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Assessment Of Gender-Based Violence In The City Of Ibadan, Oyo State, Southwest Nigeria

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Abstract
Introduction
Gender-based violence (GBV) is a significant public health issue globally, with the World Health Organization (WHO) describing it as any behavior within an intimate relationship that includes physical aggression, sexual coercion, psychological abuse, and controlling behaviors. The Economic and Social Council (ECOSOC) describes GBV as any harmful act committed against a person's will based on gender differences. GBV is recognized as a contemporary human rights concern affecting millions globally, with women and girls making up most victims. However, men and boys are also affected, though their victimization is less acknowledged, particularly due to societal perceptions of masculinity. The consequences of GBV, whether physical or psychological, are severe and can include exposure to HIV, sexually transmitted infections, unwanted pregnancies, post-traumatic stress disorder (PTSD), and depression. WHO statistics indicate that 35% of women globally have experienced intimate partner violence or non-partner sexual violence, revealing the widespread nature of the issue.
Purpose: *This study aimed to assess the prevalence and trends of gender-based violence in Ibadan, Oyo State, Nigeria. Oyo State is the fifth most populous state in Nigeria, with a GBV prevalence rate of 7.6%. By 2021, 17.1% of women in Oyo State had experienced physical violence since the age of 15. The study also seeks to explore GBV among men, adolescents, and pregnant women, as well as the help-seeking behaviors of victims and the response of healthcare providers in Ibadan.*
Method*: A quantitative, descriptive cross-sectional study was conducted, using semi-structured questionnaires hosted on Kobocollect. The research covered the 11 Local Government Areas (LGAs) of Ibadan. Data analysis was performed using SPSS Version 29, with inferential statistics used to test associations between categorical variables. Logistic regression was also employed to identify independent factors of GBV, with a statistical significance level set at* $p < 0.05$*.*
Results: *The study included 13,841 participants, comprising 2,388 pregnant women, 2,027 non-pregnant women, 4,452 adolescents, 3,688 adult men, and 1,286 healthcare providers. Among adult women, younger age groups (20-29 years) were less likely to experience GBV compared to older women. Women who were employed or had higher educational attainment were less likely to be at risk. Pregnant women aged 30-39 had a higher likelihood of experiencing GBV, while women aged 50 and above had a lower risk. Among men, younger males were more likely to experience GBV threats, with 7.1% reporting physical violence from their partners. Adolescents, particularly those aged 10-14 years, were at a higher risk of GBV compared to older adolescents. Employment status was also a significant factor, with unemployed adolescents reporting higher rates of GBV. Additionally, 22% of health facilities reported GBV cases in the past six months, with primary health centers being the most common point of care. However, there were gaps in knowledge among healthcare workers, with most failing to identify the different forms of GBV.*
Conclusion*: Age, employment status, education level, and partner's behavior (such as alcohol consumption) were significant factors influencing GBV risks in Ibadan. The findings suggest gaps in the knowledge of healthcare providers and limited long-term support for survivors of GBV. While most facilities reported cases among women, there were fewer reports of GBV among men, highlighting the need for more attention to this issue.*
Keywords: *Gender-based Violence, Nigeria, Oyo State, Ibadan, Men, Pregnant Women, Women, Adolescents, Healthcare workers, healthcare providers, Attitude, Knowledge*

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I. Introduction

"*Violence in couple relationships is a problem of power and control. It is maintained by the social structures of oppression in which we live—based on gender, class, age, and race inequalities. A national history of wars and a culture of settling conflict through force also maintain it. Both men and women learned and practiced this logic of human relations based on power and control over others; however, for men, the exercise of this power-over-others model becomes almost an obligatory criterion to our male gender identity". Oswaldo Montoya*[16]

Growing up in a predominantly patriarchal African community where women are, at best, seen and not heard, coupled with the silent and unwritten approval of the debasement of women as an acceptable social norm, fueled an interest in this research. Personal experiences of the varying forms of violence (direct and indirect) in school, the community, the workplace and even in places of worship only piqued more curiosity in examining this phenomenon.

Background of the study

Gender-based violence (GBV) significantly impacts public health worldwide and is possibly the most repressive form of gender inequality, posing a formidable hindrance to equity in the participation of men and women in social, political, and economic spheres[1]. The World Health Organization (WHO) explains the concept of gender-based violence (GBV) as 'any behavior within an intimate relationship, inclusive of acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors'[3]. Violence often occurs between people in a sexual or romantic relationship. Usually, the woman is the victim[4]. Globally, gender-based violence (GBV) is recognized as one of the significant public health problems and a contemporary human rights concern[5].

Gender-Based Violence (GBV), sometimes also referred to as Sexual and Gender-Based Violence (SGBV), is any harmful act of psychological, sexual, physical, mental, and emotional abuse that is perpetrated against a person's will and is based on socially ascribed (i.e. gender) differences between males and females.[17] The UN has developed and revised several definitions of gender-based violence over the past two and a half decades. The 11th session of the Committee on Elimination of all forms of Violence against Women (CEDAW) views gender-based violence as a form of discrimination that strongly inhibits women's ability to enjoy rights and freedoms based on equality with men.[18]

Article 1 of the Declaration on the Elimination of Violence against Women General Assembly resolution 48/104 of 20 December 1993 captured it as "Any act of violence that culminates in, or is likely to culminate in, psychological, physical, sexual harm or suffering to women, including threats of such acts, force or arbitrary deprivation of liberty, occurring in private or in public life." [18]

Perhaps the most expansive definition that acknowledged GBV as a tool of oppression and violence was proffered by the Economic and Social Council (ECOSOC) Humanitarian Affairs Segment 2006 as "Any harmful act that is committed against a person's will and is predicated on socially associated differences between males and females". As such violence is based on socially ascribed differences, gender-based violence includes but is not limited to sexual violence. While women and girls of all ages make up most victims, men and boys are both direct and indirect victims. It is clear that the effects of such violence are both physical and psychological and have long-term detrimental consequences for both the survivors and their communities."[18]. In all societies, women and girls possess less power than men over their bodies, resources and decisions. Social norms that approve of men's use of violence as a form of dominance, discipline and control strengthen gender inequality and perpetuate gender-based violence. Across the globe, women and girls – especially adolescents – face the greatest risk[19]. Gender-Based violence refers to harmful acts directed at an individual based on gender. It is rooted in gender inequality, harmful norms and the abuse of power; GBV is a severe violation of human rights and a life-threatening health and protection issue. More worrisome is the estimate that one -third women will fall victim to sexual or physical violence in their lifetime.[20,21]

The UNICEF affirmed Gender-Based Violence (GBV) as the most pervasive yet least visible human rights violation in the world.[19]. It includes sexual, physical, economic or mental (psychological) harm imposed due to culturally or socially ascribed power imbalances between males and females. It also consists of the threat of violence, coercion and denial of liberty, whether in public or private.[19,24]. The prevalence of gender-based violence worldwide is mainly due to systemic gender inequality that disempowers women, girls, and other minorities and stifles their voices so that their stories are not only unheard but their natural human rights are more easily withdrawn. If gender-based violence is any form used to establish, enforce and perpetuate unequal gender power relations, it is also clear that such power relations are also shaped by other axes of oppression, whether based on class, caste, age, sexuality and race/ethnicity [22]. The vicious cycle of violence is further perpetuated by a lack of justice, a dearth of available resources, or a lack of economic opportunities, leading to the victim being dependent on their abusers. For instance, in the United States, about two percent of rapists are

likely to face incarceration and perpetrators of honor killings worldwide are rarely persecuted, allowing violent groups and individuals to continue abusing their power without fear of repercussions.[23].

The World Bank in 2019 identified violence against women and girls (VAWG) as a global pandemic[21], with the recent 2023 statistics from the UN high commission for Refugees affirming that one in every three women will experience GBV in their lifetime [20,21]. The act of Violence against women and Girls (VAWG) is one of the most persistent, devastating and widespread human rights infringements and violations in our world today that remains largely unreported due to the silence, impunity, shame and stigma shrouding it [25]. Meanwhile, the United Nations describes VAWG as "an act of gender-based occurrence that results in, or is likely to lead to, mental, sexual, or physical infliction of harm or distress to women, including warnings of such acts, arbitrary deprivation of liberty, coercion, whether occurring in private or public life." [6.] VAWG manifests itself in physical, sexual and psychological forms such as:

- Intimate partner violence (battering, psychological abuse, marital rape, femicide);
- Sexual violence and harassment (rape, forced sexual acts, unwanted sexual advances, child sexual abuse, forced marriage, street harassment, stalking, cyber-harassment);
- Human trafficking (slavery, sexual exploitation);
- Female genital mutilation
- Child marriage

The 2023 WHO and UNFPA statistics on GBV are ominously staggering:

- About a third, (35%) of women and girls have experienced sexual or physical intimate partner violence or non-partner sexual violence[24].
- Worldwide, 7% of women have been sexually assaulted by someone other than a partner[24].
- Globally, up to 38% of murders of women are committed by an intimate partner [24].
- Across the globe, 200 million women have experienced female genital mutilation/cutting [24].
- Ninety percent (90%) of rape victims are women [26].
- An unprecedented 80% of adult victims know their rapist, while over 90% of youth victims know theirs[26].
- Many women feel that violence against wives is justified in some cases. Ethiopia, India, Bhutan, Samoa, and Laos are just some countries where over half of the women feel as such [26].
- Over 90% of offenders never see justice [26].

Gender-based violence is costly. The loss in wages is comparable to the total military spending by all countries each year[26].

Violence and assaults are devastating for survivors of the violence and their families and entail significant social and economic costs. Gender-based violence is an issue affecting every single person, either personally or by acquaintance [26].

In some countries, violence against women costs an estimated 3.7% of the GDP – more than double what some governments spend on education [24]. Gender-based violence often goes unseen, untreated, and unchecked. A way to begin correcting the injustice of violence against women is to better comprehend the different types of violence women experience and then look for ways to address each kind of violence best [26].

Suffice to say that the consequences of GBV are profound, as survivors of gender-based violence suffer devastating short- and long-term consequences to their physical and mental health[19]. Women and girls are likely to experience unwanted pregnancies, exposure to HIV or other sexually transmitted infections and severe physical injuries through GBV. Post-traumatic stress disorder (PTSD), the limited ability to complete daily tasks, depression, anxiety, and suicidal thoughts are also common.[19]. It also leads to the state of the illness (morbidity), mortality, reduced productivity, and reduced quality of life. Gender-based violence in all forms (sexual, physical, mental. psychological and economic harm) inflicted in public or private also includes threats of violence, coercion and manipulation. Across cultures, GBV can manifest in many forms, such as, sexual violence, intimate partner violence, child marriage, 'honor crimes'. and female genital mutilation. The consequences of gender-based violence can be both devastating and with life-long repercussions for survivors. It can even lead to death. [19,20]

Though women who experience GBV may report to authorities, it has been contested that men who experience GBV encounter pressure against reporting, possibly facing social stigmatization regarding their perceived lack of machismo and other denigration of their masculinity[2]. In its landmark report on violence and health, the WHO reported that "most experts believe that official statistics vastly under-represent the number of male rape victims" and "that men may be less likely or less inclined than female victims to report an assault to the relevant authorities [22].

The magnitude of gender-based violence in men as victims is under-reported and unexplored globally and in Nigeria. Gender-based violence (GBV) poses a threat to men's health. Gender-based violence against men is generally less acknowledged by the society than GBV against women, further blocking men from reporting their situation. Partly, this is because, in general, in-society, men hold power[2]. Therefore, it is hard to

view men as victims. The noxious views of masculinity often prevent men from coming forward when victims of GBV. The associated stigmatization, and the fear of not being believed, can be strong enough to discourage men from reporting the abuse. The occurrence and frequency of GBV against men are highly disputed, with varying research indicating diverse conclusions for different countries and many countries having no data[2]. Few studies have examined the prevalence, pattern and correlation of gender-based violence in men as victims in Nigeria.

Globally, one-third of women experience sexual or physical violence in their lifetime, mainly by an intimate partner. The incidence of GBV is a stark reminder of gender inequality and discrimination against women[6]. Ever-experienced GBV predicts many acute and chronic diseases and stress-related conditions among women[7].

Gender-based violence (GBV) remains a severe global public health concern during gestation. Within Sub-Saharan Africa, nearly 40% of women reported abuse by their intimate partners[8]. Due to maternal and fetal health consequences, GBV remains a global public health problem among pregnant women. It is the foremost cause of reported trauma during pregnancy, and the prevalence varies between and within countries. Several studies showed that women who had experienced GBV pre-conception continued to suffer during pregnancy[9]. Individual-level demographic, psycho-cognitive, and sociocultural factors of a woman and her intimate partner primarily determine GBV. Pre-natal GBV has been linked to adverse birth outcomes, including low birth weight (LBW) [10]. The process of how GBV exposure during pregnancy might impact birth outcomes include direct and indirect biological effects on fetal growth. Pre-natal GBV is a potentially modifiable risk factor for preventing low birth weight (LBW). An extensive cross-sectional survey conducted among 1180 pregnant women attending antenatal care in Dar-es-Salaam, Tanzania, by Mahenge and colleagues revealed significantly higher odds of post-traumatic anxiety, stress disorder and depressive symptoms in women who experienced sexual and or physical GBV during pregnancy[11]. Smoking, alcohol use and poor utilization of maternal health care are also associated with occurrences of GBV[9].

Women tend to seek help and succor after occurrences of abuse. Women's health-seeking behaviors for GBV are determined and influenced by many factors. In a study by Olaoye et al. in 2019 among women who experience GBV in Isolo, Lagos State, Nigeria, over half of the respondents (59.5%) stated that the attitude of workers at the health centers was a barrier to not seeking help. Respondents experienced various patterns of gender-based violence with low-quality help-seeking behavior. The study, which focused on health workers' management of GBV victims, proposed that workers in the health centers should be well trained to show empathy to victims[12].

Although violence at school is a new occurrence, there have been growing scientific and social concerns about this problem in recent years. Violence among young people is a significant universal problem and a gross public health issue. It accounts for preventable morbidity and mortality for men and women across different cultures. Consequently, efforts to identify predictors and protective factors have intensified. In Nigeria, few studies have explored the scope and correlation of violence in young people in schools[13]. The first-ever nationwide situational analysis survey of public-school violence in Nigeria revealed that psychological and physical violence accounted for 85 and 50 percent of the total violence experience against students. A study in Osun State, Nigeria, reported that 60.6 and 59.9 percent of males and females respectively had experienced physical or psychological violence from other students in the last year[14].

Statement of the problem

Globally, gender-based violence (GBV) is recognized as one of the significant public health problems and a contemporary human rights concern[5]. This research aligned with gender-based violence in its more inclusive sense of referring to violence that is in some direct way targeted at expressing and maintaining unequal power relations of oppressive gender orders, which includes, but is not limited to, violence against adolescent boys and girls, violence against men and violence against women.

Gender-based violence is enacted under many manifestations, from its most widespread form, intimate partner violence, to acts of violence in online spaces. These different forms are not mutually exclusive while multiple incidences of violence can happen simultaneously and reinforce each other. Inequalities encountered by a person related to their age, race, (dis)ability, social class, religion, and sexuality can also drive acts of violence [26]. One-third women experience physical and/or sexual violence in their lifetime, mainly by an intimate partner. According to data from the UNFPA, Oyo State has a GBV prevalence of 7.6% (Gombe State has the highest at 35.6% and Sokoto has the lowest prevalence at 2.6%)[27]. But by 2021, out of the estimated over 7.8 million population in Oyo State, the fifth most populous state in Nigeria, 17.1 per cent of women in the state have experienced physical violence from age 15 [28]. The Oyo State gender violence response team reported a surge in women who reported violence of all forms from 132 in 2019 to 768 in 2020 [28]. Further, the proportion of ever-partnered women and girls aged 15-49 subjected to sexual or physical violence by a current or past intimate partner in the previous 12 months in Nigeria in 2018 was estimated at an alarming 13.8% (UNFPA,

2018)[29]. These are a stark reminder of gender inequality and discrimination against women[6]. Education and employment status are critical determinants of GBV in Nigeria ([17,24,25,30,31,32]). Having ever experienced GBV is a risk factor for many acute and chronic diseases, including stress-related conditions among women[7]. Experiencing GBV is unacceptable in the face of sustainable development goal (SDG) five, which aims at both empowering and achieving gender equality among all girls and women. This SDG goal remains elusive, especially in sub-Saharan Africa, as long as GBV continues to occur[6].

Furthermore, there has been growing social and scientific concern about this problem. Violence among young people is a significant public health issue and a universal problem. Research and studies on adolescents suggest that violent behavior or the intention to use violence is associated with several contextual, individual, and situational factors. The issue devastates survivors of violence, including their families and involves significant economic and social costs. In some countries of the World, violence against women is estimated to cost up to 3.7% of their GDP – above double what most governments spend on basic education[6].

Failure at addressing this issue also entails a significant cost in the future. Some studies have suggested that children that grew up with violence were more likely to become perpetrators or survivors of GBV[31,32].

A characteristic of gender-based violence is that it knows no social or economic bounds and affects women and girls of all social and economic backgrounds; this is an issue that need be addressed in both developing and developed countries[33].

Gender-based violence (GBV) against men is generally less recognized by society than GBV against women, further blocking men from reporting their situation. Partly, this is because culturally, men are believed to wield power[2]. Therefore, it is hard to view men as victims. Investigating the occurrence, pattern, and correlations of GBV among men as victims is crucial because it will reveal the magnitude of this hidden phenomenon and inform advocacy for prevention, management, and redress. The investigation provides empirical evidence and baseline data in our environment, further providing the basis for formulating preventive strategies. It also helps design systems and responses capable of actively and appropriately meeting the needs of victims[2].

Abused GBV victims will naturally want to seek help, either via formal or informal channels. In Nigeria, maternal health-seeking behaviors are predicted by numerous interrelated factors. Little research exists on how norms and gender dynamics, including the acceptableness of diverse forms and types of intimate partner violence against women (IPVAW), influence women's decision-making autonomy, health-seeking behavior, and overall well-being[15].

Justification of the study

With the observed increasing trend in the incidence of GBV, the causes, determinants and enhancers of GBV within the Nigerian context are yet to be well studied and understood to identify pragmatic solutions to curtail the scourge. Further, most studies have elaborately explored GBV in women, an imbalance tilted against men and adolescents as victims of GBV. Deciding the incidence of violence against women and girls requires a community-based, multi-pronged approach. A sustained engagement with multiple stakeholders is also crucial. Effective initiatives address underlying causes or risk factors for violence, which includes social norms regarding gender roles and the acceptability of violence [24].

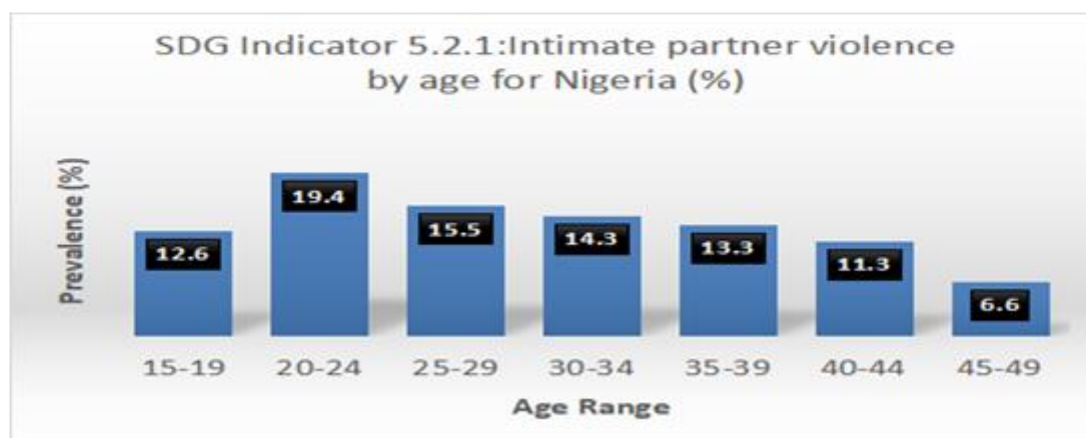
Issues revolving around GBV may not have been well studied, as such the overall increase in GBV incidence in Nigeria. Furthermore, most studies failed to focus on men and adolescents as victims. In Nigeria, like in other jurisdictions, GBV remains a challenge that significantly constrains women's autonomy and opportunities [33]. To better understand GBV within Nigeria and identify workable solutions to address the rising incidence, this study assessed gender-based violence against men, adult non-pregnant women, pregnant women and adolescents. In the same vein, the study explored the help-seeking behavior of abused victims and the response of healthcare givers to managing GBV in the city of Ibadan. The study further identified and provided newer, practical and replicable approaches, methodologies and strategies, both at the community and policy levels at addressing and reducing the incidence of gender-based violence in Ibadan and by extension, Oyo State, Nigeria.

Significance of the Study

The study investigated the occurrence, pattern, and correlations of GBV among women (pregnant and non-pregnant), adolescents and men as victims and revealed the magnitude of this hidden phenomenon and inform advocacy for prevention, management, and redress.

More precisely, this study explored and identified the pattern, prevalence and determinants of gender-based violence among adult pregnant and non-pregnant females across the 11 LGAs that comprise Ibadan city. An elaborate and robust understanding of the determinants of GBV among adult pregnant and non-pregnant women helped identify pragmatic approaches that can help arrest GBV among the target population.

This research also unraveled the burden and determinants of GBV among adolescents as victims of GBV. Data from the UNFPA population data portal reveals that 12.6% of Nigerian adolescents within the 15-19 age bracket have experienced intimate partner violence (a form of gender-based violence) including rape.[29]. The research thus sought to confirm, debunk, or refute this data, specifically among adolescents in Oyo State. So, what could have led to the abuse of adolescents? Are there predisposing factors to GBV that could be controlled or mitigated, controlled or completely removed to prevent the re-occurrence of GBV among the state's adolescents? This research unraveled this puzzle.



Source: UNFPA population data portal accessed 22-11-2023
Figure 1: Prevalence of IPV by age in Nigeria[29]

More interestingly, the study clarified the prevalence, pattern and determinants of GBV among men There is a dearth of researches and studies on GBV among men as victims compared to the female gender[13]. Scarcer is the report of such abuses from abused males. A deeper understanding of the factors predisposing to GBV among men can facilitate the identification of programmatic and pragmatic approaches that can reduce the observed trend. It is hoped that this research will herald the resolution of challenges and stigmatization attached to males reporting GBV in Ibadan, Oyo State, Nigeria.

Consequently, this research will be inconclusive without identifying the knowledge and attitude of GBV survivors about GBV, including the health-seeking behaviors of abused victims. The question of how societal norms, practices and culture have influenced GBV survivors understanding of the GBV context was unraveled. Attempts of GBV survivors to seek care (where, when, how, from whom) were also explored.

Healthcare workers are, by default, trained to manage abuse cases. However, their practices towards managing various abuse cases at health facilities remains uncertain. As such, another thrust of this research was to identify and unravel health workers' knowledge, attitude, and practice of GBV in Ibadan. A concise understanding of this phenomenon can elicit positive policy changes not only in the healthcare workers' training curriculum aimed at managing abused victims of GBV but also in health facilities set up to manage such cases that present. In Nigeria, maternal health-seeking behaviors are predicted by numerous interrelated factors. Abused GBV victims will naturally want to seek help, either via formal or informal channels. As such, the study explored and provided empirical evidence and baseline data on healthcare providers' responses to survivors of GBV. This provided the basis for formulating policies, designing preventive strategies and conceptualizing rehabilitation programs for victims, and ultimately facilitate the design of systems and responses capable of actively and appropriately meeting the needs of victims[2].

Scope of the Study

This study determined the burden of GBV among adult men, pregnant women, non-pregnant women and adolescents within Ibadan City. The study specifically explored the occurrence, pattern and correlations of gender-based violence among men, pregnant women, non-pregnant women and adolescents within the all eleven (11) LGAs that comprise Ibadan City. This research further unraveled the maternal health-seeking behavior of abused pregnant women and identified healthcare providers' responses to such survivors of GBV. Both in and out-of-school adolescents were included in the study.

Purpose of the Study

The purpose of this study was to assess the trend and patterns of gender-based violence in Ibadan, Oyo State, South western Nigeria.

Research Questions

The study provided responses to the following research questions:

1. What is the burden and determinants of GBV among adult, non-pregnant females?
2. What is the burden and associated risk factors of GBV among pregnant women?
3. What is the burden and risk factor of GBV among adolescents?
4. What is the burden and determinants of GBV among adult males?
5. What is the health workers' knowledge, attitude, and practice of GBV?
6. What is the knowledge and attitude of female study respondents towards GBV?

Objectives of the Study

General Objective

This study determined the burden of gender-based violence in the city of Ibadan, Oyo State, Nigeria. This is the broad objective.

Specific Objectives

The specific objectives of this research were to:

1. Determine the prevalence, pattern, and determinants of GBV among adult non-pregnant females in the city of Ibadan
2. Assess the prevalence, pattern, and associated risk factors of GBV among pregnant women in the city of Ibadan
3. Determine the prevalence, pattern, and risk factors of GBV among adolescents in the city of Ibadan
4. Assess the prevalence, pattern, and determinants of GBV among adult men in the city of Ibadan
5. Determine health workers' knowledge, attitude, and practice of GBV in the city of Ibadan
6. Determine the knowledge and attitude of female respondents towards GBV in the city of Ibadan

Research Hypothesis

The Null Hypothesis (H0) to be tested are:

1. Men with fewer socio-economic resources than their female partners are more likely to use physical violence and coercive control than men with resources equal to or greater than their female partners.
2. Women with more significant economic resources are less likely to experience physical violence and coercive control within intimate partnerships.
3. Men with more significant economic resources are less likely to experience gender-based violence within intimate partnerships.
4. Older women are more likely to experience GBV from their partners
5. Younger Adolescents are more at risk of GBV

Limitation of the study

Financial constrains limited the study to the 11 LGAs within Ibadan as the financial implications of conducting this type of research on a scale large enough to cover the entire State will likely require a research grant. Be that as it may, the sampling procedures and sample size for this research attempted to cover up for this limitation such that the findings from the research were extrapolated and representative for the State and geo-political zone.

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II. Review Of Literature

Introduction

Literature suggests that gender-based violence was associated with different socioeconomic, cultural, educational, and other individual factors. Gender-based violence (GBV) is a global pandemic; many have been victims long before Covid-19. The key phrases "gender-based" and "violence" will now be considered.

Empirical Studies

Gender

Gender refers to the characteristics of women, girls, men and boys that are socially constructed. This includes behaviors, roles and norms associated with being a man, boy, girl or woman, as well as relationships with each other. As a social construct, gender varies across societies and can change over time[1].

Gender is hierarchical and produces inequalities that intersect with other social and economic disparities. Gender-based discrimination intersects with other discrimination factors, such as socioeconomic status, disability, age, ethnicity, geographic location, sexual orientation and gender identity[1].

Though gender interacts with sex, it is different from sex. Sex refers to the physiological and biological attributes of males and females and intersex persons, such as hormones, reproductive organs and chromosomes. Sex and gender are related to but different from gender identity. Gender identity is a person's deeply felt experience of gender, which may or may not correspond to the person's physiology or designated sex at birth.[1]

Adolescents: The United Nations (UN) has defined adolescents as those between 10 and 19. Adolescents undergo a transition period between childhood and adulthood and, with it, significant growth and development. The age range aligns with WHO's definition of young people, which refers to individuals between the ages of 10 and 24[2]. In many communities and cultures, adolescence is marginally equated with puberty and the corresponding physical changes culminating in reproductive maturity. In other cultures, adolescence is understood in broader terms encompassing psychological, social, and moral terrain and the strictly physical aspects of maturation. In these societies, adolescence is between 12 and 20 years and is approximately equivalent to teens.[2]

Teen or adolescent violence refers to harmful behaviors or practices that can start early and continue into adulthood. The young person can be an offender, a witness or a victim of the violent act.

