

Prevalence and Patterns of Domestic Violence Against Women: A Comparative Study of Urban and Rural Communities in Anambra State, Nigeria

Chiejine Gibson Ifechukwude^{1,2}; Akubue Nnaemeka Emmanuel³ ; Ugwunweze Jacinta I. ⁴ ; Merenini Michael Chukwuebuka⁵; Okoli Adaora Ukamaka⁶; Ezika Bonaventure Chukwuebuka⁷; Ogbonna Ifeoma Vivian^{2,8} ; and Oyewumi Adesola Olayinka-Ësthêr⁹

¹Department of Community Medicine, Nnamdi Azikiwe University Teaching Hospital, Nnewi, Anambra State, Nigeria. ²Department of Population and Reproductive Health, School of Public Health, University of Port Harcourt, Nigeria. ³Department of Paediatrics, University of Nigeria Teaching Hospital, Enugu State, Nigeria. ⁴Institute of Public Health, College of Medicine, University of Nigeria, Nsukka, Nigeria. ⁵Department of Sociology, University of Abuja, Nigeria. ⁶Enugu State College of Nursing Sciences Parklane Enugu State, Nigeria. ⁷Chukwuemeka Odumegwu Ojukwu university, Anambra State, Nigeria. ⁸Department of Community Medicine, University of Port Harcourt Teaching Hospital, Nigeria. ⁹Anchor University, Lagos, Nigeria.

Corresponding author: dr gib2002@gmail.com

DOI: <https://doi.org/10.62154/ajhcer.2025.021.01012>

Abstract

Domestic violence (DV) remains pervasive worldwide, but its prevalence and patterns vary across socio-economic and cultural contexts. In Nigeria, urban and rural settings may present different risk profiles and manifestations of violence. This study assessed and compared the prevalence and patterns of DV among urban and rural women. A community-based cross-sectional comparative study of 588 women was carried out in Anambra State. Quantitative data were analysed with descriptive and inferential statistics using IBM SPSS version 25.0. The qualitative interviews with 20 survivors provided contextual understanding, and the analysis was done thematically using NVivo 13.0. The mean age of the respondents was 31.88±10.1 years. The most common age group was 20-29 years (208; 35.4%). Most of the respondents had secondary education (328; 55.8%), were married (394; 67.0%), were self-employed (331; 56.3%), and had 3-4 children (205; 34.9%). Lifetime prevalence and 12-month prevalence of DV were 58.0% and 32.3%, respectively. Urban respondents reported slightly higher lifetime prevalence and 12-month prevalence of DV (60.5%, 33.0%) compared to rural respondents (55.4%, 31.6%), though the differences were not statistically significant. Financial violence and physical violence were more common in urban areas than rural (43.2% to 31.3% and 39.8% to 34.4%, respectively). The difference in financial violence was significant (χ^2 : 12.32; P: 0.002). Emotional violence was significantly higher among rural women (26.5% to 19.7%) than urban women (χ^2 : 16.73; P: P:0.035). Qualitative accounts from the 20 women who were survivors of DV in this study confirmed these findings, highlighting financial neglect and abuse in urban settings and emotional discipline in rural communities. Domestic violence prevalence remains high in both

settings, but the types of violence vary by geography. Interventions must consider contextual differences, with economic support prioritized in urban settings and cultural norm change emphasized in rural areas.

Keywords: Domestic Violence, Prevalence, Determinants, Nigeria, Urban, Rural, Anambra.

Introduction

Domestic violence (DV) is a ubiquitous violation of women's rights and a major public health concern globally. It is defined as any act of physical, sexual, emotional, or financial abuse perpetrated by an intimate partner or family member (World Health Organization, 2021). DV contributes significantly to the burden of disease, maternal morbidity, and poor psychosocial outcomes, including depression, post-traumatic stress disorder, and reduced quality of life (Muluneh et al., 2020). It was first publicly spoken against in the 1970s (Ticu, 2020). In 1996 the World Health Organization (WHO) declared domestic violence a public health priority (World Health Organization, 2021). It cuts across all types of families irrespective of socio-economic, ethnic, cultural or religious background and place of residence, hampering women's right to participate fully in the society (Lafaurie V., 2015; Solanke, 2018). It affects all spheres of women's lives, such as self-esteem, productivity, autonomy, capacity to care for themselves and their children, ability to participate maximally in social activities, and even death (Solanke, 2018). It creates a vacuum in the social and economic development of any society. Domestic violence has other names which include gender-based violence, intimate partner violence (IPV), domestic abuse, partner abuse, spousal abuse, family violence or wife abuse. It has been defined in several ways.

