

Research Article**Impact of Intimate Partner Violence and Coping Strategies Adopted among Women in Military and Civilian Communities of Abuja Nigeria**Uzoamaka Carol CHIMAH¹, Prosper Obunikem Uchechukwu ADOGU^{2*}, Amobi Linus ILIKA³¹ Consultant Public Health Physician, Medical department, Ministry of Defence Headquarters, Abuja, Nigeria² Associate Professor, Department of Community Medicine and PHC, Nnamdi Azikiwe University/ Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria³ Professor, Department of Community Medicine and PHC, Nnamdi Azikiwe University, Nnamdi Azikiwe University Teaching Hospital, Nnewi, Nigeria***Corresponding author**

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Abstract: Intimate partner violence (IPV) has devastating consequences for the women who experience it and a traumatic effect on children who witness it. Abused women are not passive victims but rather they adopt active strategies to maximize their safety and that of their children. This study determined the impact of IPV and coping strategies adopted among women in military and civilian communities of Abuja, Nigeria. Data was collected from 260 married or co-habiting women in civilian and military populations, on impact of IPV among them and adopted coping strategies including suggested solutions to evade or cushion the effect. Focus group discussions (FGDs) were also conducted to complement quantitative data. Result of analyzed data was presented in charts while FGD data was subjected to content analysis. All the respondents in the FGD groups unanimously agreed that IPV impacts negatively on a victim's health. Majority of civilian 46 (42.6%) and military 59 (45.4%) IPV victims sought help from informal sectors like families, friends and churches. Most of the civilian respondents 16(14.8%) sought help because they were encouraged by family and friends while majority of the military barracks respondents 36(27.7%) sought help because they couldn't endure the violence anymore. Early behavioral change communications directed at the male child, economic empowerment of girl child coupled with prayers were some of the suggested ways of curbing IPV during the FGD. The religious communities should be sensitized to preach against IPV and IPV "drivers" as well as stigmatize abusers as a deterrent. People in position of authority/opinion leaders should speak-out and champion positive behavioural change. Economic empowerment of women should be pursued with vigor by Governments at all levels to give women enough independence and confidence to escape IPV. Government should show more commitment by ensuring speedy passage of the bill on 'Elimination of all forms of violence and discrimination against women' which will aid legal process in handling cases of IPV.

Keywords: Impact, Coping strategies, Women, Military, Civilian, Abuja, Nigeria

INTRODUCTION

Violence against women is a major public health concern because of its magnitude and negative health impact. Not only is it a violation of human rights, it also compromises a woman's physical, sexual, psychological and social wellbeing [1]. According to the United Nations, violence against women includes any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivations of liberty whether occurring in public or private life [2]. In many countries, these victimized women risk losing their income, children, shelter, land and social standing if and when they decide to quit an abusive relationship.

When they choose to remain, they suffer immensely often for the rest of their lives [3].

It has devastating consequences for the women who experience it and a traumatic effect on those who witness it, particularly children. According to Dr. Claudia Grace Moreno of WHO (Women Health and Development Division) "violence against women undermines the basis for sustainable development. It is both a consequence and a cause of gender inequality both in freedom, resource control and equity in accessing healthcare etc [3]. Intimate Partner Violence (IPV) is a major cause of mortality in that every year women experience about 4.8 million intimate partner - related physical assaults and rapes [4]. IPV resulted in 1,544 deaths in 2004, of these deaths, 25% were males

and 75% were females [5]. IPV is the most common form of violence against women and the third highest cause of death among women in the age group 15-44 years [6]. Various studies from across countries show that 40%-70% of female murder victims were killed by their husbands or boyfriends, often during an ongoing abusive relationship [7]. In the USA, one-third of women murdered each year are killed by their intimate partners [8].

The cost of IPV is enormous, a report by US Centre for Disease Control and Prevention (CDC) estimated that the cost of intimate partner violence in the US alone exceeded US\$5.8 billion per year; US\$ 4.1 billion was from direct cost of medical care and healthcare services while productivity cost accounted losses for nearly US\$1.8 billion [9]. Violence against women impoverishes individuals, families and communities, reducing the economic development of each nation [10].