Violent acts include:
- Bullying
- Fighting, including kicking, punching, hitting or slapping
- Use of weapons such as knives, guns or machetes

Some violent acts can result in more emotional than physical harm. Others can lead to severe life-threatening injury or even death.[3]

Gender-based violence (GBV) is a global human rights issue with varying social determinants. Young adults are considered high risk; national influences include norms, policies and practices.[4] A study conducted across 30 nations of the world revealed an estimated 28% of adolescent and 29% of young adult women reporting lifetime physical or sexual IPV; this phenomenon was most prevalent in the Southern and Eastern Africa. Cross-national variation in patterns of violence by age was observed, with young adult women demonstrating an increased risk for past-year IPV compared to adult women. Forced sexual debut was estimated at 12%, with the highest figures reported in East and Southern Africa. Gender-based violence is pervasive among adolescent and young adult women in low- and middle-income countries. The unique risk to youth varies across nations, indicating an age-place interaction.[4]

Violence

The WHO has defined violence as the "deliberate use of power or physical force, actual or threatened, against oneself, another person, or against a community or group, that either leads to or has a high probability of resulting in injury, death, psychological harm, maldevelopment, or deprivation". Interpersonal violence occurs between family members, intimate partners, friends, acquaintances and strangers. It includes child maltreatment, youth violence, intimate partner violence, sexual violence, elder abuse and violence against women and girls. It is both predictable and preventable[5]

Death from interpersonal violence represents only a fraction of the extent of interpersonal violence; for every death, there are many more cases of violence leading to various health and social consequences[5]; exposure to violence increases the risk of becoming a victim of or a perpetrator of future violence. Interpersonal violence is strongly gendered; men are disproportionately represented among victims of violent death, while violence against women is a pervasive criminal and human rights issue rooted in gender inequalities and harmful gender roles and norms[5].

The risk factors for interpersonal violence are multiple and occur at an individual, relationship, community and societal level. Interpersonal violence burdens public health enormously, increasing risks of lifelong health and social problems, including premature mortality. Consequently, a public health approach to violence prevention is critical. The SDGs constitute a potentially robust violence prevention agenda, and their successful implementation will contribute significantly to preventing all forms of interpersonal violence. Violence prevention requires multiple sectors to work together to implement evidence-informed solutions that focus on leaving no one behind, human rights, equity and a life-course approach [5,6,7].

The SDG "violence" indicators

The following SDG indicators below have been used to track violence across the violence-related SDG goals 3,5,8,10,11 and 16**.**[5,7,8]

3.5.2**.** Harmful use of alcohol, defined within the national context as alcohol per capita consumed in persons aged 15 years and older within a calendar year in liters of pure alcohol.

5.1.1**.** Whether or not legal frameworks are in place to enforce, promote and monitor equality and non-discrimination based on sex

5.2.1. Percentage of ever-partnered women and girls aged 15 years and older subjected to sexual, psychological or physical violence by a former or current intimate partner within the previous 12 months, by the form of violence and by age

5.2.2. Percentage of girls and women, aged 15 years and older, that experienced sexual violence by persons that are not intimate partners in the previous 12 months, by age and place of occurrence

5.3.1. Percentage of women, 20–24 years, who were in a union or married before ages 15 and 18.

5.3.2. Percentage of girls and women (15–49 years) that have undergone female genital mutilation/cutting by age

8.7.1. Percentage and total number of children (5–17 years) engaged in child labor by age and sex

10.3.1**.** Proportion of the population reporting having been or felt discriminated against or harassed in the previous 12 months based on a ground of discrimination prohibited under international human rights law

11.7.2. Percentage of victims of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months

16.1.1. Total number of victims of intentional homicide per 100,000 population, by sex and age.

16.13. The proportion of the entire population subjected to physical, psychological and sexual violence in the previous 12 months

16.14. The percentage of the population that feels safe walking alone around the area they live

16.21. The percentage of children aged 1–17 years who experienced any physical punishment and psychological aggression by caregivers in the past month

16.22. Number of victims of human trafficking per 100,000 population by sex, age and form of exploitation

16.23. The percentage of young women and men aged 18–29 years who experienced sexual violence by 18 years of age

16.31. The percentage of victims of violence in the previous 12 months who reported their abuse to relevant authorities or other officially recognized conflict resolution platforms

In 2016, the World Health Organization's (WHO's) Member States endorsed the *Global plan of action* to enhance the role of the health system within a multisectoral response to address interpersonal violence, specifically against children, girls and women, which includes improving the collection and use of robust data as one of its four strategic directions. Accurate and reliable statistics on violence against women are crucial to improve our understanding of the prevalence, nature and impact of this violence and how these may differ across settings and age cohorts and to monitor changes over time [9].

Understanding the different forms of violence

Gender-based violence is enacted under many ramifications, from its most common form, intimate partner violence, to acts of abuse and violence in cyberspaces. These varying forms are not mutually exclusive, and multiple incidences of violence can happen simultaneously and reinforce each other. Inequalities experienced by a person related to their age, social class, ability/disability, religion, and sexuality can also fuel acts of violence. It follows that while women face violence and discrimination based on gender, some experience interlocking forms of violence and abuse. The Istanbul Convention explains violence against women as having four fundamental categories: physical, sexual, psychological and economic. [10]

Violence appears different in each circumstance, while each form of violence can occur in isolation or simultaneously. All forms of violence are detrimental and imply dangerous consequences for survivors and victims.

Sexual Violence

The World Health Organization (WHO) acknowledges sexual violence as "any sexual act, an attempt to obtain a sexual act, unwanted sexual advances or comments, or acts to traffic, directed at a person's sexuality using force, by anybody, regardless of their relationship to the victim, in any setting which includes but is not limited to home and work." Sexual violence occurs everywhere.[11] It includes rape, defined as the physically forced or coerced penetration of the anus or vulva with a penis, other body part or object, unwanted sexual touching, attempted rape and other non-contact forms" [9]. Summarily, sexual violence can take the form of rape or sexual assault.[10]

Physical Violence

The World Health Organization defines physical violence as "the calculated or deliberate use of power or physical force, actual or threatened, against oneself, a person, or against a group or community, that either result in or has a high probability of resulting in injury, psychological harm, maldevelopment, deprivation or death."[10]

It is any act that causes physical harm due to unlawful physical force. Physical violence can be severe and minor assault, deprivation of liberty, restriction of movement and manslaughter.[10]

Psychological violence

Psychological (Emotional or Mental) violence is any detrimental behavior that is not physical, such as verbal abuse, manipulation, intimidation, humiliation, degradation, coercion, defamation, verbal insult or harassment and stalking.[10,11]. Other psychologically abusive behaviors include economic abuse, where a partner controls the other partner's access to necessary expenses or income, and isolation from friends or family.

Psychological abuse often happens over time, during which the victim loses their dignity, individuality or self-worth. This potentially results in dependency on a partner for feelings of self-worth or otherwise creates an environment where the victim or survivor lives in fear.

Victims of psychological violence may develop depression, anxiety, suicidal thoughts or behaviors, and ultimately post-traumatic stress disorder (PTSD). Psychological violence can be masked and impossible for outsiders to see, but that does not mean it is less harmful. Psychological violence almost always accompanies sexual and physical violence. [11]

Economic violence: Any behavior or act which results in economic threat or harm to an individual. Economic violence can take the form of restricting/withholding access to financial resources, education or the labor market, property damage, or not complying with economic responsibilities, such as alimony.[10]

It is also essential to recognize that gender-based violence may be normalized and perpetrated due to structural inequalities, such as attitudes, stereotypes and societal norms around gender generally and violence against women specifically. Therefore, it is crucial to recognize institutional or structural violence, which can be defined as the subordination of women in social, economic and political life [10].

The COVID-19 pandemic has exposed women leaders to backlash, leading to threats, abuse and harassment online and offline. Violence against women leaders can prevent them from performing their duties regardless of their position.[13]

Domestic violence

Domestic (Interpersonal) violence is the violence that takes place between intimate partners. Both men and women can be victims or perpetrators under a domestic violence framework.

However, domestic violence is broader than partner violence and encompasses or encapsulates violence toward others sharing a living space, including siblings, children or grandparents.[11]

Violence against Women and Girls VAWG

The WHO defines violence against women and girls (VAWG) as "any act of gender-based violence that culminates in, or is likely to predispose to sexual, physical or mental harm or suffering to women, including arbitrary deprivation of liberty, coercion, threats of such acts, whether occurring in public or private life." [9,12,14]

Violence against women continues to hinder the development, peace, equality, and fulfilment of women's and girls' human rights. The goal of the SDGs - to leave no one behind - cannot be realized without ending violence against women and girls.[15,16]

Violence against women and girls (VAWG) is one of the most persistent, devastating and widespread human rights violations today and remains mostly unreported due to the silence, stigma, impunity and shame attached to it. Generally, VAWG manifests itself in physical, sexual and psychological forms, encompassing [17]:

- Intimate partner violence (psychological abuse, battering, femicide. Marital rape)

- Sexual violence and harassment (forced sexual acts, unwanted sexual advances, rape, child sexual abuse, forced marriage, street harassment, stalking, cyber-harassment)
- Human trafficking (slavery, sexual exploitation)
- Female genital mutilation
- Child marriage

The adverse sexual, psychological and reproductive health outcomes of VAWG adversely affect women in all facets of their life. While gender-based violence can be experienced by anyone, anywhere and at any time, some women and girls are particularly at risk - examples of such are young girls, older women, women who identify as bisexual, lesbian, transgender people or intersex, refugees, migrants, ethnic minorities, indigenous women or women and girls living with HIV and disabilities, alongside those living through humanitarian crises.[15].

Violence against women and girls (VAWG) is more specific than gender-based violence as it only applies to individuals who identify as women or as girls. However, women experience the vast majority of gender-based violence to the extent that violence against women and gender-based violence overlap. Violence against women can be interchanged with GBV when deliberately trying to access women with aids or resources or in attempts to underscore the fact that women are the group most harmed by GBV in terms of magnitude and prevalence. Violence against women is also a more relatable term than gender-based violence for many people. Advocates for ending GBV may adopt the term violence against women to elicit awareness of the problem.[11]

Violence against women may appear different worldwide, but it is a universal experience. It prevents girls and women from completely participating in societal activities by confining women to their homes, limiting their opportunities for education and employment, and forcing women to take time to heal from violent attacks. The economic impact of violence against women -potential loss- is $1.5 trillion annually.[18] Violence against women and girls is a common phenomenon. A third of women will experience physical or sexual abuse by an intimate partner or spouse at some point. One-fifth of women were sexually abused while they were children. Violent acts – meant to curb or limit how women act and thus infringe their freedom– are often tolerated or expected by communities [11].Violence against women has been internationally recognized as a severe and pervasive phenomenon affecting women's health and lives. It has violated their rights for almost three decades[9]. Calls for its elimination have been led by women's health and rights organizations for decades. At the global level, these calls most notably date back to the 1993 United Nations Declaration on the Elimination of Violence against Women, the 1995 Beijing Platform for Action, and various other global and regional conventions and consensus documents. In 2016, the World Health Organization's (WHO's) Member States endorsed the Global Plan of Action in a bid to strengthen the role of the health system within a national response to address interpersonal violence, in particular against girls, children and women, which includes improving the collection and use of robust data as one of its four strategic directions. In 2020, the Coronavirus Disease (COVID-19) pandemic brought new attention to the importance of addressing violence against women as a public health priority. Measures taken to tackle the pandemic, such as lockdown and distancing rules, have led to increased reports of domestic violence – particularly intimate partner violence against women – to helplines, police forces and other service providers.[9] In 2021, the WHO released the report of analysis of available prevalence data from surveys and studies conducted between 2000 and 2018, obtained through a systematic and comprehensive review of all available data on the prevalence of violence against women[19]. This global report for lifetime prevalence of violence against women revealed that:

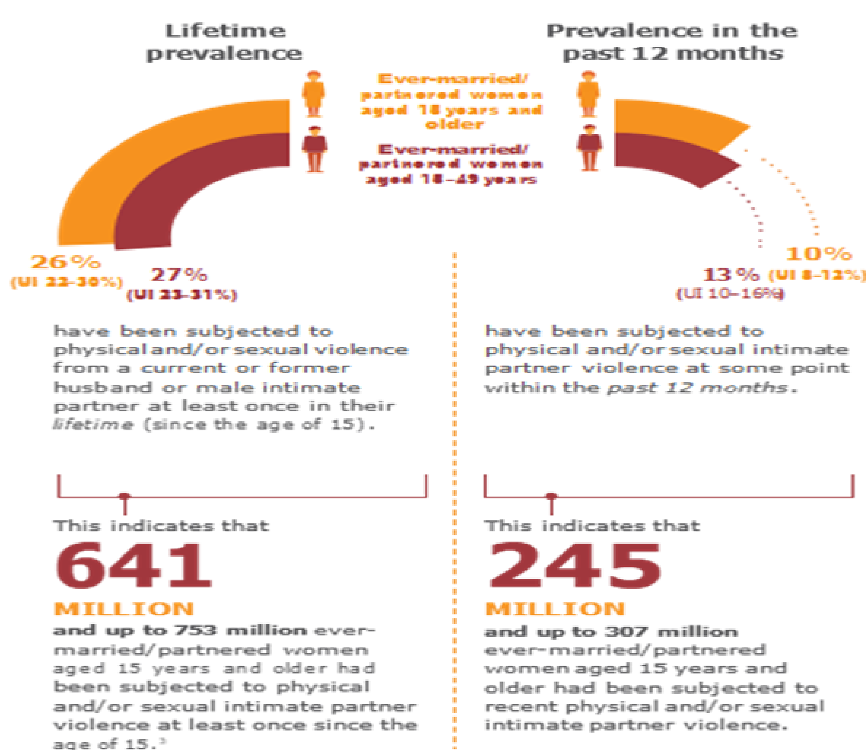

Figure 2: Global report of lifetime prevalence of violence against women

Intimate Partner Violence (IPV)

Intimate partner violence is the behavior by an intimate partner or ex-partner that causes sexual, physical or psychological harm, including sexual coercion, psychological abuse, physical aggression and controlling behaviors [9]. The WHO further found that GBV starts early among adolescents aged 15-19 years[19]:

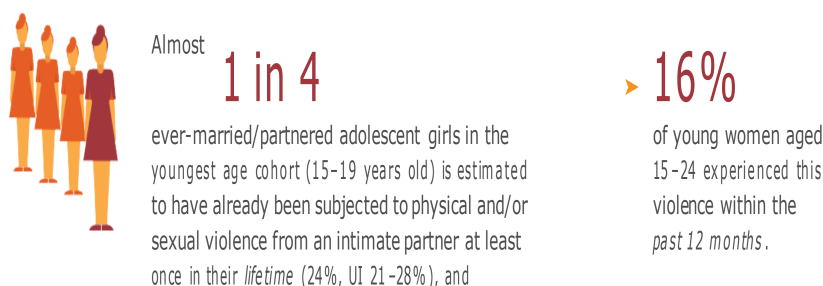

Figure 3: Pattern of GBV among adolescents

Intimate partner violence explicitly describes the violence between people in sexual or romantic relationships. [12]

Intimate partner violence (IPV) is more exclusive than domestic violence. However, it differs from gender-based violence as IPV can likely occur between partners of the same gender identity, such as in lesbian or gay relationships.[11]

Same-sex couples may experience oppression because of intolerant or discriminatory views towards them; victims of violence within same-sex relationships may be significantly disadvantaged by such intolerance [11].

Gender-based violence is a global occurrence. Girls and women are especially prone to abuse and violence as cultural norms and attitudes toward gender equality place them at a disadvantage. Gender-based violence is particularly prevalent when girls and women are migrating. [11]

The UNFPA has it on record that the prevalence of GBV among partners within Nigeria's 15-49 age bracket was 13.8 in 2018. [20]. The prevalence was highest at 19.4% among the 20–24-year age bracket and lowest at 6.6% among the 45–49-year age bracket. [20]

Non-partner sexual violence (NPSV)

Non-partner sexual violence refers to acts of sexual violence against women, experienced since the age of 15, perpetrated by someone other than a current or former husband or intimate partner (i.e., a male relative, friend, acquaintance or stranger). For this type of violence, all women are considered "at risk" and are thus included in the denominator for calculations (not only those who have been married or had an intimate partner)[19]:

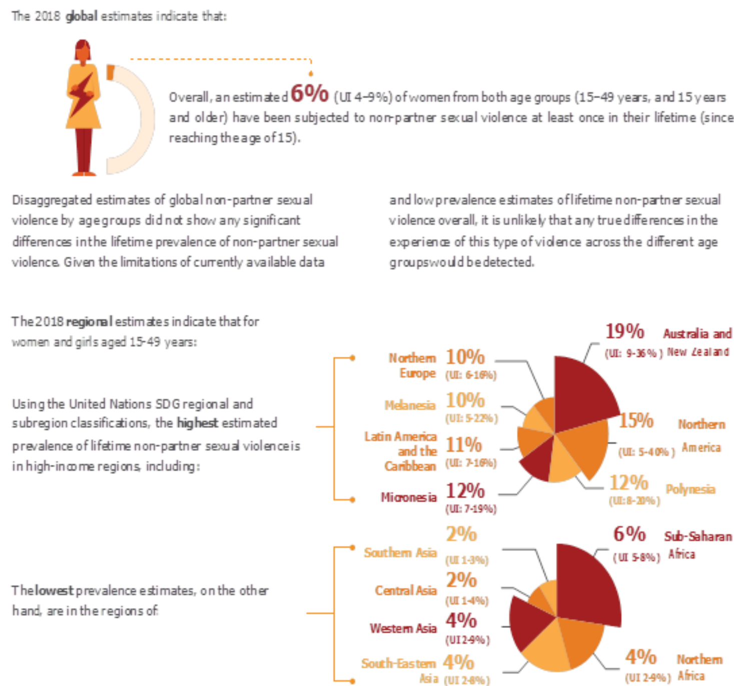

Figure 4: Trend in non-partner sexual violence (Source: WHO 2021[19])

Comparing Intimate Partner Violence (IPV) and non-partner sexual violence (NPSV)

While there are many other forms of violence that women are exposed to, these two forms represent a large proportion of the violence women experience globally. Having prevalence estimates for these two forms of violence combined provides a broader picture of the proportions and numbers of women subjected to violence during their lifetime, although this still does not represent the full extent of violence women experience. A 2018 WHO combined global estimate report for both forms of GBV revealed that 31% of women aged 15-49 years and 30% of women 15 years and older had been subjected to sexual or physical violence from any current or former husband or male intimate partner, or to sexual violence from someone who is not a current or former husband or intimate partner, or to both these forms of violence at least once since the age of 15[19]:

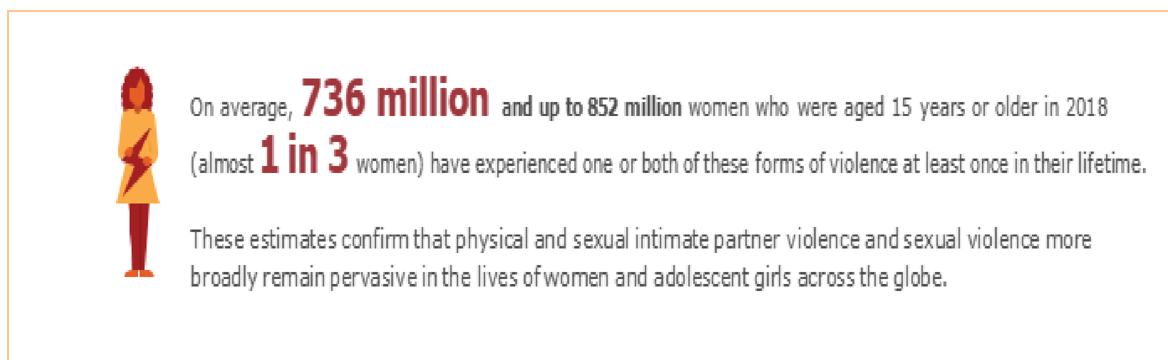

Figure 5: Occurrence of GBV and NPSV among women worldwide[19]

More specifically, in the African sub-region, the lifetime incidence of GBV and non-partner violence among women was higher in some countries when compared to others[19] as illustrated below:

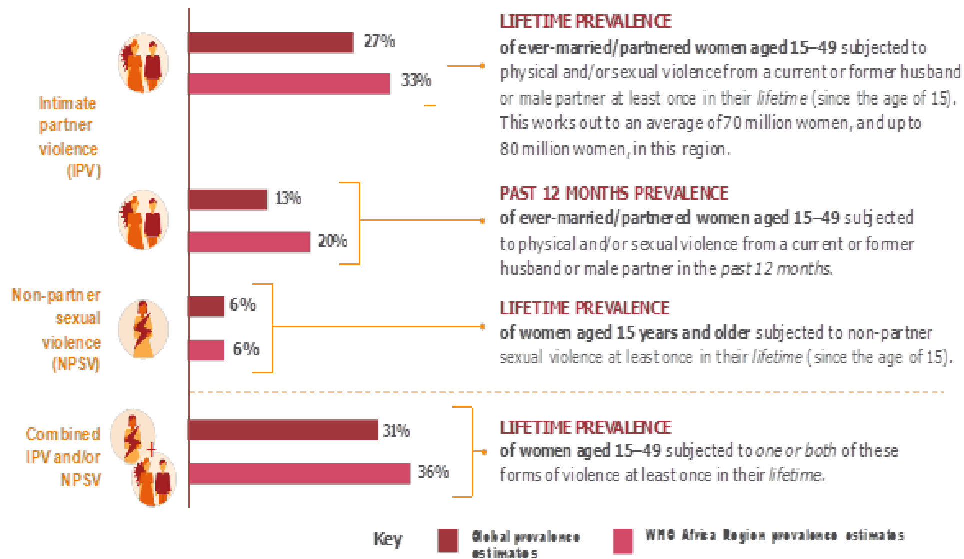

Figure 6: Lifetime prevalence of non-partner sexual violence

Gender-based Violence

Gender-based violence and domestic violence are similar concepts often interpreted as the same. However, there are important distinctions between them with varying implications for policymakers, care providers, and survivors. Breaking down these differences is essential to comprehending how survivors experience violence daily. [11]

Literature showed that different socioeconomic, cultural, educational, and other individual factors were associated with gender-based violence. Gender-based violence (GBV) is a worldwide pandemic, and many have been victims of it long before Covid-19, with international organizations documenting an increase in GBV prevalence during the pandemic. Witnessing or experiencing violence as a child is a powerful predictor for becoming a perpetrator or the victim of violence in adulthood [21]. This relation between past experiences and violence led researchers to suggest that cognitive factors, such as the perceived legitimacy of violence in family relationships, mitigate whether or not aggression is transmitted to the next generation[23]. Husbands/partners with only primary or secondary education attainment, unemployed, in a monogamous union, alcoholic or exhibiting controlling behaviors were associated with higher odds of physical and sexual GBV than those who did not [26].

Narratives and interviews from some studies showed nuanced discourses of all these gendered issues. In some societies with a male-dominant culture, high levels of education in women can put them at risk for GBV[9]. This observation has been linked to the tendency of educated women to challenge male authority[29]. Furthermore, one of the most robustly supported factors for GBV is the previous history of exposure or experience of violence, especially during the formative years[21]. Males dominated females in sexual relationships through suppression to negotiate condoms and engagement in multiple sexual partnerships. Females endured the domination of males in sexual relationships to sustain relationships. As such, poor socioeconomic status makes older men exploit and take advantage of younger females in sexual relationships. Vast age differences and the notion of fulfilling their side in paid sexual intercourse made younger females unable to negotiate safe sex [27]. Also, health providers were biased and indifferent in providing sexual and reproductive health services to emerging adults [27].

A systematic review and meta-analysis for risk and protective factors for GBV reveal that the most substantial evidence available for modifiable risk factors for GBV against women was for unplanned pregnancy and parents having less than a high-school education, factors that the authors associated with lower socioeconomic status[28]. Most research pointed to low levels of education as a risk factor for preparation and victimization[29]. Other factors related to GBV include tribe, place of residence, and partner consuming alcohol. Respondents' partners were mostly jealous and exhibited some form of controlling behavior. Physical violence was the most prevalent form, and most victims did nothing about it[31]. However, in some societies with a male-dominant culture, high levels of education in women can put them at risk for GBV[29]. This observation has been linked to the tendency of educated women to challenge male authority[29]. One of the most robustly supported factors for GBV is the previous history of exposure or experience of violence, especially during the formative years [32]. A family history of violence in both pregnant women and their partners was strongly aligned with the current existence of violence and further demonstrated that prior violence in family settings is an integral cause of continued prevalent violence [32].

Reflecting on risk factors associated with GBV makes it increasingly important to understand how specific aspects precipitate episodes of GBV [21].

Gender-based violence takes numerous forms. Intimate partner violence, child marriage, female genital mutilation, sexual violence, trafficking for sexual exploitation, female infanticide, and 'honor' crimes are familiar – intimate partner violence occurring at unexpected rates in every country [15]. Women and girls may also experience gender-based violence when deprived of nutrition and education.[15].

The United Nations defines GBV as "any act of gender-based violence that culminates in, or is likely to predispose to sexual, physical or psychological harm to women, whether occurring in private or public life." [11]

Gender-based violence is a more inclusive terminology than violence against women or girls. GBV may include violence against men, provided the violence stems from a man's gender presentation or identity.

Gender-based violence could also imply violence experienced by gender non-conforming people. It is crucial to acknowledge violence against gender non-conforming individuals because their access to care may be marginalized because of their gender predisposition. Further, conceptions of gender vary significantly worldwide, such that the man-woman binary in Western society does not always fit other cultures. Western agents acting in delicate global settings must recognize and be tolerant of these differences to adequately address issues of gender-based violence.[11]. The tolerance of gender-based violence (GBV) fosters gender inequality, ultimately undermining the ability of girls to realize their optimal potential. Violence against women is a violation and infringement of human rights worldwide**.** All women and girls have a right to be protected and should be able to pursue fulfilling educational careers, opportunities and relationships.[11]

Forms of Gender-based violence:[18]

Gender-based violence (GBV) can manifest in many forms. It is an act of violence directly related to the gender of the victim or survivors. The survivor's identity justifies the occurrence. GBV can happen in the public or private sphere, kitchens, bedrooms, streets, markets, boardrooms, or even at internally displaced persons (IDP) or refugee camps. It may manifest as street harassment, i.e., groping, whistling, or unwanted attention in published spaces, and marital rape and intimate partner violence. Many forms of GBV have been challenged as traditions in specific societies. Whether it is the trafficking of persons in India, early marriages in certain US communities, rape in South Africa and other countries around the world, sexual violence in the Democratic Republic of Congo, female genital mutilation in Nigeria, femicide in Guatemala, so-called honor killings in Iraq or Pakistan, there is no justification for violence. [18]:

Threatening to harm a woman to control her behavior can quickly degenerate into sexual coercion or physical abuse. These acts fundamentally undermine and limit the autonomy of women. Moreover, if a woman repels the abuse, she may be subjected to more violence as reprisal punishment. These occurrences can escalate to the point that a woman may be murdered by their partners or commit suicide to evade further abuse. Globally, 44% of girls aged 15-19 admit that a husband is justified in beating or hitting his wife [18].

Economic and psychological violence from GBV

Often accompanying sexual abuse and physical violence is emotional, psychological, or economic violence. Emotional abuse is when an abuser demeans their partner or makes their partner feel incapable, lesser than or dependent upon their abuser. Though psychological or emotional abuse is less visible than sexual or physical violence, it is still valid and just as harmful.

Economic violence, perpetrated by withholding money or stealing a woman's pay, is another way to control women. This makes women dependent on their partners for shelter, food and other necessities, thus retaining them in a relationship with their abusers.

Around the world, girls and women are trafficked or exploited to meet demands caused by sex tourism, gender imbalances and humanitarian crises (sexual exploitation and trafficking). Girls and women often have little or no legal protection and are bound by social and economic constraints, which reduces their ability to depart from the situation. During or after crises, the distribution or support systems breakdown may force girls and women to trade sexual acts for food or supplies.

Forced marriage, particularly child marriage, affects 1 in 5 women globally and 40% of women in developing parts of the world[18]. Early pregnancy, the greatest killer of girls aged 15-19, is closely linked to child marriage. Ninety percent of mothers under 19 who die from pregnancy or childbirth complications were married. Sometimes girls are married in fulfilment of cultural practices. Occasionally, families living through crises erroneously believe that marrying or trading off their daughters is the best way to keep them from starvation or violence.

Honor crimes, committed against women, are when women are punished by their fathers, brothers and uncles for undermining the family's honor, often simply because they were the victims of assault or sexual

harassment. For example, women have been killed in cold blood for becoming pregnant out of wedlock after they were raped.

Honor killings are common in Yemen, where conflict and famine have resulted in the world's largest humanitarian crisis[18].

Female genital mutilation or FGM, is the practice of totally or partially excising the external female genitalia, or causing injury to female genital organs, for non-medical reasons[82]. The practice is done for various reasons: to make girls "clean" or "pure" for tradition, to curtail promiscuity, or as a requirement for marriage. More recently, medicalized FGM, when a health professional performs FGM in a hospital or clinic, has become rampant in some parts of the world even though there is no medical or otherwise justification for FGM. Practiced around the world and affecting 200 million women and girls alive today, it is a manifestation of deeply entrenched gender inequality. [82]

Harassment: Women and girls face the risk and likelihood of sexual harassment daily as they walk outside, go to work or school and take public transportation. Harassment can be verbal abuse, unwanted advances, leering, or non-consensual touching. Harassment is humiliating, demoralizing and scary – one never knows if an off-color remark will escalate into a life-threatening encounter [18].