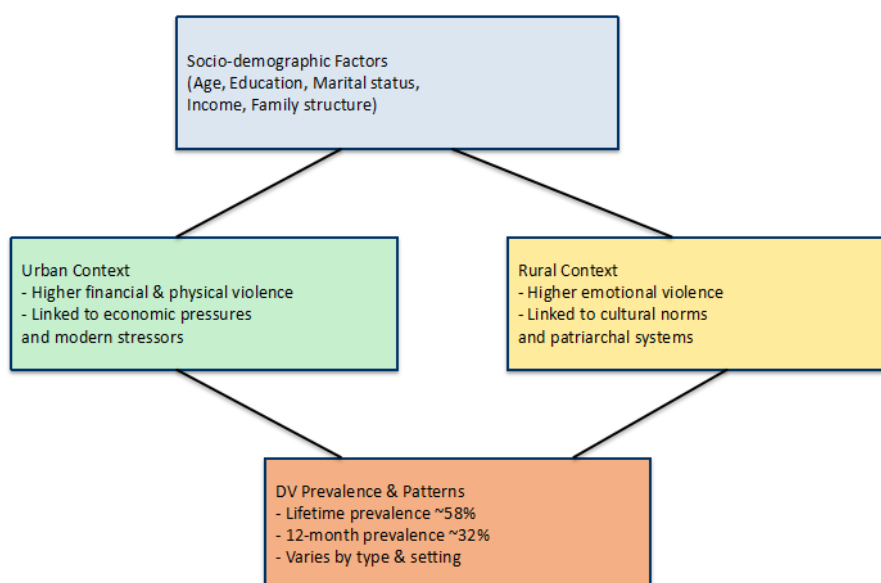
Statement of Problem

The World Health Organization (WHO) multi-country study reported that 15-71% of women had been exposed to marital violence at one point in time or the other (García-Moreno et al., 2015). Almost 1 in every 3 of women in marital relationships had experienced some forms of violence which could be physical or sexual, from their partners (World Health Organization, 2021; Abdullahi et al., 2018). The health, physical, sexual, and the general wellbeing of millions of women have been negatively affected by violence with its short and long-term consequences (World Health Organization, 2021). Several literature have indicated that religion, ethnicity and culture have deep-rooted influence on the frequency, the different types of DV experienced by exposed women; women's perception of domestic violence; women's response and help-seeking behaviours to domestic violence across the globe (Hulley et al., 2023; Oyewuwo, 2020; Plitt Donaldson, 2018; Abdullahi et al., 2017; Ishola, 2016). In African societies, violence against women is perceived as a private issue of marital affairs and women have been socialized into accepting it as a norm (Ishola, 2016). Some cultural practices in Nigeria have exposed women to all forms of abuse in their matrimonial life. Norms about marriage, predominant male positions, and forced marriages have been identified as the root of the risk factors of domestic violence in Nigeria

(Ojo Adedeji, 2023; Oyediran, 2016). To tackle the harmful effects of violence on women and society, there is an urgent need to challenge this social structure and cultural practices at all levels. In sub-Saharan Africa, estimates suggest that nearly one in three women experience intimate partner violence in their lifetime (Devries et al., 2021). In Nigeria, DV remains widespread, with prevalence rates ranging from 20% to 70%, depending on region, population, and methodology (Ajayi & Somefun, 2022). However, the dynamics of DV may differ between urban and rural populations due to variations in education, economic opportunities, and cultural norms. Urban women may be more exposed to financial and psychological violence, while rural women may experience higher levels of physical abuse reinforced by traditional gender roles (Olagunju et al., 2021). Despite the recognition of these contextual differences, limited studies have systematically compared urban and rural communities within Nigeria especially in the east. Such comparisons are critical for designing effective interventions tailored to the needs of specific populations. This study aimed to assess the prevalence and patterns of domestic violence among women in urban and rural communities of Anambra State, Nigeria.

Conceptual Framework

Socio-demographic Factors and Domestic Violence Prevalence/Patterns (Urban vs. Rural)



The above conceptual framework was developed from literature review of similar studies. This study examined the sociodemographic characteristics among women in urban and rural communities that influence the prevalence and patterns of domestic violence.

Methods**Study Design and Setting**

The study was a community-based comparative cross-sectional study conducted in Anambra State, Southeast Nigeria. Two Local governments arears LGAs were selected using probability sampling technique: Nnewi North (urban) and Anaocha (rural), to reflect diverse socio-economic and cultural contexts.