Many of the studies on women's responses to partner violence have been carried out on women using support services such as shelters or counseling services. At a population level, however, little is known about women's responses to violence, or about the help they receive from informal networks (families, friends, and so on) and formal health or social services [11]. However, abused women are not passive victims but rather they adopt active strategies to maximize their safety and that of their children. While some resist, some flee and others try to maintain peace by giving in to their husbands' demands [12-14]. A woman's response to violence depends on the options available to her. Studies have shown that between 20%-70% of abused women never told anybody about the abuse until they were interviewed. Those who reached out, do so to extended family members and friends rather than to institutions [15].

In Nigeria the Ministry of Women Affairs run a few shelter homes where abused women can seek temporary respite. Also two NGOs in the forefront of providing alleviation for abused women are Women's Rights Advancement and Protection Alternative (WRAPA) and Project Alert. These handle a lot of cases of women facing violence but their functions are more of mediation as they do not have power to prosecute or compel attendance of perpetrator.

According to WHO multi-country study (WHOMCS) in all countries under the study, the interviewer was frequently the first person that abused women had ever talked to about their partner's physical violence. As can be seen in two thirds of women who had been physically abused by their partner in Bangladesh, and about half in Samoa and provincial Thailand, had not told anybody about the violence prior to the interview. Relatively few physically abused women in any setting had told staff of formal services

or people in positions of authority such as religious or traditional leaders, health personnel, police, counselors, and staff of women's non-governmental organizations about their violence [16].

IPV is a new and evolving area of research particularly in Nigeria and as such there is dearth of literature, especially on community-based studies. The authors did not come across any study in military population in Nigeria. Meanwhile studies in military populations in the united states where there are existing alleviation programs in place showed that spouses of military personnel had two to five times higher risk of experiencing IPV than their civilian counterpart [17, 18]. So findings from this study will contribute to existing body of knowledge and may serve as a baseline for future studies in military populations. It may also serve as advocacy tool for increased sensitization and response to IPV against women especially in the military population and to develop alleviation programmes.

The aim of this study was to determine the impact and coping strategies adopted among women experiencing intimate partner violence in military and civilian communities in Abuja, Nigeria.

METHODOLOGY

Study background

This study was carried out in two locations in an army barrack and a civilian community (AMAC). AMAC is in the Abuja city plan which includes among other civilian and military settlements, the zone 2 Wuse area and Lungi military barrack:

Zone 2 Wuse Area is a civilian residential community located within Abuja Municipal Area Council. The area is bounded by Obasanjo Way to the west separating it from Zone-1, Mambolo Street to the east separating it from Zone-5, Sultan Abubakar Way to the south separating it from Zone-3 and a canal separating it from Zone 6.

Lungi Barrack is a military zone located along the Asokoro end of the Kubwa expressway. It is bounded on the East by Aso rock, west by the Kubwa expressway, north by Pape (a semi urban/rural community), and south by Mambila Barrack. It has an estimated population of 7,000 inhabitants comprising of various cadres of military personnel, their families and a few civilian staff of the Ministry of Defense; living in about 950 housing units.

Study design

This was comparative, cross-sectional survey with both quantitative and qualitative components. The study population comprised of females who were in intimate relationship with the male heads of the households in Lungi military barrack and civilian community zone 2, Wuse. Included in the study were

female intimate partners of the head of the households, who were either married or living together for at least six months or unmarried but cohabiting for at least six months. On the other hand, female military personnel who were married to civilians and households where both partners were civilians (though living in the

barrack) were excluded from the study. Widows were also excluded in both military and civilian populations.

