Ní àfẹ́sọ́nà tẹ́lè	Never married/Never had a partner/Kò lọ́kọ rí/Kò ní àfẹ́sọ́nà rí → S8	**SKIP TO/ Fi sílẹ̀ lọ sí**

When two people marry, live together or are in a relationship, they usually share both good and bad moments. I would like to ask you some questions about your current and past relationships and how your husband/partner treats (treated) you. If anyone interrupts us I will change the topic of conversation. I would again like to assure you that your answers will be kept confidential, and that you do not have to answer any questions that you do not want to. May I continue?

Nígbà tí ènìyàn méjì bá fẹ́ ara wọn, wọ́n n gbé papọ̀ tàbí wọ́n n fẹ́ ara wọn, wọ́n jọ máa n ṣe alábàápín ìgbà dáradár àti burúkú papọ̀ ni. Màá f'ẹ bi yín àwọn ìbéèrè kan nípa ìbáṣepọ̀ yín lá lọ́wọ́lọ́wọ́ yìí àti látẹ̀yìn wá àti bí ọkọ tàbí àfẹ́sọ́nà yín ṣe n hùwà (hùwà) sí i yín. Tí ẹnikẹ́ni bá dí wa lọ́wọ́ màá yí àkólé ọ̀rọ̀ náà padà. Màá tún fẹ́ fi yín lọ́kàn balẹ̀ pé àwọn ìdáhùn yín ní a ó bò fún un yín, àti pé ẹ kò nílò láti dáhùn àwọn ìbéèrè tí ẹ kò bá fẹ́ dáhùn. Ṣé mo lè tẹ̀síwájú.

701	In general, do (did) you and your (current or most recent) husband/partner discuss the following topics together: Lápapọ̀, ṣé ọkọ yín tàbí àfẹ́sọ́nà yín máa n ba yín tàbí ba yín sọ ọkankan nínú àwọn ọ̀rọ̀ wònyìí rí: a) Things that happened to him in the day/ Àwọn ohun tó ṣẹlẹ̀ sin í ọjọ́ náà. b) Things that happened to you in the day/ Àwọn ohuntó ṣẹlẹ̀ si yín ní ọjọ́ náà c) His worries or feelings/ Àwọn ohun tó kọ́ ọ lóminú tàbí àwọn ohun tó n ṣe é. d) Your worries or feelings/ Àwọn ohun tó kọ́ yín lóminú tàbí àwọn ohun tó n ṣe yín.		Yes/ Bẹ́ẹ̀ni	No/ Rárá	
		a) His day/ Ọjọ́ rẹ̀	1	2	
		b) Your day/ Ọjọ́ rẹ	1	2	
		c) His worries/ Ìkọnilóminú rẹ̀	1	2	
		d) Your worries/ Ìkọnilóminú rẹ	1	2	
702	In your relationship with your (current or most recent) husband/partner, how often would you say that you quarrel(ed)? Nínú ìbáṣepọ̀ ọkọ/àfẹ́sọ́nà yín yìí, báwo ni ẹ ṣe máa n jà sí tàbí ṣe jà sí?	Never / Kò ṣẹlẹ̀ rí..... 1 Rarely / Kò wópọ̀..... 2 Sometimes / ẹ̀ẹ̀kọ̀ọ̀kan..... 3 Often / Dáadáa..... 4			

703	I am now going to ask you about some situations that are true for many women. Thinking about your (current or most recent) husband/partner, would you say it is generally true that he: Màá fẹ́ láti bi yín báyìí nípa àwọn àsìkò kan tí ó jẹ́ òtítọ́ fún ọ̀pọ̀lọpọ̀ obìnrin. Nígbà tí ẹ n ronú nípa ọkọ/àfẹ́ṣọ́nà yín (ní àsìkò yìí), ṣé ẹ ma sọ pé bó ṣe rí káàkiri nìyẹn pé ọkọ/àfẹ́ṣọ́nà yín máa: a) Tries to keep you from seeing your friends/ Gbìyànjú má jẹ́ kí ẹ ma rí àwọn ọ̀rẹ́ yín b) Tries to restrict contact with your family/ Gbìyànjú láti dín ìkànsíraẹni ẹyin àti ìdílé yín kù. c) Insists on knowing where you are at all times/ Fi dandan lé e láti mọ ibi tí ẹ bá wà nígbà gbogbo d) Ignores you and treats you indifferently/ Kò kà yín kún, ó sì n hùwà àìnáání sí i yín e) Gets angry if you speak with another man/ Bínú tí ẹ bá bá ọkùnrin mìíràn sọ̀rọ̀ f) Is often suspicious that you are unfaithful/ Ó máa n fura ní gbogbo igbà pé ẹ kò ṣe olóòótọ́ g) Expects you to ask his permission before seeking health care for yourself/ Máa n fẹ́ kí ẹ gbàyè tí ẹ bá n lọ fún ìtọ́jú ìlera yín.		

	Always/ Ní gbogbo ìgbà	**Some-times /** ẹ̀ẹ̀kọ̀ọ̀kan	**Never/** Láéláé
a) Seeing friends/ Rírí àwọn òrẹ́	1	2	3
b) Contact family/ Kàn sí ìdílé	1	2	3
c) Wants to know/ Fẹ́ máa mọ̀	1	2	3
d)Ignores you/ Kò kà yín kún	1	2	3
e) Gets angry/ Máa n bínú	1	2	3
f)Suspicious/ Máa n fura	1	2	3
g) Health care/ Ìtọ́jú ìlera	1	2	3

The next few questions are about things that happen to many women and that your current partner, or any other partner, may have done to you. / Àwọn ìbéèrè tó kù ni àwọn ohun tó máa n Ṣẹlẹ̀ sí ọ̀pọ̀lọpọ̀ àwọn obìnrin àti àwọn ọkọ/àfẹ́ṣọ́nà yín báyìí tàbí ẹni tí ẹ ti fẹ́ rí lè ti Ṣe fún un yín.

		A) **(IF YES continue with B. If NO, skip to next item)** **(Tí ó bá jẹ́ bẹ́ẹ̀ni tẹ̀síwájú pẹ̀lú B. Tí ó bá jẹ́ rárá, fi í sílẹ̀ lọ sí èyí tó kàn)**		B) Has this happened in the past 12 months **(IF YES, ask C only. If NO ask D only)** Ṣé eléyìí Ṣẹlẹ̀ láti oSù méjìlá séyìn **(Tí ó bá jẹ́ bẹ́ẹ̀ni tẹ̀síwájú pẹ̀lú C. Tí ó bá jẹ́ rárá, Bèèrè D nìkan)**		C) In the past 12 months would you say that this has happened once, a few times or many times? **(After answering C, skip D)** Láti oSù méjìlá séyìn Ṣé ẹ ma sọ pé eléyìí Ṣẹlẹ̀ lẹ́ẹ̀kan, ìgbà díẹ̀ tàbí ọ̀pọ̀lọpọ̀ ìgbà? **(Lẹ́yìn ìdáhùn C, fi sílẹ̀ lọ D)**			D) Prior to the last 12 months would you say that this has happened once, a few times or many times? Sáájú oSù méjìlá tó lọ Ṣé ẹ eléyìí Ṣẹlẹ̀ lẹ́ẹ̀kan, ìgbà díẹ̀ tàbí ọ̀pọ̀lọpọ̀ ìgbà?		
704	Has your current husband/partner ever done any of the following things to you: Njẹ́ ọkọ yín tàbí àfẹ́ṣọ́nà yín ti Ṣe ọ̀kankan nímú àwọn nnkan wọ̀nyìí fun yín rí:	YES/ Bẹ́ẹ̀ni	NO/ Rárá	YES/ Bẹ́ẹ̀ni	NO/ Rárá	Once/ Ẹ̀ẹ̀kan	Few Times /Ìgbà díẹ̀	Many Times/ Ọ̀pọ̀lọpọ̀ ìgbà	Once/ Ẹ̀ẹ̀kan	Few Times /Ìgbà díẹ̀	Many Times/ Ọ̀pọ̀lọpọ̀ ìgbà
	i. Insulted you or made you feel bad about yourself? / Fi ìwọ̀sí kàn yín tàbí múnú yín bàjẹ́?	1	2	1	2	1	2	3	1	2	3
	ii. Belittled or humiliated you in front of other people? / Fojú kéré yín tàbí mú ọkàn yín tèba?	1	2	1	2	1	2	3	1	2	3
	iii. Did things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling or smashing things)? / Ṣe àwọn ohun tí yóò bà yín lẹ́rù tàbí dáyà fò yín (b.a. nípa ọ̀nà tó fi n wò yín, ké mọ yín tàbí tàbí lílú nnkan mọ́ nnkan)?	1	2	1	2	1	2	3	1	2	3
	iv. Threatened to hurt you or someone you care about / Halẹ̀ láti Ṣe yín léṢe tàbí ohun tí náání?	1	2	1	2	1	2	3	1	2	3

705	Has he or any other partner ever: jẹ́ òun tàbí òmíràn ti	A) **(IF YES continue with B. If NO, skip to next item) (Tí ó bá jẹ́ bẹ́ẹ̀ni tẹ̀síwájú pẹ̀lú B. Tí ó bá jẹ́ rárá, fi í sílẹ̀ lọ́ sí èyí tó kàn)**		B) Has this happened in the past 12 months **(IF YES, ask C only. If NO ask D only)** Ṣé eléyìí Ṣẹlẹ̀ láti oṢù méjìlá séyìn **(Tí ó bá jẹ́ bẹ́ẹ̀ni tẹ̀síwájú pẹ̀lú C. Tí ó bá jẹ́ rárá, Bẹ̀rè D nìkan)**		C) In the past 12 months would you say that this has happened once, a few times or many times? **(After answering C, skip D)** Láti oṢù méjìlá séyìn Ṣé ẹ ma ṣọ pé eléyìí Ṣẹlẹ̀ lẹ́ẹ̀kan, ìgbà díẹ̀ tàbí ọ̀pọ̀lọpọ̀ ìgbà? **(Lẹ́yìn ìdáhùn C, fi sílẹ̀ lọ D)**			D) Prior to the last 12 months would you say that this has happened once, a few times or many times? Sáájú oṢù méjìlá tó lọ Ṣé ẹ eléyìí Ṣẹlẹ̀ lẹ́ẹ̀kan, ìgbà díẹ̀ tàbí ọ̀pọ̀lọpọ̀ ìgbà?		
		YES /Bẹ́ẹ̀ ni	NO/ Rárá	YES/ Bẹ́ẹ̀ni	NO/ Rárá	Once/ Ẹ̀ẹ̀kan	Few Times /Ìgbà díẹ̀	Many Times/ Ọ̀pọ̀lọpọ̀ ìgbà	Once/ Ẹ̀ẹ̀kan	Few Times /Ìgbà díẹ̀	Many Times/ Ọ̀pọ̀lọpọ̀ ìgbà
	i. Slapped you or thrown something at you that could hurt you? / Gbá etí yín rí tàbí ju ohun tó lè Ṣe yín léṢe mọ́ ọ yín rí?	1	2	1	2	1	2	3	1	2	3
	ii. Pushed you or shoved you? / Tì yín tàbí bì yín síwájú rí?	1	2	1	2	1	2	3	1	2	3
	iii. Hit you with his fist or with something else that could hurt you? / Ti gba yín lẹ́Ṣẹ̀ ẹ́ rí tàbí nnkan tó le Ṣe yín léṢe?	1	2	1	2	1	2	3	1	2	3
	iv. Kicked, dragged or beaten you up? / Ta yín nípàá, fà yín nífàkufà tàbí lù yín.	1	2	1	2	1	2	3	1	2	3
	v. Chocked or burnt you on purpose? / Fi nnkan gbe yin tàbí sun yín fún ìdí kan?	1	2	1	2	1	2	3	1	2	3
	vi. Threatened to use or actually used a gun, knife or other weapon against you? / Halẹ̀ láti lo tàbí tilẹ̀ lo ìbọn, ọ̀bẹ tàbí ohun ìjà olóró mìíràn fún un yín rí?	1	2	1	2	1	2	3	1	2	3

