EFFECTS OF HEALTH EDUCATION INTERVENTION ON FAMILY VIOLENCE VICTIM`S RESPONSE AND REPORTING SYSTEM IN OGUN STATE NIGERIA

By

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Abstract

The failure of human relationship leads to family violence. On daily basis, public frowns at people violating the safety right of their family members. Therefore, this study investigated the effects of Health Education Intervention on family violence victim`s response and reporting system in Ogun State. The study is experimental with the participants randomly assigned to control and experimental groups. The study had 120 participants drawn through a multi-stage sampling procedure. The instruments used were Hurt, Insult, Threat and Scream (HITS) Instrument (r = 0.68), Family APGAR (r = 0.89) and Health Education Intervention Package named Family Violence Victim`s Response And Reporting Education (FamVRARE). Four (4) research questions raised were answered with descriptive statistics of frequency counts, percentages, mean and standard deviation scores while three hypotheses formulated were tested with t-test, and the Analysis of Covariance (ANCOVA) at 0.05 level of significance. Results revealed, amongst others, that Health Education Intervention (HEI) had significant effect on family violence victim`s response and reporting system ($t = 15.852$, $p < 0.05$). The main effect of treatment was significant ($F(1, 41) = 231.459$, $P < 0.05$), MCA shows a grand mean of 28.54, the treatment group obtained higher adjusted post-test mean score of 36.40 (i.e. 28.54+7.86) than that of the control group of 20.68 (i.e. 28.54-7.86). Based on the findings, it was concluded that Health Education Intervention had significant impact on family violence victim`s response and reporting system. It was recommended that family violence safety officers should be trained by the government and the relevant

agencies. Family violence safety unit of the police force should be established to manage family violence in the state while access to such unit at the community is made easy. Family violence safety management should be included in the health education curriculum at all levels of education.

Keywords: ***Health Education, Health Education Intervention, Family, Family Violence, Family Violence Prevention.***

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INTRODUCTION

As family members are related by blood, marriage and collateral relationship, it is expected that they relate peacefully without any form of violence. Unfortunately, the reality is that violence often occurs in families. Violence is the use of force to harm a person or damage property; overt or covert threats are legally considered as acts of violence, (Australia's National Research Organisation for Women's Safety, 2016). It is a behaviour or treatment in which physical force is exerted for the purpose of causing damage or injury; an extreme expression or powerful emotion; distortion of meaning or intent (Australian Human Rights Commission, 2017;Campo, 2015;Cox, 2015). It is an unlawful display of force tending to subdue or intimidate; to inflict harm upon; damage; violate, distort or twist the sense or intention (Dedeigbo, &Cocodia, 2016; Domestic Violence Victoria, 2015). It is a global issue and is not limited to gender, religious, cultural and income group. A wide range of studies agree that the causes of violence are multi-factorial, and that the co-occurrence of factors may increase the likelihood that a person will violate a family member, such as a parent, partner or ex-partner, child or sibling (Dowse, Soldatic, Spangaro, & van Toorn, 2016; Hooker, Kaspiew, & Taft, 2016; Lauren, 2015).

The nature of family violence with its constant recurring presence over a long period of time result in harms like previous harm, self- harm, body harm and cumulative harm to the victim, especially the children. Cumulative harm is a conceptual overview that describes the potential impact of family violence on a victim as profound and exponential, covering multiple dimensions of the impact of a recurring family violence event which may be multiple recurring events such as unrelenting low level care and neglect (Mandel, 2017; Nicholas, 2015). It consequences among family members and the community at large could not be ignored in the effort to improve the nation's health, and tackling the roots of violence as a top priority for the healthy community.

Life in family requires a degree of behavioural order for peaceful co-existence. By obeying the norms of the society and family, individuals ensure that the family

system works orderly. However, most individuals fail to follow the rules and norms either in the society or in the family and this gives rise to family violence. There is hardly any family that is not confronted with family violence. The acts which characterised violence at home are not the same everywhere; vary from culture to culture, from society to society and from family to family (Hooker, Kaspiew, & Taft, 2016).