The sample size formula for comparison of two independent group proportions was used [18]

$$\text{Minimum sample size } n/\text{group} = \frac{(Z_a + Z_b)^2 \times [p_1(1-p_1) + p_2(1-p_2)]}{d^2}$$

where n = the minimum sample size; Z_a = Standard normal deviate corresponding to a significance level of 5% = 1.96; Z_b = Standard normal deviate corresponding statistical power of 80% for a two tailed test = 0.84; p₁ (proportion 1) = 0.81 (proportion of

women who experienced physical violence in a study in a civilian community in Lagos)[19]; p₂ (proportion 2) = 0.893 (proportion of women who experienced physical abuse in military population in USA) [18]; d= Amount of difference between p₁ and p₂.

$$n/\text{group} = \frac{(1.96 \times 0.84)^2 \times [0.81(1-0.81) + (0.893)(1-0.893)]}{(0.082)^2} = 76.25$$

$$\text{Providing for 70\% response rate: } n \text{ per group} = \frac{76.25}{0.7} = 109$$

However, a sample size to 130 per group was used.

Sampling method

Abuja Municipal Area Council (AMAC) was selected purposively out of the six area councils that make up the Federal Capital Territory because it has a concentration of six barracks. Lungi barrack was selected out of the six barracks by simple cluster random sampling using ballot method while Zone 2, Wuse was purposively selected because it appeared to be the closest in features to the barracks in terms of architectural design and ethnic and religious diversity and the fact that majority of the residents are civil servants of various cadre; the area is a distance of about 8-10km away from the barrack location.

A multi-stage sampling technique was used to select a sample of 130 female respondents from each of the study population (Lungi barrack and Zone 2, Wuse).

Two-day training for the research assistants was conducted using the WHO standard training manual for the WHOMSC study [21].

The questionnaire was pre-tested in SanniAbacha Barracks and Zone 1 Wuse immediately after the training of the research assistants and thereafter corrected to remove areas of ambiguity before the data collection.

The questionnaires were administered by four trained research assistants and the researchers. Each respondent was interviewed alone using the questionnaire after obtaining an informed consent. Data was collected on socio-demographic variables, impact of IPV and coping strategies among the respondents. Completed questionnaires were reviewed by research

assistant and errors and wrong entries corrected before leaving each venue.

Data entry was done using Statistical Package for Social Sciences (SPSS) version 20.0.

The sources of help sought by respondents who have ever experienced IPV were collapsed into informal networks (family and friends), formal networks (police/ judiciary, NGOs etc) and persons in position of authority (religious leaders, traditional rulers etc) to provide larger figures for meaningful analysis. Results were presented in charts for easy appreciation.

Focus group discussions (FGDs) were also conducted. For the barrack subjects, it was conducted in one of the consulting rooms in the Medical Reception Station (MRS) located in the barrack close to the battalion administrative headquarter and well away from the residential area on a Saturday when the workers were not at work. For the civilian community, FGD was conducted in a hall in a nearby school on a Saturday evening. Three persons conducted the FGDs: a moderator, a recorder who documented the discussions and operated the tape recorder and a time-keeper/observer who kept the time and noted the non-verbal clues. The FGDs had between 8 -10 participants per group and the sessions lasted for between one and half to two hours.

A thematic analysis was subsequently done to bring out women's awareness, perceived causes and effects of IPV on the health of victims and children; also why IPV victims do not want to open- up, where abused women seek help (formal and informal networks), why abused women will remain in abusive relationships and ways of preventing IPV. The

information obtained from FGD was analyzed and the information obtained used to complement the quantitative data collected.

Ethical considerations

Permission from establishments and respondents

The study proposal was submitted to the Research and Ethics Committee of Lagos University Teaching Hospital, Idi-Araba and Federal Capital Territory Authority (Health and Human Development Department Ethics Committee. Approval was obtained from both bodies before commencement of study. Written permission was obtained from the commanding officer of the 7 Guards Battalion, Lungi Barracks. Written informed consent was also obtained from each respondent prior to interview. Verbal consent was obtained from the chairmen of the streets selected for the study before entry into the civilian community.

Serial numbers were used on the questionnaires instead of names for identification; interviews were conducted in privacy with respondents alone in their homes and at an agreed location where privacy could not be guaranteed at home. For the

qualitative data collection, informed verbal consent was obtained from participants before recording discussions and record of their names or any contact were not kept. They were also informed of who will have access to recorded information.