Study Area

The research was conducted in Anambra State, which is one of the 36 states in Nigeria. The state capital of Anambra State is Awka. The name "Anambra" is a translation from the original name of the river Omambala. Anambra State shares borders with Delta State to the west, Imo and Rivers State to the south, Enugu State to the east, and Kogi State to the north. The original Anambra State was created in 1976 when East Central State was divided into the Anambra and Imo States. There are three senatorial districts in the state, namely: (a) Anambra North senatorial district, comprising Awka North and Awka South, Njikoka, Dunukofia, Anaocha, and Idemili North and Idemili South Local Government Areas (LGAs); (b) Anambra Central senatorial district, made up of Onitsha North and Onitsha South, Ogbaru, Oyi, Ayamelum, and Anambra East and Anambra West LGAs; and (c) Anambra South senatorial district consisting of Orumba North and Orumba South, Aguata, Ihiala, Ekwusigo, and Nnewi North and South LGAs (Centre for Community and Rural Development 2024). There are 21 local government areas in the state. The indigenous ethnic groups residing in Anambra State primarily consist of the Igbo community, which represents 99% of the total population. Anambra is ranked as the eighth most prominent state within Nigeria and it is the second most densely populated state in Nigeria, following closely behind Lagos State (city population, 2023). It has a total area of 4,710 km², 1,264/km² Population Density and 2.2% Annual Population growth rate (city population, 2023). As of 2022, Anambra State projected population was 5,953,500. The male population accounts for 50.7% of the total, while the female population represents 49.3% (city population, 2023). Furthermore, the age demographic breakdown shows that individuals aged 0-14 years constitute 35.5% of the population, those aged 15-64 years make up 60.5%, and individuals above the age of 65 account for 4% of the total population (city population, 2023). The major occupation is trading and agriculture. According to the National Population Commission, Awka Anambra State, the Local Government Areas are categorised into Urban and Rural Local Government Areas. There are seven Urban Local Government Areas which include Awka South, Idemili North, Ihiala, Nnewi North, Nnewi South, Onitsha North, and Onitsha South. There are fourteen rural Local Government areas which are Aguata, Anambra East, Anambra West, Anaocha, Awka North, Ayamelum, Dunukofia, Ekwusigo, Idemili North, Idemili South, Njikoka Ogbaru, Orumba North, Orumba South, and Oyi local government area.

Quantitative Study**The Study Population**

This study population comprised all women 18 years and older living in households of the selected study areas.

Inclusion Criteria

This included all women 18 years and older who have lived in the selected communities of study for at least one year prior to the study.

Exclusion Criteria

This include women who were critically ill and not fit to participate during the study period

Sample Size Determination

The formula for comparative studies for proportions was applied to calculate the sample size for this study. The formula is $n = \frac{2(Z\alpha + Z\beta)^2 P(1-P)}{(p_1 - p_2)^2}$ (Charan et al., 2021)

Where n= Minimum sample size for each group.

The level of significance (α) and the power of the test ($1-\beta$) were set at 5% and 80% respectively

$Z\alpha$ = Standard normal deviate corresponding to the probability of type 1 error (α) at 5% =1.96

$Z\beta$ =Standard normal deviate corresponding to the probability of making type II error (β) of 20%. The power at 80% was used which is =0.84.

p_1 and p_2 were the proportion in two groups of a similar study.

P is pooled prevalence calculated by adding prevalence in group 1 and prevalence in group 2 and then dividing the sum by 2. In this study reference was made to research by Ajah *et. al.* in southeast Nigeria where the prevalence of physical domestic violence was 37.2% among the rural women and 23.5% in urban women(Ajah et al., 2014) .

Therefore, p_1 and p_2 were respectively 0.372 and 0.235

Substituting the values into the equation, $n = \frac{2(Z\alpha + Z\beta)^2 P(1-P)}{(p_1 - p_2)^2}$

$n = \frac{2(1.96 + 0.84)^2 * 0.3035 * 0.6965}{0.018769}$

$n = 15.68 * 11.2626$

$n = 176.60$

Approximately 177 participants in each group were calculated.

A 10% non-response rate was considered using the formula, $n/(1-f)$ where n= sample size, f is the proportion of non-response rate. Therefore, total sample size = $176.6 / (1-0.1) = 176.6 / 0.9 = 196.22$. Sample size for the study was approximately 196.

Therefore, sample size for the respondents in the rural and urban communities was 196 participants each. Applying a design effect of 1.5 as multistage sampling technique was used, the total sample size became $1.5 * 392 = 588$. Therefore, total number of participants was 588. The number of participants for each group was approximated to 294.

Sampling Technique

The multistage sampling technique was used for the selection of the study participants. The stages involved stratification, simple random sampling technique and the World Health Organization modified cluster sampling technique:

Stage 1: Stratification

The Local Government Areas were stratified first into the urban and rural LGAs

Stage 2: Simple random sampling technique

One LGA was selected from each stratum using simple random sampling technique. Nnewi North Local Government was randomly selected from the seven urban LGAs. From the fourteen rural Local Government areas, Anaocha Local Government Area was randomly selected.

Stage 3: Simple random sampling technique- Selection of the wards.

One ward each were selected from the Nnewi North and Anaocha LGAs by simple random sampling method. Nnewi-Ichi ward 2 was selected from Nnewi North LGA and Neni ward 1 was selected from Anaocha LGA.