Though researchers have developed a number of theories to explain criminal behaviour, but no theory is a comprehensive explanation of all types of violent behaviours at home, (Lauren, 2015). Therefore, in order to understand the fundamental causes of family violence and develop interventions to address the problem, this study was built on Ecological Theory of Violence causation and traumatic bond theory to explain the causation and why family violence victims remain victims.

The Ecological theory was propounded by Bronfenbrenner in 1977 to describe the interaction of factors at different levels of the social environment influencing family violence. Based on multiple interconnected elements of individuals, communities, institutions and cultures; a victim`s behaviour is shaped, not by her upbringing, but by current contextual factors such as the batterer, reactions received from those around, and the resources available (Malchiodi, 2015; Nigeria Watch, 2014; Queensland Government, 2016). This reciprocal interplay includes microsystems such as the family; mesosystems such as the neighbourhood and workplace; exosystems such as the broader social influence of the media; and macrosystems that are ideologies or law (Queensland Government, 2017;Ukoji&Okolie-Osemene, 2016). This means that changes in one stratum lead to changes in others. For example, mandatory reporting of partner abuse creates changes in institutions, creating change in neighbourhoods, families and individuals.

The model can be visualised as four concentric circles. The innermost circle represents the biological and personal history that each individual brings into relationships. The second circle represents the family being the immediate context in which violence takes place frequently, (Ukoji&Okolie-Osemene, 2016). The third circle represents both formal and informal situations and social structures, in which relationships are embedded in neighbourhood, workplace, social networks and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms (Lauren, 2015; White Ribbon Australia. 2017).

The traumatic bonding theory explains family violence in terms of the unique relationship and interaction that develops between a victim and the perpetrator. Traumatic bond is an emotional tie that strongly develops between two persons where one person steadily harasses, beats, threatens, abuses or intimidates the other (Phillips &Vandenbroek, 2014). Based on this theory, trauma of the abuse creates a strong emotional tie characterised by cognitive distortions and behavioural strategies that ultimately and unintentionally perpetuate the abuse and strengthen the bond (Morris, Humphreys, &Hegarty, 2015).

This tie is distinguished by mutual emotional dependency between the abuser and the victim. This emotional dependency or traumatic bond is said to develop because the abuse is characterised by intermittent reinforcement. Intermittent reinforcement involves the alternating of highly intense positive and negative abuser-victim interactions. For instance a spouse may be very abusive for a time and then replace that behaviour with intense affection, (Queensland Government, 2016). This behaviour not only strengthens the bond but also leaves the self-esteem of the victim in the hands of the abuser. This theory maintains that both the abuser and the victim suffer cognitive distortions that involve blame, responsibility, power and trust. For instance, a young victim of incest may blame himself or herself for the violence, the adult may also blame the victim. Thereby, the behaviour strategies of both parties often place the victim at the risk of revictimisation and the perpetrator at risk of revictimising, (National Sexual Assault and Domestic Family Violence Counselling Service, 2015).

Family violence occurs as a result of the unique relationship and interaction that develops between a victim and the perpetrator. Traumatic bonding is a strong emotional tie that develops between two persons where one person steadily harasses, beats, threatens, violates and intimidates the other. The implication is that this relationship places the victim at the risk of revictimisation and the perpetrator at the risk of revictimising, (IVAWS, 2017).

It is very difficult to measure the true extent of FV as most of the incidences are not reported by the victims. The International Coalition for the Responsibility to protect (2015) reveals that both men and women were unlikely to report their most recent incident of FV by a male to the police. The common reason why women victims did not contact police is because they felt the incident was too minor in nature while they preferred to deal with it as a private matter, seeing it as a shame or an embarrassment. Most victims of family violence had never spoken to anyone else about the incident, especially the women (International Violence against Women Survey IVAWS, 2017). Victims of family violence are often reluctant to view their relationship as violent or see their homes as a violent home. The surrounding issues of reporting family violence, by both male and female victims, include shame, embarrassment and guilt can prevent victims from reporting abuse.

