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Domestic Violence and Women's Health Status in Ife-North Local Government Area of Osun State, Nigeria

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DOMESTIC VIOLENCE AND WOMEN'S HEALTH STATUS IN IFE-NORTH LOCAL GOVERNMENT AREA OF OSUN STATE, NIGERIA

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CERTIFICATION

I certify that Amos Olugbenga Oyedokun has fulfilled all requirements for the M.Sc. degree in Demography and Social Statistics. This thesis is the result of research work and studies carried out by him under my supervision in the course of his programme in the Department of Demography and Social Statistics of the Obafemi Awolowo University, Ile-Ife, Nigeria.

Professor A. A. Adewuyi
Supervisor

Signature

July 9, 2004
Date

Prof. (Mrs.) A.K. Omideyi
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Signature

9 - 7 - 2004
Date

DEDICATION

This thesis is dedicated to women all over the world, especially those who are victims of domestic violence.

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ABSTRACT

This study examined and evaluated the extent and effect of domestic violence (wife battery and marital rape) on women's decision to use contraceptive methods in two randomly selected communities of Ife-North Local Government Area of Osun state.

The data for the study were obtained from a survey of four hundred and eight (408) ever-married women aged 15-49, conducted between late 2002 and early 2003, using multistage random sampling technique. Two hundred and fifty-five eligible respondents were selected from Ipetumodu using systematic random sampling technique while one hundred and fifty-three eligible respondents were selected from Asipa using a combination of systematic random sampling technique and lottery method. The information required was collected by the use of structured questionnaires and through Focus Group Discussions (FGDs). Four Focus Group Discussion sessions were held with some respondents chosen on the basis of marriage and age, that is, two sessions each in each of the two locations.

The study showed that domestic violence in form of wife battery and marital rape existed in the study area as 55.6% of the women respondents reported having been threatened with physical harassment by their partners; and 62.0% had been physically abused by their intimate partners. About 56% reported experiencing forced sexual relationship with their partners, 17.2% experienced domestic violence during pregnancy, while only 13.7% of those who had this experience took some steps to protect themselves. The major coping strategy by the victims was pacifying their husbands in crisis situation (25.7%). Although knowledge of contraceptive methods was high among women in the area (82.4%), only 30.1% reported ever using any of the known method

while 7.8% were currently using contraceptive methods without husbands' permission. Educational level of the women, spousal communication, the type of work of the respondents, income level, spouse's educational level and occupation, and attitude toward contraceptives were found to be correlates of contraceptive use in the study area. Threat of wife battering and not the actual beating contributed to the likelihood of the women not using contraceptive methods without their husbands' permission. The experience of marital rape by the women was also found to influence their decision to use contraceptive methods. However, the decision on the number of children to produce did not affect the decision to use or not to use contraceptive methods.

The study concluded that women's decision to use contraceptives had been negatively affected most significantly by socio-economic and cultural factors like spousal communication, attitude toward contraceptives, threat of battering and experience of marital rape by the women in the study area.

RESUME

Cette étude a examiné et a évalué l'étendue et l'effet de violence domestique (la pile de femme et le viol marital) sur les femmes'la décision de s d'utiliser des méthodes contraceptives. L'étude a examiné en particulier l'étendue de violence domestique, les stratégies débrouillant adoptées par les victimes et les liens entre l'expérience de battre de femme, l'attitude à et l'usage de contraceptifs dans les communautés choisies de Secteur de Gouvernement Local Ife-DU NORD d'état de Osun. Les données pour l'étude ont été obtenues d'une étude de quatre cent et huit (408) les femmes de jamais-épousé ont vieilli 15-49, dirigé entre en retard 2002 et début de l'année 2003, utilisant à plusieurs étages fait au hasard essayer la technique. Deux cent et cinquante-cinq les répondants éligibles ont été choisis de Ipetumodu utilisant systématique fait au hasard essaie la technique pendant que cent et cinquante-trois les répondants éligibles ont été choisis de Asipa utilisant une combinaison de systématique fait au hasard essaie la méthode de technique et loterie. L'information exigée a été recueillie par l'usage de questionnaires structurés et par le Foyer Groupe des Discussions (FGDs). Quatre séances de Discussion de Groupe de Foyer ont été tenues avec quelques répondants choisis en se basant sur le mariage et en se basant sur l'âge, c'est-à-dire deux séances chaque dans chacun des deux emplacements. L'étude a montré cette violence domestique dans la forme de pile de femme et de viol marital a existé dans le secteur d'étude comme 55,6% des répondants de femmes rapportés ayant été menacé avec l'harcèlement physique par leurs partenaires ; et 62,0% physiquement avait été abusé de par leurs partenaires intimes. Environ 56% éprouver rapporté a forcé la relation sexuelle avec leurs partenaires, et 17,2% violence domestique expérimentée pendant la grossesse. Seulement 13,7% de ceux qui avait cette expérience a

pris quelques-uns marche pour se protéger. Le commandant débrouillant la stratégie par les victimes pacifiait leurs maris dans la situation de crise (25.7%). Bien que la connaissance de méthodes contraceptives était haute parmi les femmes dans le secteur (82.4%), seulement 30.1% rapporté jamais utilisant n'importe quel des méthodes connues pendant que 7.8% utilisait actuellement des méthodes contraceptives sans les maris' la permission. Le niveau éducatif des femmes, la communication entre conjoints, le type de travail des répondants, le niveau de revenu, l'époux'le s niveau et l'occupation éducatives, et l'attitude vers les contraceptifs a été trouvée pour être correspond d'usage contraceptif dans le secteur d'étude. La menace de battre de femme et pas le véritable battement a contribué à la probabilité des femmes n'utilisant pas de méthodes contraceptives sans leurs maris' la permission. L'expérience de viol marital par les femmes a été aussi trouvée négativement pour influencer leur décision d'utiliser des méthodes contraceptives. Cependant, la décision sur le nombre d'enfants pour produire n'a pas affecté la décision d'utiliser ou ne pas utiliser de méthodes contraceptives. L'étude a conclu que les femmes'la décision de s d'utiliser des contraceptifs avaient été négativement affectés le plus significativement par les facteurs socio-économiques et culturels comme la communication entre conjoints, l'attitude vers les contraceptifs, la menace de battre et l'expérience de viol marital par les femmes dans le secteur d'étude.

CHAPTER ONE

1.1 INTRODUCTION

In the 1990s, violence against women has emerged as a focus of international attention and concern. In 1993, the U.N General Assembly passed the Declaration on the Elimination of Violence Against Women (Heise, 1999). At both the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing, women's organizations from around the world advocated ending gender violence as a high priority (WHO, 1997).

The Cairo Programme of Action recognized gender violence as an obstacle to women's reproductive and sexual health and rights, and the Beijing Declaration and Platform for Action devoted an entire section to violence against women (Heise, 1999). In 1999 the United Nations Population Fund declared violence against women "a public health priority" (UNFPA, 1999).

Worldwide, one of the most common forms of violence against women is abuse by their husbands or other intimate male partners. Partner violence occurs in all countries and transcends social, economic, religious, and cultural groups. Although women can also be violent and abuse exists in some same-sex relationships, the vast majority of partner abuse is perpetrated by men against their female partners.

Feminists define spousal abuse as maltreatment, mistreatment, or ill-treatment of a spouse. They believe that spousal abuse is discernible only through a scrutiny of the social situation. The Nigerian society is patterned along gender lines leading to a situation where men control women. As the dominant group, men have access to significant material resources, while women are cheapened as secondary and inferior. Men of different social classes and races can possibly use violence as a strong mode of subjecting women. Although there are several ways that men as a team reinforce female subjugation in social circumstances, violence stands as the most conspicuous and functional means of control. Even if individual men abstain from applying violence on their partners, men as a group gain from how women's lives are inhibited and contained (Omonubi-McDonnell, 2003)

Battering reinforces women's acquiescence and dependence as men wield their rights to domination. The reality of control at the social domain is the most critical factor strengthening domestic abuse at the personal level. Feminist theorists have persuasively maintained that spousal abuse is very connected to the historical formation of the family in a capitalist society, separation of the public and private/domestic domains, and specialization of permissible male and female family functions. Wife abuse has existed for centuries and continues to exist in societies of varying social and familial settings as well as different political persuasions and structures. However, as feminists evoke theoretical and empirical links between the private and the political, they bring to the fore fresh perceptions of battering: spousal abuse is not a personal issue but a social one (Omonubi-McDonnell, 2003).

While research into intimate partner abuse is in its early stages, there is growing agreement about its nature and the various factors that cause it. Often referred to as "wife-beating", "battering", or "domestic violence", intimate partner abuse is generally part of a pattern of abusive behaviour and control rather than an isolated act of physical aggression. Partner abuse can take a variety of forms including physical assault such as hits, slaps, kicks, and beatings; psychological abuse, such as constant belittling, intimidation, and humiliation; and coercive sex. It frequently includes controlling behaviours such as isolating a woman from family and friends, monitoring her movements, and restricting her access to resources (Population Reports, 1999).

In Nigeria, there is little or no information on domestic violence. There is no documentation to support its existence. The courts do not mention it, except in cases when women filing for divorce state that they have been beaten by their husbands sometimes during marriage and the truth is that many Nigerian women are victims of domestic violence. People do not talk about it because it seems to be an acceptable part of marriage. Since the norm assumes that women are subordinate to their husbands, the men could discipline their wives if they so desire (Omonubi-McDonnell, 2003).

Abuse has been found to be one of the factors limiting women's sexual and reproductive autonomy. Women who have been sexually abused are much more likely than non-abused women to use family planning clandestinely, to have had their partner stop them from using family planning, and to have a partner refuse to use a condom to prevent disease (Garcia-Moreno, 2002).

1.2 STATEMENT OF PROBLEM

The United Nations Declaration on the Elimination of Violence Against Women defines it as all gender based violence occurring in the family or the general public resulting in physical, sexual, emotional or psychological harm or suffering to women. Such violent acts include threats, coercion or arbitrary deprivation of liberty, battering, sexual abuse of female children, dowry-related violence, marital rape, female circumcision, sexual harassment, trafficking in women or forced prostitution.

Intimate partner abuse also known as domestic violence, wife-beating, and battering is almost always accompanied by psychological abuse and in one quarter to one half of cases resulted in forced sex. This is a frequent experience of most of the women involved and in fact, an atmosphere of terror often permeates abusive relationship (Heise, 1999)

Violence against women results from their secondary position and from the idea that they are supposed to be seen and never to be heard. For example, wife battery is largely based on the assumption that a man is the final authority in his house and the woman is only expected to follow his directives without questioning. Other forms of violence against women can be explained in terms of the man's right to exercise control over his wife and girl children who are considered to be his property (Albert, 1994; Okemgbo, 2001).

Various studies on factors affecting the health of women in Nigeria have often tended to examine the social, demographic, and economic and programme factors affecting the health and status of women in developing societies (Okafor, et al., 1994). However, it has been noted that the health of women can also be affected by violence against them.

Physical and sexual abuse lie behind some of the most intractable reproductive health issues of our times- unwanted pregnancies, HIV and other sexually transmitted infections, and complications of pregnancy. A growing number of studies documents the ways in which violence by intimate partners and sexual coercion undermine women's sexual and reproductive autonomy and jeopardize their health. Violence operates through multiple pathways to affect women's sexual and reproductive health. Physical violence and sexual abuse can put women at risk of infection and unwanted pregnancies directly, if women are forced to have sex, or fear to use contraception because of their partners' reaction.

Hence, this study will focus on examining the effect of domestic violence on women's decision-making power to use contraceptives in the study area.

1.3 OBJECTIVES OF THE STUDY

Principal Objective:

The study has as its primary aim, the examination of the effect of domestic violence on contraceptive use in the study area.

Specific Objectives:

1. To examine the extent of domestic violence in the study area.
2. To find out the coping strategies adopted by victims of domestic violence.
3. To examine the linkages between experience of wife battery, attitude to and use of contraceptives.

CHAPTER TWO

2.1 LITERATURE REVIEW

Violence against women has recently been acknowledged as a human rights concern with a profound impact on the physical and mental well-being of those affected by it, but it has received little attention as a public health issue (Janet de Merode, 1994).

Studies indicate that around the world, at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime. Most often the abuser is a member of her own family. Increasingly, gender-based violence is recognized as a major public health concern and a violation of human rights. (Heise, 1999)

The effects of violence can be devastating to a woman's reproductive health as well as to other aspects of her physical and mental well-being. In addition to causing injury, violence increases women's long-term risk of a number of other health problems, including chronic pain, physical disability, and depression.

Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually transmitted infections and adverse pregnancy outcomes. Yet victims of violence who seek care from health professionals often have needs that providers do not recognize, do not ask about, and do not know how to address (Population Reports, 1999).

Also, violence against women and girls includes physical, sexual, psychological, and economic abuse. It is often known as "gender based" violence because it evolves in part from women's subordinate status in society. Many cultures have beliefs, norms, and social institutions that legitimise and therefore perpetuate violence against women.

The same acts that would be punished if directed at an employer, a neighbour, or an acquaintance often go unchallenged when men direct them at women, especially within the family.

2.1.1 DOMESTIC VIOLENCE AND WOMEN

The term domestic violence is used to describe a variety of actions and omissions that occur in different relationships. The term is used narrowly to cover incidents of physical attack, when it may take the form of physical and sexual violations, such as punching, choking, stabbing, throwing boiling water or acid and setting on fire, the result of which can range from bruising to killing; what may often start out as apparently minor attacks can escalate both in intensity and frequency. Some people use the term 'domestic violence' to include psychological or mental violence, which can consist of repeated verbal abuse; harassment; confinement, and deprivation of physical, financial and personal resources (Miranda, 1994). It has been observed that in nearly 50 population-based surveys from around the world, 10% to over 50% of women reported being hit or otherwise physically harmed by an intimate male partner at some point in their lives (Population Reports, 1999). In a study conducted in Japan, 57% had suffered all three types of abuse – physical, psychological, and sexual. Only 8% had experienced physical abuse alone. (Yoshihama and

Sorenson, 1994). In Monterrey, Mexico, 52% of physically abused women had also been sexually abused by their partners (Granados, 1996).

In Leon, Nicaragua, among 188 women who were physically abused by their partners, only 5 were not also abused sexually, psychologically, or both. Most women who suffer any physical aggression generally experience multiple acts over time. In the Leon study, for example, 60% of women abused in the previous year were abused more than once, and 20% experienced severe violence more than six times. Among women reporting any physical aggression, 70% reported severe abuse (Ellsberg, et al., 1999). The average number of physical assaults in 1992 among currently abused women surveyed in London was seven (Mooney, 1993); in the USA in 1997, three (Tjaden, and Thoennes, 1998). Community-based surveys suggest that domestic violence by husband or partner is experienced by 15-20% of women in Columbia (Encuesta de prevalencia, demografia y Salud, 1990) and 26% and 33% of women in Chile and Mexico, respectively (U.N., 1993).

A study in Kenya found that 42% of women were beaten "regularly"; another in Zambia reported that 40% had been beaten by their partners, and a third in Uganda found that 46% were physically abused by a partner (U.N., 1993).

A survey in Egypt found that 35% of ever-married women had been beaten at least once since marriage: almost half of them suffered beating in the year prior to the survey as well (El-Zanaty, et al, 1996).

Wife abuse has been reported by 39% of women in Malaysia (Abdullah, et al., 1995) and 42% of women in the Republic of Korea (U.N., 1993). Wife beating has been reported by Jejeebhoy (1998) in India: 45% and 37% of women in Uttar Pradesh and Tamil Nadu respectively; 47% in Bangladesh (Schuler, et al., 1996); and 35% in rural Pakistan (Sathar, and Kazi, 1997). Data from developed countries suggest a similar situation. Domestic violence is reported by 29% of women in Canada (Rodgers, 1994) 25% in Norway and 28% in the USA (U.N., 1993)

Abuse apparently begins early in marriage when women are most vulnerable. A study of battered women in Malaysia found that for 35%, the first incident of abuse occurred with the first year of marriage, and for 55% in the second or third year (Abdullah, et al., 1995).

Justifications for violence frequently evolve from gender norms-that is, social norms about the proper roles and responsibilities of men and women (Counts, et al., 1999). Typically, men are given relatively free reign as long as they provide financially for the family. Women are expected to tend the house and mind the children and to show their husbands obedience and respect. If a man perceives that his wife has somehow failed in her role, stepped beyond her bounds, or challenged his rights, then he may react violently.

Worldwide, studies identify a consistent list of events that are said to "trigger" violence. These include: not obeying her husband, talking back, not having food ready on time, failing to care adequately for the children or home, questioning him about money or girlfriends, going somewhere without his permission, refusing him sex, or expressing suspicions of infidelity: (Armstrong, 1998; Bradley, 1985; Gonzalez Montes, 1998; Hassan, 1995; Jejeebhoy, 1998;

Michau, 1998; Osakue, and Hilber, 1998; Schuler, et al., 1996; Zimmerman, 1995) All of these constitute transgression of gender norms.

In many developing countries, women share the notion that men have the right to discipline their wives by using force. In rural Egypt, for example, at least 80% of women say that beatings are justified under certain circumstances (El-Zanaty, et al., 1996). One of the circumstances that women most often cite is refusing a man sex (Bawah, et al., 1999; David and Chin, 1998; El-Zanaty, et al., 1996; Rosales Ortiz, et al., 1999) Not surprisingly, refusing is also one of the reasons women cite most often as triggering beatings (Khan, et al., 1996; National Sex and Reproduction Research Team and Jenkins, 1994; Wood, and Jewkes, 1997; Zimmerman, 1995).

Kyriacou et al., (1998) in their study of 46 patients discovered that the strongest predictor for acute injury from domestic violence in these patients was a history of alcohol abuse by the male partner, as reported by the female partner (odds ratio, 12.9).

Studies from as diverse settings as Bangladesh, India, Malaysia, Mexico, Papua New Guinea, Zambia and Zimbabwe show that wife abuse is perceived as acceptable behaviour and justified as a normal and acceptable part of married life. (Schuler, et al., 1996; Jejeebhoy, 1998; Abdullah, et al., 1995; Glantz, and Halperin, 1996; Bradley, 1988; U.N., 1993; Njovana and Watts, 1996)

In contrast, studies pointing to the perceived unacceptability of such behaviour are rare (Choi, and Edleson, 1996).

2.1.2 WOMEN'S STATUS AND DOMESTIC VIOLENCE (RISK OF UNWANTED PREGNANCY AND CONSTRAINED CONTRACEPTIVE CHOICE).

The threat of violence also limits women's ability to make reproductive choices in terms of whether or when to become pregnant, whether and what steps to take to control fertility, or which method of contraception to adopt. It also exposes them to unwanted pregnancy and related health consequences. Moreover, in patriarchal societies in which the husband has the ultimate say in all issues – including the number of children to have and which fertility regulation method should be used, women who suffer violence are more likely than other women to experience unwanted pregnancy and constrained contraceptive choices. Women are often either reluctant to use contraception for fear of abuse from their husbands, or have indeed suffered severe beating after their contraceptive behaviour was discovered by their partners (Heise, 1994).

In some cultures husbands may react negatively because they think that protection against pregnancy would encourage their wives to be unfaithful. Where having many children is a sign of virility, a husband may interpret his wife's desire to use family planning method as an affront to his masculinity (Shedlin, and Hollerbach, 1991). In Kenya, some men say that they oppose the use of contraception because they fear it will weaken their control over their wives (Biddlecom and Fapounda, 1998; Watkins, et al., 1997).

A woman's perception of her husband's attitude toward family planning strongly influences whether or not she will use contraception, according to studies in Ghana, Indonesia, Kenya, the Philippines, and elsewhere (Biddlecom, et al., 1997; Ezeh, 1993; Joesoef, et al., 1988; Lasee, and Becker, 1997; Salway, 1994). It has been documented that across 13 DHS surveys, an average of 9% of married women with unmet need for family planning-that is, women who want to avoid pregnancy but are not using any contraceptive method – cite their husbands' disapproval as the principal reason that they do not use contraception (Bongaarts, and Bruce, 1995). While in surveys, only a minority of wives and husbands appear to disagree about using contraception, in-depth studies suggest that these couples probably represent a large share of couples with unmet need. (Robey, et al., 1996)

Women often use contraception clandestinely because they fear being beaten or abandoned if they do so openly (Garcia-Moreno, 2002). If a woman is caught in covert use of contraception, the consequences of undermining male authority can be severe. In Ghana, 51% of women and 43% of men agreed that a husband is justified in beating his wife when she uses a family planning method without his knowledge (Bawah, et al., 1999) In Cape Town, South Africa, young women described how their partners beat them and tore up their clinic contraceptive cards (Woods and Jewkes, 1997).

Fortunately, not all women who fear a negative response are necessarily at risk of abuse. Studies suggest that many husbands are more open to family planning than their wives may think. (Drennan, 1998) Communication within marriage about sex is often so limited, and most often, spouses often do not know their partners' views of family planning. Wives whose husbands actually favour family planning may assume that their husbands' attitudes mirror cultural norms that disapprove of it. In Uganda, for example, 24% of women thought their husbands disapproved of contraception when in fact their husbands approved (Blanc, et al., 1996).

General studies on family planning in Nigeria started in the early 1960s (See: Olusanya, 1966, 1967, 1969a, 1969b, 1972, 1979, 1981 and 1989; Ohadike, 1968; Morgan, 1971, 1972, 1975).

Most of these scholars have related contraceptive use with cultural and modernization variables. Generally, the level of contraceptive use is very low in Nigeria (about 4%) according to the recent Nigeria Demographic and Health Survey of 1990. In 1990, only 14 percent of married women reported having ever used a contraceptive method; by 1999, this proportion had doubled to 29 percent. Only 15 percent of married women were currently using any method, while only 9 percent were using a modern method. Although the percentage is low even for the Sub-Saharan region, there has been an improvement since 1990, when only 6 percent of married women were reported to be using any method and only 4 percent were reported to be using a modern method. (FOS, 1990; NPC, 2000)

Most of the researchers have associated the low level of use of contraceptives to customs; polygamy (Olusanya, 1966); the dominance of men (husbands) over women (wives) and desire for many children (Raimi, 1995); and to socio-economic variables like education, urbanization, and industrialization. Research in Nigeria found that the decision to have a child was made by the husband alone in 17% of cases, and 30% of couples did not discuss whether to have another child. Also, a study in Nigeria on beliefs and attitudes about sexual behaviour and contraceptive decision-making highlighted the need for information and education programmes on the use of contraceptive methods. In a study conducted in Oyo state, involving 4000 men and women aged 18-50 years, the decision about whether or when a woman should become pregnant was often a joint decision (47% of couples), but about 30% of couples never discussed it, and in 17% of cases the decision was taken by the male partner alone. The study also found that modern contraceptive methods were little used and that many respondents believed family size was determined by "God's will" (WHO, 1998).