RESULTS

Quantitative

Fig. 1 shows that majority of the women who were victims of IPV in the civilian population sought help from their families and friends 46(42.6%). In the same vein, most of the military respondents 59(45.4%) also sought help from similar sources. Less than 1% of the victims in both civilian and military population sought help from the formal network such as the police, lawyers and law courts. While 15.7% of civilian victims patronized health and social services, less than 1% of the women from military setting utilized such services. The percentage of women from military barracks who utilized other sources of help such as religious and traditional/local leaders 14(10.8%) was lower than the number among civilians’ respondents 26(24.1%).

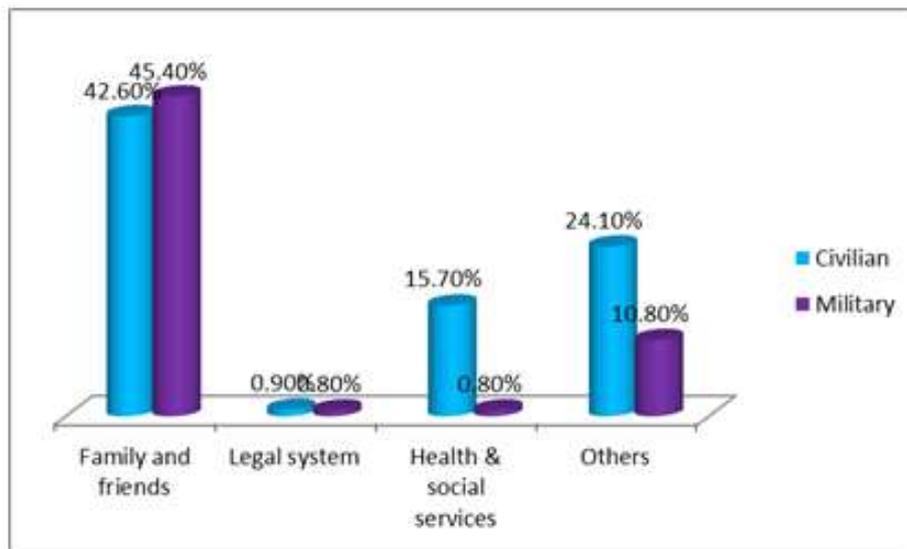


Fig. 1: Intimate partner violence victims’ self-reported sources of help

In Fig. 2, more victims of IPV from among the civilians respondents 16(14.8%) sought help because they were encouraged by family and friends than did from among the respondents from military barracks 9(6.9%). Majority of the women who were victims of IPV in the military barracks 36(27.7%) sought help because they couldn’t endure the violence anymore compared to their civilian counterpart 14(13.0%). More

women decided to seek help among the civilian respondents 15(13.9%) because they were thrown out of their homes compared to the number 1(0.8%) among the women from military population. Varying proportion of victims from both populations cited other reasons such as fear of more harm, to seek reconciliation and other reasons (needed time off, wanted to punish him etc).

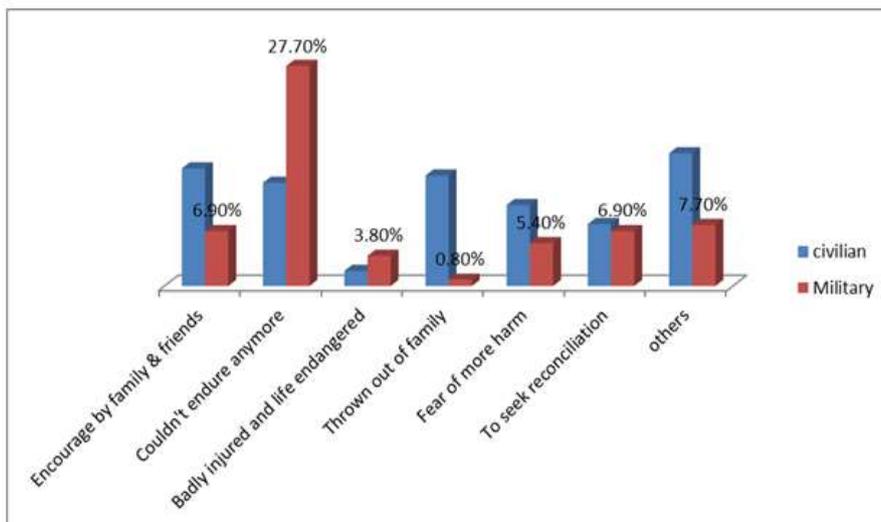


Fig. 2: Intimate partner violence victims' self-reported reasons for seeking help

