The Awareness and Management of Victims of Violence against Women by Medical Care Givers in Benin City, Edo State, Nigeria.

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Abstract
Violence against Women is a major health and human rights problem in Nigeria. The study surveyed the awareness and management of victims of violence against women (VAW) by medical care givers in three local government areas in Benin City, Edo State Nigeria. The attribution theory was adopted as the theoretical framework for this study because it best explains the roles played by various actors in the health care settings like the hospital, traditional medicine practitioners’ homes, chemists or patent medicine shops that treat minor and major ailments and injuries of women. A total of 972 questionnaires were distributed, and analyzed using SPSS version 20. The findings showed that the level of awareness was high as (86.4%) medical care givers were aware of VAW. More females, (67.3%), respondents who are 21-38 years (63.2%), married respondents (56.4%), respondents with tertiary education (84.2%), Christians (89.8%), nurses (50.8%), and respondents that have been in medical practice for less than 16 years (77.8%) were aware that VAW exists. The medical care givers were ignorant of the role of social workers in the management of victims; however, 59.5% nurses were willing to integrate social workers, with so many of other categories not willing to do so. Recommended are adequate screening of patients for violence apart from physical signs by medical caregivers with appropriate referral.
and removing cultural barriers as well as training to improve their awareness and management of victims holistically.

KEY WORDS: Awareness, Caregivers, Health, Social Worker, Victims, Women

Introduction
Violence against women (VAW) is a global problem which occurs in many forms, such as physical, sexual, psychological, emotional, spiritual and economical (Dahlberg & Krug, 2002; UNICEF, 2005; Aihie, 2009). It is without cultural, geographic, religious, social, economic and national boundaries (Chitashvili & Javakhishvili, 2010). It is a term collectively used to refer to violent acts that are primarily or exclusively committed against women basically because of their gender. It has continued to be recognized as a major public health concern and a violation of human rights (Okemini & Adekola, 2012).

The United Nations Department of Public Information (2008) estimated that globally one in three women faces some form of gender based violence during her lifetime. According to Aihie (2009) domestic violence which is the commonest form of VAW occurs globally. Tjaden and Thoennes (2002) stated that in the United States of America, each year women experience about 4.8 million intimate partner-related physical assaults and rapes. The true prevalence of intimate partner violence is unknown all over the world, but the number of the women battered or abused every year is estimated to be ranging from 1.5 to 4 million (Abama & Kwaja, 2009).

Scholars have put forward various reasons why VAW occurs. They include the patriarchal nature of the society where men have the dominion over the women, religious belief, economic and political factors (Kapoor, 2000; Karanja, 2003; World March of Women, 2000; Okeimini & Adekola, 2012; Vingard, 2010). High domineering attitude of men according to Udegbe
(1995) and Alokan (2013) promotes domestic violence especially in the rural areas in Nigeria. Ashimolowo and Otufale (2012) observed that the relationship between men and women is that of senior-junior relationship. Alokan (2013) listed causes of domestic VAW to include personality traits and mental characteristics of the perpetrators, as well as external factors in the perpetrator’s environment, such as family structure, stress, jealousy and social context.

The effect of VAW is not only on the women but also on the children, family and the entire society (Alokan, 2013), VAW therefore may greatly increase the health care needs and attention women get from medical care givers. This is because most often medical care givers are the first people that come in contact with women after violence has occurred, and also often diagnose and treat injuries of victims of VAW. These medical care givers include medical doctors, nurses, traditional birth attendants, local medicine healers and patent medicine dealers. However, it has been argued by Sasseti (1993) that medical care givers spend a lot of time screening women for other medical conditions, but very few of them screen for violence related problems or relate the health problem to violence.