Stage 4: Selection of the Households and respondents

The World Health Organization modified cluster sampling technique was employed at this stage. Starting from a prominent central point (a school), a bottle was spinned on the ground. From the direction the bottle was facing, the first house on the right was selected, and then moving clockwise, all women in each household who met the inclusion criteria were studied until the required sample size was obtained. In each household, only one eligible woman was studied and in compounds with more than one household, all eligible women were studied

Data Collection

Quantitative data were collected using structured interviewer-administered questionnaires adapted from validated instruments (WHO Multi-Country Study on Women's Health and Domestic Violence). Items assessed were overall and past 12-months prevalence of DV, and the patterns of DV. The questionnaire had three sections;

Section A: Socio-demographic characteristics of respondents

Section B: Prevalence of domestic violence

Section C: Patterns of domestic violence experienced

Validity and Reliability of Study Instrument

A semi-structured interviewer-administered questionnaire adapted from the WHO Multi-Country Study on Women's Health and Domestic Violence was used to collect data for this study (WHO Multi-Country Study on Women's Health and Domestic Violence Against Women 2005). The study instrument was reviewed by experts and my supervisors for face and content validity. The Cronbach's Alpha of the study instrument was 0.653. The questionnaires were translated to Igbo language then back translated to English to ensure that the original meanings of the research questions were retained.

Pre-Testing

The study instruments for the research were pretested in a different Local Government area in Anambra state different from the selected LGAs for the research. A pre-test of 10% (approximately 59) of the sample size (588) was used. The pre-testing assessed the validity of the questionnaire, the capability of the research assistants, the interactions and cooperation between interviewer and interviewee, time it takes to complete the interview, need for corrections in the study instrument and feasibility of the interview process.

Data Analysis

Quantitative data were analysed with the IBM SPSS version 25. Descriptive statistics summarized the sociodemographic characteristics, prevalence and the patterns of domestic violence among the urban and rural women. Chi-square tests compared the urban and rural groups.

Qualitative Study

Qualitative study type

In-depth interview (IDI) was employed in the qualitative study

Study population

It includes all the women survivors who experienced domestic violence

Inclusion criteria

It includes all the women survivors who experienced domestic violence captured during the quantitative study.

Exclusion criteria

Women who were not be able to grant the in-depth interviews (IDIs)

Sampling technique

Twenty women who experienced domestic violence were purposively selected for the study. Ten of the survivors were selected from each of the wards under study. Each of the participants that meet the criteria for the in-depth interviews (IDI) was counselled and interviewed by the principal researcher and the research assistants simultaneously after identification from the quantitative study until the required number was reached.

Method of Qualitative Data Collection

Data was collected using the in-depth interview (IDI). All respondents in the quantitative study who experienced domestic violence qualified for the in-depth interview. Ten survivors were selected from Neni ward 1 under the rural LGA (Anaocha) and ten were selected from Nnewi-Ichi ward 2 in Nnewi North LGA. Each participant was told about the essence of the IDI and its benefit. The conversations were tape-recorded and documented to improve qualitative data analysis. Before initiating the interviews, measures were taken to make participants relax using different techniques such as, small talk for a few minutes, helped them remain comfortable during the interview. We also assured participants that their

responses will be kept confidential. Each IDI lasted for about 25 to 30 minutes per participant.

Qualitative Interview Guide

The interview guide was designed to capture the participants' understanding and details of the patterns of domestic violence; as well as their reflections and recommendations on what could or should be done to reduce domestic violence. The interview guide was developed based on prior experience, expert opinions, and from reviewing relevant literature on the subject.

Interview Guide Pre-Test

The interview guide was pretested in a different community at other sites with similar characteristics for clarity, time it takes to complete each interview and for validity. This was done simultaneously with the pre-test of the quantitative study.

Qualitative Data Analysis

In-depth interviews (IDIs) explored details of the patterns of DV experiences by the survivors. It was conducted in conducive place and the interview was tape-recorded. Thematic qualitative analysis was employed to analyse the data collected through-Familiarization; coding the data to highlight specific ideas, concepts and patterns; generating themes; reviewing themes; defining and naming themes; and writing the report. The data was analysed with the Nvivo software 13.0 software.

Ethical Considerations

Ethical approval was obtained from the University of Port-Harcourt Ethics Committee. The ethical approval reference number was UPH/CEREMAD/REC/MM107/012 and dated 25th February 2025. Written informed consent was obtained, and confidentiality was assured and maintained. The survivors of domestic violence were counselled and given contacts of relevant agencies that assist survivors of DV.

