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Original Research Article

KNOWLEDGE AND ATTITUDES TOWARD DOMESTIC VIOLENCE AGAINST WOMEN IN ANAMBRA STATE, NIGERIA: AN URBAN–RURAL COMPARISON

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ABSTRACT

Domestic violence (DV) remains a major public health issue globally. Knowledge and attitudes toward DV shape women's perceptions, responses, and resilience. However, little is known about how knowledge and attitudes vary across urban and rural populations in Nigeria. This study compared the knowledge and attitudes among women in urban and rural communities in Nigeria. A community-based cross-sectional study was conducted among 588 women in Nnewi North (urban) and Anaocha (rural) LGAs of Anambra State. A multi-stage sampling method was applied. Quantitative data were collected with structured questionnaires, while qualitative data were drawn from in-depth interviews with 20 survivors. Descriptive and inferential statistics were done using the IBM SPSS software version 25.0, while thematic analysis guided qualitative insights. The mean age of the respondents was 31.88±10.1 years. The most common age group was 20-29years (208; 35.4%), had secondary education (328, 55.8%), and married (394; 67.0%). Awareness of DV was high (92.0%) in both groups, though awareness was higher among the urban women [93.5% (275) to 90.5 % (266)] with family members being the main source of information. Knowledge level was 57.3% (338) overall, but significantly higher among urban women [55.8 %(188;) to 44.2%(149)] compared to rural women ($\chi 2$: 13.11; P: 0.001). Positive attitudes toward addressing DV was 65.7% (386) generally; and more common in urban respondents than rural women [60.4% (233) to 39.6%(153)], a difference that was highly significant ($\chi 2$: 48.52; P: 0.001). Qualitative findings reinforced these results, with rural women often normalizing DV as "discipline," while urban women expressed more critical attitudes toward male dominance. Knowledge and attitudes toward DV differ significantly between urban and

rural women, suggesting that interventions must be context-specific. Public health programs should incorporate awareness campaigns and community-based initiatives to shift harmful norms and promote gender equality especially in rural areas.

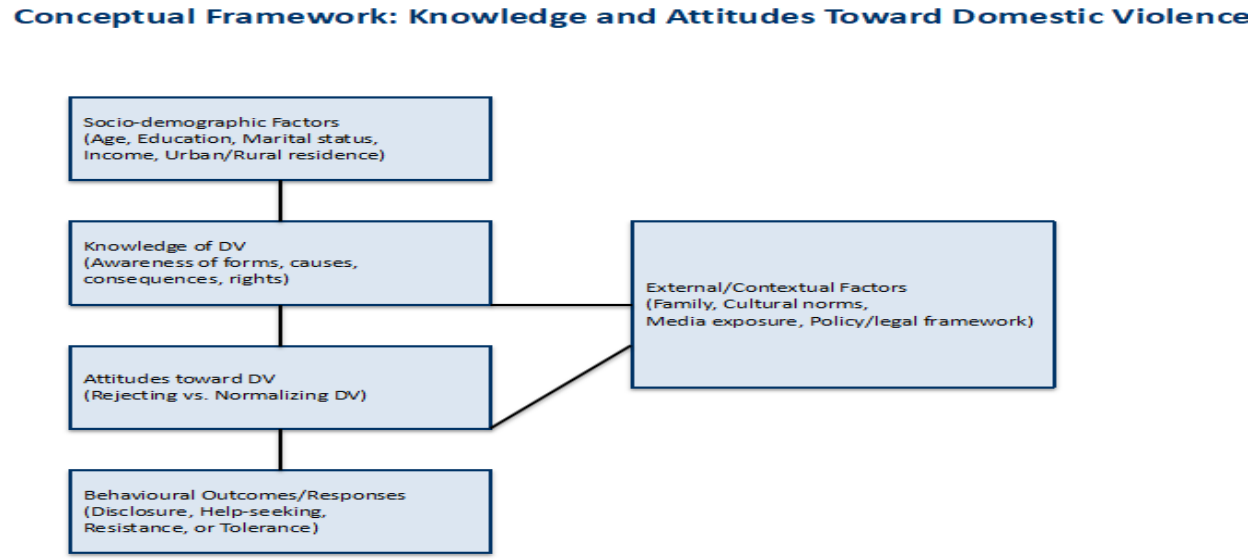
Keywords: Domestic violence, urban, rural, Nigeria, Anambra State, Awareness. Knowledge, attitude