Fig. 3 shows that the main reason why majority of the women who were victims of IPV remained in abusive relationships in both military and civilian communities was sanctity of marriage, more in the military 60(42.2%) than civilians 48(39.9%), followed by inability to support children/self also more

among military 22(16.9%) respondents compared to civilians 7(6.5%). More women from the military barrack 21(16.2%) will remain in an abusive relationship because they wouldn't want to leave their children compared to the civilian population.

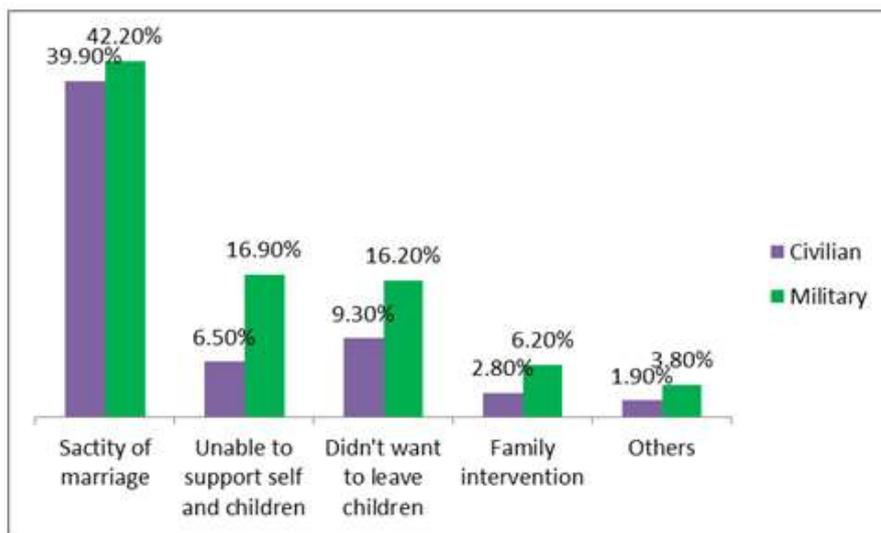


Fig. 3: Comparison of the main reason why victims of IPV remain in abusive relationships

Fig. 4 shows a comparison of respondents' suggestions for stopping IPV. Majority of the respondents in both military and civilian populations suggested women being patient, enduring and being submissive to the male partner as a way of stopping IPV. Over 56.9% and 45.4% for military/civilian

respectively, suggested women should be prayerful while 52.4%(civilian) and 40.8% (military) suggested being patient and enduring, less than 5% in both military and civilian settings suggested women empowerment, legislation against violence etc.(not shown on figure).

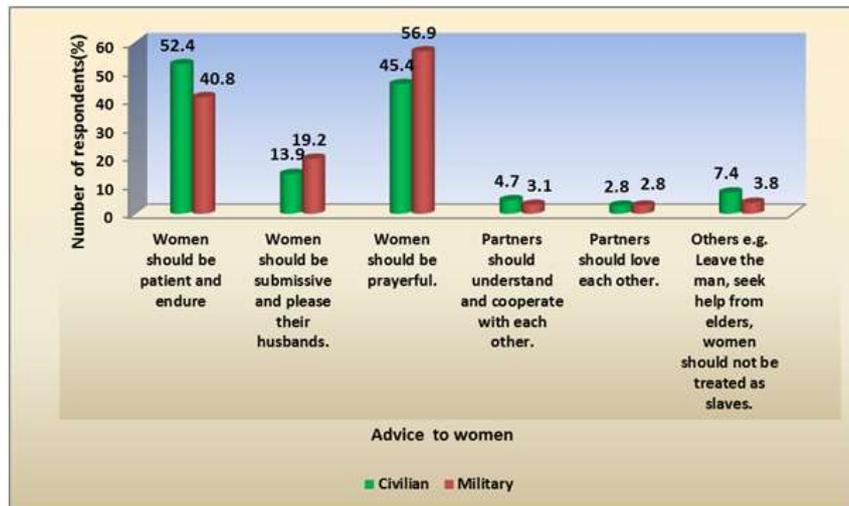


Fig. 4: Comparison of respondents reported suggestions for stopping intimate partner violence