Results

Socio-demographic Characteristics

The most common age was the 20 to 29-year age group (208;35.4%) in the general group. For the urban respondents, the most common age group was the 30 to 39-year age group (109(37.1%)). While for the rural respondents, the most common age group was the 20 to 29-year age group (113;38.4%). The mean age of the respondents was 31.88 ± 10.1 years in the total group. The mean ages for the urban and rural respondents were 31.3 ± 9.4 years and 32.4 ± 10.8 years respectively. Most of the respondents were Igbos (534; 90.8%) and Christians (512;87.1%). This was similar for the urban and rural groups. Most of the respondents were married or cohabiting (394; 67.0%) and this reflects in the urban and rural groups (180;61.2% and 214;72.8% respectively). The variable that was significant in the

sociodemographic characteristics was marital status-the singles was far more in the urban setting than the rural while the married/ cohabiting women were reasonably more in the rural group than the urban group (see table 1). Majority of the participants (513; 87.2%) were of the nuclear family and monogamous setting (413;70.2%) in the total group. This same pattern was reflected in the urban and the rural groups. There was significant difference ($P: 0.014$) in relationship type between urban and rural respondents; respondents in the monogamous setting were more in the rural setting than the urban (214;72.8% and 199; 67.7% respectively). Regarding the duration of the current relationship, the percentages of respondents for <5years, 5-10years and >10years were strikingly similar in the total group (197; 33.5%, 194;33.0% and 197;33.5% respectively). However, among the urban respondents, most of the respondents were >10 years in relationship (115, 39.1%), while among the rural respondents, most of the women were in the 5 - 10 years relationship than the urban women (120; 40.8% to 74;25.2%). The difference was significant (P -value of 0.001). Most of the women 's highest level of education was secondary school (328,55.8%) in the total group and was reflected in the urban and rural group. However, the urban women had a higher percentage of respondents who had tertiary education than their rural counterparts (112;38.1% and 87;29.6% respectively), indicating that the urban women were more educated in this study and this difference in level of education was significant (P -value is 0.005). Regarding the age difference between the spouses, the respondents whose age difference with their spouse was greater than 10 years were the most common among the total group, urban and rural respondents. The respondents with spousal age difference of greater than 10years was more in the urban settings than the rural settings (164;55.8% and 128;43.5% respectively) while 5- 10 years spousal age difference was far higher among rural than urban respondents (99;33.7% and 55;18.7% respectively). The spousal age difference between the urban and rural respondents was significant at P -value of 0.001. See table 2.

The overall prevalence and prevalence of domestic violence in the past 12 months were 58.0% (341) and 32.3% (190) respectively in the total group. In the urban and rural groups, the group the overall prevalence and prevalence of domestic violence in the past 12 months were (178;60.5%, 97;33.0% and 163;55.4%, 93;31.6%) respectively. The occurrence of domestic violence was higher among the urban respondents compare to their rural counterparts. However, the difference was not statistically significant for both overall prevalence and prevalence in the past 12 months. See table 3.

Financial and physical violence (219;37.2% and 218; 37.1% respectively) were found to be the most common patterns of violence experienced generally, and sexual violence was the least experienced. Among the urban respondents, financial violence was very common (127; 43.2%) compared to the rural respondents (92;31.3%) and it was statistically significant($P:0.002$). While among the rural respondents, physical violence was the most common pattern of violence (101;34.4%) experienced. Experience of emotional violence was noted to be higher among the rural women than the urban women (78;26.5% to 58;19.7% respectively), this difference was statistically significant($P:0.035$). The difference

in physical and sexual violence between the urban and rural respondents were not significant. See table 4

Table 1: Socio-demographic Characteristics of Respondents

Variable	Urban (294)	Rural (294)	Total (588)	Test statistics	P-value
	Frequency (%)	Frequency (%)	Frequency (%)		
Age (years)				8.80	0.066
<19	28(9.5)	22(7.5)	50(8.5)		
20-29	95(32.3)	113(38.4)	208(35.4)		
30-39	109(37.1)	95(32.3)	204(34.7)		
40-49	52(17.7)	42(14.3)	94(16.0)		
>50	10(3.4)	22(7.5)	32(5.4)		
Mean ±SD	31.3±9.4	32.4±10.8	31.9±10.1		
Ethnicity				1.10	0.578
Igbo	270(91.8)	264(89.8)	534(90.8)		
Yoruba	20(6.8)	23(7.8)	43(7.3)		
Hausa/Fulani	4(1.4)	7(2.4)	11(1.9)		
Religion				1.39	0.499
Christianity	260(88.4)	252(85.7)	512(87.1)		
Traditional	28(9.5)	32(10.9)	60(10.2)		
Islam	6(2.0)	10(3.4)	16(2.7)		
Marital status				10.27	0.016*
Single	71(24.1)	43(14.6)	114(19.4)		
Married/Cohabit	180(61.2)	214(72.8)	394(67.0)		
Divorced	19(6.5)	16(5.4)	35(6.0)		
Widow	24(8.2)	21(7.1)	45(7.7)		