Family violence victims` cultural, ethnic and religious backgrounds influence their response to the issue of violence at home and their awareness of viable resources and options. There are series of factors that may prevent the victims from leaving or make leaving more difficult for the victims, especially women. Such factors include loss of homes, the disruption of social support, disruption of children's schooling and social networks, fear of holding them as being responsible for leaving the relationship, blame for the disruption that family violence brings to children, friends and family. Controlling behaviours of the perpetrator tend to isolate the victim from social and family supports, limit access to money or transport and ultimately foster a multifaceted dependence on the relationship that makes the consequences of leaving extreme and far reaching (Malchiodi, 2015).

Fear is an all pervasive immobilisers which literally freeze victims from believing there is a way to end the family violence, stop victims from reporting to safety agents like the police or prevent victims from reaching out to other support services. The victim usually knows the perpetrator very well and is usually best placed to understand the perpetrator's capabilities. For this reason, the victim/s will try to manage the family violence privately and try to keep the peace in the home as much as possible. Occasionally, the victim will react to the perpetrator and in these instances he/she is often incorrectly identified as part of the problem (Australia`s National Research Orgaanisation for Women Safety, 2016).

Another factor that makes leaving difficult is that most victims want the violence to stop without ending or disrupting the family relationship. The family members i.e. the loved ones may be violent but it is not their total perception of the perpetrator`s behaviour, (Ukoji&Okolie-Osemene 2016; White Ribbon Australia, 2017; Yamawaki, Ochoa-Shipp, Pulsipher, Harlos, & Swindler, 2012). For all of these reasons, it is important that victims of violence are responded to with compassion, non-judgemental attitudes and respect for their life.. Some victims leave violent homes, many prepare for leaving with little efforts. Those who live with violence often leave their situation several times before the final time (Nicholas, 2015; Malchiodi, 2015).

The reasons why a victim who lives with violence may continue to stay in such home include far for their own safety and the safety of their children, fear that children may be taken away, poor transport system especially for victims in isolated and rural areas, no nearby safe home, pressure from family members to keep the family, sense of shame and guilt, involvement in a complex business and property, family values in the community, strong religious beliefs, family privacy, an independent future with lack of employable skills, lack of confidence to approach help services, internalizing negative messages like "leaving is an ultimate failure", the belief that violent behaviour is a part of relationships (White Ribbon Australia, 2017; Yamawaki, et al., 2012).

Family violence victims` human right to safety, violated by their family members needs to be taken seriously. All family members are potential victims of violence at home, not just women. The victims may not report their most recent incident of violence to the police. Therefore, Family violence must be viewed as a significant Public Health Education issue requiring urgent attention. Female victims must not be treated at the expense of male victims: both victims deserve access to relief services and this can be achieved through information, communication and education which is health education.

Health education is an intellectual, psychological and social process with dimensions of activities that increase the skills of individuals to form wise choices on personal, family and community well-being (Ajala, 2012). This process, based on scientific principles, facilitates planning and behaviour change in both health personnel and consumers, including children and youths. Health education as a

process is indispensable intervention in achieving positive individual and community health, (Lauren (2015). Health education is the process by which individuals and groups of people learn to behave in a manner conducive to the promotion, maintenance and restoration of health. Therefore, health education intervention in preventing violence at home involves the combination of learning opportunities and teaching activities designed to facilitate voluntary adaptations of behaviour that are conducive to healthy living, (Nigeria Watch, 2014); Queensland Government, 2016;Queensland Government, 2017). It is a process that informs, motivates and helps people to adopt and maintain healthy practices and lifestyles.