**Statement of the Problem**

The number of women experiencing different forms of violence is not known as many women deny abuse and very few studies have been carried out in Nigeria (Federal Ministry of Health, 2001). According to Abama and Kwaja (2009) it is estimated that one in every five women faces some form of violence during her lifetime, in some cases leading to serious injury or death. Until recently, most governments have considered violence against women (particularly “domestic” violence by a husband or other intimate partner) to be a relatively minor social problem. In many African countries such as South Africa, Uganda, Mozambique, Nigeria and Ghana, women and girls experience a lot of violent attacks from both male partners and non-partners (WHO, 2008).
Okemini and Adekola (2012) study on VAW in Rivers state on upholding the rights of women to reduce the problem found that women victims of domestic violence are 12 times more likely to attempt suicide than those who do not experience such violence - a very extreme negative health effect. This is likely due to the fact that they stay with their perpetrators for too long hiding the violence from the medical care givers even when they present signs of violence. Allen, (2014) reported that FGM is still endemic in the southern part of Nigeria, especially in the southeast and southwest geo-political zones with over 45 percent of its occurrence despite the law against it and the health implication. In all these endemic areas, rural girls and women are particularly affected as they continue to bear the health risks, social and economic costs of FGM, forced marriage, non-consensual sex and early pregnancies. FGM is globally recognized as a blatant violation of Fundamental Human Rights (Onwuzulike, 2008). Awuno, Obuehi and Nwankwo (2006) reported that the knowledge and attitude towards seeking medical care in case of exposure to sexual violence in Benin is not adequate, especially when they hide and deny the occurrence. This poses a challenge to medical care givers awareness and management of the victims, as well as increase costs to the society and the victims.

At present, many studies have been carried out on different aspects of VAW. Examples of such studies include that by Oli, Igbo and Okoye (2013) on perception of acts that constitute VAW. Haaga, Aja and Okoye (2015) carried out a study on VAW and its implications for peace and security in Nigeria, while Antai (2011) studied traumatic physical health consequences of intimate partner violence against women and the role of community-level factors. Also, Antai and Antai (2008) earlier studied the attitudes of women toward intimate partner violence among rural women in Nigeria. While a study by Alokan (2013) noted that the issue of violence to the point of killing the victim has often been treated as a non-issue. Until recently, none of these have focused on the role of medical care givers. Therefore this
study is designed to ascertain the level of awareness by different classes of medical care givers and also to find out how they manage victims of VAW in Edo State.

**Objectives of the study**

The main objective of the study was to examine the awareness and management of violence against women by medical care givers in Edo State. The specific objectives of this research included to:

1. determine the level of awareness of victims of violence against women by medical care givers in Edo State.
2. Identify how medical care givers manage victims of violence against women in Edo State.

**Literature Review**

Globally, awareness and management of victims of VAW by medical care givers is a problem which has not received adequate attention. Pancio (2014) stressed on the global action of the Convention on the Elimination of Domestic Violence against Women (CEDAW) which includes elimination of all harmful cultural practices that impede women’s rights. He observed that there is an overall lack of appropriate resource allocation in three countries for comprehensively implementing these laws in Pakistan, China and Sri Lanka which have adopted a mix of civil and criminal law to address VAW, including a national plan as against the global call for action to manage VAW. Global Alliance for Women’s Health (2009) in a detailed report revealed that concerning VAW, it is committed to advancing women’s health in all stages of life and at all policy levels through health promotion, education, advocacy and program implementation.

The implication is that women’s experiences of VAW in various forms can determine the awareness and management of their condition by medical care givers. NBS (2009) profile of men and women in Nigeria presents data on violence, including trafficking, labour, sexual exploitation and female
circumcision which also affect their health negatively. The UN Secretary General’s call for global action employs all to be at red alert on the issues of VAW such as the VAW world day when all the countries are expected to take part in the campaign and rallies for the elimination of all forms of VAW and medical care givers are key players in the management of victims. Statistics have shown that globally, women more than men mention causes of VAW as personality/behaviour issues (31% versus 21%, respectively), low education level (10% versus 4%, respectively), power issues/men seeking power (6% versus 2%, respectively), anger management issues (5% versus 2%, respectively), parenting (4% versus 1%, respectively), and ethnic background (3% versus 1%, respectively) (NBS, 2009). The implication is that globally, the women’s experience of VAW in different dimensions can determine the awareness and management of their conditions by the medical care givers. NBS (2009) profile of women and men in Nigeria presents data on violence, including trafficking, labour, sexual exploitation, and female circumcision which all can result in negative health of the victims requiring adequate response and management. The global call for all to be at red alert in the issues of VAW is to sensitize people on the need to condemn VAW all over the world to promote complete health of the women. To this effect, the 25th day of November every year is declared as the international day for the elimination of all forms of VAW, celebrated to create awareness for individuals to know that it is a matter to be taken seriously.