706	Has he or any other partner ever: Njẹ òun tàbí òmíràn ti	A) **(IF YES continue with B. If NO, skip to next item)** **(Tí ó bá jẹ́ bẹ́ẹ̀ni tẹ̀síwájú pẹ̀lú B. Tí ó bá jẹ́ rárá, fi í sílẹ̀ lọ́ sí èyí tó kàn)**		B) Has this happened in the past 12 months **(IF YES, ask C only. If NO ask D only)** Ṣé eléyìí Ṣẹlẹ̀ láti oSù méjìlá séyìn **(Tí ó bá jẹ́ bẹ́ẹ̀ni tẹ̀síwájú pẹ̀lú C. Tí ó bá jẹ́ rárá, Bèèrè D nìkan)**		C) In the past 12 months would you say that this has happened once, a few times or many times? **(After answering C, skip D)** Láti oSù méjìlá séyìn Ṣé ẹ ma ṣọ pé eléyìí Ṣẹlẹ̀ lẹ́ẹ̀kan, ìgbà díẹ̀ tàbí ọ̀pọ̀lọpọ̀ ìgbà? **(Lẹ́yìn ìdáhùn C, fi sílẹ̀ lọ D)**			D) Prior to the last 12 months would you say that this has happened once, a few times or many times? Sáájú oSù méjìlá tó lọ Ṣé ẹ eléyìí Ṣẹlẹ̀ lẹ́ẹ̀kan, ìgbà díẹ̀ tàbí ọ̀pọ̀lọpọ̀ ìgbà?		
		YES /Bẹ́ẹ̀ni	NO/ Rárá	YES/ Bẹ́ẹ̀ni	NO/ Rárá	Once/ Ẹ̀ẹ̀kan	Few Times /Ìgbà díẹ̀	Many Times/ Ọ̀pọ̀lọpọ̀ ìgbà	Once/ Ẹ̀ẹ̀kan	Few Times /Ìgbà díẹ̀	Many Times/ Ọ̀pọ̀lọpọ̀ ìgbà
	i. Physically forced you to have sexual intercourse when you did not want to? / Fi ipá mu yín lógbòndokòó ní ìbálòpọ̀ nígbà tí ẹ kò fẹ́ Ṣe?	1	2	1	2	1	2	3	1	2	3
	ii. Did you ever have sexual intercourse that was not physically forced on you, but because you were afraid of what he might do? / Njẹ́ tilẹ̀ ní ìbálòpọ̀ tí kíí Ṣe èyí tí a fi ipá mu yín lógbòndokòó láti Ṣe Ṣùgbọ́n nítorí èrù ohun tí ó lè Ṣe?	1	2	1	2	1	2	3	1	2	3
	iii. Did he ever force you to perform a sex act that you found degrading or humiliating? / Njẹ́ ó fipá mu yín Ṣe ohun tí ó jẹ́ mọ́ ìbálòpọ̀ tí ẹ rí bí i ohun tí ó n mú já èníyàn wálẹ̀ · tàbí mú ọkàn èníyàn tẹ̀ba?	1	2	1	2	1	2	3	1	2	3
	iv. Did he ever deny you from any sexual activity when you particularly wanted it? / Njẹ́ okò jẹ́ kí ẹ Ṣe iṢẹ́ ìbálòpọ̀ kan nígbà tí ẹkanlẹ̀ nílò rẹ̀?	1	2	1	2	1	2	3	1	2	3

Verify if respondent answered YES to any question in 704, 705 or 706 – Tick the appropriate box on the right. ***Fìdí ìdáhùn BẹẹNI sí ìbéèrè 704, 705 tàbí 706 múlẹ́-Sàmì síkóló tí ó yẹ ní ọ̀tún.***		**YES, SOME FORM OF VIOLENCE** **Bẹẹ̀ni, àwọn nnkan bí i èdè-ò-yedè**	**NO VIOLENCE** **Kò sí èdè-ò-yedè**	**SKIP TO/** **Fi sílẹ̀ lọ sí**
No / Nọ́mbà.	**Questions / Ìbéèrè**			
707 I	You said there have been occasions where your husband / partner has hurt you or threatened to hurt you. How many incidents of this nature do you remember in the last 12 months? Ẹ sọ pé àwọn ìsẹ̀lẹ̀ kan tí ọkọ/àfẹ́sọ́nà yín ti ṣẹ̀ yín lẹ́ṣe. Mélòó nínú àwọn ìsẹ̀lẹ̀ yìí ni ẹ rántí láti oṣù méjìlá séyìn?			

707 II	What happened in the last (or if you can remember, the last three) of these incidents? / Kín ni ó ṣẹlẹ̀ kéyìn (bí ẹ bá le rántí méta tí ó kéyìn) nínú àwọn ìsẹ̀lẹ̀ yìí? **Má Ṣe kà láti inú àkọ̀jáde, fi ìdáhùn olùfọ̀rọ̀wálẹ́n uwò Ṣe ìbámu sí irúfẹ́ èyí tó bá a lọ**	**INCIDENT/ Ìsẹ̀lẹ̀ 1**	**INCIDENT/ Ìsẹ̀lẹ̀ 2**	**INCIDENT/ Ìsẹ̀lẹ̀ 3**
		Insulted you or made you feel bad about yourself/ Fi ìwọ̀sí kàn yín tàbí múnú yín bàjẹ́..... A	Insulted you or made you feel bad about yourself/ Fi ìwọ̀sí kàn yín tàbí múnú yín bàjẹ́..... A	Insulted you or made you feel bad about yourself/ Fi ìwọ̀sí kàn yín tàbí múnú yín bàjẹ́.....A
		Belittled or humiliated you in front of other people/ Fojú kéré yín tàbí mú ọkàn yín tèba..... B	Belittled or humiliated you in front of other people/ Fojú kéré yín tàbí mú ọkàn yín tèba..... B	Belittled or humiliated you in front of other people/ Fojú kéré yín tàbí mú ọkàn yín tèba..... B
		Did things to scare or intimidate you on purpose/ Ṣe àwọn ohun tí yóò bà yín lẹ́rù tàbí dáyà fò yín (b.a. nípa ọ̀nà tó fi n wò yín, ké mọ yín tàbí tàbí lílú nnkan mọ́ nnkan)..... C	Did things to scare or intimidate you on purpose/ Ṣe àwọn ohun tí yóò bà yín lẹ́rù tàbí dáyà fò yín (b.a. nípa ọ̀nà tó fi n wò yín, ké mọ yín tàbí tàbí lílú nnkan mọ́ nnkan)..... C	Did things to scare or intimidate you on purpose/ Ṣe àwọn ohun tí yóò bà yín lẹ́rù tàbí dáyà fò yín (b.a. nípa ọ̀nà tó fi n wò yín, ké mọ yín tàbí tàbí lílú nnkan mọ́ nnkan).....C
		Threatened to hurt you or someone you care about/ Halẹ̀ láti ṣe yín lẹ́ṣe tàbí ohun tí náání..... D	Threatened to hurt you or someone you care about/ Halẹ̀ láti Ṣe yín lẹ́ṣe tàbí ohun tí náání..... D	Threatened to hurt you or someone you care about/ Halẹ̀ láti ṣe yín lẹ́ṣe tàbí ohun tí náání..... D
		Slapped you/ Gbá etí yín..... E	Slapped you/ Gbá etí yín..... E	Slapped you/ Gbá etí yín.....E

		Thrown something that could hurt you / Ju ohun tó lè ṣe yín léṣe mọ́ ọ yín..... F Pushed or shoved you/ Tì yín tàbí bì yín síwájú…..... G Hit you with his fist or something else that could hurt / Ti gba yín lẹ́ṣẹ̀ ẹ́ tàbí nnkan tó le ṣe yín léṣe..... H Kicked, dragged or beaten you up/ Ta yín nípàá, fà yín nífàkufà tàbí lù yín...I Chocked or burned you on purpose/ Fi nnkan gbe yin tàbí sun yín fún ìdí kan……..J Threatened to use, or actually used a gun, knife or other weapon on you/ Halẹ̀ láti lo tàbí tilẹ̀ lo ìbọn, ọbẹ tàbí ohun ìjà olóró mìíràn fún un yín rí..... K Forced you to do something sexual that you found degrading or humiliating/ Fipá mu ṣe ohun tí ó jẹ́ mọ́ ìbálòpọ̀ tí rí bí i ohun tí ó n mú ènìyàn wálẹ̀ tàbí mú ọkàn ènìyàn tẹ̀ba..... L You had sexual intercourse because you were afraid of what he might do/ Ní álòpọ̀ nítorí ẹ̀rù ohun tí ó lè ṣe.....M Physically forced you to have sexual intercourse when you did not want/ Fi ipá mu yín lógbòndokòó ní ìbálòpọ̀ nígbà tí ẹ kò fẹ́ ṣe..... N	Thrown something that could hurt you / Ju ohun tó lè ṣe yín léṣe mọ́ ọ yín…....F Pushed or shoved you/ Tì yín tàbí bì yín síwájú.....G Hit you with his fist or something else that could hurt / Ti gba yín lẹ́ṣẹ̀ ẹ́ tàbí nnkan tó le ṣe yín léṣe..... H Kicked, dragged or beaten you up/ Ta yín nípàá, fà yín nífàkufà tàbí lù yín...I Chocked or burned you on purpose/ Fi nnkan gbe yin tàbí sun yín fún ìdí kan……...J Threatened to use, or actually used a gun, knife or other weapon on you/ Halẹ̀ láti lo tàbí tilẹ̀ lo ìbọn, ọbẹ tàbí ohun ìjà olóró mìíràn fún un yín rí…..... K Forced you to do something sexual that you found degrading or humiliating/ Fipá mu ṣe ohun tí ó jẹ́ mọ́ ìbálòpọ̀ tí rí bí i ohun tí ó n mú ènìyàn wálẹ̀ tàbí mú ọkàn ènìyàn tẹ̀ba..... L You had sexual intercourse because you were afraid of what he might do/ Ní álòpọ̀ nítorí ẹ̀rù ohun tí ó lè ṣe..... M Physically forced you to have sexual intercourse when you did not want/ Fi ipá mu yín lógbòndokòó ní ìbálòpọ̀ nígbà tí ẹ kò fẹ́ ṣe..... N	Thrown something that could hurt you / Ju ohun tó lè ṣe yín léṣe mọ́ ọ yín….....F Pushed or shoved you/ Tì yín tàbí bì yín síwájú.....G Hit you with his fist or something else that could hurt / Ti gba yín lẹ́ṣẹ̀ ẹ́ tàbí nnkan tó le ṣe yín léṣe..... H Kicked, dragged or beaten you up/ Ta yín nípàá, fà yín nífàkufà tàbí lù yín...I Chocked or burned you on purpose/ Fi nnkan gbe yin tàbí sun yín fún ìdí kan……...J Threatened to use, or actually used a gun, knife or other weapon on you/ Halẹ̀ láti lo tàbí tilẹ̀ lo ìbọn, ọbẹ tàbí ohun ìjà olóró mìíràn fún un yín rí…..... K Forced you to do something sexual that you found degrading or humiliating/ Fipá mu ṣe ohun tí ó jẹ́ mọ́ ìbálòpọ̀ tí rí bí i ohun tí ó n mú ènìyàn wálẹ̀ tàbí mú ọkàn ènìyàn tẹ̀ba..... L You had sexual intercourse because you were afraid of what he might do/ Ní álòpọ̀ nítorí ẹ̀rù ohun tí ó lè ṣe..... M Physically forced you to have sexual intercourse when you did not want/ Fi ipá mu yín lógbòndokòó ní ìbálòpọ̀ nígbà tí ẹ kò fẹ́ ṣe..... N

707 III	Did you have any physical or sexual injuries after this incident? / Njé ẹ ní ìpalára tó hàn tàbí ti ìbálòpọ̀ lẹ́yìn ìṣẹ̀lẹ̀ yìí? **ÌṢòro tó bá ní Ṣe pèlú àròjinlẹ̀ ni a ó mójú tó tó bá yá nínú ìwé ìbéèrè yìí**	**INCIDENT 1** Yes / Bẹ́ẹ̀ni……..1 No / Rárá……..2 → 707V			**INCIDENT 2** Yes / Bẹ́ẹ̀ni……..1 No / Rárá ……..2 → 707V			**INCIDENT 3** Yes / Bẹ́ẹ̀ni……..1 No / Rárá…… 2 → 707V		
707 IV	What was the nature of the injury you had? / Irú èṣe wo ni	**INCIDENT/ Ìṣẹ̀lẹ̀ 1**	YES/ Bẹ́ẹ̀ni	NO/ Rárá	**INCIDENT/ Ìṣẹ̀lẹ̀ 2**	YES/ Bẹ́ẹ̀ni	NO/ Rárá	**INCIDENT/ Ìṣẹ̀lẹ̀ 3**	YES/ Bẹ́ẹ̀ni	NO/ Rárá
		a) Cuts, Punctures, Bites/ Gígé, Gígún, Gígé jẹ	1	2	a) Cuts, Punctures, Bites/ Gígé, Gígún, Gígé jẹ	1	2	a) Cuts, Punctures, Bites/ Gígé, Gígún, Gígé jẹ	1	2
		b) Scratches, Abrasions, Bruises/ Ara yíya, ìfarapa	1	2	b) Scratches, Abrasions, Bruises/ Ara yíya, ìfarapa	1	2	b) Scratches, Abrasions, Bruises/ Ara yíya, ìfarapa	1	2
		c) Sprains, Dislocations/ Eegun yíyẹ̀	1	2	c) Sprains, Dislocations/ Eegun yíyẹ̀	1	2	c) Sprains, Dislocations/ Eegun yíyẹ̀	1	2
		d) Burns/ Ara jíjóná	1	2	d) Burns/ Ara jíjóná	1	2	d) Burns/ Ara jíjóná	1	2

		e) Penetrating injury, Deep cuts, Gashes/ ọgbẹ́ jíjẹ, Egbò tó jinlè/ọgbẹ́ tó gùn tó tún jìn f) Broken eardrum, eye injury/ Etí jájá tabi ọgbẹ́ etí, ọgbẹ́ ojú g) Fractured/Broken bones/ Eegun kíkan h) Broken teeth/ Eyín kíkán i) Vaginal pain or discomfort/ Ìrora òbò tàbí ìnira j) Other/ Òmíràn _____ ...77	1 1 1 1 1 1	2 2 2 2 2 2	e) Penetrating injury, Deep cuts, Gashes/ ọgbẹ́ jíjẹ, Egbò tó jinlè/ọgbẹ́ tó gùn tó tún jìn f) Broken eardrum, eye injury/ Etí jájá tabi ọgbẹ́ etí, ọgbẹ́ ojú g) Fractured/Broken bones/ Eegun kíkan h) Broken teeth/ Eyín kíkán i) Vaginal pain or discomfort/ Ìrora òbò tàbí ìnira j) Other/ Òmíràn _____ 77	1 1 1 1 1 1	2 2 2 2 2 2	e) Penetrating injury, Deep cuts, Gashes/ ọgbẹ́ jíjẹ, Egbò tó jinlè/ọgbẹ́ tó gùn tó tún jìn f) Broken eardrum, eye injury/ Etí jájá tabi ọgbẹ́ etí, ọgbẹ́ ojú g) Fractured/Broken bones/ Eegun kíkan h) Broken teeth/ Eyín kíkán i) Vaginal pain or discomfort/ Ìrora òbò tàbí ìnira j) Other/ Òmíràn _____....77	1 1 1 1 1 1	2 2 2 2 2 2
707 V	Did you receive healthcare after this incident? / Njẹ ẹ gba ìtójú ìlera lẹ́yìn ìṣẹ̀lẹ̀ náà?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni……..1 No / Rárá ……..... 2 →	707VII		**INCIDENT/ Ìṣẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni……..1 No / Rárá…….... 2 →	707VII		**INCIDENT/ Ìṣẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni……..1 No / Rárá……..... 2 →	707VII	

