EXPERIENCE OF INTIMATE PARTNER VIOLENCE AMONG MARRIED MEN IN IBADAN NORTH WEST LOCAL GOVERNMENT

BY

FAMINU OLUFUNMILOLA ADEOLA
B.NSc (OBAFEMI AWOLOWO UNIVERSITY)
MATRIC NO: 181159

A PROJECT SUBMITTED TO THE DEPARTMENT OF HEALTH PROMOTION AND EDUCATION, FACULTY OF PUBLIC HEALTH, COLLEGE OF MEDICINE IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH
(POPULATION AND REPRODUCTIVE HEALTH EDUCATION)
OF THE
UNIVERSITY OF IBADAN

FEBRUARY, 2016

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

DEDICATION

To God alone be glory for great things he has done

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

ABSTRACT

Intimate partner violence is a public health issue which should be of concern to everyone. There are quite a number of studies which focus mainly on women as victims yet there exist a great percentage of men who are suffering silently from this scourge. There are very few studies that explored this area because it is a patriarchal society. This study was carried out to assess the experience of intimate partner violence among married men in Ibadan North West Local Government Area (IBNWLGA), Oyo State, Nigeria.

The study was a descriptive cross-sectional survey which involved the use of a three stage random sampling technique. The process included: random selection of seven wards out of the eleven wards in the local government; stratification of IBNWLGA into three by characteristics and selection of 400 respondents from 650 households through purposive sampling. A validated semi structured interviewer administered questionnaire was used for data collection. Descriptive statistics and t tests were used to analyse data.

Respondents' mean age was 40.5/ ±9.93, 46.3% had tertiary education and 70% were Christians. Majority of the respondents had one wife (88.5%) and over half had been married for less than ten years (59.3%). A total number of 56.8% respondents had a positive history of alcohol intake while 18.55 had ever smoked cigarette. A large percentage of the respondents (83.3%) perceived that men ought not to talk to their wives harshly. The forms of physical violence ever experienced by the men include slaps (13%), throwing an object (7.4%), bites (6.1%) and throwing punches (6.6%). The most common forms of psychological violence ever experienced by the men were nagging (36.2%), ignoring and treating him indifferently (34%), insulting and making him feel bad about himself (24.2%). Refusing to have sex with the man (29.2%) and insistence on anal sex (5.9%) were some forms of sexual violence ever experienced by the respondents. Further analysis was carried out to determine the percentage of respondents who experienced the various forms of violence alone, a combination of two forms and all the three forms too. Results are as follows; psychological violence alone- 30.7%, sexual violence alone- 21.2% , physical violence alone- 10.8%, psychological and sexual violence -16.2%, psychological and physical violence – 8.7%, physical and sexual violence -6.3%. A percentage of 6.1% had ever

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

experienced all forms of intimate partner violence. There was significant relationship between history of violence and the three forms of violence.

The experience of intimate partner violence by men is common. Public enlightenment, social support, family life education and counselling are recommended for addressing the problem.

Keywords: Intimate Partner Violence, Physical Violence, Psychological Violence, Sexual Violence, Married Men.

Word count: 424

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

ACKNOWLEDGEMENTS

To my supervisor, Professor Ademola J. Ajuwon who has been of immense help, despite his tight schedule rendered invaluable support and became part of my success story in this great citadel of learning. I am very grateful sir!

I am also grateful to Dr Oyedunni Arulogun, Dean, Faculty of Public Health, the HOD; Professor O. Oladepo for their roles in making this a reality. To all the other lecturers in the department: Dr Oyewole, Dr Oshiname, Mrs Desmennu, Mrs Oluwasaanu, Mr Dipeolu, thank you for adding value to my life. The non academic staffs deserve accolades too for attending to the needs of students appropriately. Mr John Imaledo, for his constant words of advice. The secretary to my supervisor (Mrs Babaniyi) deserves to be acknowledged for her warm reception each time we went to his office. Dr M. A. Titiloye: thanks for your support.

My special appreciation goes to the following individuals and families for their kind gestures in the course of my study: Sir Afolabi, Mrs Udele and children, Rev Sanyaolu, Rev Olatunji and Dr Olufunke Fayehun, Mrs Oluwatomisin Olalude, Mrs Bolanle Hamid, Esther Olotu, Tayo, Uwaifoh, Femi and every member of the Agbede Adodo community. Including the Nurses at Remi Babalola Red Cross Medical Centre. You all rock!

To my parents, Mr & Mrs Ajibade, Mr & Mrs Faminu, my siblings Ronke, Yetunde, Dele: I say an awesome thank you for being there for me at all times.

Now to the guys in my life; AYOBAMI, AYOMIPOSI, AYOMIKUN, You brighten my world. I love you all dearly. Thanks for being there, for denying yourselves so many times because of me.

Unto the king eternal, immortal, invisible, the only wise God: to him alone be all the glory.

FAMINU, Olufunmilola Adeola

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CERTIFICATION

I certify that this work was carried out by Olufunmilola Adeola FAMINU in the Department of Health Promotion and Education, University of Ibadan, Ibadan under my supervision.

UNIVERSITY OF IBADAN LIBRARY

SUPERVISOR

Prof Ademola J. Ajuwon

Bsc(Lagos), MPH, PhD(Ibadan)

Department of Health Promotion and Education,

Faculty of Public Health, College of Medicine,

University of Ibadan,

Ibadan, Nigeria

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE OF CONTENTS

Title page..i

Dedication..ii

Abstract..iii

Acknowledgement..v

Certification..vi

Contents..vii

List of Tables..x

List of Figures..xi

List of Appendices..xii

List of Acronyms..xiii

CHAPTER ONE: INTRODUCTION

1.1 Background of the study..1

1.2 Statement of the problem..3

1.3 Justification of the study..5

1.4 Research questions..5

1.5 Objectives..6

CHAPTER TWO: LITERATURE REVIEW

2.0 Nature of Intimate Partner Violence..7

2.1 Attitude of married men towards IPV..9

2.2 Extent of experience of IPV..10

2.3 Forms of Intimate Partner Violence..11

2.4 Causes of perpetration of IPV..13

2.5 Effects and consequences of IPV..15

2.6 Help seeking practices of men experiencing IPV..17

2.7 Screening for IPV..17

2.8 Theoretical framework..20

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

CHAPTER THREE: METHODOLOGY

3.1 Study design 23

3.2 Description of the study area..23

3.3 Study population 24

3.4 Sample size and sampling technique..24

3.5 Instrument for data collection 25

3.6 Validation and Reliability of the instrument 25

3.7 Data Collection Process 26

3.8 Data Management..27

3.9 Data Analysis..27

3.10 Ethical Considerations..28

3.11 Limitations of the Study..29

CHAPTER FOUR: RESULTS

4.1 Background Characteristics..30

4.2 Attitudes towards perpetration of violence..36

4.3 Family history of intimate partner violence..38

4.4 Experience of intimate partner violence...40

4.4.1 Experience of psychological violence...43

4.4.2 Experience of sexual violence 46

4.5 Reasons for the experience of IPV...51

4.6 Health consequences of intimate partner violence.. 53

4.7 Type of injury sustained from wife and hospital attendance 55

4.8 Disclosure of injury and alternative to non disclosure 55

4.9 Reasons for seeking help and steps to take if it happens again.......................55

4.10 Test of relationships between selected socio-demographic variables

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

and experience.......56

4.11 Test of relationship between history of IPV and forms of violence 59

CHAPTER FIVE: DISCUSSION

5.1 Discussion..60

5.2 Recommendations..62

5.3 Implications for health promotion and education...62

5.4 Conclusions..63

REFERENCES..64

APPENDICES...75

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

LIST OF TABLES

Title

4.1.1 Background Characteristics....................31

4.1.2 Percentage response on alcohol related issues 33

4.2 Attitudes towards perpetration of violence 37

4.3 Family history of Intimate Partner Violence....................39

4.4 Experience of psychological violence in the last six months....................45

4.5 Experience of sexual violence in the last six months 48

4.6 Reasons for experience of Intimate Partner Violence 52

4.7 Socio- demographic variables and experience of physical violence 57

4.7.1 Socio- demographic variables and experience of psychological violence..58

4.7.2 Socio- demographic variables and experience of sexual violence 59

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

LIST OF FIGURES

Figure 2.1	Ecological framework	22
Figure 4.1	Types of alcohol intake	35
Figure 4.2.1	Forms of physical violence ever experienced by men	41
Figure 4.2.2	Forms of physical violence experienced in the last six months	42
Figure 4.3	Forms of psychological violence ever experienced by the men	44
Figure 4.4	Forms of sexual violence ever experienced by the men	47
Figure 4.5	Experience of forms of violence	50
Figure 4.6	Percentage injured by physical violence	54

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

LIST OF APPENDICES

APPENDIX I Questionnaire on experience of intimate partner violence among Married men in Ibadan North West Local Government 75

APPENDIX II Yoruba translation of the questionnaire 81

APPENDIX III Sketch map of Ibadan North West Local Government showing the major communities and neighbourhoods 89

APPENDIX IV Ethical approval 90

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

LIST OF ACRONYMS

IPV: Intimate Partner Violence

IBNWLG: Ibadan North West Local Government

GBV: Gender Based Violence

VAM: Violence Against Men

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Intimate Partner Violence is the use of actual or threatened physical, sexual and psychological violence by a current partner (Nouri et al 2012). According to the World Health Report on Violence and Health, "IPV refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship". IPV 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. Although both men and women assume either role of victim or perpetrator, females are usually the victims in male-dominated patriarchal societies with less gender equality like Nigeria, while higher levels of male IPV victimization occur in countries with greater gender equality (Owoaje and OlaOlorun, 2012).

Intimate Partner Violence (IPV) is a common occurrence in many homes in Nigeria (Olufemi and Ojo, 2013). The increase in the numbers of the occurrence globally has made it an issue which calls for drastic attention. Intimate Partner Violence is a highly prevalent and severe problem in the United States and other societies where it has been studied. It is a national problem in every country, affecting millions of adults every year (Fang and Corso 2008). Partner violence has been socially constructed as a predominantly masculine deviance, whereby male use their power and control gained through socialization to dominate women (Bailey, Eistikovits and Buchibinder, 2012). In Nigeria, Abama and Kwaja (2009) argued that violence against women is a prevalent harm to the basic rights, freedom health and welfare of women. It occurs in many settings and at many hands, including those of relatives, acquaintances, employers, and the state. According to the authors; most forms of violence directed specifically against women in Nigeria are met with silence not only by the state but also by much of the human rights community. The problematic issue is that Intimate Partner Violence (IPV) awareness is very low in the country. In Nigeria, Intimate Partner Violence is considered to be a relatively minor social problem. Many

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

Nigerians are not aware that it is a major and problematic issue within the country. Most Nigerians are not aware of it as a criminal offence in the society. It is considered as a normal routine in every Nigerian household. Many social and economical factors had been considered as factors, which caused Intimate Partner Violence within most Nigerian homes. However, there are more hidden social and economic factors needed to be identified to broaden our knowledge on the causes of this social problem (Olufemi and Ojo, 2013).

Intimate partner violence (IPV) has been widely examined through a framework that is based on male-perpetrated violence against women. However, recent studies, including a study published in the American Journal of Public Health (2008), have initiated focus on female perpetration of IPV against male partners. The majority of such studies have not identified a framework for understanding this phenomenon. By contrast, no evidence has demonstrated that female-perpetrated violence against male partners has been a threat to the health of populations of men. Additionally, studies that have compared the prevalence of female- and male-perpetrated violence against partners have had various limitations—namely, that male-perpetrated violence against female partners is highly stigmatized and likely underreported and not comparable to violence perpetrated by women against their male partners. Further, unlike male-perpetrated IPV against female partners, which has been linked to assertion of male control and is likely rooted in gender in- equalities, female-perpetrated violence against intimate male partners, has often been documented to be more likely a result of self- defence or poor conflict management in relationship (Issue, 2008).

Intimate Partner Violence (IPV) in the last few decades has become a public health issue of immense significance all over the world (Owoaje and OlaOlorun, 2012). Such violence has been associated with serious health consequences including physical, sexual and reproductive health, psychological and behavioural problems, as well as fatal health outcomes such as homicide, suicide, and maternal mortality WHO affirms that both men and women can be victims as well as perpetrators of violence but the violence committed to women differs from the violence men are most likely to be exposed to. While men are more likely to be killed or injured in wars and physically assaulted on the street by a stranger, women are more likely to be physically assaulted or murdered by someone known, often a family member or an intimate partner. Women are also, to a larger extent than men, at risk for being sexually assaulted or

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

exploited through all their lives. Men are more likely to be the perpetrators of violence, no matter the sex of the victim (Ellsberg and Heise, 2005). Studies have shown that emotional violence and controlling behaviour are generally closely accompanied with sexual and physical abuse of women (Ellsberg and Heise, 2005).

The Population Council (2008) reported that WHO identifies the following evidence-supported risk factors for intimate partner violence; Traditional gender norms that support male superiority and entitlement, Social norms that tolerate or justify gender-based violence, Weak community sanctions against perpetrators, Poverty, High levels of crime and conflict in society more generally. Certain risk factor have also been highly associated with perpetration of IPV; such as using hard drugs or alcohol, especially drinking heavily, witnessing or being a victim of violence as a child and not having a job, which can cause feelings of stress (Obunikem, Adogu, Chimah, Ilika and Ubajaka, 2015).

1.2 Statement of the Problem

In the past few decades, concerns have been increasingly expressed about violence against women, especially intimate partner violence (IPV) in both developed and developing countries (UN, 2014). Gender-based violence has been acknowledged worldwide as violation of the basic human rights. Researchers have also been documenting the health burden (WHO, 1999) and adverse intergenerational, demographic and socio-economic consequences of such violence. In addition, as more and more evidence demonstrates the association between intimate partner violence and spread of HIV/AIDS, addressing issues of status of women, including intimate partner violence must become an integral part of addressing the HIV/AIDS pandemic (UNICEF, 2000).

The Nigerian society is a highly patriarchal one, in which men have bloated egos. Though there is a high prevalence of domestic violence against women in Nigeria as many women have died, brutalised or maimed for life by their violent male counterparts, however, there is also a prevalence of domestic violence against men, which has largely remained under-reported (Adebayo, 2014). According to Watts and Zimmermann (2002), the under-reporting of domestic violence is almost universal and may be due to the sensitive nature of the subject. Husband punching, slapping, kicking, nail scratching, sex deprivation and killing are realities that occur in Nigeria.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

The tragedy is that men who find themselves in this situation hide and do not talk openly about their experience, as talking about it will bruise their ego and expose them to ridicule in a patriarchal society. I was beaten by my wife is a misnomer! It is unheard of in a male egoistic society. Hence such men prefer to suffer in silence until it becomes critical to the point of likely death (Adebayo, 2014).

Intimate partner violence (IPV) is the most common form of violence against women and consists of a range of physical, sexual, and emotional acts perpetrated against women by a current or former husband or intimate partner (Krug et al., 2002; Rahman, Nakamura, Seino, and Kizuki, 2012). Globally, the estimate of lifetime IPV prevalence ranged between 10% and 70% (Rahman, Nakamura, Seino, and Kizuki, 2013), while in sub-Saharan Africa the prevalence of IPV is between 20% and 70% (Ellsberg, Caldera, HerraWinkvist and Kullgren, 1999; Jewkes et al, 2002; WHO, 2013). Researchers in Nigeria found an IPV prevalence rate ranging between 17% and 34% (Antai, 2011; Osuora, Omolo, Kamweya, Harder and Mutai, 2012). The huge range of IPV prevalence estimates is assumed to be related to the acceptance of IPV as a justifiable punishment and societal norm in many parts of Africa (Osuora et al., 2012). In an analysis carried out from reportage of IPV against men in the Nigerian dailies ,the highest rate at which men were victims is 62% (Animasahun, Kayode and Amarachi, 2013).

Universally, studies about GBV have been taken from the angle of the women. And to support this, legislative and health measures are taken to protect the interest of women. The argument in support of this is that there are more reports and studies on female victims of violence than male. And some viewed the fact that reports on violence against the female will provide basis for studies on the male as victims, as legal and social contexts also address male victims. This is why literature abounds that domesticates violence as domestic and social phenomenon attributed to patriarchy, and women as victims and men as perpetrators (Animasahun, Kayode and Amarachi, 2013).