Report of focus group discussion

Health impact on victims of IPV and children who witness it

All the respondents in all the FGD groups unanimously agreed that IPV impacts negatively on a victim’s health. Majority of the barrack participants mentioned impacts such as sleeplessness, hypertension, lack of self - confidence and depression while the civilian population emphasized health problems such as suicide ideation and hypochondriac (always visiting hospital for non-specific ailments). As stated by one participant and echoed by a good number “Many of the mad women you see on the streets or in psychiatric hospitals have their madness caused by marital problems”. Majority of the respondents were of the opinion that when a woman is in an abusive relationship, it affects all aspects of her life and those of her children, even the unborn child. They believed that the children may grow up to accept abuse as normal in a relationship (for the females) or become abusive (for the males). To buttress this point, a participant reported a case of a boy under 10 years from an abusive home who while playing with another said this “when I grow up, I will be beating my wife because my daddy told me that that is how to treat a woman”

Where IPV victims seek help

Majority of the FGD participants in both settings use the informal sector such as victim’s family, in-laws, friends, God in prayer (both Christians and Moslems), religious leaders (especially for Christians), village meetings etc. More than 50% of the respondents said “I just talk to my God because He is the only one that can change my partner”. Another participant said “I just take it to God in prayer, really who do I want to tell that my husband does not touch me for more than five years now and when I complain the response I get from him is who wants to touch that your rotten body. So you see it’s only God that can help me in this matter”

In the military, some victims resort to the formal sector especially when it involves severe physical violence. The case is reported to the women leader (popularly known as magajia) either by the victims, neighbours or friends, the magajia tries to mediate. If she fails, she refers the matter to the Company Sergeant Major (Coy CSM) in charge of the abuser’s military company, if he fails to handle the case; he refers it to the unit Commanding Officer (CO). The role of this whole hierarchy of people is just that of mediation, not any form of enforcement. If the CO fails to settle the matter, the family is ejected from the barrack. As one of the participants who is a victim reported “Even when I am badly wounded, I do not tell people, even at the hospital I tell some lies to cover up like “I hit my face on the door when there was no light”, because am afraid that if i report my husband, he will kill me. Besides I don’t want his job affected and I don’t want my family to be thrown out of the barrack. Where do we want to get money to start renting a place outside? So I just endure and pray he doesn’t kill me one day”. Among the civilians, participants reported that victims can seek help from the Human Right Commission, towns meetings, Ministry of Women Affairs, social welfare offices, some NGOs like WRAPA.

Why abused women remain in abusive relationships

Majority of the respondents mention reasons such as: they don’t want to leave their children, can’t support children/self, stigma of divorce/separation, loss of social identity of marriage etc.

Suggested ways of stopping IPV

Most of the participants in the military setting believed that empowering women educationally and through skill acquisition to boost their economic standing will go a long way. Behavioural change through health education was emphasized. As suggested by one participant, “You people that are close to government should please find a way to educate our

partners to know the damaging effect of these kinds of behaviour on women and children and the society as a whole.

In the civilian group, the echo was more on primary prevention, empowering the girl child and making her believe in herself and teaching the boy child to respect and regard females as partners not subordinates, starting from home through school so that by the time they are in relationship/marriage, they will know how to treat their partner. Both military and civilian groups believe that enactment of an enforceable law will serve as a deterrent to abusers.