Violence cases at home are seldomly reported or brought to the public, especially those found in the wealthy families because of its perceived dent on the image of the family. However, the opposite is the case among the low socio-economic class (Dowse, Soldatic, Spangaro, & van Toorn, 2016; Hooker, Kaspiew, & Taft, 2016). Meanwhile, cases of family violence are common, especially child killing parents, child abuse and neglect, elder abuse and neglect, wife-beating and killing as well as husband-killing. The police do not normally intervene in family disputes which are seldomly discussed publicly as long as it does not result in loss of sight, hearing, and power of speech, facial disfigurement or life threatening injuries, i.e. "previous harm". In many rural areas, the court and the police are reluctant to intervene to protect the victims who formally accuse their family members of violence if the accused did not exceed customary norms of the areas (international Coalition for the Responsibility to Protect 2015;.IVAWS, 2017; Lauren, 2015; Malchiodi, 2015; Mandel, 2017; Nicholas, 2015). This study examined the effect of Health Education Intervention on family violence victim`s response and reporting system in Ogun State.

Objectives of the Study

This study mainly examined the effects of Health Education Intervention on family violence victim`s response and reporting system and specifically identified the reporting patterns as well as mode of response and response impedance among adults in Ogun State Nigeria.

Research Questions

The following research questions were answered in this study

1. Which of the family violence response and reporting systems will be more acceptable to the respondents?
2. Which of the family violence response and reporting systems will be more acceptable by the respondents based on life stages through Health Education Intervention (HEI)?
3. Which of the family violence response and reporting systems will be more acceptable by the respondents based on marital status through Health Education Intervention (HEI)?

4. What are the perceived family violence response and reporting impedance in Ogun State?

Hypotheses

The following null hypotheses were tested at 0.05 level of significance.

1. There is no significant difference between the pre-test and post-test health education intervention scores on family violence response and reporting pattern of the respondents in group one before and after exposure to Health Education Intervention Package (HEIP) in preventing family violence.
2. Health Education Intervention (i.e. treatment with HEIP) will not have significant effect on the family violence response and reporting pattern of young and old adults of family violence in Ogun State.
3. Health Education Intervention (i.e. treatment with HEIP) will not have significant effect on the family violence response and reporting pattern of single and married respondents of family violence in Ogun State.

Methodology

This study was a quasi-experimental research in which the participants were assigned to experimental and control groups. The design for this study was Comparison-Group Design. This design involves two groups i.e. one control group and one experimental group, the experimental group was pre-tested and treated but control group was not treated. Both groups were post -tested. The identified victims were treated with a self -developed Health Education Intervention packed named Family Violence Victim`s Response And Reporting Education (Fam-VRARE). Moderating variables of life stages (18 - 35years old: young adults; 36 years and above: older adults), and marital status (married and single) were tested against the dependent variable of health living. The assignment of participants to all groups was randomly done and the random assignment was from a pool. This design was adopted because it enables the researcher to check on possible effects of pre-testing, experimental group was pre-tested while control group was not. The participants that received the treatment were those in the experimental groups. There were three (3) sessions with each of the groups: two (2) sessions for group discussion and one (1) session for consultation i.e individual counseling, with each session lasting about 45 to 60 minutes per week for twelve (12) weeks. The researcher retained the control groups due to the nature of the study because if the control group did not meet once in a while, they may be discouraged from coming back after twelve (12) weeks. Placebo treatment was given to the control group. The whole processes were far away from each other to prevent contamination of the treatment.

The population of this study comprised all adults who were family violence victims in Ijebu-igbo, Ogun State. Their violence experience made them respond appropriately to the treatment. The sample size for this study comprised 100

participants randomly drawn through religious centres in Ijebu-Igbo to agreed training centre. The sample was chosen through Multi-stage sampling procedure. Stratified sampling technique was first used to group the study location into five (5) using town as a criterion while the towns are oke-sopin, Oke-Agbo, Japara, Ojowo and Atikori. Two (2) towns were selected from the towns identified through random sampling of fish bowl methods.