Violence against men

Gender-based violence includes not only violence against women but also violence against men, boys and transgender individuals who challenge gender and heterosexual norms through their feminine appearances or sexual desire for other men[10]. Male violence is not only focused on maintaining men's power over women but also hierarchies of power among men, following a gendered logic of domination and subordination. research suggests that men's experience of forced sex go even less reported than women's[10]. Men's vulnerability to forced sex is associated with specific groups of men and boys (those who occupy subordinate positions with other men), specific contexts (conflict situations) and specific settings (all-male institutions such as prisons and the military). In its landmark report on violence and health, WHO reported that "experts are of the view that official statistics greatly under-represent the number of male rape victims" and "that males may have a lesser likelihood, than female victims, to report an assault to the appropriate authorities." [10,21]

National and Global empirical studies on GBV

In Lagos State, southern Nigeria, up to two-thirds of women have experienced domestic violence. In southeast Nigeria, 70% of respondents reported abuse in their family, with 92% of the victims being female partners and 8% being male. Further studies in Lagos State revealed that the lifetime prevalence of GBV was 73.3%. The significant predictors for GBV were; being employed, witnessing parental violence, having a partner consuming alcohol, and having other sexual partners[37].

In Ogun State, southwestern Nigeria, a study conducted by Olumide Abiodun et al. among pregnant HIV-positive women concluded that the prevalence of lifetime intimate partner violence was 24.02%[39]. Younger age, the experience of GBV in previous relationships, and having multiple sex partners were related to the experience of GBV within the preceding 12 months ($p < .05$). Also, the partners' age, alcohol intake, and current smoking status were associated with the experience of GBV within the preceding 12 months ($p < .05$). After regression analysis, participants' age (adjusted odds ratio [AOR] = 0.892, 95% confidence interval [CI] = [0.831, 0.957]), the experience of GBV in a previous relationship (AOR = 12.841, 95% CI = [4.303, 38.318]), and partners' current smoking status (AOR = 4.874, 95% CI = [1.252, 18.969]) retained association with the experience of GBV within the preceding 12 months. As such, GBV among HIV-positive women accessing HIV care occurs in a complicated, context-specific way [39].

In Osogbo, Osun State, southwestern Nigeria, Adejoke Abiodun et al. established a correlation between GBV and post-partum depression[40]. The study affirmed that respondents that experienced GBV were five times as likely to have post-partum depression compared to those that did not experience GBV. Logistic regression showed that GBV independently predicted post-partum depression in respondents (OR 4.799, CI 1.844-12.493).[40].

A study on women's perception of wife-beating in Nigeria showed that 64.4% and 50.4% of ever-married and unmarried women, respectively, expressed consent for wife-beating[22]. The "changing nature of GBV over time" is also emphasized because many older women experience changes in the violence, for example, the transition from physical to psychological abuse in the relationship[23]. On the National level, 16.25% of respondents in Nigeria's demographic and health survey had experienced GBV, with the south-south region recording the highest prevalence of 27.10%[24]. The most significant determinants of GBV at the national level and across the areas were high levels of alcohol intake by some husbands, an increase in the number of co-wives, increased parity, wealth index and low levels of women's education[24]. Furthermore, studies have shown that women's tendency to negotiate safer sex accounted for significant additional contributions to the variance in physical, sexual, and emotional violence experience[25]. The other contributions suggest that specific

interventions may be needed to improve women's negotiation skills to reduce husband-perpetrated violence risk [25]. The odds of occurrences of physical violence were about five times higher at age >=55 years than at ages 15-24 years[26].

Solanke et al., 2018 revealed that less than one-tenth of the surveyed Nigerian women witnessed inter-parental violence, and women exposed to inter-parental violence compared with non-exposed women had a higher prevalence of all forms of GBV[30]. In a different study to understand the relationship between psychiatric morbidity and GBV amongst pregnant women and partner alcohol use in southwestern Nigeria, the past 12-month prevalence of GBV was 24.8%, with emotional abuse being the most typical (89.8%). Forty-six participants (11.6%) screened positive for probable psychiatric morbidity. Predictors of GBV included partner alcohol use in the past 12 months[32]. Further, in Osun state, southwestern Nigeria, a 2021 study conducted by Olusola Ayeni and Serap Tekbas revealed that exposure to severe violence (18.25%) and sexual violence (12.9%) is more frequent among the violent acts reported. It was also found that alcohol consumption by pregnant women and their partners influenced the occurrence of GBV[33]. The pregnant women who were victims of domestic violence were inclined to seek support from family members and friends without informing the authorities or other agencies whose purposes were to combat violence. Screening all pregnancies at various times is essential because some women do not disclose abuse. Screening for GBV should occur at the initial prenatal visit, at least once per trimester, and at the post-partum checkup [33].

In a survey conducted by Ayo Adebowale in 2018, it was revealed that 4.7% of couples surveyed had experienced some form of GBV, emotional, physical and sexual violence, respectively[77]. Also, GBV prevalence was 27.0%, 23.7%, 22.0% and 18.7% among couples with age differences of 0–4, 5–9, 10–14 and ≥15 years, respectively; this pattern was exhibited across all domains of GBV. Among women who experienced physical violence, 20.5% had only bruises, 8.0% had at least one case of eye injuries, sprains or dislocations, and 3.7% had one or more claims of wounds, broken bones or teeth. The identified predictors of GBV were: family size, ethnicity, household wealth, education, number of marital unions and husband drinking alcohol [77]. The unadjusted likelihood of GBV was 1.60 (C.I=1.30–1.98, $p < 0.001$) and 1.35 (CI =1.10–1.64, $p < 0.01$) higher in households where the spousal age difference was 0–4 and 5–9 years respectively than the likelihoods among those with a spousal age difference ≥ 15 years, but the strength of the association weakens when other variables were included in the model. The study concluded that the level of GBV was generally high in Nigeria, but it reduced with an increasing spousal age difference, thus underscoring the need for men to reach a certain level of maturity before marriage, as this is likely to reduce the level of GBV in Nigeria[35]. A follow-up study conducted in 2020 by Kupoluyi revealed that women who have experienced any form of GBV were significantly influenced by their education, occupation, the number of living children, and marital duration to discontinue contraception while still at risk of becoming pregnant[36].

A study conducted by Benabo et al. in 2018 to investigate the effect of women's status and community norms aligned with Oluyemisi et al. study of 2020 demonstrated that almost a quarter of women in Nigeria reported having ever experienced intimate partner violence[44, 45]. Higher women's status reduced the odds of GBV (OR = 0.47; 95% CI = 0.32–0.71). Community norms among men which justified GBV against women affected the observed protective effect of higher women's status against GBV and reversed the odds (OR = 1.89; 95% CI = 1.26–2.83). Conclusively, besides women's status, community norms towards GBV are an essential factor in the occurrence of GBV. Thus, addressing intimate partner violence against women begs for community-wide approaches to changing norms among men and improving women's status.

Studies from Sokoto, northwest Nigeria, revealed that up to 83.5% of respondents in a survey on GBV were in a monogamous setting. Three-quarters (75%) of them were Muslims mostly from urban areas; (72.1%), and 36.4% had a university or HND degree. The majority of them responded correctly to questions on GBV; overall, up to 99.2% of them had good knowledge of GBV. About 33% of the respondents have experienced GBV while pregnant and up to 61.7% of them said they did nothing because of fear. Some of the controlling behaviors of male partners included always asking for permission before seeing friends and family members and also controlling their finances. Similarly, in Kaduna, Northwestern Nigeria, 67% of mothers experienced at least one of the three forms of GBV during pregnancy. Relative to the 33% of women with no prenatal exposure to any form of GBV, a reduction in birth weight of 94 g (95% CI: −202 to 15) for prenatal exposure to emotional GBV, 162 g (95% CI −267 to −58) for physical GBV and 139 g (95% CI −248 to −30) for sexual GBV was observed. The combination of all three forms of GBV was associated with a 223 g reduction in birth weight (95% CI −368 to −77)[34]. Increasing occurrences of each of the three types of GBV were associated with greater reductions in birth weight. For physical GBV, relative to no exposure to any form of GBV, birth weight was lower by 112 g (95% CI −219 to −4) with 1–5 instances and 380 g (95% CI −553 to −206) for >5 instances over the pregnancy. As such, maternal exposure to GBV was associated with shifting of the birth weight distribution among term newborns. A dose-response relationship was observed between the frequency of GBV and birth weight[34]. Among breastfeeding mothers, compared to mothers who experienced no GBV, those who experienced GBV had a 26% reduced likelihood of Exclusive Breastfeeding (EBF) practice. Also, a unit dose

of maternal GBV experience was associated with a 5% reduced likelihood of EBF practice. Among the three forms of GBV, physical GBV had the highest effect size. Physical GBV was associated with a 37% reduced likelihood of EBF practice, while psychological GBV was associated with a 34% reduced likelihood of EBF practice when compared to the respective reference groups. On the other hand, those who reported sexual GBV were just as likely to breastfeed as those who did not[18]. As such, maternal GBV is associated with EBF practices. In Abuja, north-central Nigeria, 29.2% of women surveyed had experienced gender-based violence in the past 1 year, with 5.2% being IPV in the index pregnancy. Sexual partners were the main perpetrators of GBV (65.7%), while 34.3% were by someone else other than their sexual partners. Among those abused in the current pregnancy, 55.6% of respondents were abused once and the remaining 44.4% were abused more than once. Gender-based violence was associated with higher chances of cesarean section ($p = 0.001$), increased risk of lesser birth weight babies ($p = 0.014$), and maternal complications in pregnancy ($p = 0.030$). Thus, the prevalence of GBV in pregnancy in Abuja is high with associated poor maternal and fetal outcomes. Expectedly, women experiencing emotional violence are less likely to use institutional delivery services, and hence are susceptible to increased risk of reproductive complications[32]. In Ethiopia, one in five pregnant women experienced GBV, strongly associated with depression[41].

Enforcing existing legislation and screening for intimate partner violence during routine antenatal care may help reduce its prevalence and ensure a positive pregnancy experience for Nigerian women[43].

In Makurdi, Benue state, a statistically significant relationship was demonstrated between GBV and post-partum depression (PPD). The prevalence of PPD and GBV were high, affecting approximately a quarter of postpartum women in Makurdi. Thus, GBV was found to contribute to the development of PPD, hence the need for screening of these conditions by physicians[46].

A 2019 study conducted by Lawal et al, among dating students in a Nigerian university, revealed that age, alcohol attitude and self-esteem directly affect students' attitudes toward psychological abuse, control, and physical violence respectively. Interactively, age and self-esteem have a significant effect on students' attitudes toward psychological control. As such, younger age, poor self-respect and approval of alcohol use directly affect dating university students' attitudes toward GBV. These findings accentuate the importance of maturity, alcohol risk reduction intervention and assertiveness skills in attitudinal change regarding engaging in gender-based violence[47].

Specifically, adolescents from Nigeria were more likely to be exposed to GBV and family violence and were more likely to endorse violence against women than adolescents from South Africa[48]. Male adolescents were more likely to endorse violence against women (VAW) than were female adolescents. Similarly, higher age, being male, being from Nigeria, being in a relationship, and greater exposure to family violence were associated with higher endorsement of violence against women[48].

In Borno state, economic factors, male dominance, and culture seem to be the major contributory factors responsible for the increase in the rate of gender-based violence. Gender-based violence was found to be a public health issue and calls for urgent attention. There is the need for government to grant soft loans for low-income households in order to get them to engage in economic activities, such as small and medium scale enterprises, and by so doing, the rate of gender-based violence will reduce[49]. Insertion of the human security perspective into policies is essential for abolishing these practices[50].

Gender-based violence (GBV) among pregnant women is of great concern due to the deleterious impacts on the pregnancy, such as antepartum hemorrhage, intrauterine growth retardation, trauma, perinatal death, abortion/miscarriage, low birth weight, preterm delivery, as well as the risk of homicide[51]. In Sub-Saharan Africa, nearly 40% of women have reported experiences of abuse by their intimate partners. The prevalence of domestic violence during pregnancy in Nigeria ranges between 2.3-44.6%, with lifetime prevalence rates between 33.1-63.2%[51].

In Egypt, among ever-married males, 77.1% accepted GBV, 82.2% had wives whose age at marriage was less than 18 years, 81.8% were from rural residences, 88.4% of whom parents were not giving any response to mistakes and 83.9% of those with a positive attitude toward divorcing their wives accepted GBV with a statistically significant difference. Further, significant predictors for condoning GBV were: rural residence, an attitude that makes husbands divorce their wives and parents' response to mistakes. The significant correlates of married men's acceptance of GBV were rural residence, respondents with an attitude toward divorcing their wives and inappropriate parents' response to mistakes [52].

In Kenya, the prevalence of lifetime and recent physical violence among adolescent girls and young women was 18.0% and 10.7%, respectively. Lifetime and recent sexual violence were reported by 20.5 and 9.8% of respondents, with the main perpetrators of violence being intimate partners53. Further, a study found that almost a third (32%) of young women in the 18–24 age bracket and 18% of young males experienced sexual violence before 18[54]. The cross-country study conducted in Nigeria, Malawi, Kenya, and Jamaica revealed that Bullying was indicated to be as common a form of GBV as threats of physical violence (52 percent), with girls more affected than boys. Students also indicated being called inappropriate names (67

percent) and being pushed (63 percent) by fellow schoolmates. However, it was revealed that students have also been targets of sexual harassment online via social media—a form of GBV in schools often mentioned by students, making it the most prevalent form of GBV in the study of primary schools across all countries [54].

In Ethiopia, a study found that the prevalence of GBV among pregnant women was quite common, with slightly more than 1 in 4 pregnant women experiencing GBV during pregnancy, similar to the Nigerian pattern[55]. Mothers' educational status, intimate partners' educational status, and intimate partners' alcohol use were significantly associated with GBV among pregnant women [53]. Perceiving violence or force as a means to settle interpersonal conflicts, supportive attitudes toward wife-beating in society, acknowledgement of violence as an expression of masculinity, and strict gender role differences were positively associated with GBV in pregnancy [56, 57, 58]. Another study conducted among pregnant women attending ante-natal clinics (ANCs) in some states of Ethiopia revealed the prevalence of gender-based violence during current pregnancy to be 41.1%[52]. Of this, the prevalence of sexual, physical and psychological violence was 19.8%, 29.1%, and 21%, respectively.

In a cross-country study across 16 sub-Saharan African countries, the proportion of women in polygamous marriages in the 16 countries was 20.2%, ranging from as high as 40% in Chad to as low as 1.6% in South Africa. The prevalence of GBV was 30.7% in the 16 countries, ranging from as high as 44% in Uganda to as low as 12.7% in South Africa. The odds of GBV were higher among women in polygamous marriages in Angola, Burundi, Ethiopia, Uganda, Malawi, Mozambique, Zambia and Zimbabwe. However, they were lower among women in polygamous marriages in Cameroon and Nigeria, and this persisted after controlling for the level of education, place of residence, wealth quintile, media exposure, and justification of violence. This study established a significant association between polygyny and gender-based violence. The practice of GBV in sub-Saharan Africa is fused into the socio-cultural norms and religious traditions of most countries in the sub-Saharan African region. The findings imply that family structures expose women to gender-based violence[60]. However, a study conducted in Zimbabwe revealed no significant association between women's educational attainment and GBV [61].

Gender-based violence is pervasive in the US, with nearly 25% of surveyed women and 7.6% of surveyed men alluding to being raped or sexually assaulted by a date, former or current spouse or a cohabiting partner at some point in their lifetime. Further, 1.5% of surveyed women and 0.9% of surveyed men said they were physically assaulted or raped by a partner in the previous 12 months [68]. Women are at significantly greater risk of intimate partner violence than men. However, this contradicts data from the National Family Violence Survey, which consistently shows that men and women are equally likely to be physically assaulted by an intimate partner. Studies are needed to determine how different survey methodologies affect women's and men's responses to questions about gender-based violence [68].

Recent information from a population-based, random-digit-dial telephone survey, which began in the US in 2010 and is currently ongoing, shows that approximately a third of women (37.3%) and men (30.9%) have experienced stalking, physical violence or sexual violence by an intimate partner in their lifetime and that 23.2% of women and 13.9% of men have been subjected to severe physical or sexual violence by an intimate partner. The survey also assessed the frequency of the following consequences of violence: injury, need for medical care, or post-traumatic stress symptoms. One in 4 women and 1 in 10 men stated that they had at least one of these consequences of violence. These prevalence estimates have remained essentially unchanged since 2010, underscoring an opportunity for the prevention of this serious public health issue[69]. Furthermore, although gender-based violence occurs across all social strata, locations, and cultural backgrounds, prevalence estimates vary according to demographic characteristics. Prevalence is highest among young adults (18 to 24 years of age) compared to other age cohorts. There is a higher prevalence of victimization among persons who identify themselves as sexual and gender minorities among certain racial and ethnic minority groups (including Native Americans, those who identify themselves as multiracial, and non-Hispanic black women), and among people with mental and physical disabilities, suggesting that there are interactions between intimate partner violence and certain forms of societal marginalization[69]. An overlap between intimate partner violence and human trafficking has also been identified; traffickers may initially act as caring, romantic partners and then use coercive and controlling tactics similar to those used by perpetrators of intimate partner violence [69].

In Saudi Arabia, a West Asian country, the most common impacts of domestic violence DV on women were medical or behavioral problems (72%) and psychiatric problems (58%). The most common reactions to GBV were seeking separation (56%) and doing nothing (41%). More than 90% of children of abused women suffer psychological or behavioral problems. In conclusion, GBV against Saudi women is considerable, and the response is generally passive. Promoting a culture non-tolerant to domestic violence and providing accessible, effective, and trustful social services to abused women are critically needed [70].

In Peru, south America, emotional distress, suicidal thoughts or attempts were higher among women who had ever experienced sexual or physical violence than those who had no experience. Also, the prevalence of injury among women who had ever experienced GBV varies from 19% in Ethiopia (in Africa) to 55% in

Peru, while abused women were also twice more likely to report poor health and physical and mental health problems than non-abused women[71].

In India, a South Asian country, a study examined the correlation between GBV and child mortality and morbidity. Morbidity and mortality were higher among the children whose mothers faced physical, emotional, or sexual violence perpetrated by the partner than those who did not encounter any violence. Multivariate analysis revealed that maternal exposure to physical and sexual violence significantly increased the risks of childhood diarrhea and fever, and emotional violence was associated with an increased likelihood of diarrhea, fever, and acute respiratory infection (ARI) in the past two weeks among under-five children. Moreover, in crude analysis, women's experience of physical and emotional violence was associated with increased odds of infant and under-five mortality. These associations were insignificant in the adjusted study. Similarly, no significant association was established between maternal exposure to GBV and child mortality (1 to < 5 years) [74]. Further, no significant association was found between maternal exposure to GBV and child mortality (1 to < 5 years) [75].

Rural residency, lower educational status of partners, frequent alcohol abuse by partners, early initiation of antenatal care, the age of women between 17–26 years, and choice of partner by the women only were statistically significant factors associated with gender-based violence towards pregnant women[72]. A similar study among ever-married women in Ethiopia revealed that over 30% of participants were subjected to GBV. Living in rural areas, being divorced, having primary and secondary education, being 25–39 years old, and being poor were predictors of GBV against women in Ethiopia[73].

In the Gambia, the prevalence of physical violence, sexual violence and emotional violence was 20.6%, 4.3%, and 15.1%, respectively. Women married at age 18 ~ 24, lived with 3 ~ 4 and ≥ five children, witnessed parental violence, partner's primary education, were accused of unfaithfulness, and partner's alcohol consumption, are more likely to report GBV. Unemployed women were also found to be less likely to report GBV[59].

In conclusion, findings suggest a high prevalence of GBV among Angolan women where the husband's alcohol drinking, women's religious background, spousal frequency of attending church and age difference appeared to be the most important predictors of GBV or intimate partner violence. Non-pregnant women who experienced emotional and sexual GBV had increased odds of healthcare visits during the last 12 months. Those who experience emotional and sexual GBV might be more likely to suffer from medical conditions and thus should be given special attention in primary care settings[62,63].

A 2018 study conducted in South Africa by Sally et al. confirmed a similar trend to what obtains in other African countries[63]. However, qualitative analysis of 95 counselling case notes revealed that domestic violence within the household was not limited to intimate partners, with domestic violence often perceived as 'normal' behavior by the study respondents [64].

Theory: Individual psychopathology of victims	Level of Focus: Perpetrator	Explanations for GBV: Abusive behavior results from mood disorders (depression, anxiety), personality disorders (borderline, antisocial behaviors)	Critique: These disorders can involve aggression but they do not cause IPV nor explain how perpetrators' aggression is typically targeted toward intimate partners.
	Victim	Psychoneurological effects of brain injury and posttraumatic stress disorder	Blames the victim for GBV related to her pathology or ulterior
Evolution Theory	Perpetrator	Abuse is deliberately provoked by women to meet their need for suffering (female masochism) or to indirectly benefit by being abused (secondary gain). Extreme jealousy and violent male behavior date back to evolutionary forces to reproduce and pass along genes for survival of the species. Serve as risk factors for IPV occurrence, more severe GBV,	The majority of men do not exhibit violent behavior toward their intimate partners IPV causes significant morbidity and mortality. Alcohol/drug use may potentiate abusive behaviors
	Social Norms	Leads to biochemical disinhibition whereby a person's usual voluntary capabilities re impaired	Partners are not always intoxicated or impaired when abusive or are abusive when they are intoxicated
Family system and family stress	Family Members and their interactions	Family functioning such as role expectations, communication patterns and power status of family members are affected by the response and feedback of family members.	Minimize the responsibility of the perpetrator and exaggerates the responsibility of the victim
Social Learning Theory	Perpetrator	Family violence is the result of behaviors of both perpetrator and victim; usually, all involved family members are exposed. As children grow, these behaviors are reinforced by the society	Not all children who are exposed to abuse during childhood become abusive as adults; not all perpetrators were abused as children. . Does not incorporate other

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Table 1. Historical Theories of the Causes of GBV83

Integration of scholarship from various disciplines led to more comprehensive and contemporary explanations for GBV, such as theories that describe gender-based inequities based on systems of oppression and power and socio-cultural models that draw from various traditional theories[83]. However, the historical theories above need to thoroughly explain why an individual perpetrates GBV. For example, although social learning theory proposes that aggression toward an intimate partner is a learned behavior that can be transmitted from generation to generation, not all children exposed to aggressive parents become perpetrators.

The Contemporary Theories

Theory	Level of Focus	Explanations for GBV	Critique
Feminist Theories-Gender-based inequities	Social systems of power and oppression	Patriarchal Societies which support male domination and authority in family. Social and cultural systems that foster violence against women, particularly IPV and threaten women's rights	A sexist society and family systems, family interactions within a social context of a highly violent cultureandcultural norms legitimizing violence against family members
Socializationon for masculinity	Social influenceon boys/men	Boys are socialized for the male role from an early age. The ideal male is authoritative, has sexual prowess, is invulnerable, competitive, tough, brave, self-sufficient, and never discloses emotion.	The family is inherently at high risk for violence by virtue of the quantity andemotional intensity of interaction; the broad range of activities over which conflict can occur;the involuntary nature of family membership; the impingement of family members on each other'spersonal space, time, andlifestyles; and the assumption of family members that they have the right to try to change each other's behavior
Socio-cultural model	Family member relationships within a broader societal context	Multifactorial model of GBV:combines elements of family systems theory, social learning theory, social structures, and cultural factors (norms).	

This takes us to the contemporary theories of GBV. The Social Cultural Model, a multifactorial model of GBV, combined elements of family systems theory, social learning theory, social structures, and cultural factors and was first developed by Murray Straus and his colleagues[83] This social-cultural model places family violence in the context of a high level of violence in our culture, the sexist organization of our society and family systems, and cultural norms. These theories are summarized above.

The Feminist Theory and Feminist intersectionality

Feminist theory of gender-based oppression has evolved to account for additional factors and complexities that intersect with gender to place disadvantaged women and other vulnerable groups in establishing equitable power relationships with their partners and society. Much of this scholarship came from social scientists, domestic violence advocates, and minority women who conceptualized VAW as more than just a gender issue. Black Feminist Theory emerged in response to the predominately white women's feminist movement and the predominately male black civil rights movement, neither of which ultimately represented the experience of being Black and a woman. In Black Feminist Theory, the interaction between gender, race, and class is conceptualized as part of an overarching structure of domination[88]

Similarly, Chicanas and Latinas felt their concerns were not adequately represented by the Chicano or women's movements. Chicana Feminist Theory describes the dynamics between race/ethnicity, social class, linguistics, and nationalism. Chicana feminists also focused on approaches they felt were unique to their culture, such as the need to challenge traditional and exaggerated gender roles in Latino households while preserving strong family structures and the vital role of women in the home[85]. Native American and other indigenous feminists find that postcolonial frameworks that emphasize the role of historical trauma, as well as the many different tribal traditions in male-female relationships, are essential in understanding the often high rates of GBV among aboriginal peoples worldwide[89]

Feminist scholars and activists have expanded the application of intersectionality theory to other socially constructed identities and social locations that marginalize people, beyond race, class and gender, for example, disability. Social justice models applied to women with disabilities distinguish between the biological state of impairment and the social construct of disability that reflects socio-cultural and environmental restrictions rather than individual limitations. Nixon[90] argued that women with disabilities who are being abused or who are vulnerable to being abused might be silenced or made invisible by intersecting aspects of oppression based on social identity, for example, disablism, sexism, ageism, and structural oppression by organizations, social movements and society in general.

Feminist intersectionality is built upon the assumptions that every social group has unique qualities; that individuals are positioned within social structures that influence power relationships; and that there are interactions between different social identities, for example, race, gender, and class, that have multiplicative adverse effects on health and well-being [83]. Feminist intersectionality is a body of knowledge that is driven by the pursuit of social justice and seeks to explain the processes by which individuals and groups in various

oppressed social positions, such as gender, race, ethnicity, class, age, sexual orientation, disability status, and religion, resulting in inequitable access to resources, which in turn results in societal inequities and social injustice[88,91.92]. Health disparities, which are gaps in access to and quality of health care in disaffected racial, ethnic, and socioeconomic groups, are examples of social inequity.

Feminist theorists in nursing and other social sciences have recommended feminist intersectionality to obtain a more comprehensive understanding of the multiplicative effects of social inequalities experienced by vulnerable and marginalized groups and conduct research and develop interventions that address health disparities[93].

Intersectionality operates at two levels: (i) as a tool for analyzing structural oppression and (ii) as a framework for understanding how individuals' intersectional identities contour their lives[94]. Though these levels can be considered separately, they are intertwined and interrelated. The application of intersectionality to GBV involves: (i) examining how structural inequities enable and foster GBV and (ii) examining the influence of disadvantaged social identities on women's responses to GBV, which are inherently related to the responses of helping professionals and social agencies to women experiencing GBV[84,87,95-99].

The first analysis addresses the question, "What about our society makes GBV such a prevalent, persistent, and intractable problem?" The second analysis provides multiple lenses to consider women's responses to GBV. For example, what does considering disability (or any other disadvantaged social identity as a vector of analysis adds to our understanding of GBV and a woman's response to it? What do we learn when we consider that this same woman is an immigrant? And that she is unemployed? And most importantly, what are the individual, organizational, social, and political remedies available to nurses working with survivors of GBV and other forms of VAW? [83]

The Social Ecological Model (SEM)

The SEM assumes that the causes of violence against women and girls are myriad and of varying forms, including individual, relationship, community, and societal factors. The social-ecological model recognizes that the root cause of GBV is gender inequality which presents as unequal distribution of power and resources between men and women. Gender-based violence, discrimination and inequality can be expressed through different mechanisms. These include discriminatory laws, including unequal access to social, academic, political and economic power, socially constructed/ misconstrued norms of masculinity and femininity, and gender roles and stereotypes[80]. In addition to the root causes of GBV, other factors operating at the individual and relationship levels can affect the probability that a woman or girl will experience violence. These factors include age, education level, alcohol or drug use, poverty, acceptance of violence, unemployment, and depression, among many others. This research adopts the social-ecological model to analyze the magnitude and occurrence of GBV risks in Oyo State.

This model assumes that factors at the individual, interpersonal, community and policy levels can determine the experience of GBV by a woman or girl. The general policies available to deter the perpetration of GBV, the existing punitive measures for GBV offenders, existing mechanisms available at workplaces and schools to discourage perpetrators, academic status, economic status and societal status can all predispose a woman or girl experiencing GBV. For males, on the other hand, it is assumed that socioeconomic factors strongly come to bear on the experience of GBV.