707 VI	Did you go to: Njé ẹ lọ si: How much total money did you have to spend? Èló ni iye owó tẹ́ ná lápapò?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** Hospital/ Ilé ìwòsàn……. Chemist/ Ilé ologùn òyìnbó…… Dentist/ Ọ̀dọ̀ Dókítà eléyín…….…… Traditional healer / Òlùwòsàn íbìílẹ̀…… Other: Òmíràn: _____ .....77 Amount spent on: Iye tí ẹ ná: a) Service: Isẹ́: _____ b) Transport: Owó ọkọ: _____ c) Medicine: Òògùn: _____	YES/ Bẹ́ẹ̀ni 1 1 1 1	NO/ Rárá 2 2 2 2	**INCIDENT/ Ìṣẹ̀lẹ̀ 2** Hospital/ Ilé ìwòsàn……. Chemist/ Ilé ologùn òyìnbó…… Dentist/ Ọ̀dọ̀ Dókítà eléyín…….…… Traditional healer / Òlùwòsàn íbìílẹ̀…… Other: Òmíràn: _____ .....77 Amount spent on: Iye tí ẹ ná: a) Service: Isẹ́: _____ b) Transport: Owó ọkọ: _____ c) Medicine: Òògùn: _____	YES/ Bẹ́ẹ̀ni 1 1 1 1	NO/ Rárá 2 2 2 2	**INCIDENT/ Ìṣẹ̀lẹ̀ 3** Hospital/ Ilé ìwòsàn……. Chemist/ Ilé ologùn òyìnbó…… Dentist/ Ọ̀dọ̀ Dókítà eléyín…….…… Traditional healer / Òlùwòsàn íbìílẹ̀…… Other: Òmíràn: _____ .....77 Amount spent on: Iye tí ẹ ná: a) Service: Isẹ́: _____ b) Transport: Owó ọkọ: _____ c) Medicine: Òògùn: _____	YES/ Bẹ́ẹ̀ni 1 1 1 1	NO/ Rárá 2 2 2 2

707 VII	Did you have to take time off work after this incident? / Ṣé ẹ ní láti gbàyè níbi iṣẹ́ lẹ́yìn ìṣẹ̀lẹ̀ yìí ni?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni.....1 No / Rárá..... 2 →	707IX	**INCIDENT/ Ìṣẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni.....1 No / Rárá..... 2 →	707IX	**INCIDENT/ Ìṣẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni.....1 No / Rárá..... 2 →	707IX
707 VIII	How many days did you have to take off because of this incident? / Ọjọ́ mélòó ni ẹ fi gbàyè níbi iṣẹ́ lẹ́yìn ìṣẹ̀lẹ̀ yìí? Did you still get paid during the days you had to take off work? / Ṣé wọ́n ṣì tún sanwó fún yín lásìkò àyè tẹ gbà yìí?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** No. of days off/ Iye ọjọ́..... ☐☐ Yes / Bẹ́ẹ̀ni .....1 No / Rárá 2		**INCIDENT/ Ìṣẹ̀lẹ̀ 2** No. of days off / Iye ọjọ́.....☐☐ Yes / Bẹ́ẹ̀ni .....1 No / Rárá 2		**INCIDENT/ Ìṣẹ̀lẹ̀ 3** No. of days off / Iye ọjọ́.....☐☐ Yes / Bẹ́ẹ̀ni .....1 No/Rárá 2	

707 IX	Did you have to stop housework after this incident? / Ṣé ẹ kò ṣiṣẹ́ ilé mọ́ léyìn ìṣẹ̀lẹ̀ yìí?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni..... 1 No / Rárá..... 2 → 707XIV				**INCIDENT/ Ìṣẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni.....1 No / Rárá..... 2 → 707XIV				**INCIDENT/ Ìṣẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni.....1 No / Rárá.....2 → 707XIV			
707 X	What are the types of work you had to forego? / Irú àwọn isẹ́ wo lẹ ní láti fi sílẹ̀?	**INCIDENT/Ìṣẹ̀lẹ̀1** Caring for children/ Ìtọ́jú ọmọ.	**YES/** Bẹ́ẹ̀ni **1**	**NO/** Rárá **2** →	707-XIII	**INCIDENT/ Ìṣẹ̀lẹ̀2** Caring for children/ Ìtọ́jú ọmọ.	**YES/** Bẹ́ẹ̀ni **1**	**NO/** Rárá **2** →	707-XIII	**INCIDENT/Ìṣẹ̀lẹ̀3** Caring for children/ Ìtọ́jú ·mọ.	**YES/** Bẹ́ẹ̀ni **1**	**NO/** Rárá **2** →	707-XIII
707 XI	You said you could not take care of the children, were they fed by someone else or fed themselves ? /ẹ sọ pé ẹ kòlè mójútó àwọn ọmọ, ṣé elòmíràn ni ó bọ́ wọn ni àbí wọ́n n bọ́ ara wọn?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** Fed by someone else/ ẹlòmíràn ló n bọ́ wọn..... 1 Fed themselves/ Wọ́n bọ́ ara wọn..... 2 Fed by you, but food was of poor quality/Èmi náà ni mo bọ́ wọn Ṣùgbọ́n oúnjẹ wọn kò dára tó..... 3 Went hungry/ Ebí pa wón ni.....4				**INCIDENT/ Ìṣẹ̀lẹ̀ 2** Fed by someone else/ ẹlòmíràn ló n bọ́ wọn.....1 Fed themselves/ Wọ́n bọ́ ara wọn..... 2 Fed by you, but food was of poor quality/ Èmi náà ni mo bọ́ wọn Ṣùgbọ́n oúnjẹ wọn kò dára tó..... 3 Went hungry/ Ebí pa wón ni..... 4				**INCIDENT/ Ìṣẹ̀lẹ̀ 3** Fed by someone else/ ẹlòmíràn ló n bọ́ wọn.....1 Fed themselves/ Wọ́n bọ́ ara wọn..... 2 Fed by you, but food was of poor quality/ Èmi náà ni mo bọ́ wọn Ṣùgbọ́n oúnjẹ wọn kò dára tó.....3 Went hungry/ Ebí pa wón ni..... 4			

707 XII	Did any of your children have to miss school after this incident? / Ṣé ọ̀kankan nínú àwọn ọmọ yín ní láti pa ilé ìwé jẹ nítorí ìṢẹ̀lẹ̀ yìí? IF YES how many school days did they miss? / **Tó bá jẹ́ bẹ́ẹ̀ni**, iye ọjọ́ mélòó ni wọ́ pa jẹ	**INCIDENT / Ìsẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni…….. 1 No / Rárá……..2 IF YES/ /**Tó bá jẹ́ bẹ́ẹ̀ni**, Number of school days missed/ Iye ọjọ́ tí wọ́n pa jẹ…….☐☐			**INCIDENT / Ìsẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni…….. 1 No / Rárá…….. 2 IF YES/ /**Tó bá jẹ́ bẹ́ẹ̀ni**, Number of school days missed/ Iye ọjọ́ tí wọ́n pa jẹ…….☐☐			**INCIDENT / Ìsẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni…….. 1 No / Rárá…….. 2 IF YES/ /**Tó bá jẹ́ bẹ́ẹ̀ni**, Number of school days missed/ Iye ọjọ́ tí wọ́n pa jẹ…….☐☐		
707XIII	What are the other types of work you had to forego? / Àwọn iṣẹ́ mìíràn wo lẹ ní láti fi sílẹ̀?	**INCIDENT/ Ìsẹ̀lẹ̀ 1**	**YES/** Bẹ́ẹ̀ni	**NO/** Rárá	**INCIDENT/ Ìsẹ̀lẹ̀ 2**	**YES/** Bẹ́ẹ̀ni	**NO/** Rárá	**INCIDENT/ Ìsẹ̀lẹ̀ 3**	**YES/** Bẹ́ẹ̀ni	**NO/** Rárá
		m) Fetching water/ Omi pípọn….....	1	2	a) Fetching water/ Omi pípọn….....	1	2	a) Fetching water/ Omi pípọn….....	1	2
		n) Fetching firewood / Igi ṣíṣàjọ….....	1	2	b) Fetching firewood / Igi ṣíṣàjọ….....	1	2	b) Fetching firewood / Igi ṣíṣàjọ….....	1	2
		o) Ironing/ Aṣọ lílọ….....	1	2	c) Ironing/ Aṣọ lílọ….....	1	2	c) Ironing/ Aṣọ lílọ….....	1	2

		p) Washing clothes / Aṣọ fífọ….. q) Sweeping/ Ìlẹ gbígbá….. r) Washing dishes/ Abọ́ fífọ……. s) Washing vehicle / Fífọ ohun ìrinnà…..… t) Dispose garbage/ Dídalẹ̀nù..... u) Cooking/ Oúnjẹ sísè…….... v) Caring for sick/ Ṣíṣe ìtọ́jú aláìsàn..... w) Shopping/household needs/ Ríra ohun tí ilé nílò... x) Running errands / Rírán níṣẹ́..... Other housework: Isẹ́ ilé mìíràn.....	1 1 1 1 1 1 1 1 1 1	2 2 2 2 2 2 2 2 2 2	d) Washing clothes / Aṣọ fífọ….. e) Sweeping/ Ìlẹ gbígbá….. f) Washing dishes/ Abọ́ fífọ……. g) Washing vehicle / Fífọ ohun ìrinnà…..……. h) Dispose garbage/ Dídalẹ̀nù..... i) Cooking/ Oúnjẹ sísè…….... j) Caring for sick/ Ṣíṣe ìtọ́jú aláìsàn…….... k) Shopping/household needs/ Ríra ohun tí ilé nílò…….. l) Running errands / Rírán níṣẹ́..... Other housework: Isẹ́ ilé mìíràn.....	1 1 1 1 1 1 1 1 1 1	2 2 2 2 2 2 2 2 2 2	d) Washing clothes / Aṣọ fífọ….. e) Sweeping/ Ìlẹ gbígbá….. f) Washing dishes/ Abọ́ fífọ……. g) Washing vehicle / Fífọ ohun ìrinnà…….. h) Dispose garbage/ Dídalẹ̀nù..... i) Cooking/ Oúnjẹ sísè…….... j) Caring for sick/ Ṣíṣe ìtọ́jú aláìsàn..... k) Shopping/household needs/ Ríra ohun tí ilé nílò……. l) Running errands / Rírán níṣẹ́..... Other housework: Isẹ́ ilé mìíràn.....	1 1 1 1 1 1 1 1 1 1	2 2 2 2 2 2 2 2 2 2

707 XIV	Did your husband/ partner have to take time off from work after this incident? / Ṣé ọkọ/àfẹ́ṣọ́nà rẹ ní láti gbàyè ni iṣẹ́ nítorí ìṣẹ̀lẹ̀ yìí?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni…..1 No / Rárá……2 →	707XVI	**INCIDENT/ Ìṣẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni…….1 No / Rárá…….2 →	707XVI	**INCIDENT/ Ìṣẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni…….1 No / Rárá……2 →	707XVI
707 XV	How many days did he (your husband/ partner) have to take off because of this incident? / Àyè ọjọ́ mélòó ni ó (ọkọ/àfṣọ́nà rẹ) ní láti gbà níbi iṣẹ́? Did he get paid for the days he had to take off from work? / Ṣé wọ́n san owó àwọn ọjọ́ tó gba àyè rẹ̀ yìí níbi iṣẹ́?	**INCIDENT 1** No. of days off / Iye ọjọ́……..☐☐ Yes/Bẹ́ẹ̀ni ……..1 No/Rárá …….. 2		**INCIDENT 2** No. of days off / Iye ọjọ́……..☐☐ Yes/Bẹ́ẹ̀ni ……..1 No/Rárá …….. 2		**INCIDENT 3** No. of days off / Iye ọjọ́……..☐☐ Yes/Bẹ́ẹ̀ni ……..1 No/Rárá …….. 2	