Social work is a profession and career that involves several interconnecting processes and techniques including methods for helping individuals to cope with their problems. According to Dubois and Miley (2002) one of the goals of social work profession is to identify gaps and barriers in social service. In practice, professional social workers may be involved in a few or all of the roles of a social worker depending on their job and the approach to practice that they want to adopt. Iwarimie- Jaja (2013) describes some of the roles as elucidated as a Teacher, Enabler, Educator, Mediator and
Advocate, Broker, Organizer, Manager, Activist, Facilitator, Evaluator and Analyst. He asserted that social workers help people who have social problems to function within their situation; such as find a shelter or housing program for victims and are often involved in the process of admission, discharge planning as well as coordinating after-care services such as at-home care, follow-up appointments or finding the patient a rehabilitation facility, if needed. Browning (2002) revealed the social workers services to clients (individuals, groups or communities) going through short-term crisis, suffering from chronic illnesses, facing a life-threatening disease, or in need of long-term care or rehabilitation.

In the management of victims of VAW, social workers manage the social aspect of the care of the victim and collaborate with medical care givers to achieve victims’ optimum health care. Brown (2015) noted that advocacy and social service provision aimed at increasing awareness and hastening progress towards ending VAW and providing counseling and referral services for the care and treatment of physical, mental and psychological problems are the social workers’ role. Parrish (2010) identified advocacy role of social workers that ensures that all women are entitled to safety from violence through collaborative effort and team work approach with other care givers and also engage in home visit and counseling victims and their relatives on how best to keep them from further violence. Social workers make referrals to appropriate facilities for further management such as to the ministry of women affairs for care of women and children where necessary, relocating them to safety or shelter where they can be protected, rehabilitated and empowered as need be to overcome their difficulties. In line with the National Association of Social Work (NASW) (2016) Standard 6 care planning and intervention role, social workers practicing in health care settings shall develop and implement evidence-informed care plans that promote client well-being and ensure a client- and family-centered continuum of care.
Theoretical framework

The attribution theory was adopted as the theoretical framework for this study because it best explains the roles played by various actors in the health care settings like the hospital, traditional medicine practitioners’ homes, chemists or patent medicine shops that treat minor and major ailments and injuries of women. The perception of the internal attribution (attitudes, character or personality) and the external attribution which explains why an individual behaves the way she or he does, because of certain factors come into play when medical care givers are carrying out their care of the victims. This corroborates Parrish (2010) position that the theory explains how people perceive and assess the causes of behavior and its consequences and that people are likely to attribute changes in their own behaviour to external influences but attribute changes in other people to internal characteristics or traits. The structural basis of the theory is that, in the healthcare setting, injuries of victims are treated and other aspects of their feelings are not attended to, and part of the medical care givers role from the view of Mead (1934) is to screen patients by asking them leading questions that help victims disclose their problems with confidence. They are also to counsel and respect the victims’ feelings as well as assure them of confidentiality. Also, victims of VAW have a role to play to ensure that they disclose the sources of their injuries to their medical care givers devoid of their social and cultural inhibitions as part of gender socialization, not hiding the problem in order to get full and proper management (Ezuma, 2001).

Also, medical care givers have to play their role to achieve the total wellbeing of the victims but if the medical care giver attributes the causes to certain rationalization to the victim, it is likely to affect his or her management of the victim. For example if the medical care givers apply victim blame (Grubb & Turnner 2012), they are more likely not to take adequate action to manage the victim. Equally related to self-partner attributions (Flynn & Graham, 2010), causal attribution theory is useful for
understanding the importance of perceptions surrounding VAW and for articulating how this knowledge can be used in the development of effective prevention programming. Karamagi, Tumwine, Tylleskar, and Heggenhougen (2006), from their study in Uganda found punishment for perceived wrongdoing by the women to be a cause of violence by their husbands. Therefore, if the medical care givers also perceive that this is a normal phenomenon, they are not likely to see it as a problem that requires management, rather they will see it as a deserved punishment for which they have no concern about.