To identify those that have experienced family violence, the researcher administered Hurt, Insult, Threat and Scream (HITS) instrument on a significant proportion of the adult population. It was on the basis of the HITS scores, agreement on time for the training, training centres and interest of the participants that the researcher purposively drew a total of 50 participants out of those that scored 10 and above from each town selected. Therefore, at the consent of the participants, the researcher purposively drew a total of 100 adult victims that participated in this study. The 100 participants were randomly assigned to both experimental and control groups. The experimental and control group locations were Oke-Sopin and Atikori, the experimental groups were treated and the post test was administered to the two (2) groups. No treatment was administered to the control group but the subjects were tested after the treatment of experimental group.

Meanwhile, based on the attendance of the participants during the treatment, the data analysed according to the group were: Location A Group 1 = 50 and Location B Group 49. Based on participants attendance 17% subject mortality emerged while 83% were analysed because some of the selected participants who started the training did not continue to the end of the programme.

Results and Discussion

Question 1: Which of the family violence response and reporting systems will be more acceptable to the respondents?

Table 1: The Percentage Distribution of Acceptable Family Violence Reporting Systems

Reporting Systems	Frequency	Percent
Family	38	38%
Religious leader	26	26%
Friend	24	24%
Security agents	12	12%
Total	**100**	**100%**

The result in Table 1 shows the percentage distribution of the family violence reporting systems captured in the study as acceptable to the sampled victims. The result in the table shows that 38 (38%) victims indicated the family as their

acceptable reporting system, 26 (26%) victims indicated religious leaders as their acceptable reporting system, 24 (24%) victims indicated friends as their acceptable reporting system while 12 (12%) victims indicated security agents as their acceptable reporting system. It thus appears from the results in table 1 that the most acceptable reporting system by victims of family violence is the family.

Question 2: Which of the family violence response and reporting systems will be more acceptable by the respondents based on life stages through Health Education Intervention (HEI)?

Table 2: Distribution of Acceptable Family Violence Reporting Systems by Life Stages

Reporting Systems	Young Adults	Old Adults	Total
Family	32 (32%)	6 (6%)	38 (38%)
Religious leaders	21 (21%)	5 (5%)	26 (26%)
Friends	7 (7%)	17 (17%)	26 (26%)
Security agents	3 (3%)	9 (9%)	12 (12%)
Total	**63 (63%)**	**37 (37%)**	**100 (100%)**

The result in Table 2 shows the percentage distribution of the sampled young and old victims of family violence reporting system through Health Education Intervention. The result in the table shows that out of the 38 (38%) victims that indicated the family as their more acceptable reporting system, 32 (32%) are younger adults while 6 (6%) are older adults. Out of the 26 (26%) victims that indicated religious leaders as their more acceptable reporting system, 21 (21%) are younger adults while 5 (5%) are older adults. Of the 24 (24%) victims that indicated friends as their more acceptable reporting system, 7 (7%) are younger adults while 17 (17%) are older adults, and of the 12 (12%) victims that indicated security agents as their more acceptable reporting system, 3 (3%) are young adults while 9 (9%) are older adults. It thus appears from the results in table 8 that based on life stages, the younger victims of family violence indicate the family as their more acceptable reporting system of family violence than the older victims through HEI.

Question 3: Which of the family violence response and reporting systems will be more acceptable by the respondents based on marital status through Health Education Intervention (HEI)?