The study will provide an insight into the experience of Intimate Partner Violence among the married men in Ibadan North West local governments. It will also reveal the forms of Intimate Partner Violence experienced by the men and investigate the

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

reasons behind it. Furthermore, it will help to identify help seeking practices by those experiencing the act.

1.3 Justification of the study

In intimate partner violence, man is culturally assumed as the aggressor and the victim a female. Current research provides little insight into the risks a man faces if he is assaulted by a woman in an intimate relationship. Family violence research has focused on the relative risks that men and women face and mask the high number of men at risk, because of the large number of women who are injured as a result of domestic violence. Our judicial systems are based on the premise that guilt follows the offender, not the offended (Adebayo, 2014). The opposite is the case in violence against men in which shame and guilt becomes the hallmark of the victim with resultant possible multiple psychological effects such as drug and alcohol abuse, mood disorders, and suicide (Dvenye and Gbeneol, 2009). The present analyses indicate that men are among those who are likely to be on the receiving end of acts of physical aggression (Kumar, 2012). The extent to which this involves mutual combat or the male equivalent to "battered women" is at present unresolved (Adebayo, 2014).

Studies on IPV directed at men are less explored, however recently women's use of IPV and men's victimization is gaining growing attention (Obunikem et al., 2015). The study will provide data on men's experience of IPV especially within the community. There would also be evidence to demonstrate that women are perpetrators so that awareness could be created on the issue. This evidence could be used to provide information to health workers on the need to screen men for IPV and provide intervention to address the issue.

1.4 Research Questions

1. What is the attitude of married men towards IPV?
2. To what extent have married men experienced violence perpetrated by their partners?
3. What are the causes of perpetration of IPV towards men?
4. What are the help seeking practices among married men experiencing IPV?

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

1.5 Objectives of the study

The aim of this study is to investigate the experience of IPV among married men in Ibadan North West Local Government area.

The specific objectives are to:

- To determine attitude of married men in Ibadan North West Local Government on IPV
- To document the extent to which married men experienced IPV from their partners
- To identify the causes of perpetration of IPV towards men
- To identify help seeking practices among those experiencing IPV

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER TWO

LITERATURE REVIEW

2.0 Nature of intimate partner violence

WHO defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation' (Krug et al. 2002). Partner abuse can take a variety of forms including physical assault such as hitting, slapping, kicking and beating; psychological abuse such as constant belittling, intimidation and humiliation Justification for violence and coercive sex frequently evolves from social norms about the proper roles and responsibilities of men and women. Typically, men are given relatively free reign as long as they provide financially for the family. Women on the other hand are expected to tend the house, mind the children and show their husband 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. Intimate partner abuse occurs in all countries and transcends social, economic, religious and cultural groups (Fawole, Aderonmu and Fawole, 2005).

Domestic violence against men deals with domestic violence experienced by men or boys in an intimate relationship such as marriage, cohabitation, dating, or within a family. Whereas women who experience domestic violence are openly encouraged to report it to the authorities, it has been argued that men who experience such violence often encounter pressure against reporting, with those that do facing social stigma regarding their perceived lack of machismo and other denigrations of their masculinity. Additionally, intimate partner violence (IPV) against men is generally less recognized by society than IPV against women, which can act as a further block to men reporting their situation (Lupri and Grandin, 2004).

Thompson, Basile, Hertz, and Sitterle (2006) defined IPV as actual or threatened physical or sexual violence or psychological/emotional abuse. It includes threatened physical or sexual violence when the threat is used to control a person's actions. Various types of violence, whether physical, emotional, sexual, or even witnessing

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

violence, may influence the growing child to believe that the violence is normal (Fagan, 2005).

Common terms used to describe IPV are domestic abuse, spousal abuse, domestic violence, courtship violence, battering, marital rape, and date rape. The incidence of partner abuse varies based on different methods and definitions used to define the problem. Actions that are highly correlated with IPV events are risky behaviours such as engaging in high-risk sexual behaviours, tobacco and illicit drug use, drinking and driving, alcohol abuse (Roberts, Auinger, and Klein, 2005), ineffective social skills, and inability to manage anger (Foshee et al., 2008).

According to Schuler (2010), male victims of intimate partner violence are secluded victims in the American society. She opined further that increase of female perpetrators of intimate partner violence could be a rise in female aggression due to gang association.

In an empirical study cited by Johnson in 2005, it was found that males are as likely to be victims of intimate partner violence as women. This concept is in conflict with the feminist concept of intimate partner violence and had called to question the social control of gender and patriarchy. As a result, men who report abuse from an intimate partner are viewed as cowards. Extremely embarrassed by this predicament, male victims are afraid of being laughed at or scorned.

According to Adeyeri (2013), while it is a fact that women suffer as victims of domestic violence it is also a fact that men suffer as victims of domestic violence as well. While the majority of domestic violence victims are women, male-oriented abuse occurs more often than many think. Naturally, men are stronger than women, but that does not necessarily make it easier for them to have their way all the time. The problem is that the man who suffers domestic violence is hardly given a listening ear. He is first of all assumed to be the aggressor even if he has bruises all over him. An abused man faces a shortage of resources, scepticism from the police and other major legal obstacles especially when it comes to gaining custody of his children from an abusive mother.

The various advocacy and sensitization is more or less in favour of women victims, thereby leaving the men victims to suffer in silence. There is great similarity between

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

female and male victims and their abusers. The biggest difference is that male victims find themselves in the same position women were 30 years ago. Their problem is viewed as of little consequence, or they are to blame, and there are few available resources for male victims (Adebayo, 2014).

Domestic violence mostly leaves the victim depressed and anxious irrespective of gender. There may be a resort to alcohol abuse or drugs or engage in unprotected sex. Domestic violence can even trigger suicide attempts. Consequently, male victims should be listened to and cared for. Male victims also must be prepared to speak out their situations.

2.1 Attitudes of married men towards Intimate Partner Violence

A study was conducted in eight countries namely; Bosnia, Brazil, Chile, Croatia, Democratic Republic of Congo, India, Mexico and Rwanda where it was concluded that men's attitude towards IPV was shaped by prevailing norms related to masculinity and gender equality in most societies (Fleming, McCleary-Sills, Morton, Levtov, Heilman, Barker, 2015).

According to John (2010), culture in the local context in Nigeria incorporates belief and norms that assigns and regulates power relationships in society including marital relationships. He further stated that belief in the inherent superiority of males and a patriarchal society give men a proprietary right of ownership of women especially where the issue of bride price is a valued demand from in laws. Furthermore, in a multi country study conducted by WHO in 2010, the following were identified: • A man has a right to assert power over a woman and is considered socially superior • A man has a right to physically discipline a woman for 'incorrect' behaviour • Physical violence is an acceptable way to resolve conflict in a relationship • Sexual intercourse is a man's right in marriage • A woman should tolerate violence in order to keep her family together • There are times when a woman deserves to be beaten • Sexual activity (including rape) is a marker of masculinity • Girls are responsible for controlling a man's sexual urges.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

2.2 Extent of experience of Intimate Partner Violence

In 2013, the American Centres for Disease Control and Prevention (CDC) found that from a sample of 16,000 U.S. adults, 26% of homosexual men, 37.3% of bisexual men, and 29% of heterosexual men had been a victim of IPV. Also in India, more than 98% of Indian husbands face domestic violence (Punjab news 2012). In this group, 22,000 men have terminated their lives in reverse due to harassment from their wives. Also more than two – thirds of married men in India between the ages of 15 and 49 are victims of forced sex by their girl friends.

This emotional betrayal and sympathetic situation arises because patriarchy as an ideological mode defines the system of male domination and female subjugation in the society (Fayankinnu 2012). It defines sexist supremacy as men are perceived as the leader and thus superior to women. This is expected to be demonstrated in every male–female association (Fayankinnu 2012). A situation of overt and covert power. While overt power explains the ability to suppress or intimidate the women, covert power explains the situation of little or no importance exhibited in the men's attempt to treat the women as the weaker sex and thus becomes subtle, serene, calm and cool with the women (Fayankinnu 2012). When this is demonstrated to the fullest women tend to take advantage of men and thus reports of cases of violence against men in its physical form are got. If some men are capable of exhibiting their overt powers through violence, the women that are described as docile, gentle and imbued with covert powers to have the capability of displaying these powers. These powers are displayed through deliberate delay of food, grumbling, withholding of sex or demanding of sex when a man is fatigued or put up other acts that are likely to debase the ego or psyche of the man. This is what Kuhl (2001) referred to as domestic vandalism.

Fayankinnu (2012) in a study carried out in Nigeria reported that 84.2% of the sampled men reported to have experienced at least an act of domestic violence and that verbal or psychological violence took 76% and 60.8% respectively while sexual violence was 58.9% and 68.8%.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

2.3 Forms of intimate partner violence

There are many different forms of intimate partner violence, and a person may be subjected to more than one type at a time. Different types of abuse include:

- Physical Abuse
- Emotional or Psychological Abuse
- Sexual Abuse
- Economic or Financial Abuse

2.3.1 Physical Abuse

The most obvious form of abuse, physical abuse, is characterized by the infliction of injury or injuries. It is often the most visible type of abuse, and also the most lethal. Sometimes referred to as battering, physical assaults often start small, maybe a small shove during an argument, or forcefully grabbing a wrist, but over time, physical abuse usually becomes more severe, more frequent, and can result in the death of the victim. Physical violence in particular is very common among intimate partners in both developed and developing countries. Physical violence is the intentional use of physical force with the potential for causing death, disability, injury or harm (Adebayo and Kolawole 2013). Physical violence includes but it is not limited to, scratching, pushing, shoving and throwing, grabbing, biting, choking, shaking, slapping, punching, burning, use of a weapon and use of restraints or ones' body size, or strength against another person (Adebayo, 2014).

2.3.2. Emotional or Psychological Abuse

Defined as routinely making unreasonable demands or the intentional infliction of anxiety, hurt, guilt or fear through verbal or nonverbal acts, emotional abuse serves to degrade and undermine an individual's sense of self-worth and self-esteem while rejecting their opinions and needs. It is designed to further control the victim by instilling fear and ensuring compliance. It may include:

- Verbal attacks including name-calling, yelling, putting down, insults, humiliation, etc.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

Intimidation including gestures, looks, throwing/smashing/breaking things, punching the wall, throwing a glass, etc.

- Threats including threats to kill, threats to disappear with the children, threats to report the partner to Social Services as an unfit parent, threats to harm a significant third party (i.e. a family member), threats to leave or to commit suicide
- Isolating the victim from family members, friends, or regular activities (prevented from seeing or talking to others, not allowed to go out)
- Denying the abuse ever happened, shifting responsibility for abuse, or using the statement "It's your fault."
- Exposing a child to family violence, threatening to harm themselves, threats to harm property or pets

2.3.3. Sexual Abuse

Sexual abuse is defined as any sexual encounter without consent and includes:

- Any unwanted touching, unsafe or forced sexual activity, be it oral, anal or vaginal
- Forcing the victim to perform sexual acts
- Painful or degrading acts during intercourse (i.e. urinating on victim)
- Manipulating for sexual purposes
- Unwanted petting, fondling, beating sexual parts of the body, forced prostitution, sex with weapons, rape with a foreign object, etc.
- Forced stripping, forced sex when the partner refuses/is sick or tired
- Date rape or marital rape
- Excessive jealousy
- Sexual criticism
- Sadistic sexual acts

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

- Taking unwanted sexual photos and/or videos
- Undermining a person's sexuality with derogatory comments, withholding of sexual affection, and unfounded allegations of promiscuity and/or infidelity (i.e. "You are such a worthless slut/whore/etc.")
- Humiliating, criticizing, or trying to control a person's sexuality or reproductive choices

2.3.4. Economic or Financial Abuse

Defined as the control of a person's financial resources, as well as educational and employment opportunities, economic abuse can take many forms, from denying a partner all access to funds, to making the partner solely responsible for all finances (i.e. putting all the bills in the partners' name) while handling money irresponsibly himself/herself. It may include: Making, or attempting to make, a person financially dependent by maintaining control over all household income, and/or not disclosing family income or resources; Stealing from, defrauding, manipulating, exploiting or inappropriately using the victim's finances; Demanding pay checks; Forbidding employment/the search for a job, controlling partner's choice of occupation, or harassing the individual at his/her workplace or school; Preventing the partner from attending school; Making the partner beg for money for necessary items like personal hygiene items and children's items; Stealing or destroying the victim's personal belongings; Refusing to pay the victim court-ordered child or spousal support; Forcing the victim to obtain credit, then ruining their credit rating or future ability to obtain credit.

2.4 Causes of perpetration of intimate partner violence

Dutton and Nicholls (2005), write that traditional feminist theory "views all social relations through the prism of gender relations and holds, in its neo-Marxist view, that men (the bourgeoisie) hold power advantages over women (the proletariat) in patriarchal societies and that all domestic violence is either male physical abuse to maintain that power advantage or female defensive violence, used for self-protection. In this sense, any IPV committed by women against men is by way of self-defence. Linda Kelly writes that "in conceding that women do engage in acts of domestic

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

violence, female use of violence is justified as self-defence — a lifesaving reaction of women who are being physically attacked by their male partners.

In 2006, Medeiros and Straus conducted a study using a sample of 854 students (312 men and 542 women) from two American universities. They identified fourteen specific risk factors common amongst both males and females who had committed IPV; poor anger management, antisocial personality disorders, borderline personality disorders, tendency to dominate relationships, substance abuse, criminal history, posttraumatic stress disorders, depression, communication problems, jealousy, sexual abuse as a child, stress, and a general attitudinal approval of partner violence. In 2014, a study conducted in the United States involving 1,104 male and female students in their late teens and early twenties found that women are more likely than men to be controlling and aggressive towards their partners, more likely to demonstrate a desire to control their partners, and more likely to use physical aggression in ensuring that control. The main author of the study, Elizabeth Bates, wrote "this suggests that intimate partner violence may not be motivated by patriarchal values and needs to be studied within the context of other forms of aggression, which has potential implications for interventions."

In a study conducted in 2012, about 2,474 men in Africa according to the Domestic Violence and Victims Support Unit were beaten by their wives in 2011. The bone of contention against the men includes poverty, alcoholism, drug use, frustration, intimidation, irresponsibility and denial of sex (Alooma 2012).

However, studies about domestic violence in Nigeria are still at the teething age (Dvenye and Gbeneol 2010). Though this is caused by various factors such as the ego factor, that could not make a man report how he was battered by his wife, methods of identifying what constitutes violence against men, and whether the violence is motivated by self-defence from perceived and actual bodily and psychological threat from men or a retaliation of previous victimization has been a major problem to researchers. Another major flaw in information accessibility is the authenticity of data and information source on violence against men (VAM) that are used for analysis and judgment, and on availability of specific data on the men involved; since this will give clearer and authentic pictures than focusing on medical and police reports which may not always be available (Animasahun et al, 2013).

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

2.5 Effects and Consequences of IPV

The effects of intimate partner violence can be in different dimensions which include:

1. Effect on Children: There has been an increase in acknowledgement that a child who is exposed to domestic abuse during his upbringing will suffer in his development and psychological welfare (Dodd, 2009). Some emotional and behavioural problems that can result due to domestic violence include increased aggressiveness, anxiety, and changes in how a child socializes with friends, family and authorities. Problems with attitude and cognition in schools can start developing, along with a lack of skills such as problem-solving. Correlation has been found between the experience of abuse and neglect in childhood and perpetrating domestic violence and sexual abuse in adulthood (Sadeler, 1994). Additionally, in some cases, the abuser will purposely abuse the mother in front of the child to cause a ripple effect, hunting two victims simultaneously. It has been found that children who witness mother-assault are more likely to exhibit symptoms of posttraumatic stress disorder (PTSD) (Lehmann, 1995).