Since attribution theory focuses on the ways in which people explain the events that happen to them and on how these perceptions are determined by their perspective in the event (Fiske & Taylor, 1991) the medical care givers being not left out will be negatively affected in their behavior toward the victims of VAW and their management. Weiner's (1992) attribution theory of motivation is particularly helpful for understanding the relevance of perceived reasons for intimate partner violence for intervention and prevention efforts in the management of VAW. Therefore, the medical care givers may not bother to ask, if they usually attribute VAW to women being troublesome or if the male medical care givers, for instance attribute women as people one should not inquire deeply into their affairs or as troublesome. To this end the medical care givers may think it is not really any business of theirs to probe further about the real problem of victims of VAW since their duty is to treat and not to interfere with people’s internal problem. This can in turn influence the way the medical care givers manage their patients/ victims of VAW.

**Methodology**

This study made use of survey research design. The selection was made such that the sample was a representative of the whole population. According to May (2001) the application of this method is appropriate in obtaining the behavioral pattern of a given population on the basis of their
knowledge, opinion, attitude and perception concerning a given social phenomenon. This research design therefore was appropriate in this study of the socio-cultural factors that determine the awareness and management of victims of VAW by medical care givers in Edo state.

The population for the study comprised of the medical care givers- all doctors, nurses, traditional medicine practitioners and patent medicine dealers in Benin City. A total population of 6,179 medical care givers registered in the state were used for the study (Source: Ministry of Health as at February, 2016) comprising of 2,742 doctors, 1800 nurses, both private self-employed (owners of clinics and maternities) and government employed, 537 traditional medicine practitioners and 1,100 patent medicine dealers. The sample size for the study was computed statistically using the Yaro Yamane (1967) statistical formula on finite population for deriving sample size and it was 1,130.

Results and Discussion of Findings
Table 1. Distribution of respondents’ socio-demographic characteristics (n=972)

<table>
<thead>
<tr>
<th>Socio-demographic Variables</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>318</td>
<td>32.7</td>
</tr>
<tr>
<td>Female</td>
<td>654</td>
<td>67.3</td>
</tr>
<tr>
<td>Total</td>
<td>972</td>
<td>100</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 20</td>
<td>26</td>
<td>2.0</td>
</tr>
<tr>
<td>21 – 38 yrs</td>
<td>64</td>
<td>63.2</td>
</tr>
<tr>
<td>39 – 56 yrs</td>
<td>290</td>
<td>29.8</td>
</tr>
<tr>
<td>57+ yrs</td>
<td>42</td>
<td>4.3</td>
</tr>
<tr>
<td>Total</td>
<td>972</td>
<td>100</td>
</tr>
<tr>
<td>Marital status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>548</td>
<td>56.4</td>
</tr>
<tr>
<td>Single</td>
<td>356</td>
<td>31.6</td>
</tr>
<tr>
<td>Widowed</td>
<td>29</td>
<td>3.0</td>
</tr>
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</table>
### Demographic Information