Female education has been seen as a key determinant of contraceptive use. Better educated women are argued to be more willing to engage in innovative behaviour than are less educated women, and in many Third World contexts, the use of contraception remains innovative (Caldwell, 1979; Dyson and Moore, 1983). Better-educated women are also argued to have more knowledge of contraceptive methods or of how to acquire them than are less educated women because of their literacy, greater familiarity with modern institutions, and greater likelihood of rejecting a fatalistic attitude towards life. There is good evidence that, for whatever reason, women's education does indeed promote the use of contraception in most developing countries outside of tropical Africa (Cochrane, 1979).

Female autonomy and seclusion are also argued to influence contraceptive use. Together, these variables determine the degree of women's dependency on their in-laws which, in turn, is said to determine their likelihood of engaging in innovative behaviour (Dyson and Moore 1983). The main logical weakness of this hypothesis is that it assumes that women's in-laws will oppose the use of contraception rather than require it of them. This may not be true. Moreover, how equal husband and wife are is frequently argued to influence contraceptive use. Equality between spouses is supposedly linked to the likelihood of communicating about such matters as fertility control, and communication is in turn argued to influence the use of contraception or at least the effectiveness of its use. The evidence in support of this hypothesis is apparently weak (Beckman, 1983, Hollerbach, 1983).

Finally, in some cultures, the egalitarian ness of the relationship between spouses is also said to influence contraceptive use by influencing the extent to which the couple abides by a sexual double standard. Where such a double standard exists making it acceptable for husbands, but not wives, to have extra or pre-marital sexual relations – men may worry that the use of female contraceptive methods will free the wife to violate this norm.

There is some evidence to suggest that women who have suffered violence are more likely than non-abused women to undergo abortion if they become pregnant: 42% of women in one study at an abortion clinic in Canada had suffered physical violence by their current partner and 17% had suffered sexual abuse (Lumsden, 1997). At the same time, women whose pregnancies are unwanted or mistimed appear to be at considerably greater risk of abuse than women whose pregnancies are wanted (four times higher in one study in the U.S.A) (Gazmararian, et al., 1995).

Adolescents (and young women) are particularly vulnerable to violence and forced sex since women in this age group tend to be particularly disadvantaged in gender power dynamics and find it difficult to negotiate sexual relations. The deleterious consequences of forced sex are often compounded by the additional trauma of pregnancy. In a maternity hospital in Lima, Peru for example, 90% of young mothers aged 12-16 years were victims of rape: the majority by a relative (Heise, et al., 1995).

2.1.3 WOMEN'S STATUS AND DOMESTIC VIOLENCE:

Governments the world over are abusing the human rights of women by failing to give them a fair standard of health care, according to a report commissioned by the World Health Organisation (WHO). International human rights treaties forbid sex discrimination and guarantee the right to health.

Women's status is multi-faceted, making it difficult to measure uniquely: not only can it vary along different dimensions such as decision-making power, freedom of movement, access to education, etc., but it can also vary between the different spheres in which women function, such as the domestic and non-domestic (Mason, 1986; Whyte, 1978; Omideyi, 1999). Yet many states fail in their duty to prohibit customs that damage women's health and to provide services that will make women healthier. The low status of women leads to denial of their rights to proper health. Half a million women die each year from avoidable causes related to pregnancy and childbirth yet many societies accept maternal death as the natural order of things (Safe Motherhood, 1993).

The threat of violence also appears to have a more indirect bearing on reproductive ill health. Battered women are frequently the most powerless and least likely to have the decision-making authority, mobility or control over resources needed to seek appropriate and timely health care, whether for themselves or for their infants. Evidence from the USA suggests, for example, that no more than one third of battered women seek care for injuries sustained (Helton, et al., 1987). In a study in rural India, although 90% of battered women reported that their injuries were serious enough to warrant medical care, only 38% did indeed seek treatment and few admitted the cause of their injuries to care providers (L.Visaria, personal communication).

Battered women are also more likely than other women to delay seeking reproductive health care. Studies from the USA find that battered women are more likely to delay attending antenatal care until the third trimester (McFarlane, et al., 1992; Parker et al., 1994; Taggart, Mattson, 1996). Likewise, in the slums of Mumbai, India, battered women are constrained from making decision regarding nutrition or health care for themselves or their infants (Ramasubban, Singh, 1998).

Deficiencies in health care systems also make it difficult for battered women to seek care. Within relationships, male control of wealth and decision-making and relationship instability are strongly associated with abuse (Heise, 1999). It was once thought that women with many children were at increased risk of abuse. Research now indicates, however, that domestic abuse increases women's risk of having many children by limiting their ability to control the timing of sex and the use of contraception. (Ellsberg, 2000)

2.1.4 PREVALENCE OF RAPE AND SEXUAL ASSAULT:

Less information exists on sexual abuse. Data suggest that marital rape (or rape by partner) is experienced by between 5% and 10% of all women. In Colombia, for example, 7% of rural women and 9% of urban women reported having been raped by their husband after marriage (Encuesta de prevalencia, demografia y salud, 1990). In Mexico, 6% reported marital rape, in Central America, the figure was 12% (Cox, 1992) and in India 10% (L. Visaria, personal communication).

Moreover, statistics from around the world suggest that sexual coercion is common in the lives of women and girls. Six well-designed studies from the United States, for example, suggest that between one in five and one in seven U.S women will be the victim of a completed rape in her lifestime (Koss 1993; Kilpatrick, Edmunds, and Seymour 1992). The U.S data are consistent with studies of rape in other parts of the world. Studies of rape among college age women in Canada, New Zealand, the United Kingdom, and the United States reveal remarkably similar rates of completed rape across countries (Dekeseredy and Kelly, 1993; Gavey, 1991; Beattie, 1992; Koss, Gidycz and Wisniewski, 1987). A study among adult women (many of them college students) in Seoul, Korea, yielded a slightly lower rate of completed rape, but an equally high rate of attempted rape (Shim, 1992). All of these studies used adaptations of the same survey instrument, based on the Sexual Experiences Survey (SES) by Koss and Oros (1982). It has to be noted that definition of rape differ especially comparing figures in U.S. with that of United Kingdom.

Women have also been subjected, throughout history, to repeated and especially brutal rape as part of war. In recent years, mass rape in war has been documented in Bosnia, Cambodia, Liberia, Peru, Somalia and Uganda (Swiss and Giller, 1993). A European Community fact-finding team estimates that more than 20,000 Muslim women have been raped in Bosnia since the fighting began in April 1992. Many have been held in "rape camps" where they have been raped repeatedly and forced to bear Serbian children against their will (Post, 1993). These examples notwithstanding, rape in war is neither a new phenomenon nor one limited to developing countries.

2.1.5 CONTRACEPTIVE KNOWLEDGE, ATTITUDE AND PRACTICE

Much unmet need for family planning persists, even in settings where knowledge of contraceptive methods is high. Studies suggest that many potential users choose not to use more reliable methods due to misperceptions and concern about health-related risks. For example, a study in the Maldives found that knowledge of family planning was universal, but only 30% of couples were using a contraceptive method. Several studies, including one from Malaysia, found that non-use of contraceptives was linked to fears about side effects.

In most developing countries surveyed by the Demographic Health Survey in 1988, more than three-quarters of women can name at least one modern method of contraception spontaneously-that is, without prompting. In seven African Countries, however - Burundi, Ghana, Liberia, Mali, Niger, Senegal, and Uganda-fewer than 40% of married women are able to name any modern family planning method spontaneously (Rutenberg, et al., 1991). In and several sub-Saharan countries, many married women are not able to name any modern family planning method after prompting. In Nigeria, for example, the 1990 Demographic Health Survey reported that only 44% of married women recognized any family planning method, modern or traditional, even after being prompted, while in 1999, the proportion had grown to 64 percent. In all surveyed countries except Mali, Niger, Senegal, and Togo, awareness of modern methods exceeds awareness of traditional methods, often by a wide margin. For example, in Pakistan, 77% of married women recognize a modern method compared with 26% who recognize a traditional method; in Mexico, 93% know of a modern method compared with 72% who know of a traditional method. Among all surveyed countries, oral contraceptives and female sterilization are most widely recognized, followed by injections and the IUD. Male sterilization is least known.

Excluding China, 38% of all women of reproductive age in the developing world who are married or living in consensual unions are currently using family planning, according to an estimate by Mary Beth Weinberger based on survey data. This level is well below the contraceptive prevalence of over 70% estimated for the developed world, ranging from 58% in Japan through 74% in the United States and 81% in the United Kingdom to 84% in Norway. The averages conceal wide variation.

Among surveyed countries, contraceptive prevalence ranges from below 10% in seven Sub-Saharan African Countries and in Yemen to 70% or more in China, Costa Rica, Mauritius, and South Korea. It is nearly 70% in three other countries –Brazil, Colombia, and Thailand (Population Reports, 1992) In Latin America and the Caribbean as a whole, contraceptive prevalence is 57%, Weinberger estimates (Weinberger, 1992). Prevalence exceeds 50% in 10 Latin American and Caribbean countries-Brazil, Colombia, Costa Rica, the Dominican Republic, Ecuador, Jamaica, Mexico, Panama, Peru, and Trinidad and Tobago. Among all surveyed Latin American and Caribbean countries, contraceptive prevalence is below the 38% average for the developing world only in Bolivia, Guatemala, and Haiti.

In five of the six surveyed countries of the Near East and North Africa, contraceptive prevalence is near or above the developing-world average-for example, in Jordan, 35%, and in Tunisia, 51%. Contraceptive prevalence is well above average in three of the four Asian countries surveyed by DHS – Indonesia, at 50%; Sri Lanka, at 62%; and Thailand, at 68%. In Pakistan, however, only 12% of married women use contraception, according to the 1990-91 DHS – Among countries with independent surveys, contraceptive prevalence in Bangladesh is 40%; in India, 45%; in the Philippines, 43%; and in Vietnam, 53%. Contraceptive prevalence is lowest in Sub-Saharan Africa, where prevalence exceeds the average for the developing world only in Zimbabwe, at 45%. In only two other countries does prevalence exceed 25% - Botswana, at 35%, and Kenya, at 27%. Prevalence is below 10% in Burundi, Liberia, Mali, Niger, Nigeria, Sudan, and Uganda.

Data from Nigeria Demographic Health survey 1999 reveals that on overall use of family planning methods, among all women, about a quarter (27%) have ever used a method and less than a fifth (17%) have used a modern method. The percentage of married women who ever used a contraceptive method is highest among the 30-34 age group (36%) and expectedly lowest among the 15-19 age group (7%). The level of ever use has increased significantly since 1990. In 1990, only 14 percent of married women reported having ever used a contraceptive method; by 1999, this proportion had doubled to 29 percent.

Current use of family planning methods refers to the use of contraceptive methods at the time of the survey. Analysis of current use of family planning methods is conventionally based on women who are currently married, since they are the most likely to be regularly exposed to the risk of pregnancy. Only 15% of married women are currently using any method, while only 9% are using a modern method. Although the percentage is low even for the sub-Saharan region, there has been an improvement since 1990, when only 6 percent of married women were reported to be using any method and only 4 percent were reported to be using a modern method (FOS, 1992).

Contraceptive use is highest among married women in their 30s and early 40s (about 20 percent) and lowest among the 15-19 age groups (4 percent). This finding is expected since younger women are more likely than older women to want another child soon. While periodic abstinence is the most widely used method for all age groups (5percent of married women), younger women are the next most likely to use either injectables or the pill, while older women are more likely to use IUDs. Results from the Integrated Baseline Health Survey (IBHS) in Nigeria indicate that contraceptive prevalence rate is still low in Nigeria and varies by demographic and socio-economic characteristics. Preliminary analysis of the IBHS data reveal that: (i) 19.3 percent of all women in the catchment population were using a method of contraception at the time of the survey, (ii) current use of contraception among all women varies by region – it is highest in Lagos (27.6%) and is lowest in the North (9.1%); this is close to what Oyekanmi and Adedokun reported in 1997. (iii) Current use of contraception is higher among currently married women in all regions; (iv) among all women and currently married women, contraceptive use increases as age increases up to the late thirties; after age 40, contraceptive use declines; (v) among all women and currently married women, formal education is positively correlated with current use of contraception (Feyisetan and Bamiwuye, 1998).

The data from a study covering three states of South-Western Nigeria also reveal about 63% of men compared to just 35% of women would approve of the use of family planning. About 36% of the respondents gave an indication that their spouses would not stop them from using family planning methods (37.3% male as against 35.5% females). Education, attitude and children ever born are also found to be significant socio-economic and demographic factors that influence husband's knowledge and use of contraceptive. Men strongly appear to control important decisions, including fertility and contraceptive use decision in the family. (Adewuyi and Ogunjuyigbe, 2003; Oyekanmi and Adedokun, 1997)

Lastly, access to source of information has been found to be positively related to contraceptive use and women who have adequate knowledge of family planning source are substantially more likely to be using family planning than women who do not know a source (Ebigbola, and Ogunjuyigbe 1998). Therefore, promoting family planning on radio or television can be an important means of raising awareness, improving knowledge, and stimulating use of modern contraceptive methods (Feyisetan and Ainsworth, 1994; Olaleye and Bankole, 1994).

In conclusion, Nigeria was a signatory to the global decision (through the ICPD Programme of Action in 1994) 'to place human beings, rather than human numbers at the centre of all population and development activities, and to empower women and to adopt an integrated response in the decades ahead' (UNFPA, 1995:12). Some progress has been made in creating awareness, reviewing existing policies and adopting other ones, to suit the mood of the world in the decades ahead. Greater and faster progress will be achieved if broad advocacy and other needs of women's organizations and NGOs in the areas of reproductive health, women's rights and gender policy are identified and met. (Adedokun, 2000)

2.1.6 THE HEALTH CONSEQUENCES OF GENDER-BASED VIOLENCE AND THE COST OF VIOLENCE AGAINST WOMEN

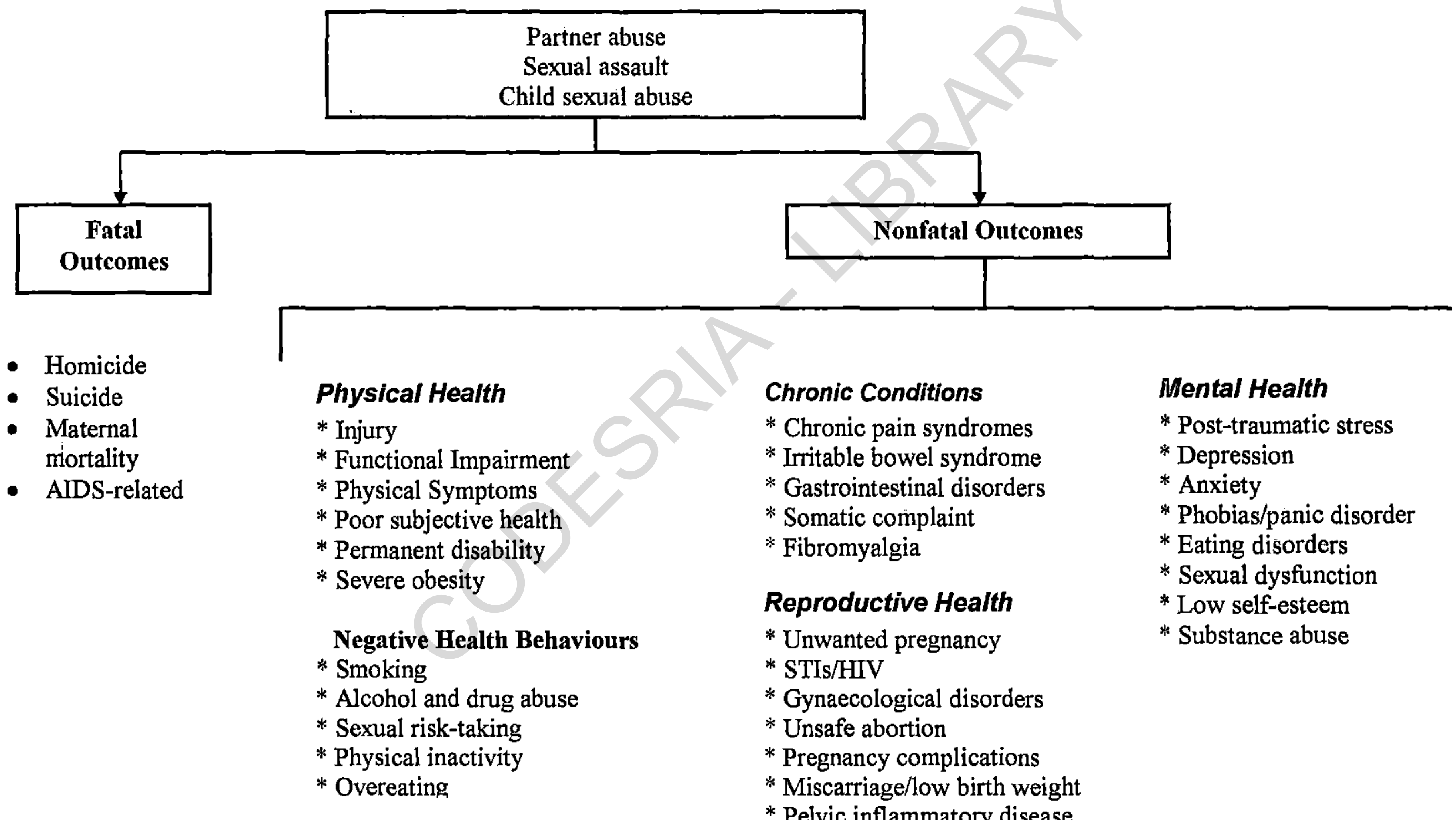
Violence against women has been linked to many serious health problems, both immediate and long term. These include injuries, sometimes leading to death or disability, a variety of chronic physical conditions; reproductive health problems; mental health disorders, including suicide, and unhealthy behaviour, such as drug abuse as can be seen in the adapted figure below.

The economic costs of violence against women and girls are enormous. They involve the cost of medical and psychological help where it is used, the lost income, the judicial and enforcement costs where they are called upon, and the costs of incarceration of the perpetrators. Clearly, a better investment of public money would be in the prevention of violence than in the post hoc treatment of victims and/or perpetrators.

From figure 1 below, the health outcomes of Violence against women divides into two broad types namely: Fatal outcomes and Non-fatal outcomes. Under the non-fatal outcomes are reproductive health issues ranging from unwanted pregnancy, STIs/HIV, unsafe abortion, to pregnancy complications and so on.

The main focus of this study is to examine the effect of domestic violence otherwise known as Partner abuse on use or non-use of contraceptives which have implications for unwanted pregnancy and fertility regulation.

Figure 1. Health Outcomes of Violence Against Women



Source: Center for Health and Gender Equity (CHANGE)

2.2 THEORETICAL FRAMEWORK

Everyone fears male violence, even other men. How we explain male violence affects our ability to address it and to make the world a safer place for women and children.

Theories attempting to explain male violence are many and complex and some of the theories are Social and Historical Determinism theory, Socio-Biological theory, Historical Rationale theory, Social Construction theory, Ideology of dominance theory, the Frustration-aggression theory, Bio-medical thesis, Deprivation thesis, Socio-psychological theories, and Observational learning theory.

In most sub-Saharan African societies, men are at the apex of family and societal hierarchy. Male position and decision-making authority over domestic issues means that they "play an instrumental role in every aspect of sexual and reproductive dynamics, from the timing of intercourse and contraceptive use to STD treatment and antenatal care". Thus, men function as 'gatekeepers' to women's sexual and reproductive health because of many powerful roles they play in society as husbands, fathers, uncles, religious leaders, doctors, policy makers, local and national leaders (Varga, 2001; Drennan, 1998). This privileged position enjoyed by men is the creation of society, which can be understood in the context of gender roles and the patriarchal system.

Gender refers to the social construction of roles and expectations for males and females. The UNAIDS (1999) defines gender as the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles, which ascribe to men and women differential access to power, including productive resources and decision-making authority. The differentiation between men's and women's roles and expectations involves a hierarchy in which men's activities and attributes are more highly valued so that men are given greater leverage over decision-making and recourses than women. Almost everywhere, but more fundamentally in Africa, the family remains the prime agent of socialization, the environment where sex-based roles and attitudes are learned and exhibited. Writing on gender socialization, Ampofo (2001) observed that sexual initiation and practice result from an assortment of social, economic and gender dynamics rooted in family systems, peer relationships and social institutions. Her review of writings on gender socialization and sexual attitudes and behaviour reveals that in almost all societies, the particular personality differences observed between males and females emerge from the different ways in which the sexes are socialized. Often such gender socialization develops within the context of gender inequalities and the tendency for social arrangements to reinforce the position of the dominant male group or the dependence of females on males.

Within the context of socialization, every society prescribes appropriate roles for males and females, and these norms are inculcated and imbibed by individuals from childhood, and from one generation to another. The mores and folkways of the society, which a child learned from his parents and kinsmen, are internalized and become part of his personality and he feels guilty if he acts against them. Thus, sex roles and gender identities are formed through a process whereby an individual comes to acquire, value and adopt gender appropriate behavioural patterns. In all Nigerian societies, boys and girls learn early in life to distinguish between male and female roles by watching and helping their parents and elders around them, who also provide specific instructions on family and societal norms and appropriate behaviour. Whereas boys stay close to their fathers and are trained in male assignments and also prepared to take up the roles of fathers and heads of households, girls learn domestic chores from their mothers and significant female elders and are taught maternal responsibilities, including how to be a good and submissive wife. Women are conditioned to accept male dominance and to believe that they can reach a man's heart through his stomach (through preparing delicious food). As Ampofo (2001) has noted for Ghana, gender norms dictate that while girls should remain uninformed about sexual matters, boys are instructed on sexual matters by peers and family members; they are raised to see male aggression as a virtue and are overtly or covertly encouraged to experiment with sex as a sign of maturity. Other social institutions that reinforce differential socialization include puberty rite for girls and various initiation rites for boys; since these ceremonies signify sexual maturity, sex-role expectations are inculcated in this final phase before impending marriage. All these help to buttress the ideology of male dominance over females, and give males sexual latitudes which are denied females; it is with this orientation that a woman moves into a man's house and family at marriage, and is subjected to a new male dominant environment different from the one she was familiar with. From Ampofo's extensive review of the literature, she drew out three main features of gendered socialization:

One, children learn to distinguish female and male role expectations from an early age. Two, boys are generally taught to be tough, decisive, powerful and decision-makers; girls, on the other hand, are socialized to be passive, innocent, submissive and to refrain from decision-making. Three, the socialization of children into gender roles such that men are justified as decision-makers and women for childbearing/ rearing roles, leads to double standards in sexual relations, resulting in differences in girl's and boy's attitudes and behaviour regarding sexual matters.