1.0 INTRODUCTION

Domestic violence (DV) is a pervasive violation of women's rights, with significant health and social consequences. Globally, one in three women experiences physical or sexual violence in her lifetime, most commonly by an intimate partner (World Health Organization, 2021). Beyond physical injuries, DV is linked to depression, post-traumatic stress, reproductive health complications, and reduced socioeconomic participation (Muluneh et al., 2020). It is a human rights violation that affects women, families, and society in general. It interferes with Sustainable Development Goals (SDG) 3 and 5, hindering the achievement of good health and well-being for all and stagnating the attainment of gender equity and equality.

Domestic violence is as old as man and culture; it started in the history of man and is manifested in different forms and patterns. Over time and because of its consequences, domestic violence is becoming recognised as a global pandemic and a major public health challenge (Ansari *et al*., 2016). Domestic violence is one of the most important reproductive health and rights, gender and public health challenges that affect women and adolescents Children, men, the community, society, the nation and the globe (Abdullahi et al., 2017). Though there is increasing evidence that men also experience domestic violence (Obarisiagbon, 2019), but women experience the bulk of domestic violence. Domestic violence may lead to homicide. The United Nations Office on Drugs and Crime (UNODC) report on gender-related killing of women and girls found that globally, a staggering 87 000 women were intentionally killed in 2017. Even more worrying is that 60% of these killings were perpetrated by intimate partners or family members including parents, children or any other member of their family. Most of the murder were by intimate partners and close family members according to UNODC Executive Director at the launch of the report in 2018 (UNODC, 2021). Knowledge and attitudes toward DV are critical for prevention and intervention. Knowledge allows women to recognize violent behaviours, while attitudes influence whether violence is tolerated or resisted. In sub-Saharan Africa, cultural norms rooted in patriarchy often normalize violence, with women socialized to accept abuse as a form of discipline (Izugbara et al., 2020). In Nigeria, despite increasing advocacy, many women still perceive DV as justifiable under certain circumstances, such as disobedience or refusal of sex (Ajayi & Somefun, 2022). Urban and rural populations may differ in their knowledge and attitudes due to variations in education, media access, and exposure to gender equality campaigns. Urban women often have greater access to information and support services, whereas rural women may remain embedded in traditional patriarchal systems that reinforce harmful norms (Anikwe et al., 2023). However, few researches have systematically compared these differences in the eastern part of Nigeria.

Conceptual framework



The above conceptual was developed from literature review of similar studies.
This study assessed knowledge and attitudes toward DV among women in urban and rural communities of Anambra State, providing evidence for context-specific strategies to promote gender equality and reduce violence.

2.0 METHODS

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, lhiala, Ekwusigo, and Nnewi North and South LGAs (Centre for Community and Rural Development 2024). It is divided into 21 local government areas. 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. Moreover, 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 km^2, 1,264/km^2 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, 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.

Study Design

The study was a Community-based cross-sectional with both quantitative and qualitative data collection methods

Quantitative study

The Study Population

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

Inclusion criteria

This included all women 18 years and older married or not, who have lived in the selected community of study for at least one year prior to the study.

Exclusion criteria

The women who were not medically fit to participate in 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 $n = 2(Z\alpha+Z\beta)^2 P (1-P)/(p_1 - p_2)^2$ (Charan et al., 2021)
Where n= Minimum sample size for each group.
The level of significance (α) and the power of the test (1-β) were set at 5% and 80% respectively
Zα= Standard normal deviate corresponding to the probability of type 1 error (α) at 5% =1.96
Zβ =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.

p1 and p2 were the proportion in two groups of a similar study.
P is pooled prevalence calculated by adding prevalence is group 1 and prevalence in group 2 and then dividing the sum by 2. In this research reference was made to a 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) .
Substituting the above values into the equation, $n = 2(Z\alpha+Z\beta)^2 P (1-P)/ (p1 -p2)^2$
$n= 2(1.96 + 0.84)^2 * 0.3035*0.6965/0.018769$
n= 15.68 * 11.2626
n= 176.60
Approximately 177 participants in each group was calculated.
A 10% non-response rate was considered
Therefore, n was approximately 196.
Therefore, sample size population for the respondents in the rural and urban communities was 196 participants each giving a total of 392 for the study.
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 with the World Health Organization modified cluster sampling technique –