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated</td>
<td>28</td>
<td>2.9</td>
</tr>
<tr>
<td>Divorced</td>
<td>11</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>972</td>
<td>100</td>
</tr>
<tr>
<td>Level of education:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal education</td>
<td>35</td>
<td>3.6</td>
</tr>
<tr>
<td>Primary education</td>
<td>16</td>
<td>1.6</td>
</tr>
<tr>
<td>Secondary</td>
<td>103</td>
<td>10.6</td>
</tr>
<tr>
<td>Tertiary</td>
<td>818</td>
<td>84.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>972</td>
<td>100</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>873</td>
<td>89.8</td>
</tr>
<tr>
<td>Islam</td>
<td>67</td>
<td>6.9</td>
</tr>
<tr>
<td>African traditional religion</td>
<td>32</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>972</td>
<td>100</td>
</tr>
<tr>
<td>Occupation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>254</td>
<td>26.1</td>
</tr>
<tr>
<td>Nurse</td>
<td>494</td>
<td>50.8</td>
</tr>
<tr>
<td>Patent medicine dealer</td>
<td>129</td>
<td>13.3</td>
</tr>
<tr>
<td>Traditional medicine</td>
<td>95</td>
<td>9.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>972</td>
<td>100</td>
</tr>
<tr>
<td>Employment status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>132</td>
<td>13.6</td>
</tr>
<tr>
<td>Private employed</td>
<td>355</td>
<td>36.5</td>
</tr>
<tr>
<td>Government employed</td>
<td>428</td>
<td>44.0</td>
</tr>
<tr>
<td>Unemployed</td>
<td>57</td>
<td>5.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>972</td>
<td>100</td>
</tr>
<tr>
<td>Place of residence (LGA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ikpoba-okha</td>
<td>288</td>
<td>29.6</td>
</tr>
<tr>
<td>Egor</td>
<td>318</td>
<td>32.7</td>
</tr>
<tr>
<td>Oredo</td>
<td>366</td>
<td>37.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>972</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Source:** Field survey, 2017
Table 1: shows the demographic characteristics of respondents. The table summarizes as indicated above, age of respondents that majority of the care givers in this study were females, and mainly young 21-38 years (67.3%) while the least age group were 20 years and below (2%). Also, majority of the respondents were married (56.4%) while the least group were divorced (1.1%). Most of the respondents had tertiary level of education (84.2%) while the least group had no formal education (3.6%). The result showed that Christianity was the predominant religion practiced by respondents and the most predominant occupation category of the sampled respondents were Nurses (50.8%) while the patent medicine dealers were the least (9.8%). Mostly, 44.0% were Government employed and most of them 37.7% reside in Oredo LGA, Edo State.

**Level of Awareness of VAW among medical care givers**

The interest here is to determine the relationship between the level of awareness of VAW by medical care givers and management of victims. See table below.

**Table 2: Distribution of level of Awareness of VAW among the medical care givers (n=972)**

<table>
<thead>
<tr>
<th>Level of awareness</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>840</td>
<td>86.4</td>
</tr>
<tr>
<td>No</td>
<td>100</td>
<td>10.3</td>
</tr>
<tr>
<td>Not sure</td>
<td>32</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>972</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**Source:** *Field survey, 2017*

The information above shows that out of the 972 respondents in this study, a vast majority 86.4% were aware of VAW, while only 10.3% were not aware and 3.3% not sure. This majority being aware of victim is expected to manage victims of VAW well if they are skilled to do so, but it was reported or discovered that many of them claimed not to have managed victims.
basically not because they have not seen them but because the victims themselves cover up or hide the problem as reported by a doctor.

**Awareness of VAW by religious affiliation of the respondents and awareness of victims.**

In the face of different religious affiliation, the awareness of VAW by the respondents based on their religion was tested to know how it affected their management of victims of VAW as presented in the figure 1 below.

**Fig.1: Distribution of respondents on religious affiliation and awareness of VAW**

![Distribution of respondents on religious affiliation and awareness of VAW](image)

**Source: Field survey, 2017**

Fig. 1 above shows the respondents’ religious affiliation. A vast majority (92.5%) who were Christians were aware, (5.7%) Muslims were aware and only (1.8%) of traditionalists were aware. A large number (75%) practicing Christianity were not aware, (16%) Islam and (9%) African traditionalist were also not aware, while (65.6%) of Christians were not sure, (9.4%) Muslims and (25%) traditionalists also were not sure. This showed that
more Christian medical care givers dominated the area of study and were also more aware of VAW than others. Indicating that awareness of VAW cuts across religious affiliations.

**Age of respondents and awareness of group involved in raising awareness of VAW**

It was necessary to find out the medical care givers’ knowledge of any group involved in raising awareness of VAW by their age as presented below.