Also importantly, the Nigerian family system, by giving women restricted access and control of means of production and reproduction, provides the organizing principles of female subordination (Bandarage, 1997). For instance, patriarchy, the control of the family by men, which often involves patrilineality or descent traced through paternal line, and patrilocality or marital residence with husband's kin, is at the root of both gender socialization and male dominance in sexual, reproductive and productive issues.

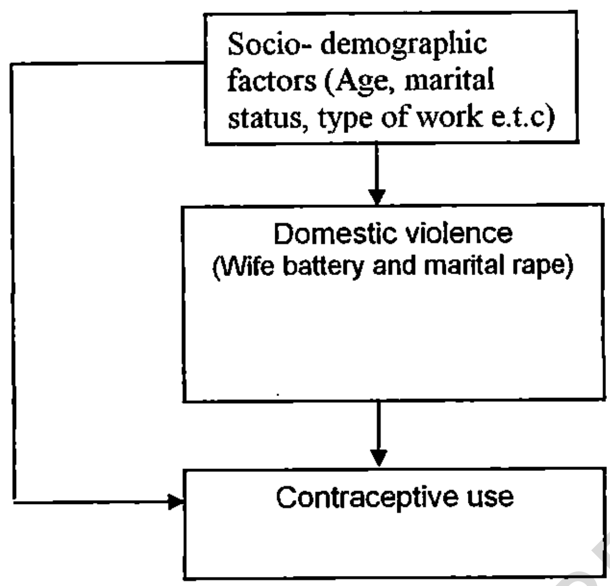
Nigeria is a patriarchal society, and patriarchy influences all aspects of social life and relationships. In fact, many feminist theorists see patriarchy as the original form of social hierarchy from which all other forms of stratification and domination have evolved (Bandarage, 1997). Within this social order, men, as heads of households, claim ownership over both women and children. The control of women's sexuality became crucial as families and clans, or even ethnic groups, began to compete for supremacy and numerical strength. Thus, increased pressure was placed on women to reproduce, and the male dominant culture ensured that women's social status was defined more by their roles as mothers (Bandarage, 1997).

Although women bear children and receive status from them, they do not make fertility decisions. Usually, such decisions are the prerogatives of husbands, who often enforce their decisions with psychological and sexual control, and even violence against women. Thus sexuality, fertility and reproductive health reflect the dominant male interests. Men dictate the sexual life of women and invoke various sanctions to have their way.

Therefore, combinations of social and historical determinism, historical rationale, and social construction theory, ideology of dominance and deprivation thesis are applicable to this study.

2.3 CONCEPTUAL FRAMEWORK

Figure 2: A conceptual model for understanding the implications of Domestic violence on contraceptive use.



The conceptual framework of the study is shown in figure 2 above. From the figure, it is clear that the demographic and socio-economic characteristics of women can directly affect their decision to use or not to use contraceptive methods. Also, their socio-economic/demographic background can predispose them to domestic violence which is evident in the decision-making power about their reproductive health lives.

As long as men are given the right to control women's behaviours and use violence as an acceptable way of exerting power, violence is perpetuated against them. Abuse of women is a general phenomenon affecting women irrespective of their age, status, religion, or educational level. Educated women as well as illiterates, employed or unemployed, all face the same problem of abuse, though in varying degrees.

In any typical patriarchal society, men are usually more educated and hence are better placed economically than women who rarely go to school and consequently engage mostly in very low-income yielding occupations. To a large extent, this brings them to a very low economic decision-making power. Thus, women with this kind of status depend largely on their husbands for financial support, and are strictly under their exploitations since they can be beaten if they fail to be submissive to them. Therefore, considering all the efforts at empowering women, "has there been any success?" The crucial role of decision-making by women at the family and other levels will help in the achievement of reproductive health goals.

This work will then bring to the limelight, the correlates of contraceptive use and the effect of domestic violence (wife battery and marital rape) on women's contraceptive use in the study area.

2.4 HYPOTHESES

1. Women that have been beaten or battered are less likely to use contraceptives without husband's permission than their counterparts with no such experience.
2. Women that experience marital rape are less likely to use contraceptives than their counterparts with no such experience.
3. Women with more power to decide the number of children to bear are more likely to use contraceptives than their counterparts with no such power.

CHAPTER THREE

3.0 RESEARCH DESIGN AND METHODOLOGY

The main source of data for this study is from a sample survey of some part of South-Western, Nigeria. This chapter describes the research design, the sampling procedure, interviewing and statistical techniques employed in this research.

3.1 THE STUDY AREA:

The study was carried out in Ife – North Local Government Area of Osun State. Two communities were randomly selected, namely: Ipetumodu representing the semi-urban area and Asipa, representing the rural area.

Ife-North according to the 1991 census, has the total population of 133,258 (NPC 1992) but when projected to 2004 using the exponential growth formula ($P_t = P_0e^{rt}$) with the growth rate of 2.83% and time interval of 13 years, the projected total population is put at approximately 192,518.

Ipetumodu is the Local Government headquarters with moderate social amenities like school, electricity, pipe-borne water, supermarket, post-office, police-barracks, dispensaries/clinics/hospitals, banks e.t.c.

Asipa is a typical rural area with few social amenities. It is situated very close to Ipetumodu and that accounts for its choice. Also, so that the two areas of contrasting features will be available to present two sets of conditions that are not similar thereby making comparisons possible.

In these two survey areas, the major ethnic group is the Yorubas and it is a typical patriarchal society. The choice has been because of the evidence of domestic violence in the area.

3.2 SAMPLE SIZE

Having considered the availability of resources, the requirements of the proposal plan of analysis and having answered the questions on reasonable estimates of key proportions to be measured in the study, degree of accuracy required, confidence level, size of the population and minimum difference expected to be statistically significant, a simple formula was adopted taking into consideration that the total population size is greater than 10,000.

$$n = \frac{Z^2 pq}{d^2}$$

Where n = the desired sample size (when population is greater than 10,000)

Z = the standard normal deviate, usually set at 1.96 (or more simply at 2.0), which corresponds to the 95% confidence level.

P = the proportion in the target population estimated to have a particular characteristic. For example, estimated proportion of married women currently using family planning methods from 1999 Nigeria Demographic and Health Survey was put at 15% (NPC, 2000); although if there is no reasonable estimate, 50% (0.50) can be used.

Q = 1.0 – P

d = degree of accuracy desired, usually set at 0.05 or occasionally at 0.02.

Using the more convenient 2.0 for the Z- statistic, and P= 0.50; then the sample size is

$$n = \frac{(2)^2 (0.50)(0.50)}{(0.05)^2} = 400$$

NOTE: If P=0.15 and Q=0.85 is used, n=204 which sample size is too small for this kind of research work.

To cater for those questionnaires that will be lost eventually, four hundred and twenty questionnaires were taken out to the field, to the targeted four hundred ever-married women aged 15 – 49 and out of which four hundred and eight questionnaires were retrieved and analyzed.

3.3 SAMPLE SELECTION

The sampling design used in this study was the multistage random sampling technique to ensure the representative-ness of the sample. In the semi-urban area selected, that is, Ipetumodu, two hundred and fifty-five eligible respondents were selected because of its size and the heterogeneous nature of its population. Five streets were randomly selected out of eighteen (18) major streets namely: Ajebamidele – Okooko road otherwise known as Ipetumodu – Asipa road, Sooko street, Isale- Ola street, Baakun street and Ayetoro street.

The listing of all the households in the randomly selected streets was done and a total of fifty-one (51) households were selected from each street using systematic random sampling technique. Suppose there are 200 households in each of the selected streets and a total of 50 households are needed for the interview. 200 (N) will be divided by 50 (n) to get the k-factor. If K is 4 and if the first unit drawn is number 3 (r), the subsequent units are numbers r + k, r+2k, r+ 3k...which are 7, 11 ,15 (e.t.c) until the 50th unit is selected. Hence, a total of fifty – one (51) households were systematically selected from each street. From the randomly selected households, a listing of all the members of the households was done and one eligible female respondent was randomly selected for the interview. Eligibility was based on age and marital status. In a situation where there were more than one eligible female respondent in the selected household, the lottery method was used to select the respondent that was interviewed. However, if there was no eligible respondent in the selected household, the next household was selected from the street.

Asipa, being the rural area selected was divided based on the compounds and eligible female respondents interviewed due to its smallness and homogeneity. All the nine compounds were covered, namely Balogun's , Animun's, Asipa's, Akinfambi's, Oosa's, Eesarun's and areas like Oke-Ola, Obada and Oke-odo. Within each compound however, a listing of all the households was done and a total of 17 households were selected from each compound using systematic random sampling technique. A listing of all the members within the selected households was done and one eligible female respondent was randomly selected for the interview based on age and marital status criteria. In a situation where there were more than one eligible female respondent in the selected household, the lottery method was used to select the respondent that was interviewed. However, if there was no eligible respondent in the selected household, the next household was selected from the same compound. In all, one hundred and fifty-three respondents were selected in Asipa.

3.4 DATA COLLECTION

An important component of any survey is the selection of the appropriate methods for data collection. Questionnaire and Focus Group Discussion (FGD) were used for this study. The use of FGD is to get in-depth information about domestic violence and the use of contraceptives among the women in the area and to complement the quantitative information. A questionnaire containing the important questions was designed.

The personal interview technique or questionnaire method that was used has many advantages. It can be used with all segments of the population especially the illiterates since only verbal responses are required. A high response rate can be obtained with persistent follow-ups since most people are willing to co-operate in the face-to–face situation. The presence of an interview helps to clarify some complex questions. It makes probing possible and easily done by the experienced skilled field workers. However, the major weaknesses of the technique relate to cost, the time frame for the completion of the survey and the possible negative effects of the presence of an interviewers.

Interviewers were recruited and trained with the objectives of the study in mind and how the study will be conducted. The interviewers are educated and versatile in both English language and the vernacular. Two of them had at least secondary school education while two were Nigerian National Certificate of Education (NCE) holders and the last one is a University Undergraduate. Their skills made the data collection a little bit easier although some problems were encountered.

There were four (4) sessions of Focus Group Discussion although six sessions was proposed; two in Ipetumodu and two in Asipa while an additional new person was recruited in the area to help as facilitator and others serve as recorders while the entire coordination was done by the research student. The data was collected between late 2002 and early 2003.

3.5 SURVEY INSTRUMENTS

One of the major tasks undertaken as part of the preparatory activities for this study was the design of the questionnaire and the execution of the actual fieldwork.

The questionnaire was drawn after the proposal for the research work has been defended and approved by the Supervisor. Some of the questions taken into consideration before the questionnaire was drawn are:

1) Is the proposed question related to the major research questions?
2) Can reliable information about the item be obtained under field conditions?
3) Can the information be effectively processed taken into consideration the method of analysis to be used?
4) Are there surveys that have had such questions before?
5) Will the questions be correctly understood and interpreted by the field workers or the respondents?

The original questionnaire was prepared in English language. As language are important sources of non-sampling errors in surveys, efforts was made to interview people in their local language which is mainly Yoruba especially for those who are not learned; that is illiterates and semi-illiterates. The questionnaire was divided into three sections A to C. Section A deals with the Socio-economic and Demographic background of the respondents, Section B deals with Domestic Violence (Verbal, Emotional/Psychological, Physical and Sexual abuse) while Section C deals with Contraceptive use (Knowledge, Attitude and Practice).

3.6 THE FIELDWORK AND PROBLEMS ENCOUNTERED

There were some field operational problems. As expected, some women declined from the interview under the pretence of lack of time to respond to the questions in the questionnaire.

Also, there was a high level of illiteracy among many of the women we encountered and were it not for the training experience of the interviewers, the data would have been a mess.

Moreover, it was a time of political campaign in preparation for the 2003 elections and so many of them thought we had something to do with the campaign and some of them demanded gifts or benefits that will accrue to them for answering the questions. The interviewers then had to explain to them that they had nothing to do with politics and to create good rapport with them.

In addition, despite the training, some questions were misinterpreted by some interviewers and some of them who filled the questionnaires themselves committed the same error. Some responses are not reliable, for example, income of the respondents, age at first sexual intercourse and the person with whom they had it.

Furthermore, there is gross under-reporting of the prevalence of domestic violence in the study area as many of the women hid or dodged the questions relating to battering and intimate sexual abuse (forced sexual relationship with spouse otherwise called marital rape). Nevertheless, the interviewers tried their best in probing further to get something tangible from the respondents.

Finally, some of the people meant to be questioned during the Focus Group Discussion sessions were absent though they had been properly invited. Their age composition then made it difficult to have six sessions and that was the main reason the proposed six FGD sessions was cut down to four comprising of those between ages 15 and 29 years and those between ages 30 and 49 years accounting for the two FGD sessions in Ipetumodu and the remaining two in Asipa area of Ife-North local Government area of Osun State, Nigeria. The response rate in the questionnaire method was 97.4%.

3.7 DATA PROCESSING AND ANALYSIS FORMAT

The checking of the questionnaires was done on the field to make sure that the questionnaires were properly filled. Data entry and editing was done using EPI INFO Version 6.04 programme. Subsequent analyses were done after data cleaning using SPSS Version 11. Several Statistical measures were used in the analysis of the data. These include frequencies, cross tabulations and means. These are descriptive measures or statistics that determine the composition of the respondent with respect to their socio-economic and demographic characteristics. This is referred to as the first level of the analyses.

In the second level, bivariate analysis was carried out to explain the relationship between two variables (the independent and the dependent variables in the study).

At the third and final level, there was a multivariate logistic regression which was used to quantify the relationship between the independent variables, the intermediate variable (Domestic violence) and the dependent variables (Contraceptive use) in the study. Logistic regression model was used because the dependent variable which is contraceptive use is dichotomous (use or non-use of contraceptives).

The general model of this logistics regression is of the form

$$\text{Log}\left[p / 1\text{-}p \right] = b_0 + b_1X_1 + b_2X_2 + \ldots + b_kX_k$$

Where $X_1, X_2, \ldots, X_k$ are set of independent variables, b_0 is a constant while b's are regression coefficients. P is the probability of use of contraceptives without husband's permission among women in the study area.

The dependent variable for this study is Contraceptive use. The independent variables include socio-economic and demographic factors like age, type of marriage, educational level, religion, marital status, occupation, family structure and so on.

The intermediate or intervening variable is domestic violence (wife battery and intimate sexual abuse or forced sexual encounter between intimate partners otherwise called marital rape).

CHAPTER FOUR

4.0 UNIVARIATE, BIVARIATE, MULTIVARIATE ANALYSES AND TESTING OF HYPOTHESES

4.1 Socio-economic and demographic characteristics of the respondents

This chapter discusses the socio-economic and demographic characteristics of the respondents at the time of the survey. A discussion of the background characteristics of the respondents is essential for the survey findings on domestic violence and contraceptive use, because some of the socio-economic and demographic characteristics of the women may expose them to domestic violence and in turn affect their use of contraceptive. The variables analyzed include age, level of education, marital status, type of marriage, religion, children ever born (CEB), and income level of the respondents, Husband's level of education, husband's occupation and choice of spouse.

4.1.1 AGE

Table 4.1.1: Percentage Distribution of Respondents by their Current Age:

Current Age	Semi-Urban	Rural	Total
15 – 24	9.8(25)	9.2(14)	9.6(39)
25 – 34	35.3(90)	37.3(57)	36.0(147)
35 – 44	36.1(92)	35.3(54)	35.8(146)
45 – 49	18.8(48)	18.3(28)	18.6(76)
Total	100.0(255)	100.0(153)	100.0(408)
Mean Age	34.93 years	34.47 years	34.76 years

Source: field survey, 2003

From the above table, information on current age was gathered from 255 respondents in the Semi-urban area chosen while a total of 153 respondents gave their responses from the rural area. In all, 408 respondents gave their responses to question on current age.

The distribution shows that about 10.0% of the respondents are below age 25. In terms of rural /Semi-urban differential, the proportion of the respondents who are below age 25 from the semi-urban area is about 10.0% while it is 9.2% in the case of the rural area. The highest proportion is in the age-group 25 – 34, followed by age-group 35 – 44 for both total and the rural area while for the semi-urban area the highest proportion is in age-group 35 – 44, followed by 25 – 34. The overall mean age of the respondents for the study is 34.76 years; 34.93 years for the semi-urban area and 34.47 years for the rural area meaning about equal mean age for both semi-urban and rural areas.

4.1.2 Age at First Marriage

Since it is possible for a woman to marry more than once as a result of factors like divorce or re-marriage after the death of the first partner, it becomes therefore necessary for the respondents to indicate their age at their first marriage irrespective of their current marital union status. This is shown in table 4.1.2 below.

Table 4.1.2: Percentage Distribution of respondents by Age at First Marriage

Age at first marriage	Semi-Urban	Rural	Total
15 - 19	9.8(25)	13.7(21)	11.3(46)
20 – 24	47.8(122)	61.4(94)	52.9(216)
25 – 29	32.9(84)	19.6(30)	27.9(114)
30 – 34	9.0(23)	4.6(7)	7.4(30)
35 – 39	0.4(1)	0.7(1)	0.5(2)
40 – 44	-	-	-
45 - 49	-	-	-
Total	100.0(255)	100.0(153)	100.0(408)
Mean age at first marriage	23.17 years	21.86 years	22.68 years
Median age at first marriage	23 years	21 years	22 years

Source: field survey, 2003

Table 4.1.2 shows that women marry at a relatively early age in the area surveyed. More than half of the respondents (64.2%) reported that they married for the first time before their 25th birthday. For the women under study, early marriage did exist but was uncommon. Comparing the semi-urban women with their rural counterparts, greater proportion of the respondents in the rural area have married before age 20 (about 14% compared to 10% in the semi-urban area) and 75% of women in the rural area have married before age 25 compared to 57% of women in the semi-urban area. Thus marrying at younger age is more pronounced in the rural area than in the semi-urban area. Postponement of marriage to later years/ages is more pronounced in the semi-urban area as about 42% of the respondents got married above age 24 compared to just 24% of those in the rural area. Some of the likely reasons for this are exposure to better educational facilities and better working opportunities and the attendant challenges that accompany such opportunities. The semi-urban area is obviously more developed than the rural area in that early marriage is obviously less in the semi-urban area (9.8%) than in the rural area (13.7%). Only 7.9% of the respondents married above age 30; 9.4% in the semi-urban area and 5.3% in the rural area. The mean age at first marriage for the study is 22.68 years while the median age at first marriage is 22 years. The estimated median age at first marriage is higher than 18 years reported in 1999 Nigeria Demographic and Health Survey (NPC, 2000). Comparing between semi-urban and rural areas, the estimated mean age at first marriage for the former is 23.17 years, and the median age at first marriage is 23 years, while the estimated mean and the median age at first marriage for the latter are 21.86 years and 21 years respectively. This indicates that women marry relatively earlier in the rural area than in the semi-urban area because of fewer challenges in the former. This is in consonance with the earlier findings in 1999 Nigeria Demographic and Health Survey although the currently estimated figures are slightly higher than 19 years and 17 years reported for the urban and rural women respectively (NPC, 2000).

4.1.3 Age at First Birth

There was a question on age at first birth. The responses are shown in the table below.

Table 4.1.3: Percentage Distribution of Respondents by Age at first birth

Age at first birth	**Semi-Urban**	**Rural**	**Total**
15 - 19	5.9(15)	13.1(20)	8.6(35)
20 – 24	47.1(120)	57.5(88)	51.0(208)
25 – 29	31.0(79)	24.2(37)	28.4(116)
30 – 34	11.8(30)	4.6(7)	9.1(37)
35 – 39	1.2(3)	0.7(1)	1.0(4)
40 – 44	-	-	-
45 - 49	-	-	-
No Response	3.1(8)	-	2.0(8)
Total	100.0(255)	100.0(153)	100.0(408)
Median age at first birth	24 years	22 years	23 years

Source: field survey, 2003

Table 4.1.3 shows that 8.6% of the respondents started childbearing below age 20. Greater proportion of the respondents had their first babies between age 20 and 29 (79.4%), while 10.1% of the women had their first issue at age 30 and above. The overall mean age at first birth for the study is 23.58 years while the median age at first birth is 23 years. This figure is slightly higher than the median age of 20 years reported in year 2000 (NPC, 2000). In the semi-urban area, the mean age at first birth is 24.23 years while it is 22.54 years in the rural area. The median age at first birth for the semi-urban area is 24 years and 22 years for the rural area. Relating the mean age at first birth (23.58 years) to the mean age at first marriage, (22.68 years) it could be inferred that the women seemed to conceive barely one year after their marriage. In terms of semi-urban – rural differentials, many rural women started childbearing earlier than their semi-urban women counterparts.

4.1.4 EDUCATIONAL LEVELS

Education of the women has been found to be positively correlated to their decision-making ability about the use of contraceptives. Also education plays an important role in shaping attitudes, opinions, values and exposure to new ideas and alternative lifestyles might lead a person to question traditional norms and practices (InKelen, 1973).

The pattern of distribution by their educational levels in the study is presented in Table 4.1.4

Table 4.1.4: Percentage Distribution of Respondents by educational level

Educational Level	Semi-Urban	Rural	Total
None	13.7(35)	19.0(29)	15.7(64)
Primary	17.3(44)	34.6(53)	23.8(97)
Secondary	37.6(96)	35.3(54)	36.8(150)
Tertiary	31.4(80)	11.1(17)	23.8(97)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

The table above shows that 15.7% of the women interviewed for this study has no formal education. This is more pronounced in the rural area (19.0%) than in the semi-urban area (13.7%). This is because there are more challenges and facilities in the semi-urban area selected for this study. The proportion of women with primary education as their highest educational level is considerably higher in the rural area (34.6%) than in the semi-urban area (17.3%).

The proportion is however, higher for post-primary and post-secondary levels in the semi-urban area. In all, more than half of the women attended primary and secondary schools. About 24% of the respondents however, attended higher institutions, 31.4% ands 11.1% in the semi-urban and rural areas respectively.

4.1.5 MARITAL STATUS

The table below shows the marital status of the respondents as at the time of this study.