The Socio-cultural Framework (SCF)

While the social-cultural framework places family violence in the context of high violence in our culture, the sexist organization of our society and family systems and cultural norms legitimize violence against family members. According to this model, family interactions inherently lead to violent behaviors, mainly due to the manifestation of these societal influences at the level of family structure, parental behavior and childrearing norms, and individual interactions[87].

Conceptual Framework

To ensure a robust understanding of the causes and determinants of GBV, the theories and frameworks need to be integrated. As such, for this research, the author will adopt the WHO Ecological Framework.

The Ecological Framework

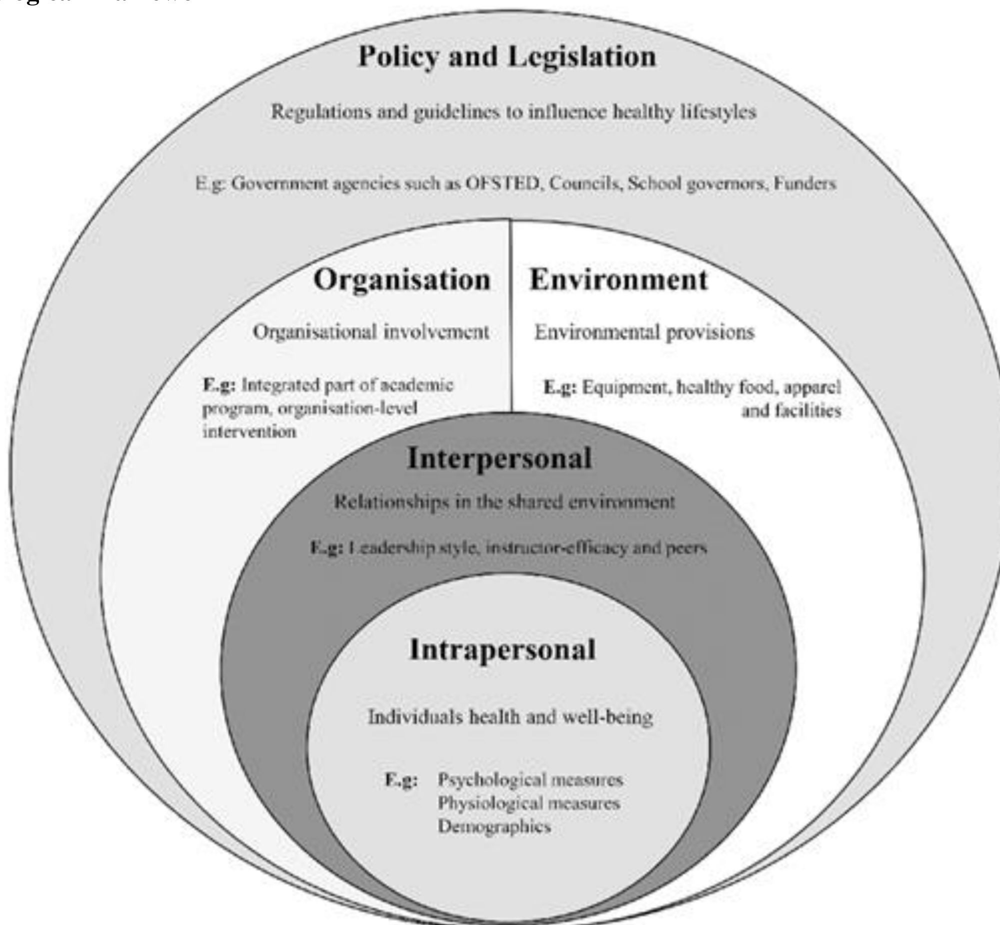

Figure 7: The WHO Ecological Framework[83]

The Ecological Framework

The WHO adopts the ecological framework to describe the causes and determinants of GBV[83] An ecological framework describes violence as a global public health problem. The framework integrates research findings and theories from many disciplines, including feminist theories, into the explanation of the origin of GBV. Within the ecological framework, GBV is understood as a multifaceted phenomenon resulting from a dynamic interplay among individuals, relationships, communities, and societal factors that influence an individual's risk of perpetrating or becoming a victim of violence. At the individual level, the person who commits or is a victim of abuse and violence possesses biological and personality traits and a personal history that shape their behaviors and interactions with other individuals, for example, with intimate partners and with the broader community and society. Individual-level factors that are associated with GBV perpetration include:

1. Demographic factors such as age, education and income,
2. Witnessing domestic violence as a child,
3. Experiencing physical or sexual abuse as a child, and
4. Substance use.

A personal history of multiple interpersonal traumas, for example, GBV, child abuse, and rape, is associated with post-traumatic stress disorder and other adverse health outcomes for victims; therefore, cumulative trauma is an individual factor influencing women's responses to GBV[83]. The acceptable norms within society may influence the family's beliefs and acceptance of GBV. For example, a family based in a community that sees women as "slaves" will likely raise male children holding on to the same belief.

The norms of parental behavior and childbearing also influence an individual at the intra-personal level. Parents' standards and way of upbringing, including the inter-relationship between the parents, visible to the children, may determine a child's acceptability or predisposition to GBV in later life. The attitude and practices of parents to GBV eventually rub off on the children, thus determining their attitudes and practices toward GBV in later life.

The second level of influence includes close relationships with partners, family members and peers that can affect the risk of the individual perpetrating or becoming a victim of violence. Several aspects of the

relationship level, especially in terms of family structure and functioning, have been identified as risk factors for the development of GBV. These include:

1. Male economic and decision-making authority in the family,
2. Male control of wealth and resources in the family, and
3. Marital conflict, especially in relationships with asymmetrical power structures.

At the interpersonal level, the practice of role models and peers to GBV invariably influences a person's disposition to experience or engage in GBV. What peers say or do among themselves can be binding, consciously or otherwise. It follows that peers who share or engage in GBV ultimately influence their elks to practice GBV or otherwise if the peers do not engage in GBV. Peer pressure has been shown to influence the development or sustenance of behavior strongly. The role of culture, which is the way of life, further plays a vital role in determining a person's disposition to engage in GBV. Individuals grow to acknowledge the cultural preferences in a society; behaviors are formed and choices made, including preferences for engaging in GBV. The cultural stand on GBV can also determine an individual's predisposition to engaging in GBV.

The third level of factors is the community and includes settings such as neighborhoods, schools, and workplaces. Research has demonstrated that communities with high levels of social disorganization, for example, residential mobility, high population densities and lack of cohesion among residents, are associated with higher levels of violence. Community poverty, unemployment, and alcohol outlets have also been identified as risk factors for violence perpetration, victimization by violence, or both. According to social disorganization theory, poverty at the community level may underlie much stress and conflict within intimate couples, such that community poverty manifests at the relationship level [84]. The stigmatization that GBV survivors face from society poses a challenge to prompt reporting of GBV assaults by survivors. The approach of healthcare providers to GBV survivors can also determine whether or not a GBV survivor will access care at a health facility or report the attack. The existence of a curriculum on managing GBV survivors by healthcare providers also has a bearing on the documented occurrence of GBV.

The fourth and last level of factors is the societal level. This includes broad societal elements that create a climate that encourages or discourages violence at the community, relationship and individual levels, including the rules, norms, and social expectations that govern personal behavior and social inequities between groups, for example, patriarchal systems, oppression, poverty, sexism, and health disparities [85]. For example, sources of support and formal assistance may not be readily available to socially marginalized women, thus making them vulnerable to GBV and impacting their responses to violence. This ecological approach to understanding violence integrates research findings from various disciplines into a comprehensive framework that improves our understanding of the context, causes, and impact of GBV in the lives of women and the environment in which they are responding to it. The ecological model for GBV intervention implies that strategies must be developed that target multiple levels, that is, individual, family, community, and societal [83]. The existing or available punitive measures for GBV offenders can serve as a deterrent or otherwise to individuals committing GBV. If there is no definite, firm and enforced punishment in place or instituted for GBV offenders, some individuals will likely be encouraged to perpetuate GBV, with a certainty of getting away scot-free with it. This pushes the incidence of GBV upwards.

Summary of gaps in knowledge

Though the predictors of gender-based violence vary in intensity and magnitude across climes and continents, the incidence of GBV remains unacceptably high. Most studies also focused more on women as victims, with just a few of the researches targeting men and adolescents as victims of GBV. There also appears to be a dearth of research exploring the ability of healthcare providers to manage GBV cases. With an expanding social awareness about gender-based violence (the case of the 40-year-old famous Nigerian gospel singer, Osinachi, who was assaulted to an untimely death by her spouse readily springs to mind), occurrences of GBV in Nigeria now sparks public outcries; sadly, a tell-tale sign of the persistence of the social menace. Bothersome also is the disposition and attitude of healthcare providers toward managing victims of GBV in Nigeria. As such, much could be learnt and deduced from this research that seeks to assess the prevalence and pattern of GBV among men as victims and beams a searchlight on the capability and knowledge of healthcare providers at managing GBV cases in southwestern Nigeria.

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III. Research Methodology

Introduction

This section will explicitly unbundle the research approach, state the delimitations and scope of the study with reference to the study location. The data collection and analysis methods will also be discussed.

Delimitation of the study

The study was delimited to the 11 LGAs that make up Ibadan City.

Geographical area

The study location comprised the 11 LGAs that constitute Ibadan City. The LGAs are Ibadan North, Ibadan North East, Ibadan North West, Ibadan South East, Ibadan South West, Akinyele, Lagelu, Ido, Ona-Ara, Oluyole and Egbeda.

Oyo State

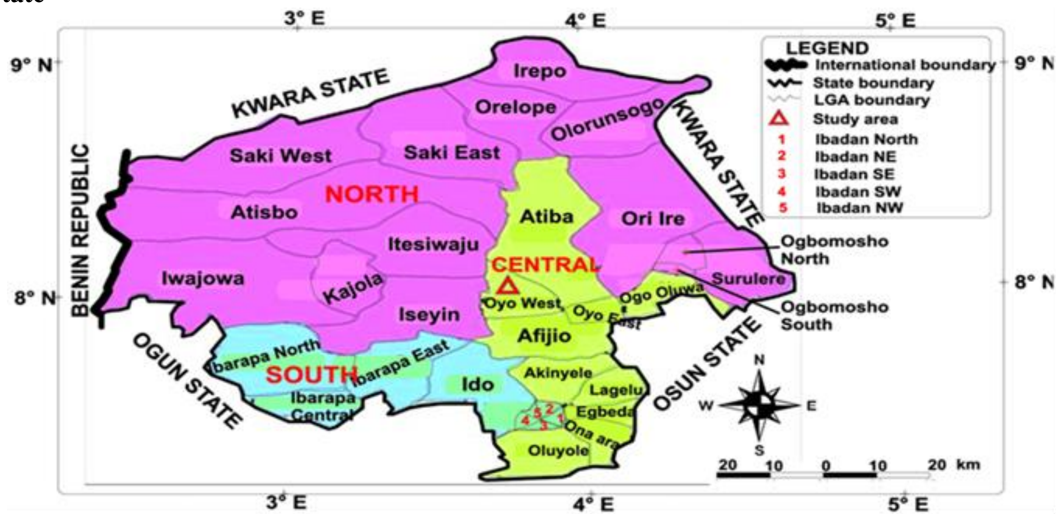

Figure 8: Map of Oyo State

Oyo State was carved out from the old Western State in 1976. The State sobriquet (The Pace Setter State) was ascribed because it recorded 'FIRST' in many aspects of human endeavors. These include the first Nigerian University- University of Ibadan; the first national stadium in Africa-Liberty Stadium, now Obafemi Awolowo Stadium, Ibadan; the first television station in Africa- Western Nigerian Television, now Nigerian Television Authority, Ibadan; the first General Hospital in Nigeria- Adeoyo General Hospital Ibadan, now Adeoyo Maternity Teaching Hospital, Ibadan; the first teaching hospital in Nigeria- University College Hospital, Ibadan; the first high rise building in Nigeria-Cocoa House, Ibadan and the first five-star hotel in Nigeria-Premier Hotel, Ibadan.

In 1991, Osun State was carved out of the old Oyo State. Ibadan remains the administrative headquarter of the State from the Western region days and is reputed as the largest indigenous city in Africa. The State is bounded in the North by Kwara State, in the South by Ogun State, in the east by Osun State and in the West by the Republic of Benin, which offers unique opportunities for cross-border trading. The landscape is bisected into four equal parts by latitude 80^0N and longitude 40^0E. It occupies a land area of 27,148 square kilometers. The projected population figure for the State by 2022 is 9,546,933, of which 477,347 are estimated to be pregnant women[1].

There are 33 Local Government Areas (LGAs), 33% urban and 66% rural[8]. The State has a total of 351 wards. Most of the State's inhabitants are farmers, petty traders and artisans, with a smaller proportion being civil servants. Like other states of the Federation, it has three senatorial districts: Oyo North (13 LGAs), Oyo Central (11 LGAs) and Oyo South with 9 LGAs. The State has a 32-member cabinet in the State House of Assembly, 14 Federal House of Representatives members, and three National Assembly senators.

Oyo State is predominantly agrarian, with about 60 – 70% of the productive workforce engaged in agriculture, and most are practiced in the northern part of the State. The rest of the productive workforce is split between those engaged in the informal sector, the Civil Service, mining activities in the northern part of the State and pockets of Fast-Moving Consumer Goods Industries (FMCGs) operative mainly in Ibadan. Some of the goods produced include biscuits, vegetable oil and plastics.

Like other states in the Western geo-political zone, the absolute poverty rating is 29.4% while relative poverty is 9.8% UNGMPI 2018, although poverty rating differs by location and settlement type. There is likely a rise in these rates with the current economic recession. The State has a per capita GDP of US $34.5, an education index of 0.8523, a gender inequality index of 0.418, and a human development index of 0.47651.

Ibadan city

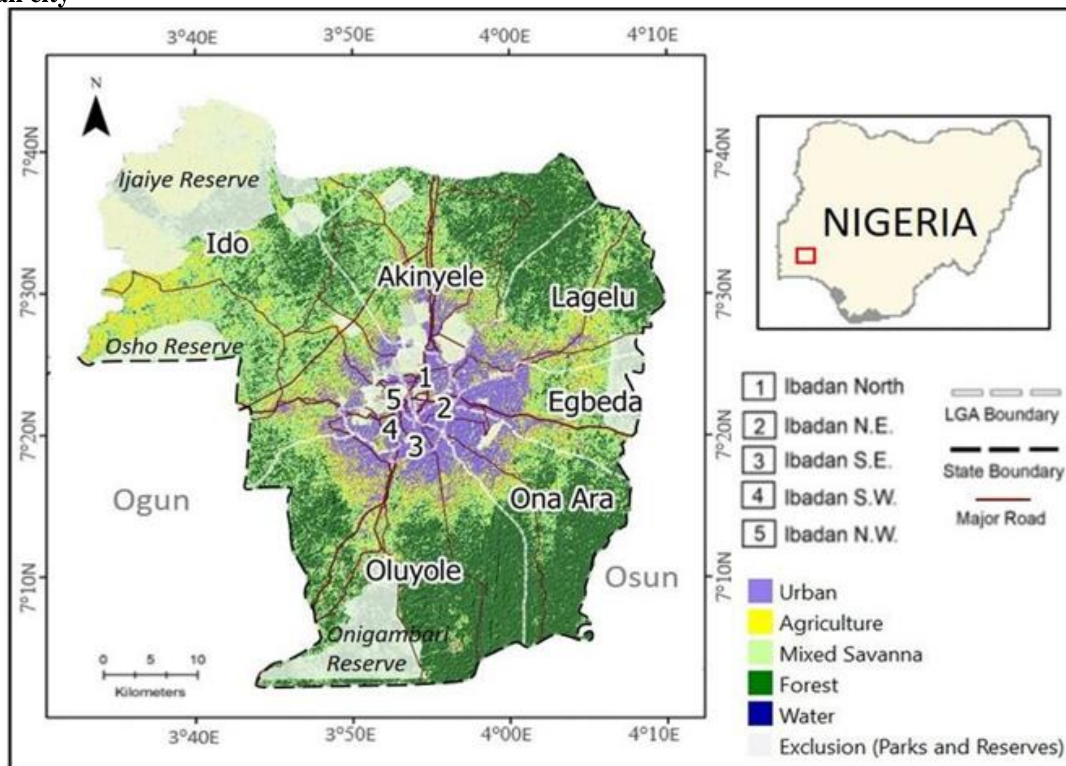

Figure 9: Map of Ibadan showing the 11 Local Government Areas[9]

Ibadan is the most populous and capital city of Oyo State, Nigeria. It ranks as Nigeria's third largest city by population after Lagos and Kano. As of 2021, it had a population of 3,649,000. It is Nigeria's largest city by geographical area. During Nigeria's independence in 1960, Ibadan was the country's largest and most populous city and the second most populous in Africa behind Cairo. Ibadan is situated in southwestern Nigeria. The city lies 128 kilometers (80 miles) inland northeast of Lagos and 530 kilometers (330 miles) southwest of Abuja, the Nation's capital. It is a popular transit point between the coastal region and the country's hinterland areas. Ibadan was the administrative hub of the old Western Region since the early days of the British colonial era. An appreciable portion of the city's ancient protective walls still stand today. The major inhabitants of the city are the Yorubas, as well as various communities (notably Igbo, Hausa, and Efik) from other parts of the country. Ibadan Metropolis covers an area of 3,080 km2 (1,190 sq. mi), while urban Ibadan covers an estimated area of 6,800 km2 (2,600 sq. mi) [1].

The Ibadan city comprises 11 LGAs: Akinyele, Oluyole, Egbeda, Ona Ara, Lagelu, Ido, Ibadan North, Ibadan North east, Ibadan North West, Ibadan Southeast and Ibadan Southwest.
Ibadan City is the study site for this research.

Research design

The research was a quantitative, descriptive cross-sectional study. This choice of research design analyzed the target population and further focused on numerical data to assess the determinants and magnitude of GBV in Ibadan. It also investigated the causes of GBV and further identified the effect it had, most especially on women and adolescents. The research design provided sufficient insights into prevailing GBV behaviors among the population and the results will be extrapolated to the general population of Oyo State. The adoption of the quantitative, descriptive, cross sectional study design ultimately provided a snapshot as to the pattern of GBV in Oyo State that will elicit evidence-based decision making and policy formulation.

Research Methodology
Study population

The population comprised pregnant women, non-pregnant women, men, adolescents and healthcare workers. For this research, the study population are described as follows:
Pregnant women: A woman in any stage of gestation
Non-pregnant women: Women that are not in a state of gestation
Men: Adult human beings that are of and/or identify as a male gender

Adolescents: Adolescence is the stage of life between childhood and adulthood usually from ages 10 to 19.
Health care workers: A doctor, registered nurse (RN), community health extension worker (CHEW) or a community health officer (CHO)

Sample size
This was determined using the Raosoft online sample size calculator[2]:
Sample size (n) and margin of error (E) are given by:
E. = Sqrt [(N - n) x/n(N-1)]

Where N is assumed to be the population size; r is the fraction of responses the researcher is investigating; Z(c/100) is the critical value for the confidence level c.
The Raosoft sample size calculator was used with the following considerations:
· population of young people in Ibadan > 20,000
· Confidence Interval at 95%; Margin of Error =2.5%,
· Response distribution of 50%; The minimum sample is 1535 participants
· Consideration for attrition of 20%
· Final sample size for the study was a minimal 1843 respondents per targeted study population group. A total of 13,841 persons, comprising 2388 pregnant women, 2027 non-pregnant women, 4452 adolescents, 3688 adult males and 1286 healthcare providers were included in the study.

Sampling technique
A multi-stage sampling procedure was adopted as follows:
i. First Stage
All 11 LGAs within the Ibadan metropolis were selected.

ii. Second Stage

From the list of wards in the 11 LGAs, five wards were randomly selected. As such, a total of 55 wards were selected.

iii. Third Stage

The list of communities in the selected wards was obtained from the Ministry of Lands and Housing. Five communities were selected by ballot from the 55 wards; this gave a total of 275 communities to covered

iv. Fourth Stage
All households, houses, secondary schools and health facilities in the selected communities were included.

v. Fifth Stage

All married men, pregnant women, non-pregnant women, adolescents and healthcare providers who met the inclusion criteria were included till the sample size per LGA was achieved. The sample size distribution per LGA was based on the 2022 projected population estimates and was not equal across the board.

Description of the Research Instrument

The main instrument for data collection was a structured questionnaire, developed by the researcher and hosted on KoboCollect. The questionnaire was designed based on literature searches, and adaptations were made. The study questionnaire was a composite, semi-structured questionnaire combining information from:
i. Consent form: The form was designed to obtain and document the informed consent of respondents to be part of the study.
ii. **Personal Information form[3]**: As deployed in a study by Yasemin Erkal Aksoy et al. in Turkey in 2021, a study aimed at identifying factors affecting the levels of distress during pregnancy, sexual relationship power and intimate partner violence. This form was designed to obtain information on respondents' socio-demographic parameters.
iii. **Domestic Violence Safety Assessment Tool (DVSAT)[4]**: Domestic Violence Safety Assessment Tool (DVSAT) developed was by the new south Wales bureau of crime statistics and research and is for use by non-government service providers and government agencies. The DVSAT was deployed in a 2018 study by Claire Ringland[4] on Domestic Violence Safety Assessment Tool (DVSAT) and intimate partner repeat victimization. The DVSAT has primarily been designed for use in intimate partner violence situations and aimed to determine a victim's risk of intimate partner repeat victimization. Respondents were mainly required to give a yes or no answer, after which a scale was used to determine the respondent's risk of GBV and repeat victimization.
iv. Danger assessment tool[5]: The Danger Assessment (DA) is an instrument designed and intended to assess the likelihood of near- lethality or lethality occurring in a case of gender-based violence[5]. The tool was

developed and first deployed during a survey titled "The Danger Assessment: Validation of a Lethality Risk Assessment Instrument for Intimate Partner Femicide, 2008"[5]. The tool is a lethality risk assessment instrument designed to assess the lethality or near lethality occurring in cases of GBV[4].

v. Tilburg Pregnancy Distress Scale revised (TPDS-R)[3]: The Tilburg Pregnancy distress scale was initially deployed in a study by Yasemin Erkal Aksoy et al. in 2012: The longitudinal study researched the effect of a woman's "power" on sexual decisions during pregnancy and the occurrence of GBV. The Tilburg Pregnancy Distress Scale revised (TPDS) was previously developed to measure pregnancy-specific distress, resulting in a 16-item screening scale with a partner involvement dimension (PI) and a negative affect dimension (NA) before its review in 2016. The revised TPDS-R provided a robust screening tool to identify pregnant women at risk of pregnancy-specific distress accurately[6].

vi. The UNFPA GBV Assessment and situation analysis tools[7]: The tool was developed jointly by the UNFPA, International Medical Corp, Global Protection Cluster and the Australian Government. It is a set of tools developed, used and revised in field sites. As such, GBV program managers and researchers are expected to draw from existing and tested materials to develop assessment tools that are appropriate and relevant for use in a specific setting. The GBV Assessment (areas of enquiry) and the sexual violence assessment (short interview form), having been previously validated, were adapted for use in this research due to their appropriateness in providing the necessary probing questions to determine respondents' predisposition to GBV. The tools probed general information and GBV basics, including community profiles and help-seeking practices of GBV survivors[7].

vii. Adapted tool for violence against women in a low-income country[7]. The tool, adapted from literature, assessed violence against women in a low-income country setting. The tool was validated for consistency using Cronbach's alpha (or coefficient alpha) in a study by Agumasie Semahegn et al. in 2019. Cronbach's alpha (α, or coefficient alpha) measures internal consistency or reliability, that is, how closely a set of items are related as a group. The tool measures women's decision-making autonomy on household matters and their attitude towards inequitable gender norms. The tool also comprised an intimate partner violence assessment scale that probed into and identified the physical, psychological and sexual responses or reactions of an intimate partner under some specified circumstances. The tool further established a woman's attitude and acceptability towards wife beating[8]. For this research, the inter-relatedness of the variables in the tools was measured using Cronbach's alpha coefficient set at the minimum recommended value of 0.7.

viii. Structured Questionnaire for healthcare providers: This questionnaire was adapted to determine the attitude and response of healthcare providers to GBV survivors; the questionnaire was validated and pre-tested before deployment on the field.

Validity of research instrument: Validity refers to the accuracy of a measure, that is, the extent to which the instrument measures what it was designed to measure. The sub-components of the research tool have been validated over time and across previous research; however, this adopted research tool was pre-tested before final deployment to the field. The pretest was done at Ibarapa east (bordering Ido LGA) and Afijio LGA (bordering Akinyele LGA). Both are neighboring LGAs outside the 11 Ibadan LGAs. Pre-test was done among 200 women, 200 adolescents 200 men and 100 healthcare providers. Local interpretation of terms and terminologies were factored into the revised tools for appropriateness. The pre-test was also used to determine the duration for responding to the tools as this informed the total number of questionnaires to be administered daily by research assistants.

Reliability of research instrument: refers to the consistency of a measure or tool, that is, the extent the instrument yields the same result over multiple trials. All the sub-components of the tool adapted for this research passed through the test-retest reliability test. The test-retest approach was deployed at measuring reliability through administration of the tools twice over a period of time to a group of individuals. It also measured the external consistency of the tool. The scores for time 1 and time 2 were correlated and the stability of the tool was evaluated over time. The test-retest method of reliability test was adopted because variables, expected to stay constant, were being measured.

Re-validation of tools

The adapted tool was re-validated for reliability and pre-tested before final deployment on the field. The adapted instrument for this research was re-validated for internal consistency and subsequently pre-tested at Akinyele and Ibarapa east LGAs before the full rollout. The instruments were subjected to reliability through test and re-test methods using 100 non-pregnant women, 100 pregnant women, 100 adolescents, 100 men and 50 healthcare providers outside the study population. The reliability index of the instrument was tested from Cronbach alpha computation. A Cronbach's alpha coefficient 0.70 was determined, with an item-total score of correlations of 0.20 in each item[6]. Questionnaires were both respondent and interviewer-administered.

External Validity
The test-retest method was deployed at measuring the external validity of the tools.

Internal Validity
A pilot testing of the validated instruments was conducted to help identify and rule out ambiguities, biases or weaknesses in the instrument before large scale deployment. The pilot testing was conducted at Ido and Akinyele Ona Ara and Oluyole LGAs among 200 men, 200 women, 200 adolescents and 100 healthcare workers. The questions in the instrument wer further carefully designed to avoid leading questions and ambiguous wordings

Data collection approach
A quantitative data collection approach was employed. The research tools were deployed on the Kobocollect app. The instrument (questionnaire) was administered by the researcher with the aid of twenty -two (22) trained research assistants who interpreted and collected responses using the Kobocollect App (the main instrument for data collection) from consenting participants at the schools, health centers, General Hospitals and communities on the spot. The research assistants were recruited from the health promotion and education department of the UCH while they were supported by ward focals persons from the study LGAs. The ward focal persons provided the needed community entry and mobilization of study participants within their communities.

Literate and willing respondents were able to self-administer the Kobocollect questionnaires. The healthcare providers' questionnaires were both interviewer administered and self-administered.

Data analysis
Composite, semi-structured questionnaires were used to collect study-related data. The Questionnaires were both respondent and interviewer-administered. Data analysis was done using the SPSS Version 29 launched in September 2022.

A summary of the statistics is presented using frequency tables and charts. Inferential statistics, to test for associations between categorical variables, was done using the Chi-square test for qualitative variables.
Logistic regression analysis was done to identify independent factors of GBV.
Statistical significance level(p) was set at $p < 0.05$ at a 95% confidence interval.

Data Management and measurement of outcome variables

Research Objectives	Study design	Approach	Statistical Analysis Method
i. To determine the prevalence, pattern and determinants of GBV among adult females. The Domestic Violence assessment tool (DVAT) for pregnant and non-pregnant women will be deployed for data collection,	Cross sectional	Quantitative	Descriptive, Logistics regression; Chi square test
ii. To assess the prevalence, pattern and associated risk factors of GBV among pregnant women. The Domestic Violence assessment tool (DVAT) for pregnant and non-pregnant women will be deployed for data collection	Cross sectional	Quantitative	Logistics regression; Chi square test
iii. To determine the prevalence, pattern and risk factor of GBV among adolescents. The revised Danger assessment tool will be deployed for information collection among the adolescents	Cross sectional	Quantitative	Logistics regression; Chi square test
iv. To assess the prevalence, pattern and determinants of GBV among adult men. The Domestic Violence assessment tool (DVAT) for Adult Males will be deployed for data collection	Cross sectional	Quantitative	Logistics regression; Chi square test
v. To determine health workers' knowledge, attitude, and experience of GBV. The health worker's structured questionnaire will be deployed	Cross sectional, descriptive	Quantitative	Logistics regression, Chi square test

vi. To determine the knowledge and attitude of respondents towards GBV.The VAW (Sections 8-13 of the DVAT) which has been incorporated into the DVAT will be used for data collection	Comparative, descriptive study	Quantitative	Logistics regression, Chi square test

Table 1: Data analysis plan

Ethical considerations

Ethical approvals were obtained from the ethics committee of the Lead City University and the ethics and research committee domiciled within the directorate of planning, research and statistics of the State Ministry of Health. Necessary ethical approvals were further obtained from the state Ministry of Education. Written consents, which was documented, was obtained from all respondents.