Note: SD: Standard deviation, %: Percentage, *: Significant P-value

Table 2: Socio-demographic Characteristics of Respondents

Variable	Urban (294)	Rural (294)	Total (588)	Test statistics	P-value
	Frequency (%)	Frequency (%)	Frequency (%)		
Family type				2.58	0.138
Extend	31(10.5)	44(15.0)	75(12.8)		
Nuclear	263(89.5)	250(85.0)	513(87.2)		
Relationship type				8.50	0.014*
Monogamy	199(67.7)	214(72.8)	413(70.2)		
Not married	69(23.5)	43(14.6)	112(19.0)		
Polygamy	26(8.8)	37(12.6)	63(10.7)		
Duration of current relationship				17.29	0.001*

Variable	Urban (294)	Rural (294)	Total (588)	Test statistics	P-value
< 5 years	105(35.7)	92(31.3)	197(33.5)		
5- 10 years	74(25.2)	120(40.8)	194(33.0)		
> 10 years	115(39.1)	82(27.9)	197(33.5)		
Education				12.80	0.005*
Non	4(1.4)	18(6.1)	22(3.7)		
Primary	17(5.8)	22(7.5)	39(6.6)		
Secondary	161(54.8)	167(56.8)	328(55.8)		
Tertiary	112(38.1)	87(29.6)	199(33.8)		
Age difference				17.46	0.001*
<5yr	75(25.5)	67(22.8)	142(24.1)		
5-10yr	55(18.7)	99(33.7)	154(26.2)		
>10yr	164(55.8)	128(43.5)	292(49.7)		

Note: %: Percentage, *: Significant P-value

Table 3: Prevalence of domestic violence

Variable	Urban (294)	Rural (294)	Total (588)	Test statistics	P-value
	Frequency (%)	Frequency (%)	Frequency (%)		
Overall prevalence	178(60.5)	163(55.4)	341(58.0)	1.57	0.210
DV in last 12 months	97(33.0)	93(31.6)	190(32.3)	0.12	0.724

Table 4: Patterns of domestic violence experienced

Variable	Urban	Rural	Total	Test statistics	P-value
	Frequency (%)	Frequency (%)	Frequency (%)		
Emotional	58(19.7)	78(26.5)	136(23.1)	6.73	0.035*
Financial	127(43.2)	92(31.3)	219(37.2)	12.32	0.002*
Physical	117(39.8)	101(34.4)	218(37.1)	2.04	0.361
Sexual	22(7.5)	26(8.8)	48(8.2)	0.95	0.623

%: Percentage, *: Significant P-value

Qualitative Narratives

The experience of violence by the survivors of DV were narrated. Physical violence was narrated by one of the rural respondents (22-year-old house wife, who has completed secondary school education). She expressed very emotionally *"my husband is a carpenter and came home angry and frustrated one day..... he asked for food, immediately I said food is not ready, I received very painful slap on my face and he walked out immediately."* (ID1 3).

IDI 13 said "I am a trader; I do not have strength to do house chores because of business and my sister who would have assisted me travelled. My oga refuse to understand, he complains that am very lazy and useless and threatens to hurt me.....". The family could not afford the services of a helper; and spouse always complains and abuses her.

A 24-year-old civil servant in urban community who had completed secondary school education, married for 3 years to a trader said emotionally " my husband is a trader and because of the bad economy, business is not doing well...any time I ask for money he would complain there is no money, and I will respond that he must bring out money and he would start abusing me and may want to slap me....He waste money on girls outside... I advise every woman to look for work or a way of making money to help her family". (IDI 20)

IDI 4 was a 28year old rural woman who sells clothes on the streets. She said " ...when a man is too jealous it is very dangerous.. I am very afraid of been hurt physically because he could be very aggressive if I don't pick his call on time...."

IDI 9(32 year old urban woman) said " ... I must be sincere with you, sometimes I am very scared my husband will actually hurt me. Sometimes my heart will be beating very fast because he shouts at me a lot..."

"A woman that always challenges the husband will be receiving beating" (Rural 10, hair stylist, 36 years).

The qualitative interviews provided detailed insights to the patterns of the DV experienced by survivors. Urban women often described financial neglect by spouse and it triggers violence. Most of the rural survivors emphasized physical violence as 'normal discipline' for perceived disobedience or rudeness to the spouse.