Table 4.1.5: Percentage Distribution of respondents by Marital Status

Marital Status	**Semi-Urban**	**Rural**	**Total**
Married	87.8(224)	94.1(144)	90.2(368)
Widowed	7.8(20)	5.2(8)	6.9(28)
Divorced	1.6(4)	-	1.0(4)
Separated	2.7(7)	0.7(1)	2.0(8)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

Table 4.1.5 shows that, 90.2% of the sampled women populations is currently married, and are with their partners at the time of the survey. Divorce rate is quite low (1.0%) in the study area due majorly to the influence and efforts of in-laws in settling quarrels and because of increasing stigma placed on a woman who is a divorcee. Divorce rate figure is placed at 1.6% in semi-urban area under study while it is non-existent in the rural area which shows that matrimonial harmony is maintained in the rural area than in the semi-urban area. However, the table shows that about 10% of the marital unions have been dissolved. The dissolution was mostly due to the demise of husband (6.9%) rather than divorce or separation. Dissolution by death of husband is higher in the semi-urban area (7.8%) than in the rural area (5.2%). In all, 2.0% of the women are living away from their husbands, 2.7% in the semi-urban area; 0.7% in the rural area but not legally separated at the law court.

4.1.6 TYPE OF MARRIAGE

Polygyny is a common phenomenon permeating the social fabric in many parts of Nigeria. To assess the level of polygyny among the Yoruba women surveyed, they were asked to indicate their type of marriage. Table 4.6 shows the response of the women.

Table 4.1.6: Percentage Distribution of Respondents by Type of marriage

Type of Marriage	Semi-Urban	Rural	Total
Monogamous	71.0(181)	66.7(102)	69.4(283)
Polygynous	28.2(72)	33.3(51)	30.1(123)
No Response	0.8(2)	-	0.5(2)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

The table above indicates that more than half of the respondents are the only wives of their husbands (69.4%), 71.0% in the semi-urban area and 66.7% in the rural area, while a considerable proportion of the women are in polygynous union (30.1%). Despite the fact that Christianity as a religion is exerting a great deal of influence on the composition or structure of marital union, many Yorubas still have great inclinations toward polygyny. It is clear from the table that a little above one-quarter of the respondents live in a polygynous family in the semi-urban area (28.2%) while 33.3% expectedly practice same in the rural area.

4.1.7 PARITY

The distribution of women by the number of children ever born (CEB) is presented in the table below:

Table 4.1.7: Percentage Distribution of Women by Children Ever Born (CEB).

Children Ever Born	**Semi-Urban**	**Rural**	**Total**
0	3.5(9)	1.4(2)	2.7(11)
1 – 4	71.0(181)	69.3(106)	70.3(287)
5+	25.5(65)	29.4(45)	27.0(110)
Total	100.0(255)	100.0(153)	100.0(408)
Mean CEB	3.35	3.72	3.49

Source: field survey, 2003

Considering the fact that a woman's inability to conceive and have children may expose such a woman to various forms of abuse in the hand of her intimate partner, we therefore need to see the distribution of the women respondents by children ever born. The table above shows that the proportion of women with no children ever born is only 2.7%; 3.5% in the semi-urban area and 1.4% in the rural area. Those with maximum of four children are 70.3%; 71.0% in the semi-urban area and 69.3% in the rural area. Those with more than four children are slightly higher in the rural area (29.4%) than in the semi-urban area (25.5%). This shows that desire for larger family size is more pronounced in the rural area and the likely reasons for this may be old-age security, low level of contraceptive acceptance and use, fear of the number of children that will eventually survive out of the children ever born and so on. The estimated mean children ever born of 3.49 is close to the 3.81 reported for Nigeria in the 1999 Nigeria Demographic and Health Survey (NPC, 2000) although there are variations between the semi-urban and the rural area.

4.1.8 WORKING STATUS

The table below shows the working status of the women under study. Questions related to whether they are working or not may serve as an indicator of domestic violence and at the same time serve as a reason for not using contraceptives especially the modern ones. See the summary of their responses below:

Table 4.1.8: Percentage Distribution of Respondents by whether Currently Working

Currently Working	Semi-Urban	Rural	Total
Yes	94.1(240)	96.7(148)	95.1(388)
No	5.9(15)	3.3(5)	4.9(20)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From table 4.1.8, exactly 95.1% of the respondents are currently working; 94.1% in the semi-urban area and about 97% in the rural area. As at the time of this survey, about 5% of the respondents were not working for reasons best known to them; about 6% in the semi-urban area and about 3% in the rural area.

4.1.9 OCCUPATION

Working women are expected to be able to take decisions regarding their reproductive life especially in the area of deciding whether to use or not to use contraceptives. Also, their working status enables them to be financially independent and this may either expose them to domestic violence or reduce same. However, the nature of job a woman engages in matters a lot as there are complex interrelationships between domestic violence and nature of job a woman engages in on one hand and between occupation of a woman and use and non-use of contraceptives on the other.

Table 4.1.9: Percentage Distribution of Respondents by occupation

Type of Occupation	Semi-Urban	Rural	Total
Farming	1.2(3)	2.0(3)	1.5(6)
Artisan(e.g. weaving)	14.5(37)	8.5(13)	12.3(50)
Petty trading	36.1(92)	64.7(99)	46.8(191)
Housewife	2.4(6)	2.6(4)	2.5(10)
Business	129(33)	9.2(14)	11.5(47)
Civil Service	22.0(56)	8.5(13)	16.9(69)
Professional (e.g. Nurse, Doctor etc)	4.7(12)	2.0(3)	3.7(15)
Others (e.g. Pensioner etc)	2.0(5)	0.7(1)	1.5(6)
No Response	4.3(11)	2.0(3)	3.4(14)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From the table above, it is clear that petty trading seems to be the major occupation of the women (46.8%), followed by civil service (16.9%) and the least occupation happened to be farming and those of them who are pensioners (1.5%). There are more petty traders in the rural area (64.7%) compared to the semi-urban area (36.1%) while the reverse is the case when we consider those who are professionals and those in the civil service (4.7% versus 2.0%; 22.0% versus 8.5%).

4.1.10 MAIN REASON FOR WORKING

This is to elicit information regarding their experiences as far as domestic violence is concerned. The table below shows their responses to why they are working.

Table 4.1.10: Percentage Distribution of Respondents by reasons for working

Main Reason for Working	**Semi-Urban**	**Rural**	**Total**
Economic necessity	34.6(83)	20.3(30)	29.1(113)
Finance Independence	37.1(89)	63.5(94)	47.2(183)
Pursue Career/Profession	3.3(8)	0.7(1)	2.3(9)
Use education/Skill	3.8(9)	2.7(4)	3.4(13)
Help with family business/Farm	15.8(38)	10.1(15)	13.7(53)
Like to Work	5.0(12)	2.0(3)	3.9(15)
Others	0.4(1)	0.7(1)	0.5(2)
Total	100.0(240)	100.0(148)	100.0(388)

Source: field survey, 2003

From table 4.1.10, a considerable proportion of the women were working so as to be financially independent (47.2%); 37.1% in the semi-urban area and 63.5% in the rural area. Another 29.1% of the women were working for economic necessity; expectedly, 34.6% in the semi-urban area and 20.3% in the rural area. About 14.0% of the women were helping with family business/farm; 15.8% in the semi-urban area and 10.1%in the rural area. It is noteworthy that some of the women are working to pursue a career or a profession (2.3%); Use education or a skill already acquired (3.4%) and because they like to work (3.9%). For each of the three reasons just mentioned above, the semi-urban area has higher proportion of women compare to the rural area.

4.1.11 MAIN REASON FOR NOT WORKING

Table 4.1.11: Percentage Distribution of Respondents by why not working at the time of the Survey

Main reason for not working	Semi-Urban	Rural	Total
No financial need to work	6.7(1)	-	5.0(1)
Unable to find work	6.7(1)	60.0(3)	20.0(4)
Have no special skill	13.3(2)	-	10.0(2)
Need to Care for Children	6.7(1)	-	5.0(1)
Husband objects	66.7(10)	40.0(2)	60.0(12)
Total	100.0(15)	100.0(5)	100.0(20)

Source: field survey, 2003

From table 4.1.11, more than half of the women were not working as at the time of the survey because their husbands object (60.0%); 66.7% in the semi-urban area and 40.0% in the rural area. Only 20.0% of the women are not working because of joblessness; 6.7% in the semi-urban area and 60.0% in the rural area.

4.1.12 RELIGIOUS AFFILIATION

Religion is a very important factor as we consider the issue of domestic violence and contraceptive use. Religious background of an individual will affect and influence one's behaviour, attitude and sometimes decision concerning a particular phenomenon. Responses of the respondents are hereby presented below.

Table 4.1.12: Percentage Distribution of Respondents by Religious Affiliation.

Religion	Semi-Urban	Rural	Total
Christianity	88.6(226)	72.5(111)	82.6(337)
Islam	11.0(28)	27.5(42)	17.2(70)
Others (e.g. Jehovah's Witness)	0.4(1)	-	0.2(1)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

It is clear from the table above that the greatest proportion of the women are Christians (82.6%) whether in the semi-urban area or in the rural area. Those in the others' category are in the minority and there are more Moslems in the rural area (27.5%) than in the semi-urban area (11.0%).

4.1.13 LEVEL OF INCOME

Table 4.1.13: Percentage Distribution of women by their income levels (per annual income)

Income per annum	Semi-Urban	Rural	Total
Less than ₦100,000	53.3(136)	60.8(93)	56.1(229)
Above ₦100,000	24.3(62)	5.9(9)	17.4(71)
No Response	22.4(57)	33.3(51)	26.5(108)
Total	100.0(255)	100.0(153)	100.0(408)
Mean Annual Income	₦83,222.94	₦39,940.59	₦68,506.94

Source: field survey, 2003

The table above shows that the greatest percentage of the women surveyed earn less than ₦8,333 in a month (56.1%); 53.3% in the semi-urban area and 60.8% in the rural area. About 17% of the respondents earn above ₦8,333 in a month; 24.3% in the semi-urban area because of better working conditions and facilities and only 5.9% in the rural area. There is a high level of non-response because many people do not know how much they are collecting or earning monthly while others deliberately conceal the amount as it is expected to be a confidential matter. There is a clear evidence of poverty among the women in the surveyed area because in all cases, more than half of the women earn far less than ₦10,000 in a month and this will definitely affect their decision-making ability negatively since many of them will have to depend on their spouse for sustenance. As a result, they can suffer as victims of domestic violence and will not be able to single-handedly decide whether to use contraceptives or not without their husbands' permission. The mean annual income for the surveyed women population is ₦68,506.94 while that of the semi-urban area (₦83,222.94) is far greater than that of the rural area (₦39,940.59).

4.1.14 CHOICE OF SPOUSE

It is expected that those women who choose their spouses themselves would have made a right and wise choice of picking the spouses they love and this will go a long way to fostering marital harmony and cohesion. As a result, we need to know whether their spouses were chosen for them by a third party or whether they chose their spouses themselves. The responses are presented below:

Table 4.1.14: Percentage Distribution of Respondents by choice of spouse

Choice of Spouse	**Semi-Urban**	**Rural**	**Total**
Personal choice	85.5(218)	88.2(135)	86.5(353)
Parents chose	7.1(18)	7.2(11)	7.1(29)
No Response	7.5(19)	4.6(7)	6.4(26)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From the table above, about 87% of the women chose their spouses themselves; about 86% and 88% in the semi-urban and rural areas respectively. Exactly 7.1% of the women had their spouses chosen for them by their parents; 7.1% in the semi-urban area and expectedly 7.2% in the rural area.

4.1.15 RESPONDENTS' HUSBANDS' CHARACTERISTICS

4.1.15.1 LEVEL OF EDUCATION

Table 4.1.15.1: Percentage Distribution of Respondents by Husbands' Level of Education.

Husbands' Level of Education	Semi-Urban	Rural	Total
None	9.8(25)	17.0(26)	12.5(51)
Primary	7.1(18)	13.1(20)	9.3(38)
Secondary	34.1(87)	36.6(56)	35.0(143)
Tertiary	46.7(119)	31.4(48)	40.9(167)
No Response	2.4(6)	2.0(3)	2.2(9)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

It is clear from the table above that the respondents' partners are relatively literate as about 41% of those husbands had their education up to tertiary level while 35% attended school up to secondary school level. In spite of a relatively high level of literacy, about 13% of the respondents' husbands have no formal education at all.

When the place of residence is considered, it is clear that there are more illiterates in the rural (17.0%) than in the semi-urban area under study (9.8%). Also, more husbands in the rural area had their formal education up to Primary school level (13.1%) than their counterparts in the semi-urban area (7.1%). Moreover, 34.1% as against 36.6% had their formal education up to secondary school level in the semi-urban area while more husbands in the semi-urban area had their formal education up to tertiary level (46.7%) and the figure for the rural area is put at 31.4%.

4.1.15.2 OCCUPATION OF HUSBANDS

Table 4.1.15.2: Percentage Distribution of Respondents by Occupation of Husband.

Husbands' Occupation	Semi-Urban	Rural	Total
Farming	18.4(47)	36.6(56)	25.2(103)
Artisan	14.1(36)	15.7(24)	14.7(60)
Petty trading	5.1(13)	3.9(6)	4.7(19)
Business	14.1(36)	10.5(16)	12.7(52)
Civil Service	29.8(76)	23.5(36)	27.5(112)
Professional	11.8(30)	5.2(8)	9.3(38)
Others (e.g. Herbalist, Clergy etc)	5.1(13)	3.9(6)	4.7(19)
No Response	1.6(4)	0.7(1)	1.2(5)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From the table above, the largest proportion of the respondents husbands are civil servants (27.5%); followed by those artisans (14.7%) while those trading or in fairly big businesses are 4.7% and 12.7% respectively. Comparing the semi-urban to the rural area, it is clear from the table that the figures are higher for rural area when the occupation are informal ones like farming (36.6%); artisan (15.7%), but when skills and high-level formal education are needed, the figures are higher on the side of the semi-urban area. For example, 29.8% of those husbands in the semi-urban area engages in civil service; 11.8% as professionals; 14.1% as businessmen and so on.

4.1.16 SPOUSAL HABITATION

Table 4.1.16: Percentage distribution of respondents by whether the partners regularly live with the respondents or not.

Spousal habitation	**Semi-urban**	**Rural**	**Total**
Lives with me	84.7(216)	85.6(131)	85.0(347)
Lives elsewhere	15.3(39)	14.4(22)	15.0(61)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From the table above, exactly 85.0% of the respondents have their partners living with them regularly, 84.7% in the semi-urban area and about 86.0% in the rural area while 15.0% of them had their partners staying elsewhere, 15.3% in the semi-urban area and 14.4% in the rural area.

4.2 TYPES OF DOMESTIC VIOLENCE

4.2.1 FREQUENCY OF DOMESTIC VIOLENCE

(Verbal, Emotional/Psychological, physical and sexual abuse)

Table 4.2.1: Percentage Distribution of respondents by frequency of domestic violence (within the last one year to the time of the survey)

Question on frequency of domestic violence	Semi-Urban	Rural	Total
Ignored your feelings			
Never	85.5(218)	82.4(126)	84.3(344)
At least once	14.5(37)	17.6(27)	15.7(64)
Total	100.0(255)	100.0(153)	100.0(408)
Ridiculed or insulted women as a group			
Never	83.9(214)	84.3(129)	84.1(343)
At least once	16.1(41)	15.7(24)	15.9(65)
Total	100.0(255)	100.0(153)	100.0(408)
Ridiculed or insulted your most-valued beliefs, your religion, heritage or class			
Never	91.0(232)	93.5(143)	91.9(375)
At least once	9.0(23)	6.5(10)	8.1(33)
Total	100.0(255)	100.0(153)	100.0(408)
Withheld approval, appreciation or affection as punishment			
Never	90.2(230)	90.2(138)	90.2(368)
At least once	9.8(25)	9.8(15)	9.8(40)
Total	100.0(255)	100.0(153)	100.0(408)
Continuously criticized you, called you names, shouted at you			
Never	90.6(231)	85.6(131)	88.7(362)

At least once	9.4(24)	14.4(22)	11.3(46)
Total	100.0(255)	100.0(153)	100.0(408)
Humiliated you in private			
Never	83.9(214)	90.8(139)	86.5(353)
At least once	16.1(41)	9.2(14)	13.5(55)
Total	100.0(255)	100.0(153)	100.0(408)
Humiliated you in public			
Never	92.5(236)	91.5(140)	92.2(376)
At least once	7.5(19)	8.5(13)	7.8(32)
Total	100.0(255)	100.0(153)	100.0(408)
Refused to socialize with you			
Never	89.4(228)	90.2(138)	89.7(366)
At least once	10.6(27)	9.8(15)	10.3(42)
Total	100.0(255)	100.0(153)	100.0(408)
Kept you from working			
Never	92.9(237)	95.4(146)	93.9(383)
At least once	7.1(18)	4.6(7)	6.1(25)
Total	100.0(255)	100.0(153)	100.0(408)
Made all decisions			
Never	80.0(204)	86.9(133)	82.6(337)
At least once	20.0(51)	13.1(20)	17.4(71)
Total	100.0(255)	100.0(153)	100.0(408)
Controlled your money			
Never	94.1(240)	94.1(144)	94.1(384)
At least once	5.9(15)	5.9(9)	5.9(24)
Total	100.0(255)	100.0(153)	100.0(408)
Refused to share money			
Never	91.8(234)	94.1(144)	92.6(378)
At least once	8.2(21)	5.9(9)	7.4(30)
Total	100.0	100.0(153)	100.0(408)
Took car keys or money away from			

you			
Never	86.7(221)	96.1(147)	90.2(368)
At least once	13.3(34)	3.9(6)	9.8(40)
Total	100.0(255)	100.0(153)	100.0(408)
Regularly told you to leave			
Never	89.4(228)	92.8(142)	90.7(370)
At least once	10.6(27)	7.2(11)	9.3(38)
Total	100.0(255)	100.0(153)	100.0(408)
Threatened to hurt you and children			
Never	91.8(234)	92.8(142)	92.2(376)
At least once	8.2(21)	7.2(11)	7.8(32)
Total	100.0(255)	100.0(153)	100.0(408)
Punished or deprived the children when angry…			
Never	92.9(237)	92.2(141)	92.6(378)
At least once	7.1(18)	7.8(12)	7.4(30)
Total	100.0(255)	100.0(153)	100.0(408)
Abused, tortured or killed pets to hurt you			
Never	96.5(246)	90.2(138)	94.1(384)
At least once	3.5(9)	9.8(15)	5.9(24)
Total	100.0(255)	100.0(153)	100.0(408)
Destroyed furniture, broke appliances			
Never	96.5(246)	96.7(148)	96.6(394)
At least once	3.5(9)	3.3(5)	3.4(14)
Total	100.0(255)	100.0(153)	100.0(408)
Wielded a gun in a threatening way			
Never	99.2(253)	98.7(151)	99.0(404)
At least once	0.8(2)	1.3(2)	1.0(4)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

The table above shows the frequency of domestic violence by types against women (verbal, emotional/psychological, physical and sexual) within the last one year to the time of the survey in the study area. It is noteworthy to say that a higher percentage reported never having experienced any of the types of domestic violence listed in the table. About 16.0% of women had their feeling ignored by their partners and were also ridiculed or insulted; 8.1% had their most-valued beliefs, religion, heritage or class insulted; 9.8% had their appreciation or affection withheld as punishment; 11.3% had themselves criticized or shouted at; 13.5% of those women were humiliated in private and 7.8% in the public; 10.3% had their husband's refusal to socialize with them; 6.1% were kept from working by their partners; 17.4% had their husbands making all decisions; 5.9% had their money controlled and 7.4% of them could not have their share of the money in the family; 9.8% had their family car keys or money seized by their partners and about 10% had their husbands telling them regularly to leave; 7.8% had threats of hurting them and their children; 7.4% had their children punished or deprived when the husband was angry at them; 5.9% of the women were abused, tortured or had their pets killed to hurt them; 3.4% had the family furniture destroyed or the family appliances broken while only 1.0% had a gun wielded at them in a threatening way. This figure is very low may be because it is not part of our culture to possess guns anyhow like we have it in the developed countries of the world except the local Dane guns used by the local hunters around.

Observing the semi-urban/rural differential generally, we see very slight differences in the figures except on the issue of private humiliation – 16.1% for the semi-urban and 9.2% for the rural areas; 7.1% were kept from working in the semi-urban area while about 5% had similar experience in the rural area; 20.0% also experienced partners making all decisions in the semi-urban area while only 13.1% had similar experience in the rural area; 13.3% had their car keys or money seized in the semi-urban are while 3.9% had such experience in the rural area; 3.5% experienced abuse, torture and killing of pets in the semi-urban area while this kind of experience is more in the rural area (9.8%); 0.8% of the women in the semi-urban area had experienced a gun threat while 1.3% of the rural women had experienced similar event.

4.2.2 KNOWLEDGE AND EXPERIENCE OF DOMESTIC VIOLENCE

Table 4.2.2.1: Percentage Distribution of Respondents by answer to whether they had experienced one form of domestic violence or the other from their intimate partners

Questions on Domestic Violence	Semi-Urban	Rural	Total
Partner done the following to you?			
Threatened to beat, slap, kick or physically harm you the wife			
Yes	52.5(134)	60.8(93)	55.6(227)
No	47.5(121)	39.2(60)	44.4(181)
Total	100.0(255)	100.0(153)	100.0(408)
Actually beaten, slapped, kicked or physically harmed the wife			
Yes	62.7(160)	60.8(93)	62.0(253)
No	37.3(95)	39.2(60)	38.0(155)
Total	100.0(255)	100.0(153)	100.0(408)
Denied the wife sex			
Yes	6.3(16)	10.5(16)	7.8(32)
No	93.7(239)	89.5(137)	92.2(376)
Total	100.0(255)	100.0(153)	100.0(408)
Gone Outside marriage relationship to play sex			
Yes	14.1(36)	12.4(19)	13.5(55)
No	85.9(219)	87.6(134)	86.5(353)
Total	100.0(255)	100.0(153)	100.0(408)
Separated from you			
Yes	7.5(19)	13.1(20)	9.6(39)
No	92.5(236)	86.9(133)	90.4(369)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From table 4.2.2.1, 55.6% of the women under study have received threats to be beaten, slapped, kicked or physically harmed from their husbands; 52.5% in the semi-urban and 60.8% in the rural area. Exactly 62.0% of the women have actually been beaten, slapped, kicked and physically harmed by their intimate partners, 62.7% in the semi-urban and 60.8% in the rural area. Exactly 7.8% have been denied sex, 6.3% in the semi-urban and 10.5% in the rural area meaning that the experience is higher in the rural than in the semi-urban area. About 14.0% of the women under study reported that their husbands went outside marriage relationship to play sex; 14.1% in the semi-urban area and 12.4% in the rural area. About 10.0% of the women reported separation; 7.5% in the semi-urban area and 13.1% in the rural area.