Table 3: Distribution of Acceptable Family Violence Reporting Systems by Marital Status

Reporting Systems	Single	Married	Total
Family	23 (23%)	15 (15%)	38 (38%)
Religious leaders	11 (11%)	15 (15%)	26 (26%)
Friends	12 (12%)	12 (12%)	24 (24%)
Security agents	4 (4%)	8 (8%)	12 (12%)
Total	**50 (50%)**	**50 (50%)**	**100 (100%)**

The result in Table 3 shows the percentage distribution of the sampled victims of family violence reporting system through health education intervention based on marital status. The result in the table shows that out of the 38 (38%) victims that indicated the family as their more acceptable reporting system, 23 (23%) are unmarried (single) while 15 (15%) are married. Out of the 26 (26%) victims that indicated religious leaders as their more acceptable reporting system, 11 (11%) are single while 15 (15%) are married. Of the 24 (24%) victims that indicated friends as their more acceptable reporting system, 12 (12%) are single while 12 (12%) are married, and of the 12 (12%) victims that indicated security agents as their more acceptable reporting system, 4 (4%) are single while 8 (8%) are married. It thus appears from the results in table 3 that based on marital status, the unmarried victims of family violence who indicated the family as their acceptable reporting system of family violence through HEI is more than the married.

Question 4: What are the perceived family violence response and reporting impedance in Ogun State?

Table 4: The Percentage Distribution of Perceived Barriers to Family Violence Prevention

Perceived Barriers	Frequency	Percent
Economy (financial dependency)	16	16%
Culture	11	11%
Social isolation	10	10%
Religion	11	11%
Family secret	18	18%
Response of safety agents	10	10%
Victim's personality/perception/willingness	12	12%
Victim's personal experience	12	12%
Total	**100**	**100%**

The result in Table 4 shows the percentage distribution of barriers to family violence prevention in Ogun State as perceived by the sampled victims. The result in the

table shows that 16 (16%) victims perceived financial dependency as barrier to family violence prevention while 11 (11%) victims indicated culture as their own perceived barrier. Also, 10 (10%) victims indicated social isolation as their own perceived barrier while 11 (11%) victims indicated religion as their own perceived barrier. A total of 18 (18%) victims indicated family secrecy as their own perceived barrier while 10 (10%) victims indicated response from safety agents as their own perceived barrier. Of all the sampled respondents 12 (12%) indicated victim's personality/perception/willingness and victim's personal experience respectively as their own perceived barriers. It thus appears from the results in table 10 that keeping family-secret secret (i.e. family secrecy) out of the eight perceived barriers of family violence prevention is the most popular barrier among victims of family violence in Ogun State.

Hypothesis 1: There is no significant difference between the pre-test and post-test Health Education Intervention scores of family violence response and reporting patterns of the victims in control and experimental group after the treatment.

Table 5: The Difference between Victims' Pre-test and Post-test HEI Scores of Family Violence Reporting Patterns

Treatment Groups	N	Mean	S.D.	df	*R*	*T*	Sig. of *t*
Pre-test Scores	25	16.25	2.89	24	0.11	15.852	.000*
Post-test Scores		25	30.85		3.55		

* indicates significant t at p < 0.05

Table 5 shows the result of the paired-samples t-test of difference between the pre-test and post-test mean health education intervention scores of family violence reporting patterns of the victims in group one. The result shows a significant outcome ($t = 15.852$, $p < 0.05$). This outcome implies that there is significant difference between the victims' pre and post-test HEI scores of family violence reporting patterns. Table 5 shows that the mean post-test HEI score of 30.85(S.D.= 3.55) recorded by the victims in group one is not just higher than the mean pre-test HEI score of 16.25 (S.D.= 2.89) recorded by the victims. The difference between the mean scores is statistically significant. As a result, the null hypothesis one (H01) was rejected.

Hypothesis 2: Health Education Intervention (i.e. treatment with HEIP) will not have significant effect on the family violence response and reporting patterns of young and old victims of family violence in Ogun State.