2. Physical Effect: Bruises, broken bones, head injuries, lacerations and internal bleeding are some of the acute effects of a domestic violence incident that require medical attention and hospitalization (Jones, 1997). Some chronic health conditions that have been linked to victims of domestic violence are arthritis, irritable bowel syndrome (Berrios, 1991)

3. Psychological Effect: Among victims who are still living with their perpetrators, high amounts of stress, fear and anxiety are commonly reported. Depression is also common, as victims are made to feel guilty for 'provoking' the abuse and are frequently subjected to intense criticism. It is reported that 60% of victims meet the diagnostic criteria for depression, either during or after termination of the relationship, and have a greatly increased risk of suicide (Barnett, 2001). The most commonly referenced psychological effect of domestic violence is Post-Traumatic Stress Disorder (PTSD). According to Vitanza, Vogal and Marshall (1995), PTSD (as experienced by victims) is characterized by flashbacks, intrusive images, exaggerated startle response, nightmares, and avoidance of triggers that are associated with the abuse. These symptoms are generally experienced for a long span of time after the

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

victim has left the dangerous situation. Many researchers state that PTSD is possibly the best diagnosis for those suffering from psychological effect of domestic violence, as it accounts for the variety of symptoms commonly experienced by victims of trauma.

4. Long-term Effect: Intimate partner violence can trigger many different responses in victims, all of which are very relevant for a professional working with a victim. Major consequences of domestic violence victimization include psychological/mental health issues and chronic physical health problems. A victim's overwhelming lack of resources can lead to homelessness and poverty.

Though more women are recipients of violence than men, the pay –back of the women which is more psychological than physical tends to have more lasting and devastating effects on men than the physical one which readily attracts attention and sympathy. Such actions as harassment, abuse, hunger and wrong diet are likely to produce more emotional effects than physical violence (Animasahun et al, 2013).

Also, when some men's ego are abused as in psychological torture, they go into alcoholism and the hangover can cause depression and thence induce high blood pressure and stroke.

The most recent guidelines of the United States Preventive Services Task Force found insufficient evidence for screening for family violence due to lack of studies showing that a primary care based screening intervention helps reduce harmful outcomes . In addition, the potential for negative outcomes of screening has not been examined. Rather, the success of screening interventions tends to be measured in number of disclosures rather than in improvement of the survivor's overall condition. Most studies of screening either lack a measure for the potential harm of disclosure or minimize such potential in written reports. Although studies have shown higher disclosure in certain specialties, the difference in outcomes by specialty has not been well described. Rhodes and colleagues reported that many inquiries about IPV in an emergency room setting by physicians were perfunctory and did not lead to documentation or referral for other help (Liebschutz, Battaglia, Finley and Averbuch, 2008).

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

2.6 Help seeking practices by men who experienced IPV

Determining the rate of IPV against males can be difficult, as men are often more reluctant than women to report their abuse or seek help (Sullivan, 2013). One of the reasons for this is that IPV against men is generally less recognized by society than IPV against women. Additionally, heterosexual male victims of IPV are often judged harshly for "allowing" themselves to be beaten by a woman. This view is based upon the general rule that men are physically stronger than women, and, therefore, should be able to prevent any kind of female violence; a view which disregards that violent women tend to use objects during IPV at a higher rate than violent men (Kumar, 2012).

Due to embarrassment, male victims do not approach professional services. Swan, et al (2008) noted two studies that examined the psychological aggression and physical violence of women, concluded that, "women use higher levels of moderate physical violence than their partners used against them and about the same level of severe physical violence," Male victims of intimate partner violence may experience broken limbs, stab wounds, teeth marks, deep scratches and lacerations, inappropriate comments, fear and intimidation, and emotional aggression (Barber, 2008). Consequently, these male victims may refuse physical examination by nurses, particularly female nurses or seek the support of health professionals and services (Barber, 2008).

2.7 Screening for IPV

What constitutes screening for IPV? Screening in medical practice is defined as a process designed to identify previously unrecognised disease or defect using tests, examinations or other procedures that are applied rapidly. Screening aims to sift out apparently healthy people from those who may have the disease. Screening is not usually diagnostic. It can be performed for the whole population (mass screening), involve a variety of tests on the same occasion (multiple or multiphase screening), and/or aim at the early detection of a specific condition in presumably healthy

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

individuals (prescriptive screening). For the purpose of this dissertation, however, screening for the 'disease' – in this case IPV – is the process of questioning patients or clients visiting health facilities about a possible history of physical, sexual or psychological violence from their intimate partners. Thus, clinicians are tasked routinely to raise the possibility of abuse with clients, regardless of the reason for their visit. This process, which is routine in several countries, is acceptable to women, and is regarded as good practice. A number of instruments have been developed and utilised to screen women for IPV, mostly within industrialised high-income countries (John, 2010)

Attempting definitions of the behaviours that constitute intimate partner violence has raised the question of having 'gold standards' that would determine an acceptable instrument to be used for its screening. However, the basis of a screening tool lies in its capacity to identify potential victims and meet the World Health Organisation's screening principles. Thus, a protocol that is simple, yet comprehensive enough to offer referrals and prompt management of IPV, is to be preferred. A universal screening protocol developed by the Taskforce on Health Effects of Woman Abuse, London, Ontario, Canada meets this criterion. The protocol aims to identify physical, sexual and/or emotional abuse and offers steps to be taken to manage them. In general, the protocol probes clients on whether they are experiencing abuse, offers information on domestic violence, offers support for victims of abuse, informs patients of legal and other remedies, enables the performance of a safety assessment, and makes access to referrals easy (John, 2010).

Despite the potential benefits of screening, studies have abundantly indicated that few healthcare providers screen their clients for IPV, which suggests that there are barriers to implementation. Such barriers may stem from individual, organisational and socio-cultural factors. These factors are likely to affect inquiry into IPV (barriers from the care provision perspective) as well as response to inquiry (barriers from the client perspective). Disclosure of IPV is likely to be affected by the methodology used to collect information on it. Screening protocol design issues, e.g. the formulation of questions etc, are likely to affect respondents' feelings of security and privacy, thereby affecting disclosure of abuse (Ellsberg et al., 1999; Krug et al., 2002; Swahnberg and Wijma, 2007). Thus, healthcare providers' knowledge and training are likely to play a major role in accurate screening. Though evidence in developed

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

societies suggests that women in general feel comfortable in responding to IPV questions in clinical settings (Stenson et al., 2001; Stenson et al., 2005; Swahnberg and Wijma, 2007), it remains unclear whether such findings can be replicated in developing countries. Data from African countries, including Nigeria, suggest that over 60% of women regard domestic violence as a justified domestic matter (Hindin, 2003; Oyediran and Isiugo-Abanihe, 2005; Lawoko, 2006), raising concerns about how they would view screening for IPV in healthcare. Such an attitude among women might work to impede screening for IPV in this societal setting (John, 2010).

Challenges to these endeavours rest on the identification of provider-related/client-related barriers to screening for IPV in healthcare, in particular in a Nigerian context, and on suggesting appropriate measures to manage such barriers. Identification and management of such barriers may prove significant milestones in improving provider-client relations, and thereby client satisfaction with care. From a research point of view, management of barriers to screening for IPV may improve disclosure and enhance better understanding of the extent, nature, and health and social implications of IPV in Nigeria and in similar societal contexts (John, 2010).

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

2.8 THEORETICAL FRAMEWORK

THE ECOLOGICAL MODEL

This model considers the complex interplay between individual, relationship, community, and societal factors. It allows an understanding of the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. The overlapping rings in the model illustrate how factors at one level influence factors at another level.

Besides helping to clarifying these factors, the model also suggests that in order to prevent violence, it is necessary to act across multiple levels of the model at the same time. This approach is more likely to sustain prevention efforts over time than any single intervention.

Individual

The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviours that ultimately prevent violence. Specific approaches may include education and life skills training.

Relationship

The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle-peers, partners and family members-influences their behaviour and contributes to their range of experience. Prevention strategies at this level may include parenting or family-focused prevention programs, and mentoring and peer programs designed to reduce conflict, foster problem solving skills, and promote healthy relationships.

Community

The third level explores the settings, such as schools, workplaces, and neighbourhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

perpetrators of violence. Prevention strategies at this level are typically designed to impact the social and physical environment – for example, by reducing social isolation, improving economic and housing opportunities in neighbourhoods, as well as the climate, processes, and policies within school and workplace settings.

Societal

The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

UNIVERSITY OF IBADAN LIBRARY

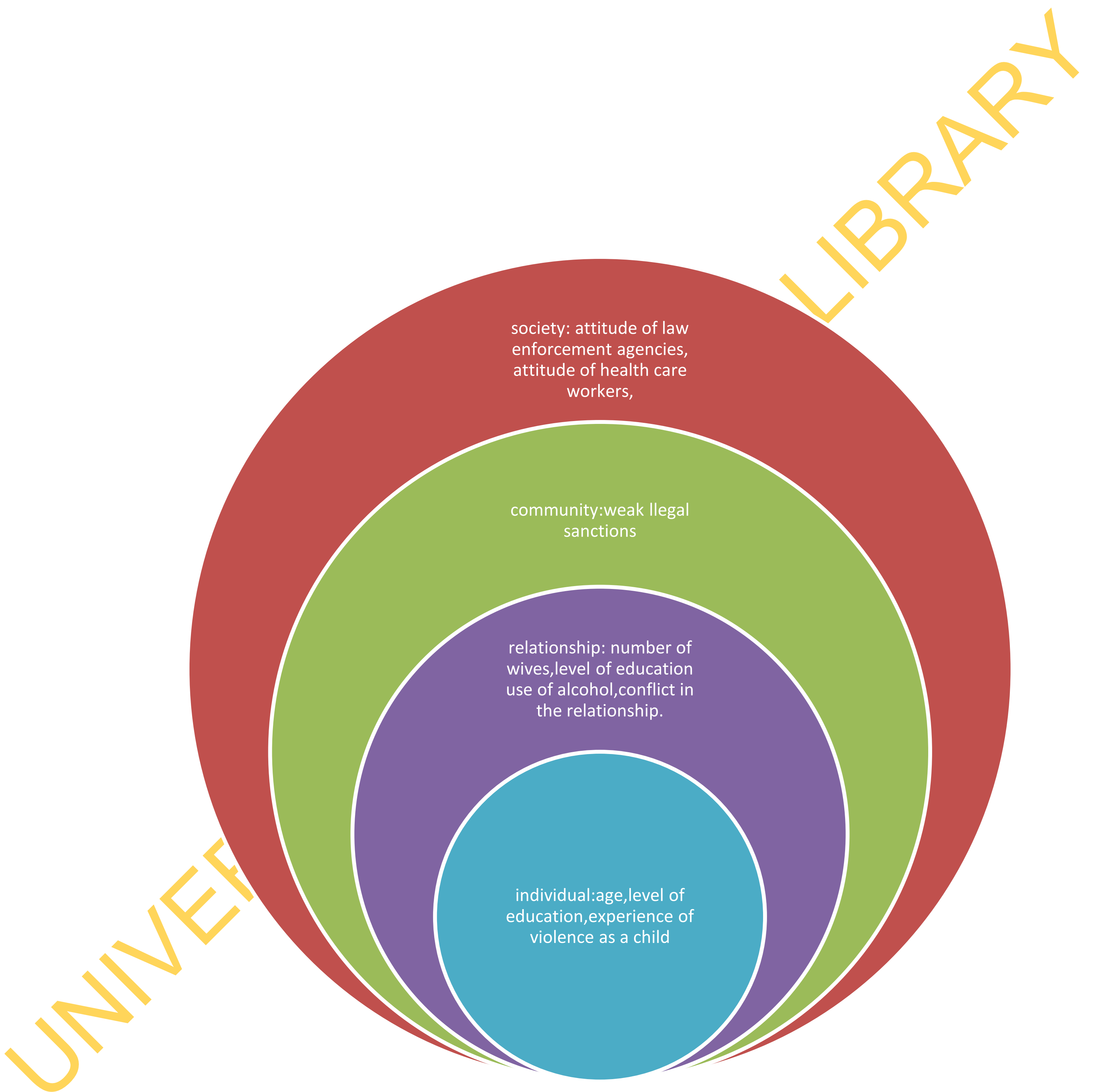


Figure2.1 Ecological Model

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER THREE

METHODOLOGY

3.0 Study design

The study was a descriptive cross-sectional design aimed at getting in depth information by investigating the experience of intimate partner violence among married men in Ibadan North West Local Government.

3.1 Description of the study area

The study was carried out in Ibadan North West Local Government Area in Oyo state. Its administrative headquarters is at Dugbe/Onireke. It has an area of 26km and estimated population of 196,844. Ibadan North West Local Government was created in 1991 by the then military head of state; Major General Ibrahim Gbadamosi. It is divided into eleven wards. It is bounded on the north by Ido Local Government, in the west by Ibadan South West Local Government, in the east by Ibadan North Local Government and in the south by Ibadan South East Local Government. The inhabitants include Yoruba, Hausa, Igbo and other tribes in Nigeria who engage in farming, trading and civil service. A predominantly urban area, Ibadan North West local government has within its jurisdiction: Onireke, Sapati, AgbedeAdodo, Beere, Asukunna, Ayeye, Dugbe, Eleyele, Inalende, Ologuneru etc to mention a few. The local government is home to one of the major sports facilities in the state i.e. Adamasingba sports complex. There are many health facilities in the area which include Jericho nursing home, chest hospital and Oniyanrin primary health centre. The state office of the Federal Road Safety Commission is located in the local government. The commercial activities in the local government take place mainly in Agbeni, Ogunpa, Dugbe and Eleyele markets. These account for 3% of the total land area. It must however be noted that commercial activities also take place along the major roads in the local government. The major industrial establishments in the local government are publishing, matchmaking, plantain and fruit processing industries which are located at Jericho and Eleyele areas respectively. There are many educational institutions which include both private and public enterprise.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

3.2 Study population

The study focused on the married men in Ibadan North West local Government area, Oyo state.

3.2.1 Inclusion Criteria: All men who are currently married were included in the research study. All married men who provided informed consent.

3.2.2 Exclusion Criteria: The unmarried men and all women were excluded in the research study.

3.3 Sample size

The sample size (n) was determined by using Leslie Kish (1965) sample size formula:

- $n = \frac{Z^2 p(1-p)}{d^2}$
- Where n=minimum sample size required
- Z=standard normal deviate usually set at 1.96 which is the confidence level
- P=Prevalence 62%
- In an analysis carried out from reportage of IPV against men in the Nigerian dailies, the highest rate at which men were victims is 62%.(Animasahun, Kayode & Amarachi, 2013)
- d=absolute deviation from true value set at 5%

From the above equation, a total of 362 respondents will be recruited for this study. To make up for loss due to follow, 10% of the total respondents would be calculated and added. Therefore, 10% of 362 will be 36.2. Total number of respondents is approximately 400.

3.4 Sampling techniques

Multi stage sampling technique which involved three steps were adopted so that there will be equal representation.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Stage one: At stage one from the 11 wards in the Ibadan north-west local government a deep ballot system was adopted to select 7 wards to represent the entire population due to heterogeneous nature of the population.

Stage two: the stratified method was used to group the selected wards into three categories: Urban, Urban-slum and Transitory.

Stage three: the houses within the communities were selected by purposive sampling. The local government could not provide adequate data on the number of houses; however an estimate was given as approximately 650 households. Respondents were selected randomly from this sample.

3.5 Instrument for data collection

Quantitative method was used to obtain data. The questionnaire was semi-structured and included both open-ended and closed-ended questions. Questionnaires were interviewer administered (See appendix I for the questionnaire). The questionnaire consisted of 5 sections. Section A had sixteen (16) questions; section B contained eleven (11) questions. Section C had four (4) questions; section D constituted the bulk of the questionnaire with thirty-three (33) questions and section E had seven (7) questions in all. The questions were adapted from the National Demographic Health Survey that was published in the year 2013.

- Section A: addressed the socio-demographic characteristics of the respondents
- Section B: this focused on the attitudes of the respondents towards perpetration of violence
- Section C: explored the family history of violence
- Section D: documented the extent of experience of intimate partner violence
- Section E: examined the health consequences as well as help seeking practices among the victims of intimate partner violence.