Table 4.2.2.2: Percentage Distribution of Respondents by experience of domestic violence from intimate partners, the steps taken and action of men in crisis situation

Questions on Domestic Violence	Semi-Urban	Rural	Total
Experienced domestic violence during pregnancy			
Yes	14.1(36)	22.2(34)	17.2(70)
No	85.9(219)	77.8(119)	82.8(338)
Total	100.0(255)	100.0(153)	100.0(408)
Any step to protect self?			
Yes	12.5(32)	15.7(24)	13.7(56)
No	87.5(223)	84.3(129)	86.3(352)
Total	100.0(255)	100.0(153)	100.0(408)
Steps taken to protect self			
Ran away from home	9.4(3)	16.7(4)	12.5(7)
Reported to his family	6.3(2)	-	3.6(2)
Keep quiet & pacify him by all means	50.0(16)	25.0(6)	39.3(22)
Prayer & Calling others to help	12.5(4)	4.2(1)	8.9(5)
I went to the hospital	18.8(6)	54.2(13)	33.9(19)
Confused	3.1(1)	-	1.8(1)
Total	100.0(32)	100.0(24)	100.0(56)
Main thing men do when they have misunderstanding with their partners			
Abandon/Ignore wife and children.	29.0(74)	22.2(34)	26.5(108)
Refuse to eat at home	4.3(11)	3.9(6)	4.2(17)
He will show his anger e.g. using abusive words	4.7(12)	7.8(12)	5.9(24)
Beat the wife	3.5(9)	3.9(6)	3.7(15)
Make all decisions	0.4(1)	-	0.2(1)

Refuse to share money	2.7(7)	-	1.7(7)
Restrain wives' movement	0.4(1)	0.7(1)	0.5(2)
Marry other wives	1.2(3)	1.3(2)	1.2(5)
Go outside marriage to play sex	2.4(6)	2.0(3)	2.2(9)
Hurt children at home	0.4(1)	-	0.2(1)
Send wife and children out	1.6(4)	2.6(4)	2.0(8)
Call for elders' intervention	-	1.3(2)	0.5(2)
Settle amicably with spouse	4.7(12)	6.5(10)	5.4(22)
Pray to God	0.8(2)	-	0.5(2)
No Response	43.9(112)	47.7(73)	45.3(185)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From table 4.2.2.2 above, 17.2% reported experiencing domestic violence during pregnancy; 14.1% in the semi-urban area and 22.2% in the rural area.

On whether the women took any step to protect themselves, 13.7% said they did; 12.5% in the semi-urban area and 15.7% in the rural area while a higher percentage did not for reasons ranging from lack of facilities for protection and the fact of having to stay and to get the problems solved since the women may not want to go back to their fathers' houses. Among those that took steps to protect themselves; a higher proportion either kept quiet and pacify their husbands by all means (39.3%); 50.0% in the semi-urban area and 25.0% in the rural area or went to the available hospital for treatment (33.9%); 18.8% in the semi-urban area and 54.2% in the rural area. About 13.0% reported running away from their matrimonial home; 9.4% in the semi-urban area and 16.7% in the rural area. It is noteworthy to mention that none of the women contacted the police when it happened. Exactly 3.6% reported the event to the husbands' family and particularly in the semi-urban area (6.3%).

Moreover, on the main thing men do when there is conflict in the family, a larger percentage of the women reported that their husbands often abandon or ignore them and their children (26.5%); 29.0% in the semi-urban area and 22.2% in the rural area while 5.9% reported use of abusive language by husbands against their wives; 4.7% and 7.8% in the semi-urban and rural area respectively. About 5.0% of the women reported that their husbands often settle amicably with their wives; 4.7% and 6.5% in the semi-urban and rural area respectively. Only 3.7% reported beating from husbands; 3.5% in the semi-urban area and 3.9% in the rural area among various other things that men in the area do.

Women in the focus group discussion, in responding to the same question corroborated the ideas earlier expressed in the interview method. A woman in the semi-urban area aged 15-29 responded by saying:

> *"They will abandon wife and children and will not play with their family as the use to do before. Rather, they will frown their face and will not inform anyone about their movement again".*

Another woman in the rural area indicated that *"when men are angry, they will neglect their duties at home, stay longer outside the home and may even beat their wives".*

The responses of the older women on this question were the same with that of the younger women under study.

Table 4.2.2.3: Percentage Distribution of Respondents by experience of domestic violence from intimate partners, consequences and rationale for domestic violence in marital unions

Questions on Domestic Violence	Semi-Urban	Rural	Total
Ever Suffered any of the following as a result of a quarrel /disagreement with intimate partner?			
Pain (Muscular, abdominal etc.)			
Yes No Total	9.0(23) 91.0(232) 100.0(255)	13.1(20) 86.9(133) 100.0(153)	10.5(43) 89.5(365) 100.0(408)
Bites/Cuts			
Yes No Total	4.7(12) 95.3(243) 100.0(255)	9.2(14) 90.8(139) 100.0(153)	6.4(26) 93.6(382) 100.0(408)
Chronic headaches			
Yes No Total	11.4(29) 88.6(226) 100.0(255)	13.1(20) 86.9(133) 100.0(153)	12.0(49) 88.0(359) 100.0(408)
Bruises			
Yes No Total	3.9(10) 96.1(245) 100.0(255)	5.9(9) 94.1(144) 100.0(153)	4.7(19) 95.3(389) 100.0(408)
Burns/Scalds			
Yes No Total	0.4(1) 99.6(254) 100.0(255)	6.5(10) 93.5(143) 100.0(153)	2.7(11) 97.3(397) 100.0(408)
Broken bones			
Yes No Total	0.8(2) 99.2(253) 100.0(255)	2.0(3) 98.0(150) 100.0(153)	1.2(5) 98.8(403) 100.0(408)
Recurrent Vaginal infections			
Yes No Total	2.7(7) 97.3(248) 100.0(255)	2.6(4) 97.4(149) 100.0(153)	2.7(11) 97.3(397) 100.0(408)
Sleep and eating disorder			
Yes No Total	7.8(20) 92.2(235) 100.0(255)	3.9(6) 96.1(147) 100.0(153)	6.4(26) 93.6(382) 100.0(408)
Permanent Injuries e.g. loss of vision/learning etc			
Yes No Total	0.8(2) 99.2(253) 100.0(255)	- 100.0(153) 100.0(153)	0.5(2) 99.5(406) 100.0(408)
Pregnancy miscarriage			

Yes No Total	7.5(19) 92.5(236) 100.0(255)	2.0(3) 98.0(150) 100.0(153)	5.4(22) 94.6(386) 100.0(408)
Ever received treatment for injuries inflicted by a person with whom they have intimate relationship			
Yes No Total	11.8(30) 88.2(225) 100.0(255)	7.8(12) 92.2(141) 100.0(153)	10.3(42) 89.7(366) 100.0(408)
Main reason for domestic violence in marital unions			
Money matter	25.9(66)	41.8(64)	31.9(130)
Sexual matter	6.3(16)	6.5(10)	6.4(26)
Food issue	5.1(13)	5.2(8)	5.1(21)
Stubbornness of the wife	13.3(34)	3.3(5)	9.6(39)
Lack of mutual understanding, love and tolerance	22.7(58)	22.2(34)	22.5(92)
Satan	1.6(4)	1.3(2)	1.5(6)
Role conflict on child's discipline	0.8(2)	2.0(3)	1.2(5)
Men's wickedness	0.4(1)	-	0.2(1)
Husband's alcoholism	1.6(4)	-	1.0(4)
Unfaithfulness/Infidelity	3.5(9)	1.3(2)	2.7(11)
Wife's dirty habit	-	0.7(1)	0.2(1)
No Response	18.8(48)	15.7(24)	17.6(72)
Total	100.0(255)	100.0(153)	100.0(408)
Do you know any woman around your neighbourhood suffering as a victim of domestic violence?			
Yes No Total	48.2(123) 51.8(132) 100.0(255)	51.0(78) 49.0(75) 100.0(153)	49.3(201) 50.7(207) 100.0(408)

Source: field survey, 2003

From the table above, 10.5% of the women reported having ever suffered from pain as a result of quarrel or disagreement with intimate partner; 9.0% in the semi-urban area and 13.1% in the rural area. About 6.0% had suffered from bites/cuts; 4.7% in the semi-urban area and 9.2% in the rural area; 12.0% had suffered from chronic headaches, 11.4% in the semi-urban area and 13.1% in the rural area; 4.7% from bruises, 3.9% in the semi-urban area and 5.9% in the rural area; 2.7% had suffered from burns/scalds, 0.4% in the semi-urban area and 6.5% in the rural area; 1.2% had broken bones, 0.8% from the semi-urban area and 2.0% from the rural area; 2.7% had recurrent vaginal infections, 2.7% in the semi-urban area and 2.6% in the rural area; 6.4% suffered from sleep and eating disorder, 7.8% in the semi-urban area and 3.9% in the rural area; 0.5% reported permanent injuries like partial loss of hearing and 0.8% in the semi-urban area. Only 5.4% reported having suffered pregnancy miscarriage; 7.5% in the semi-urban area and 2.0% in the rural area. Exactly 10.3% reported having received treatment for injuries inflicted by a person with whom they have intimate relationship, 11.8% and 7.8% in the semi-urban and rural areas respectively.

Main reason(s) for domestic violence in marital unions reported by the women under the study are as follows: the most commonly reported reason being money matter (31.9%); 25.9% in the semi-urban area and 41.8% in the rural area followed by lack of mutual understanding, love and tolerance (22.5%); 22.7% in the semi-urban area and 22.2% in the rural area. Only 9.6% reported stubbornness of the wife, 13.3% in the semi-urban area and 3.3% in the rural area, followed by sexual matter (6.4%), 6.3% in the semi-urban area and 6.5% in the rural area. The least reported reasons are men's wickedness (0.2%); 0.4% in the semi-urban area only and wife's dirty habit (0.2%); 0.7% in the rural area only.

A focus group discussant aged 15-29, in response to the question of the main reason for domestic violence in marital union said:

"Lack of love and mutual understanding, unfaithfulness, food and sexual matter, rebellion, lack of respect for the husbands are major reasons she knew in the area". In the rural area also, a woman said: *"Neglect of duty on the part of the husband, inability of the wife to satisfy their husbands with good food and sex/childbearing and childrearing, are known reasons for domestic violence in marital unions".* Older women in addition to the submissions of the younger women added some other points like wife's dirty habit and neglect of children, laziness on the part of the wife, and particularly sexual-related matters.

When the women were asked whether they knew any woman around their neighbourhood who happened to be a victim of domestic violence, about half of the women said they knew such women (49.3%), 48.2% in the semi-urban area and a higher percentage of 51.0% in the rural area.

Table 4.2.2.4: Percentage Distribution of Respondents by experience of domestic violence (Marital Rape) from intimate partners and coping strategies for victims of domestic violence

Questions on Domestic Violence	Semi-Urban	Rural	Total
Main coping strategy adopted by victims of domestic violence			
Settle amicably by pacifying the man	23.5(60)	29.4(45)	25.7(105)
Leave the man	3.9(10)	2.0(3)	3.1(13)
Trying to understand the man through patience and tolerance	15.3(39)	11.1(17)	13.7(56)
Separation	9.8(25)	2.0(3)	6.9(28)
Keep quiet/Silence	0.8(2)	-	0.5(2)
Pray for Divine intervention	1.6(4)	4.6(7)	2.7(11)
Seek family's intervention	1.2(3)	2.0(3)	1.5(6)
No Response	43.9(112)	49.0(75)	45.8(187)
Total	100.0(255)	100.0(153)	100.0(408)
Ever been forced against your will to have sexual intercourse with your husband?			
Yes	57.6(147)	52.9(81)	55.9(228)
No	42.4(108)	47.1(72)	44.1(180)
Total	100.0(255)	100.0(153)	100.0(408)
Ever refused husband's approach when not ready?			
Yes	48.2(123)	54.9(84)	50.7(207)
No	51.8(132)	45.1(69)	49.3(201)
Total	100.0(255)	100.0(153)	100.0(408)

If no, why? (State the main reason)			
I love him	56.1(74)	39.1(27)	50.2(101)
For him to abstain from extra-marital affairs	19.7(26)	27.5(19)	22.4(45)
I need a baby	0.8(1)	2.9(2)	1.5(3)
Husband is wicked and can beat me up	12.9(17)	5.8(4)	10.4(21)
He is my husband	9.8(13)	15.9(11)	11.9(24)
I love it and I am always ready	0.8(1)	8.7(6)	3.5(7)
Total	100.0(132)	100.0(69)	100.0(201)

Source: field survey, 2003

Table 4.2.2.4 reveals that, among the reported main coping strategies often adopted by victims of domestic violence are amicable resolution through pacifying of the man (25.7%); 23.5% in the semi-urban area and a higher percentage of 29.4% in the rural area. This is followed by trying to understand the man through patience and tolerance (13.7%); 15.3% in the semi-urban area and 11.1% in the rural area. Exactly 10.0% reported leaving the man or separation as a coping strategy; 13.7% in the semi-urban area and 4.0% in the rural area. Only 1.5% reported seeking family's intervention; 1.2% in the semi-urban area and a higher 2.0% in the rural area. Others suggested keeping quiet/silence (0.5%); and praying for divine intervention (2.7%).

The result from the focus group discussion is close to what we have in the interview method. A young female semi-urban discussant said: *"When there is problem, I will kneel down to beg my husband, cook good and favourite food, if need be, with my money and submit to him (sexually) to pacify his anger"*. The responses from the rural discussants are not different from that of their semi-urban counterparts. However, the older women discussants added points like washing the clothes of the man more than ever before, prompt cooking of the man's food and enticement through every means possible with the sole aim of winning the man to their side again.

Furthermore, about 56.0% reported ever been forced against their will to have sexual intercourse with their husbands; 57.6% in the semi-urban area and 52.9% in the rural area. When further questioned on whether they had ever refused their husbands' approach when not ready, more than half of the women reported having done it (50.7%); 48.2% in the semi-urban area and 54.9% in the rural area while about 49% of the women had never refused their husbands' approach even when not ready, 51.8% in the semi-urban area and 45.1% in the rural area.

Some of those women who have never refused their husbands' approach have not done so because they love their husbands (50.2%), 56.1% in the semi-urban area and 39.1% in the rural area. Others did not so as to prevent their husbands from indulging in extra-marital affairs with other women outside (22.4%); 19.7% and 27.5% in the semi-urban and rural areas respectively. This is followed by the fact that men are the heads of the unions and therefore have the right to ask for it whenever they are ready (11.9%); 9.8% and 15.9% in the semi-urban and rural areas respectively. Others reported that they are always ready (3.5%); the husband is wicked and can beat them up (10.4%); 12.9% in the semi-urban area and 5.8% in the rural area while some reported the need of a baby (1.5%); 0.8% in the semi-urban area and 2.9% in the rural area. This last category is those still expecting a baby.

4.2.3 SEXUAL EXPERIENCE AND EXPERIENCE OF RAPE

Table 4.2.3.1: Percentage Distribution of Respondents by their first sexual experience and experience of rape

Characteristics	Semi-Urban	Rural	Total
Age at First Sexual intercourse			
<18 years	8.2(21)	11.1(17)	9.3(38)
18 and above	89.4(228)	84.3(129)	87.5(357)
No Response	2.4(6)	4.6(7)	3.2(13)
Total	100.0(255)	100.0(153)	100.0(408)
Mean age at First Sexual intercourse	21.57 years	20.55 years	21.19 years
With whom did you have your first sexual intercourse			
Boyfriend	92.2(235)	89.5(137)	91.2(372)
Just a casual man	3.5(9)	5.2(8)	4.2(17)
Former husband	1.2(3)	1.3(2)	1.2(5)
No Response	3.1(8)	3.9(6)	3.4(14)
Total	100.0(255)	100.0(153)	100.0(408)
Did you ever tell anyone about it?			
Yes	27.1(69)	24.2(37)	26.0(106)
No	72.9(186)	75.8(116)	74.0(302)
Total	100.0(255)	100.0(153)	100.0(408)
If yes, who?			
Friend	37.7(26)	81.1(30)	52.8(56)
Mother	50.7(35)	8.1(3)	35.8(38)
Sister	8.7(6)	10.8(4)	9.4(10)
Others (Father or Pastor)	2.9(2)	-	1.9(2)
Total	100.0(69)	100.0(37)	100.0(106)
If no, why not?			
Embarrassed	18.8(3)	37.5(3)	25.0(6)
No one to tell	6.3(1)	-	4.2(1)
Happen to many women	31.3(5)	62.5(5)	41.7(10)
Scared	6.3(1)	-	4.2(1)
It was my own fault	37.5(6)	-	25.0(6)
Total	100.0(16)	100.0(8)	100.0(24)

Source: field survey, 2003

From table 4.2.3.1 above, a little below 10.0% of the women had their first intercourse before age 18 and 87.5% had theirs after age 18. Exactly 8.2% had their first sexual encounter before 18 years of age in the semi-urban area while it is 11.1% in the rural area; 89.4% had their first sexual encounter after 18 years of age in the semi-urban area and 84.3% in the rural area. The mean age at first sexual intercourse is 21.19years; 21.57years in the semi-urban area and a lower 20.55years in the rural area. A very large proportion of the women had their first sexual encounter with a boyfriend (91.2%); 92.2% in the semi-urban area and 89.5% in the rural area while 4.2% reported having their first sexual intercourse with just a casual man; 3.5% in the semi-urban area and a higher 5.2% in the rural area. Only 1.2% had their first sexual intercourse with their former husband; 1.2% and 1.3% in the semi-urban and rural areas respectively. This last category is those not living presently with their former husbands.

Exactly 26.0% of the women told some people about their first sexual experience; 27.1% and 24.2% in the semi-urban and rural areas respectively. The larger proportion of the women told their friends (52.8%); 37.7% in the semi-urban area and 81.1% in the rural area followed by those who told their mothers (35.8%); 50.7% in the semi-urban area and 8.1% in the rural area. Only 9.4% told their sisters; 8.7% in the semi-urban area and 10.8% in the rural area while 1.9% told others like their father or Pastor. Out of 74.0% who did not tell anybody about the experience; 72.9% in the semi-urban area and 75.8% in the rural area, 41.7% believed it happened to many women, followed by those embarrassed and those who accepted the event as their fault (25.0%); 18.8% and 37.5%; 37.5% and 0.0% in the semi-urban and rural areas respectively.

4.3 HOUSEHOLD DECISION- MAKING

Table 4.3.1: Percentage Distribution of Respondents by types of household decision-making

Household Decision-making	Semi-Urban	Rural	Total
Who decides on the following in your family?			
Whether or not to use contraceptives			
Husband	24.7(61)	36.9(55)	29.3(116)
Wife	4.5(11)	5.4(8)	4.8(19)
Joint decision	57.1(141)	57.7(86)	57.3(227)
Husband's relatives	3.6(9)	-	2.3(9)
Others	10.1(25)	-	6.3(25)
Total	100.0(247)	100.0(149)	100.0(396)
Time to have sex			
Husband	58.9(145)	78.5(117)	66.3(262)
Wife	4.1(10)	3.4(5)	3.8(15)
Joint decision	37.0(91)	18.1(27)	29.9(118)
Total	100.0(246)	100.0(149)	100.0(395)
Number of children to have			
Husband	29.0(70)	53.4(78)	38.2(148)
Wife	5.8(14)	4.1(6)	5.2(20)
Joint decision	54.8(132)	42.5(62)	50.1(194)
Others	10.4(25)	-	6.5(25)
Total	100.0(241)	100.0(146)	100.0(387)
Whether or not to go to hospital/clinic in case of any health problem			
Husband	26.9(66)	40.3(60)	32.0(126)
Wife	16.7(41)	27.5(41)	20.8(82)
Joint decision	46.1(113)	26.8(40)	38.8(153)
Any of us concerned	10.2(25)	5.4(8)	8.4(33)
Total	100.0(245)	100.0(149)	100.0(394)

Source: field survey, 2003

NOTE: The percentages exclude no response category.

From table 4.3.1 above, 57.3% of the women reported decision on contraceptive use a joint decision; 57.1% in the semi-urban area and 57.7% in the rural area followed by those who reported that the decision lies in the hand of the husband solely (29.3%); 24.7% in the semi-urban area and 36.9% in the rural area. Only 4.8% reported it is the duty of the wife; 4.5% and 5.4% in the semi-urban and rural areas respectively. 66.3% reported it is the husband's duty and right to decide on time to have sex; 58.9% in the semi-urban area and 78.5% in the rural area. 29.9% reported it is a joint decision; 37.0% in the semi-urban area and 18.1% in the rural area while 3.8% of the women decide on when to have sex; 4.1% in the semi-urban area and 3.4% in the rural area.

On the number of children to have, 50.1% reported it is a joint decision; 54.8% and 42.5% in the semi-urban and rural areas respectively. This is followed by those who reported that the husbands decide on the number of children to have (38.2%); 29.0% in the semi-urban area and a higher proportion of 53.4% in the rural area.

Finally, 38.8% reported whether or not to go to hospital/clinic in case of any health problem as a joint decision; 46.1% in the semi-urban area and 26.8% in the rural area. This is followed by those who reported that it was the husband that decide on such issue (32.0%); 26.9% in the semi-urban area and a higher percentage of 40.3% in the rural area.