Stage one: Stratification
The Local Government Areas were stratified first into the urban and rural LGAs and one LGA was selected from each stratum using simple random sampling technique by balloting. One urban LGA was randomly selected from the seven urban LGAs and Nnewi North Local Government Area was selected. There are fourteen rural Local Government areas, one rural LGA was randomly selected which was Anaocha Local Government Area.

Stage two: Simple random sampling technique- Selection of one ward
It involved the selection of one ward each from the Nnewi North and Anaocha LGAs that were studied. The simple random sampling was applied, Nnewi-Ichi ward 2 was selected from Nnewi North LGA and Neni ward 1 was selected from Anaocha LGA.

Stage three: Selection of the Households and respondents
It involved the final selection of the households and respondents. The World Health Organization modified cluster sampling technique was used. Starting from a prominent point (the main market) 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
Eight female research assistants who have completed at least secondary school and can read and understand English were recruited and trained. Quantitative data were collected using structured interviewer-administered questionnaires adapted from validated instruments. Items assessed awareness, knowledge, and attitudes toward DV. The questionnaire had three sections;

Section A: Socio-demographic characteristics of respondents

Section B: Knowledge of domestic violence

Section C: Attitude toward domestic violence

IDIs explored perceptions of DV. The IDI was conducted simultaneously after the quantitative data collection by the principal investigator and the research assistants in a conducive place and the interview was tape-recoded. Thematic qualitative analysis was used in this study to analyse the in-depth interviews through the following steps: Familiarization; coding the data to highlight specific ideas, concepts and patterns; generating themes; reviewing themes; defining and naming themes; and writing up. The data was analysed with the Nvivo software 13.0 software.

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 questionnaires were translated to Igbo language then back translated to English to ensure that the original meanings of the research questions were maintained. This was to improve validity and reliability of the study tool.

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 necessary corrections in the study instrument and feasibility of the sampling procedures. This was to put in all corrections in the study procedure before the actual study was done.

Data Analysis

Quantitative data were analysed with IBM SPSS version 25. Descriptive statistics summarized awareness, knowledge, and attitudes. Data were organized and documented in tables, frequencies, percentages and figures. The variables of respondents were described using simple frequencies, measures of central tendency, and measures of variability. Chi-square tests compared urban and rural groups. Qualitative data were transcribed, translated, and analysed thematically to complement quantitative findings.

Qualitative Study

Qualitative study type

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

Study population

All the women survivors who experienced domestic violence

Inclusion criteria

All the women survivors who experienced domestic violence and were captured during the quantitative study.

Exclusion criteria

Women who were not able to spend the time for the in-depth interview (IDI)

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 had 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 chosen from Nnewi-Ichi ward 2 in Nnewi North LGA. Each participant was told about the essence of the IDI and its benefit. The IDI was conducted simultaneously after the quantitative

data collection by the principal investigator and the research assistants in a conducive place. 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 detailed knowledge and perception 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

Thematic qualitative analysis was used in this study to analyse the in-depth interviews through the following steps: Familiarization; coding the data to highlight specific ideas, concepts and patterns; generating themes; reviewing themes; defining and naming themes; and writing up. 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. Participation in the study was voluntary. The survivors of domestic violence was given referral notes for appropriate attention.

3.0 RESULTS

Socio-demographic Characteristics

The most frequent age group was the 20 to 29-year age group (208; 35.4%) followed by the 30 to 39-year age group (204; 34.7%) in the total group. For the urban respondents, the commonest age group was the 30 to 39-year age group (109(37.1%)), followed by the 20 to 29-year age group (95; 32.3%). While for the rural respondents, the most common age group is the 20 to 29-year age group (113; 38.4%), followed by the 30 to 39-year age group (95; 32.3%). 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 result is the same for the urban and rural groups. Most of the respondents were married or cohabiting (394; 67.0%). This is the same for the urban and rural groups (180; 61.2% and 214; 72.8% respectively). The variable that was significant in the above table was marital status; the singles were far more in the urban setting than the rural, while the married/ cohabiting were reasonably more in the rural group than the urban group (see table 1)