3.6 Validation and Reliability of the Instrument

3.6.1 Validity

The draft of the questionnaire was developed through consultation of relevant literatures, review by experienced researchers to ensure face and content validity. Comments from supervisor were used to further fine-tune the instrument. The step

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

taken to ascertain the validity of the study instrument before the commencement of the study was that the instrument was pre-tested among married men in Ibadan North local government which shared similar characteristics with Ibadan North West local government. Necessary corrections were effected based on the analysis of the pre-test. Some of the questions that were open-ended were changed to close-ended to facilitate appropriate responses.

3.6.2 Reliability

The questionnaires used in pre-testing were coded and analysed using Cronbach's Alpha correlation coefficient Statistical Package for Social Sciences (SPSS) version 20. Alpha (Cronbach's) is a model of internal consistency, based on the average inter-item correlation. This was done to ascertain the psychometric properties of the instrument. According to this approach, a result showing correlation coefficient equal or greater than 0.05 is said to be reliable. The result of the analysis of the data collected during the pre-test was 0.861 which shows that the instrument is very reliable.

3.7 Data Collection Process

Six male research assistants were recruited for the study. Three of them were fresh graduates from the university while the other three were secondary school certificate holders. They were fluent in English and Yoruba languages. Training for the assistants lasted for three days with each session lasting for five hours each. The training commenced with self introduction of the trainees, the investigator followed by background of the study and objectives. Contents of the training focused on interview techniques, interpersonal and communication skills. Demonstrations and role plays were employed to ensure transfer of skills. A copy of the instrument was given to each of the trainees to take home and read over for better understanding. This was also done to ensure that issues generated in the course of reading through would be thrashed out on subsequent meeting days.

The draft questionnaire and its Yoruba translation were reviewed for content validity by the researcher's supervisor. The Yoruba version of the questionnaire was later back-translated to English by another Yoruba language expert. Visits were made to all

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

the wards in company of four research assistants to establish rapport with them and to intimate them with the study objectives prior to the interview. The administration of questionnaires were done by the trained six research assistants on married men (within the urban, urban slum and transitory sections of the IBNWLGAs') that gave their consent to the research ethics read to them at the point of interview.

Face to face interviews were conducted for the respondents in a confidential location that is void of distraction for the respondents. Face to face interviews was conducted because of the nature of the study. It is important to observe non verbal cues of the respondents and to elicit the appropriate responses to the questions. The data collection process involved the following steps:

1. Identification/ visits to each of the wards
2. Paying courtesy calls on the head of each ward to intimate him about the commencement of the study and to seek for permission to conduct interviews.
3. Administration of the questionnaires to the study participants

3.8 Data Management

The investigator checked all the administered questionnaires and edited them for the purpose of completeness and accuracy. Serial numbers were assigned to each questionnaire for easy identification, also for correct data entry and analysis. A coding guide was developed to code and enter each question into the computer for analysis. Analysis was done using the Statistical Package of SPSS Version 20. The data entered were subjected to descriptive and inferential statistical analyses. Finally information obtained were summarized and presented in tables and charts.

3.9 Data Analysis

Efforts made to analyse the data include the following:

1. The quality of information collected was checked by the researcher in the field. This entails reviewing the pattern of responses of each participant as recorded in the questionnaire. Problems discovered during data collection were immediately resolved in the field.
2. A serial number was assigned to each of the questionnaires for easy identification and recall of any instrument with problems.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

3. Administered questionnaires were edited and coded by the investigator with the use of coding guide. The data in each questionnaire was entered into a computer for analysis.
4. The data was analysed using both inferential and descriptive statistics. Student t-test was used in the analysis for test of relationships.

There were seven items considered under physical violence. These are; slaps, use of sharp objects or broken bottle, use of dangerous weapons, throwing heavy object, kicking, dragging or beating the partner, biting and punching. These items were assigned one point each with an aggregate of seven points for the physical form of violence. Respondents were then scored based on their experience of at least one form. The experience of the men were computed against the age, level of education, number of wives, years of marriage and use of alcohol with the use of student t-tests.

Under psychological violence, items considered were as follows; belittling and humiliating, intimidating and scaring, insulting and making him feel bad, ignoring and treating him indifferently and nagging. The maximum number of scores attainable was five points based on the premise that each item has been assigned one point each. The respondents who had experienced at least one form of this psychological violence were calculated and these were computed against the demographic variables earlier mentioned.

Sexual violence had five items which were equally assigned one point each making a total of five points. Respondents who experienced at least one form of sexual violence were compared with the age, level of education, number of wives, years of marriage and use of alcohol using the student t test.

The higher the score, the more the experience of violence. This applies to the three forms of violence.

3.10 Ethical Considerations

This study was consistent with the ethical principles guiding the use of human participants in research. Ethical approval was sought from the Oyo State Ministry of Health Ethical Review Committee (appendix iii). Informed consent was obtained from each participant before enrolling him into to the study. However, participants were given opportunity to withdraw freely during the study. No identifier such as

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

names of respondents was used. Confidentiality of each participant was maximally maintained during and after the collection of his data.

Information gathered from the respondents was stored in the computer and this cannot be accessed by unauthorized persons.

3.11 Limitations of the Study

The study was very sensitive as men who are exposed to intimate partner violence were viewed as "weak or cowards" in the patriarchal society we are in. Therefore it was not an easy task eliciting such information from them. It should also be noted that men find it difficult to open up on history of violence in their own family too.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER FOUR

RESULTS

4.1: Background characteristics

The social demographic characteristic of respondents is presented in Table 4.1.1 The ages of the respondents ranged from 20- 75 years with a mean age of 40.5/± 9.93 .The majority (79.5%) of the respondents were Yoruba. Highest level of education of the respondents surveyed were tertiary education at 46.3%. At 70%, Christians constituted majority of the respondents interviewed. Three hundred and fifty five (88.5%) respondents were in monogamous marriages while 2.3% had more than two wives. The years of marriage ranged from one to sixty years, at 59.3% were the respondents who had been married for ten years and less which was the highest. From the list of occupations engaged in by respondents, self employed men ranked as the highest at 31.3% while civil servants constituted 23% of the total sample.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table 4.1.1: Socio- Demographic Characteristics (A) **n=400*

Age (Years)	**Frequency**	**Percentage (%)**
20-29	27	6.8
30-39	169	42.3
40-49	125	31.3
50-59	51	12.8
60-69	16	4.0
70 and above	4	1.0
No response	8	2.0
Religion		
Christianity	280	70.0
Islam	118	29.5
Traditional	1	0.3
No Response	1	0.3
Educational qualifications		
None	5	1.3
Primary School	50	12.5
Secondary School	157	39.3
Tertiary	185	46.3
No Response	3	0.8
Number of wives		
1	354	88.5
2	32	8.0
More than 2	9	2.2
Years of marriage		
1-10	237	59.3
11-20	90	22.5
21-30	39	0.3
31-40	17	31.3
41-50	6	28.0
51-60	2	10.8
No response	9	2.3
Occupation		
Unemployed	1	0.3
Self Employed	125	31.3
Businessman	112	28.0
Private Organization	43	10.8
Civil Servant	92	23.0
Retired	4	1.0
No Response	23	5.8

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Background drinking and smoking habits

The respondents drinking and smoking habits revealed that 56.8% respondents reported that they had ever drunk alcohol among which current drinkers were 62.1%. A total number of seventy four respondents had ever smoked cigarette while thirty (40.5%) are current smokers.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table: 4.1.2: Percentage response on alcohol related issues

Alcohol related issues	Frequency	Percentage
Ever drank alcohol	227	56.8
Currently drinking alcohol	141	62.1
Alcohol intake in the last one week	116	82.3
Ever smoked a cigarette	74	18.5
Current smokers	30 (of 74)	40.5

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Types of alcohol intake

Further analysis shows the types of alcohol intake in Figure 4.1 a total percentage of 45% respondents chose beer as the type of alcohol they drink, 18% drink palm wine, 17% drink wine, 16% drink beer while 4% drink ogogoro

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

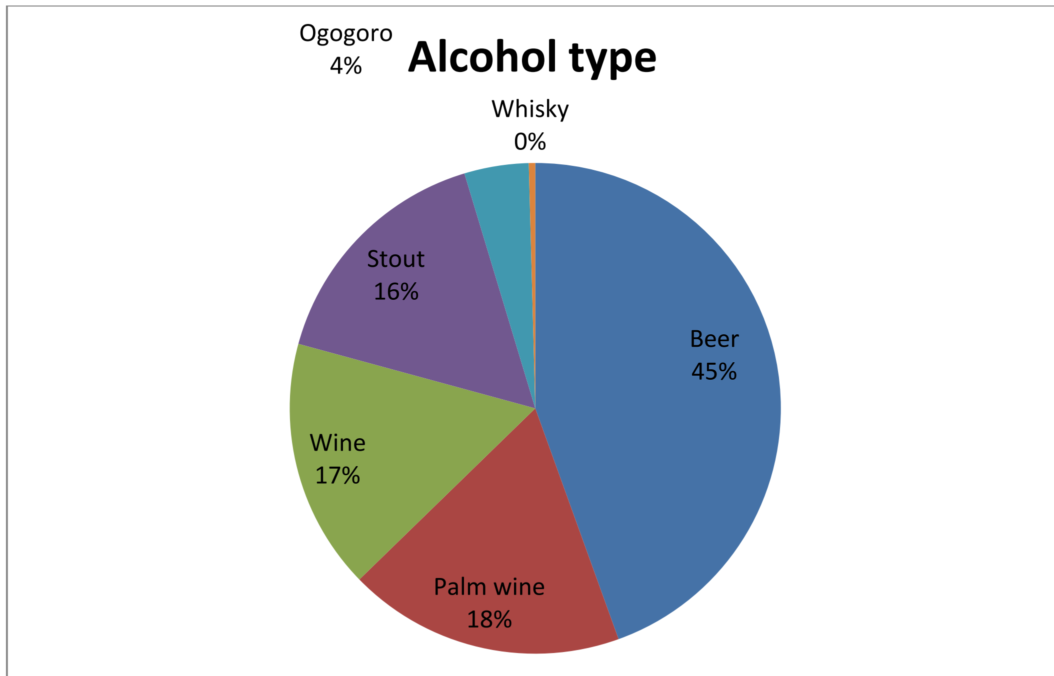


FIGURE 4.1: TYPES OF ALCOHOL INTAKE

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4.2 Attitudes towards perpetration of violence

A large percentage of the respondents (83.3%) perceived that it is not the duty of a man to beat his wife if she misbehaves. Almost half of the respondents (40.5%) supported the idea that men ought not to talk to their wives harshly. A good number of the respondents (60%) expressed a positive view that a man has the right to have sex with a woman on whom he has spent a lot of money on. Majority of the respondents (73.5%) agreed that women usually say 'no' to the first sexual gestures from their men but they will yield if the man put enough pressure on them. Reasons like a married man forcing his wife to have sex with him (57.5%), men coercing their wives to have sex with them (48.3%), the right of a man to have sex with the woman on whom he has paid bride price (60%), women provoking their husbands to have sex with them forcibly (48.8%), women enjoying sex better when they are forced (44%) and a man having the right to insult or belittle his wife (54%) were all adjudged to be correct by the respondents. However, there were just a few of the respondents (45.5%) who felt that rape does not occur when a woman refuses sex in the matrimonial setting.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table 4.2 Attitudes towards perpetration of violence

Statements about violence	**Yes n (%)**
A man has the duty to beat up his wife if she misbehaves	51(12.8%)
A man has the right to talk harshly to his wife if she refuses his instruction	209(52.3%)
A man has right to have sex with his partner if he has spent a lot of money on her	240(60.0%)
Women usually say 'no' to the first sexual gestures from their men but they will yield if the man put enough pressure on them	294(73.5%)
A married man can force his wife to have sex with him	148(37.0%)
Men sometimes sexually coerce their partners whenever they are unable to control their sexual appetite and it is usually understood by their wives	193(48.3%)
A man has the right to have sex with the woman on whom he paid her bride price at any time and at all cost	137(34.3%)
Rape occurs when woman refuses her husband to have sex with him	180(45%)
Women at times provoke their husband to have sex with them forcefully	195(48.8%)
Some women enjoy sex better when their husband apply force on them	176(44.0%)
A man can insult his wife or make her feel bad about herself	173(43.3%)

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4 .3 Family history of intimate partner violence

From table 4.3, it can be deduced that: a total number of three hundred and twenty five respondents (81.3%) had not witnessed a situation where the father hit the mother physically. Some (32.8%) responded positively that their fathers insulted their mothers. When the respondents were asked if their father had ever accused the mothers wrongly, 24.5% responded in the affirmative. Majority of the respondents (374) claimed that their fathers had never thrown an object at their mothers before.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table 4.3: Family history of intimate partner violence

Statement	Yes n (%)
Ever witnessed a situation where your father hit your mother	70(17.5)
Your father insulted your mother verbally	131(32.8)
Your father accused your mother wrongly	98(24.5)
Your father threw an object at your mother	21(5.3)

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4.4: Experience of intimate partner violence

The types of violence perpetrated by the wives are physical, psychological and sexual. As shown in figure 4.2.1, forms of physical violence ever experienced by the respondent are slaps (13%) which is followed by throwing an object at 7.4%. the least forms of physical violence recorded are use of sharp objects, kicking or dragging and use of dangerous weapons all at 3.6%. Figure 4.2.2 showed the occurrence of physical violence in the previous six months preceding the study. From a total number of fifty-one men who were ever slapped by their wives, 58.8% experienced it in the last six months. A total number of fourteen partners had ever used sharp objects on the men, from whom 57.1% of the men experiencing it in the last six months.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