4.4 KNOWLEDGE, ATTITUDE AND PRACTICE OF CONTRACEPTION

Table 4.4.1: Percentage Distribution of Respondents by Knowledge of Contraception, methods known and source of knowledge

Knowledge of Contraception	Semi-Urban	Rural	Total
Heard of any contraceptive method			
Yes	83.9(214)	79.7(122)	82.4(336)
No	16.1(41)	20.3(31)	17.6(72)
Total	100.0.(255)	100.0(153)	100.0(408)
Methods heard about			
Pills			
Yes	58.8(150)	47.1(72)	54.4(222)
No	41.2(105)	52.9(81)	45.6(186)
Total	100.0(255)	100.0(153)	100.0(408)
IUD/Coil			
Yes	43.9(112)	35.9(55)	40.9(167)
No	56.1(143)	64.1(98)	59.1(241)
Total	100.0(255)	100.0(153)	100.0(408)
Injectable			
Yes	56.5(144)	50.3(77)	54.2(221)
No	43.5(111)	49.7(76)	45.8(187)
Total	100.0(255)	100.0(153)	100.0(408)
Diaphragm/Foam/Jelly			
Yes	14.5(37)	8.5(13)	12.3(50)
No	85.5(218)	91.5(140)	87.7(358)
Total	100.0(255)	100.0(153)	100.0(408)
Condom/Durex			
Yes	63.9(163)	64.7(99)	64.2(262)
No	36.1(92)	35.3(54)	35.8(146)
Total	100.0(255)	100.0(153)	100.0(408)

Female Sterilization			
Yes	12.5(32)	17.6(27)	14.5(59)
No	87.5(223)	82.4(126)	85.5(349)
Total	100.0(255)	100.0(153)	100.0(408)
Male Sterilization			
Yes	10.6(27)	7.2(11)	9.3(38)
No	89.4(228)	92.8(142)	90.7(370)
Total	100.0(255)	100.0(153)	100.0(408)
Norplant			
Yes	7.8(20)	2.6(4)	5.9(24)
No	92.2(235)	97.4(149)	94.1(384)
Total	100.0(255)	100.0(153)	100.0(408)
Periodic Abstinence			
Yes	16.1(41)	13.7(21)	15.2(62)
No	83.9(214)	86.3(132)	84.8(346)
Total	100.0(255)	100.0(153)	100.0(408)
Withdrawal			
Yes	25.1(64)	14.4(22)	21.1(86)
No	74.9(191)	85.6(131)	78.9(322)
Total	100.0(255)	100.0(153)	100.0(408)
Traditional (e.g. ring, belt, charm etc)			
Yes	22.4(57)	22.9(35)	22.5(92)
No	77.6(198)	77.1(118)	77.5(316)
Total	100.0(255)	100.0(153)	100.0(408)
Lactational Amenorrhea			
Yes	5.1(13)	3.3(5)	4.4(18)
No	94.9(242)	96.7(148)	95.6(390)
Total	100.0(255)	100.0(153)	100.0(408)
Source of information			
Television			

Yes	25.9(66)	26.8(41)	26.2(107)
No	74.1(189)	73.2(112)	73.8(301)
Total	100.0(255)	100.0(153)	100.0(408)
Radio			
Yes	41.6(106)	52.3(80)	45.6(186)
No	58.4(149)	47.7(73)	54.4(222)
Total	100.0(255)	100.0(153)	100.0(408)
Hospital/Clinic			
Yes	56.9(145)	41.8(64)	51.2(209)
No	43.1(110)	58.2(89)	48.8(199)
Total	100.0(255)	100.0(153)	100.0(408)
Printed materials			
Yes	8.6(22)	8.5(13)	8.6(35)
No	91.4(233)	91.5(140)	91.4(373)
Total	100.0(255)	100.0(153)	100.0(408)
My husband			
Yes	4.7(12)	8.5(13)	6.1(25)
No	95.3(243)	91.5(140)	93.9(383)
Total	100.0(255)	100.0(153)	100.0(408)
Others (Church, training workshop /seminar, Public programmes)			
Yes	6.7(17)	1.3(2)	4.6(19)
No	93.3(238)	98.7(151)	95.4(389)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From table 4.4.1 above, a greater proportion of the women had heard about some contraceptive methods (82.4%); a higher 83.9% in the semi-urban area and 79.7% in the rural area. This shows a high level of knowledge about contraceptive methods in both locations. The method heard about mostly is condom or Durex (64.2%); 63.9% in the semi-urban area and 64.7% in the rural area. This is followed by pills (54.4%); 58.8% and 47.1% in the semi-urban and rural areas respectively. Exactly 54.2% have heard about injectables; 56.5% in the semi-urban area and 50.3% in the rural area. These data reveal that a larger proportion of the women did not understand that breast-feeding (Lactational Amenorrhea) is a method of contraception as just 4.4% of the women reported having heard about it; a larger proportion of them in the educated semi-urban area (5.1%) while 3.3% of them in the rural area have heard about this method. A considerable proportion of the women still use traditional methods in the study area (22.5%); 21.1% still practice coitus interruptus with their husbands; and 15.2% still use periodic abstinence.

The major source of information to the contraceptive methods is the hospital or clinic around the area (51.2%); 56.9% in the semi-urban area and 41.8% in the rural area. This is followed by the media (radio, television and printed materials) having 45.6%, 26.2%, and 8.6% respectively. Apart from the hospitals or clinics, radio in particular is a major source (45.6%); 41.6% in the semi-urban area and 52.3% in the rural area. It is noteworthy to mention that some of the women heard about it through their husbands (6.1%); 4.7% in the semi-urban area and 8.5% in the rural area while only 4.6% heard through other means like workshops and seminars in the churches.

Table 4.4.2: Percentage Distribution of Respondents by Attitude to Contraception

Attitude to Contraception	Semi-Urban	Rural	Total
Have you and your spouse ever talked about using some family planning method?			
Yes	42.0(107)	30.7(47)	37.7(154)
No	58.0(148)	60.3(106)	62.3(254)
Total	100.0(255)	100.0(153)	100.0(408)
If yes, when was the last time? (code in months)			
< 3 months ago	39.3(42)	29.8(14)	36.4(56)
Between 3 and 6 months ago	13.1(14)	19.1(9)	14.9(23)
Between 7 and 9 months ago	5.6(6)	12.8(6)	7.8(12)
Between 10 and 12 months ago	9.3(10)	12.8(6)	10.4(16)
More than a year ago	32.7(35)	25.5(12)	30.5(47)
Total	100.0(107)	100.0(47)	100.0(154)
Approve of any Family Planning Method			
Yes	48.2(123)	38.6(59)	44.6(182)
No	51.8(132)	61.4(94)	55.4(226)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

Table 4.4.2 reveals that, on the discussion about family planning use, 62.3% of the couples have never discussed about it together; 58.0% in the semi-urban area and higher 69.3% in the rural area. This shows that spousal communication about contraception is low in the study area.

Among those who discussed about family planning, about 36% of the women reported having discussion about it less than three months to the time of the survey; 39.3% in the semi-urban area and 29.8% in the rural area. This is followed by those who had discussion about it more than a year ago to the time of the survey (30.5%); 32.7% and 25.5% in the semi-urban and rural areas respectively. About 45% of the women approve of any family planning method; 48.2% in the semi-urban area and 38.6% in the rural area.

Table 4.4.3: Percentage Distribution of Respondents by Ever Practice of Contraception/ methods ever used and reasons for never use

Practice of Contraception	Semi-Urban	Rural	Total
Ever used any of the methods?			
Yes	34.5(88)	22.9(35)	30.1(123)
No	65.5(167)	77.1(118)	69.9(285)
Total	100.0(255)	100.0(153)	100.0(408)
If yes, which of them?(main method ever used)			
Pill			
Yes	22.7(20)	17.1(6)	21.1(26)
No	77.3(235)	82.9(147)	78.9(382)
Total	100.0(255)	100.0(153)	100.0(408)
IUD/Coil			
Yes	19.3(17)	5.7(2)	15.4(19)
No	80.7(238)	94.3(151)	84.6(389)
Total	100.0(255)	100.0(153)	100.0(408)
Injectable			
Yes	11.4(10)	17.1(6)	13.0(16)
No	88.6(245)	82.9(147)	87.0(392)
Total	100.0(255)	100.0(153)	100.0(408)
Condom or Durex			
Yes	29.5(26)	22.9(8)	27.6(34)
No	70.5(229)	77.1(145)	72.4(374)
Total	100.0(255)	100.0(153)	100.0(408)

Female Sterilization			
Yes	1.1(1)	-	0.8(1)
No	98.9(254)	-	99.2(407)
Total	100.0(255)	-	100.0(408)
Norplant			
Yes	3.4(3)	17.1(6)	7.3(9)
No	96.6(252)	82.9(147)	92.7(399)
Total	100.0(255)	100.0(153)	100.0(408)
Periodic Abstinence			
Yes	6.8(6)	17.1(6)	9.8(12)
No	93.2(249)	82.9(147)	90.2(396)
Total	100.0(255)	100.0(153)	100.0(408)
Traditional (e.g. ring, belts, charms etc)			
Yes	1.1(1)	-	0.8(1)
No	98.9(254)	-	99.2(407)
Total	100.0(255)	-	100.0(408)
Lactational Amenorrhea			
Yes	4.5(4)	2.9(1)	4.1(5)
No	95.5(251)	97.1(152)	95.9(403)
Total	100.0(255)	100.0(153)	100.0(408)
Duration of use in months			
< 6 months	15.9(14)	17.1(6)	16.3(20)
6 – 12 months	22.7(20)	37.1(13)	26.8(33)
Above 12 months	61.4(54)	45.7(16)	56.9(70)
Total	100.0(88)	100.0(35)	100.0(123)

If not using, why? (Main reason)			
Want more babies	48.5(81)	49.2(58)	48.8(139)
I hate it (not interested)	35.3(59)	32.2(38)	34.0(97)
My partner and I hate it	1.2(2)	-	0.7(2)
Fear of side effect	2.4(4)	0.8(1)	1.8(5)
I am old already	3.0(5)	1.7(2)	2.5(7)
Don't need it / Not useful	4.2(7)	4.2(5)	4.2(12)
Nursing a baby now	-	0.8(1)	0.4(1)
Husband not around	-	1.7(2)	0.7(2)
Have enough children	3.6(6)	8.5(10)	5.6(16)
I am a widow	0.6(1)	-	0.4(1)
Don't want it again	-	0.8(1)	0.4(1)
Husband using	0.6(1)	-	0.4(1)
No time	0.6(1)	-	0.4(1)
Total	100.0(167)	100.0(118)	100.0(285)

Source: field survey, 2003

Table 4.4.3 shows that, while about 30% have ever used any of the methods; 34.5% in the semi-urban area and 22.9% in the rural area. The method mostly used by the women is Condom/Durex (27.6%); 29.5% in the semi-urban area and 22.9% in the rural area , followed by Pills (21.1%) and the least used methods are female sterilization and traditional methods (0.8%) which are majorly practiced in the semi-urban area.

Those women who have ever used any of the methods, have varying duration of use ranging from over one year (56.9%); 61.4% in the semi-urban area and 45.7% in the rural area to between 6 – 12 months (26.8%) and lastly, less than 6 months (16.3%).

Those women who reported never use gave reasons like wanting more babies (48.8%); 48.5% and 49.2% in the semi-urban and rural areas respectively, followed by hatred or lack of interest in family planning methods (34.0%); not having need of any method (4.2%); having enough children (5.6%); old age (2.5%); fear of side effect (1.8%) and so on.

Table 4.4.4: Percentage Distribution of Respondents by Current Practice of Contraception, methods currently using, source where obtained, reasons for not currently using and partners' reaction toward contraceptive usage in time past

Practice of Contraception	Semi-Urban	Rural	Total
Currently using a method without husband's permission			
Yes	7.1(18)	9.2(14)	7.8(32)
No	92.9(237)	90.8(139)	92.2(376)
Total	100.0.(255)	100.0(153)	100.0(408)
Main method currently using			
Pill	27.8(5)	7.1(1)	18.8(6)
IUD/Coil	33.3(6)	-	18.8(6)
Injectable	11.1(2)	21.4(3)	15.6(5)
Condom	5.6(1)	-	3.1(1)
Female Sterilization	5.6(1)	28.6(4)	15.6(5)
Periodic Abstinence	5.6(1)	7.1(1)	6.3(2)
Male Sterilization	-	-	-
Norplant	11.1(2)	28.6(4)	18.8(6)
Withdrawal	-	7.1(1)	3.1(1)
Total	100.0(18)	100.0(14)	100.0(32)
Source where obtained			
Hospital/Clinic/Maternity	88.9(16)	92.9(13)	90.6(29)
Chemist/Medicine store	5.6(1)	7.1(1)	6.3(2)
Others	5.6(1)	-	3.1(1)
Total	100.0(18)	100.0(14)	100.0(32)
Main reason for not currently using			
Want more babies	5.9(14)	4.3(6)	5.3(20)
I hate it	24.5(58)	23.0(32)	23.9(90)
My partner and I hate it	11.8(28)	13.7(19)	12.5(47)
My spouse objected my using it	13.1(31)	14.4(20)	13.6(51)

Fear of side effect	6.8(16)	6.5(9)	6.6(25)
Old already	18.1(43)	20.1(28)	18.9(71)
Don't need it	9.3(22)	10.8(15)	9.8(37)
Nursing a baby	0.4(1)	-	0.3(1)
Have enough children	3.8(9)	3.6(5)	3.7(14)
I am a widow	0.4(1)	-	0.3(1)
Don't want it again	0.8(2)	-	0.5(2)
Husband using	1.3(3)	1.4(2)	1.3(5)
I have no child yet	3.4(8)	1.4(2)	2.7(10)
No time	0.4(1)	-	0.3(1)
Fear of disappointment	-	0.7(1)	0.3(1)
Total	100.0(237)	100.0(139)	100.0(376)
Does your husband approve of the method you are using?			
Yes	83.3(15)	78.6(11)	81.3(26)
No	16.7(3)	21.4(3)	18.8(6)
Total	100.0(18)	100.0(14)	100.0(32)
If no, why not?(Main reason given)			
He says it hinders sexual pleasure	33.3(1)	-	16.7(1)
He says it makes wife promiscuous	33.3(1)	-	16.7(1)
He says it causes infertility	-	33.3(1)	16.7(1)
He does not like it	33.3(1)	-	16.7(1)
Still want more children	-	33.3(1)	16.7(1)
Don't want him to know	-	33.3(1)	16.7(1)
Total	100.0(3)	100.0(3)	100.0(6)
Husband ever object using any contraceptive method			
Yes	18.0(46)	13.1(20)	16.2(66)
No	82.0(209)	86.9(133)	83.8(342)
Total	100.0(255)	100.0(153)	100.0(408)
Any violent reaction to drive home his point?			
Frown and left	4.3(2)	-	3.0(2)

Slapped, kicked or beat	6.5(3)	10.0(2)	7.6(5)
Refuse to eat at home	10.9(5)	5.0(1)	9.1(6)
Refuse to perform his responsibilities	23.9(11)	35.0(7)	27.3(18)
Threatened to deal with me	10.9(5)	10.0(2)	10.6(7)
Complained he hated it	43.5(20)	40.0(8)	42.4(28)
Total	100.0(46)	100.0(20)	100.0(66)
If pregnant when not ready for it, what main thing will you do?			
Abortion	13.3(34)	22.2(34)	16.7(68)
Accept as God's will	2.7(7)	-	1.7(7)
Carry the baby to maturity and deliver	40.0(102)	33.3(51)	37.5(153)
It can never happen	9.0(23)	5.9(9)	7.8(32)
Already old	2.7(7)	1.3(2)	2.2(9)
I am a widow	1.6(4)	-	1.0(4)
I will go for antenatal care	4.7(12)	-	2.9(12)
I don't know	25.9(66)	37.3(57)	30.1(123)
Total	100.0(255)	100.0(153)	100.0(408)

Source: field survey, 2003

From table 4.4.4, the data on current use of contraceptive methods without husband's permission reveal that 92.2% are not currently using any method without husbands' permission; 92.9% in the semi-urban area and 90.8% in the rural area. This shows that despite the fact that some have used a method before, not many of them are currently using such method. The data for ever use of a method are higher than the reported data for current use (7.8%); 7.1% in the semi-urban area and 9.2% in the rural area. The main methods currently in use among current users are Pills, IUD/Coil and Norplant (18.8%) while the least used are Condoms and withdrawal method (3.1%). Majority of the current users got their contraceptive methods from hospital/clinic/maternity (90.6%). Those women not currently using gave reasons like personal hatred for the methods (23.9%) and the fact that they needed more babies (5.3%) with semi-urban – rural differentials.

The younger women focus group discussants reported unanimously that the reasons for low use of especially modern contraceptives are *"the fear of side effects and the information that it can cause infertility".* The older women however asserted that, *"it was because there are no family planning experts who could give people proper information and guidance on the use of the contraceptive methods".*

On whether their husbands approve of the methods currently in use by the women under study, 18.8% reported that their husbands did not approve of the methods they are using; 16.7% in the semi-urban area and 21.4% in the rural area. This proportion represents those clandestinely using the family planning methods since they are using them without their husbands' approval. Some of the women under study reported that their husbands did not like it (16.7%); 33.3% in the semi-urban area. Others reported that they still want more children (16.7%) while some men feel that it hinders sexual pleasure and causes infertility (16.7%). About 17% of the women under study are using the methods without the knowledge and approval of their husbands while 16.7% of the men said it could make their wives promiscuous.

When asked whether their husbands have ever objected their using any contraceptive method, 16.2% responded in the affirmative; 18.0% in the semi-urban area and 13.1% in the rural area; Exactly 42.4%, 43.5% in the semi-urban area and 40.0% in the rural area reported that their husbands complained he hated using contraceptives and 27.3%, 23.9% in the semi-urban area and 35.0% in the rural area reported that their husbands refused to perform his responsibilities at home in his bid to show his anger and objection towards the use of contraceptive methods. Other reactions from husbands' side are threat to deal with the wife (10.6%); refusal to eat at home (9.1%); slapping, kicking, or beating (7.6%); frowning and leaving the homes (3.0%).

On what will be the action or reaction of the women if they are pregnant when not ready for the baby, less than half of the women said that they will carry the baby to maturity and deliver it (37.5%); 40.0% in the semi-urban area 33.3% in the rural area. About 17% of the women said that they will go and abort the foetus; 13.3% and 22.2% in the semi-urban and the rural areas respectively. Over 30.1% were undecided on what their action or reaction would be; 25.9% and 37.3% in the semi-urban and rural areas respectively.

4.5 BIVARIATE ANALYSIS

This section presents the bivariate relationship between the socio-economic/demographic characteristics of the respondents and their spouses on the one hand and current contraceptive use on the other.

Also, the bivariate relationship between the respondents' household decision-making type and current contraceptive use was examined.

Moreover, the bivariate relationship between the domestic violence variables and current contraceptive use was examined.

In addition, bivariate relationship between knowledge and attitude of the respondents and current contraceptive use was observed.

Lastly, bivariate relationship between the socio-economic/demographic background of the respondents and exposure to and experience of domestic violence was examined.

The relationship test was carried out using chi-square and all the relevant variables are presented in the various tables below:

4.5.1 BIVARIATE ANALYSIS OF RELATIONSHIP BETWEEN SOCIO-ECONOMIC/DEMOGRAPHIC BACKGROUND OF THE WOMEN AND CURRENT USE OF CONTRACEPTIVES.

Table 4.5.1.1: Relationship between some selected background characteristics of the respondents and current use of contraceptives

Background characteristics	Current Contraceptive use					
	Semi-urban		Rural		Total	
	N	%	N	%	N	%
Educational Level						
None	35	-	29	-	64	-
Primary	44	2.3**	53	9.4	97	6.2**
Secondary	96	4.2**	54	11.1	150	6.7**
Tertiary	80	16.3**	17	17.6	97	16.5**
Occupation						
Farming	3	-	3	33.3**	6	16.7**
Artisan	37	2.7*	13	38.5**	50	12.0**
Petty-trading	92	3.3*	99	2.0**	191	2.6**
Housewife	2	50.0*	2	-	4	25.0**
Business	33	6.1*	14	7.1**	47	6.4**
Civil service	56	14.3*	13	15.4**	96	14.5**
Professional	12	25.0*	3	33.3**	15	26.7**
Others	5	-	1	-	6	-
Income Level						
<₦100,000.00	136	5.1*	93	8.6	229	6.6*
>₦100,000.00	62	14.5*	9	11.1	71	14.1*
Husband's educational level						
None	25	-	26	-	51	-
Primary	18	16.7	20	10.0	38	13.2*
Secondary	87	3.4	56	8.9	143	5.6*
Tertiary	119	9.2	48	14.6	167	10.8*
Husband's occupation						
Farming	47	-	56	5.4	103	2.9*
Artisan	36	5.6	24	8.3	60	6.7*
Petty-trading	13	7.7	6	-	19	5.3*
Business	36	8.3	16	25.0	52	13.5*
Civil service	76	7.9	36	5.6	112	7.1*
Professional	30	20.0	8	25.0	38	21.1*
Others e.g Pastor, herbalist...	13	-	6	16.7	19	5.3*
Spousal Habitation						

Lives with wife	216	4.6**	131	9.2	347	6.3**
Lives elsewhere	39	20.5**	22	9.1	61	16.4**
Working status						
Yes	240	7.5	148	8.1*	388	7.7
No	15	-	5	40.0*	20	10.0

Source: field survey, 2003

**Significant at p<0.01

*Significant at p<0.05

The table above reveals that current contraceptive use, increases with educational level of the respondents generally, and in all cases. This shows that the higher the level of education of the women, the higher the level of current use of contraceptives. This has been documented by several authors and found in many literatures and the relationship is statistically significant generally and in the semi-urban area in particular.

The result of association between occupation and current use of contraceptive reveals that generally, the highest level of current use among the professionals, followed by the housewives although this may be due to chance considering the absolute total for that group, the farmers and those of them who are civil servants, the least users are those in petty-trading. When controlling for place of residence, the highest current users in the semi-urban area are the professionals with exception of the housewives because of its small value, the least users being the artisans. Contrary to expectation, the rural respondents in the study area have the highest users among the artisans, even higher than the semi-urban figure, followed by the professionals and farmers, and then the civil servants while the least users are the petty-traders and those in business. The relationship is statistically significant in all cases for the women under the study.

With respect to income level and current use of contraceptives, those women earning more than ₦100,000.00 per annum use contraceptives more than those earning less than the same amount in all cases. This is because such categories of women will be able to afford even the modern methods which their counterparts with lower income may not be able to afford. The relationship is significant for all the women and for those in the semi-urban area.

The result further reveals that respondents' husbands' educational level has something to do with current use of contraceptives. The result reveals the highest level of use of contraceptives among those whose husbands attained up to at least primary school level although this may be due to chance as the absolute figure for that group is small compared to those in the other categories. This is followed by those whose husbands attained up to tertiary level because the more enlightened a husband is , the higher the level of acceptance of contraceptive methods and his level of support for the wife to use such method. In all cases, the least users are those women whose husbands had their education up to at least the secondary level and the relationship is statistically significant for the generality of the women.

As regard husband's occupation and current use of contraceptives, the result reveals that the more formal the occupation of husbands, the higher the level of current use of contraceptives among their wives. This is evident from the table where the highest proportion of current users are among those whose husbands are professionals in all cases, while the least current users are among those whose husbands are farmers. There are variations between the semi-urban and the rural areas and the relationship is statistically significant for all the women.