Discussion

This study examined the prevalence and patterns of domestic violence (DV) among women in urban and rural communities in southeast region of Nigeria. The mean age of respondents was 31.9±10.1 years, with the majority in the 20–29-year age group. This is consistent with reproductive-aged populations where DV is commonly studied (Ajayi & Somefun, 2022). Most respondents were married, self-employed, and living in nuclear, monogamous households, reflecting typical family structures in southeaster Nigeria. The lifetime prevalence of DV in this study was 58.0%, with a 12-month prevalence of 32.3%. These rates are comparable to findings in other parts of Nigeria and sub-Saharan Africa, where lifetime prevalence has ranged from 45% to 70% (Anikwe et al., 2023; Muluneh et al., 2020). In Uganda, for instance, 56% of women reported lifetime experiences of DV, while 28% reported recent violence (Sserwanja et al., 2021). The persistently high prevalence underscores DV as a critical public health problem across African societies. The urban respondents reported slightly higher prevalence rates of overall DV and DV in the last 12 months. This pattern is consistent with studies suggesting that urban environments may expose women to additional stressors such as, economic difficulties in business, financial neglect from spouse and marital conflicts linked to modern economic pressures (Ajayi & Somefun, 2022). Conversely, some studies have reported higher prevalence in rural areas,

where cultural acceptance of wife-beating is stronger (Dickson et al., 2021). This indicates that the urban–rural divide in DV prevalence may be context-specific, shaped by socioeconomic and cultural dynamics.

It was found in this study that financial violence was significantly more common in urban areas (43.2%) compared to rural areas (31.3%), a finding consistent with previous research showing that economic neglect and financial control are increasingly prevalent in urban households (Ambakederemo & Edewor, 2021). Qualitative interviews in this study reinforced this, with urban survivors describing financial neglect and diversion of family resources to extramarital relationships as triggers of conflict. Physical violence was also common, slightly higher in urban areas (39.8%) compared to rural (34.4%). These findings diverge from earlier studies in northern Nigeria and Ethiopia, which reported higher physical violence in rural communities due to entrenched patriarchal practices (Bulto et al., 2021). The relatively high rates in urban areas in this study may reflect rising stress associated with economic pressures and shifting gender dynamics in modern households. Emotional violence was significantly higher among rural women than the urban women (26.5% vs. 19.7%). This is consistent with findings from Ghana and Uganda, where rural women reported higher rates of psychological abuse, often normalized as “discipline” (Dickson et al., 2021; Sserwanja et al., 2021). Qualitative narratives in this study revealed that rural survivors frequently perceived emotional abuse as corrective behaviour rather than violence, aligning with feminist perspectives that highlight how cultural norms perpetuate women’s acceptance of subordination (Izugbara et al., 2020). Our study emphasized that DV is highly prevalent across both settings, but its forms differ contextually. Urban women face higher risks of financial neglect and physical abuse, while rural women experience more emotional abuse embedded within patriarchal cultural expectations. These distinctions are critical for directing intervention programmes. Urban programs must address economic pressures and spousal financial neglect, while rural programs should focus on transforming cultural attitudes that normalize emotional abuse.

Conclusion

Domestic violence remains highly prevalent among women in both urban and rural communities of Anambra State, Nigeria. While overall prevalence did not differ significantly between the two groups, distinct patterns emerged as financial and physical violence were more common among urban women, whereas emotional violence was more prevalent in rural settings. These findings highlight the need for context-specific approaches to DV prevention and response.

Recommendations

The government and lawmakers should strengthen enforcement of the Violence Against Persons (Prohibition) Act across urban and rural areas, with provisions for economic neglect and emotional abuse. Stakeholders should implement culturally sensitive awareness campaigns in rural areas to challenge the normalization of emotional abuse as “discipline.”

The government, non-governmental organization and philanthropists should improve in the aspect of economic empowerment through improving financial literacy, skill acquisition programs and economic support programs especially for women in urban settings to mitigate risks of financial violence. In the Health system, the primary healthcare workers should be trained to routinely screen for all forms of DV, and provide referral pathways for survivors. There should be more accessible government and private facilities specialised to handle DV and provide succour to survivors.

Collaboration is key to ameliorating DV. Therefore, it is pivotal to foster partnerships between government, civil society, and traditional leaders to address socio-cultural and economic determinants of DV.

Limitations of the Study

This study employed a cross-sectional design, which limits causal interpretations of the relationship between socio-demographic characteristics and DV patterns. Information from the male spouses would have added more details to the research but they were not captured.

The reliance on self-reported data may have led to underreporting due to stigma or fear of retaliation. Furthermore, the qualitative component was limited to 20 survivors, which may not capture the full breadth of experiences. Despite these limitations, the mixed-methods design enhanced the validity of findings by combining statistical analysis with in-depth contextual insights.

Future Directions

Future research should adopt longitudinal designs to explore trends in DV over time and assess the impact of interventions. Comparative studies across multiple states in Nigeria would help determine whether observed urban–rural differences are generalizable. Involving the males in subsequent studies will provide more comprehensive information that will improve policy development. In addition, expanding qualitative work to include men’s perspectives could also illuminate underlying drivers of domestic violence and inform gender-transformative approaches.