For women who are currently in abusive relationships, some of the participants said “seek help now before you die and waste your life and make your children suffer”. Others said, “just be patient and pray, there is nothing God cannot do”

DISCUSSION

In this study less than 50% of victims in both military and civilian populations did seek help from anywhere and majority of those that did, sought help from family (victim's family and in-laws) followed by priest/religious leaders, then friends. Very few respondents sought help from the formal sector and majority of those that did were from among the civilian respondents. Most of the abused respondents never told anyone about their plight because of societal norms which view violence by an intimate partner as a minor issue. For those that decided to open up, the response they got even from the informal sector (extended family and friends) was discouraging. Some studies corroborate these findings. Studies have shown that between 20%-70% of abused women never told anybody about the abuse until they were interviewed. Those who reached out did so to extended family members and friends rather than to institutions [15]. According to WHO study two-thirds of women who had been physically abused by their partners in Bangladesh and half in Samoa and provincial Thailand had not told anybody about it prior to the interview [16]. In contrast about 80% of the physically abused had told someone, usually, family and friends. But even in these settings, 2 out of 10 women had kept silent about their experiences [11]. In all settings, women who had experienced severe physical violence were more likely to talk to someone than those who had experienced moderate physical violence [11].

The commonest health impact of IPV on the women in this part of the world appears to be psychological. This can be gleaned from the ‘military’ participants’ utterances in the FGD that sleeplessness, hypertension, lack of self-confidence and depression as some of the impacts. Similarly, the civilian population emphasized emanating health problems IPV such as suicide ideation and hypochondriac (always visiting hospital for non-specific ailments). One of the

participants was even emphatic that many of the ‘mad’ women seen on the streets or in psychiatric hospitals have their madness caused by marital problems”. This largely psychological manifestation of IPV among women in this part of the world could be traced to the tendency of the sufferers to bottle-up and pretend that such situations do not exist all in an attempt to preserve the sanctity of their marriage. The culture of silence in the midst of IPV among the respondents is further corroborated by majority of the respondents in both military and civilian populations who suggested women should be patient, enduring and submissive to the male partner as a way of stopping IPV. In the western world, the manifestation of IPV appears to be more of physical than psychological because such violence is resisted by the women leading to a possible physical conflict with the perpetrator. This can result in injuries or even death as can be attested to by a study in the USA, which found that one-third of all women murdered each year are killed by their intimate partners [22].

IPV affects not just the woman but also the children who witness such acts. Children have highly impressionable minds and frequent acts of IPV in their homes can negatively mold their character such that they grow into perpetrators of IPV when they get married. This poses a threat to the continuity of the family as an important unit and bastion of conflict resolution among couples within the society. Little wonder then that majority of the victims’ self-reported sources of help for IPV in this study are family and friends. This finding is supported by the Nigerian 2008 national demographic and health survey (NDHS) which also reported that majority of women who ever experienced physical or sexual violence sought help from their family, followed by in-laws and friends in that order of priority [23].

CONCLUSION

It is recommended that NGOs working in this area should be encouraged on short term to establish temporary shelters where feasible, provide empowerment programmes and assist victim in seeking legal redress where necessary. The religious communities, since they are important source where IPV victims seek support should be sensitized to be more proactive in preaching against IPV and IPV “drivers” as well as stigmatize abusers as a deterrent. They should also assist in providing support for victims. People in position of authority/opinion leaders should speak-out and champion positive behavioural change among couples in intimate relationships.

Furthermore, at all levels of their development, young people should be taught to have respect for human life and rights to enable them build from violent-free families to violent-free society.

The military community in particular should develop policy and enabling environment for abused

women to speak-out and seek redress. Healthcare providers should be sensitized through advocacy by pressure groups to actively screen every woman accessing healthcare for IPV and treat or refer appropriately.

Moreover, economic empowerment of women should be pursued with vigor by Governments at all levels to give women some level of independence and confidence to escape IPV. In addition, Government should ensure speedy passage of the bill on 'Elimination of all forms of violence and discrimination against women which will aid legal process in handling cases of IPV. It should also focus on strategies to ensure the full implementation of the contents of the National Gender Policy which will include programmes that will alleviate poverty and empower women and give them a voice to speak-out and stand up for their human rights.

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