707 XVI	Did your husband/ partner have to stop or reduce the work he usually does around the house? Ṣé ọkọ/àfẹ́ṣọ́nà rẹ ní láti dín iṣẹ́ ilé tí ó máa n ṣe kù?	**INCIDENT / Ìsẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni……..1 No / Rárá…….. 2 →	707XVIII		**INCIDENT/ Ìsẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni…….1 No / Rárá…….. 2 →	707XVIII		**INCIDENT/ Ìsẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni…….. 1 No / Rárá……..2 →	707XVIII		
707 XVII	What are the types of work he had to forego? / Irú àwọn iṣẹ́ wo ni ó ní láti fi sílẹ̀?	**INCIDENT/ Ìsẹ̀lẹ̀ 1**	YES/ Bẹ́ẹ̀ni	NO/ Rárá	**INCIDENT/ Ìsẹ̀lẹ̀ 2**	YES/ Bẹ́ẹ̀ni	NO/ Rárá	**INCIDENT/ Ìsẹ̀lẹ̀ 1**	YES/ Bẹ́ẹ̀ni	NO/ Rárá
		a) Fetching water/ Omi pípọn……..	1	2	a) Fetching water/ Omi pípọn……..	1	2	a) Fetching water/ Omi pípọn……..	1	2
		b) Fetching firewood/ Igi ṣíṣàjọ……..	1	2	b) Fetching firewood/ Igi ṣíṣàjọ……..	1	2	b) Fetching firewood/ Igi ṣíṣàjọ……..	1	2
		c) Caring for children/ ṣíṣe ìtọ́jú àwọn ọmọ……..	1	2	c) Caring for children/ ṣíṣe ìtọ́jú àwọn ọmọ……..	1	2	c) Caring for children/ ṣíṣe ìtọ́jú àwọn ọmọ……..	1	2
		d) Ironing/ Aṣọ lílọ…….	1	2	d) Ironing/ Aṣọ lílọ…….	1	2	d) Ironing/ Aṣọ lílọ…….	1	2
		e) Washing clothes / Aṣọ fífọ……..	1	2	e) Washing clothes / Aṣọ fífọ……..	1	2	e) Washing clothes / Aṣọ fífọ……..	1	2
		f) Sweeping/ Ìlẹ̀ gbígbá……	1	2	f) Sweeping/ Ìlẹ̀ gbígbá……	1	2	f) Sweeping/ Ìlẹ̀ gbígbá……	1	2
		g) Washing dishes/ Abọ́ fífọ……..	1	2	g) Washing dishes/ Abọ́ fífọ……..	1	2	g) Washing dishes/ Abọ́ fífọ……..	1	2
		h) Washing vehicle / Fífọ ohun ìrinnà……	1	2	h) Washing vehicle / Fífọ ohun ìrinnà……..	1	2	h) Washing vehicle / Fífọ ohun ìrinnà……	1	2

		i) Dispose garbage/ Dídalẹ̀nù.....	1	2	i) Dispose garbage/ Dídalẹ̀nù.....	1	2	i) Dispose garbage/ Dídalẹ̀nù.....	1	2
		j) Cooking/ Oúnjẹ sísè…….....	1	2	j) Cooking/ Oúnjẹ sísè…….....	1	2	j) Cooking/ Oúnjẹ sísè…….....	1	2
		k) Caring for sick/ Ṣíṣe ìtọ́jú aláìsàn…..	1	2	k) Caring for sick/ Ṣíṣe ìtọ́jú aláìsàn…..	1	2	k) Caring for sick/ Ṣíṣe ìtọ́jú aláìsàn…..	1	2
		l) Shopping/household needs/ Ríra ohun tí ilé nílò...	1	2	l) Shopping/household needs/ Ríra ohun tí ilé nílò...	1	2	l) Shopping/household needs/ Ríra ohun tí ilé nílò...	1	2
		m) Running errands / Rírán níṣẹ́.....	1	2	m) Running errands / Rírán níṣẹ́.....	1	2	m) Running errands / Rírán níṣẹ́.....	1	2
		Other housework: Isẹ́ ilé mìíràn.....	1	2	Other housework: Isẹ́ ilé mìíràn.....	1	2	Other housework: Isẹ́ ilé mìíràn.....	1	2
707 XVIII	Did you go to the police and/or file a formal complaint after this incident? / Sé ẹ ní láti lọ sọ́dọ̀ ọlọ́pàá tàbí fí ẹ̀sùn kàn án lábẹ́ òfin lẹ́yìn ìṣẹ̀lẹ̀ yìí?	**INCIDENT / Ìṣẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni…..1 No / Rárá..... 2 →	707XXII		**INCIDENT / Ìṣẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni……1 No / Rárá..... 2 →	707XXII		**INCIDENT / Ìṣẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni……1 No / Rárá…….. 2 →	707XXII	

707 XIX	Did you pay for transport to get to the police station? Sé ẹ ní láti san owó ọkọ lọ sọ́dọ̀ àwọ́n ọlọ́pàá? If YES how much did you pay? / **Tó bá jẹ́ bẹ́ẹ̀ni**, èló ni ẹ san?	**INCIDENT/ Ìsẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni.....1 How much was the transport cost: Èló ni iye owó ọkọ náà: _____ No / Rárá..... 2	**INCIDENT/ Ìsẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni.....1 How much was the transport cost: Èló ni iye owó ọkọ náà: _____ No / Rárá 2	**INCIDENT/ Ìsẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni.....1 How much was the transport cost: Èló ni iye owó ọkọ náà: _____ No / Rárá 2
707 XX	Did you have to pay the police any money? / Ṣé ẹ ní láti sanwó fún àwọn ọlọ́pàá? If YES how much did you pay them? / **Tó bá jẹ́ bẹ́ẹ̀ni**, èló ni ẹ san fún wọn?	**INCIDENT/ Ìsẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni..... 1 Amount paid: Iye owó tí ẹ san: _____ No / Rárá..... 2	**INCIDENT/ Ìsẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni..... 1 Amount paid: Iye owó tí ẹ san: _____ No / Rárá..... 2	**INCIDENT/ Ìsẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni..... 1 Amount paid: Iye owó tí ẹ san: _____ No / Rárá..... 2

707 XXI	Did the complaint go to court? / Ṣé ẹ̀sùn náà délé ẹ̀jọ́? If YES, did you pay any court, lawyer fees?/ **Tó bá jẹ́ bẹ́ẹ̀ni**, ṣé ẹ sanwó ilé-ẹjọ́, agbẹjọ́rò	**INCIDENT/ Ìsẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni…….. 1 Amount paid? Iye owó tí ẹ san? Court fees: Owó ilé-ẹjọ́: _____ Lawyer: agbẹjọ́rò: _____ Transport: Owó ọkọ̀: _____ No / Rárá…….. 2	**INCIDENT/ÌSẹ̀Lẹ̀ 2** Yes / Bẹ́ẹ̀ni…….. 1 Amount paid? Iye owó tí ẹ san? Court fees: Owó ilé-ẹjọ́: _____ Lawyer: agbẹjọ́rò: _____ Transport: Owó ọkọ̀: _____ No / Rárá…….. 2	**INCIDENT/ÌSẹ̀Lẹ̀ 3** Yes / Bẹ́ẹ̀ni…….. 1 Amount paid? Iye owó tí ẹ san? Court fees: Owó ilé-ẹjọ́: _____ Lawyer: agbẹjọ́rò: _____ Transport: Owó ọkọ̀: _____ No / Rárá…….. 2
707 XXII	Did you leave the house after this incident? Ṣé ẹ fi ilé slẹ̀ léyìn ìṢẹ̀lẹ̀ náà?	**INCIDENT/ Ìsẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni……1 No / Rárá…… 2 → 707XXIV	**INCIDENT/ Ìsẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni…… 1 No / Rárá…… 2 → 707XXIV	**INCIDENT/ Ìsẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni…… 1 No / Rárá…… 2 → 707XXIV

707 XXIII	Where did you go when you left the house? / Níbo lẹ lọ nígbà tẹ file sílè? How many days did you spend there? / Ọjọ́ mélòó ni ẹ lè níbẹ̀? Did you have to pay any money to stay there? If YES how much did you have to pay per day? / Ṣé ẹ ní l’ati san owó Kankan láti lè gbé níbẹ̀? Tó bá jé **bẹ́ẹ̀ni** èló ni ẹ san fún ọjọ́?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** Shelter/ Ibi ìforípamọ́ sí............ Family/ Ìdílé................... Friends/ Ọ̀ré............... Others : / Òmíràn: __________ .... 77 No. of days away from home/ Iye ọjọ́ tí ẹ lò kúrò nílé............. ☐☐☐ Yes / Bẹ́ẹ̀ni.............1 Daily rate: Iye owó lójumọ́ kan: ________________ No / Rárá................ 2	YES/ Bẹ̀ẹ̀ni 1 1 1	NO/ Rárá 2 2 2	**INCIDENT/ Ìṣẹ̀lẹ̀ 2** Shelter/ Ibi ìforípamọ́ sí............ Family/ Ìdílé................... Friends/ Ọ̀ré............... Others : / Òmíràn: __________ .... 77 No. of days away from home/ Iye ọjọ́ tí ẹ lò kúrò nílé............. ☐☐☐ Yes / Bẹ́ẹ̀ni.............1 Daily rate: Iye owó lójumọ́ kan: ________________ No / Rárá................ 2	YES/ Bẹ̀ẹ̀ni 1 1 1	NO/ Rárá 2 2 2	**INCIDENT/ Ìṣẹ̀lẹ̀ 3** Shelter/ Ibi ìforípamọ́ sí............ Family/ Ìdílé................... Friends/ Ọ̀ré............... Others : / Òmíràn: __________ .... 77 No. of days away from home/ Iye ọjọ́ tí ẹ lò kúrò nílé............. ☐☐☐ Yes / Bẹ́ẹ̀ni.............1 Daily rate: Iye owó lójumọ́ kan: ________________ No / Rárá................ 2	YES/ Bẹ̀ẹ̀ni 1 1 1	NO/ Rárá 2 2 2
707 XXIV	Did you go to any other authorities in the community after this incident? / Ṣé ẹ lọ sọ́dọ̀ àwọn aláṣẹ àdúgbò kankan lẹ́yìn ìṣẹ̀lẹ̀• yìí?	**INCIDENT/ Ìṣẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni............... 1 No / Rárá.............. 2 →	707XXVI		**INCIDENT/ Ìṣẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni............... 1 No / Rárá.............. 2 →	707XXVI		**INCIDENT/ Ìṣẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni................1 No / Rárá.................2 →	707XXVI	

707 XXV	Were there any costs related to this action? / Njẹ owó sísan kan jẹ mọ́ èyí? If YES, how much? / Tó bá jẹ Bẹ́ẹ̀ni, èló ni?	**INCIDENT/ Ìsẹ̀lẹ̀ 1** Some amount of money was paid? / Iye owó kan jẹ́ sísan. Yes / Bẹ́ẹ̀ni..... 1 Fees: / Owó: _____ Transport / Owó ọkọ: _____ No / Rárá..... 2			**INCIDENT/ Ìsẹ̀lẹ̀ 2** Some amount of money was paid? / Iye owó kan jẹ́ sísan. Yes / Bẹ́ẹ̀ni..... 1 Fees: / Owó: _____ Transport / Owó ọkọ: _____ No / Rárá..... 2			**INCIDENT/ Ìsẹ̀lẹ̀ 3** Some amount of money was paid? / Iye owó kan jẹ́ sísan. Yes / Bẹ́ẹ̀ni..... 1 Fees: / Owó: _____ Transport / Owó ọkọ: _____ No / Rárá..... 2		
707 XXVI	I know that these are difficult experiences to deal with. Did you feel any of the following because of this incident? / Mo mọ̀ pé àwọn ìrírí yìí le láti gbé pẹ̀lú. Ṣé àwọn nnkan wọ̀nyìí ṣe yín lẹ́yìn ìsẹ̀lẹ̀ yìí?	**INCIDENT/ Ìsẹ̀lẹ̀ 1**	YES/ Bẹ́ẹ̀ni	NO/ Rárá	**INCIDENT/ Ìsẹ̀lẹ̀ 2**	YES/ Bẹ́ẹ̀ni	NO/ Rárá	**INCIDENT/ Ìsẹ̀lẹ̀ 3**	YES/ Bẹ́ẹ̀ni	NO/ Rárá
		e) Your daily work suffered/ Isẹ́ ojúmọ́ fara ko.....	1	2	a) Your daily work suffered/ Isẹ́ ojúmọ́ fara ko.....	1	2	a) Your daily work suffered/ Isẹ́ ojúmọ́ fara ko.....	1	2
		f) Felt unable to play a useful part in life/ Ó le láti lè ṣe bí ẹ ṣe máa n ṣe tẹ́lẹ̀.....	1	2	b) Felt unable to play a useful part in life/ Ó le láti lè ṣe bí ẹ ṣe máa n ṣe tẹ́lẹ̀.....	1	2	b) Felt unable to play a useful part in life/ Ó le láti lè ṣe bí ẹ ṣe máa n ṣe tẹ́lẹ̀.....	1	2
		g) Found it difficult to enjoy daily activities/ Ó le láti lè gbádùn isẹ́ ojúmọ́.....	1	2	c) Found it difficult to enjoy daily activities/ Ó le láti lè gbádùn isẹ́ ojúmọ́.....	1	2	c) Found it difficult to enjoy daily activities/ Ó le láti lè gbádùn isẹ́ ojúmọ́.....	1	2
		h) Had the thought of ending your life/ Ní èrò láti pa ara yín.....	1	2	d) Had the thought of ending your life/ Ní èrò láti pa ara yín.....	1	2	d) Had the thought of ending your life/ Ní èrò láti pa ara yín.....	1	2