Declaration of interests

We declare no competing interests

Source of Funding

The research was self-funded.

References

Abdullahi, U., Binti, R., Cusairi, M., Faizaz, S., & Abdullah, B. (2018). The Influence of Culture in Domestic Violence. 2(6), 273–286.

- Ajah, L. O., Anthony, C., Nkwo, P. O., Nwakoby, B., & Ezeonu, P. (2014). Comparison of domestic violence against women in urban versus rural areas of Southeast Nigeria. *International Journal of Women's Health*, 865–872.
- Ajayi, A. I., & Somefun, O. D. (2022). Intimate partner violence and its associated factors among women in Nigeria: A multilevel analysis. *BMC Women's Health*, 22(1), 32. <https://doi.org/10.1186/s12905-022-01598-2>
- Ambakederemo, T. E., & Edewor, P. A. (2021). Socioeconomic determinants of intimate partner violence among women in Nigeria. *Gender & Behaviour*, 19(1), 17232–17247.
- Anikwe, C. C., Nwafor, J. I., Umeokonkwo, C. D., & Okeke, T. C. (2023). Intimate partner violence among married women in Southeast Nigeria: Prevalence and predictors. *BMC Public Health*, 23(1), 451. <https://doi.org/10.1186/s12889-023-15421-9>
- Bulto, G. A., Kebede, A. A., & Alemu, W. G. (2021). Domestic violence and associated factors among married women in Ethiopia: A systematic review and meta-analysis. *Reproductive Health*, 18(1), 190. <https://doi.org/10.1186/s12978-021-01248-1>
- City population (2025). Anambra State, Nigeria. Available at: https://www.citypopulation.de/en/nigeria/admin/NGA004_anambra/. Accessed July 20th, 2025.
- Charan, J., Kaur, R., Bhardwaj, P., Singh, K., Ambwani, S. R., & Misra, S. (2021). Sample size calculation in medical research: a primer. *Annals of the National Academy of Medical Sciences (India)*, 57(02), 074–080.
- Dickson, K. S., Adde, K. S., & Ameyaw, E. K. (2021). Women's knowledge and attitudes towards intimate partner violence in Ghana. *Journal of Interpersonal Violence*, 36(17–18), NP9397–NP9418. <https://doi.org/10.1177/0886260519881521>.
- García-moreno, C., Zimmerman, C., Morris-gehring, A., Heise, L., Amin, A., Abrahams, N., & Oswaldo, M. (2015). Violence against women and girls; Addressing violence against women: a call to action. *The Lancet*, 385(9978), 1685–1695. [https://doi.org/10.1016/S0140-6736\(14\)61830-4](https://doi.org/10.1016/S0140-6736(14)61830-4)
- Lafaurie V., M. M. (2015). Intimate partner violence against women during pregnancy: a critical reading from a gender perspective. *Revista Colombiana de Enfermagem*, 10(10), 64–77.
- Izugbara, C., Tenkorang, E. Y., & Ezech, A. (2020). Men, masculinity, and domestic violence in Nigeria. *Social Science & Medicine*, 265, 113451. <https://doi.org/10.1016/j.socscimed.2020.113451>
- Muluneh, M. D., Francis, L., Agho, K., & Stulz, V. (2020). Gender-based violence against women in sub-Saharan Africa: A systematic review and meta-analysis of cross-sectional studies. *International Journal of Environmental Research and Public Health*, 17(3), 903. <https://doi.org/10.3390/ijerph17030903>
- Olagunju, O. S., Bolarinwa, O. A., & Adebayo, A. M. (2021). Intimate partner violence in sub-Saharan Africa: The role of cultural norms and economic status. *Journal of Family Issues*, 42(9), 2071–2090. <https://doi.org/10.1177/0192513X20981168>
- Oni, O., Samuel, G., & Oladeji, D. (2021). Feminist perspectives on intimate partner violence in Nigeria: A sociological analysis. *Gender Studies International Forum*, 87, 102456. <https://doi.org/10.1016/j.wsif.2021.102456>
- Solanke, B. L. (2018). Does exposure to interparental violence increase women's risk of intimate partner violence? Evidence from Nigeria demographic and health survey. *BMC Int Health Hum Rights*, 18(1). <https://doi.org/https://doi.org/10.1186/s12914-018-0143-9>
- Sserwanja, Q., Musaba, M. W., & Mukunya, D. (2021). Factors associated with attitudes toward intimate partner violence among women in Uganda: A cross-sectional survey. *BMC Public Health*, 21(1), 204. <https://doi.org/10.1186/s12889-021-10239-7>.

- Ticu, I. (2020). Short incursion in the history of domestic violence. LOGOS, UNIVERSALITY, MENTALITY, EDUCATION, NOVELTY. Section: Law, 8(1), 35-46.
- World Health Organization. (2021). Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. World Health Organization.