Endnotes

1. Olalekan Kazeem, Tanimola Mokanjuola Akande, AG Salaudeen, Nadir Hussain. Influence of Socio Demography Factors on Knowledge of Intimate Partner Violence among Soldiers in Ibadan: A Cross Sectional Survey. ResearchGate, 2018
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3 Yasemin Erkal Aksoy, Bihter Akın, Sema Dereli Yılmaz. Factors affecting the levels of distress during pregnancy, sexual relationship power and intimate partner violence. Taylor and Francis online, 2021
4 Claire Ringland, The Domestic Violence Safety Assessment Tool (DVSAT) and intimate partner repeat victimisation, NSW Crime and justice bulletin, 2018
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7. UN Population Fund (UNFPA), GBV Assessment & Situation Analysis Tools, February 2012, available at: https://www.refworld.org/docid/5c3465c64html [accessed 1 April 2023]
8. Oyo State Factsheet 2022
9. Researchgate. www.researchgate.net/figure/The-Ibadan-metropolitan-region-showing-the-11-LGAs-and-2020-land-use,18/01/2024)

IV. Results

Introduction

This chapter presents the findings from the study, addressing each of the research questions based on the data collected from the sampled populations. The results highlight the burden and determinants of gender-based violence (GBV) among different demographic groups, as well as the knowledge, attitudes, practices and care-seeking behaviour related to GBV in the city of Ibadan.

The first research question focused on the burden and determinants of GBV among adult females. A total of 2,388 adult females completely filled the needed information and the findings reveal the prevalence of GBV in this population, including the various socio-demographic factors associated with increased risk. The analysis explores key determinants such as age and education to understand the underlying causes of GBV among adult females.

The second research question addressed the burden and associated risk factors of GBV among pregnant women. Among the 2,027 female respondents who completed the questionnaire, the results highlight the unique vulnerabilities faced by pregnant women in relation to GBV. The study examines how sociodemographic factors, influence the risk of violence during pregnancy.

The third research questions explore the burden and risk factors of GBV among adolescents. With a sample of 4,452 adolescents, the study identifies the prevalence of GBV in this group and the specific risk factors that make adolescents particularly vulnerable to GBV. Certain socio-demographic factors were analyzed to provide a comprehensive understanding of adolescent GBV.

The fourth research question examines the burden and determinants of GBV among adult males. From the sample of 3,688 adult males, the results highlight the prevalence of GBV experienced by males, along with the determinants that may contribute to this violence. The study sheds light on the often-overlooked issue of male GBV and explores their socio-demographic determinants.

The fifth research question focuses on the knowledge, attitude, and practice of health workers in relation to GBV. This section explores the level of awareness among healthcare providers, their attitudes towards GBV victims and the practices they employ in addressing GBV cases in health facilities.

The Sixth research question investigates the knowledge and attitudes of Ibadan respondents towards GBV and examine the extent to which victims seek medical attention.

Objective 1: Prevalence, Pattern and Determinants of GBV Among Adult Females in the city of Ibadan

Table 4.1.1:
Sociodemographic Characteristics of Adult Female in the city of Ibadan
N=2388

Variables	Frequency (n)	Percentage (%)
Age (Years)		
20-29	933	39.1
30-39	773	32.4
40-49	414	17.3
≥50	268	11.2
Mean (SD)	34.7 (11.3)	
Education level		
No formal education	135	5.7
Primary	242	10.1
Secondary	1397	58.5
First degree	471	19.7
PGD	143	6.0
Employment Status		
Currently Employed	1121	46.9
Not currently employed	1129	47.3
Not employed in last 12 months	138	5.8
Occupation		`
Professional/Management	220	9.2
Cleric	116	4.9
Sales/services	857	35.9
Skilled	612	25.6
Unskilled	113	4.7
Agriculture/Farmer	78	3.3
Apprentice	196	8.2
Student	117	4.9
Housewife	79	3.3
Marital Status		
Never married	371	15.5
Married	1695	71.0
Living together	130	5.4
Divorced	42	1.8
Separated	65	2.7
Widowed	85	3.6
Residence		
Rural	677	28.4
Urban	1711	71.6
Number of children		
None	549	23.0
1-2	747	31.3
3-4	816	34.2
5-8	272	11.4
>8	4	0.2
Years of Marriage		
≤5 years	1116	46.7
6 -10 years	505	21.1
>10 years	767	32.1

The sociodemographic characteristics of the adult female population totaling 2388 are described in table 4.1.1. Description is in terms of age, education, employment, occupation, marital status, residence, number of children, and years of marriage.

The age distribution shows that the majority of the respondents are in the younger age groups, with 39.1% between 20-29 years and 32.4% between 30-39 years with the mean age of 34.7 years with a standard deviation of 11.3 years.

In terms of educational attainment, the majority of the women have completed at least secondary education, with 58.5% having a secondary level of education and an additional 19.7% holding a first degree. Only a small percentage of the population has no formal education (5.7%) or holds a postgraduate degree

(6.0%). Employment status is nearly evenly split between those currently employed (46.9%) and those not currently employed (47.3%), with a small percentage (5.8%) not having been employed in the last 12 months.

The occupations vary widely, with the largest group working in sales/services (35.9%), and followed by skilled workers (25.6%). A smaller percentage is in professional/management roles (9.2%) or are unskilled workers (4.7%).

On their marital status, a large majority of the women reported being married (71.0%), with a small proportion reportedly single (15.5%) or in other categories such as living together (5.4%), divorced (1.8%), separated (2.7%) or widowed (3.6%). Most of the respondents reside in urban areas (71.6%). Slightly over a third (34.2%) of the women had 3-4 children, while only a small percentage had more than eight children (0.2%).

Finally, the years of marriage among those married indicate that nearly half have been married for five years or less (46.7%) and almost a third had been married for more than ten years (32.1%).

Table 4.1.2:
Sociodemographic Characteristics of Partner/Spouses of Adult Females in Ibadan
N = 2388

Variables	Frequency (n)	Percentage (%)
Age (years)		
20-29	525	22.0
30-39	708	29.6
40-49	683	28.6
≥50	472	19.8
Mean (SD)	37.6 (18.8)	
Education level		
No formal education	228	9.5
Primary	191	8.0
Secondary	1215	50.9
First degree	554	23.2
PGD	200	8.4
Employment Status		
Currently Employed	1228	51.4
Not currently employed	995	41.7
Not employed in last 12 months	165	6.9
Occupation		
Professional	404	16.9
Cleric	177	7.4
Sales/services	528	22.1
Skilled	659	27.6
Unskilled	355	14.8
Agriculture/Farmer	140	5.9
Apprentice	60	2.5
Student	65	2.7
Knows how much partner earns		
Yes	549	23.0
No	1839	77.0
Smokes		
Yes	171	7.2
No	2049	85.8
Don't Know	168	7.0
Takes hard drugs		
Yes	27	1.1
No	2160	90.5
Don't Know	201	8.4
Consumes Alcohol		
Yes	548	22.9
No	1692	70.9
Don't Know	148	6.2

Table 4.1.2 shows the sociodemographic characteristics of the partners or spouses of the adult females sampled. The age distribution shows that the majority of the partners are relatively young, with 22.0% in the 20-29 age group, and the largest proportion (29.6%) between 30-39 years old. The mean age of the partners is 37.6 years, with a standard deviation of 18.8 years, indicating a broad age range.

Educational attainment among the partners is fairly distributed, with half of them having completed secondary education (50.9%), and approximately, a quarter, first degree (23.2%). A smaller percentage has no formal education (9.5%) or a postgraduate degree (8.4%).

Regarding employment status, over half of the partners are currently employed (51.4%), while 41.7% are not currently employed, and a smaller group has not been employed in the last 12 months (6.9%). Their occupations vary widely, with the largest groups working in skilled labor (27.6%) and sales/services (22.1%) while a smaller proportion is engaged in professional roles (16.9%) or unskilled work (14.8%).

The data also reveal that a large majority of the adult females do not know how much their partners earn (77.0%) while lifestyle factors such as smoking, drug use, and alcohol consumption are also highlighted with 7.2% of the partners smoking, 1.1% taking hard drugs and 22.9% consuming alcohol.

Table 4.1.3:
Danger Assessment in Abusive Relationship among Adult Females living in Ibadan
N = 2388

Risk indicator	Frequency (%)	Percentage (%)
Partner ever threatened to harm or kill you	108	4.5
Partner ever used physical violence against you	244	10.2
Partner ever choked, strangled or suffocated you or attempted to do any of these things	80	3.4
Partner ever threatened or assaulted you with any weapon (including knives and/or other objects)	72	3.0
Partner ever harmed or killed a family pet or threatened to do so	37	1.5
Partner ever been charged with breaching an apprehended domestic violence order	33	1.4
Relationship between client and partner		
Violence or controlling behaviour from partner is becoming worse or more frequent	96	4.0
Partner stalked, constantly harassed or texted/ emailed you	126	5.3
Partner control access to money	157	6.6
There has been a recent separation (in the last 12 months) or one imminent	117	4.9
Background of partner		
Partner or the relationship have financial difficulties	345	14.4
Partner is unemployed	478	20.0
Partner has mental health problems (including undiagnosed conditions) and/or depression?	28	1.2
Partner have a problem with substance abuse such as alcohol or other drugs	77	3.2
Partner ever threatened or attempted suicide	29	1.2
Partner is currently on bail or parole, or has served a time of imprisonment or has recently been released from custody in relation to offences of violence	19	0.8
Partner has access to firearms or prohibited weapons	18	0.8
Information about Children's risk		
Household has children who are less than 12 months apart in age	388	16.2
Partner ever threatened or used physical violence toward me at any time	145	6.1
Partner ever harmed or threatened to harm your children	55	2.3
There is conflict between me and partner regarding child contact or residency issues and/or current Family Court proceedings	28	1.2
There are children from a previous relationship present in the household	128	5.4
Sexual assault		
Partner has ever done things to me, of a sexual nature, that made me feel bad or physically hurt me	91	3.8
Partner has ever been arrested for sexual assault	32	1.3

The table (4.1.3) describes the pattern of risk indicators associated with abusive relationships among adult females in Ibadan. Up to 10% of respondents reported that their partner ever used physical violence against them; 6.6% of the women reported their partners controlled their access to money, with 14.4% of partners currently experiencing financial difficulties. Further, a fifth (20.0%) of the respondent's partners are unemployed. Additionally, 6.1% of the respondents indicated that their partner had threatened or used violence at any time.

Less frequently experienced indicators as highlighted from the table are on sexual assaults where about 3.8% of respondents reported being subjected to sexual actions by their partner that made them feel bad or caused physical harm and 3.4% indicated that their partners choked, strangled, or suffocated them or attempted to do so.

Moreover, the table reveals the potential for escalated risks in relationships as 4.0% of respondents observed that violence or controlling behavior from their partner is worsening. Households having children less than 12 months apart in age was reported by 16.2% of the respondents.

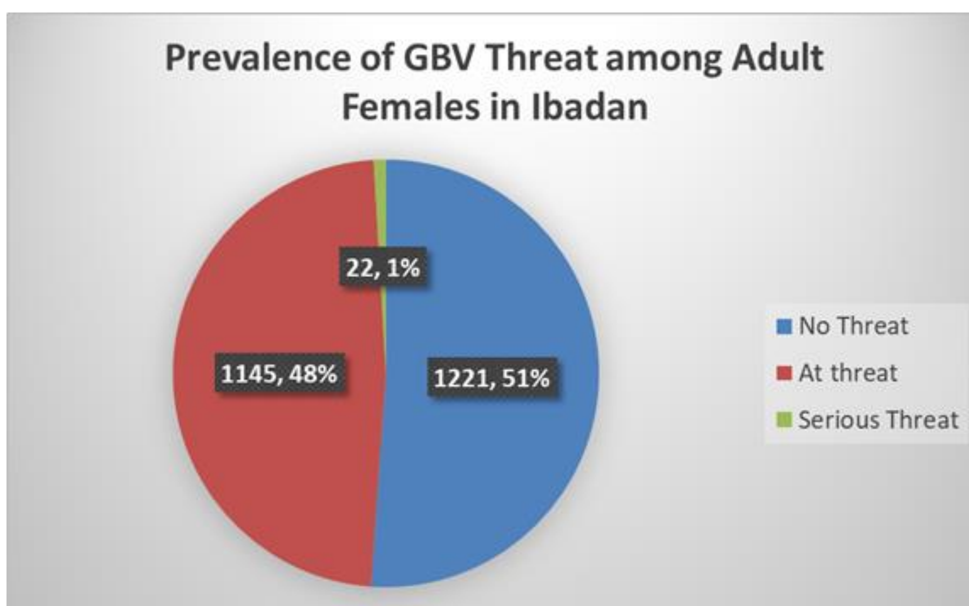

Figure 4.1: Pie chart describing the classification according to threat of GBV among Adult females in Ibadan.

In figure 4.1, the prevalence of GBV threats as reported shows that while half (51%) of the female adults sampled had no form of GBV threat, almost half (48%) are at threat of GBV. An almost negligible percentage of the respondents (1%) were found to be at serious threat of GBV.

Table 4.1.4: Sociodemographic determinants of GBV threat among adult female

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Age group (Yrs)				
20 - 29	523 (56.1)	410 (43.9)	16.643	0.001*
30 – 39	371 (48.0)	402 (52.0)		
40 - 49	190 (45.9)	224 (54.1)		
≥50	137 (51.1)	131 (48.9)		
Employment status				
Currently employed	674 (60.1)	447 (39.9)	80.679	<0.001*
Not currently employed	468 (41.5)	661 (58.5)		
Not employed in last 12 months	79 (57.2)	59 (42.8)		
Residence				
Rural	329 (48.6)	348 (51.4)	2.428	0.119
Urban	892 (52.1)	819 (47.9)		
Education level				
No formal education	79 (58.5)	56 (41.5)	32.773	<0.001*
Primary	108 (44.6)	134 (55.4)		
Secondary	666 (47.7)	731 (52.3)		
Tertiary	368 (59.9)	246 (40.1)		
Number of Children				
None	346 (63.0)	203 (37.0)	43.997	<0.001*
1-2	370 (49.5)	377 (50.5)		
3-4	379 (46.4)	437 (53.6)		
5-8	123 (45.2)	149 (54.8)		
>8	3 (75.0)	1 (25.0)		
Years of Marriage				
1-5	650 (58.2)	466 (41.8)	42.567	<0.001*
	230 (45.5)	275 (54.5)		

6-10 >10	341 (44.5)	426 (55.5)		

The table (4.1.4) presents the socio-demographic determinants of being at threat of gender-based violence (GBV) among adult females with Age, employment status, education level, number of children and years of marriage being reported as factors.

There is a significant relationship between age and the threat of GBV, with a lower proportion of younger women aged 20-29 years at threat (43.9%) of GBV compared to older age groups like women aged 40-49 years (54.1%) (p=0.001). Women who are currently employed are less likely to be at threat (39.9%) compared to those who are not employed in the last 12 months (42.8%) or currently unemployed (58.5%) (p<0.001). Women with tertiary education have lower proportion at threat of GBV (40.1%) compared to those with secondary education (52.3%) or primary education (55.4%) (p<0.001).

Similarly, both the number of children and years of marriage are significantly associated with GBV threat (p<0.001). Women with no children (37.0%) or fewer children (1-2) (50.5%) are less likely to be at threat compared to those with 5-8 children (54.8%) and those whose children are five or less (41.8%). Women who have been married longer (more than 10 years) are more likely to be at threat (55.5%).

Table 4.1.5: Logistic Regression model on determinants of GBV threat among adult female

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
20-29	2.154	0.001	1.391	3.335
30-39	1.867	0.001	1.286	2.713
40-49	1.568	0.009	1.119	2.197
≥50 (Reference Category)	1.000			
Employment Status				
Currently employed				
Not currently employed	0.707	0.070	0.487	1.028
Not employed in the last 12 months (RC)	1.636	0.009	1.132	2.367
	1.000			
Education level				
No formal education	0.806	0.291	0.540	1.203
Primary	1.236	0.209	0.888	1.721
Secondary	1.240	0.041	1.009	1.523
Tertiary (RC)	1.000			
Residence				
Rural	1.174	0.090	0.975	1.414
Urban (RC)	1.000			
Number of Children				
None				
1-2	1,558	0.715	0.144	16.812
3-4	2.869	0.383	0.268	30.697
5-8	2.825	0.389	0.267	29.934
>8	3.082	0.350	0.291	32.602
	1.000			
Years Married				
1-5	0.507	<0.001	0.366	0.703
6-10	0.771	0.074	0.579	1.026
>10	1.000			

The logistic regression model presented in Table 4.1.5 examines the sociodemographic determinants of the threat of gender-based violence (GBV) among adult females.

Age shows a significant association with the threat of GBV as women aged 20-29 years (OR = 2.154, p = 0.001), 30-39 years (OR = 1.867, p = 0.001), and 40-49 years (OR = 1.568, p = 0.009) are at significantly higher risk of GBV compared to those aged 50 years and above (reference category). Women who are not currently employed have significantly higher odds of GBV threat (OR = 1.636, p = 0.009) compared to those who have not been employed in the last 12 months (reference category). Women with tertiary education (reference category) are less likely to be at threat of GBV compared to those with secondary education (OR = 1.240, p = 0.041).

Similarly, years married show significant associations with the threat of GBV. Women with shorter marriages (1-5 years, OR = 0.507, p < 0.001) are associated with a lower threat of GBV compared to marriages lasting more than 10 years.

Table 4.1.6: Partner's characteristics and GBV threat among Partners of adult females in Ibadan

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Partner's Age (Yrs)				
20 - 29	333 (63.4)	192 (36.6)	40.878	<0.001*
30 – 39	334 (47.2)	374 (52.8)		
40 – 49	326 (47.7)	357 (52.3)		
≥50	228 (48.3)	244 (51.7)		
Partner's Employment Status				
Currently employed				
Not currently employed			96.206	<0.001*
Not employed in last 12 months	727 (59.2)	501 (40.8)		
	391 (39.3)	604 (60.7)		
	103 (62.4)	62 (37.6)		
Partner's education level				
No formal education				
Primary	195 (85.5)	33 (14.5)	141.953	<0.001*
Secondary	89 (46.6)	102 (53.4)		
Tertiary	527 (43.4)	688 (56.6)		
	410 (54.4)	344 (45.6)		
Partner consumes alcohol				
No				
Yes	940 (55.6)	752 (44.4)	128.783	<0.001*
I don't know	172 (31.4)	376 (68.6)		
	109 (73.6)	39 (26.4)		
Partner smokes				
No	1052 (51.3)	997 (48.7)	40.657	<0.001*
	56 (32.7)	115 (67.3)		
Yes	113 (67.3)	55 (32.7)		
I don't know				
Partner takes hard drug				
Yes			13.721	0.001*
	7 (25.9)	20 (74.1)		
No	1093 (50.6)	1067 (49.4)		
	12 (60.2)	80 (39.8)		
I don't know				
Know partners' earning				
No				
Yes	958 (52.1)	881 (47.9)	2.968	0.085
	263 (47.9)	286 (52.1)		

The table (4.1.6) describes the relationship between partners' characteristics and the threat of gender-based violence (GBV) among adult females in Ibadan.

There is a significant association between a partner's age and the threat of GBV (p<0.001). The threat of GBV is higher among women whose partners are aged 30-39 years (52.8%), 40-49 years (52.3%), and 50 years and above (51.7%), compared to those with younger partners aged 20-29 years (36.6%). Women whose partners are currently employed are less likely to be at threat (40.8%) compared to those whose partners are not currently employed (60.7%). Interestingly, partners not employed in the last 12 months are associated with a lower threat (37.6%) of GBV (p<0.001). Women whose partners have no formal education are less likely to be at threat of GBV (14.5%) compared to those whose partners have primary (53.4%), secondary (56.6%), or tertiary education (45.6%) (p<0.001).

The consumption of alcohol, smoking, and taking hard drugs by the partner are all significantly associated with a higher threat of GBV (all p-values < 0.001). Women whose partners consume alcohol (68.6%), smoke (67.3%), or take hard drugs (74.1%) face a significantly higher threat of GBV compared to those whose partners do not engage in these behaviors.

Table 4.1.7: Logistic Regression model on partners' characteristics and GBV threat among Adult females in Ibadan

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
20-29	0.823	0.190	0.614	1.102
30-39	1.230	0.117	0.949	1.594
40-49	1.180	0.207	0.912	1.528
≥50 (Reference Category)	1.000			
Employment Status				
Currently employed				
Not currently employed	0.516	0.001	0.347	0.768

Not employed in the last 12 months (RC)	1.661 1.000	0.012	1.119	2.464
Education level				
No formal education	0.182	<0.001	0.116	0.285
Primary	0.845	0.352	0.593	1.205
Secondary	1.119	0.280	0.913	1.371
Tertiary (RC)	1.000			
Consumes alcohol				
Yes	0.205	<0.001	0.105	0.400
No	0.401	<0.001	0.316	0.509
Don't know	1.000			
Smokes				
Yes	0.753	0.429	0.373	1.520
No	0.887	0.569	0.588	1.339
Don't know	1.000			
Takes hard drugs				
Yes	0.766	0.631	0.258	2.272
No	0.517	0.196	0.190	1.404
Don't know	1.000			
Knows partners' earning				
No				
Yes	0.723 1.000	0.004	0.580	0.901

The logistic regression model in Table 4.1.7 describes the relationship between partners' characteristics and the threat of gender-based violence (GBV) among adult females in Ibadan.

Partners who are currently employed have significantly lower odds of being associated with GBV threat (OR = 0.516, p = 0.001) compared to those who were not employed in the last 12 months (reference category) while partners who are currently not employed have significantly higher odds (OR = 1.661, p = 0.012). Partners with no formal education have significantly lower odds of being associated with GBV threat (OR = 0.182, p < 0.001) compared to those with tertiary education (reference category).

Moreso, partners who consume alcohol have lower odds (OR = 0.205, p < 0.001) of being associated with GBV threat compared to those who do not know their partner's alcohol consumption status (reference category). Women who do not know their partner's earnings have significantly lower odds of being at threat of GBV (OR = 0.723, p = 0.004) compared to those who do know.

Objective 2: Prevalence, Pattern and Determinants of GBV Among Pregnant Women in the city of Ibadan

Table 4.2.1: Sociodemographic Characteristics of Pregnant Women in Ibadan
N=2027

Variables	Frequency (n)	Percentage (%)
Age (Years)		
20-29	1041	51.4
30-39	878	43.3
40-49	102	5.0
≥50	6	0.3
Mean (SD)	29.8 (5.8)	
Education level		
No formal education	70	3.5
Primary	221	10.9
Secondary	1227	60.5
First degree	386	19.0
PGD	123	6.1
Employment Status		
Currently Employed	949	46.8
Not currently employed	975	48.1
Not employed in last 12 months	103	5.1
Occupation		
Professional/Management	156	7.7
Cleric	114	5.6
Sales/services	666	32.9
Skilled	733	36.2
Unskilled	73	3.6
Agriculture/Farmer	33	1.6
Apprentice	148	7.3
Student	53	2.6
House-wife	51	2.5
Marital Status		

Never married	62	3.1
Married	1838	90.7
Living together	107	5.3
Divorced	3	0.1
Separated	17	0.8
Residence		
Rural	614	30.3
Urban	1413	69.7
Number of children		
None	315	15.5
1-2	1184	58.4
3-4	469	23.1
5-8	59	2.9
Years of Marriage		
≤5 years	1248	61.6
6 -10 years	531	26.2
>10 years	248	12.2

The table (4.2.1) describes sociodemographic characteristics of pregnant women in Ibadan totaling 2027. More than half of the pregnant women (51.4%) are between 20-29 years old; with a mean age of 29.8 years and a standard deviation of 5.8 years. Others are in the 30-39 age group (43.3%) and small minority are 40 years and above. Most of the women have attained at least a secondary level of education (60.5%), with a considerable percentage having a first degree (19.0%). Only a small proportion has no formal education (3.5%) or has pursued postgraduate studies (6.1%).

Employment status shows a nearly even split between those currently employed (46.8%) and those not currently employed (48.1%), with a small percentage (5.1%) having been unemployed in the last 12 months. The largest group was involved in skilled labor (36.2%) and sales/services (32.9%). A smaller percentage work in professional/management roles (7.7%) or are engaged in unskilled labor (3.6%).

On marital status, majority of the pregnant women are married (90.7%), with a small proportion living together with a partner (5.3%) or never married (3.1%). A substantial majority reside in urban areas (69.7%) and most women have 1-2 children (58.4%), while a smaller percentage have three or more children. A large proportion of the women have been married for five years or less (61.6%), with a smaller group married for more than ten years (12.2%).

Table 4.2.2: Sociodemographic Characteristics of Partner/Spouses of Pregnant Women in Ibadan N = 2027

Variables	Frequency (n)	Percentage (%)
Age (years)		
20-29	405	20.0
30-39	1071	52.8
40-49	488	24.1
≥50	63	3.1
Mean (SD)	35.1 (7.9)	
Education level		
No formal education	54	2.7
Primary	112	5.5
Secondary	1145	56.5
First degree	531	26.2
PGD	185	9.1
Employment Status		
Currently Employed	1178	58.1
Not currently employed	801	39.5
Not employed in last 12 months	48	2.4
Occupation		
Professional	310	15.3
Cleric	185	9.1
Sales/services	478	23.6
Skilled	664	32.8
Unskilled	204	10.1
Agriculture/Farmer	103	5.1
Apprentice	60	3.0
Student	23	1.1
Knows how much partner earns		
Yes		
No	681	33.6
	1346	66.4
Smokes		
Yes	134	6.6

No	1797	88.7
Don't Know	96	4.7
Takes hard drugs		
Yes	29	1.4
No	1879	92.7
Don't Know	119	5.9
Consumes Alcohol		
Yes	532	26.2
No	1416	69.9
Don't Know	79	3.9

Table 4.2.2 describes the characteristics of the partners/spouses of pregnant women in Ibadan. The age distribution shows that the majority of the partners are in their 30s, with 52.8% aged 30-39 years and a mean age of 35.1 years, indicating that most of these partners are in their mid-adulthood. A smaller percentage are younger (20.0%), aged 20-29 years or older (3.1%) aged 50 years and above. Majority have completed at least secondary education (56.5%) and a substantial proportion holding a first degree (26.2%) while smaller percentage have no formal education (2.7%) or have pursued postgraduate studies (9.1%).

On employment, majority of the partners are currently employed (58.1%), while 39.5% are not currently employed and a small percentage has not been employed in the last 12 months (2.4%). The occupational distribution is diverse, with the largest group working in skilled labor (32.8%) and sales/services (23.6%). A smaller proportion is engaged in professional roles (15.3%) or unskilled labor (10.1%).

Lifestyle factors indicate that approximately one-quarter of the partners consume alcohol (26.2%) while smoking is less prevalent, with only 6.6% reporting that their partners smoke; the use of hard drugs is rare among this group, with 92.7% not using hard drugs. Additionally, more than two-thirds (66.4%) of the women do not know how much their partners earn.

Table 4.2.3: Danger Assessment in Abusive Relationship among Pregnant Women living in Ibadan
N = 2027

Risk indicator	Frequency (n)	Percentage (%)
Partner ever threatened to harm or kill you	80	3.9
Partner ever used physical violence against you	223	11.0
Partner ever choked, strangled or suffocated you or attempted to do any of these things	70	3.5
Partner ever threatened or assaulted you with any weapon (including knives and/or other objects)	44	2.2
Partner ever harmed or killed a family pet or threatened to do so	32	1.6
Partner ever been charged with breaching an apprehended domestic violence order	29	1.4
Relationship between client and partner		
Violence or controlling behaviour from partner is becoming worse or more frequent	93	4.6
Partner stalked, constantly harassed or texted/ emailed you	197	9.7
Partner control access to money	274	13.5
There has been a recent separation (in the last 12 months) or one imminent	82	4.0
Background of partner		
Partner or the relationship have financial difficulties	348	17.2
Partner is unemployed	432	21.3
Partner has mental health problems (including undiagnosed conditions) and/or depression?	32	1.6
Partner have a problem with substance abuse such as alcohol or other drugs	77	3.8
Partner ever threatened or attempted suicide	30	1.5
Partner is currently on bail or parole, or has served a time of imprisonment or has recently been released from custody in relation to offences of violence	24	1.2
Partner have access to firearms or prohibited weapons	26	1.3
Information about Children's risk		
Household have children who are less than 12 months apart in age	1115	56.8
Partner ever threatened or used physical violence toward me at any time	201	9.9
Partner ever harmed or threatened to harm your children	57	2.8
There is conflict between me and partner regarding child contact or residency issues and/or current Family Court proceedings	32	1.6
There are children from a previous relationship present in the household	120	5.9

Sexual assault		
Partner has ever done things to me, of a sexual nature, that made me feel bad or physically hurt me	139	6.9
Partner has ever been arrested for sexual assault	43	2.1

Table 4.2.3 presents a danger assessment of abusive relationships among pregnant women living in Ibadan. A significant portion of women have experienced severe forms of abuse. Specifically, 11% of the women reported that their partners had used physical violence against them, while 3.9% had been threatened with harm or death. Additionally, 3.5% of the respondents reported incidents of choking, strangulation, or suffocation and 2.2% had faced threats or assaults involving weapons. Partner control finances of pregnant women as 13.5% of women indicate that their partner controls access to money. Furthermore, 9.7% reported being stalked, harassed, or constantly contacted by their partner through text, email, or other means.