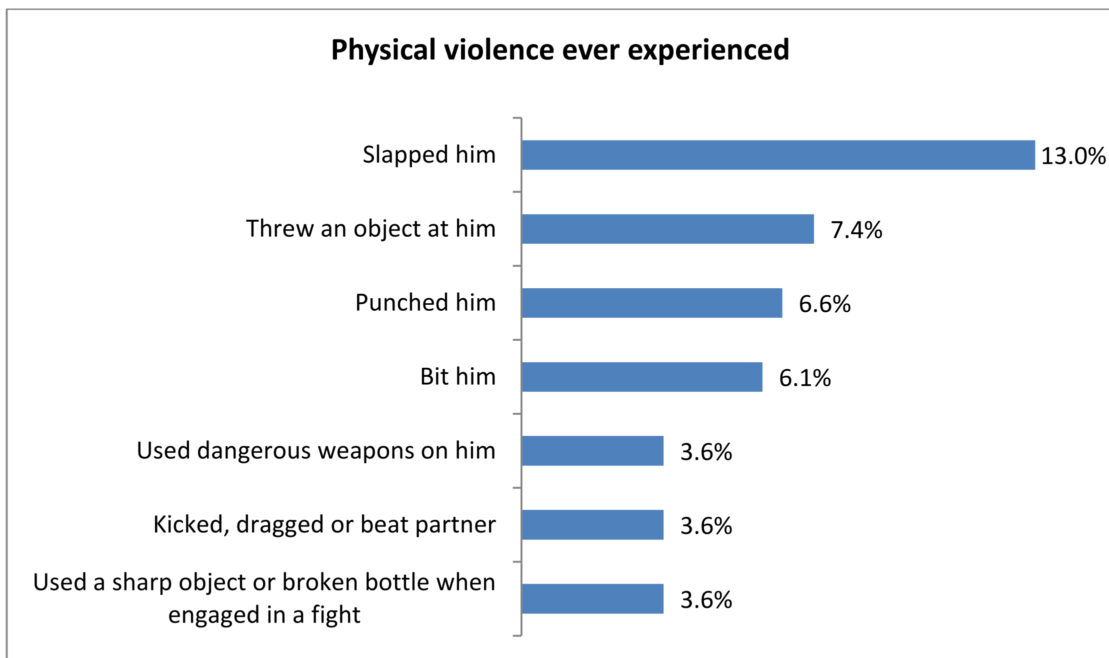


Figure 4.2.1 Forms of physical violence ever experienced by the men

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

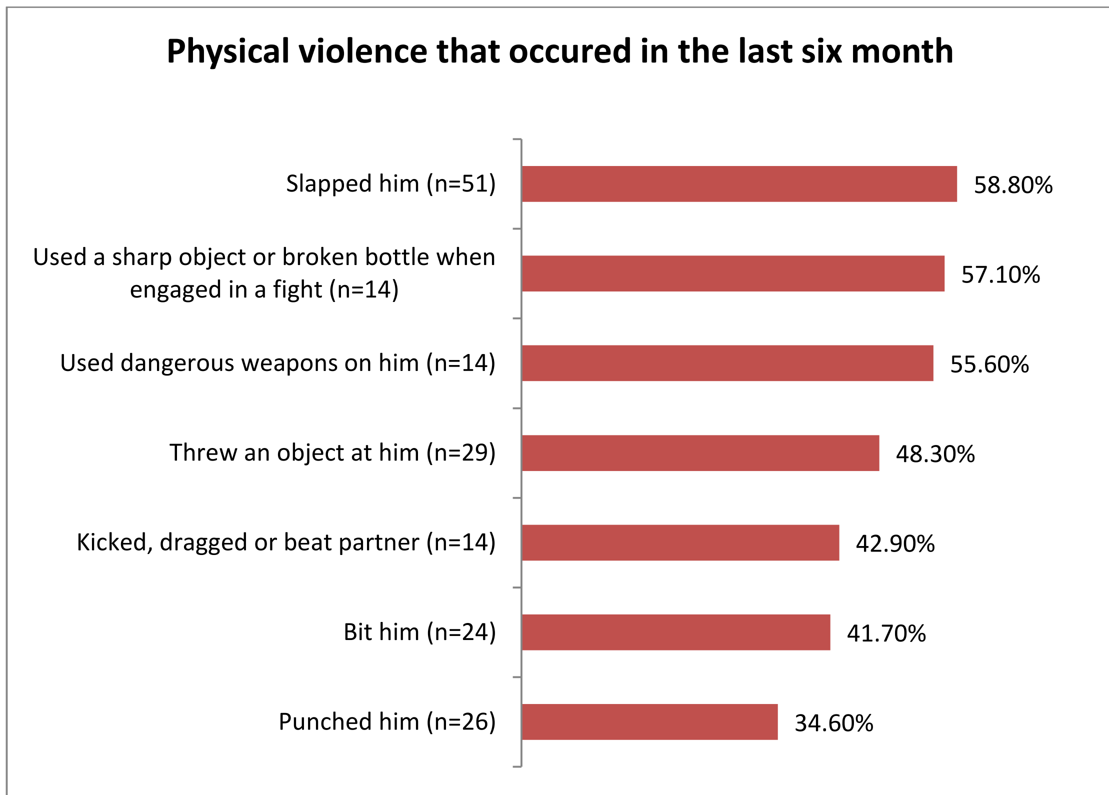


Figure 4.2.2 Forms of physical violence experienced by the men in the last six months

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

4.4.1 Experience of psychological violence

Quite a number of women subject their spouses to psychological violence through nagging (36.2%), treating the men indifferently ranks next to this at 34%. The least form of psychological violence experienced by the men is belittling them and humiliating them in front of other people (13.5%).

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

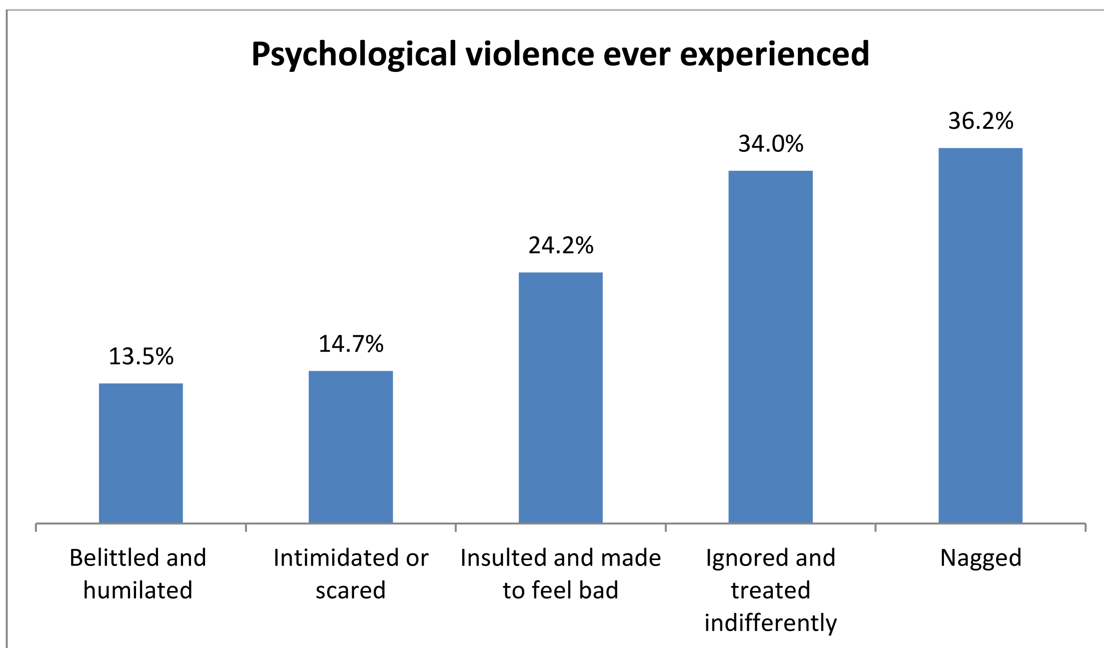


Figure 4.3 Forms of psychological violence ever experienced by the men

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table 4.4 Experience of psychological violence

Psychological violence behaviour	Occurred in the last six months		Total
	Yes n (%)	No n (%)	n (%)
She ignore and treat indifferently	121(91.0)	12(9.0)	133(100)
She nagged him	119(85.0)	21(15.0)	140(100)
She belittled and humiliate him	30(56.6)	23(43.4)	53(100)
She insulted and made him feel bad	71(74.7)	24(25.3)	95(100)
She did things to intimidate or scare you	29(58.0)	21(42.0)	50(100)

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4.4. 2 Experience of sexual violence

The respondents experienced sexual violence most (29.2%) when their partners refused to have sex with them in order to hurt them. Respondents (7.5%) were forced to do something sexually that they found degrading or humiliating by their spouses. 4.4% of the men also engaged in sexual intercourse with their wives because they were afraid of what they might do to them.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

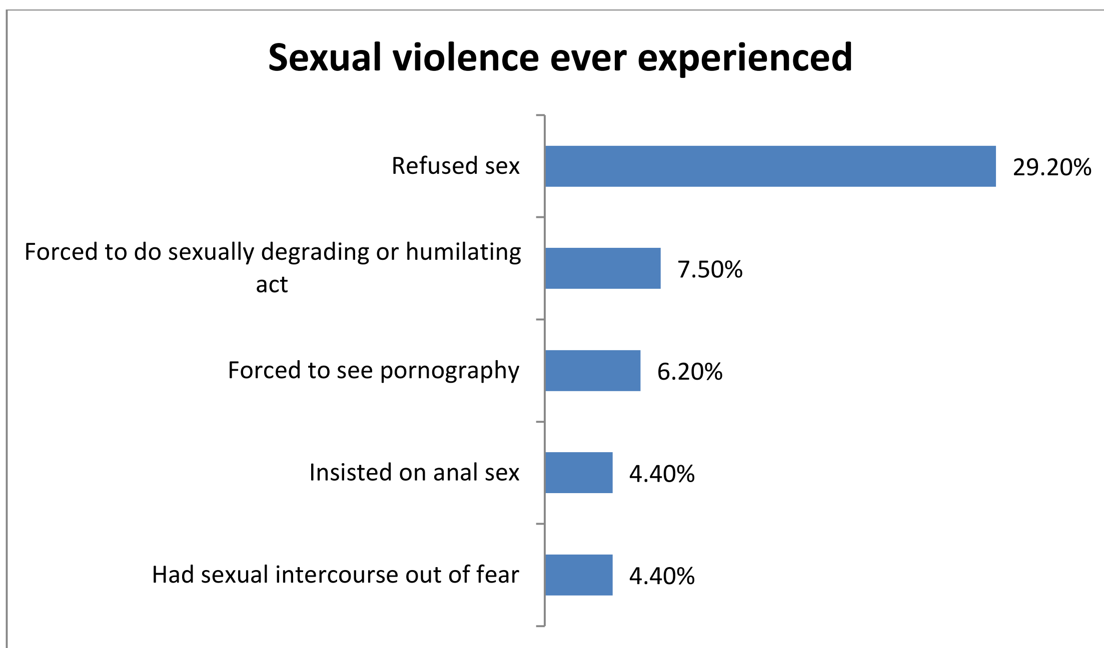


Figure4.4 Forms of sexual violence ever experienced by the men

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table 4.5 Experience of sexual violence in the last six months

Sexual violence behaviour	Occurred in last six months		Total
	n (%)	N (%)	(%)
She forced him to see pornography	20(83.3)	4(16.7)	24(100)
She refused to have sex with him	96(84.2)	18(15.8)	114(100)
She forced him to do sexually degrading or humiliating acts	15(51.7)	14(48.3)	29(100)
He had sexual intercourse out of fear	7(41.2)	10(58.8)	17(100)
She insisted on having anal sex	15(65.2)	8(34.8)	`23(100)

- *Non responses were excluded*

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

From figure 4.5:The percentage of men who experienced psychological violence alone is 30.7% which is the highest, followed by sexual violence (21.2%), physical violence (10.8%) is the least form of violence ever experienced alone by the men. Men who have ever experienced all the three forms of violence are 6.1%, while 16.2% had ever experienced psychological and sexual violence. This is the highest figure when comparing those who had experienced at least two forms of violence.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

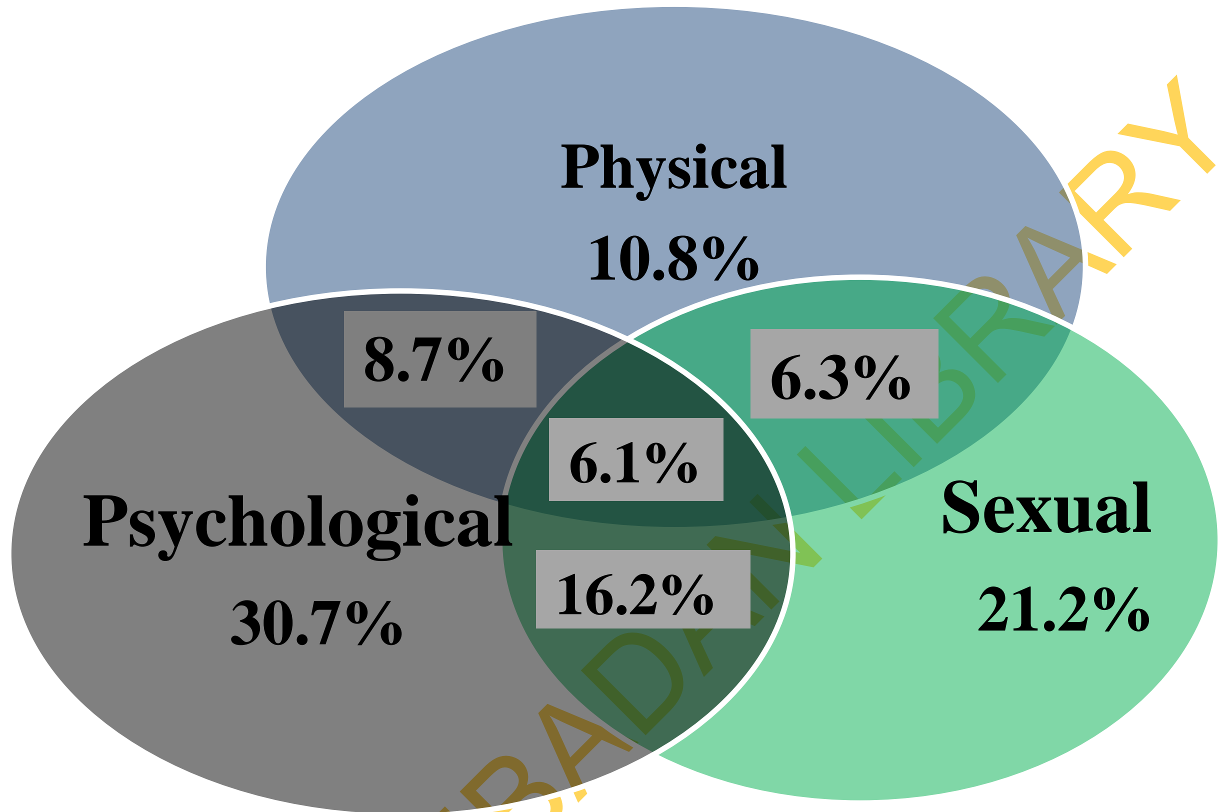


Figure 4.5: Forms of violence experienced by the respondents

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4.5 Reasons for the experience of IPV

The outline of the reasons the men gave which accounted for why IPV is being perpetrated against them as displayed in the table below. Finance ranked high in the list as two hundred and forty one (68.5%) respondents agreed that IPV occurs because of this. Lack of understanding between couples also contributed to the perpetration of violence. Lack of sex is also a major cause of violence as one hundred and ninety three respondents (55.3%) said so. Other reasons being jealousy (50.3%) and infidelity (52.8%). Reasons such as religious (29.7%) and alcohol (41.1%) do not contribute to the men's experience of violence.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table 4.6: Reasons for the experience of IPV

Reasons	**Yes** n (%)
Finance	241(68.5)
Lack of understanding	237(66.5)
Lack of sex	193(55.3)
Infidelity	185(52.8)
Jealousy	179(50.3)
Alcohol	148(41.1)
Religious	103(29.7)

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4.6 Health consequences of intimate partner violence

The graph displayed that eighteen respondents (4.5%) had suffered physical injuries as a result of violence inflicted by their wives.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

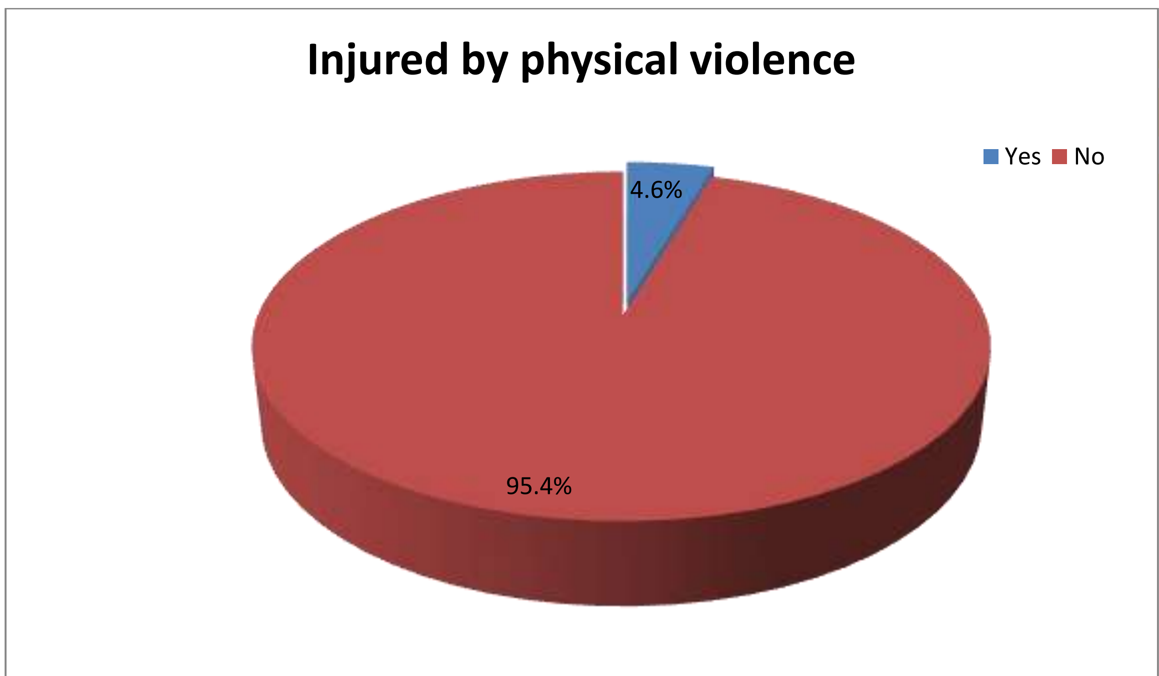


Figure 4.6 percentage injured by physical violence

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4.7 Type of injury sustained from wife and hospital attendance

Injuries suffered by respondents' as a result of physical violence by their wives include fractures (1%), cuts (0.8%), with the least being bruises at 0.3%. A small percentage (3%) of the respondents admitted visiting the hospitals as a result of injuries sustained during violence in the home.