When spousal habitation and current use of contraceptives was examined, the result reveals that those whose husbands live elsewhere were currently using contraceptives more than their counterpart whose husbands live with them generally and when the place of residence was controlled for, the situation was the same in the semi-urban area while the reverse is the case for the rural area.

This is contrary to expectation, although the relationship may be due to chance as the absolute figures for each category reveals. The relationship has been shown to be significant generally and among semi-urban women.

With respect to the working status of the respondents, current use of contraceptives by women working at the time of the survey was higher compared to those not working, for the overall women and in the rural area. There is statistically significant relationship only at the rural area.

4.5.2: BIVARIATE RELATIONSHIP BETWEEN TYPE OF HOUSEHOLD DECISION-MAKING AND CURRENT USE OF CONTRACEPTIVES

Table 4.5.2.1: Relationship between the type of household decision-making and current use of contraceptives

Type of household decision-making	**Current Contraceptive use**					
	Semi-urban		**Rural**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
Decision-maker on the use of contraceptive methods						
Husband	61	11.5	55	10.9**	116	11.2**
Wife/self	11	18.2	8	37.5**	19	26.3**
Joint decision	141	5.0	86	4.7**	227	4.8**
Husband's relatives	9	11.1	-	-	9	11.1**
Others	25	-	-	-	25	-
Decision-maker on the number of children to have						
Husband	70	7.1	78	12.8**	148	10.1
Wife/Self	14	7.1	6	33.3**	20	15.0
Joint decision	132	8.3	62	1.6**	194	6.2
Others	25	-	-	-	25	-

Source: field survey, 2003

**Significant at $p<0.01$

*Significant at $p<0.05$

The table above reveals a higher level of current contraceptive use among women in households where wives are the decision-makers on the use or non-use of contraceptives, followed by where that decision was by the husbands and least user among those households where such decision is taken jointly. This scenario is true even in both the semi-urban and rural area under the study. The relationship is significant for all the women generally and among the rural women in particular.

Also, it is clear from the table above that there are more current contraceptive users in households where wives are the decision-makers on the number of children to have, followed by where the husbands are the decision-makers and the least where such decision is taken jointly. There was only a slight variation between the semi-urban and the rural area because in the semi-urban area, current contraceptive use is higher where the decision on the number of children to have is taken as a joint one while the figure for the remaining two categories are the same. There is a significant relationship only at the rural area.

4.5.3 BIVARIATE RELATIONSHIP BETWEEN SOME SELECTED DOMESTIC VIOLENCE VARIABLES AND CURRENT USE OF CONTRACEPTIVES

Table 4.5.3.1: Relationship between those who have experienced some form of domestic violence from their partners and current use of contraceptives

Domestic violence variables	**Current Contraceptive use**					
	Semi-urban		**Rural**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
Ever been threatened by your partner						
Yes	134	3.7*	93	3.2**	227	3.5**
No	121	10.7*	60	18.3**	181	13.3**
Ever been actually beaten by your partner						
Yes	160	4.4*	93	4.3*	253	4.3**
No	95	11.6*	60	16.7*	155	13.5**
Ever suffered broken bones as a result of quarrel with intimate person						
Yes	2	50.0*	3	33.3	5	40.0**
No	253	6.7*	150	8.7	403	7.4**
Ever experienced marital rape						
Yes	147	7.5	81	6.2	228	7.0
No	108	6.5	72	12.5	180	8.9
Frequency of humiliation in private...						
Never	214	5.6*	139	9.4	353	7.1
At least once	41	14.6*	14	7.1	55	12.7

Source: field survey, 2003

**Significant at $p<0.01$

*Significant at $p<0.05$

The table above reveals that generally and almost in all cases, those women who have ever been threatened by their partners, ever been actually beaten by their partners, ever experienced marital rape, ever been humiliated in private at least once, twelve months to the time of the survey, were currently using contraceptives lesser than their counterparts who have never experienced such things, that is, the more likely the experience of domestic violence, the less likely the current use of contraceptives because of the fear of further abuse by their partners. Those who have ever experienced marital rape and currently using contraceptives were 7.0%, higher in the semi-urban area (7.5%) and lower in the rural area (6.2%) compared to their counterpart who have never experienced such. The result further explained generally that those women, who have ever experienced broken bones as a result of quarrel with intimate persons, are currently using contraceptives more than their counterpart with no such experience although this result may be due to chance if the absolute figure for that particular category is taken into consideration. Generally speaking, all the domestic violence variables listed above were statistically significant except experience of marital rape and frequency of humiliation in private.

4.5.4 BIVARIATE RELATIONSHIP BETWEEN KNOWLEDGE AND ATTITUDE OF WOMEN ABOUT CONTRACEPTIVES AND CURRENT USE OF CONTRACEPTIVES

Table 4.5.4.1: Relationship between Knowledge and attitude of the respondents and current use of contraceptives

Knowledge, attitude of women toward contraceptives	Current Contraceptive use					
	Semi-urban		Rural		Total	
	N	%	N	%	N	%
Ever heard about Pills						
Yes	150	10.0*	72	6.9	222	9.0
No	105	2.9*	81	11.1	186	6.5
Ever heard about Norplant						
Yes	20	20.0*	4	-	24	16.7
No	235	6.0*	149	9.4	384	7.3
Ever heard about periodic abstinence						
Yes	41	9.8	21	33.3**	62	17.7**
No	214	6.5	132	5.3**	346	6.1**
Ever heard about withdrawal method						
Yes	64	15.6**	22	13.6	86	15.1**
No	91	4.2**	131	8.4	322	5.9**
Ever heard about other traditional methods e.g douching…						
Yes	57	15.8**	35	8.6	92	13.0*
No	198	4.5**	118	9.3	316	6.3*
Ever heard about Lactational amenorrhea						
Yes	13	7.7	5	40.0*	18	16.7
No	242	7.0	148	8.1*	390	7.4
Hospital/clinic as a source of information about contraceptive methods						
Yes	145	10.3*	64	9.4	209	10.0
No	110	2.7*	89	9.0	199	5.5
Spousal communication about use of some methods of family planning						
Yes	107	12.1**	47	23.4**	154	15.6**
No	148	3.4**	106	2.8**	254	3.1**
Approve of any family planning method						
Yes	123	11.4**	59	20.3**	182	14.3**
No	132	3.0**	94	2.1**	226	2.7**

Source: field survey, 2003

**Significant at p<0.01
*Significant at p<0.05

The table above reveals generally that women who have heard about some methods of contraception were currently using a contraceptive method more than their counterparts who reported not having heard about such methods particularly pills, norplant, periodic abstinence, withdrawal method, other traditional methods and Lactational amenorrhea but when the place of residence was controlled for, those rural women who have heard about pills and other traditional methods, were currently using contraceptives, lesser than their counterparts who reported never heard about such methods of contraception. The relationship is statistically significant on the whole for knowledge about periodic abstinence, and withdrawal method. In the semi-urban area, the relationship is statistically significant for all the methods mentioned except periodic abstinence and Lactational amenorrhea and in the rural area, only periodic abstinence and Lactational amenorrhea are statistically significant.

On the source of information about contraceptive methods, those women who heard about it in the hospital/clinic were currently using a contraceptive method more than their counterpart who did not hear through such a medium. This situation is true for all women under study irrespective of where they live and it is statistically significant among the semi-urban women.

When spousal communication and approval of contraceptive methods were examined against current contraceptive use, it was found that women in households where there is discussion among spouses about the use of contraceptives practiced contraception more than their counterparts who did not have such discussion and it is statistically significant in all cases, and those women who approved of any family planning method practiced contraception more than their counterparts who did not approve of any method, place of residence notwithstanding. This is statistically significant for all women and in all places.

4.5.5 BIVARIATE RELATIONSHIP BETWEEN SOCIO-DEMOGRAPHIC BACKGROUND OF THE RESPONDENTS AND EXPERIENCE OF MARITAL RAPE

Table 4.5.5.1: Relationship between the background characteristics of the respondents and experience of marital rape

Background characteristics of the respondents	**Ever experienced marital rape**					
	Semi-urban		**Rural**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
Main reason for working						
Economic necessity	83	49.4*	30	36.7	113	46.0*
Financial independence	89	66.3*	94	57.4	183	61.7*
Pursue career...	8	25.0*	1	100.0	9	33.3*
Use of education	9	55.6*	4	75.0	13	61.5*
Family business	38	57.9*	15	53.3	53	56.6*
Like to work	12	83.3*	3	33.3	15	73.3*
Others	1	-	1	-	2	-
Husbands' Occupation						
Farming	47	63.8*	56	51.8	103	57.3
Artisan	36	41.7*	24	54.2	60	46.7
Petty-trading	13	76.9*	6	83.3	19	78.9
Business	36	61.1*	16	37.5	52	53.8
Civil service	76	63.2*	36	47.2	112	58.0
Professional	30	46.7*	8	87.5	38	55.3
Others e.g Pastor, herbalist...	13	30.8*	6	50.0	19	36.8

Source: field survey, 2003

*Significant at $p<0.05$

The table above shows that, respondents' main reason for working may be an important indicator of their experience of marital rape as those working for likeness sake and with experience of marital rape has the highest proportion (73.3%); followed by those working for financial independence (61.7%), then those who desire to use education (61.5%), and so on while the least is found among those working to pursue a career /profession (33.3%). The pattern differs between the semi-urban and the rural area and this is statistically significant generally and in the semi-urban area.

In addition, generally, the women whose husbands were petty-traders experienced marital rape more than others, followed by those whose husbands are civil servant, and then those whose husbands are farmers while the least experience of marital rape was seen among those women whose husbands are either Pastors or herbalists (e.t.c.) Here, religion may be an important factor at reducing the experience of marital rape among the women. When the place of residence was controlled for, there were some slight variations between the two areas under study. In the semi-urban area, the highest proportion of women who have experienced marital rape was found among petty-traders, but among the professionals in the rural area while for the two areas respectively, we have the least proportion among the others category and those who are into business. This is statistically significant in the semi-urban area only.

4.6 MULTIVARIATE ANALYSIS AND TESTING OF HYPOTHESES

This section examines the impact of domestic violence against women on contraceptive use in selected parts of Osun State. Some selected variables relevant to the hypotheses were examined using logit regression model. Under this approach, the dependent variable for each observation in this study takes the value of 1 if the respondent was currently using any method of contraception without husband's permission in the study area at the time of the survey and a value of 0 is assigned if otherwise (that is, not currently using any method of contraception). The independent variables eventually selected were educational level of the women under study, occupational type, the income level of the women, respondents' partners' educational level and occupational type, spousal habitation, respondents' working status, main reason for working and main reason for not working, types of household decision-making, knowledge about contraceptive methods, spousal communication about use of family planning methods, source of information about family planning methods, and attitude to family planning methods. These variables were selected because they were the variables shown to be significant and relevant from the result of the chi-square test carried out at the second level of the analysis.

Domestic violence variables used for the testing of the hypotheses are whether they have been beaten/battered or not, whether they have been forced against their will to have sexual intercourse with their husbands or not, whether they have ever suffered any hurt/health problem as a result of a quarrel/disagreement with an intimate person and finally, the frequency of verbal, of emotional/psychological, physical and sexual abuse suffered from intimate partner within the last one year to the time of the survey. These domestic violence variables are the intermediate/intervening variables for the study, although the main focus of the study is to examine the effect of these domestic violence variables on current use of contraceptive methods without husband's permission among the women in the study area.

The general model of the logistic regression equation is of the form:

$$\text{Log}\left[p / 1\text{-}p \right] = b_0 + b_1X_1 + b_2X_2 + \dots + b_kX_k$$

where $X_1, X_2, \dots, X_k$ are set of independent variables, b_0 is a constant while b's are regression coefficients. P is the probability of use of contraceptives without husband's permission.

4.6.1 SOME CORRELATES OF CURRENT CONTRACEPTIVE USE IN IFE-NORTH LOCAL GOVERNMENT AREA OF OSUN STATE

Table 4.6.1 provides a summary of the correlates of current contraceptive use. Presented in the table are the correlates, the b – coefficient and the unadjusted prevalence odds ratio for the association between the correlates and current contraceptive use without husband's permission in the study area.

Table 4.6.1: LOGISTIC REGRESSION OF LIKELIHOOD OF USING CONTRACEPTIVES WITHOUT HUSBAND'S PERMISSION IN IFE-NORTH LOCAL GOVERNMENT AREA OF OSUN STATE

CORRELATES	CONTRACEPTIVE USE					
	Semi-urban		Rural		Total	
	B Coeff	Odds Ratio	B Coeff	Odds Ratio	B Coeff	Odds Ratio
Educational Level						
None	RC	RC	RC	RC	RC	RC
Primary	12.161	191097.5	-3.792	.023	8.762	6387.065
Secondary	3.384	29.474*	-14.019	.000	1.008	2.739
Tertiary	2.752	15.669*	-14.246	.000	.688	1.990
Spousal Habitation						
Lives with me	RC	RC	RC	RC	RC	RC
Lives elsewhere	2.862	17.502**	.753	2.123	1.920	6.824**
Kind of work						
Farming	RC	RC	RC	RC	RC	RC
Artisan	-.825	.438	.342	1.407	-9.217	.000
Petty-trading	-8.918	.000	.514	1.671	-7.771	.000
Housewife	-10.117	.000	4.752	115.841*	-7.229	.001
Business	-3.300	.037	-11.735	.000	1.325	3.761
Civil Service	-9.480	.000	.718	2.050	-7.289	.001
Professional	-8.424	.000	-	-	-8.007	.000
Others	-9.588	.000	-	-	-8:936	.000
Partner threatened to beat, slap, kick...						
Yes	RC	RC	RC	RC	RC	RC
No	1.500	4.482	11.643	113856.8	2.156	8.639**
Partner actually beat, slapped, kicked...						
Yes	RC	RC	RC	RC	RC	RC
No	.285	1.330	-9.262	.000	-.372	.689
Suffered broken bones as a result of quarrel with intimate person						

Yes	RC	RC	RC	RC	RC	RC
No	-3.476	.031*	.060	1.062	-1.864	.155
Ever been forced against their will to have sexual intercourse with their husbands						
Yes	RC	RC	RC	RC	RC	RC
No	-.118	.889	1.403	4.065	.405	1.500
Decision-maker on whether or not to use any contraceptive method						
Husband	RC	RC	RC	RC	RC	RC
Wife	-5.546	.004	-.016	.984	-5.565	.004
Joint decision	-6.188	.002	-2.769	.063*	-6.623	.001
Husband's relatives	-4.521	.011	-	-	-4.766	.009
Others	-5.946	.003	-	-	-5.739	.003
Decision-maker on the number of children to have						
Husband	RC	RC	RC	RC	RC	RC
Wife	-6.370	.002	-1.933	.145	-7.440	.001
Joint decision	-6.761	.001	-3.385	.034*	-8.078	.000
Others	-7.343	.001	-	-	-7.369	.001
Heard about Periodic Abstinence						
Yes	RC	RC	RC	RC	RC	RC
No	.998	2.713	-3.859	.021**	-1.016	.362*
Heard about Lactational Amenorrhea						
Yes	RC	RC	RC	RC	RC	RC
No	2.185	8.892	-6.348	.002*	.868	2.382
Spousal Communication about Family Planning methods						
Yes	RC	RC	RC	RC	RC	RC
No	-1.000	.368	-1.684	.186	-1.177	.308*

Source: field survey, 2003

**Significant at p<0.01

*Significant at p<0.05

RC – Reference Category

Table 4.6.1 reveals that spousal habitation, threat from husband to beat, slap, kick or physically harm the wife, knowledge about periodic abstinence and spousal communication play an important role in the use or non-use of contraceptives in the study area. Those women whose partners are living elsewhere are about seven times more likely to use contraceptives than their counterparts whose partners are living with them (P=.000).

The likely reason for this may because of the absence of the husbands at home with them and consequently a higher level of control over their reproductive lives in the former compared to those in the latter group. Also, those women whose partners have never threatened to beat, slap, kick or physically harm are about nine times more likely to use contraceptives than their counterparts who have been threatened at one time or the other in time past (P=.006). This shows that the fear of been beaten by their partners is strong enough to hinder those women who might naturally want to use any of the contraceptive methods, especially if the partner has shown any objection in time past. Moreover, the result shows that those women who have never heard about periodic abstinence are about 36% less likely to use contraceptives than their counterparts who have heard about the method (P=.047).

Finally, those women who have never talked or discussed about using some methods of family planning with their partners (spousal communication) are shown to be about 31% less likely to use contraceptives than their counterparts who have discussed with their partners at one time or the other (P=.026).

From the table however, some other factors like the educational level of the respondents, experience of broken bones as a result of a quarrel/disagreement with an intimate person, kind of work, decision-maker about whether or not to use any contraceptive method, decision-maker on the number of children to have, ever heard about Periodic Abstinence and Lactational Amenorrhea are statistically significant considering the semi-urban/rural differential.

Those women with primary education and above in the semi-urban area are many times more likely to use contraceptives than their counterparts with no education at all (P=.021 and P=.012) and those women whose partners live elsewhere in the same location are about eighteen times more likely to use contraceptives than their counterparts whose partners live with them (P=.000).

The result reveals that those women who have never suffered broken bones in the semi-urban area are about 3% less likely to use contraceptives than their counterparts with such experience in the same area (P=.040).

In the rural area, kind of work, decision-maker on whether or not to use any contraceptive method and the number of children to have were found to be statistically significant. From the table above, those who are full-time housewives are so many times more likely to use contraceptives than their counterparts who are into farming (P=.021) while there is no significant difference between those in business and those who are farmers in the rural area. Those women in the remaining categories are more likely to use contraceptives than their counterparts in farming. Those households in the rural area where wives are the decision-makers on whether or not to use any contraceptive method, the result reveals that about 98% of the women are less likely to use contraceptives than their counterparts where husbands are the decision-makers. Also, those households where decisions are taken jointly, the women are about 6% less likely to use contraceptives compared to those households where husbands are the decision maker (P=.035). On the decision-maker on the number of children to have, where wives decide, they are about 15% less likely to use contraceptives than their counterparts where husbands are the decision-makers and in households where it is a joint decision, the women are about 3% less likely to use contraceptives when compared to those households where husbands decide in the rural area (P=.023). Those women who have never heard about Periodic Abstinence and Lactational Amenorrhea is about 2% and 0.2% less likely to use Contraceptives than their counterparts who have ever heard about the methods mentioned in the rural area (P=.001 and P=.012).

Those women who have not been actually beaten or battered according to the result are about 69% less likely to use contraceptives more than their counterparts who have actually been beaten or battered in the study area, while in the semi-urban area, those women who have never been beaten or battered are one time more likely to use contraceptives than their counterparts with such experience. In the rural area, women who have never been beaten or battered do not differ significantly from those that have been beaten or battered considering their less likelihood of using contraceptive methods without husbands' permission.

Those women who have never been forced against their will to have sexual intercourse with their husbands are one time more likely to use contraceptives than their counterparts with such experience. In the semi-urban area, women with no such experience as marital rape are about 89% less likely to use contraceptives while in the rural area there is a different scenario. Rural women with no experience of marital rape are about four times more likely to use contraceptives than their counterparts with such experience.

Women within households where the decision-maker on the number of children to have are not husbands do not differ significantly from those in which the decision-makers are husbands, meaning that the decision-maker apart from the husbands on the number of children to have, have far less influence on the use of contraceptives in the study area while in the semi-urban area, the situation is the same.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 SUMMARY AND CONCLUSION

This survey is a maiden work on domestic violence and contraceptive use in the study area particularly and in Osun State in general. It was conducted for the purpose of obtaining a baseline data on the impact of domestic violence on contraceptive use in the study area. It has been shown that domestic violence (wife battery and marital rape) exist in the study area and that there is relatively low level of contraceptive use.

The socio-economic/demographic factors responsible for low level of contraceptive use in this survey include educational level of the respondents, and spousal habitation (whether the spouse co-habits with the woman or live elsewhere.), kind of work, income level, husband's level of education, and occupation. Also, the significant domestic violence variables include ever been threatened to be beaten or battered by partner, ever suffered broken bones as a result of quarrel/disagreement with an intimate person, although there are variations when their place of residence was controlled for.

In addition, types of household decision-making was found to be among the correlates of contraceptive use, especially, the decision-maker about whether to use any contraceptive method or not, and the number of children to have. There are variations when the place of residence was controlled for.

Moreover, when knowledge of and attitude to contraceptive methods was examined against its use, knowledge about Periodic Abstinence, withdrawal and other traditional methods, spousal communication and whether approve of any family planning method were found to be responsible for the low rate of contraceptive use in the study area although there are variations when their residence was controlled for.

On the coping strategies adopted by victims of domestic violence, a larger proportion of the women preferred amicable settlement when in crisis and they often choose to pacify and tolerate their men when there is crisis. Many of the women choose to apologize to their men when there is misunderstanding instead of moving out of their matrimonial homes. It is noteworthy to mention that none of the women respondents in the study area contacted the police for intervention. It was discovered that what men do most in the study area when they have misunderstanding with their partners is to ignore or abandon them and refuse to perform their duties.

It was hypothesized that women who have been beaten/battered are less likely to use contraceptives than their counterparts with no such experience but found contrary to expectation that those women who have never been beaten or battered by their husbands are about 69% less likely to use contraceptives without their husbands' permission in the study area while the hypothesis is only true for the semi-urban women only as those that have never been beaten/battered are 1.330 more likely to use contraceptives than their counterparts who have ever been beaten/battered although none of the relationship is statistically significant. The first hypothesis is only true and even statistically significant for those women whose partners have ever threatened to beat, slap, kick or physically harm and controlling for the place of residence, those women who have never been beaten or battered are much more likely to use contraceptives than their counterparts with such experience.

Also, the result of the logistic regression made it clear that experience of marital rape does influence their decision to use contraceptives without husbands' permission. Those women who have not been forced against their will to have sexual intercourse with their partners are 1.500 more likely to use contraceptives than their counterparts with such experience, and even as much as four times more likely in the rural area under study. In the rural area, those women who have not been forced against their will to have sexual intercourse with their partners are about 89% less likely to use contraceptives than their counterparts with such experience.

Moreover, women with more power to decide the number of children to produce have been found to be less likely to use contraceptives without husbands' permission than their counterparts with no such power. By implication, decision-maker about the number of children to produce has less influence on contraceptive use. Even when the place of residence was controlled for, the situation is still the same.

Despite the fact that domestic violence in form of verbal, emotional/psychological, physical and sexual abuse exist in the study area, it is doubtful whether there are health facilities that can cater for the need of these victims and presently there are no legal provision or facilities for those victims of domestic violence where the perpetrators of these various forms of domestic violence can be reported and punished.