Table 1: Socio-demographic characteristics of respondents

Variable	Urban (294) Frequency (%)	Rural (294) Frequency (%)	Total (588) Frequency (%)	Test statistics	P-value
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

In the study, the commonest source of information on domestic violence was from family members and the least common source was social media. Family members as a source of information was highest among the urban respondents compared to the other general and rural groups. Friends were the highest source of information in the rural group than the other groups (See figure 1)

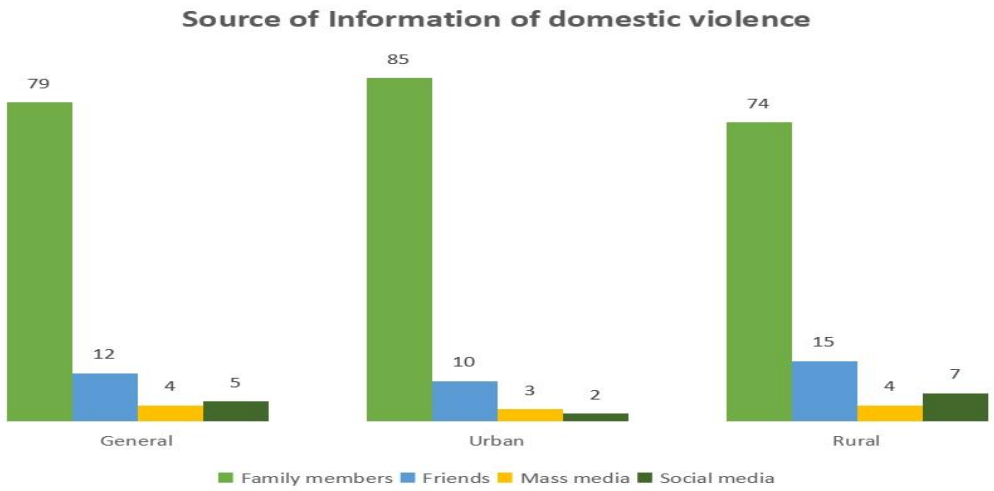


Figure 1: Source of information of domestic violence

The study shows that 92.0% (560) of the respondents have heard of domestic violence. For the urban and rural respondents, it is 93.5% (275) and 90.5 %(266) respectively which indicates that respondents in the urban setting are more aware of (domestic violence). The respondents with a total knowledge score ≤ 50.0% have poor knowledge, above 50% to 70.0% have fair knowledge, and those with above 70.0% have good knowledge. Good knowledge was above average in the general group (338; 57.3).

Good knowledge of domestic violence was higher among the urban respondents (188; 55.8%) than in the rural respondents (149; 44.2%). Fair and poor knowledge were higher among the rural respondents than the urban respondents (84; 53.8%, 61; 64.2% and 72; 46.2%, 34; 35.8% respectively). The knowledge difference between the urban and rural setting was statistically significant ($\chi 2$: 13.11; P: 0.001). Attitude was graded, respondents with cumulative attitude score of ≤ 50.0% have poor attitude, cumulative score of above 50% to 70% was fair attitude, and above 70% was positive attitude. Positive attitude of the general group was 65.7% (386 ;). Positive attitude was higher among urban respondents (233; 60.4%) compare to the rural respondents (153; 39.6%). And

fair and poor attitudes were far higher among the rural respondents than the urban respondents. The difference in attitude was very significant ((χ2: 48.52; P: 0.001). See table 2

Table 2: Awareness, Knowledge and Attitude to domestic violence

Variable	Urban (294) Frequency (%)	Rural (294) Frequency (%)	Total (588) Frequency (%)	Test statistics	P-value
Awareness	275(93.5)	266(90.5)	560(92.0)	1.87	0.17
Knowledge level				13.11	**0.001***
Good	188(55.8)	149(44.2)	338(57.3)		
Fair	72(46.2)	84(53.8)	156(26.5)		
Poor	34(35.8)	61(64.2)	95(16.2)		
Attitude				48.52	**0.001***
Positive	233(60.4)	153(39.6)	386(65.7)		
Fair	46(31.3)	101(68.7)	147(25.0)		
Poor	15(27.3)	40(72.7)	55(9.4)		

%: Percentage, *: Significant P-value

Qualitative accounts revealed that some rural women accepted DV as justified in cases of disobedience or disrespect: "When a woman talks too much at the man, she will be receiving beating" (Rural 10, hair stylist, 36 years). In contrast, urban respondents were more critical: "Most men would like only their opinion to stand and not allow the female's opinion to stand" (Urban 7, teacher, 25 years).