707XXVII	IF YES to any of the questions above (707 XXVI), did you seek healthcare or other forms of support or therapy to soothe the difficulties? / Tó bá jẹ́ **Bẹ́ẹ̀ni** sí ọ̀kan nínú àwọn ìbéèrè òkè yìí (707 XXVI), Ṣé ẹ lọ fún ìtọ́jú ìlera tàbí ọ̀nà àbáyọ mìíràn kúrò nínú ìṣòro yì?	**INCIDENT/ Ìsẹ̀lẹ̀ 1** d) Medical or psychological therapy/ Ìṣègùn ọ̀rọ̀ tàbí ìtọ́jú àìsàn ọpọlọ..... e) Traditional healer/ Olùwòsàn ìbílẹ̀..... f) Others: Òmíràn.....	YES/ Bẹ́ẹ̀ni 1 1 1	NO/ Rárá 2 2 2	**INCIDENT/ Ìsẹ̀lẹ̀ 2** a) Medical or psychological therapy/ Ìṣègùn ọ̀rọ̀ tàbí ìtọ́jú àìsàn ọpọlọ..... b) Traditional healer/ Olùwòsàn ìbílẹ̀..... c) Others: Òmíràn.....	YES/ Bẹ́ẹ̀ni 1 1 1	NO/ Rárá 2 2 2	**INCIDENT/ Ìsẹ̀lẹ̀ 3** a) Medical or psychological therapy/ Ìṣègùn ọ̀rọ̀ tàbí ìtọ́jú àìsàn ọpọlọ..... b) Traditional healer/ Olùwòsàn ìbílẹ̀..... c) Others: Òmíràn.....	YES/ Bẹ́ẹ̀ni 1 1 1	NO/ Rárá 2 2 2
707XXVIII	Was any cost involved in the treatment or therapy? / Ṣé ìtọ́jú tàbí ìwòsàn yìí la ti owó lọ? IF YES, how much? / **Tó bá jẹ́ bẹ́ẹ̀ni**, èló ni?	**INCIDENT/ Ìsẹ̀lẹ̀ 1** Yes / Bẹ́ẹ̀ni..... 1 Amount paid: Iye owó: _____ No / Rárá..... 2			**INCIDENT/ Ìsẹ̀lẹ̀ 2** Yes / Bẹ́ẹ̀ni..... 1 Amount paid: Iye owó: _____ No / Rárá..... 2			**INCIDENT/ Ìsẹ̀lẹ̀ 3** Yes / Bẹ́ẹ̀ni..... 1 Amount paid: Iye owó: _____ No / Rárá..... 2		

707XXIX	We have talked about various fees and other costs you had to bear. Did you pay for all these fees out of your own pocket or did others pay for some of the fees? / A ti sọ̀rọ̀ nípa oríṢiríṢi owó tí ẹ san àtí àwọn owó mìíràn tí ẹ fara gbá. Ṣé ẹ san gbogb owó yìí láti inú àpò ara yí àbí àwọn kan san níbẹ̀?	**INCIDENT/ Ìsẹ̀lẹ̀ 1** Self / Fúnra alára….....….....1 Husband / Ọkọ (àfẹ́ṣọ́nà)….....2 Natal family / ìdílé ìbí.....….....3 Self and husband / Fúnra alára àti ọko (àfẹ́ṣọ́nà)..... 4 Self and natal / Fúnra alára àti ìdílé ìbí..... 5 Husband and natal / Ọko (àfẹ́ṣọ́nà) àti ìdílé ìbí.....6	**INCIDENT/ Ìsẹ̀lẹ̀ 2** Self / Fúnra alára….....….....1 Husband / Ọkọ (àfẹ́ṣọ́nà)….....2 Natal family / ìdílé ìbí.....….....3 Self and husband / Fúnra alára àti ọko (àfẹ́ṣọ́nà)..... 4 Self and natal / Fúnra alára àti ìdílé ìbí..... 5 Husband and natal / Ọko (àfẹ́ṣọ́nà) àti ìdílé ìbí.....6	**INCIDENT/ Ìsẹ̀lẹ̀ 3** Self / Fúnra alára….....….....1 Husband / Ọkọ (àfẹ́ṣọ́nà)….....2 Natal family / ìdílé ìbí.....….....3 Self and husband / Fúnra alára àti ọko (àfẹ́ṣọ́nà)….....4 Self and natal / Fúnra alára àti ìdílé ìbí..... 5 Husband and natal / Ọko (àfẹ́ṣọ́nà) àti ìdílé ìbí..... 6

SECTION/ ÌPÍN 8	COMPLETION OF INTERVIEW/ Ìparí ìfọ̀rọ̀wánilẹ́nuwò	
801	We have now finished the interview. Do you have any comments, or is there anything else you would like to add? / A ti parí ìfọ̀rọ̀wánilẹ́nuwò náà báyìí. Ṣé ẹ ní àríwísí, tàbí Ṣé nnkan mìíràn wà tí ẹ fé láti fi kun?	
802	I have asked you about many difficult things. How has talking about these things made you feel? Mo ti bi yín nípa àwọn ohun kan tí ó le. Báwo ni ọ̀rọ̀ wa ṣe jẹ́ kí ẹ ní ìmọ̀ lára sí?	Good/Better Dára/dára si.....1 Bad/Worse Kò dára/kò dára rárá.....2 Same/No difference Bákan náà/kò sí ìyàtọ̀…….....3

FINISH (A) – IF RESPONDENT HAS DISCLOSED PROBLEMS/VIOLENCE

ÌPARÍ (A)- Tí Olùfọ̀rọ̀wálẹ́nuwò bá fi Ìṣòro/Èdè-ò-yedè hàn

Finally, I would like to thank you very much for helping with this research. I appreciate the time you have taken. I realise that these questions may have been difficult for you to answer, but it is only by hearing from women themselves that we can have a better understanding of their health and experiences of violence. Ní ìgúnlẹ̀, Má fẹ́ láti dúpẹ́ púpọ̀ lọ́wọ́ yín pé ẹ ràn wá lọ́wọ́ nínú iṣẹ́ ìwádìí yìí. Mo moore àkókò yín tí ẹ ti lò. Mo rí i dájú pé àwọn ìbéèrè yìí le láti dáhùn, ṣùgbọ́n nípa gbígbọ́ lẹ́nu àwọn obìnrin fúnra wọn ni yóò jẹ́ kí á ní òye ìlera àti èdè-ò-yedè wọn.

From what you have told me, I can tell that you have had some difficult times in your life. No one has the right to treat someone else in that way. However, from what you have told me I can see that you are strong, and have survived through some difficult circumstances. Láti inú èyí tí ẹ ti sọ Fún mi, mo lè sọ pé ẹ la àwọn àkókò líle kan kọjá nínú ay'e yín. Kò sí ẹni tí ó ní àṣẹ láti láti hu irú ìwà báyẹn sí ẹlòmíràn ní ọ̀nà yẹn. Ju gbogbo rẹ̀ lọ, láti inú ohun tí ẹ ti sọ fún mi, mo rí i wí pé ẹ lágbára, ẹ sì ti rù àwọn ìgbà líle yìí là.

Here is a list of organisations that provide support, legal advice and counselling services to women in Kwara State. Please do contact them if you would like to talk over your situation with anyone. Their services are free, and they will keep anything that you say private. You can go whenever you feel ready to, either soon or later on. Èyí ni àwọn ẹgbẹ́ tí ó n pèsè àtìlẹ́yìn, ìmọ̀ràn ní ọ̀nà òfin àti ìtọ́sọ́nà fún àwọn obìnrin ní Ìpínlẹ̀ Kwárà. ẹ jọ̀wọ́, ẹ máa kàn sí wọn tí ẹ bá ti fẹ́ sọ̀rọ̀ nípa bí nnkan ṣe rí pẹ̀lú ẹnikẹ́ni nínú wọn. ọ̀fẹ́ ni iṣẹ́ wọn, wọn yòó sì pa ohun tí ó ní ṣe pẹ̀lú etímìíràn-ò-gbọdọ̀ gbọ́ mọ́. ẹ lè lọ nígbàkúùgbà tí ẹ bá fẹ́, bóyá láìpẹ́ tàbí tó bá yá.

FINISH (B) – IF RESPONDENT HAS NOT DISCLOSED PROBLEMS/VIOLENCE

ÌPARÍ (B)- Tí Olùfọ̀rọ̀wálẹ́nuwò kò bá fi Ìṣòro/Èdè-ò-yedè hàn

Finally, I would like to thank you very much for helping with this research. I appreciate the time that you have taken. I realise that these questions may have been difficult for you to answer, but it is only by hearing from women themselves that we can have a better understanding of their health and experiences in life. Ní ìgúnlẹ, Má fẹ́ láti dúpẹ́ púpọ̀ lọ́wọ́ yín pé ẹ ràn wá lọ́wọ́ nínú iṣẹ́ ìwádìí yìí. Mo moore àkókò yín tí ẹ ti lò. Mo rí i dájú pé àwọn ìbéèrè yìí le láti dáhùn, ṣùgbọ́n nípa gbígbọ́ lẹ́nu àwọn obìnrin fúnra wọn ni yóò jẹ́ kí á ní òye ìlera àti ìrírí ayé wọn.

In case you ever hear of another woman who needs help, here is a list of organisations that provide support, legal advice and counselling services to women in Kwara State. Please do contact them if you or any of your friends or relatives need help. Their services are free, and they will keep anything that anyone says to them private. O ṣeéṣe o kí ẹ gbọ́ nípa obìnrin mìíràn tí ó nílò ìrànlọ́wọ́, èyí ni àwọn ẹgbẹ́ tí ó n pèsè àtìlẹ́yìn, ìmọ̀ràn ní ọ̀nà òfin àti ìtọ́sọ́nà fún àwọn obìnrin ní Ìpínlẹ̀ Kwárà. ẹ jọ̀wọ́, ẹ máa kàn sí wọn tí ẹ bá ti fẹ́ sọ̀rọ̀ nípa bí nnkan ṣe rí pẹ̀lú ẹnikẹ́ni nínú wọn. ọ̀fẹ́ ni iṣẹ́ wọn, wọn yòó sì pa ohun tí ó ní ṣe pẹ̀lú etímìíràn-ò-gbọdọ̀ gbọ́ mọ́. ẹ lè lọ nígbàkúùgbà tí ẹ bá fẹ́, bóyá láìpẹ́ tàbí tó bá yá

Appendix3

MINISTRY OF WOMEN AFFAIRS

Telegrams: WOMEN, ILORIN
Telephone: PBX 222864
Telex: 33106 WOMEN

MWA/420/VOL3/13

Ref. No
STATE SECRETARIAT
PRIVATE MAIL BAG 1576
ILORIN,
KWARA STATE,
NIGERIA

6th September 20 11

Professor Rauf Naguib
Head, Biomedical Computing $ Engineering
Technologies Applied Research Group
Conventry University
Priority Street,
Conventry Cvi 5fB.

RE: PHD RESEARCH BY MR L. OLAYANJU.

Please recall your letter of July 22, 2011 on the above subject matter and to convey the approval of the Honourable commissioner to swing into action immediately and the findings of the research activity should be forwarded to us for our record purpose.

2. Acknowledge the receipt accordingly.

Yusuf S.A
For: Honourable Commissioner

Coventry University
Priory Street
Coventry CV1 5FB
Telephone 024 7688 7688

Professor Paul Ivey
Dean of Faculty

Professor Raouf Naguib
Professor of Biomedical Computing
Head, Biomedical Computing & Engineering
Technologies Applied Research Group (BIOCORE)

The Honourable Commissioner for Women's Affairs
Mrs Comfort Ayodele Afolayan
Ministry of Women's Affairs
Kwara State Secretariat
P.M.B 1576
Ilorin, Nigeria

22 July 2011

Dear Madam,

RE: PHD RESEARCH BY MR L. OLAYANJU

Mr. L. Olayanju is a research student with the Biomedical Computing and Engineering Technologies (BIOCORE) Applied Research Group, Coventry University, UK. He is conducting a study on Intimate Partner Violence (IPV) – any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those involved in the relationship.

This research is focused mainly on women in Kwara State, and will provide key information on the magnitude of IPV among women and its link to adverse health outcomes in the State. The successful completion of the research will help support the development of programmes, as well as facilitate already available ones relating to the prevention of violence against women in the State, and ultimately lead to greater women empowerment and promotion of gender equality that constitute part of the major goals of your Ministry at the moment.