4.8. Disclosure of injury and alternative to non disclosure

Respondents did not admit disclosing the real cause of their injury when they had to seek for help outside the home. Respondents (99.0%) did nothing while two (0.5%) lied and another 0.5% had a form of self treatment.

4.9 Reasons for seeking help and steps to take if it happens again

Majority of the respondents (99.5%) did not seek for help while only two of them sought for care. Majority of the respondents (98.5%) declined comment on what to do if the event occurs again. A small percentage of 0.2 respondents claimed that it will not happen again and that they would keep off the relationship.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4.10 Test of relationships between selected socio-demographic variables and experience of Intimate Partner Violence.

The socio-demographic variables that were tested against the forms of violence are age, level of education, number of wives, years of marriage and intake of alcohol. T test was performed as reflected in table 4.7. There is no significant relationship between these variables and experience of physical violence. However, considering the age of the respondents, it could be perceived that men aged more than 50 years experienced physical violence more. Respondents who had more education experienced physical violence more than those who had no form of formal education. Men who had more than one wife were exposed to physical violence more while those aged below 30 years had more experience also. Those that took more alcohol had more experience of physical violence.

From table 4.7.1, there is no significant relationship between the variables and experience of psychological violence. Respondents who are less than 50 years of age had a mean score of 1.28 which indicated that they experienced psychological violence more. The men that had no form of formal education had more experience of psychological violence with a mean score of 2.4. The more wives they married, the more their experience of violence. As they advanced in years of marriage, there is a reduction in experience of psychological violence. The level of alcohol intake increased with experience of psychological violence.

Table 4.7.2 showed that there is significant relationship between years of marriage and experience of sexual violence. The younger the men are, the less the experience of sexual violence. The men that had no form of formal education experienced sexual violence more. Marriage to just one wife exposed them to sexual violence. While intake of alcohol increased with experience of sexual violence.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

Table 4.7 Socio-demographic variables and experience of physical violence

Experience of Physical Violence	N	Mean	Std Deviation	Std Error Mean	t	Df	p-value
Age							
Less than 50 years	322	0.42	1.111	0.062	-0.099	391	0.92
50 years and above	71	0.44	1.052	0.125			
Level of Education							
No Education	5	0.60	0.894	0.400	.350	395	0.73
Had Education	392	0.42	1.124	0.057			
Number of Wives							
One	354	0.39	1.046	0.056	-1.329	43.516	0.19
More than One	41	0.76	1.714	0.268			
Years of Marriage							
30years and below	366	0.41	1.126	0.059	0.054	389	0.96
Above 30years	25	0.40	1.080	0.216			
Ever drank alcohol							
Yes	227	0.49	1.213	.081	1.035	398	0.30
No	173	0.37	1.035	.079			

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table 4.7.1 Socio-demographic variables and psychological violence

Experience of Psychological Violence	N	Mean	Std Deviation	Std Error Mean	t	Df	p-value
Age							
Less than 50 years	322	1.28	1.806	0.101	0.789	391	0.431
50 years and above	71	1.10	1.465	0.174			
Level of Education							
No Education	5	2.40	1.517	0.678	1.519	395	0.129
Had Education	392	1.21	1.740	0.088			
Number of Wives							
One	354	1.21	1.761	0.094	-0.705	393	0.481
More than One	41	1.41	1.581	0.247			
Years of Marriage							
30years and below	366	1.23	1.750	0.091	0.645	389	0.519
Above 30years	25	1.00	1.633	0.327			
Ever drank alcohol							
Yes	227	1.36	1.473	0.098	1.641	398	0.102
No	173	1.07	2.031	0.154			

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Table 4.7.2 Test of relationship between socio-demographic variables and sexual violence

	N	Mean	Std Deviation	Std Error Mean	t	Df	p-value
Age							
Less than 50 years	322	0.53	0.847	0.047	1.119	391	0.264
50 years and above	71	0.41	0.645	0.077			
Level of Education							
No Education	5	0.80	0.837	0.374	0.748	395	0.455
Had Education	392	0.52	0.846	0.043			
Number of Wives							
One	354	0.51	0.859	0.046	0.191	393	0.849
More than One	41	0.49	0.597	0.093			
Years of Marriage							
30years and below	366	0.52	0.856	0.045	1.893	35.651	0.067
Above 30years	25	0.32	0.476	0.095			
Ever drank alcohol							
Yes	227	0.54	0.888	0.059	0.661	398	0.509
No	173	0.49	0.782	.0059			

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

CHAPTER FIVE

DISCUSSION, RECOMMENDATION AND CONCLUSION

5.1 DISCUSSION

This study assessed the experience and perpetration of intimate partner violence among married men by their wives. The implications of these violent behaviours for health planning are discussed in this chapter. These offered recommendations to address the problem. The major findings of the study are as follows:

- Married men experienced the three forms of violence
- The experience of psychological violence was more than physical and sexual
- There is a significant relationship between intake of alcohol and experience of psychological trauma
- Married men who witnessed violence as a child also had the experience as adults.
- The experience of IPV could result to physical injuries

This Domestic Violence (IPV) is not confined to any segment of society as it occurs across ethnic, racial and socio-economic boundaries and the rates are similar across rural and urban area (Valentine, Oehme and Martin, 2012). The perpetrators include people from all occupations of life. This was also observed in this study as married men from all walks of life participated in the study.

Of all the socio-demographic variables examined (age, level of education, years of marriage, and number of wives) middle-aged men experienced more forms of violence than others in the study. A good number of the respondents who acquired more than a secondary school education also had high forms of violence. This might have been because educated people are more exposed to information and more aware of their rights.

In this study, majority (56.8%) of the respondents take alcohol and upon further analysis, the relationship between alcohol intake and experience of psychological violence was significant. They might have resulted to alcohol use and abuse because of psychological trauma being experienced at home. This finding is similar with the

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

report by Animasahn, et al (2013) that states that when the ego is abused due to psychological torture, men go into alcoholism.

This study revealed that 32.8% of the respondents witnessed some form of violence towards their mothers by the spouses. This might have shown that violence learnt from the parents is being repeated by some of the respondents in this study. This is similar to the finding from a study by (Whitting et al, 2009), where experiencing violence as a child increases the likelihood of violence in one's adult life. Also in this study, psychological form of violence ranked highest as the most commonly suffered by men. This might be because of the physical strength of women which does not match that of the men therefore translating to psychological trauma. This is new information because previous studies (Odimegwu, 2012,) and (Kumar, 2012) had shown that physical violence is the higher form of violence experienced by men.

The consequences of IPV range from immediate and long term health outcomes to economic effects. These include physical injuries leading to contusions, abrasions, trauma-related joint disorders, acute sprains and strains, low back pain, cervical pain and degenerative joint disease. Others are psychosocial /mental disorders - substance abuse, family and social problems, depression, anxiety/neuroses and tobacco use (Agada, 2011). In this study, respondents suffered a wide range of health consequences such as bruises (0.3%), cuts (0.8%), fractures (1%), and sprains (0.5%).

The most common reasons for not reporting domestic violence to police are that victims view the incident as a personal or private matter, they fear retaliation from their abuser, and they do not believe that police will do anything about the incident (Greenfield et al, 1998). This is similar to the findings from this study as the men found it difficult to report cases of violence against them.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

5.2 Recommendations

In view of the findings of this study and implications of violence on the health of men and the children inclusive, the following recommendations on what needs to be done to identify and curb perpetration of violence against men by their intimate partners are made.

1. There should be creation of awareness in the society on the growing scourge of men as victims of IPV.
2. Development of Policies that will provide for the needs of the victims must be put in place. They should not be victimised by the legal system
3. Health workers must be educated on how to identify and treat victims.
4. There should be greater advocacy to enlighten the public about the existence and reality of the evil of domestic violence against men by government agencies and civil rights organizations. This will help in groups and civil balancing the gender discourse on domestic violence and bring about better families in the Nigerian society.
5. Heads of household within the community should be instrumental in providing counsel to victims and the perpetrators, social support groups for women would equally be instrumental in addressing the issue.

5.3 Implications for health promotion and education

The findings from this study have implications for reproductive health education. From this study, it was deduced that the men experience different forms of intimate partner violence. However this population does not disclose this occurrence due to the society they live in and their ego as men. Therefore, to improve and promote the health of the men, the following methods are to be put in place. These are training, advocacy and counseling.

Training: health promoters should conduct training sessions at regular intervals for health care providers and law enforcement agents. This is aimed at informing them that men also experience IPV and they should be treated seriously. The health workers must be able to diagnose and provide care for victims. Furthermore, law enforcement agencies should be given health education on occurrence of IPV with men at the

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

receiving end. Laws and policies should be enacted to protect men in abusive relationships.

Advocacy: this is one of the health promotion strategies that can be used to assist the marginalized or underprivileged group of people in the community to benefit from the available programs. It is a way of giving support to a course on behalf of a group of people who cannot defend their interest. It involves speaking, acting, writing with minimal conflicts of interest on behalf of disadvantaged group to promote, protect and defend their welfare and justice. Household heads within the community who settle disputes and restore order are pivotal here. They will ensure that homes where IPV occurs are guided through and restored. This will give them a voice and ensure that their rights are being protected and defended. In the same vein, women groups that serve as social support groups should call the perpetrators to order to ensure peace within the community

Counseling: this is a process of assisting a person to identify his problems and proffer solutions to resolve them. This is another vital method that could be employed to combat the menace of IPV once it had been identified. Health workers, law enforcement agents and significant others within the society should make use of this method to address this issue.

5.4 Conclusion

From the study, it was discerned that men do experience intimate partner violence especially sexual, physical and psychological forms. Nigeria is a patriarchal society where men dominate and make decisions for the family; therefore it appears to be that violence against them is unheard of. Men also tend to keep mute on the issue and do not desire to expose themselves as victims. They find it difficult to seek help. A multi-sectoral approach which will involve the individual, family, community and institution should therefore be put in place to curb it.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

REFERENCES

Abama, E. and Kwaja, C. M. A. (2009). Violence against Women in Nigeria: How the Millennium Development Goals Addresses the Challenge. *The Journal of Pan African Studies*; 3(3), 23-34.

Abrahams, N., Jewkes, R., Laubscher, R. and Hoffman, M. (2006). Intimate partner violence: prevalence and risk factors for men in Cape Town, South Africa. *Violence Vict.;* 21: 247-263.

Adebayo, A.A. and Kolawole, T.O. (2013). Domestic Violence and Death: Women as Endangered Gender in Nigeria. *American Journal of Sociological Research;* 3(3), 53-60.

Adebayo, A.A. (2014). Domestic Violence against Men : Balancing the Gender Issues in Nigeria, 4(1), 14–19.

Adeyeri, A. (2013). Nigeria: Domestic Violence - A Society Biased Against Males? *Available at allafrica.com. Retrieved on 15th August, 2014*

Agada, O. (2011). Intimate Partner Violence: A Public Health Problem. *Afrimedic Journal*; 2 (1): 34-35

Alooma, I. (2012). Oko sa nile fu`n Iyawo (Husband runs away from home) *Alaroye WorldInformation Agents;* 35 (20). Pp.19.

Animasahun, K. and Amarachi, A.Y. (2013). Dimensions of Gender Based Violence in Africa : the Common and induced. *Journal of Research and development*; 1(2), 62–78.

Antai, D.E. and Antai, J.B. (2008). Attitudes of women toward intimate partner violence: a study of rural women in Nigeria. *Rural Remote Health*; 8(3):996.

Antai, D. (2011). Traumatic physical health consequences of intimate partner violence against women: What is the role of community factors? *BMC Women's Health;* 11, 56.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Bamiwuye, S.O. and Odimegwu, C. (2014). Spousal violence in sub-Saharan Africa: does household poverty-wealth matter? *Reproductive Health;* 11, 45.

Barber, C. (2008). Domestic violence against men. *Nursing Standard*, *22*(51), 35-39.

Barnett, (2001). Why battered women do not leave: External inhibiting factors, social support and internal inhibiting factors. *Trauma, Violence and Abuse*. 2 (1), 3-35.

Bates, E.A., Graham-Kevan, N. and Archer, J. (2014). Testing predictions from the male control theory of men's partner violence. *Aggressive Behaviour;* **40** (1): 46–50.

Berrios, D.G. (1991). Domestic violence: Risk factors and outcomes. *Western Journal of Medicine;* 17 (2), 133-143.

Centers for Disease Control and Prevention (2011). Division of Violence Prevention, Centers for Disease Control and Prevention. *Understanding Intimate Partner Violence. Atlanta, GA: 2011. Available from http://www.cdc.gov/violenceprevention/pdf/IPV_factsheet-a.pdf.*

Corvo, K. (2006). Violence, separation, and loss in the families of origin of domestically violent men. *Journal of Family Violence;* 21, 117–125.

Crowell, B. and Sugarman, D.B. (1996). An analysis of risk markers in husband to wife violence: The current state of knowledge. *Violence and Victims*; 1 (2), 101-124.

Currie, D.H. (1998). Violent men or violent women? Whose definition counts? In R. Kennedy Bergen (ed.), Issues In Intimate Violence, Sage, Thousand Oaks,California.

Daly, C.C. (2005). Definition of terms: Spirituality versus religiousness. *Southern Medical Journal; 98*, 1238–1239.

Davies, A. (1999). Violence against women and its effects. *Journal of Personal Guidance;* 2(2), 78-85

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Dodd, L.W. (2009). Therapeutic groupwork with young children and mothers who have experienced domestic abuse. *Education Psychology in Practice;* 25 (21)

Goetz, A.T. (2010). The evolutionary psychology of violence. *Psicothema;* 22 (1), 15-21

Dutton, D.G. and Golant, S.K. (1995). The batterer: A psychological profile. Basic Books.

Dutton, D.G., Nicholls, T.L. (September 2005). "The gender paradigm in domestic violence research and theory: Part 1 — The conflict of theory and data" (PDF). *Aggression and Violent Behavior* **10** (6): 680–714.

Dienye, P.O. and Gbeneol, P.K. (2009). Domestic Violence Against Men in Primary Care in Nigeria. *American Journal of Men's Health;* 3(4) 333–339

Ellsberg, M.C., Pena, R., Herrera, A., Liljestrand, J. and Winkvist, A. (1999). Wife abuse among women of childbearing age in Nicaragua. *Am. J. Public Health*; 89(2):241–244.

Fagan, A.A. (2005). The relationship between adolescent physical abuse and criminal offending: Support for an enduring and generalized cycle of violence. *Journal of Family Violence;* 20, 279–290.

Fang, X. M. and Corso, P.S. (2008). Gender Differences in the Connections between Violence Experience as a Child and Perpetration of Intimate Partner Violence in young Adulthood. *Journal of Family Violence;* 23, 303-313.

Fawole, O.I., Aderonmu, A.L and Fawole, A.O. (2005). Intimate Partner Abuse: Wife Beating among Civil Servants in Ibadan, Nigeria. *African Journal of Reproductive Health;* Vol. 9, No. 2, pp. 54-64.

Fayankinnu, E.A (2012). Gender Based Violence in Akungba – Akoko of South Western Nigeria: Are men Victimized? *URL//uaps2007.princeton.edu/download. Aspx?submissionld=70115.*

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Fleming, P.J., McCleary-Sills, J., Morton, M., Levtov, R., Heilman, B. and Barker, G. (2015). Risk Factors for Men's Lifetime Perpetration of Physical Violence against Intimate Partners: Results from the International Men and Gender Equality Survey (IMAGES) in Eight Countries. *PLoS ONE* 10(3): e0118639.