5.2 RECOMMENDATION

This study has been able to establish the fact that domestic violence in various forms and shades exist in the study area. It also shows relatively low level of contraceptives use associated with their experience of domestic violence and as a result, policies and programmes need to be reoriented to incorporate strategies to combat domestic violence and other forms of violence. Such strategies must address not only the immediate health needs of battered women, but also the root causes of violence –unequal gender relations and the way these relations reinforce women's powerlessness. This undoubtedly will require the health sector to interact actively with other sectors –including women's organizations – in raising awareness of the extent of the problem as well as in promoting behavioural changes and negotiating skills of women.

Studies linking domestic violence with reproductive ill-health argue compellingly for the integration of services in order to identify, refer and prevent domestic violence in primary or reproductive health programmes. They argue also for health programmes to be vigilant, sensitive and responsive to the conditions of battered women, by way of services, counselling, and referrals to appropriate legal agencies. At the same time, community education efforts, directed towards adolescents women, men and family elders, must forcefully convey the need for gender equity and respect for women's rights generally, including their right to be free from violence. Moreover, people need be made aware of the various means (legal, social support, health care, etc.) available to women for protecting themselves against violence. Presently, there are no such means of protection for women experiencing domestic violence and so should be established in the study area. There is also a need to highlight the likely consequences of domestic violence on women's lives and health and on the lives of the infants they bear. The aim should be to reverse social attitudes and beliefs that legitimize male violence, with promotion of responsible sexual and gender attitudes among men. Above all, the efforts must promote women's understanding of their strategic needs and empower them to resist abuse.

5.3 AREAS FOR FURTHER RESEARCH

The present study focused on the domestic violence and its implications for contraceptive use. The gap in understanding about domestic violence and its consequences for reproductive health are numerous and formidable. Community and health facility-based and behavioural research is needed in developing countries on the context and health consequences of domestic violence. Also needed are appropriate study methodologies and designs and such methodologies must enable women to overcome their reluctance to discuss this issue and this may require greater reliance on qualitative methods.

Priority areas for research are as follows:

1.) Domestic violence and underlying gender power imbalances.
2.) The consequences of domestic violence for safe pregnancy and childbearing.
3.) Domestic violence, unwanted pregnancy, and constrained contraceptive choices.
4.) The prevalence and consequences of sexual violence.
5.) The vulnerability of adolescents and the elderly to sexual abuse.
6.) The role of men in domestic violence.
7.) The role of the health sector.

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APPENDIX I

QUESTIONNAIRE FORMAT

Department of Demography and Social Statistics, Faculty of Social Sciences, OAU, Ile-Ife.

"STUDY ON DOMESTIC VIOLENCE AND CONTRACEPTIVE USE IN IFE-NORTH LOCAL GOVERNMENT AREA OF OSUN STATE, NIGERIA".

TO WHOM IT MAY CONCERN

Dear Madam,

This questionnaire is to elicit information on issues affecting the health of women in this area. It is purely an academic exercise for the award of a M.Sc. degree and it has nothing to do with you as a person. Therefore, your sincere and honest response will be highly appreciated and the information you will supply will be treated confidentially.

Thank you.
The research Student.
Department of Demography and Social Statistics, OAU, Ile-Ife.

Eligibility: Ever Married women aged 15-49.
Questionnaire Number______________________________

Place of interview; ______________________________

Time Interview started; ______________________________

Time Interview ended; ______________________________

SECTION A

SOCIO ECONOMIC AND DEMOGRAPHIC BACKGROUND

Write or tick as appropriate

1. (a) How old are you now? ____________________
   (b) What is your age at first marriage? ________________
   (c) What is your age at first birth? ________________

2. (a). What is your highest level of education?
   1. None ( ) 2. Primary Incomplete ( ) 3. Primary Complete ( ) 4.Secondary Incomplete ( ) 5. Secondary Complete ( ) 6.TTC/NCE ( ) 7. Polytechnic/University ( ) 8.Others Specify ________________
   (b) Please, supply your years of schooling ______________

3. (a) What is your Marital Status? 1. Married ( ) 2. Widowed ( ) 3. Divorced ( ) 4. Separated ( ) 5. Others, specify ____________
(b) How old was your current partner at marriage? ____________
(c) Does your spouse regularly live with you or does he stay elsewhere? 1. Lives with me ( ) 2. Lives elsewhere ( )
(d) If staying elsewhere, who is he staying with? 1. Alone ( ) 2. Other wife/woman ( ) 3. Don't know ( ).

4. (a) What type of marriage do you have? 1. Monogamous ( ) 2.Polygynous ( ) 3. Others specify ( ).
(b) How many other wives does your husband have apart from you? ____________
(c) What is your order amidst the wives? ____________

5 (a) What is the number of children you have ever born? ____________
(b) How many of them are boys? ____________
(c) How many of them are girls? ____________
(d) How many of your children are alive now?
Sons alive ____________ Daughters alive ____________
(e) How many of your children live with you at home?
Sons at home ____________ Daughters at home ____________
(f) How many of your children live elsewhere?
Sons elsewhere ____________ Daughters elsewhere ____________
(g) How many of your children are now dead?
Sons dead ____________ Daughters dead ____________

6. What is your religion? ____________

7. How often do you attend services in the last four weeks at a church/mosque/temple etc. 1. Never ( ) 2. Once a week ( ) 3. Twice or more in a week ( ).

8. What ethnic group do you belong to? ____________

9. Are you currently working? 1. Yes ( ) 2. No ( ).

10. What is the kind of work you do now to earn money? 1. Farming ( ) 2.Artisan e.g. weaving ( ) 3. Petty trading ( ) 4. Housewife ( ) 5.Business ( ) 6. Civil Service ( ) 7. Professional e.g. Doctors, Lawyers etc ( ) 8. Others, Specify ____________

11. Do you do that work as an employee working for someone else, a self-employed, a family worker working for others. Family members or as an employer who hires others to work for you?
1. Employee ( ) 2. Self employed ( ) 3. Family worker ( ) 4.Employer ( ) 5. Others specify ____________.

12. Do you do the work in the home or do you go somewhere else to work?
1. Work at home ( ) 2. Work elsewhere ( )

13. What is your MAIN reason for working? 1. Economic necessity ( ) 2.Financial independence ( ) 3. Pursue career/profession ( ) 4. Use education or skill ( ) 5. Help with family business/farm ( ) 6. Like to work ( ) 7. Nothing else to do ( ) 8.Othersspecify ____________

14. Please kindly state your income ____________

15. If your answer to (9) above is No, why are you not working at this time? 1.No financial need to work ( ) 2. Unable to find work ( ) 3. Have no special skill ( ) 4. Dislike working ( ) 5. Need to care for children ( ) 6.Too much housework ( ) 7. Husband objects ( ) 8. Parents object ( ) 9. In-laws object ( ). Others Specify ________________
16. What is the highest level of education attained by your husband? 1.None ( ) 2.Primary Incomplete( ) 3. Primary complete ( ) 4. Secondary incomplete ( ) 5. Secondary Complete ( ) 6. TTC/NCE ( ) 7.Polytechnic/University ( ). 8. Others Specify ________________
17. What is his occupation? 1. Farming ( ) 2. Artisan e.g. weaving ( )3. Petty trading ( ) 4. Business ( ) 5. Civil Service ( ) 6. Professional e.g. Doctors, Lawyers etc ( ) 7. Others, Specify________________
18. Did you choose your current husband or did your parents choose him for you 1. I chose ( ) 2. Parents chose ( ) 3.Otherspecify________________

SECTION B

DOMESTIC VIOLENCE (Verbal, Emotional/Psychological, physical and Sexual Abuse)

		Frequency of abuse					
		Never	Once	Twice	3-5 times	6-10 times	>10 times
19.	How frequently has your partner ever done any of these things to you? (within the last year)						
a.	Ignored your feelings						
b.	Ridiculed or insulted women as a group						
c.	Ridiculed or insulted your most valued beliefs, your religion, heritage or class						
d.	Withheld approval, appreciation, or affection as punishment						
e.	Continuously criticized you, called you names, shouted at you						
f.	Humiliated you in private						
g.	Humiliated you in public						
h.	Refused to socialize with you						
i.	Kept you from working						
j.	Made all decisions						
k.	Controlled your money						
l.	Refused to share money						
m.	Took car keys or money away from you						
n.	Regularly told you to leave						
o.	Threatened to hurt you and children						
p.	Punished or deprived the children when angry at you						
q.	Abused, tortured or killed pets to hurt you						
r.	Destroyed furniture, broke appliances						
s.	Wielded a gun in a threatening way						

20. Has your partner done the following to you?
    (a). Threatened to beat, slap, kick or physically harm you?
    1. Yes( ) 2. No ( )
    (b). Actually beaten, slapped, kicked or physically harmed you?
    1. Yes ( ) 2. No ( )
    (c). Denied you sex? 1. Yes ( ) 2. No ( )
    (d). Gone outside marriage relationship to play sex?
    1. Yes( ) 2. No ( )
    (e) Separated from you? 1. Yes ( ) 2. No ( )

21. (a.) Did this happen when you were pregnant? 1. Yes ( ) 2. No ( )
    (b). Did you take any step to protect yourself? 1. Yes( ) 2.( )
    (c).What are the steps taken? ______________________________
    ____
    ____
    (d). What other main thing do men do when they have some misunderstanding with their partners (Specify) ______________

22. Have you ever suffered any of the following as a result of a quarrel/disagreement with an intimate person? Circle ALL THAT APPLY:

		Yes	No
(a).	Pain (Muscular, abdominal etc)	1	2
(b).	Bites/Cuts	1	2
(c).	Chronic headaches	1	2
(d).	Bruises	1	2
(e).	Burns/scalds	1	2
(f).	Broken bones	1	2
(g).	Recurrent vaginal infections	1	2
(h).	Sleep and eating disorders	1	2
(i).	Permanent injuries (loss of vision/hearing, physical disfigurement)	1	2
(j).	Pregnancy miscarriage	1	2
(k).	Others ______________ (Specify)		

23. Have you ever received treatment for injuries inflicted by a person with whom you have intimate relationship? 1. Yes( ) 2. No ( )
24. What do you think is the reason why there is domestic violence in marital unions? ______________________________
25. Do you know any woman around your neighbourhood who suffered as a victim of domestic violence? 1.Yes( ) 2.No ( )
26. What do you think is the main coping strategy adopted by victims of domestic violence in this area? ______________________
27. How old were you at your first sexual intercourse? ______________
28. With whom did you have your first sexual intercourse? ____________
29. What was the relationship between you and the person? ____________
30. How old were you when this happened? ______________________
31. Did you ever tell anyone about any of this in an attempt to get help?
    1. Yes ( ) 2. No ( )

32. If yes, who? (a) Friend ( ) (b) Mother ( ) (c) Sister ( ) (d) Other relative ( ) (e). Policemen ( ) (f) Others (Specify) ________________
33. Was that person able to help you? 1. Yes( ) 2. No ( )
34. If no, why not? 1. I was threatened ( ) 2. Embarrassed ( ) 3. No one to tell ( ) 4. Happens to many women ( ) 5. Scared ( ) 6. It was my own fault ( ) 7.Others (Specify) ____________.
35. Have you been forced against your will to have sexual intercourse with your husband? 1. Yes ( ) 2. No ( )
36a. Have you ever refused your husband's approach when you were not ready? 1. Yes( ) 2. No ( )
b. If no, give the main reason ________________________________
37. Who decides on the following in your family?
    (a). Whether or not to use any contraceptive method? 1. Husband ( ) 2. Wife ( ) 3.Joint decision ( ) 4.Husband's relatives ( ) 5. Others (Specify) ________________
    (b). The time to have sex. 1.Husband ( ) 2.Wife ( ) 3.Joint decision ( )
    (c). The number of children to have 1. Husband ( ) 2. Wife ( ) 3.Joint decision ( ) 4. Others Specify) ____________________
    (d). Whether or not to go to hospital/clinic in case of any health problem. 1. Husband ( ) 2. Wife ( ) Joint Decision ( ) 4. Any of us concerned ( ).

SECTION C

CONTRACEPTIVE USE (KNOWLEDGE, ATTITUDE AND USE)

38. Have you heard of methods that a couple could use to prevent or delay a pregnancy? 1.Yes( ) 2.No( )
39. (a). There are ways/methods by which couples can delay or prevent pregnancy, which of these ways/methods have you ever heard about ? (Tick as many as you know) 1. Pill ( ) 2. IUD/Coil ( ) 3. Injectable ( ) 4. Diaphragm/Foam/Jelly ( ) 5. Condom or Durex ( ) 6. Female sterilization ( ) 7. Male sterilization ( ) 8. Norplant ( ) 9. Periodic Abstinence ( ) 10. Withdrawal ( ) 11. Traditional (e.g. ring, belts, charms) ( ) 12.Lactational Amenorrhea ( ) 13. Others (Specify) ____________________
(b). What was your source/medium of information? 1.Television ( ) 2.Radio ( ) 3. Hospital/Clinic ( ) 4. Printed materials ( ) 5. My husband ( ) 6.Others (Specify) ____________________
40. In general, have you and your spouse ever talked about using some methods of family planning? 1. Yes ( ) 2. No ( )
41. If yes, when was the last time you discussed family planning (Code in months) 1. Less than 3 months ago ( ) 2. Between 3 and 6 months ago ( ) 3. Between 7 and 9 months ago ( ) 4. Between 10 and 12 months ago ( ) 5. More than a year ago ( ) 6. Others (Specify) ______________
42. Do you approve of any family planning method? 1. Yes ( ) 2. No ( ).
43 (a). Have you ever used any of the methods? 1. Yes ( ) 2. No ( ).
   (b). If yes, which one of them? ____________________

(c). For how long have you or your spouse been using the method(s) you mentioned? (Duration of use in months) ____________

(d). If your answer to (44a) is no, why? ____________

44 (a). Are you currently using any method without husband's permission? 1. Yes ( ) 2. No ( ).

(b). If yes, which one? ____________

(c). Where did you go the last time to obtain the method you are currently using? ____________

(d). If no, what is the main reason you are not currently using a method? ____________

45 (a). Does your husband approve of the method you are using? 1. Yes ( ) 2. No ( ).

(b). If no, why not? ____________

46. Has your husband ever objected your using any contraceptive method in the time past? 1. Yes ( ) 2. No ( ).

47. To drive home his point, what did he do? (any violent reaction?) ____________

48. If you get pregnant when you ought not to as a result of not using any contraceptive method, what will you do? ____________

APPENDIX II

FOCUS GROUP DISCUSSION FORMAT

(1) There could be misunderstanding between a husband and his wife. Sometimes, this can lead to conflict if not wisely dealt with. What in your opinion could cause such misunderstanding or conflict in a home?

(2) What are some of the things men around here do to show they are offended /angry?

(3) During conflict period, what action do women around here take to protect themselves especially if their home is hot?

(4) What are the contributions of the relatives and the community during crisis in the home?

(5) Has anyone of us here encountered any form of domestic violence before? (We want to learn from your experiences and on how the conflict was eventually resolved).

(6) What should warrant a man beating his wife? Is it good for a man to beat his wife for any reason?

(7) Is it right for a man to force his wife to have relationship when the wife is not ready? (Why and why not) Is that not rape?

(8) Sometimes some women do get pregnant when they ought not to. Why is it so?

(9) Many of us have heard about various Family Planning Methods/Modern contraceptive methods. Why are many women not using these methods?

(10) Does a man have the right to restrain his wife from using contraceptives (especially the modern types)?

APPENDIX III

TABLE 4.7: Summary of Focus Group Discussion Data

Question and Responses	Semi-urban		Rural	
	15-29	30-49	15-29	30-49
Causes of misunderstanding in homes.				
Wife's lack of submission	++	+	+	++
Child training	+	+	+	-
Sexual relationship	++	++	++	-
Promiscuity/unfaithfulness	+	+	+	-
Wife's neglect	++	++	+	++
Husband's irresponsibility	++	+	++	-
Intrusion of the third party	-	-	-	+
Lack of true love and mutual understanding	+	+	+	+
Action of men when angry				
Frowning, abandonment and neglect of family members	+	+	+	+
Staying outside longer	+	+	+	+
Use of abusive language	+	-	+	-
Coping strategies for victims				
Appeasing with food and sex	++	+	+	+
Yielding to correction and apologizing	-	+	+	+
Separation for a while if the husband is violent	-	-	-	+
Relative and community's contributions in family conflict resolution				
Escalation (negative)	++	++	++	++
Reproach/Ridicule	++	++	++	++

In-laws' intervention in case of prolonged crisis	-	-	-	+
Personal experience of past family conflict and resolution				
Submission	+	+	+	+
Satisfying the man with everything including sex	+	+	+	+
Any justification for wife beating?				
It is wrong because women are weaker vessels	++	++	+-	++
It is good to instill sense to them/control them	-	-	+	-
Any justification for marital rape?				
It is wrong because women are not machines and perpetrators to be punished	+	+	+	+
Reasons for unintended pregnancy				
Non-use of contraceptives because of fear of side effects	+	+	+	+
Men's excessive love for sex/woman's joblessness	+	-	+	+
Monogamy	-	-	+	-
Inadequate experience about sexual intercourse	-	-	+	-
Failure of family planning methods	-	+	-	-
Polygyny and competition for children	-	-	-	+
Over-protecting men from	-	-	-	+

having extra-marital affairs				
Reasons for non-use of contraceptive methods.				
Fear of side effects	++	++	++	++
It can cause infertility	+	-	+	-
Wrong information and lack of qualified personnel	+	+	+	-
It does not work for some women	+	-	+	-
Religious belief/denominational stand	-	+	-	-
Government's neglect of the rural areas	-	-	-	++
Disagreement	-	-	-	+
Government's unserious ness	-	+	-	-
Men restraining women from using contraceptive methods.				
It is right for men to be in control	+-	+	+-	+-
With faithfulness, love and understanding, there will be no problem	-	-	+	+

Source: Field survey, 2003

KEY:

++ Where opinion was strongly expressed by the discussants

+ Where opinion was expressed by the discussants

- Where opinion was not expressed by the discussants

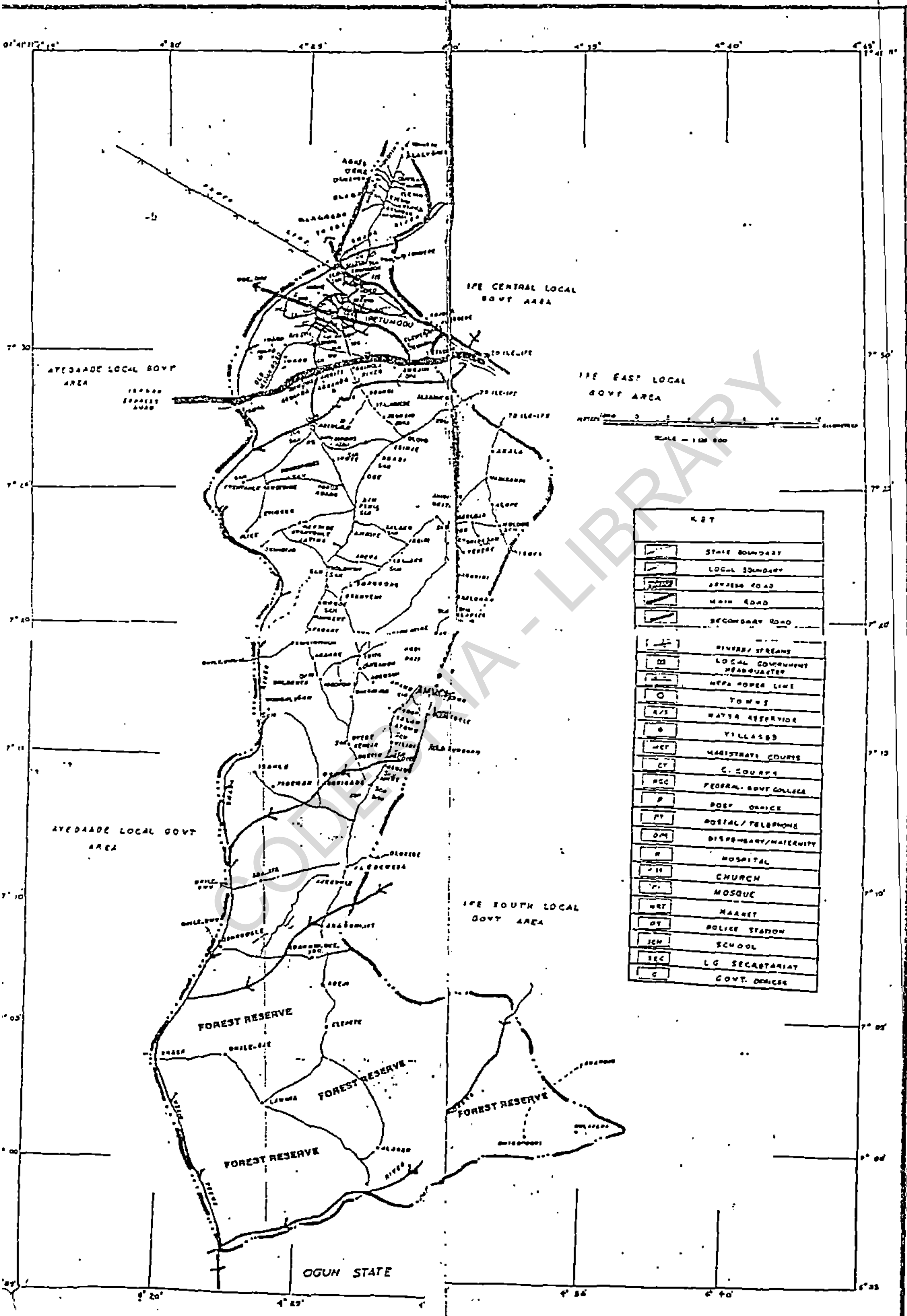
+ - Where there was divided opinion among the discussants

APPENDIX IV

IFE NORTH LOCAL GOVERNMENT

OSUN STATE NIGERIA

PROVISIONAL MAP



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OCT 1998

NOTES: BOUNDARIES SHOWN ON THIS MAP ARE APPROXIMATE USERS NOTING CORRECTIONS OR ADDITIONS TO THIS MAP ARE REQUESTED TO ANNOTATE AND SEND IT TO THE OFFICE OF SURVEYOR GENERAL OF OSUN STATE FOR ONWARD TRANSMISSION TO THE CHIEF CONSULTANT. TSL 1998