Mr. Olayanju requires your approval and support in conducting this research, and it would be greatly appreciated if you could afford him the assistance requested.

Thank you for your anticipated support.

Yours sincerely,

Raouf Naguib
Professor of Biomedical Computing
Head, BIOCORE

Faculty of Engineering & Computing
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2007

Low Risk Research Ethics Approval Checklist

Applicant Details

Name: Lateef Olayanju	E-mail: olayanjl@coventry.ac.uk
Department: BIOCORE	Date: 20th July, 2011
Course: PhD	Title of Project: Intimate Partner Violence (IPV) in Kwara State, Nigeria: Magnitude, Risk Factors and Cost Estimation

Project Details

Summary of the project in jargon-free language and in not more than 120 words:

The research is in the area of intimate partner violence (IPV) – any behaviour within an intimate relationship that causes physical, sexual or psychological harm to those in the relationship. IPV is known to affect vast number of women around the world. In fact, research studies show that one out of every three women in an intimate relationship is affected by the violence. Despite this high level of IPV occurrence around the world and its pervasiveness, very few research have been carried out to explore such violence in Nigeria. Towards this void in knowledge, this research aims to shed some light on the IPV problem in Nigeria by considering the magnitude and likely risk factors of IPV using a focused population-based study. Besides, the research also considers the cost of IPV on households and community at large, as estimates of such financial burden are important for apportioning resources to support different prevention programmes and for conducting cost-benefit analysis of programmes designed to reduce the impacts of IPV, as well as for highlighting the nature of the violence

Research Objectives

- To estimate the prevalence and distribution of IPV amongst women in Kwara State
- To identify likely risk factors of IPV in Kwara state
- To identify help seeking attitudes of IPV victims in the Kwara state
- To estimate the cost of IPV – for households/individuals and community/service providers – in Kwara state
- To make recommendations based on the findings of the study

Research Design (e.g. Experimental, Desk-based, Theoretical etc)

The research is a cross-sectional population-based survey

Methods of Data Collection

Data will be collected using standardised questionnaires that will be administered in a face-to-face interview and will be covered by local ethical approval from the Kwara state government

Participants in your research

1. Will the project involve human participants?	Yes	

If you answered **Yes** to this questions, this may **not** be a low risk project.

- If you are a student, please discuss your project with your Supervisor.
- If you are a member of staff, please discuss your project with your Faculty Research Ethics Leader or use the Medium to High Risk Ethical Approval or NHS or Medical Approval Routes.

Risk to Participants

2. Will the project involve human patients/clients, health professionals, and/or patient (client) data and/or health professional data?		No
3. Will any invasive physical procedure, including collecting tissue or other samples, be used in the research?		No
4. Is there a risk of physical discomfort to those taking part?		No
5. Is there a risk of psychological or emotional distress to those taking part?		No
6. Is there a risk of challenging the deeply held beliefs of those taking part?		No
7. Is there a risk that previous, current or proposed criminal or illegal acts will be revealed by those taking part?		No
8. Will the project involve giving any form of professional, medical or legal advice, either directly or indirectly to those taking part?		No

If you answered **Yes** to **any** of these questions, this may **not** be a low risk project.

- If you are a student, please discuss your project with your Supervisor.
- If you are a member of staff, please discuss your project with your Faculty Research Ethics Leader or use the Medium to High Risk Ethical Approval or NHS or Medical Approval Routes.

Risk to Researcher

9. Will this project put you or others at risk of physical harm, injury or death?		No
10. Will project put you or others at risk of abduction, physical, mental or sexual abuse?		No
11. Will this project involve participating in acts that may cause psychological or emotional distress to you or to others?		No
12. Will this project involve observing acts which may cause psychological or emotional distress to you or to others?		No
13. Will this project involve reading about, listening to or viewing materials that may cause psychological or emotional distress to you or to others?		No
14. Will this project involve you disclosing personal data to the participants other than your name and the University as your contact and e-mail address?		No
15. Will this project involve you in unsupervised private discussion with people who are not already known to you?		No
16. Will this project potentially place you in the situation where you may receive unwelcome media attention?		No
17. Could the topic or results of this project be seen as illegal or attract the attention of the security services or other agencies?		No
18. Could the topic or results of this project be viewed as controversial by anyone?		No

If you answered **Yes** to **any** of these questions, this is **not** a low risk project. Please:

- If you are a student, discuss your project with your Supervisor.
- If you are a member of staff, discuss your project with your Faculty Research Ethics Leader or use the Medium to High Risk Ethical Approval route.

Informed Consent of the Participant

19. Are any of the participants under the age of 18?		No
20. Are any of the participants unable mentally or physically to give consent?		No
21. Do you intend to observe the activities of individuals or groups without their knowledge and/or informed consent from each participant (or from his or her parent or guardian)?		No

If you answered **Yes** to **any** of these questions, this may **not** be a low risk project. Please:

- If you are a student, discuss your project with your Supervisor.
- If you are a member of staff, discuss your project with your Faculty Research Ethics Leader or use the Medium to High Risk Ethical Approval route.

Participant Confidentiality and Data Protection

22. Will the project involve collecting data and information from human participants who will be identifiable in the final report?		No
23. Will information not already in the public domain about specific individuals or institutions be identifiable through data published or otherwise made available?		No
24. Do you intend to record, photograph or film individuals or groups without their knowledge or informed consent?		No
25. Do you intend to use the confidential information, knowledge or trade secrets gathered for any purpose other than this research project?		No

If you answered **Yes** to **any** of these questions, this may **not** be a low risk project:

- If you are a student, discuss your project with your Supervisor.
- If you are a member of staff, discuss your project with your Faculty Research Ethics Leader or use the Medium to High Risk Ethical Approval or NHS or Medical Approval routes.

Gatekeeper Risk

26. Will this project involve collecting data outside University buildings?	Yes	
27. Do you intend to collect data in shopping centres or other public places?		No
28. Do you intend to gather data within nurseries, schools or colleges?		No
29. Do you intend to gather data within National Health Service premises?		No

If you answered **Yes** to **any** of these questions, this is **not** a low risk project. Please:

- If you are a student, discuss your project with your Supervisor.
- If you are a member of staff, discuss your project with your Faculty Research Ethics Leader or use the Medium to High Risk Ethical Approval or NHS or Medical Approval routes.

Other Ethical Issues

30. Is there any other risk or issue not covered above that may pose a risk to you or any of the participants?		No
31. Will any activity associated with this project put you or the participants at an ethical, moral or legal risk?		No

If you answered **Yes** to these questions, this may **not** be a low risk project. Please:

- If you are a student, discuss your project with your Supervisor.
- If you are a member of staff, discuss your project with your Faculty Research Ethics Leader.

Principal Investigator Certification

If you answered **No** to **all** of the above questions, then you have described a low risk project. Please complete the following declaration to certify your project and keep a copy for your record as you may be asked for this at any time.

Agreed restrictions to project to allow Principal Investigator Certification

Please identify any restrictions to the project, agreed with your Supervisor or Faculty Research Ethics Leader to allow you to sign the Principal Investigator Certification declaration.

Participant Information Leaflet attached.
Informed Consent Forms attached.
Risk Assessment Form attached.

Principal Investigator's Declaration

Please ensure that you:

- Tick all the boxes below and sign this checklist.
- Students must get their Supervisor to countersign this declaration.

I believe that this project **does not require research ethics approval**. I have completed the checklist and kept a copy for my own records. I realise I may be asked to provide a copy of this checklist at any time.	YES
I confirm that I have answered all relevant questions in this checklist honestly.	YES
I confirm that I will carry out the project in the ways described in this checklist. I will immediately suspend research and request a new ethical approval if the project subsequently changes the information I have given in this checklist.	YES

Signatures

If you or your supervisor do not have electronic signatures, please type your name in the signature space. An email sent from the Supervisor's University inbox will be accepted as having been signed electronically.

Principal Investigator

Signed: ..... (Principal Investigator or Student)

Date: 12/09/2011

Students storing this checklist electronically must append to it an email from your Supervisor confirming that they are prepared to make the declaration above and to countersign this checklist. This-email will be taken as an electronic countersignature.

Student's Supervisor

Countersigned.....(Supervisor)

Date 19/9/11

I have read this checklist and confirm that it covers all the ethical issues raised by this project fully and frankly. I also confirm that these issues have been discussed with the student and will continue to be reviewed in the course of supervision.

Appendix4

Variable	Type	Code (showing reference category in the analyses)
Woman's age group	Categorical	18 – 29 (*Reference category*) 30 – 39 40 – 49 50 – 59 60 and above
Partner's age group	Categorical	18 – 29 (*Reference category*) 30 – 39 40 – 49 50 – 59 60 and above
Parenthood status	Categorical	No (*Reference category*) Yes
Marital/ relationship status	Categorical	Currently married (*Reference category*) Currently living with a man, but not married Currently having a regular partner who lives apart Divorced/ broken up with partner/ widowed
Location	Categorical	Ilorin (*Reference category*) Offa Erin-Ile
Woman literate	Categorical	Yes (*Reference category*) No
Partner literate	Categorical	Yes (*Reference category*) No
Woman's educational attainment	Categorical	Higher (*Reference category*) Secondary Primary or none
Partner's educational attainment	Categorical	Higher (*Reference category*) Secondary Primary or none
Partnership educational difference	Categorical	Same level (*Reference category*) Partner better educated Woman better educated
Woman in employment	Categorical	Yes (*Reference category*) No
Partner in employment	Categorical	Yes (*Reference category*) No
Nature of woman's work	Categorical	Salaried (*Reference category*) Self-employed

		Unpaid family worker
Nature of partner's work	Categorical	Salaried (*Reference category*) Self-employed Unpaid family worker
Partnership employment	Categorical	Both employed (*Reference category*) Only woman employed Only partner employed Both unemployed
Woman's frequency of communication with family	Categorical	Corresponds at least once a week (*Reference category*) Corresponds at least once a month Corresponds like once a year or hardly ever
Woman's proximity to her family	Categorical	Lives with family of birth (*Reference category*) Lives near Lives further away
Choice of spouse/partner	Categorical	Both chose (*Reference category*) Woman chose Others chose with woman's consent Others chose without woman's consent
Partner's general history of physical aggression	Categorical	No (*Reference category*) Yes Woman unaware
Partner engaged in affairs with other women	Categorical	No (*Reference category*) Yes May have Woman unaware
Partner's use of alcohol	Categorical	Never (*Reference category*) Everyday Once a week 1 – 3 times a month Less than once a month Woman unaware
Partner's history of drug use	Categorical	Never (*Reference category*) Every day 1 – 4 times a month Woman unaware
Partner's controlling Behaviour	Categorical	None (*Reference category*) One Two or Three Four or more
Woman's acceptance of violence (wife beating)	Categorical	Disagrees with all of the reasons to bit wife (*Reference category*) Agrees with one or more of the reasons to bit wife

Woman has ever been pregnant		No (*Reference category*) Yes May be
Contraception refusal by partner	Categorical	No (*Reference category*) Yes
Categorical number of children	Categorical	5 or more (*Reference category*) 3 – 4 1 – 2 None
History of miscarriages, stillbirths and abortions	Categorical	No (*Reference category*) Yes
Sex of child(ren)	Categorical	Only male (*Reference category*) Only female Both male and female No children at all
Partnership involves financial commitments	Categorical	No payments (*Reference category*) Dowry Bride price Both dowry and bride price Woman unaware
Partnership age difference	Categorical	Woman is same age (*Reference category*) Woman older Woman is 1-4 years younger Woman is 5-9 years younger Woman is 10 or more years younger
Partnership discord	Categorical	Never (*Reference category*) Rarely Often/ Sometimes
Level of female illiteracy in community	Continuous	*Number*
Level of male illiteracy in community	Continuous	*Number*
Proportion of women with higher education in community	Continuous	*Number*
Proportion of men with higher education in community	Continuous	*Number*
Level of female unemployment in	Continuous	*Number*

community		
Level of male unemployment in community	Continuous	*Number*
Proportion of couples without employment in community	Continuous	*Number*
Level of women's acceptance of violence (wife beating) in community	Continuous	*Number*
Proportion of men using alcohol daily in community	Continuous	*Number*
Level of illicit drug use by men in the community	Continuous	*Number*
Level of general trust in the community	Continuous	*Number*
Level of social cohesion and reciprocated exchange in community	Continuous	*Number*

Appendix5

Programme/Policy type	Programme example	Aim
School-based Programmes	School-based intervention for younger children (e.g., 'Feeling Yes, Feeling No' in Canada, and Good-Touch/Bad –Touch® in the US). School-based intervention for adolescents (e.g., Youth Relationship Project in Canada, Safe Dates Programme and Acquaintance Rape Prevention Programme in the US).	School-based interventions with younger children typically aim to build children's knowledge about child sexual abuse and their capacity to protect themselves. While at the adolescent stage, the main focus of school-based interventions is to increase women's knowledge, self-protection skills, and awareness of available services for intimate partner violence victims, as well as to address men's knowledge, attitudes and behaviour.
Community-based Prevention	Small group participatory workshop (e.g., Choose Respect in the US, Stepping Stones in South Africa and Program H in Brazil). Large scale "edutainment" or campaign effort (e.g., Sisters for life in South Africa). Parenting education (e.g., early childhood home-visitation programme to Prevent Violence in the US).	Designed to challenge existing beliefs, build pro-social skills, promote reflection and debate, and encourage collective action. Cultivation of change agents that would result in changes in attitudes and ultimately lead to reduction in IPV. To improve parent-child interactions and bonding by reducing abusive or harsh punishment. And to promote less rigid and more equitable roles between boys and girls.
Structural and Policy Approach	Microfinance Scheme and Women Empowerment Programme involving Conditional Cash Transfers (e.g., Oportunidades Programme in Mexico, Bangladesh Rural Advancement Committee (BRAC) Development Programme in Bangladesh). Specially Designed Police Stations For Women	The major foci of this approach are in the area of: fostering gender equality and women's empowerment, legal reform and strengthening criminal justice responses and integrating intimate-partner and sexual violence prevention into other programme areas.