Foshee, V.A., Karriker-Jaffe, K. J., Reyes, H. L. M., Ennett, S. T., Suchindran, C., Bauman, K. E., and Benefield, T. S. (2008). What accounts for demographic differences in trajectories of adolescent dating violence? An examination of intrapersonal and contextual mediators. *Journal of Adolescent Health;* 42, 596–604.

Gage, A.J. (2005). Women‟s experience of intimate partner violence in Haiti. *Soc. Sci. Med.;* 61(2):343–364.

Garcia-moreno, J.H.A., Ellsberg, M., Heise, L. and Watts, C.H. (2006). WHO Multi-Country Study on Partner Violence: Findings from the WHO Multi-Country Study on Women's Health and Domestic Violence. *Lance*; 368:1260-95.

Golding, J.M. (1999). Intimate partner violence as a risk factor for mental disorders: A Meta analysis. *J. Fam. Viol.;* 14:99–132.

Goodwin, M.M., Gazmararian, J.A., Johnson, C.H., Gilbert, B.C. and Saltzman, L.E. (2000). The PRAMS Working Group. Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996–1997. *Matern. Child Health J.;* 4(2):85–92.

Graham-Kevan, N., and Archer, J. (2008). Does controlling behavior predict physical aggression and violence to partners? *Journal of Family Violence;* 23, 539–548.

Halford, W.K., Farrugia, C., Lizzio, A. and Wilson, K. (2010). Relationship aggression, violence and self-regulation in Australian newlywed couples. *Australian Journal of Psychology*; 62: 2, 82 — 92.

Hamberger, L.K., Saunders, D.G. and Hovey, M. (1992). Prevalence of domestic violence in community practice and rate of physician inquiry. *Fam. Med.*; 24:283–287.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Hamburger, L.K.; Lohr, J.M.; Bonge, D. and Tolin, D.F. (1996). A large sample empirical typology of male spouse abusers and its relationship to dimension of abuse. *Violence and Victims;* 11 (4), 277-292

Harvey, P. and Gow, P. (1994). Sex and violence: Issues in representation and experience. London: Routledge. ISBN 0-415-05734-5.

Heise, L., Ellsberg, M. and Gottenmoeller, M. (1999). Ending violence against women (Population Reports, Series L, No. 11). Baltimore: Population Information Program, Johns Hopkins University School of Public Health.

Heise, L., Ellsberg, M. and Gottmoeller, M. (2002). A global overview of gender-based violence. *Int. J. Gynaecol. Obstet.;* 78 Suppl 1:S5-14.

Hindin, M.J. (2003). Understanding women's attitudes towards wife beating in Zimbabwe. *Bull World Health Organ*; 81(7):501-508.

Ibadan North West Local Government Record (2005), Oyo State Budget Unit

Ilika, A.L., Okonkwo, P.I. and Adogu, P. (2002). Intimate partner violence among women of childbearing age in a primary health care centre in Nigeria. *African Journal of Reproductive Health;* 6, 53-58.

Issue, A. G. (2008). Intimate partner violence: *Letters;* 98(2), 197–198.

Jewkes R (2002). Intimate partner violence: causes and prevention. *Lancet; 359(9315):1423-9.*

Jewkes, R.K., Levin, J.B.and Penn-Kekana, L.A. (2005). Risk factors for domestic violence: findings from a South African cross-sectional study. *Soc. Sci. Med.*; 55(9):1603-175.

John, I. A. (2010). Screening for intimate partner Screening for intimate healthcare in in Kano , Nigeria : in barriers violence healthcare Kano , for healthcare Nigeria : and professionals challenges for healthcare professionals Ime Akpan John.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Johnson, M. P. (1995). Intimate terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family; 57*, 283–294.

Johnson, R., Gilchrist, E., Beech, A. R., Weston, S., Takriti, R. and Freeman, R. (2006). A psychometric typology of U.K. domestic violence offenders. *Journal of Interpersonal Violence*; 21, 1270-1285.

Jones, R.H. (1997). The American college of obstetricians and gynaecologists: A decade of responding to violence against women. *International Journal of Gynecology and Obstetrics;* 58 (1), 43-50.

Kalra, M. (1996). Juvenile delinquency and adult aggression against women. (Unpublished M.A. Thesis) Wilfrid Laurier University. http://scholars.wlu.ca/etd/570/

Kimmel, M. S. (2001). Male victims of domestic violence: A substantive and methodological review, Report to the Equality Committee of the Department ofEducation and Science, Ireland.

Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B. and Lozano, R. (2002). World report on violence and health. Geneva, Switzerland: World Health Organization.

Kumar, A. (2012). "Domestic Violence against Men in India: A Perspective". Journal of Human Behavior in the Social Environment 22 (3): 290–296.

Lehamann, P.J. (1995). Children who witness mother-assault: An expander posttraumatic stress disorder conceptualization. (Unpublished M.A. Thesis) Wilfrid Laurier University. http://scholars.w/u.ca/etd/193

Liebschutz, J., Battaglia, T., Finley, E. and Averbuch, T. (2008). Disclosing intimate partner violence to health care clinicians - what a difference the setting makes: a qualitative study. *BMC Public Health;*8, 229.

Kelly, L. (2003). Disabusing the Definition of Domestic Abuse: How Women Batter Men and the Role of the Feminist State. *Florida State University Law Review* **30** (4): 818–819.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Lawoko S. (2006). Factors associated with attitudes towards violence: a study of women in Zambia. *Violence Vict*; 21, 645–656.

Lupri, E. and Grandin, E. (2004). Intimate partner abuse against men. National Clearing house on Family Violence. Archived from the original(PDF) on January 4, 2009.

Mahapatra, N. (2012). South Asian Women in the US and their Experience of Domestic Violence. *Journal of Family Violence;* 27, 381-390.

Medeiros, R.A. and Straus, M.A. (2006). "Risk Factors for Physical Violence Between Dating Partners: Implications for Gender-Inclusive Prevention and Treatment of Family Violence". In Hamel, John; Nicholls, Tonia. Family Approaches to Domestic Violence: A Practitioner's Guide to Gender-Inclusive Research and Treatment (PDF). New York: Springer. pp. 59–87.

National Population Commission (NPC) [Nigeria] and ICF International. (2014). Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

Njenga, F. (1999). "If your Husband is Abusive, Leave Him!" in Conveying Concrete WomenReport on Gender – Based Violence.

Noonan, R. K. and Charles, D. (2009). Developing teen dating violence prevention strategies: Formative research with middle school youth. *Violence Against Women*; 15, 1087–1.

Nouri et al. (2012). Prevalence and Determinants of Intimate Partner Violence against Women in Marivan County. *Iran Journal of Family Violence;* 27, 391-399.

Obunikem, P., Adogu, U., Chimah, U. C., Ilika, A. L., and Ubajaka, C. F. (2015). Factors Associated with Intimate Partner Violence among Wives of Military and Civilian Men in Abuja Nigeria, (April), 61–73.

Odimegwu, O. (2012). The Modern Man in Kenya. Available at Nigeriafilms.com

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Office of Violence Against Women (2007). About domestic violence. Retrieved June 13, 2014 from http://www.isdoj.gov/ovw/domviolence.htm

Olufemi, M. and Ojo, D. (2013). A Sociological Investigation of Awareness and Causes of Intimate Partner Violence in Nigeria : A Survey of Agege , Lagos State ., 9(2).

Osuora, D., Antai, D., Ezeudu, C. and Chukwujekwu, E. (2012). Effect of maternal exposure to intimate partner violence on under-five mortality in Nigeria. *Niger Journal of Paediatrics, 39(3), 97–104.*

Owoaje, E. T. and OlaOlorun, F. M. (2012). Women at risk of physical intimate partner violence: a cross-sectional analysis of a low-income community in southwest Nigeria. *African Journal of Reproductive Health;* 16, 43–53.

Oyediran, K.A. and Isiugo-Abanihe, U. (2005). Perceptions of Nigerian women on domestic violence: evidence from 2003 Nigeria Demographic and Health Survey. *Afr. J. Reprod. Health;* 9(2):38-53.

Pourreza A., Batebi, A. and Moussavi, A. (2004). A survey about knowledge and attitudes of people towards violence against women in community family settings. *Iranian Public Health Journal;* 33(2),33-37.

Punjab News: "Violence against India Men – some interesting statistics.''URL:*http://www.punjabnewsline.com/content/save-indian-family-foundation-openspatialachapther.*

Rahman, M., Nakamura, K., Seino, K. and Kizuki, M. (2013). Does gender in- equity increase the risk of intimate partner violence among women? Ev- idence from a national Bangladeshi sample. *PLoS ONE, 9(2), e91448.*

Roberts, T. A., Auinger, P., and Klein, J. D. (2005). Intimate partner abuse and the reproductive health of sexually active female adolescents. *Journal of Adolescent Health,* 36, 380–385.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Rosen, K.H., Stith, S.M., Few, A.L., Daly, K.L. and Tritt, D.R. (2005). A qualitative investigation of Johnson's typology. *Violence and Victims;* 20 (3), 319-334.

Sadeler, C. (1994). An ounce of prevention: The life stories and perceptions of men who sexually offended against children. (Unpublished M.A. Thesis) Wilfrid Laurier University. http://scholars.wlu.ca/etd/634

Seltzer, J.A. and Kalmuss, D. (1988). Socialization and stress explanations for spouse abuse. *Social Forces; 67(2), 473-491.*

Schwartz, J., Hage, S., Bush, I., and Burns, L. (2006). Unhealthy parenting and potential mediators as contributing factors to future intimate violence: A review of the literature. *Trauma, Violence and Abuse*, 7, 206–221.

Sharps, P., Campbell, J.C., Campbell, D., Gary, F. and Webster, D. (2003). Risky Mix: Drinking, Drug Use, and Homicide. *NIJ Journal* 250: 8–13, NCJ 196546.

Steele, B.F. (1974). A psychiatric study of parents who abuse infants and small children. In C.H.

Stenson, K., Saarinen, H., Heimer, G. and Sidenvall, B. (2001). Women's attitudes to being asked about exposure to violence. *Midwifery*; 17(1):2-10.

Stenson, K., Sidenvall, B. and Heimer, G. (2005). Midwives' experiences of routine antenatal questioning relating to men's violence against women. *Midwifery*; 21(4):311-21.

Stop violence Against Women (2010). Retrieved on April 24, 2015, from http://www.stopvaw.org/Domestic_Violence_and_Housing.html.

Straus, M.A. (June 2010). "Thirty Years of Denying the Evidence on Gender Symmetry in Partner Violence: Implications for Prevention and Treatment" (PDF). *Partner Abuse* **1** (3): 333.

Swahnberg, K. and Wijma, K. (2007). Validation of the Abuse Screening Inventory (ASI). *Scandinavian Journal of Public Health*; 35(3):330-4.

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Thaler, K. (2011). Drivers of Male Perpetration of Family and Intimate Partner Violence in Cape Town. Centre for Social Science Research (CSSR) Working Paper, No. 289.

This Day (2011). Domestic violence: When law fails to protect. http://www.thisdaylive.com

Thompson, M. P., Basile, K. C., Hertz, M. F., and Sitterle, D. (2006).Measuring intimate partner violence victimization and perpetration: A compendium of assessment tools. Retrieved from *http://www.cdc.gov/ncipc/dvp/compendium/IPV %20Compendium.pdf.*

Tjaden, P. and Thoennes, N. (2000). Extent, Nature and Consequences of Intimate Partner Violence: Findings from the National Violence against Women Survey. Washington, DC: US Department of Justice*; Publication NCJ 181867.*

United Nations (1993). General assembly declaration on the elimination of violence against women. http://www.unhchr.ch/huridocda/huridoca.nsf

Uthman, O.A., Lawoko, S. and Moradi, T. (2009). Factors associated with attitudes towards intimate partner violence against women: a comparative analysis of 17 sub-Saharan countries. *BMC Int Health Hum Rights;* 9: 14.

Valentine, C., Oehme, K. and Martin, A. (2012). Correctional Officers and Domestic Violence: Experiences and Attitudes. *Journal of Family Violence*; 27: 531-545.

Sullivan, V. (2013). Help domestic abuse victims for 35 years. *The Delco Times*. Retrieved November 30, 2015.

Vitanza, S., Vogal, L.C. and Marshall, L.L. (1995). Distress and symptoms of posttraumatic stress disorder in abused women. *Violence and Victim;* 10 (1) 23-34.

Watts, C., and Zimmerman, C. (2002). Violence against women: Global scope and magnitude. *Lancet*, 359, 1232-1237.

Whitting, J. B., Simmons, L. A., Havens, J. R., Smith, D. B., and Oka, M. (2009). Intergenerational Transmission of Violence- the Influence of Self –

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Appraisals, Mental Disorders and Substance Abuse. *Journal of Family Violence;* 24, 639-648.

WHO (2002). Injury: a leading cause of the global burden of disease. Krug E, editor. Geneva:

WHO,(2005). Addressing Violence against Women and Achieving Millennium Development Goals: *WHO/FCH/ CWH/05.1 (http;//www.who.int/gender/en).*

World Health Organisation (2002). Intimate Partner Violence. Retrieved from http://www-who.int/violence_injury_prevention/violence/world_report/factsheets

World Health Organisation (2001). Putting women first: ethical and safety recommendations for research on domestic violence against women. World Health Organization Geneva, Switzerland. 2001.

Wijma, B., Schei, B., Swahnberg, K., Hilden, M., Offerdal, K., Pikarinen, U., Sidenius, K., Steingrimsdottir, T., Stoum, H. and Halmesmäki, E. (2003). Emotional, physical, and Sexual abuse in patients visiting gynaecology clinics: a Nordic cross-sectional study. *Lancet*; 361 (9375) 2107-2113.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

QUESTIONNAIRE

Experience of Intimate Partner Violence among Married Men in Ibadan North West Local Government Area, Ibadan, Oyo State

Dear Respondent,

My name is FAMINU OLUFUNMILOLA , a Postgraduate student of Department Of Health Promotion and Education, College of Medicine, University of Ibadan. I am conducting a study on the **Experience of intimate partner violence among married men.** The study aims at obtaining relevant information from male adults who are currently married in Ibadan North West Local Government. The information collected will be used for research purposes only. Names are not required and all answers will be treated with confidentiality. I shall be grateful for your honest replies.

Thank you for your co-operation.

Please tick or fill appropriately.

General information

Date of interview: .... Place of interview: ....

Identification number: ....

SECTION A

Socio demographic characteristic of respondents

1. How old are you? ______________________ (Years)
2. Ethnicity: 1. Yoruba 2. Hausa 3. Igbo 4. Others specify ________________
3. What is your religion? 1. Christianity ( ) 2. Islam ( ) 3. Traditional ( ) 4. Others specify __________________
4. What is your educational qualification? 1. None ( ) 2. Primary school ( ) 3. Secondary School ( ) 4. Tertiary ( )
5. How many wives do you have? _________________
6. How long have you been married? ______________________
7. What is your occupation?_______________________
8. Have you ever drink alcohol? 1. Yes ( ) 2. No( ) (if "No" skip to Q15)

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

9. Do you drink now? ________________

10. Did you take alcohol this previous week?______________________

11. Which of the following do you normally take? 1. Beer( )
    2. Ogogogro/burukutu/paraga( ) 3. Stout ( ) 4. Wine ( ) 5. Palm wine ( )
    6. Others (please specify)...........................

12. Have you ever been drunk? 1. Yes ( ) 2. No ( ) (if No skip to Q15)

13. How often do you get drunk? 1. Rarely 2. Frequently 3. Occasionally

14. Have you ever smoked a cigarette? 1. Yes ( ) 2. No ( )

15. Do you smoke now?1. Yes ( ) 2. No ( )

16. How many sticks of cigarette have you smoked in the last three days?.....................

SECTION B

Attitudes towards perpetration of violence.