Table 3: Association of knowledge and attitude to experience of DV

Variable	Experience of DV		Test statistics	P-value
	Yes (n,%)	**No (n,%)**		
Knowledge			3.53	0.172
Good	199(59.1)	138(40.9)		
Fair	95(60.9)	61(39.1)		
Poor	47(49.5)	48(50.5)		
Attitude			19.36	**0.001***
Positive	226(58.5)	160(41.5)		
Fair	70(47.6)	77(52.4)		
Poor	45(81.8)	10(18.2)		

It was found that women with fair knowledge experienced DV the most (95;60.9%), followed by women with good knowledge (199;59.1%) and poor knowledge (47;49.5%). However, this was not statistically significant. For attitude, women with poor attitude experienced DV the most (45; 81.8%), followed by those with a positive attitude (226; 58.5%) and this association was significant (χ2: 19.36, P: 0.001)

Qualitative Result

All the 20 survivors of domestic violence outrightly said domestic violence was not acceptable.

The responses from survivors in the urban community include, *''there is nothing good about domestic violence'', ''it is not good to beat wife'', ''beating a wife is bad*.

The responses from the rural survivors include *''It is abnormal to beat wife'', ''men are wicked'', ''the woman will not be happy''*

4.0 DISCUSSION

This study assessed knowledge and attitudes toward domestic violence (DV) among women in urban and rural communities of Anambra State, Nigeria. Awareness of DV was generally high (92.0%) in both urban and rural communities, though slightly higher among urban respondents (93.5% vs. 90.5%). Family members emerged as

the most common source of information, underscoring the centrality of informal networks in shaping women's understanding of DV.

The high awareness levels in this study are consistent with findings from Ethiopia and Ghana, where awareness of DV exceeded 85% among reproductive-aged women (Bulto et al., 2021; Dickson et al., 2021). However, the reliance on family members as a primary source of information may reflect limited access to institutional or media-based education in rural areas, highlighting the role of community norms in shaping perceptions (Abeya et al., 2021).

In terms of knowledge, this study found that 57.3% of respondents demonstrated good knowledge, significantly higher among urban women (55.8%) than rural women (44.2%). Similar patterns have been reported in sub-Saharan Africa, where urban women consistently demonstrate higher recognition of DV due to greater access to education, media, and advocacy programs (Ambakederemo & Edewor, 2021; Ajayi & Somefun, 2022). In contrast, rural women are more likely to interpret violence as a private family matter or an acceptable corrective measure. This urban–rural gap is reflective of broader socio-economic disparities that influence women's empowerment and autonomy (Muluneh et al., 2020).

Attitudes toward DV further reinforced these differences. In this study, 65.7% of respondents held positive (non-tolerant) attitudes toward DV, but urban women were significantly more likely to reject violence (60.4% vs. 39.6%). This aligns with studies in Nigeria and Uganda showing that urban women are more likely to oppose DV, while rural women often justify it under conditions such as neglect of household duties or disobedience (Sserwanja et al., 2021; Anikwe et al., 2023).

The study examined the association between women's knowledge and attitudes toward domestic violence (DV) and their experience of abuse in urban and rural communities of Anambra State, Nigeria. The findings revealed that women with fair knowledge of DV had the highest prevalence of violence (60.9%), followed by those with good knowledge (59.1%) and poor knowledge (49.5%), although this association was not statistically significant. By contrast, attitude was significantly associated with DV: women with poor attitudes toward DV experienced the highest prevalence (81.8%) compared to those with positive attitudes (58.5%).