	(e.g., *Comisaria de la Mujer* in Nicaragua).	For example the Conditional Cash Transfer Scheme is Targeted at poor households, by dispensing cash to women in such households provided they attend health and nutrition classes, send their children to school and receive periodic health check-ups.
Media Interventions/ Public Awareness Campaigns	Mass Communication Strategy (e.g., *Somos Diferentes, Somos Iguales* in Nicaragua, 'My strength is not for hurting' in the US).	These are aimed at altering mainly attitudes towards gender norms by raising awareness about violence issues pertaining to such norms throughout the society.
Interventions to reduce alcohol and substance misuse	Counselling intervention implemented by health workers on harmful effects of binge drinking (e.g., Alcoholic Anonymous in India). Regulation of alcohol pricing and taxation (*Although a widely tested programme pertaining to this strategies is yet to be carried out, as far as it could be ascertained, research by Markowitz, 2000 provides evidence supporting its likely effectiveness*). Regulating alcohol availability (e.g., Halls Creek Alcohol Restriction Programme in Australia, Coupon-based alcohol rationing system in Greenland, Diadema Alcohol sale restriction programme in Brazil).	To create self-help support group to aid alcoholics in quitting excessive use of alcohol. Increasing the price of alcohol (e.g., by 1%) in order to decrease binge drinking. Restricting hours of alcohol sale to prevent IPV and reduce seriousness of abuse.

Note: further information regarding these different policies/programmes can be obtained from: Harvey, A., Garcia-Moreno, C. and Butchart, A. (2007) *Primary prevention of intimate-partner violence and sexual violence: Background paper for WHO expert meeting*. Geneva: WHO; WHO (2010) *Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence*. Geneva: WHO; WHO (2009) *Violence prevention: The evidence: Promoting gender equality to prevent violence against women*. Geneva: WHO; Pronyk, P.M., Hargreaves, J.R., Kim, J.C., Morison, L.A., Phetla, G., Watts, C., Busza, J. and Porter, J.D.H. (2006) 'Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial.' *Lancet* 368, 1973 – 1983; Markowitz, S. (2000) 'The price of alcohol, wife abuse, and husband abuse.' *Southern Economic Journal* 67 (2): 279 – 303.

Appendix6

Intimate Partner Violence against Women in Nigeria: A Preventive Framework

This questionnaire is pertaining to the validation of a framework for the prevention of Intimate Partner Violence (IPV) against Women, which was designed as part of a PhD research exploring the issues of IPV in Nigeria.

Any information provided will be treated with confidentiality and used for research purpose only.

To afford you a perfect understanding of the proposed framework and facilitate the accurate completion of this questionnaire, a schematic representation and a brief description of the framework is provided as an attachment to this document.

Thank you for your anticipated support.

Lateef Olayanju
(PhD Research Student, Coventry University, UK)

1.	What is your view on the three-tier IPV prevention framework proposed in this research as shown in figure 1 (schematic representation)? Do you believe it is comprehensive enough?

I think the framework is intelligently put together and comprehensive in terms of coverage. It considers the issue of violence as not only a health problem but one that requires the collaborative work of various stakeholders from different sectors of the society, which is very important in perfectly addressing the IPV problem.

2.	Usage of Information Technology was proposed as part of the framework to make the whole host of IPV prevention activities seamless and provide information storage backbone for the proposed preventive framework, what do you think about this and how effective do you think its implementation would be?

I think it is an added advantage to include Information Technology (IT) usage, and I am sure that the implementation of the IT should be fine if properly arranged.

3.	Do you believe Information Technology has a role to play in preventing IPV, whether through awareness raising or other means?

Usage of Information Technology (IT) is very important in any prevention programme, especially in the area of Health-information campaigns where IT could be used to reach wider audience and get more people to desist from abusive acts.

4.	Can you kindly provide your perception of how IPV could be prevented in Nigeria?

IPV can be prevented in Nigeria by embarking on health-information campaigns to change community norms that expose women to abuse, and by training health-sector staff about IPV and giving them the right resources to help abused women.

5.	Do you think implementation of the proposed framework will be feasible in Nigeria? If not, why do you believe it would not and what do you think could be done to make it work?

Yes, the implementation of the framework is possible.

6.	What are your views as to the effectiveness of the framework in terms of the primary prevention strategies proposed to address IPV?

I believe the primary prevention framework will be effective in preventing IPV in Nigeria, because it considers the likely root causes of the problem and includes a package of evidence based strategies to solve them.

7.	Do you think the secondary prevention plan proposed in the framework is robust enough to support abused women and prevent recurrence of abuse?

I think the secondary prevention plan is robust and should be effective in supporting the abused women.

8.	What do you think about the structure and likely effectiveness of the proposed tertiary prevention of IPV in the framework?

The structure of the tertiary prevention layer is simple and well designed, but I believe it should include as part of the strategies the incorporation of specialised curricula on violence against women into health worker training. Because in the long run, this will also help in preventing IPV.

9.	As highlighted in the framework, networking and close co-operation between the relevant stakeholders is crucial to the success of the proposed plan, do you believe such co-operation is achievable, if not what could be the restraining factors/ inhibitors?
Of course it is achievable. The ministry of health has always being active in multisectoral initiatives and most of the time these close co-operations have resulted into achievement of desired goals. Therefore, I believe co-operation between different stakeholders as proposed in this framework will also be successful in preventing IPV in Nigeria.	
10.	If the framework is adopted by the Nigerian Government (State/ Federal) will you be willing to be part of its implementation?
Yes, as the custodians of health and well-being in the state we will be happy to be part of a health improvement plan like the one proposed in the framework.	
In addition to the covered areas in the previous questions, do you have further comments about the proposed framework?	
-	

Thank you for taking the time to complete the questionnaire.

[Ministry of Health]

DIRECTOR
PRIMARY H...
MINISTRY OF HEAL... HEADQUARTERS
P. M. B. 1395 ... STATE

DR MRS FOLORUNSHO
13-06-2014.

Intimate Partner Violence against Women in Nigeria: A Preventive Framework

This questionnaire is pertaining to the validation of a framework for the prevention of Intimate Partner Violence (IPV) against Women, which was designed as part of a PhD research exploring the issues of IPV in Nigeria.

Any information provided will be treated with confidentiality and used for research purpose only.

To afford you a perfect understanding of the proposed framework and facilitate the accurate completion of this questionnaire, a schematic representation and a brief description of the framework is provided as an attachment to this document.

Thank you for your anticipated support.

Lateef Olayanju
(PhD Research Student, Coventry University, UK)

1.	What is your view on the three-tier IPV prevention framework proposed in this research as shown in figure 1 (schematic representation)? Do you believe it is comprehensive enough?

The framework is comprehensive, it includes the important organisations or agencies that handle IPV cases and are relevant to the prevention of violence. It also gives oversight of running the different prevention programmes to two appropriate establishments, the Ministries of Women Affairs and Ministry of Health.

2.	Usage of Information Technology was proposed as part of the framework to make the whole host of IPV prevention activities seamless and provide information storage backbone for the proposed preventive framework, what do you think about this and how effective do you think its implementation would be?

Considering the number of organisations or agencies identified in the framework, I think the application of Information Technology will be useful in managing the activities of these agencies.

Thinking about the implementation, it will be expensive and will require the support of specialists to set up the necessary systems. All these factors may slow down the implementation, but I believe the application of Information Technology is possible and relevant in solving the IPV problem in Nigeria.

3.	Do you believe Information Technology has a role to play in preventing IPV, whether through awareness raising or other means?

As explain earlier, I believe Information Technology has a role to play.

4.	Can you kindly provide your perception of how IPV could be prevented in Nigeria?

The major and most important way, I think, is to empower women and advocate against practices that can lead to IPV in the society.

5.	Do you think implementation of the proposed framework will be feasible in Nigeria? If not, why do you believe it would not and what do you think could be done to make it work?

The proposed framework, I think, is perfect and I believe it will work in this society.

6.	What are your views as to the effectiveness of the framework in terms of the primary prevention strategies proposed to address IPV?

The primary prevention activities are properly structured, and I think they will go a long way in helping to prevent IPV within this society, if implemented.

7.	Do you think the secondary prevention plan proposed in the framework is robust enough to support abused women and prevent recurrence of abuse?

I think the secondary prevention plan is robust. Like I said before, it includes the important organisations or agencies that handle IPV cases and are relevant to the prevention of violence. It also gives oversight of monitoring to two appropriate ministries, the Women Affairs and Health.

8.	What do you think about the structure and likely effectiveness of the proposed tertiary prevention of IPV in the framework?

I think the structure of the tertiary framework is good.

9.	As highlighted in the framework, networking and close co-operation between the relevant stakeholders is crucial to the success of the proposed plan, do you believe such co-operation is achievable, if not what could be the restraining factors/ inhibitors?
Yes. I believe this type of co-operation is achievable and will work very well, if properly planned.	
10.	If the framework is adopted by the Nigerian Government (State/ Federal) will you be willing to be part of its implementation?
My ministry is willing to be part of the implementation, and will support the activities as outlined in the framework.	
In addition to the covered areas in the previous questions, do you have further comments about the proposed framework?	
Nil	

Kwara State Min. of Women Affairs & ... P M B 1476, Ilorin
Sign
Date 09/9/14

ALHAJA MINOTA-SALAWU.
DIRECTOR.

Thank you for taking the time to complete the questionnaire.

[Ministry of Women Affairs]

Kwara State Min. of Women Affairs & ... P M B 1476, Ilorin
Sign
Date

Intimate Partner Violence against Women in Nigeria: A Preventive Framework

This questionnaire is pertaining to the validation of a framework for the prevention of Intimate Partner Violence (IPV) against Women, which was designed as part of a PhD research exploring the issues of IPV in Nigeria.

Any information provided will be treated with confidentiality and used for research purpose only.

To afford you a perfect understanding of the proposed framework and facilitate the accurate completion of this questionnaire, a schematic representation and a brief description of the framework is provided as an attachment to this document.

Thank you for your anticipated support.

Lateef Olayanju
(PhD Research Student, Coventry University, UK)

1.	What is your view on the three-tier IPV prevention framework proposed in this research as shown in figure 1 (schematic representation)? Do you believe it is comprehensive enough?
	I believe the framework is comprehensive because it covers the major activities I think are needed to address IPV in Nigeria, and it also includes the major relevant stakeholders.

2.	Usage of Information Technology was proposed as part of the framework to make the whole host of IPV prevention activities seamless and provide information storage backbone for the proposed preventive framework, what do you think about this and how effective do you think its implementation would be?

I think it is a very good addition to the framework, because I believe usage of IT is inextricably linked to the success of programmes and running of establishments in the modern world we live in.

3.	Do you believe Information Technology has a role to play in preventing IPV, whether through awareness raising or other means?

IT has immense role to play in prevention of all forms of violence including IPV. One can use this type of technology to manage programmes, raise awareness, store information and monitor progress of interventions.

4.	Can you kindly provide your perception of how IPV could be prevented in Nigeria?

IPV could be prevented in Nigeria by creating an ambience of non-tolerance of this kind of violence using punitive measure against perpetrators of abuse, informing women of their rights and by empowering women through microfinance schemes.

5.	Do you think implementation of the proposed framework will be feasible in Nigeria? If not, why do you believe it would not and what do you think could be done to make it work?
Yes, I think it is feasible.	
6.	What are your views as to the effectiveness of the framework in terms of the primary prevention strategies proposed to address IPV?
I think the primary prevention strategies are elegantly structured, and will be very effective in preventing IPV and its concomitant issues.	
7.	Do you think the secondary prevention plan proposed in the framework is robust enough to support abused women and prevent recurrence of abuse?
The secondary prevention plan is robust and adequate to cater for the needs of women, but I believe there is a need to include agencies such as the Citizens Mediation & Conciliation Centre and The Centre for Alternative Dispute Resolution in the secondary prevention plan of the framework. Because they provide an important avenue for settling this kind of issues in an amicable way.	
8.	What do you think about the structure and likely effectiveness of the proposed tertiary prevention of IPV in the framework?
The structure of the tertiary prevention is good and should be effective in providing long-term support for the women.	