**Table 3: Distribution of respondents by age and groups involved in raising awareness of VAW. (Percentages in parentheses) (n=972)**

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 20</td>
<td>7 (1.6)</td>
<td>5 (4.5)</td>
<td>4 (2.2)</td>
<td>26 (100)</td>
</tr>
<tr>
<td>21 – 38</td>
<td>278 (45.27)</td>
<td>212 (34.52)</td>
<td>124 (20.19)</td>
<td>614 (100)</td>
</tr>
<tr>
<td>39 – 56</td>
<td>144 (49.65)</td>
<td>93 (32.06)</td>
<td>53 (18.27)</td>
<td>290 (100)</td>
</tr>
<tr>
<td>57+</td>
<td>21 (50)</td>
<td>16 (38.09)</td>
<td>5 (11.90)</td>
<td>42 (100)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>450 (100.0)</strong></td>
<td><strong>336 (100.0)</strong></td>
<td><strong>186 (100.0)</strong></td>
<td><strong>972 (100.0)</strong></td>
</tr>
</tbody>
</table>

**Source:** Field Survey, 2017

Information in table 3 shows the respondents within the age range of 21-38 years that (61.8%) have knowledge about groups involved in raising awareness of VAW, 63.1% did not, while 66.7% were not sure of such group. Among the respondents within the age range of 39-56 years, 32.0% had knowledge of such group, 27.7% did not, while 28.5% were not sure. Meanwhile, only 4.7% among those respondents who were 57 years and above had knowledge of such group raising awareness, 4.8% did not, and 2.7% were not sure. On the other hand, among the respondents who were 20 years and below, 1.6% had knowledge, 4.5% did not and 2.2% were not
sure. This implication is that the knowledge of medical care givers about groups involved in raising awareness differs across age groups, but it was more among those aged 21-38 years. Thus the younger the age of medical care givers, the more knowledge of such group they have and the better equipped in their management of victims of VAW for counselling and necessary action.

**Medical care givers and management of victims of VAW**

Response to victims by medical care givers was examined by seeking to know their opinion on the role they have to play in helping victims of VAW as Alokan (2013) found that medical practitioners do not see themselves as being able to play a major role in helping women with regards to domestic violence.

**Management of victims of VAW by how often the medical care givers encounter victims.**

The concern here was to find out how often respondents encountered victims of VAW in their various health care setting and practice with the view to ascertain whether they manage victims or not.

*Table 4: Distribution of respondents by Gender and encounter of victims of VAW (Percentages in parentheses) (n=972)*

<table>
<thead>
<tr>
<th>Sex</th>
<th>How often respondents encounter victims of VAW</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very often</td>
<td>Often</td>
</tr>
<tr>
<td>Male</td>
<td>15 (27.3)</td>
<td>57 (30.3)</td>
</tr>
<tr>
<td>Female</td>
<td>40 (72.7)</td>
<td>131 (69.7)</td>
</tr>
<tr>
<td>Total</td>
<td>55 (100.0)</td>
<td>188 (100.0)</td>
</tr>
</tbody>
</table>

*Source: Field Survey, 2017*
In Table 4: 27.3% of males encountered the victims very often, 30.3% of the same category often, 33.8% encountered rarely while 27.3% did not encounter any victims. Whereas among females, 72.7% encountered the victims very often, 69.7% encountered often, 66.2% rarely encountered victims while 72.7% of the said category had not encountered victims. This implied that more female medical care givers encountered victims of VAW. Also more female respondents rarely encountered victims than males. The showed that females were more in encountering victims of VAW than the males and this is a determinant of their awareness and management of victims of VAW.

Respondents’ age was used to ascertain how often they encountered victims of VAW with the view to ascertain how it affected their management.

<table>
<thead>
<tr>
<th>Age</th>
<th>Very often</th>
<th>Often</th>
<th>Rarely</th>
<th>None</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 20</td>
<td>2 (3.6)</td>
<td>2 (1.1)</td>
<td>21 ()</td>
<td>1 (9.1)</td>
<td>26 ()</td>
</tr>
<tr>
<td>21 – 38</td>
<td>35 (63.6)</td>
<td>125 (66.5)</td>
<td>448 (62.4)</td>
<td>6 (54.5)</td>
<td>614 (63.2)</td>
</tr>
<tr>
<td>39 – 56</td>
<td>17 (30.9)</td>
<td>49 (26.1)</td>
<td>220 (30.6)</td>
<td>4 (36.4)</td>
<td>290 (29.8)</td>
</tr>
<tr>
<td>57+</td>
<td>1 (1.8)</td>
<td>12 (6.4)</td>
<td>29 (4.0)</td>
<td>0 (0.0)</td>
<td>42 (4.3)</td>
</tr>
<tr>
<td>Total</td>
<td>55 (100.0)</td>
<td>188 (100.0)</td>
<td>718 (100.0)</td>
<td>11 (100.0)</td>
<td>972 (100.0)</td>
</tr>
</tbody>
</table>