Pregnant women indicated that 21.3% of the partners were unemployed and 17.2% faced financial difficulties. A smaller percentage of partners had mental health issues (1.6%) or problems with substance abuse (3.8%). A substantial majority (56.8%) of households has children less than 12 months apart in age, 9.9% of women reported that their partners had used physical violence against them and 2.8% stated that their partners had harmed or threatened to harm their children, 6.9% of women reporting that their partner had subjected them to sexual acts that made them feel bad or physically hurt them and 2.1% of partners had been arrested for sexual assault.

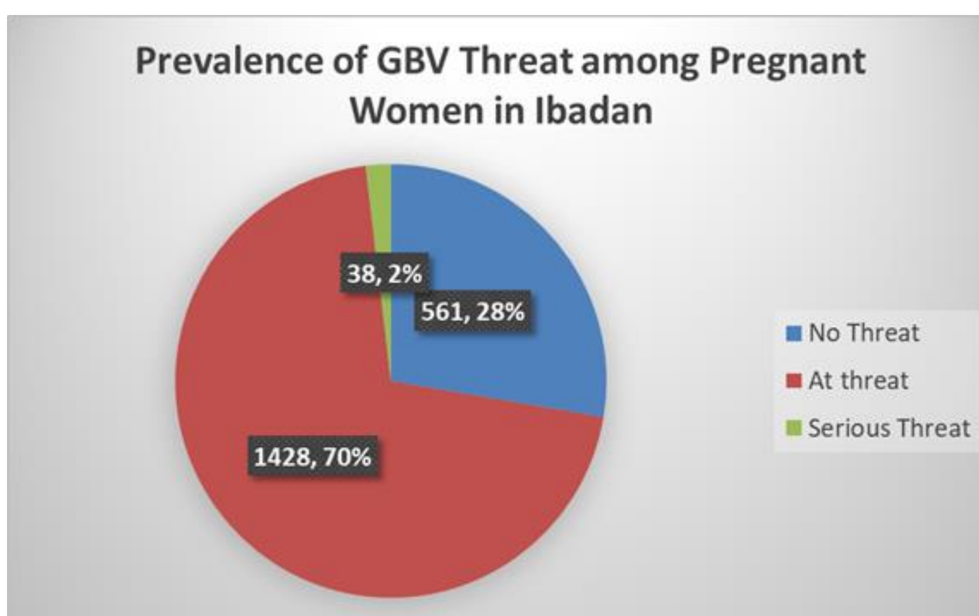

Figure 4.2: Pie chart describing the classification according to threat of GBV among Pregnant Women in Ibadan.

Prevalence of GBV threats as reported, shows that most (70%) of the pregnant women were at GBV threat, almost half (48%) are at threat of GBV while more than quarter (28.0%) have no threat of GBV. Two percent had serious threat of GBV (Fig. 4.2).

Table 4.2.4: Sociodemographic determinants of GBV threat among Pregnant Women

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Age grouped (Yrs)				
20 - 29				
30 – 39	318 (30.5)	723 (69.5)	13.698	0.003*
40 - 49	215 (24.5)	663 (75.5)		
≥50	24 (23.5)	78 (76.5)		
	4 (66.7)	2 (33.3)		
Employment status				
Currently employed				
Not currently employed	297 (31.3)	652 (68.7)	11.683	<0.001*
Not employed in last 12 months	239 (24.5)	736 (75.5)		
	25 (24.3)	78 (75.7)		
Residence				

Rural	166 (27.0)	448 (73.0)	0.181	0.671
Urban	395 (28.0)	1018 (72.0)		
Education level				
No formal education	16 (22.9)	54 (77.1)	5.326	0.149
Primary	53 (24.0)	168 (76.0)		
Secondary	334 (27.2)	893 (72.8)		
Tertiary	158 (31.0)	351 (69.0)		
Number of Children				
None	99 (31.4)	216 (68.6)	9.964	0.019*
1-2	339 (28.6)	845 (71.4)		
3-4	114 (24.3)	355 (75.7)		
5-8	9 (15.3)	50 (84.7)		
Years of Marriage				
1-5	375 (30.0)	873 (70.0)	10.267	0.006*
6-10	133 (25.0)	398 (75.0)		
>10	53 (21.4)	195 (78.6)		

Table 4.2.4 presents the sociodemographic determinants of GBV threat among pregnant women. Age significantly influences the threat of GBV among pregnant women as younger women aged 20-29 (69.5%) and 30-39 (75.5%) are more likely to report being at risk of experiencing GBV while women aged 50 and above appear to have a lower risk (33.3%) (p = 0.003).

Women who are not currently employed or have not been employed in the last 12 months are more likely to experience GBV (75.5%) compared to those who are currently employed (68.7%) (p<0.001).

The number of children a woman has is another significant factor in GBV threat. Women with no children (68.6%) or fewer children (1-2) (71.4%) are less likely to experience GBV compared to those with 5-8 children (84.7%) (p = 0.019).

The duration of marriage also shows a significant relationship with GBV threat. Women who have been married for more than 10 years are more likely to experience GBV (78.6%) compared to those married for 1-5 years (70.0%) (p = 0.006).

Table 4.2.5: Logistic Regression model on determinants of GBV threat among Pregnant Women

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
20-29	5.895	0.051	0.995	34.936
30-39	7.476	0.026	1.279	43.720
40-49	6.199	0.046	1.032	37.241
≥50 (Reference Category)	1.000			
Employment Status				
Currently employed	0.683	0.120	0.422	1.105
Not currently employed	0.933	0.778	0.575	1.513
Not employed in the last 12 months (RC)	1.000			
Education level				
No formal education	1.346	0.335	0.736	2.462
Primary	1.286	0.192	0.881	1.875
Secondary	1.132	0.307	0.893	1.435
Tertiary (RC)	1.000			
Residence				
Rural	1.012	0.911	0.815	1.257
Urban (RC)	1.000			
Number of Children				
None	0.512	0.125	0.218	1.205
1-2	0.552	0.153	0.244	1.248
3-4	0.581	0.181	0.262	1.287
5-8 (RC)	1.000			
Years Married				
1-5	0.790	0.290	0.510	1.223
6-10	0.873	0.523	0.576	1.324
>10	1.000			

The logistic regression analysis in Table 4.2.5 describes the determinants of GBV threat among pregnant women. Age shows a significant association with the risk of GBV during pregnancy. Women aged 30-39 have an OR of 7.476 (p = 0.026), indicating that they are approximately 7.5 times more likely to be at risk of GBV. Similarly, women aged 40-49 have an OR of 6.199 (p = 0.046), suggesting a higher risk relative to the reference group (≥50 years).

Other factors, such as employment status, education level, residence, number of children, and years of marriage, do not show statistically significant associations with GBV risk.

Table 4.2.6: Partner's characteristics and GBV threat among Partners of Pregnant Women in Ibadan

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Partner's Age (Yrs)				
20 - 29	127 (31.4)	278 (68.6)	14.897	0.002*
30 – 39	308 (28.8)	763 (71.2)		
40 – 49	104 (21.3)	384 (78.7)		
≥50	22 (34.9)	41 (65.1)		
Partner's Employment Status				
Currently employed	350 (29.7)	828 (70.3)	6.765	0.034*
Not currently employed	202 (25.2)	599 (74.8)		
Not employed in last 12 months	9 (18.8)	39 (81.2)		
Partner's education level				
No formal education	15 (27.8)	39 (72.2)	3.782	0.286
Primary	25 (22.3)	87 (77.7)		
Secondary	307 (26.8)	838 (73.2)		
Tertiary	214 (29.9)	502 (70.1)		
Partner consumes alcohol				
Yes	172 (31.4)	376 (68.6)	128.783	<0.001*
No	940 (55.6)	752 (44.4)		
I don't know	109 (73.6)	39 (26.4)		
Partner smokes				
Yes	26 (19.4)	108 (80.6)	11.382	<0.001*
No	497 (27.7)	1300 (72.3)		
I don't know	38 (39.6)	58 (60.4)		
Partner takes hard drug				
Yes	8 (27.6)	21 (72.4)	1.145	0.565
No	515 (27.4)	1364 (72.6)		
I don't know	38 (31.9)	81 (68.1)		
Know partners' earning				
No	373 (27.7)	973 (72.3)	0.003	0.960
Yes	188 (27.6)	493 (72.4)		

Table 4.2.6 describes the relationship between various partner characteristics and the threat of GBV among pregnant women in Ibadan. There is a significant association between the partner's age and the threat of GBV (p = 0.002) indicating that younger partners, particularly those aged 20-29 (68.6%), are associated with a lower threat of GBV compared to older age groups. There is a significant relationship between the partner's employment status and the threat of GBV (p = 0.034). Partners who are not currently employed or were not employed in the last 12 months are more likely to be associated with GBV threat (81.2%).

There is an association between the consumption of alcohol by the partner and the threat of GBV (p < 0.001). Partners who consume alcohol are more likely to be associated with a higher threat of GBV (68.6%) compared to those who do not (44.4%). Smoking is also significantly associated with the threat of GBV (p < 0.001). Partners who smoke (80.6%) are more likely to be linked with GBV threat compared to non-smokers (72.3%).

Table 4.2.7: Logistic Regression model on Partner's characteristics and GBV threat

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
20-29	1.176	0.586	0.657	2.103
30-39	1.431	0.208	0.819	2.499
40-49	2.064	0.015	1.152	3.698
≥50 (Reference Category)	1.000			
Employment Status				
Currently employed				
Not currently employed	0.504	0.078	0.235	1.079
Not employed in the last 12 months (RC)	0.634	0.244	0.295	1.364
	1.000			
Education level				
No formal education	1.057	0.869	0.547	2.042
Primary	1.259	0.376	0.755	2.100
Secondary	1.031	0.797	0.817	1.302
Tertiary (RC)	1.000			
Consumes alcohol				
Don't know	0.140	<0.001	0.066	0.296
Yes	0.246	<0.001	0.179	0.340
No (RC)	1.000			
Smokes				
Don't know	1.036	0.940	0.416	2.583
Yes	1.442	0.182	0.842	2.469
No (RC)	1.000			
Takes hard drugs				
Don't know	2.295	0.135	0.773	6.813
Yes	1.836	0.194	0.735	4.585
No (RC)	1.000			
Knows partners' earning				
No				
Yes (RC)	0.953	0.685	0.755	1.203
	1.000			

The logistic regression analysis in Table 4.2.7 examines the influence of partner characteristics on the threat of GBV among pregnant women. On partner's age, the odds ratios indicate a significant association between the partner's age and the threat of GBV. Partners aged 40-49 have higher odds ratio of 2.064 (p = 0.015), suggesting they are more likely to be associated with GBV compared to those aged 50 and above, who serve as the reference category. Partners aged 30-39 also show a higher but less pronounced association (OR = 1.431, p = 0.208).

Similarly, on alcohol consumption, partners who consume alcohol have a significantly higher odds ratio of 0.246 (p < 0.001), indicating a substantial association with GBV threat compared to those whose alcohol consumption status is unknown.

Objective 3: Prevalence, Pattern and Determinants of GBV Among Adolescents in the city of Ibadan

Table 4.3.1: Sociodemographic Characteristics of Adolescents in Ibadan

N=4452

Variables	Frequency (n)	Percentage (%)
Age		
Minimum	10	
Maximum	19	
Mean (SD)	15.1 (1.8)	
Education level		
No formal education	234	5.3
Primary	929	20.9
Secondary	3253	73.1
First degree	16	0.4
PGD	20	0.4
Employment Status		
Currently Employed	268	6.0
Not currently employed	2475	55.6
Not employed in last 12 months	1709	38.4
Occupation		
Professional	7	0.2
Cleric	6	0.1
Sales/services	77	1.7
Skilled	89	2.0
Unskilled	104	2.3

Agriculture/Farmer	14	0.3
Apprentice	1184	26.6
Student	2899	65.1
Housewife	72	1.6
Marital Status		
Never married	4312	96.9
Married	77	1.7
Living together	56	1.3
Divorced	1	0.0
Separated	6	0.1
Residence		
Rural	1357	30.5
Urban	3095	69.5
Number of children		
None	4342	97.5
1	94	2.1
2	16	0.4
Gender		
Male	1861	41.8
Female	2591	58.2

Table 4.3.1 describes the socio-demographic characteristics of adolescents in Ibadan. The sample consisted of 4,452 adolescents with a mean age of 15.1 years, ranging from 10 to 19 years. Participants' highest education level was mainly completion of secondary education (73.1%) while about one-fifth (20.9%) had attained only primary education and others had reached the level of first degree or postgraduate studies, both constituting just 0.4% each, with 5.3% of the adolescents had no formal education.

In terms of employment, more than half of the adolescents were not currently employed (55.6%) while 38.4% had not been employed in the last 12 months and only a small fraction (6.0%) were currently employed. In relation to the employment status, occupational distribution shows a majority of the adolescents identified as students (65.1%). A smaller percentage was involved in apprenticeships (26.6%) and even fewer worked in unskilled (2.3%) and skilled (2.0%) jobs or other occupations such as sales/services (1.7%) and agriculture/farming (0.3%). A minimal number reported being professionals (0.2%) or clerics (0.1%).

The adolescents had mostly never been married (96.9%), with only 1.7% being married and 1.3% living together with a partner. Instances of divorce and separation were extremely rare, accounting for less than 0.2% of the sample. Additionally, the majority of the adolescents resided in urban areas (69.5%), while 30.5% lived in rural areas.

Regarding the number of children, almost all adolescents had no children (97.5%), with only 2.1% having one child and a negligible 0.4% having two children. Gender distribution in the sample showed a slight predominance of females (58.2%) over males (41.8%).

Table 4.3.2: Sociodemographic Characteristics of Adolescents' Partner/Spouses
N = 327

Variables	Frequency (n)	Percentage (%)
Age (years)		
Minimum	14	
Maximum	55	
Mean (SD)	17.1 (10.1)	
Education level		
No formal education	19	5.8
Primary	19	5.8
Secondary	245	74.9
First degree	11	3.4
PGD	11	3.4
Not Available	22	6.7
Employment Status		
Currently Employed	95	29.1
Not currently employed	166	50.8
Not employed in last 12 months	29	8.9
Not Applicable	37	11.3
Occupation		
Professional	2	0.6
Sales/services	55	16.8
Skilled	72	22.0
Unskilled	30	9.2
Agriculture/Farmer	8	2.4
Apprentice	57	17.4
Student	60	18.3
Housewife	10	3.1

Not Applicable	32	10.1
Knows how much partner earns		
Yes		
No	25	7.6
Not Applicable	260	79.5
	42	12.9
Smokes		
Yes	25	7.6
No	41	12.5
Don't Know	261	79.9
Takes hard drugs		
Yes	33	10.1
No	12	3.7
Don't Know	282	80.2
Consumes Alcohol		
Yes	18	5.5
No	103	31.5
Don't Know	206	63.0

The table (4.3.2) described characteristics of the partners or spouses of the adolescent participants, totaling 327 individuals. The ages of these partners ranged from 14 to 55 years, with a mean age of 17.1 year. In terms of educational attainment, partners had completed secondary education (74.9%), while a smaller number had only primary education (5.8) or no formal education at all (5.8%). A minority had pursued higher education, with 3.4% holding a first degree or postgraduate diploma and 6.7% had unreported educational backgrounds.

Employment status varied among the partners, with slightly over half (50.8%) not currently employed. Around 29.1% were currently employed, while 8.9% had not been employed in the last 12 months and 11.3% fell into the "not applicable" category. The occupational distribution among the partners revealed that the largest group was engaged in skilled labor (22.0%), followed by those in sales or services (16.8%) and apprenticeships (17.4%). Other notable occupations included students (18.3%), unskilled workers (9.2%), and a small percentage of professionals (0.6%). Additionally, some partners were identified as housewives (3.1%), and a segment (10.1%) had occupations that were not applicable.

The study also looked at the partners' financial transparency and substance use. A majority of the adolescent participants (79.5%) reported that they did not know how much their partners earned, with only 7.6% being aware of their partner's income. Substance use among the partners was reported as 7.6% were smokers and 10.1% as users of hard drugs. However, the vast majority of the participants (79.9% and 80.2%, respectively) were either unaware of or did not acknowledge their partner's smoking or drug use habits. Alcohol consumption was noted among 31.5% of the partners, while a significant number of participants (63.0%) did not know if their partner consumed alcohol.

Table 4.3.3: Pattern of GBV among Adolescents

Variables (13)	Frequency (n)	Percentage (%)
Number of times slapped and/or pushed without injuries/lasting pain		
0		
1	2	15.4
2	7	53.8
3	1	7.7
8	2	15.4
	1	7.7
Number of times punched/kicked/bruised/cut you with continued pain		
0		
1	9	69.2
2	2	15.4
4	1	7.7
	1	7.7
Number of times ex/partner beat you up with severe confusions, burns etc		
0		
1	11	84.6
5	1	7.7
	1	7.7
Number of times ex/partner threatened to use weapon causing injury		
0	10	76.9
2	3	23.1
Number of times weapon was used causing wounds		
0	10	76.9
1	1	7.7
2	2	15.4

The table described the pattern of Gender-Based Violence (GBV) among adolescents, focusing on the type, frequency and severity of the various forms of abuse experienced by the participants within the past year(Table 4.3.3). Regarding incidents where participants were slapped or pushed without sustaining injuries or lasting pain, a majority (53.8%) reported experiencing this type of abuse at least once, while 15.4% experienced it three times, and another 7.7% reported experiencing it eight times within the past year.

Similarly, when examining more severe physical violence, such as being punched, kicked, bruised, or cut with continued pain, 69.2% of the participants reported never experiencing this, while 15.4% experienced it once, and smaller percentages reported experiencing this twice or four times.

When it came to more severe forms of violence, such as being beaten up with severe contusions, burns, or other serious injuries, 84.6% of the participants reported that they had never experienced this. However, 7.7% experienced this type of violence once, and another 7.7% experienced it five times under the review year. Additionally, 23.1% of the participants reported that their ex-partner or current partner had threatened to use a weapon against them, causing injury, while 76.9% did not experience such threats.

Finally, regarding the actual use of a weapon that caused wounds, 15.4% reported this occurrence twice, and 7.7% reported it happening once, with the majority (76.9%) not having experienced this form of violence.

Table 4.3.4: Danger Assessment in Abusive Relationship among Adolescents
N = 327

Statements	Freq (%)	Score
1. Partner is constantly jealous and/or possessive of you	118 (36.1)	4
2. Partner tries to isolate you socially	63 (19.3)	3
3. Physical violence increased in severity or frequency over the past year	36 (11.0)	2
4. Partner threatened you with a gun over the past year	13 (4.0)	2
5. Have lived with partner in the past year	77 (23.5)	2
6. Partner had ever threatened to abuse a previous intimate partner/family/friends	30 (9.2)	2
7. Partner uses illegal drugs	17 (5.2)	1
8. Partner is an alcoholic or problem drinker	42 (12.8)	1
9. Partner tries to control/limit my spirituality	43 (13.1)	1
10. Partner constantly blames you or put you down	37 (11.3)	1
11. Partner destroyed/threatened to destroy something that belongs to me	28 (8.6)	1
12. Partner has threatened to harm		
➢ Pet	99 (30.3)	1
➢ Elderly family member	28 (8.6)	1
➢ Person I care for with a disability	5 (1.5)	1
13. Partner has ever violated a restraining order	28 (8.6)	1
14. Partner stalks you (follow/spy/drops threatening message etc)	39 (11.9)	1
15. If abused by partner, and calls for help, people will not take me seriously	42 (12.8)	1
16. Fear of reinforcing negative stereotypes about sexual relationships and/or being discriminated against will prevent me from seeking help if being abused by partner	24 (7.3)	1
17. Will keep serious difficulty with partner a secret out of fear or shame	37 (11.3)	1
18. I have threatened or tried to kill myself	12 (3.7)	--
TOTAL OBTAINABLE SCORE	**28**	

The assessment of danger in abusive relationships among adolescents, as shown in table 4.3.4 reveals a substantial 36.1% reported that their partner was constantly jealous or possessive which carries the highest score of 4 on the danger scale. Additionally, 19.3% of the adolescents indicated that their partners tried to isolate them socially, which scored a 3.

Physical violence was reported to have increased in severity or frequency over the past year by 11% of the respondents, which, although lower in frequency, still represents a critical danger signal with a score of 2. The threat of violence involving a weapon was reported by 4.0% of the participants, specifically involving a gun, which also scored a 2. The experience of living with the partner within the past year, reported by 23.5%, was also associated with a higher risk score of 2.

Other concerning behaviors include the partner's history of threatening previous intimate partners, friends, or family members, reported by 9.2%, and the partner's substance abuse issues, such as illegal drug use (5.2%) and alcoholism (12.8%). Furthermore, 30.3% of adolescents reported that their partner had threatened to harm a pet, elderly family member, or a person they care for with a disability.

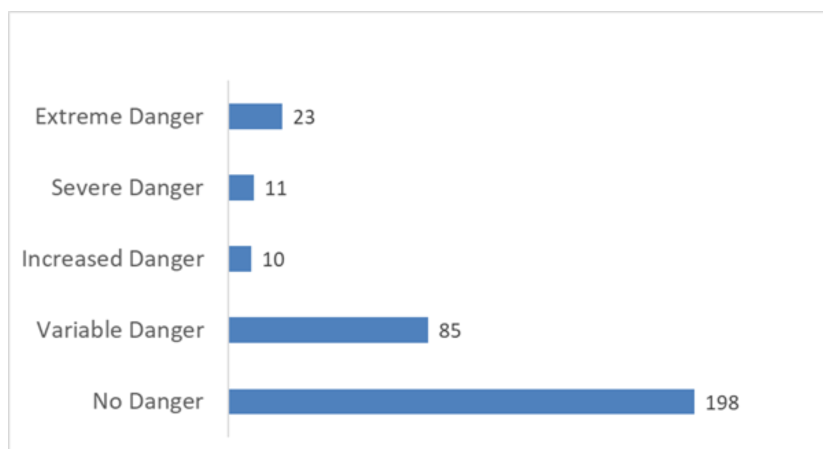

Figure 4.3: Bar chart showing the classification of GBV danger among Adolescents in Ibadan

Of the 327 adolescents who reported to have a partner/spouse or be in a relationship, 198 (60.6%) were assessed to have no danger of GBV while 85 (25.9%) were assessed with variable danger, 10 (3%) with increased danger, 11 (3.3%) with severe danger and 23 (7%) were assessed to be at extreme danger of GBV (Fig 4.3).

Table 4.3.5: Sociodemographic characteristics and GBV risks among Adolescents in Ibadan

Variables	Danger of GBV		CHI²	P-VALUE
	NO	YES		
Age (Yrs)				
10 – 14	13 (40.6)	19 (59.4)	5.896	0.021*
15 – 19	185 (62.7)	110 (37.3)		
Employment Status				
Currently employed	40 (71.4)	16 (28.6)	11.996	0.002*
Not currently employed	110 (53.4)	96 (46.6)		
Not employed in last 12 months	48 (73.8)	17 (26.2)		
Education level				
No formal education	13 (50.0)	13 (50.0)	4.189	0.247
Primary	24 (55.8)	19 (44.2)		
Secondary	159 (63.1)	93 (36.9)		
Tertiary	2 (33.3)	4 (66.7)		
Gender				
Male	46 (55.4)	37 (44.6)	1.225	0.268
Female	152 (62.3)	92 (37.7)		
Residence				
Rural	87 (58.8)	61 (41.2)	0.353	0.552
Urban	111 (62.0)	68 (38.0)		

The analysis of sociodemographic characteristics and their association with the risk of gender-based violence (GBV) among adolescents in Ibadan (Table 4.3.5) revealed that age and employment status influence risk of GBV among the study population.

The study indicated that age was significantly associated with the risk of GBV. Specifically, adolescents aged 10-14 years were more likely to be at risk, with 59.4% of this age group experiencing GBV, compared to 37.3% in the 15-19 age group (p= 0.021).

Employment status also showed a significant association with GBV risk. Adolescents who were not currently employed had a higher risk of GBV, with 46.6% reporting such experiences, compared to 28.6% of those currently employed and 26.2% of those not employed in the last 12 months (p=0.002).

In contrast, educational level, gender and residence did not show significant associations with GBV risk. Although there were differences in the percentages of adolescents experiencing GBV across various education levels, these differences were not statistically significant (p = 0.247). Similarly, gender did not significantly impact the risk of GBV, with both males and females reporting similar experiences (p = 0.268). Residence, whether rural or urban, did not significantly affect GBV risk among adolescents in the study. The

findings indicated that 58.8% of rural adolescents and 62.0% of urban adolescents reported GBV risk, with no significant difference between the two groups (p = 0.552).

Table 4.2.6: Logistic Regression model on sociodemographic determinants of GBV risks among Adolescents

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
10 - 14	2.430	0.026*	1.114	5.298
15 - 19 (Reference Category)	1.000			
Employment Status				
Currently employed	1.341	0.488	0.585	3.075
Not currently employed	2.825	0.002*	1.467	5.442
Not employed in the last 12 months (RC)	1.000			
Education level				
No formal education	0.721	0.743	0.101	5.117
Primary	0.397	0.337	0.060	2.619
Secondary	0.275	0.159	0.045	1.659
Tertiary (RC)	1.000			
Residence				
Rural	1.059	0.813	0.659	1.701
Urban	1.000			
Gender				
Male	1.249	0.410	0.735	2.123
Female	1.000			

The logistic regression analysis on the sociodemographic determinants of gender-based violence (GBV) risks among adolescents identified age and employment status as factors influencing the likelihood of experiencing GBV (Table 4.3.6). Age was a significant determinant, with adolescents aged 10-14 years being 2.43 times more likely to be at risk of GBV compared to their older counterparts aged 15-19 years, as indicated by an odds ratio (OR) of 2.430 and a p-value of 0.026.

Similarly, adolescents who were not currently employed were 2.825 times more likely to experience GBV compared to those who had not been employed in the last 12 months, with a statistically significant p-value of 0.002.

Table 4.3.7: Partners' characteristics and GBV risk among Adolescents in Ibadan

Variables	Danger of GBV		CHI^2	P-VALUE
	NO	YES		
Age (Yrs)				
10 – 14	193 (61.7)	120 (38.3)	3.777	0.090
15 – 19	5 (35.7)	9 (64.3)		
Employment Status				
Currently employed	64 (67.4)	31 (32.6)	3.940	0.135
Not currently employed	92 (55.4)	74 (44.6)		
Not employed in last 12 months	42 (63.6)	24 (36.4)		
Education level				
No formal education	23 (56.1)	18 (43.9)	8.628	0.033*
Primary	6 (31,6)	13 (68.4)		
Secondary	157 (64.1)	88 (35.9)		
Tertiary	12 (54.5)	10 (45.5)		
Know Partners' earning				
No	179 (59.3)	123 (40.7)	2.705	0.135
Yes	19 (76.0)	6 (24.0)		
Takes alcohol				
Yes	12 (66.7)	6 (33.3)	8.563	0.014*
No	99 (68.8)	45 (31.2)		
I don't know	87 (52.7)	78 (47.3)		
Smokes				
Yes	16 (64.0)	9 (36.0)	3.893	0.143

	58 (69.0)	26 (31.0)		
No	124 (56.9)	94 (43.1)		
I don't know				
Hard drugs				
Yes	22 (66.7)	11 (33.3)	6.229	0.044*
	42 (73.7)	15 (26.3)		
No	134 (56.5)	103 (43.5)		
I don't know				

The table (4.3.7) describes the analysis of partners' characteristics and their association with the risk of GBV among adolescents in Ibadan, showing that education level, alcohol consumption and use of hard drugs among the partners' influenced GBV risks.