9.	As highlighted in the framework, networking and close co-operation between the relevant stakeholders is crucial to the success of the proposed plan, do you believe such co-operation is achievable, if not what could be the restraining factors/ inhibitors?
This kind of co-operation is absolutely achievable, but there is a need for serious oversight on the side of the government to ensure proper or efficient multi-sectoral collaboration.	
10.	If the framework is adopted by the Nigerian Government (State/ Federal) will you be willing to be part of its implementation?
Yes, if called upon to be part of the implementation of the framework.	
In addition to the covered areas in the previous questions, do you have further comments about the proposed framework?	
There are different ways in which information technology could be used to support the activities put together in this framework, and because of this I believe there should be further research exploring the application of different systems and their users' specifications.	

Thank you for taking the time to complete the questionnaire.

[Judiciary]

MAGISTRATE BOSEDE ABE-IEMO

FAMILY COURT JUDGE
Sign...
Date...
KWARA STATE

Intimate Partner Violence against Women in Nigeria: A Preventive Framework

This questionnaire is pertaining to the validation of a framework for the prevention of Intimate Partner Violence (IPV) against Women, which was designed as part of a PhD research exploring the issues of IPV in Nigeria.

Any information provided will be treated with confidentiality and used for research purpose only.

To afford you a perfect understanding of the proposed framework and facilitate the accurate completion of this questionnaire, a schematic representation and a brief description of the framework is provided as an attachment to this document.

Thank you for your anticipated support.

Lateef Olayanju
(PhD Research Student, Coventry University, UK)

1.	What is your view on the three-tier IPV prevention framework proposed in this research as shown in figure 1 (schematic representation)? Do you believe it is comprehensive enough?

I believe the framework is comprehensive and will provide a strong foundation in addressing the issues of Intimate Partner Violence against women in Nigeria. I think the different strategies blended together will provide the government and other relevant stakeholders the chance to comprehensively tackle the IPV problem.

2.	Usage of Information Technology was proposed as part of the framework to make the whole host of IPV prevention activities seamless and provide information storage backbone for the proposed preventive framework, what do you think about this and how effective do you think its implementation would be?

I believe it is an excellent idea to use information technology in addressing Intimate Partner Violence issues in Nigeria, because it will help in effectively managing the different programmes proposed and serve as a means of record keeping.

Despite the advantages stated above, it is going to be a very expensive venture to embark on and many of the identified stakeholders may not really have the kind of resources needed for implementing the information technology systems.

3.	Do you believe Information Technology has a role to play in preventing IPV, whether through awareness raising or other means?

As explained above, I believe Information Technology has a role to play. IT can help provide a way of efficiently storing information and help in health campaigns to inform women on how different services available can support them.

4.	Can you kindly provide your perception of how IPV could be prevented in Nigeria?

I think IPV can be prevented in Nigeria by mainly empowering women and improving their status in the society.

5.	Do you think implementation of the proposed framework will be feasible in Nigeria? If not, why do you believe it would not and what do you think could be done to make it work?

I believe the implementation of the proposed framework will be feasible in Nigeria. But it will require a lot of government backing.

6.	What are your views as to the effectiveness of the framework in terms of the primary prevention strategies proposed to address IPV?

I believe the primary prevention layer in the framework is well designed and contains critical strategies that are very likely to help prevent violence from occurring in the first place. But I think there is a need for a segment in the primary prevention layer on allocation funds for further research into violence against women issues in general. For example, the allocated funds could be used to support social-science or epidemiological research on developing new interventions.

7.	Do you think the secondary prevention plan proposed in the framework is robust enough to support abused women and prevent recurrence of abuse?

I think the secondary prevention layer is robust, considering the collaboration between different sectors and referral system built into the secondary layer of the framework. Because women who have experienced IPV are likely to seek and require help from different agencies and a strong response to aid these women should not be confined to a particular sector, it should rather rely on broader links between different sectors, just as proposed in the framework.

8.	What do you think about the structure and likely effectiveness of the proposed tertiary prevention of IPV in the framework?

For me the most important part of the tertiary prevention of IPV as proposed in the framework is the introduction of the transitional housing scheme, which is more or less not in existence in the country at the moment. I believe this will help reduce abuse against women and could even help save a lot of lives, because women that are constantly abused by their partners and lacking financial resources will have a place to go to escape severe abuse and not necessarily have to put up with such abuse.

9.	As highlighted in the framework, networking and close co-operation between the relevant stakeholders is crucial to the success of the proposed plan, do you believe such co-operation is achievable, if not what could be the restraining factors/ inhibitors?

I believe such co-operation is achievable, but it will require a lot of planning and the government will need to take the responsibility to ensure that all relevant stakeholders are brought to the table and have equal say in the fight against IPV.

10.	If the framework is adopted by the Nigerian Government (State/ Federal) will you be willing to be part of its implementation?

My organisation will be more than willing to be part of this great plan to solve a major public health problem – IPV against women in Nigeria. As you are aware, part of our work include improving women's health, reducing maternal mortality and infant mortality, which are all related to the issue of IPV. So being part of the implementation of this wonderfully developed framework is something we will really consider.

In addition to the covered areas in the previous questions, do you have further comments about the proposed framework?

Although the framework includes a segment for impact assessment and costs effectiveness analysis, I think the framework should also include a segment for the allocation of funds to support further research into the epidemiology of violence against women in general.

Thank you for taking the time to complete the questionnaire.

[NGO]

STAKEHOLDER 5

Intimate Partner Violence against Women in Nigeria: A Preventive Framework

This questionnaire is pertaining to the validation of a framework for the prevention of Intimate Partner Violence (IPV) against Women, which was designed as part of a PhD research exploring the issues of IPV in Nigeria.

Any information provided will be treated with confidentiality and used for research purpose only.

To afford you a perfect understanding of the proposed framework and facilitate the accurate completion of this questionnaire, a schematic representation and a brief description of the framework is provided as an attachment to this document.

Thank you for your anticipated support.

Lateef Olayanju
(PhD Research Student, Coventry University, UK)

1.	What is your view on the three-tier IPV prevention framework proposed in this research as shown in figure 1 (schematic representation)? Do you believe it is comprehensive enough?
	I believe the framework is comprehensive and well rounded.

2.	Usage of Information Technology was proposed as part of the framework to make the whole host of IPV prevention activities seamless and provide information storage backbone for the proposed preventive framework, what do you think about this and how effective do you think its implementation would be?

Information Technology is widely used to support different activities by various organisations nowadays, and I think the usage of it in supporting the activities in the proposed framework is really important.

With the usage of computers becoming a commonplace in Nigeria, I think with adequate planning the implementation of Information Technology to support the IPV prevention programs in the framework will be effective in the country.

3.	Do you believe Information Technology has a role to play in preventing IPV, whether through awareness raising or other means?

Regarding the use of Information Technology to raise awareness on IPV, I believe that too is important. This is because people use computers and other technologies widely these days and get their information mainly from the internet. Therefore, disseminating information using these modern technologies will help reach greater number of people.

4.	Can you kindly provide your perception of how IPV could be prevented in Nigeria?

I think IPV could be prevented in Nigeria by creating a greater partnership between law enforcement agencies, criminal justice establishments and health agencies to share a common violence prevention agenda and have a single vision on the problem, just as proposed in the this framework.

5.	Do you think implementation of the proposed framework will be feasible in Nigeria? If not, why do you believe it would not and what do you think could be done to make it work?

I really believe the framework will be feasible in the country.

6.	What are your views as to the effectiveness of the framework in terms of the primary prevention strategies proposed to address IPV?

The primary prevention strategies are well rounded and provide important opportunity to stop violence from occurring in the first place.

7.	Do you think the secondary prevention plan proposed in the framework is robust enough to support abused women and prevent recurrence of abuse?

I genuinely believe that the secondary prevention plan is perfect, it is exactly what I think is needed to address the IPV problem in Nigeria.

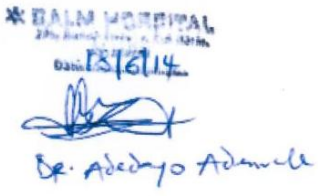
8.	What do you think about the structure and likely effectiveness of the proposed tertiary prevention of IPV in the framework?

I think the tertiary prevention plan is okay, but I would like to see a special segment on treatment for abusers included in the plan.

9.	As highlighted in the framework, networking and close co-operation between the relevant stakeholders is crucial to the success of the proposed plan, do you believe such co-operation is achievable, if not what could be the restraining factors/ inhibitors?
I think the close co-operation between the different sectors is what is needed to solve the IPV problem and I believe such co-operation is achievable.	
10.	If the framework is adopted by the Nigerian Government (State/ Federal) will you be willing to be part of its implementation?
I believe the health sector has an important role to play in preventing IPV. Therefore, if the framework is implemented in the country I would absolutely like to be part of it.	
In addition to the covered areas in the previous questions, do you have further comments about the proposed framework?	
I believe the health system is the first point of contact for women who are victims of IPV, and it will be very important to give greater focus on how healthcare policies could be designed to help support these women and address the IPV problem.	

Thank you for taking the time to complete the questionnaire.

[Hospital]



STAKEHOLDER 6

Intimate Partner Violence against Women in Nigeria: A Preventive Framework

This questionnaire is pertaining to the validation of a framework for the prevention of Intimate Partner Violence (IPV) against Women, which was designed as part of a PhD research exploring the issues of IPV in Nigeria.

Any information provided will be treated with confidentiality and used for research purpose only.

To afford you a perfect understanding of the proposed framework and facilitate the accurate completion of this questionnaire, a schematic representation and a brief description of the framework is provided as an attachment to this document.

Thank you for your anticipated support.

Lateef Olayanju
(PhD Research Student, Coventry University, UK)

1.	What is your view on the three-tier IPV prevention framework proposed in this research as shown in figure 1 (schematic representation)? Do you believe it is comprehensive enough?
I believe the framework is highly comprehensive and would really be helpful in solving the issues of Intimate Partner Violence in Nigeria. I also believe that this will provide an important opportunity for the country to also address other forms of violence, because there is great overlap or, if you like, relationship between Intimate Partner Violence and other forms of abuse like discrimination against women in the work place, issues of child labour, human trafficking and even terrorism (as we are seeing in the Northern part of the country at the moment).	

2.	Usage of Information Technology was proposed as part of the framework to make the whole host of IPV prevention activities seamless and provide information storage backbone for the proposed preventive framework, what do you think about this and how effective do you think its implementation would be?

I think it is a very good idea to employ information technology in the fight against Intimate Partner Violence, because it will make the different programmes proposed more manageable and also provide a way of recording important information that can be of great use later in the future. But regarding the effectiveness of implementing this type of system, I think we need to consider the availability of skilled individuals that will manage the system and the running costs. These factors are very important to consider, especially when we mull over the fact that there is no regular electric power supply in the country and the system will definitely rely on this kind of power supply. Having said this, the implementation can still be highly effective if the framework receives the strong backing and support of the government.

3.	Do you believe Information Technology has a role to play in preventing IPV, whether through awareness raising or other means?

Yes, I believe Information Technology has a role to play, because a lot of people now get their information from the internet, and therefore raising awareness by disseminating information through this kind of technology will be very helpful.

4.	Can you kindly provide your perception of how IPV could be prevented in Nigeria?

I believe IPV can be prevented in Nigeria by promoting gender equality and giving female children the opportunity to go to school just like their male peers.

5.	Do you think implementation of the proposed framework will be feasible in Nigeria? If not, why do you believe it would not and what do you think could be done to make it work?

I believe the implementation of the proposed framework will be feasible in Nigeria, but it will require the strong backing of the government in order for it to be really effective.

6.	What are your views as to the effectiveness of the framework in terms of the primary prevention strategies proposed to address IPV?

I think the proposed primary prevention approach in the framework is broad-based and the design has taken into consideration the underlying issues that are likely to give rise to IPV. Therefore, I believe the design is well articulated and would make great contribution to the prevention of the issue in Nigeria.

7.	Do you think the secondary prevention plan proposed in the framework is robust enough to support abused women and prevent recurrence of abuse?

The secondary prevention layer is highly robust, especially the network of different stakeholders in the design, which I believe will help provide a greater avenue to support abused women and help solve a huge part of the IPV problem.

8.	What do you think about the structure and likely effectiveness of the proposed tertiary prevention of IPV in the framework?

I believe the tertiary prevention layer is adequate and well designed to help abused women in terms of psychological counselling and also empowerment.

9.	As highlighted in the framework, networking and close co-operation between the relevant stakeholders is crucial to the success of the proposed plan, do you believe such co-operation is achievable, if not what could be the restraining factors/ inhibitors?

I believe such co-operation is achievable, but there is a serious need for all stakeholders to have 'equal desire' in ensuring that the issue of IPV in the country is greatly reduced. In addition, just as identified in the framework, the government will need to co-ordinate and bring together the different stakeholders through the means of regular meetings and joint trainings to achieve the desired results.

10.	If the framework is adopted by the Nigerian Government (State/ Federal) will you be willing to be part of its implementation?
I believe my organisation will like to be part of the implementation of this extraordinary framework designed to prevent IPV against women, especially in terms of public awareness campaigns.	
In addition to the covered areas in the previous questions, do you have further comments about the proposed framework?	
I think the strategies in the framework should be implemented in stages, rather than all programmes proposed running at the same time. This will help in reducing costs and providing adequate time for the relevant stakeholders to take in all the necessary steps proposed in the framework, because some of these activities are new and will require some getting used to.	

Thank you for taking the time to complete the questionnaire.

[Media]