Source: Field Survey, 2017

In Table 5:, among respondents 21-38 years, 63.6% encountered VAW victims very often, 66.5% often, 62.4% rarely and 54.5% at no time respectively. Whereas among 35-56 years, 30.9% encountered victims very often, 26.1%, 30.6% and 36.4% encountered victims often, rarely and at no time respectively. The least proportion of the encounter was among those
less than 20 years of age, where only 3.6%, encountered the victims very often, 1.1%, 2.9% and 9.1% encountered victims, often, rarely and at no time respectively. This implied that everyone across all age group encountered VAW victims, most especially the 21-38 years; a situation where 62.4% rarely encountered victims of VAW, it will be difficult to manage victims. Therefore the younger the age of the among respondents 21-38 years, 63.6% encountered VAW victims very often, 66.5%, 62.4%, and 54.5% encountered victims, often, rarely and at no time respectively. Whereas among 39-56 years, 30.9% encountered the victims very often, 26.1%, 30.6% and 36.4% medical care givers, often, rarely and did not encounter victims respectively. The majority 62.4% rarely encountered victims. A middle aged doctor in an IDI had this to say: “in the real sense, patients hardly report violence and even when they do, they don’t tell the whole truth about the extent or if there is injury to protect themselves and their abusers”.

**Conclusion**
The result of the study shows that the level of awareness was high (86.4%) among medical care givers were aware, only 10.3% were not aware and 3.3% were not sure which revealed that there are victims of VAW and medical care givers who manage them to ensure their well-being in Benin city, Edo state. This is consistent with the research findings of Chitaschvili and Javakhishvili, (2010) in Georgia that women experience physical, emotional injuries due to violence and that a number of injuries occur as a result of physical violence during pregnancy or sexual violence as well as psychological violence from social and emotional violence

To confirm Awuno, Obuehi and Nwankwo, (2006) finding in Nigeria and in Edo state in particular that medical care givers are not known to be trained on how to manage victims of VAW as a whole, medical care givers’ response to training need was well received, therefore training is one of the factors that determine the awareness and management of victims. This was evident from patent medicine dealers responses that they have never
received any form of training neither are they aware of any group raising awareness about VAW. This supports the Grubb and Turnner’s, (2012) assertion that medical care givers are not likely to take adequate action to manage the victims since they do not have what it takes to do so.

With regards to the major impediments in managing the victims of VAW by medical care givers, gender was found to be a challenge among medical care givers. As among females, 66.2% had faced challenges. This indicated that more females than males have faced challenges in management of victims of VAW. These challenges ranged from not knowing the standard of care of the victims as well as the victims themselves not admitting occurrence of VAW and fear of exposing themselves to ridicule should there be an attempt to trace the perpetrator and prosecution. Furthermore, some of these female medical care givers themselves were victims, making it more challenging, knowing that they could not help the victims in their cultural beliefs and socialization. It therefore necessitates creating awareness in them which will in turn increase their knowledge of how to manage the patients and victims. Where the female medical care givers are victims themselves, as found in the study, it agrees with Vinguard,(2010) that nurses in Egypt found themselves as victims which they describe as humiliating and restrict their decisions in health care setting thus, reinforcing feelings of stigma and self-blame in their response to VAW. The attribution theory plays out in this case where medical care givers prefer not to get involved in what they regard as private life issue because they feel it is not their business interfering in what they feel is caused by the victims and they feel the women are usually the cause of the problem by their dressing or not respecting patriarchy.

Recommendations
(a) Seminars and workshops to create awareness about VAW should be organized. There is the need to create awareness at these fora, to
underscore the fact that Health care givers needed to be aware of VAW and manage victims properly
(b) There should be public enlightenment through the mass media on the negative effects of domestic violence against women, especially wife battery the health outcomes.
(c) Medical professionals are in position to help abused women; after physical treatment, they should refer them to counselors and psychotherapists for further management.

References