Table 6: The Difference between the Family Violence Reporting Systems Scores of Young and Old Adults

Family Violence Reporting Scores	N	Mean	S.D.	df	*t*	Sig. of *t*
Young Adults	63	8.43	2.31	98	.312	.755
Old Adults	37	8.27	2.66			

* indicate significant t at $p < 0.05$

Table 6 shows the result of the independent samples t-test of difference between the mean scores obtained by young and old adults in the family violence reporting systems scale. The result shows a non-significant outcome ($t = .312$, $p > 0.05$). This outcome implies that there is no significant difference between the family violence reporting systems scores of the sampled young and old adults after exposure or non to the treatment package. Table 4.26 shows that the mean family violence reporting systems, 8.43 (S.D.= 2.31) recorded by the young adults is merely higher than the mean family violence reporting systems score, 8.27 (S.D.= 2.66) recorded by the old adults, the difference between their mean scores is not statistically significant. As a result, the null hypothesis two (H02) was hereby retained.

Hypothesis 3: Health Education Intervention (i.e. treatment with HEIP) will not have significant effect on the family violence response and reporting patterns of single and married victims of family violence in Ogun State.

Table 7: The Difference between the Family Violence Reporting Systems Scores of Single and Married Victims

Family Violence Reporting Scores	N	Mean	S.D.	df	*t*	Sig. of *t*
Single Victims	50	8.26	2.50	98	.368	.714
Married Victims	50	8.46	2.38			

* indicate significant t at $p < 0.05$

Table 7 shows the result of the independent samples t-test of difference between the mean scores obtained by the single and married victims of family violence in the family violence reporting systems. The result shows a non-significant outcome ($t = .368$, $p > 0.05$). This outcome implies that there is no significant difference between the family violence reporting systems scores of the sampled single and married victims after exposure or non to the treatment package. Table 7 shows that the mean family violence reporting systems, 8.26 (S.D. = 2.50) recorded by the unmarried (single) victims is merely lesser than the mean family violence reporting systems score, 8.46 (S.D. = 2.38) recorded by the married victims. The difference between their mean scores is not statistically significant. As a result, the null hypothesis three (H03)was hereby retained.

Discussion

The result in Table 1 shows that the most acceptable reporting system of family violence is the family. The implication is that respondents refer to tack and manage family violence within their family settings instead of involving external. This finding is in line with the findings of Hooker, Kaspiew& Taft (2016) and Mandel (2017) that family violence is a deadly condition covered up by the victims because of the fear of social isolation, family status and religion. This is also indicated by Frohmader, Dowse &Didi (2015), Malchiodi (2015);Morris, Humphreys &Hegarty (2015) who submitted that family violence victims still find it difficult to report family violence issues outside their family setting.

The result in Table 2 shows that based on life stages, the younger adults indicated the family as the acceptable reporting system of family violence through HEI than the older victims. The result in Table 3 shows that based on marital status, single respondents indicated the family as the acceptable reporting system of family violence through HEI more than married respondents. This finding is in line with that of the Australia's National Research Organisation For Women's Safety (2016); Australian Human Rights Commission (2017), and National Sexual Assault and Domestic Family Violence Counselling Service (2015) that family violence prevention is a difficult task in every community because most victims prefer to keep issues of their family jealously due to fear of the unknown in order to retain unity in the family and uphold their family social status.

The implication of the result in Table 4 is that keeping issues in family secret (i.e. family secrecy) is the major and popular barrier of family violence prevention among family violence respondents in Ogun State. This finding is in line with Hegarty (2015), National Sexual Assault and Domestic Family Violence Counseling Service (2015) and Queensland Government (2016)that the major challenge to the prevention of family violence is the effect of the privatization, through social isolation, of the family violence victims while the effect of social isolation on the victims prompted them to make family issues, especially family violence secret (Domestic Abuse Intervention Programs, 2017; Dowse, Soldatic, Spangaro& van Toorn, 2016).

Hypothesis one: There is no significant difference between the pre-test and post-test Health Education Intervention scores of family violence reporting pattern of the respondents in group one before and after exposure to Health Education Intervention Package (HEIP) in preventing family violence.