Educational level of the partner significantly impacts the risk of GBV. Adolescents whose partners had only primary education exhibited a higher risk of GBV, with 68.4% of such cases reporting GBV compared to 31.6% who did not (p = 0.033). This suggests that lower educational attainment among partners may be associated with a heightened risk of GBV.

Similarly, the partner's consumption of alcohol was significantly associated with GBV risk. Adolescents who were unsure if their partner consumed alcohol were more likely to report GBV (47.3%) compared to those who knew their partner did not consume alcohol (31.2%) or those who knew their partner did (33.3%). (p=0.014).

The use of hard drugs by the partners also showed a significant relationship with GBV risk. Adolescents whose partners used hard drugs reported a higher incidence of GBV (33.3%) compared to those whose partners did not (26.3%) or those who were unsure (43.5%) (p-0.044).

Table 4.3.8: Logistic Regression model on partners' characteristic determinants of GBV risks among Adolescents

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
10 – 14	0.389	0.115	0.120	1.259
15 - 19 (Reference Category)	1.000			
Employment Status				
Currently employed	0.934	0.866	0.424	2.057
Not currently employed	1.300	0.472	0.636	2.659
Not employed in the last 12 months (RC)	1.000			
Education level				
No formal education	1.596	0.454	0.469	5.436
Primary	2.192	0.249	0.577	8.335
Secondary	0.725	0.502	0.284	1.853
Tertiary (RC)	1.000			
Knows partners' earnings				
Yes	2.068	0.159	0.753	5.681
No	1.000			
Takes alcohol				
I don't know	1.581	0.144	0.855	2.921
Yes	1.029	0.964	0.305	3.466
No	1.000			
Smokes				
I don't know	0.716	0.490	0.277	1.849
Yes	1.155	0.814	0.349	3.821
No	1.000			
Hard drugs				
I don't know	2.614	0.079	0.896	7.623
Yes	1.511	0.501	0.454	5.027
No	1.000			

Table 4.3.8 describes the logistic regression analysis on partners' characteristics and their association with the risk of GBV among adolescents. Though the associations were not statistically significant. age of the adolescent, categorized as 10-14 years versus 15-19 years, did not show a significant effect on GBV risk, with an odds ratio (OR) of 0.389 and a p-value of 0.115. Employment status of the partner also did not emerge as a significant predictor of GBV risk. Partners who were not currently employed had an OR of 1.300 compared to those who were employed, with a p-value of 0.472.

Additionally, partner's characteristics like educational level, knowing the partner's earnings, substance use and use of hard drugs did not reach statistical significance.

Objective 4: Prevalence, Pattern and Determinants of GBV Among Adult Male in the city of Ibadan

Table 4.4.1: Sociodemographic Characteristics of Adult Male

N=3688

Variables	Frequency (n)	Percentage (%)
Age (Years)		
20-29	1019	27.6
30-39	1211	32.8
40-49	924	25.1
≥50	534	14.5
Mean (SD)	37.6 (11.6)	
Education level		
No formal education	215	5.8
Primary	375	10.2
Secondary	2028	55.0
First degree	831	22.5
PGD	239	6.5
Employment Status		
Currently Employed	1771	48.0
Not currently employed	1713	46.4
Not employed in last 12 months	204	5.5
Occupation		
Professional/Management	479	13.0
Cleric	272	7.4
Sales/services	853	23.1
Skilled	1087	29.5
Unskilled	259	7.0
Agriculture/Farmer	222	6.0
Apprentice	245	6.6
Student	150	4.1
Housewife	121	3.3
Marital Status		
Never married	620	16.8
Married	2710	73.5
Living together	193	5.2
Divorced	54	1.5
Separated	67	1.8
Widowed	44	1.2
Residence		
Rural	1050	28.5
Urban	2638	71.5
Number of children		
None	638	17.3
1-2	1270	34.4
3-4	1241	33.6
5-8	458	12.4
>8	81	2.2
Years of Marriage		
≤5 years	1138	37.1
6 -10 years	816	26.6
>10 years	1114	36.3

Table 4.4.1 described the sociodemographic characteristics of adult male in Ibadan. The study population is predominantly middle-aged, with the average age being 37.6 years. Most respondents are in the 30-39 age group (32.8%), followed by those aged 20-29 (27.6%) and 40-49 (25.1%). A smaller proportion of the population is aged 50 and above (14.5%). In terms of education, the majority of respondents have attained at least a secondary education, with more than half of them holding this qualification (55%). A substantial portion also holds a first degree (22.5%), while a smaller group has obtained a postgraduate degree (6.5%) with another minority who has no formal education (5.8%) or only primary education (10.2%).

Employment status varies among the respondents, with nearly half currently employed (48%) and a closer number not currently employed (46.4%). A smaller group reported not having been employed in the last 12 months (5.5%). Regarding occupation, the most common jobs are in skilled labor (29.5%) and sales/services (23.15), with fewer individuals in professional or management roles (13%). Also, smaller proportion of the adult male works in clerical positions (7.4%), unskilled jobs (7%), agriculture (6%), or are engaged in apprenticeships (6.6%). The population also includes a few students (4.1%) and housewives (3.3%).

Most respondents are married (73.5%), with a large majority reporting being in this status. A smaller proportion has never married (16.8%) and even fewer are living together (5.2%), divorced (1.5%), separated (1.8%) or widowed (1.2%). The distribution of residence shows that the majority live in urban areas (71.5%)

with a smaller group residing in rural locations (28.5%). In terms of family size, most respondents have between one to four children, with the largest group having 1-2 children (34.4%). A notable portion has no children (17.3%), while only a small percentage has more than four children (16.6%). Among those who are married, majority has been married for five years or less (37.1%), with the some having longer marriages of more than 10 years (36.3%).

Table 4.4.2: Sociodemographic Characteristics of Partner/Spouses of Adult males
N = 3068

Variables	Frequency (n)	Percentage (%)
Age (years)		
20-29	1203	39.2
30-39	1146	37.4
40-49	498	16.2
≥50	221	7.2
Mean (SD)	33.2 (10.6)	
Education level		
No formal education	173	5.6
Primary	373	12.2
Secondary	1857	60.5
First degree	489	15.9
PGD	176	5.7
Employment Status		
Currently Employed	1374	44.8
Not currently employed	1523	49.6
Not employed in last 12 months	171	5.6
Occupation		
Professional	247	8.1
Cleric	169	5.5
Sales/services	1124	36.6
Skilled	891	29.0
Unskilled	277	9.0
Agriculture/Farmer	106	3.5
Apprentice	192	6.3
Student	62	2.0
Knows how much partner earns		
Yes	25	7.6
No	260	79.5
Not Applicable	42	12.9
Smokes		
Yes	51	1.7
No	2885	94.0
Don't Know	132	4.3
Takes hard drugs		
Yes	16	0.5
No	2914	95.0
Don't Know	138	4.5
Consumes Alcohol		
Yes	276	9.0
No	2673	87.1
Don't Know	119	3.9

Table 4.4.2 described the sociodemographic characteristics of the partners or partners of adult males which present a predominantly younger population. The mean age of the partners is 33.2 years with a standard deviation of 10.6 years. The largest group of partners falls within the 20-29 age range, comprising 39.2% of the population and those aged 30-39 (37.4%), while a smaller percentage is aged 40-49 (16.2%) and an even smaller group is 50 years or older (7.2%).

On education, a significant majority of the partners have attained secondary education, accounting for 60.5% of the population. A smaller but notable proportion has achieved a first degree (15.9%), while those with no formal education or only primary education make up 5.6% and 12.2%, respectively. Additionally, 5.7% have pursued postgraduate education. Employment status among the partners is relatively balanced, with 44.8% currently employed, while 49.6% are not currently employed. A small percentage (5.6%) has not been employed in the last 12 months. In terms of occupation, the majority are engaged in sales/services (36.6%) or skilled labor (29.0%). Smaller percentages work in professional roles (8.1%), unskilled jobs (9%), clerical positions (5.5%), or agriculture (3.5%), with a few involved in apprenticeships (6.3%) or still studying (2%).

On awareness of their partners' income, smoking habits, drug use, and alcohol consumption. Approximately four-of-five (79.5%) of the partners do not know how much their partners earn while in terms of

health-related behaviors, the overwhelming majority of partners neither smoke (94.0%) nor use hard drugs (95.0%). However, 9.0% consume alcohol, with a small percentage of the population either not knowing or refusing to disclose their habits regarding smoking (4.3%), drug use (4.5%) and alcohol consumption (3.9%).

Table 4.4.3: Danger Assessment in Abusive Relationship among Adult male living in Ibadan
N = 3068

Risk indicator	Frequency (n)	Percentage (%)
Partner ever threatened to harm or kill you	109	3.6
Partner ever used physical violence against you	218	7.1
Partner ever choked, strangled or suffocated you or attempted to do any of these things	75	2.4
Partner ever threatened or assaulted you with any weapon (including knives and/or other objects)	82	
Partner ever harmed or killed a family pet or threatened to do so	47	2.7
Partner ever been charged with breaching an apprehended domestic violence order	39	1.3
Relationship between client and partner		
Violence or controlling behaviour from partner is becoming worse or more frequent	107	3.5
Partner stalked, constantly harassed or texted/ emailed you	164	5.3
Partner control access to money	270	8.8
There has been a recent separation (in the last 12 months) or one imminent	139	4.5
Background of partner		
Partner or the relationship have financial difficulties	361	11.8
Partner is unemployed	662	21.6
Partner has mental health problems (including undiagnosed conditions) and/or depression?	35	1.1
Partner have a problem with substance abuse such as alcohol or other drugs	47	1.5
Partner ever threatened or attempted suicide	46	1.5
Partner is currently on bail or parole, or has served a time of imprisonment or has recently been released from custody in relation to offences of violence	20	0.7
Partner have access to firearms or prohibited weapons	25	0.8
Information about Children's risk		
Household have children who are less than 12 months apart in age	459	15.0
Partner ever threatened or used physical violence toward me at any time	160	5.2
Partner ever harmed or threatened to harm your children	42	1.4
There is conflict between me and partner regarding child contact or residency issues and/or current Family Court proceedings	74	2.4
There are children from a previous relationship present in the household	142	4.6
Sexual assault		
Partner has ever done things to me, of a sexual nature, that made me feel bad or physically hurt me	79	2.6
Partner has ever been arrested for sexual assault	21	0.7

The table presents an assessment of danger in abusive relationships among adult males living in Ibadan (Table 4.4.3). Of the respondents who had partners/spouses, 7.1% reported experiencing physical violence from their partners, making it the most common form of abuse in the section. Additionally, 3.6% had been threatened with harm or death by their partners. Other severe forms of abuse, such as choking, strangulation, or suffocation attempts, were reported by 2.4% of the respondents. Meanwhile, 2.7% reported threats or assaults involving weapons and 1.5% indicated that their partner had harmed or threatened to harm a family pet.

Also on controlling behaviors, 8.8% of respondents indicated that their partners controlled their access to money while 5.3% of respondents reported being stalked, harassed, or constantly contacted by their partners. Another 3.5% noted that the violence or controlling behavior in their relationship was worsening over time.

The background of the abusive partners reveals additional risk factors with approximately one-fifth (21.6%) of the partners being unemployed and 11.8% with financial difficulties. Although less common, mental health issues, including depression, were reported in 1.1% of cases and 1.5% of partners had substance abuse problems. Also, 1.5% of respondents mentioned that their partner had threatened or attempted suicide and 0.7% indicated that their partner had a history of violent offenses or was currently on bail or parole.

On presence of children in these households fifteen percent of respondents reported having children who were less than 12 months apart in age. Additionally, 5.2% of respondents experienced physical violence in

front of their children and 1.4% reported that their partner had threatened or harmed their children. Conflict regarding child custody or residency was reported by 2.4% of respondents, while 4.6% indicated the presence of children from previous relationships.

Finally, on issues of sexual assault within these relationships, while 2.6% of respondents reported that their partner had engaged in sexually abusive behavior, a smaller percentage (0.7%) noted that their partner had been arrested for sexual assault.

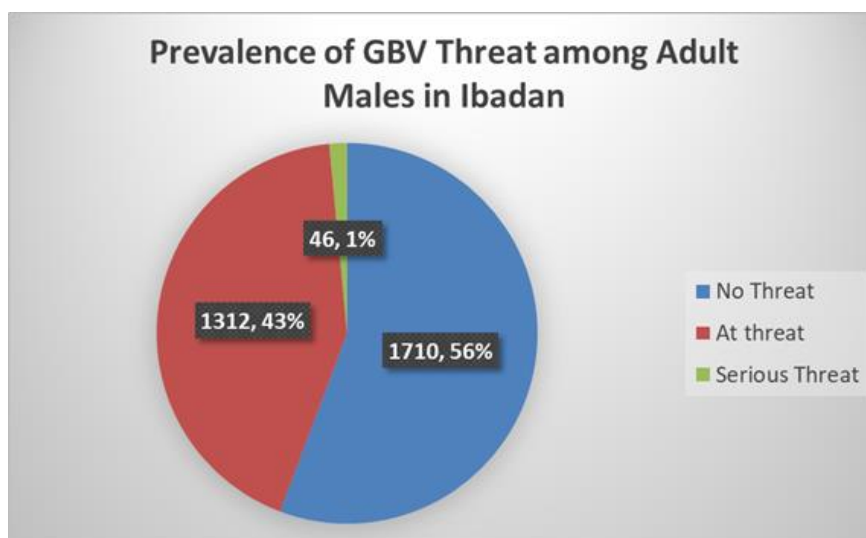

Figure 4.4: Pie chart describing the classification according to threat of GBV among Adult males in Ibadan

The pie-chart describes threat of GBV as assessed among adult male in Ibadan (Fig. 4.4). While most of the adult males were not at threat of GBV (56%), forty-three percent were at threat of GBV and a percent of them at serious threat.

Table 4.4.4: Sociodemographic determinants of GBV threat among adult male

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Age grouped (Yrs)				
20 - 29	267 (55.2)	217 (44.8)	3.156	0.368
30 – 39	619 (54.0)	528 (46.0)		
40 – 49	524 (57.7)	300 (56.7)		
≥50	300 (56.7)	229 (43.3)		
Employment status				
Currently employed	1047 (66.5)	527 (33.5)	159.807	<0.001*
Not currently employed	589 (43.3)	772 (56.7)		
Not employed in last 12 months (RC)	74 (55.6)	59 (44.4)		
Residence				
Rural	482 (55.3)	390 (44.7)	0.105	0.746
Urban	1228 (55.9)	968 (44.1)		
Education level				
No formal education	106 (65.8)	55 (34.2)	23.613	<0.001*
Primary	174 (52.3)	159 (47.7)		
Secondary	887 (52.8)	794 (47.2)		
Tertiary	543 (60.8)	350 (39.2)		
Number of Children				
None	60 (72.3)	23 (27.7)	10.466	0.033*
1-2	693 (55.7)	551 (44.3)		
	678 (55.3)	549 (44.7)		

3-4	251 (54.9)	206 (45.1)		
	28 (49.1)	29 (50.9)		
5-8				
>8				
Years of Marriage				
1-5	728 (64.0)	410 (36.0)	49.757	<0.001*
6-10	417 (51.1)	399 (48.9)		
	565 (50.7)	549 (49.3)		
>10				

The table (4.4.4) presents an analysis on the association of sociodemographic characteristics and Gender-Based Violence (GBV) threat among adult males in Ibadan, comparing those who reported experiencing GBV threats to those who did not. The analysis found no significant association between age group and the experience of GBV threats (p=0.368) and between residence and GBV threat (0.746).

However, employment status showed a significant association with GBV threat (p<0.001) as significant higher proportion of individuals who were not currently employed reported experiencing GBV threats (56.7%) compared to those who were employed (33.5%). Similarly, education level was significantly associated with GBV threat (p<0.001) as higher proportion of individuals with primary education (47.7%) or secondary education (47.2%) were more likely to experience GBV threats compared to those with tertiary education (39.2%).

The number of children was also found to be a significant determinant (p=0.033). Those with no children reported the lowest incidence of GBV threat (27.7%), while the proportion slightly increased with the number of children, and particularly increased among those with more than eight children (50.9%). Lastly, years of marriage showed a strong association with GBV threat (p<0.001). Individuals married for 1-5 years had lower proportion of reported GBV threats (36%) compared to those married for more than 10 years (49.3%).

Table 4.4.5: Logistic Regression model on determinants of GBV threat among adult male

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
20-29	2.603	<0.001	1.813	3.739
30-39	1.935	<0.001	1.443	2.594
40-49	1.140	0.290	0.894	1.455
≥50 (Reference Category)	1.000			
Employment Status				
Currently employed				
Not currently employed	0.585	0.005	0.403	0.849
Not employed in the last 12 months (RC)	1.516	0.028	1.047	2.196
	1.000			
Education level				
No formal education	0.525	0.001	0.360	0.765
Primary	0.850	0.256	0.643	1.125
Secondary	0.922	0.380	0.768	1.106
Tertiary (RC)	1.000			
Residence				
Rural	1.025	0.769	0.868	1.211
Urban (RC)	1.000			
Number of Children				
None				
1-2	0.392	0.014	0.185	0.829
3-4	0.925	0.788	0.525	1.630
5-8	0.782	0.391	0.446	1.371
>8	0.780	0.406	0.434	1.401
	1.000			
Years Married				
1-5	0.328	<0.001	0.251	0.429
6-10	0.675	0.001	0.536	0.850
>10	1.000			

The logistic regression model presented in the table assesses the sociodemographic determinants of Gender-Based Violence (GBV) threat among adult males in Ibadan (Table 4.4.5). Age is shown to be a significant factor, with younger males (particularly those aged 20-29 and 30-39) having a higher likelihood of experiencing GBV threats compared to those aged 50 and above. Specifically, males aged 20-29 have an odds ratio of 2.603 (p < 0.001), meaning they are over 2.6 times more likely to experience GBV threats than those

aged 50 and above. Similarly, those aged 30-39 have an odds ratio of 1.935 (p < 0.001), indicating a nearly doubled risk of GBV threat compared to those 50 years and above.

Also, currently employed individuals are less likely to experience GBV threats, with an odds ratio of 0.585 (p = 0.005), compared to those not employed in the last 12 months. On the other hand, those not currently employed but who were employed at some point have a higher likelihood of facing GBV threats, with an odds ratio of 1.516 (p = 0.028) when compared to those who have not been employed in the last 12 months.

Individuals with no formal education are less likely to experience GBV threats, with an odds ratio of 0.525 (p = 0.001), compared to those with tertiary education. However, the likelihood of experiencing GBV threats slightly increases as the education level rises to primary and secondary education, though these associations are not statistically significant. Also, individuals with no children are less likely to experience GBV threats, with an odds ratio of 0.392 (p = 0.014), compared to those with more than eight children.

Lastly, the duration of marriage is significantly associated with GBV threat risk. Those married for 1-5 years are less likely to experience GBV threats, with an odds ratio of 0.328 (p < 0.001), while those married for 6-10 years also have a reduced likelihood, with an odds ratio of 0.675 (p = 0.001).

Table 4.4.6: Partner's characteristics and GBV threat among adult males in Ibadan

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Partner's Age (Yrs)				
20 - 29	689 (57.3)	514 (42.7)	2.366	0.500
30 – 39	628 (54.8)	518 (45.2)		
40 – 49	268 (53,8)	230 (46.2)		
≥50	125 (56.6)	96 (43.4)		
Partner's Employment Status				
Currently employed	946 (68.9)	428 (31.1)	173.669	<0.001*
Not currently employed	684 (44.9)	839 (55.1)		
Not employed in last 12 months	80 (46.8)	91 (53.2)		
Partner's education level				
No formal education	108 (62.4)	65 (37.6)	14.921	0.002*
Primary	221 (59.2)	152 (40.8)		
Secondary	984 (53.0)	873 (47.0)		
Tertiary	397 (59.7)	268 (40.3)		
Partner consumes alcohol				
Yes	101 (36.6)	175 (63.4)	45.135	<0.001*
No	1542 (57.7)	1131 (42.3)		
I don't know	67 (56.3)	52 (43.7)		
Partner smokes				
Yes	23 (45.1)	28 (54.9)	4.871	0.088
No	1622 (56.2)	1263 (43.8)		
I don't know	65 (49.2)	67 (50.8)		
Partner takes hard drug				
Yes	7 (43.8)	9 (56.2)	6.969	0.031*
No	1640 (56.3)	1274 (43.7)		
I don't know	63 (45.7)	75 (54.3)		

The table (4.4.6) presents the relationship between various partners' characteristics Gender-Based Violence (GBV) threats among adult males in Ibadan. The partner's age (p=0.500) does not show a statistically significant association with GBV threats. Similarly, (partner's smoking habit does not show to have a significant association (p=0.088)

However, the partner's employment status reveals a significant relationship with GBV threats (p < 0.001). Partners who are not currently employed (55.1%) or have not been employed in the last 12 months (53.2%) have higher proportions of being associated with GBV threats when compared to those currently employed (31.1%).

The partner's education level is also significantly associated with GBV threats (p = 0.002). Those whose partners had no formal education or only primary education were more likely to experience GBV threats compared to those with partners who had secondary or tertiary education. For instance, 40.8% of those with partners who had primary education reported GBV threats, compared to 47.0% for secondary education.

Alcohol consumption by the partner is another significant factor (p < 0.001). Partners who consume alcohol are more likely to be associated with GBV threats, with 63.4% of those whose partners consume alcohol reporting GBV threats, compared to 42.3% of those whose partners do not consume alcohol.

Drug use by the partner show a statistical significant association with GBV threat (p = 0.031). Partners who take hard drugs are more likely to be linked to GBV threats, with 56.2% of those whose partners use drugs reporting GBV threats, compared to 43.7% of those whose partners do not use drugs.

Table 4.4.7: Logistic Regression model on Partner's characteristics on GBV threat

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
20-29	0.917	0.582	0.674	1.248
30-39	1.015	0.925	0.744	1.385
40-49	1.181	0.335	0.842	1.656
≥50 (Reference Category)	1.000			
Employment Status				
Currently employed				
Not currently employed	0.355	<0.001	0.255	0.494
Not employed in the last 12 months (RC)	1.058	0.732	0.767	1.460
	1.000			
Education level				
No formal education	0.543	0.001	0.374	0.787
Primary	0.590	<0.001	0.445	0.783
Secondary	0.906	0.324	0.745	1.102
Tertiary (RC)	1.000			
Consumes alcohol				
Yes	0.236	<0.001	0.124	0.451
No	0.411	<0.001	0.311	0.543
Don't know	1.000			
Smokes				
Yes	1.207	0.687	0.482	3.022
No	0.859	0.635	0.459	1.607
Don't know				
Takes hard drugs	1.455			
Yes	0.816	0.555	0.418	5.061
No	1.000	0.715	0.274	2.430
Don't know				

The logistic regression model analyzes the impact of various partner characteristics on the likelihood of experiencing Gender-Based Violence (GBV) threats among adult males (Table 4.4.7).

Employment status, demonstrates a significant association with GBV threats as partners who are currently employed are significantly less likely to be associated with GBV threats, with an odds ratio of 0.355 (p < 0.001), compared to those not employed in the last 12 months.

Education level also plays a significant role in GBV threats. The odds ratios for partners with no formal education and primary education relative to those with tertiary education are 0.543 (p = 0.001) and 0.590 (p < 0.001) respectively.

Alcohol consumption by the partner shows a strong and significant association with GBV threats. Partners who consume alcohol have an odds ratio of 0.236 (p < 0.001), and those whose alcohol consumption status is unknown have an odds ratio of 0.411 (p < 0.001). Both groups are significantly associated with a lower likelihood of GBV threats compared to partners who do not consume alcohol.

Objective 5: Healthcare Workers Knowledge, Attitude and Practice of GBV in Ibadan

Table 4.5.1 Characteristics of Healthcare Workers in Ibadan

N=1286

Variables	Frequency (n)	Percentage (%)
Age (Years)		
≤25	110	8.6
26-34	436	33.9
35-44	491	38.2
45-54	214	16.6
≥55	35	2.7

Mean (SD)	37.7 (8.9)	
Health Facility level		
Health Post	57	4.4
Primary Health Clinic/Center	649	50.5
General Hospital	440	34.2
Tertiary Hospital	84	6.5
Others (Private etc)	56	4.4
Gender		
Male	214	16.6
Female	1072	83.4
Profession		
Health Assistant	220	17.1
Nurse/Midwife	446	34.7
CHEWS	220	17.1
CHO	42	3.3
Doctors	33	2.6
Lab Tech/Scientists	38	3.0
Medical Record	65	5.1
Pharmacist/technician	24	1..9
Others	198	15.4

Table 4.5.1 provides a summary of the characteristics of healthcare workers in Ibadan, with a sample size of 1,286. The majority of the workforce is concentrated in the age group of 35-44 years (38.2%), with a mean age of 37.7 years (SD = 8.9). Only 2.7% are 55 years or older.

In terms of health facility distribution, most workers are employed in Primary Health Clinics/Centers (50.5%), followed by General Hospitals (34.2%). Gender distribution shows a predominance of female healthcare workers (83.4%), while males constitute only 16.6%. Professionally, the largest groups are Nurses/Midwives (34.7%) and Health Assistants and CHEWs (17.1%).

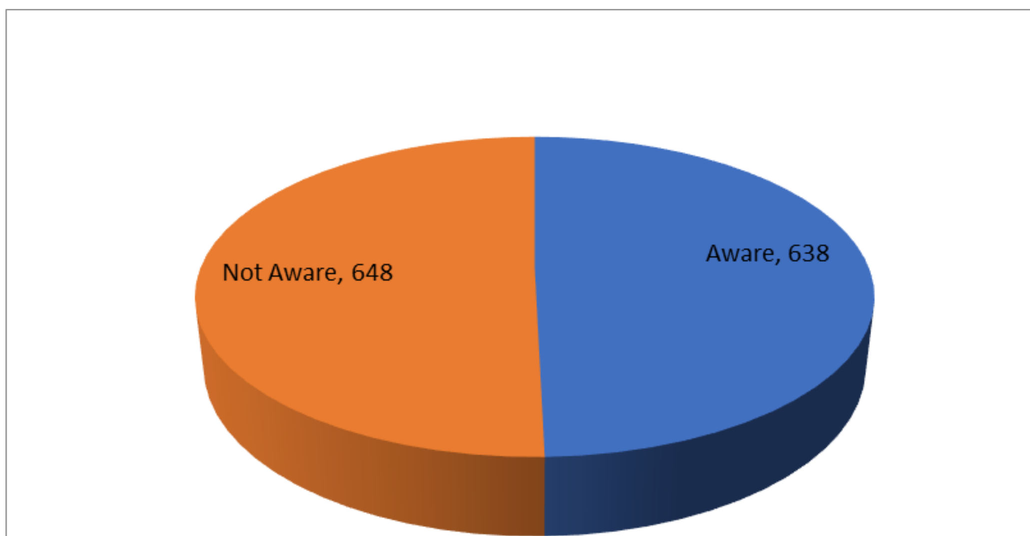

Figure 4.5: Distribution of Healthcare providers according to GBV awareness

The pie chart (Figure 4.5) depicts healthcare providers' awareness of gender-based violence (GBV) shows a nearly even split between those who are aware and those who are not. Out of a total of 1,286 healthcare providers, 638 (49.6%) are aware of GBV, while 648 (50.4%) are not aware.

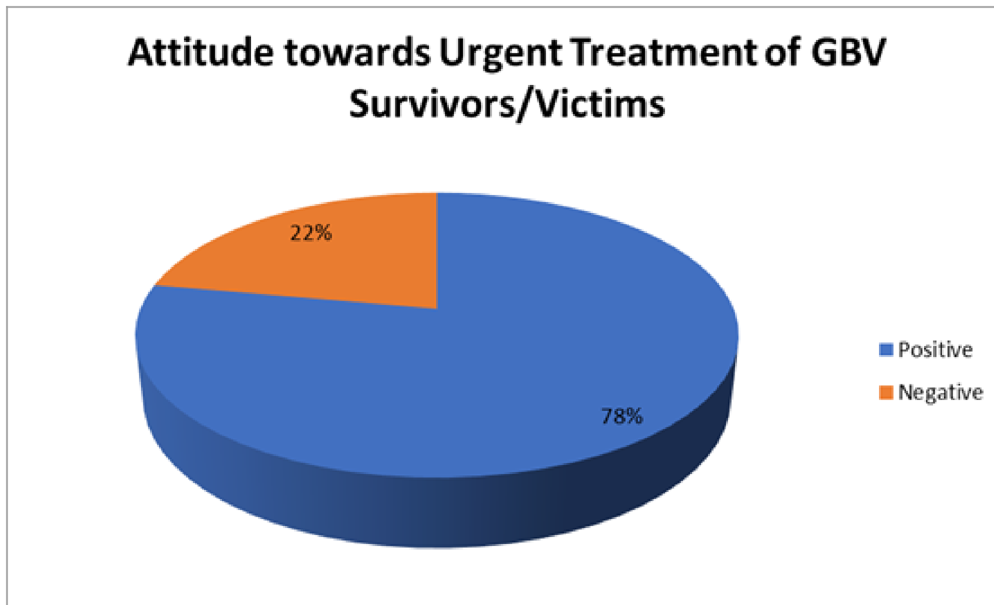

Figure 4.6: Attitude towards urgent treatment of GBV survivors/victims

The pie chart (Fig. 4.6) illustrates attitudes toward the urgent treatment of GBV survivors/victims reveals majorly, positive stance among healthcare providers. Out of a total of 1,286 respondents, 1,001 (77.7%) express a positive attitude towards the urgent treatment of GBV survivors while, 285 (22.3%) have a negative attitude.