Please tick (√) the most appropriate answer to you here

Statements		**Yes**	**No**	**Undecided**
i.	Does a man have the duty to beat up his wife if she misbehaves?			
ii.	Does a man have the right to talk harshly to his wife if she refuses his instruction			
iii.	Does a man have right to have sex with his partner if he has spent a lot of money on her?			
iv.	Women usually say 'no' to the first sexual gestures from their men but they will yield if the man put enough pressure on them			
v.	Is it wrong for a married man to force his wife to have sex with him			
vi.	Men sometimes sexually coerce their partners whenever they are unable to control their sexual appetite and it is			

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

	usually understood by their wives			
vii.	Does a man have the right to have sex with the woman on whom he paid her bride price at any time and at all cost			
viii.	Rape occurs when woman refuses her husband to have sex with him			
ix.	Women at times provoke their husband to have sex with them forcefully			
x.	Some women enjoy sex better when their husband apply force on them			
xi.	Is it wrong for a man to insult his wife or make her feel bad about herself			

SECTION C

Family History of Intimate Partner Violence

Respond to the following questions by answering "Yes" or "No". Which of these has ever happened in your home?

	Statement	**Yes**	**No**
18	Have you ever witnessed a situation where your father hit your mother?		
19	Your father insulted your mother verbally?		
20	Your father accused your mother wrongly?		
21	Your father threw an object at your mother?		

SECTION D

Extent of Experiences of Violence

Thank you for the time you have taken to answer these questions. I will like to ask you about some forms of violence perpetrated by women on their partners. Kindly indicate which one you have experienced from her.

22. Have you ever experienced any of the following perpetrated by your wife?

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

22a	Physical Violence Behaviour	Ever happened		Occurred in the last six months	
		Yes(1)	No(2)	Yes(1)	No(2)
I	Slap you				
Ii	Throw an object at you				
Iii	Bite you				
Iv	Did she punch you				
V	Used a sharp object or broken bottle when she engaged you in a fight				
Vi	Kicked, dragged or beat you up				
Vii	Used dangerous weapons on you				
Viii	Others (specify)				

	22.B Psychological violence behaviour	Ever happened		Occurred in the last six months	
		Yes(1)	No (2)	Yes(1)	No(2)
I	Does she ignore and treat you indifferently				
Ii	Nag?				
Iii	Belittle you and humiliate you in front of other people				
Iv	Insult you and make you feel bad about yourself				
V	Do things to intimidate or scare you				

UNIVERSITY OF IBADAN LIBRARY

	22C. Sexual violence behavior	**Ever happened**		**Occurred in last six months**	
		Yes(1)	No(2)	Yes(1)	No(2)
I	Forced to see sexually explicit materials such as pornography (blue film & magazine) when not in the mood				
Ii	Refused to have sex with you in order to hurt you				
Iii	Forced to do something sexually that you found degrading or humiliating				
Iv	Had sexual intercourse with her because you were afraid of what she might do to you				
V	She insisted on having anal sex				
Vi	Others (specify)				

23. Has any of your friends reported cases of violence against them by their wives?

1. Yes ( ) 2.No ( )

24. If "YES", to Question 23, please state the form of violence? ____________________

25. What do you think is the reason for this behaviour? Please tick the appropriate response

	Statement	**YES**	**NO**	**UNDECIDED**
25.1	Finance			
25.2	Lack of Sex			
25.3	Alcohol			
25.4	Jealousy			
25.5	Religious			
25.6	Infidelity			
25.7	Lack of understanding			
25.8	Others			

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

SECTION E

Health Consequences of Intimate Partner Violence and Help seeking Practices

Health consequences refer to physical harm to the body such as cuts, burns, sprains, broken bones or psychological disturbance.

27. Have you ever been injured as a result of physical violence by your wife?

1.Yes ( ) 2. No ( )

28. If "YES", please state the type of injury

i. ________________________________

ii. ________________________________

iii ________________________________

iv ________________________________

v. ________________________________

29. Have you ever visited hospital/clinic/chemist due to injuries from your wife?

1. Yes ( ) 2. No ( )

30. Did you disclose the real cause of your injury? 1. Yes ( ) 2. No ( )

31. If NOT, what did you do? __________________________________

32. If you received help, why did you do so? __________________________________

33. What steps will you take if such thing/event occur again?_________________________

Thank you for your participation

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

YORUBA TRANSLATION

IWE MO GBA LATI KO PA

Oruko mi ni Olufunmilola Faminu. Mo je akeko ni isori ti o ngbe eto ilera laruge ati kikoni re (Ipa ti imo eko mimo iye eniyan ati ilera ti o romo Bibisi/Piposi), eka ti o nko ni ni sise eto ilera fun mutu-muwa ti ile iwe giga Fasiti Ibadan, ni U.C. H, Ibadan.

Mo nse iwadi lenu awon Baale ni agbegbe Ariwa Iwo-orun Ibadan lori "Iriri ati ihuwa ipa ti o ma nwaye laarin tokotaya paapaa lati odo aya si oko".

Awon ibeere kan wa nibe ti o le nira lati dahun. Mo fe mu da yin loju pe asiri ni gbogbo awon oro ti a ba so yoo je laarin wa. A ko ni beere oruko yin rara tori wipe a ko ni so idahun yin papo mo yin rara. Idahun yin yoo ran ijoba lowo lati gbe eto kale ti yoo mu opin baa won rogbodiyan wonyi.

Didahun ibeere yi ni otito yoo ran iwadi yi lowo pupo.

E ni anfaani lati so wipe e ko fe kopa tabi lati fa seyin kuro leyin igba ti e ti bere. Inu wa yoo dun gidigid ti e ba fi otito dahun awon ibeere wonyi ti e si fi tifetife kopa.

IPIN A

Alaye nipa yin

1. Omo odun melo ni yin? ______________________ (Ọdún)

2. Eya wo niyin:

   1. Yorùbá
   2. Hausa
   3. Igbo
   4. Omiran (e daruko) ________________

3. Esin wo ni e nse

   1. Igbagbo
   2. Musulumi

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

3. Esin ibile

4. Omiran (e daruko) _______________

4. Ipele ẹkọ wo ni e ka ju ti e si ni iwe eri re?

1. N o ka'we Kankan

2. Iwe eri eko alabere

3. Iwe Eri eko girama ipele akoko (J.S.S)

4. Iwe Eri eko girama agba (S.S.S)

5. Iwe Eri eko giga (NCE, OND, HND, Bachelor)

6. Iwe eri eko Masita

5. Iyawo melo ni e ni _________________

6 Odun kelo ni yi ti e ti gbeyawo _______________________

7. Iru igbeyawo wo ni e se? __________________________

1. Soosi

2. Mosalasi

3. Kootu

4. Ibile

5. Omiran (e daruko)

8 Ise wo ni e nse? ________________________

9. Nje e ti mu oti ri?

1. Bẹẹni 2.Bẹẹkọ (ti o ba je beeko,e lo si ibeere 15)

10. Nje e mu oti ni sin yi? __________________

11. Awọn ọjọ melo ni e mu oti ni osu kan? _________________________

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

12. Ewo ninu awọn wọnyi ni oti ti e ma mu?

1. Bia
2. ogogogro / burukutu / paraga
3. Sitaotu
4. Waini
5. Emu
6. Omiran (e daruko)

13. Nje e ti mu oti yó ri?

1. Bẹẹni 2. Bẹẹkọ

14. Bawo ni e se mu oti to

1. Mo nmu bi alaimu
2. nigbagbogbo
3. Lẹẹkọọkan

15. Ṣé e ma mu siga?

1. Bẹẹni 2. Bẹẹkọ

16. Ṣe e si ma mu siga bayi?

17. Siga melo ni e ti mu lati bi ọjọ mẹta sehin?

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

IPIN B

Awon iha ti a ko si ọna iwa-ipa

Idi Pataki	Beeni	Beeko
1. Se oko ni eto lati lu iyawo re ti o ba huwa aito		
2. Se o bojumu ki oko so oro odi si iyawo re ti ko ba gboran si lenu		
3. Se okunrin ni eto lati ni ajosepo pelu aya re nitoripe o ti nawo le lori		
4. Obinrin ma ntiju ni akoko ti okunrin ba denu ife ko won sugbon won ma ngba lehin opolopo atotonu		
5. Nje o bojumu ki oko fi ipa ba iyawo re ni ajosepo		
6. Ko si ohun ti o buru bi oko ba fi agidi ba iyawo re ni ajosepo nigbati ko ba wun bi?		
7. Nje o leto ki oko fi ipa ba iyawo re ni ajosepo nigbakugba ti o ba wun nitoripe o ti san owo ori re		
8. Se oko jebi esun ifipabanilopo lodo iyawo re		
9. Awon obinrin miran ki gba lati se eto fun oko won afi ti o ba fi ipa mu won		
10. Obinrin miran feran ifipabanilopo		
11. Se ohun ti o to ni ki oko ma re iyawo re sile ni awujo abi ki ma soro abuku si		

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

IPIN D:

Dahun si ibeere nipa awọn wọnyi, dahun Bẹẹni Bẹẹkọ.

18. Nje o ti ri ki baba rẹ lu ìyá rẹ bi?

1. Beeni 2. Beeko

19. Nje baba re kan iya re labuku ri?

1. Bẹẹni 2. Beeko

20. Nje baba re fi esun ainidi kan iya re ri?

1. Bẹẹni 2. Beeko

21. Nje baba rẹ ma nju nnkan lu iya re bi?

1. Bẹẹni 2. Beeko

22. Nje baba re kọ lati se itoju awọn ọmọ?

1. Bẹẹni 2. Beeko

IPIN E

Ihuwa ipa nipa ibagbepo

E ṣeun fun awọn akoko ti e fi sile lati dahun ibeere wonyi. Jowo tọkasi eyi ti o ti ni ìrírí rẹ ri.

23. Nje e ti ni iriri iwa-ipa lati odo aya yin ri?

1. Bẹẹni 2. Beeko

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

24. Rogbodiyan lilu

Rogbodiyan ki a luni	O ma nsele nigbagbogbo Beeni (1) Beeko(2)	O sele ni osu kefa seyin Beeni (1) Beeko (2)
Won ma nfo yin leti		
Won ma nju nnkan lu yin		
Won ma nge yin je		
Won ma fun yin ni ese		
Won ma nfo igo mo yin lori		
Won ma ngba yin bi boolu		
Won ma nfi ohun ija oloro bi obe ba yin ja		
Omiran (e daruko re)		

25.

Rogbodiyan okan	O ma nsele nigbagbogbo Beeni (1) Beeko(2)	O sele laarin osu mefa seyin Beeni(1) Beeko(2)
Won kan yin labuku		
Won ma nyo yin lenu		
Won tembelu yin		

AFRICA DIGITAL HEALTH REPOSITORY PROJECT
UNIVERSITY OF IBADAN LIBRARY

Won ki bowo fun yin/won nkegan yin		
Won nderu ba yin lati se yin lese		
Won ko bikita nipa awon omo yin		
Omiran (e daruko)		

26.

Rogbodiyan nipa biba ara eni sun	O ma nsele nigbagbogbo Beeni(1) Beeko(2)	O sele ni osu bi mefa seyin Beeni(1) Beeko(2)
Won ma nfi ipa mu yin lati wo awon aworan ibasepo bi buulu fimu		
Won kii fe se ti eyin ba beere fun		
Won ma nba yin se awon ere ife lodi si ife yin		
Won ma nfi ipa ba yin se ajosepo		
Won ma nba yin se ere ife ni ona aito(ibalopo furo)		
Omiran (e daruko)		

27. Kini e ro pe o fa awon isele yi?

1. ____

2. ____

3. ____

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4. ____

5. ____

IPIN E

Ipalara ti o ma nwaye nidi rogbodiyan wonyi.

28. Nje e ti farapa nipa rogbodiyan ti aya yin nda sile ninu ile ri ?

1. Bẹẹni 2. Beeko

29. Ti o ba je bẹẹni,e jọwọ iru ipalara wo ni e ni

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. _____________________________

30. Nje won ti gba yin sile ni ile iwosan nitori ipalara ti e dojuko wonyi ri?

1. Bẹẹni 2. Beeko

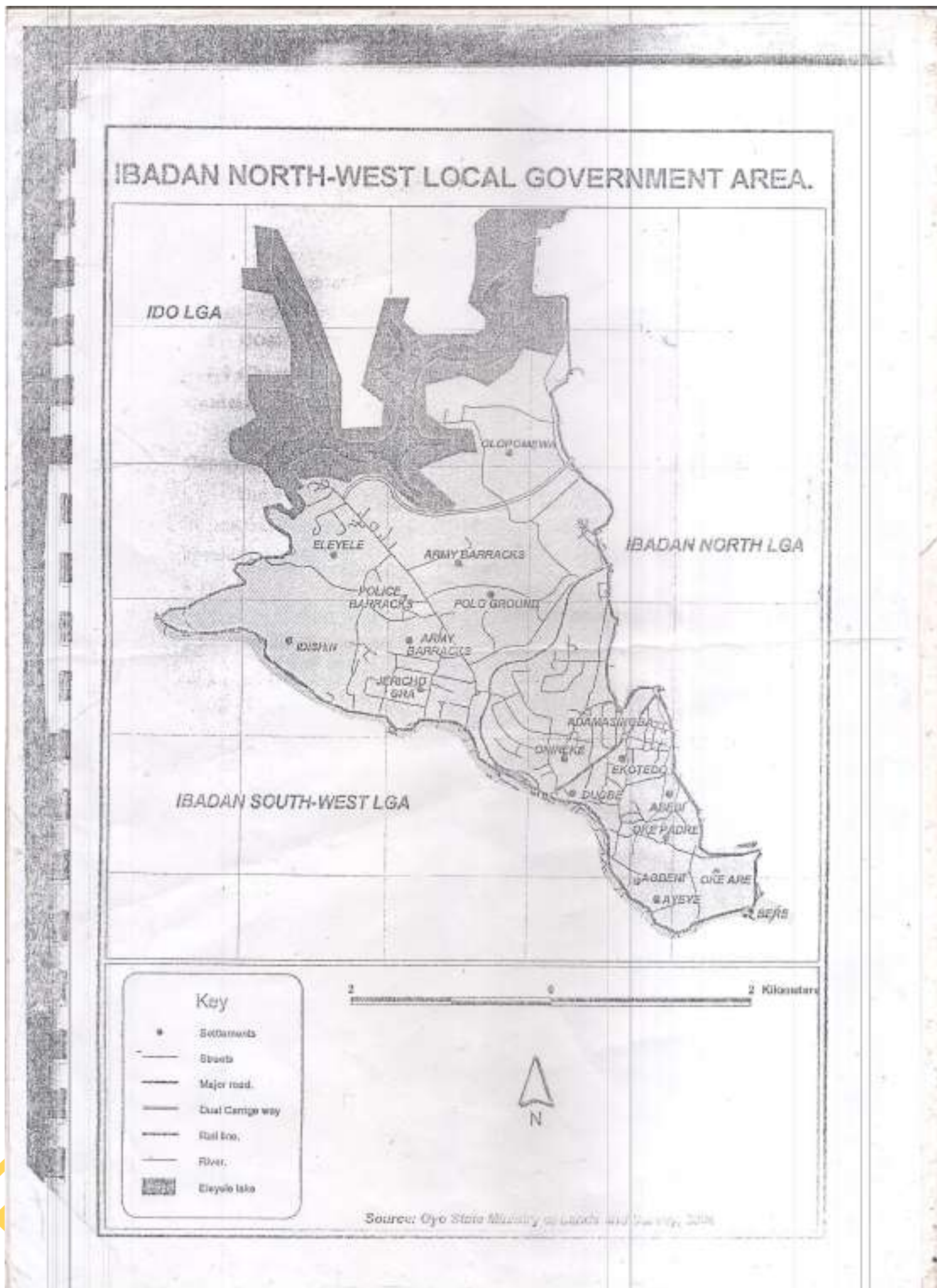
31.Bi o ba je beeko, nibo e ti gba itoju? ________________________________

32. Nje e jewo fun olutoju alaisan ohun ti o sele ni pato?

33. Ti o ba lọ fun iranlọwọ, ẽṣe ti iwọ ṣe bẹẹ?

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY



SKETCH MAP OF THE IBADAN NORTH WEST LOCAL GOVERNMENT

AFRICA DIGITAL HEALTH REPOSITORY PROJECT