The finding that knowledge alone was not a significant protective factor against DV aligns with other recent studies in sub-Saharan Africa. For example, Ajayi and Somefun (2022) reported that although awareness of DV was relatively high among Nigerian women, it did not necessarily translate into reduced experiences of violence. Similarly, Sserwanja et al. (2021), in Uganda, found that knowledge of DV was insufficient to reduce its prevalence unless accompanied by shifts in attitudes and gender norms. This suggests that while knowledge may raise awareness, entrenched cultural practices and power imbalances can limit its impact in reducing women's vulnerability to violence. In contrast, women's attitudes toward DV demonstrated a significant relationship with their experiences of abuse in this study. Women with poor attitudes (those more likely to justify or accept DV) were significantly more likely to experience violence than those with positive, rejecting attitudes. This finding corroborates evidence from Ghana, where Dickson et al. (2021) observed that acceptance of wife-beating increased the likelihood of experiencing intimate partner violence. Likewise, Anikwe et al. (2023) in Southeast Nigeria reported that women who normalized DV or perceived it as a form of discipline were more likely to experience repeated abuse. These results underscore the critical role of attitudinal change in DV prevention. Our qualitative insights further highlight that women who perceive DV as justified in certain situations (e.g., disobedience, questioning male authority) often fail to resist or report violence, reinforcing cycles of abuse. This finding supports the argument by Izugbara et al. (2020) that the persistence of DV in Nigeria is deeply rooted in patriarchal ideologies that position women as subordinate to men.

Qualitative findings from this study supported this trend, with rural women describing DV as "discipline" or a husband's right, while urban women were more critical of male dominance and financial neglect. These results can be interpreted within the framework of feminist theory, which views DV as a manifestation of structural patriarchy. Women in rural settings, where patriarchal norms remain more entrenched, are socialized to normalize violence, whereas urban women exposed to rights-based discourses and education may be more inclined to challenge such norms (Izugbara et al., 2020). This has critical implications for public health, as normalizing violence reduces disclosure, discourages help-seeking, and perpetuates intergenerational cycles of abuse.

Overall, the findings suggest that while awareness of DV is high across both urban and rural settings, knowledge and attitudes remain uneven, with rural women significantly disadvantaged. Furthermore, findings suggest that interventions targeting DV should move beyond simply raising awareness of its forms and consequences. Rather, programs must address the underlying cultural and normative frameworks that shape women's and men's attitudes toward violence. Community dialogues, media campaigns, gender-transformative education, and

engagement of traditional and religious leaders may be particularly effective in challenging harmful norms and fostering positive attitudes that reject all forms of violence.

5.0 CONCLUSION

Awareness of DV among women in Anambra State is generally high, but gaps in knowledge and attitudes persist between urban and rural communities. Urban women demonstrated significantly better knowledge and more positive attitudes compared to rural women, where normalization of DV remains prevalent. Addressing these disparities requires targeted interventions that challenge harmful cultural norms while promoting women's rights and empowerment.

Recommendations: The government and policy makers should strengthen the implementation of the Violence against Persons (Prohibition) Act at community level, with emphasis on rural areas.
Stakeholders, government and non-government organizations should intensify efforts in the engagement of religious and traditional leaders to challenge cultural norms that frame DV as "discipline. "It is pivotal for the government through the ministry of health to integrate DV education into maternal and reproductive health services to increase women's knowledge. The government through the ministry of orientation in collaboration with other ministries include education should expand radio and television campaigns tailored to rural audiences to reinforce anti-violence messaging.
The government should promote female education as a long-term strategy to improve knowledge and attitudes toward DV.

Limitations of the Study: This study was cross-sectional in design, which limits causal inferences between socio-demographic characteristics and attitudes toward DV. The reliance on self-reported data may have introduced social desirability bias, particularly given the sensitive nature of DV. Additionally, qualitative findings were limited to 20 in-depth interviews, which may not capture the full range of women's experiences. Nonetheless, the mixed-methods approach strengthened the study by providing both statistical evidence and rich contextual narratives.

Future Directions: Future research should adopt longitudinal designs to assess how women's knowledge and attitudes toward DV evolve over time and in response to interventions. Further qualitative studies with larger samples are needed to explore cultural beliefs and intergenerational transmission of DV norms. Comparative studies across multiple states in Nigeria would also help determine whether the urban–rural differences observed here are generalizable.

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