The findings did not support this hypothesis. Therefore, the hypothesis was rejected. The result revealed that HEIP has effect on the respondents` family violence reporting pattern in group one and this effect was attributed to the eight (8) weeks treatment given to the group. The result reaffirms that intervention improves family violence victims` ability to report cases of violence at home (Campo &Tayton 2015, and Queensland Government 2017). The findings are also in line with those of Campo, (2015), and White Ribbon Australia (2017) that constant family violence

prevention programmes in the community would foster and encourage victims to report violence episodes at home.

Hypothesis two: Health Education Intervention (i.e. treatment with HEIP) will not have significant effect on the family violence reporting systems scores of young and old adults of family violence in Ogun State.

The seventeenth hypothesis stated that Health Education Intervention (i.e. treatment with HEIP) will not have significant effect on the family violence reporting systems scores of young and older respondents of family violence in Ogun State. The result in Table 4.26 shows a non-significant outcome. The mean of the family violence reporting systems scores recorded by the young adults is slightly higher than the mean of the family violence reporting systems scores recorded by the older adults with the mean difference not statistically significant. The null hypothesis two (H02) was thereby retained. This agrees with the submissions of Dedeigbo&Cocodia (2016) and Mandel (2017)that the victims of family violence are likely not to report the case to the police or other external facilities outside their family. This is also supported by Frawley, Dyson, Robinson & Dixon (2015), and Usman&Olatunji, (2016) that most victims find it difficult to report violence case at home due to fear of the unknown and social isolation. Hypothesis three: Health Education Intervention (i.e. treatment with HEIP) will not have significant effect on the family violence reporting systems scores of single and married respondents of family violence in Ogun State.

The third hypothesis stated that Health Education Intervention (i.e. treatment with HEIP) will not have significant effect on the family violence reporting systems scores of single and married respondents of family violence in Ogun State. The result in Table 4.2shows a non-significant outcome. The mean of the family violence reporting systems scores recorded by the unmarried (single) respondents is slightly lesser than the mean of the family violence reporting systems scores recorded by the married respondents with the mean difference not statistically significant. The null hypothesis third (H03) was hereby retained. This is in line with the assertion by Malchiodi (2015), Hooker, Kaspiew& Taft (2016) and Mandel (2017) that the Victims of family violence are less likely than victims of other types of violence to report the case to the police or other external facilities because of the concerns about privacy. This also was supported by Morris, Humphreys &Hegarty (2015) and National Sexual Assault and Domestic Family Violence Counselling Service, (2015) that the victims would find it difficult to report cases of violence at home because of fear of reprisal and the desire to protect perpetrators, but they are more likely to call for protection if they are informed in such a way that they would perceive family violence as a manace (Cox 2015, and White Ribbon Australia, 2017)

Conclusion

The study has provided meaningful insight into the effect of HEI in fostering Family Violence response and reporting in Ogun State. The family was the most accepted reporting system by victims of family violence. The younger and single victims of

family violence accepted the family reporting system of family violence through HEI more than the older and married victims. Keeping family-secret safe (i.e. family secrecy) was the most popular barrier of family violence prevention among victims in Ogun State. HEI had potency to prevent family violence and the intervention had same effect on the single, married, young and older adults. Health Education Intervention (i.e. treatment with HEIP) did not differentiate significantly between single and married victims of family violence in Ogun State on the family violence reporting systems preferred.

Recommendations

Based on the outcome of the study, the following recommendations were made:

i. Family violence safety security unit should be established by the government and community. A unit of police force should be created to manage family violence in the state and access to this police unit should be available for all people in the community.
ii. The Police officers to be assigned to this unit should be trained specially on family violence management and Fam-VRARE should be included in their training curriculum so that they can have better understanding of family violence victims' management.
iii. Family violence safety strategies management should be included in the Health Education Curriculum at all levels of education.
iv. Fam-VRARE should be included in the medical curriculum with emphasis on assessment, diagnosis, treatment and safety plans of the victims.
v. Fam-VRARE Project should be floated in all institutions like the health, educational, religious institutions and communities in the state.

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