Table 4.5.2 Knowledge of GBV among HCW in Ibadan
N = 638

S.No		Freq/Percent (n/%)	Allotted Point
(i)	Knows the meaning of GBV		1
	Yes	154 (24.1)	
	No	484 (75.9)	
(ii)	Numbers of common types(forms) of GBV identified		5
	0	11 (1.8)	
	1	494 (77.4)	
	2	109 (17.1)	
	3	14 (2.2)	
	4	9 (1.4)	
	5	1 (0.2)	

The table (4.5.2) presents the knowledge of gender-based violence (GBV) among healthcare workers (HCWs) in Ibadan. Out of the **638** respondents, only **24.1%** (154) correctly knew the meaning of GBV, while a majority **75.9%** (484) did not, indicating a significant gap in basic understanding of GBV among HCWs.

When asked to identify the common types of GBV, **77.4%** of respondents identified only one type, and **17.1%** identified two types, while only **1.4%** could identify four types. A small fraction (**2.2%**) of HCWs could identify three types, with just **0.2%** identifying all five common types of GBV, demonstrating limited knowledge of the different forms of GBV.

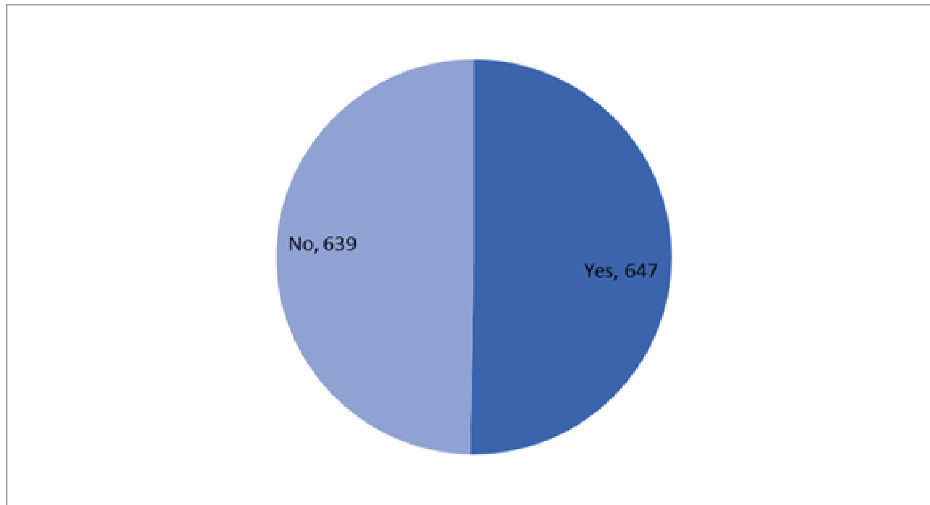

Figure 4.7: Pie-chart distribution of HCW according to treatment of GBV survivors at health facility

The pie chart shows an almost equal distribution of HCWs treating GBV survivors, with 50.3% providing care and 49.7% not involved, indicating a balanced but slightly more common involvement in GBV survivor treatment across health facilities (Table 4.7).

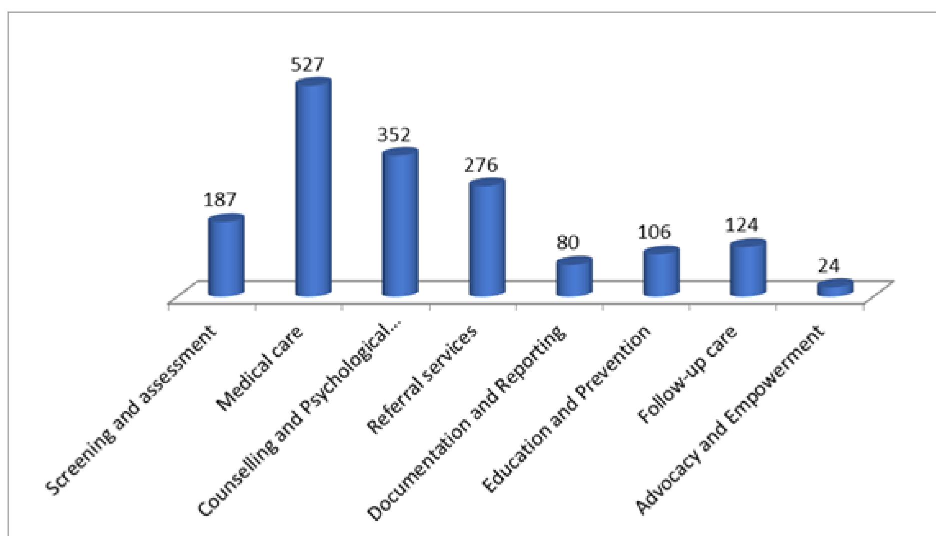

Figure 4.8: Bar-chart distribution of Services Offered to GBV Survivors at health facilities in Ibadan

The bar chart (Fig. 4.8) illustrates the kinds of services offered to GBV survivors at health facilities in Ibadan. Medical care is the most frequently provided service, representing 81.5% (527 out of 647) of the total services offered. Counselling and psychological support follows with 54.4% (352), while referral services accounting for 42.7% (276). Screening and assessment services make up 28.9% (187), showing that health facilities prioritize medical treatment, mental health support, and referrals for survivors.

On the lower end, follow-up care is provided in 19.2% (124) of cases**,** education and prevention in 16.4% (106), and documentation and reporting in only 12.4% (80). The least common service is advocacy and empowerment**,** offered in just 3.7% (24) of cases. These figures suggest that while immediate care is prioritized, there may be gaps in long-term support and empowerment initiatives for GBV survivors.

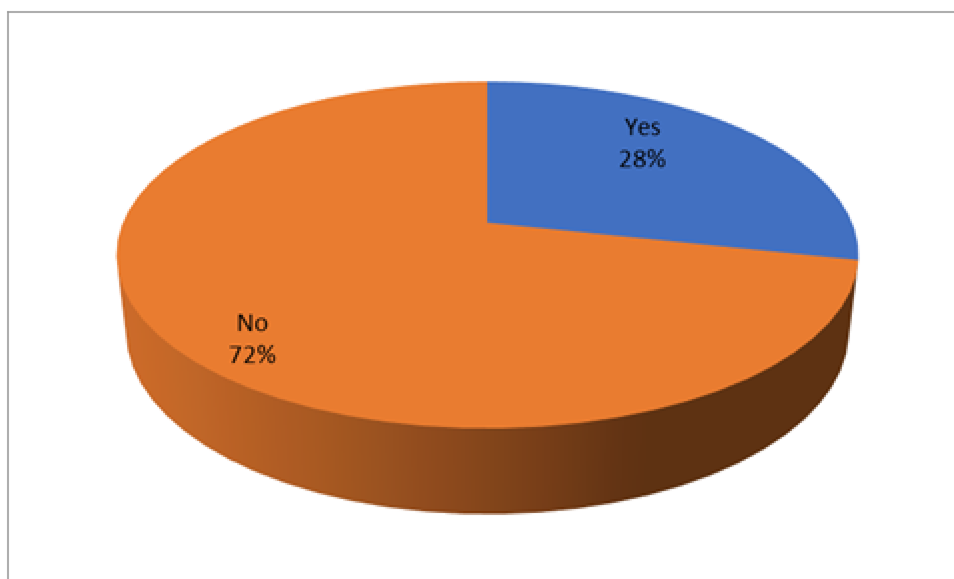

Figure 4.9: Proportion of Facilities Providing Post-Exposure Prophylaxis (PEP) Services in Ibadan (%)

The pie chart shows that the majority of facilities in Ibadan (71.6%) do not provide Post-Exposure Prophylaxis (PEP) services, with only 28.4% offering these services (Table 4.9).

Table 4.7.1 GBV Services Offered to Victims at Health Facilities in Ibadan
N=647

Variables	Frequency (n)	Percentage (%)
STI related services offered to GBV victims (Multiple responses)		
None		
Give prophylactic treatment	201	31.1
Refer to an STI/STD clinic	254	39.3
Send swab to a lab for STI test	280	43.3
Other services	32	4.9
	10	1.5
Facility offer counselling to survivors/victims		
Yes	476	73.6
No	171	26.4
Refer victims for other services providers such as police, courts		
Yes	138	21.3
No	509	78.7
Facility collects physical evidence from survivor/victims		
Yes		
No	38	5.9
	609	94.1
Facility used a pre-packaged rape kit for rape case examination		
Yes		
No	77	11.9
	570	570
Facility have a steady supply of rape kit (77)		
Yes	37	5.7
No	40	6.2
Facility supply of kits comes from the police (77)		
Yes		
No	30	4.6
	47	
Facility keeps records of Examined GBV cases		
Yes	289	44.7
No	358	55.3
Facility have specific forms used for GBV case management		
Yes	192	29.7
No	455	70.3
Facility have protocols/guideline in GBV case management		
Yes	150	23.2
No	497	76.8

The table (4.7.1) presents findings on the availability of GBV services offered to victims at health facilities in Ibadan. It shows that a notable percentage of caregivers reported that health facilities provide STI-related services, with 43.3% referring victims to an STI/STD clinic, 39.3% giving prophylactic treatment and 4.9% sending swabs for STI tests, though 31.1% do not offer any such services. Most (73.6%) of facilities offer counselling to survivors, but only 21.3% refer victims to other service providers, like police or court.

The table also reveals that only 5.9% of facilities collect physical evidence and 11.9% use a pre-packaged rape kit for examination, though just 5.7% have a steady supply of kits. Less than half (44.7%) of HCW reported that facilities keep records of examined GBV cases, but less than a third have specific forms (29.7%) or protocols/guidelines (23.2%) for GBV case management.

Objective 6: Knowledge and Attitude of respondents towards GBV in the city of Ibadan

Table 4.6.1: Knowledge and Attitude of Adult female on Assumed Justifiable reason for GBV

	Reasons for husband to beat wife	n/%	Score
1.	1. If wife goes out without informing her husband		
	Yes	70 (2.9)	0
	No	2318 (97.1)	1
2.	If wife neglects the children		
	Yes	75 (3.1)	0
	No	2313 (96.9)	1
3.	If wife argues with her husband		
	Yes	57 (2.4)	0
	No	2331 (97.6)	1
4.	If wife burns the food		
	Yes	73 (3.1)	0
	No	2315 (96.9)	1
5.	If wife refuses to have sex with him		
	Yes	104 (4.4)	0
	No	2284 (95.6)	1

The table (4.6.1) presents the knowledge and attitudes of adult females on assumed justifiable reasons for gender-based violence (GBV) by partners in a relationship. Findings indicate that most adult females do not consider the reasons justifiable for GBV, although a small percentage of respondents still hold beliefs that could perpetuate violence. Out of the 2,388 sampled adult females, only 2.9% agreed that a husband is justified in beating his wife if she goes out without informing him, while the vast majority (97.1%) disagreed. Similarly, 3.1% felt that neglecting children is a justifiable reason for violence, with 96.9% rejecting this notion.

Regarding other situations, 2.4% of respondents agreed that arguing with a husband could justify violence, while 97.6% disagreed. When asked if burning food was a justifiable reason, 3.1% agreed, while 96.9% did not. Finally, 4.4% of adult females believed that refusing sex with their husband justified GBV, with 95.6% rejecting this justification.

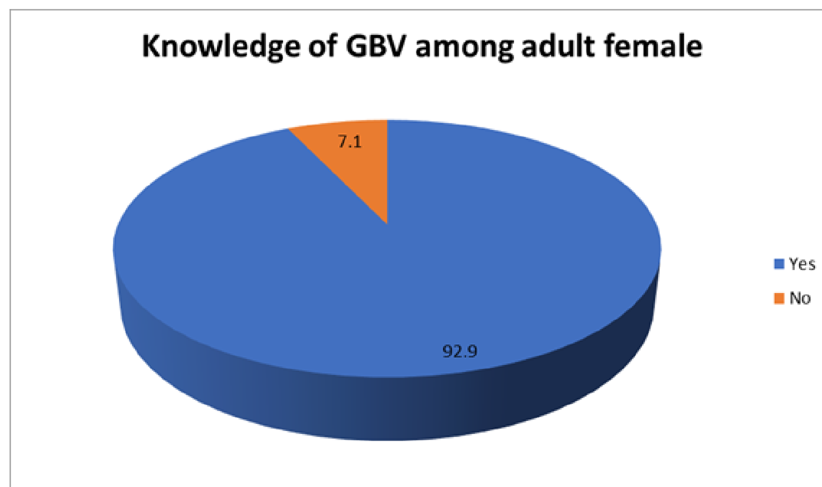

Figure 4.11: Percentage distribution of adult female according to knowledge of GBV practice

Most of the adult female (92.9%) has knowledge of GBV practice while 7.1% of them still justify practices of GBV in a relationship (Fig. 4.11).

Table 4.6.2: Knowledge and Attitude of Pregnant Women on assumed Justifiable reason for GBV

	Reasons for husband to beat wife	n/%	Score
1.	If wife goes out without informing her husband Yes No	63 (3.1) 1964 (96.9)	0 1
2.	If wife neglects the children Yes No	73 (3.6) 1954 (96.4)	0 1
3.	If wife argues with her husband Yes No	64 (3.2) 1963 (96.8)	0 1
4.	If wife burns the food Yes No	81 (4.0) 1946 (96.0)	0 1
5.	If wife refuses to have sex with him Yes No	100 (4.9) 1927 (95.1)	0 1

The table (4.6.2) presents the knowledge and attitudes of adult pregnant females on assumed justifiable reasons for gender-based violence (GBV) by partners in a relationship. Findings indicate that most adult pregnant females do not consider any reasons justifiable for GBV, although a small percentage of respondents still hold beliefs that could perpetuate violence. Out of the 2,027 sampled pregnant women, only 3.1% agreed that a husband is justified in beating his wife if she goes out without informing him, while the vast majority (96.9%) disagreed. Similarly, 3.6% felt that neglecting children is a justifiable reason for violence, with 96.4% rejecting this notion.

Regarding other situations, 3.2% of respondents agreed that arguing with a husband could justify violence, while 96.8% disagreed. When asked if burning food was a justifiable reason, 4% agreed, while 96% did not. Finally, 4.9% of adult females believed that refusing sex with their husband justified GBV, with 95.1% rejecting this justification.

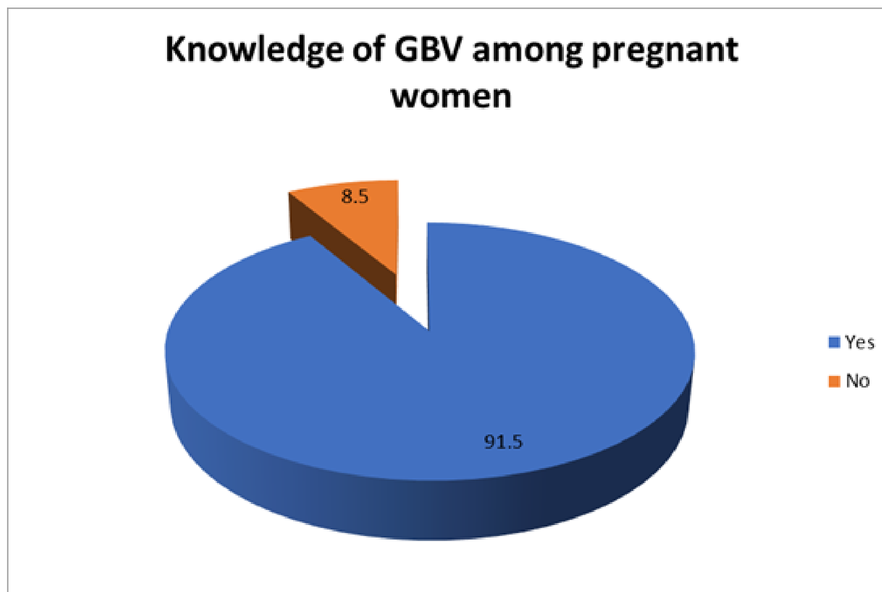

Figure 4.12: Percentage distribution of adult female according to knowledge of GBV practice

Most of the adult female (91.5%) has knowledge of GBV practice while 8.5% of them still justify practices of GBV in a relationship (Fig. 4.12).

Table 4.6.3 Post-Exposure Prophylaxis Offered to GBV Victims at Health Facilities in Ibadan N=232

Variables	Frequency (n)	Percentage (%)
Method of dispensing full PEP drugs to survivor/victims		
First drug under DOTS, then all of remaining		
All drugs given at one time	83	35.8
Seven day supply given		
	84	36.2
	65	28.0
Survival consent to HIV testing before PEP		
Yes	151	65.1
No	81	34.9
PEP Regimen prescribed to GBV victims		
Tenofovir	117	50.4
Abacavir	100	43.1
Raltegravir	40	17.2
Dolutegravir	40	17.2
Lamivudine	58	25.0
Others (Analgesics, Hydrocortisone)	7	3.0

The table (4.6.3) details the distribution of Post-Exposure Prophylaxis (PEP) methods offered to GBV victims at health facilities in Ibadan. Of the facilities providing PEP, 36.2% administer all drugs at once, while 35.8% use a Directly Observed Treatment Short-course (DOTS) approach for the first drug and then provide the remaining drugs and 28.0% give a seven-day supply at once.

Regarding HIV testing before initiating PEP, 65.1% of facilities require consent for testing, while 34.9% do not, indicating a majority adherence to HIV testing protocols. The PEP regimen varies as well, with 50.4% of facilities prescribing Tenofovir, 43.1% prescribing Abacavir and 17.2% each for Raltegravir and Dolutegravir. Other medications such as Lamivudine and additional treatments make up 25.0% and 3.0% respectively.

Table 4.6.4: Prevalence of reported GBV cases at health facilities in Ibadan in the last 6 months (n=647)

	None	One	2 – 5	>5
	(n/%)	(n/%)	(n/%)	(n/%)
Male adult (≥18yrs) survivors/victims presented in the last 6 months	498 (77.0)	19 (2.9)	101 (15.6)	29 (4.5)
Female adult (≥18yrs) survivors/victims presented in the last 6 months	440 (68.0)	53 (8.2)	114 (17.6)	40 (6.2)
Male adult survivors/victims presented in a (1) month averagely	519 (80.2)	26 (4.0)	93 (14.4)	9 (1.4)
Female adult survivors/victims presented in a (1) month averagely	484 (74.8)	37 (5.7)	125 (19.3)	1 (0.2)
Male adult survivors/victims presented in 2023	415 (64.1)	59 (9.1)	139 (21.5)	34 (5.3)
Female adult survivors/victims presented in 2023	300 (46.4)	64 (9.9)	206 (31.8)	77 (11.9)
Male child (<18yrs) survivors/victims presented in the last 6 months	521 (80.5)	23 (3.6)	86 (13.3)	17 (2.6)
Female child (<18yrs) survivors/victims presented in the last 6 months	497 (76.8)	27 (4.2)	70 (10.8)	53 (8.2)

The table (4.6.4) presents the prevalence of reported GBV cases at health facilities in Ibadan across different categories. A total 647 Health facilities were captured in the study. Among male adult survivors (≥18 years) in the last six months, the majority of facilities (77.0%) reported no cases, with 15.6% seeing between 2-5 cases and 4.5% reporting more than 5 cases. Comparatively, female adults presented more frequently, with 68.0% of facilities reporting no cases, 17.6% seeing between 2-5 cases and 6.2% seeing more than 5 cases. This indicates that female adults are more likely to present as GBV survivors than male adults.

On monthly average, 80.2% of facilities reported no male adult GBV survivors, while 14.4% handled between 2-5 cases. For female adults, 74.8% of facilities reported no cases, with 19.3% seeing 2-5 cases on average. For 2023 as a whole, 64.1% of facilities reported no male adult cases, while 31.8% of facilities reported 2-5 cases among female adults, showing higher reporting for females.

Among children under 18 years, 80.5% of facilities reported no male child cases in the last six months, while 76.8% of facilities reported no female child cases. However, female children were more frequently seen, with 8.2% of facilities seeing more than 5 cases.

V. Discussion

Summary of Main findings

A total of 13,841 persons, comprising 2388 pregnant women, 2027 non-pregnant women, 4452 adolescents, 3688 adult males and 1286 healthcare providers were included in the study.

Adult Non-Pregnant Females

Among adult non-pregnant females sampled, up to 10% of respondents reported that their partner ever used physical violence against them; 6.6% of the women reported their partners controlled their access to money, 3.8% of respondents reported being subjected to sexual actions by their partner that made them feel bad or caused physical harm and 3.4% indicated that their partners choked, strangled, or suffocated them or attempted to do so.

There is a significant relationship between age and the threat of GBV, with a lower proportion of younger women aged 20-29 years at threat (43.9%) of GBV compared to older age groups like women aged 40-49 years (54.1%) (p=0.001). Women who are currently employed are less likely to be at threat (39.9%) compared to those who are not employed in the last 12 months (42.8%) or currently unemployed (58.5%) (p<0.001). Women with tertiary education have lower threat of GBV (40.1%) compared to those with secondary education (52.3%) or primary education (55.4%) (p<0.001).

Similarly, both the number of children and years of marriage are significantly associated with GBV threat (p<0.001). Women with no children (37.0%) or fewer children (1-2) (50.5%) are less likely to be at threat compared to those with 5-8 children (54.8%) and those whose children are five or less (41.8%). Women who have been married longer (more than 10 years) are more likely to be at threat of GBV (55.5%).

Logistics progression shows a significant association with the threat of GBV as women aged 20-29 years (OR = 2.154, p = 0.001), 30-39 years (OR = 1.867, p = 0.001), and 40-49 years (OR = 1.568, p = 0.009) are at significantly higher risk of GBV compared to those aged 50 years and above (reference category). Women who are not currently employed have significantly higher odds of GBV threat (OR = 1.636, p = 0.009) compared to those who have not been employed in the last 12 months (reference category). Women with tertiary education (reference category) are less likely to be at threat of GBV compared to those with secondary education (OR = 1.240, p = 0.041).

Similarly, years married show significant associations with the threat of GBV. Women with shorter marriages (1-5 years, OR = 0.507, p < 0.001) are associated with a lower threat of GBV compared to marriages lasting more than 10 years.

There is a significant association between partner's age and the threat of GBV (p<0.001). The threat of GBV is higher among women whose partners are aged 30-39 years (52.8%), 40-49 years (52.3%), and 50 years and above (51.7%), compared to those with younger partners aged 20-29 years (36.6%). Women whose partners are currently employed are less likely to be at threat (40.8%) compared to those whose partners are not currently employed (60.7%). Interestingly, partners not employed in the last 12 months are associated with a lower threat (37.6%) of GBV (p<0.001). Women whose partners have no formal education are less likely to be at threat of GBV (14.5%) compared to those whose partners have primary (53.4%), secondary (56.6%), or tertiary education (45.6%) (p<0.001).

The consumption of alcohol, smoking, and taking hard drugs by the partner are all significantly associated with a higher threat of GBV (all p-values < 0.001). Women whose partners consume alcohol (68.6%), smoke (67.3%), or take hard drugs (74.1%) face a significantly higher threat of GBV compared to those whose partners do not engage in these behaviors.

Partners who are currently employed have significantly lower odds of being associated with GBV threat (OR = 0.516, p = 0.001) compared to those who were not employed in the last 12 months (reference category) while partners who are currently not employed have significantly higher odds (OR = 1.661, p = 0.012). Partners with no formal education have significantly lower odds of being associated with GBV threat (OR = 0.182, p < 0.001) compared to those with tertiary education (reference category).

Partners who consume alcohol have lower odds (OR = 0.205, p < 0.001) of being associated with GBV threat compared to those who do not know their partner's alcohol consumption status (reference category). Women who do not know their partner's earnings have significantly lower odds of being at threat of GBV (OR = 0.723, p = 0.004) compared to those who do know.

As touching on the knowledge and attitudes of adult females on assumed justifiable reasons for gender-based violence (GBV) by partners in a relationship, findings indicate that most adult females do not consider the reasons justifiable for GBV, although a small percentage of respondents still hold beliefs that could

perpetuate violence. Out of the 2,388 adult females sampled, only 2.9% agreed that a husband is justified in beating his wife if she goes out without informing him, while the vast majority (97.1%) disagreed. Similarly, 3.1% felt that neglecting children is a justifiable reason for violence, with 96.9% rejecting this notion. Regarding other situations, 2.4% of respondents agreed that arguing with a husband could justify violence, while 97.6% disagreed. When asked if burning food was a justifiable reason, 3.1% agreed, while 96.9% did not. Finally, 4.4% of adult females believed that refusing sex with their husband justified GBV, with 95.6% rejecting this justification.

Adult Pregnant Females

Age significantly influences the threat of GBV among pregnant women as younger women aged 20-29 (69.5%) and 30-39 (75.5%) are more likely to report being at risk of experiencing GBV while women aged 50 and above appear to have a lower risk (33.3%) ($p = 0.003$).

Women who are not currently employed or have not been employed in the last 12 months are more likely to experience GBV (75.5%) compared to those who are currently employed (68.7%) ($p<0.001$).

The number of children a woman has is another significant factor in GBV threat. Women with no children (68.6%) or fewer children (1-2) (71.4%) are less likely to experience GBV compared to those with 5-8 children (84.7%) ($p = 0.019$).

The duration of marriage also shows a significant relationship with GBV threat. Pregnant women who have been married for more than 10 years are more likely to experience GBV (78.6%) compared to those married for 1-5 years (70.0%) ($p = 0.006$).

Specifically, 11% of the pregnant women reported that their partners had used physical violence against them irrespective of their physiological status, while 3.9% had been threatened with harm or death. Additionally, 3.5% of the respondents reported incidents of choking, strangulation, or suffocation and 2.2% had faced threats or assaults involving weapons. As high as 13.5% of the pregnant women indicate that their partner controls access to money.

Logistics regression reveals that age bears a significant association with the risk of GBV during pregnancy. Women aged 30-39 have an OR of 7.476 ($p = 0.026$), indicating that they are approximately 7.5 times more likely to be at risk of GBV. Similarly, women aged 40-49 have an OR of 6.199 ($p = 0.046$), suggesting a higher risk relative to the reference group (≥50 years). There is a significant association between the partner's age and the threat of GBV ($p = 0.002$) indicating that younger partners, particularly those aged 20-29 (68.6%), are associated with a lower threat of GBV compared to older age groups. There is a significant relationship between the partner's employment status and the threat of GBV ($p = 0.034$). Partners who are not currently employed or were not employed in the last 12 months are more likely to be associated with GBV threat (81.2%).

There is an association between the consumption of alcohol by the pregnant women's partners and the threat of GBV ($p < 0.001$). Partners who consume alcohol are more likely to be associated with a higher threat of GBV (68.6%) compared to those who do not (44.4%). Smoking is also significantly associated with the threat of GBV ($p < 0.001$). Partners who smoke (80.6%) are more likely to be linked with GBV threat compared to non-smokers (72.3%).

Findings indicate that most adult pregnant females do not consider any reasons justifiable for GBV, although a small percentage of respondents still hold beliefs that could perpetuate violence. Out of the 2,027 pregnant women sampled, only 3.1% agreed that a husband is justified in beating his wife if she goes out without informing him, while the vast majority (96.9%) disagreed. Similarly, 3.6% felt that neglecting children is a justifiable reason for violence, with 96.4% rejecting this notion.

Regarding other situations, 3.2% of respondents agreed that arguing with a husband could justify violence, while 96.8% disagreed. When asked if burning food was a justifiable reason, 4% agreed, while 96% did not. Finally, 4.9% of adult females believed that refusing sex with their husband justified GBV, with 95.1% rejecting this justification.

Adult Men

Interestingly, among the adult male respondents who had partners/spouses, 7.1% reported experiencing physical violence from their partners, making it the most common form of abuse in the section. Additionally, 3.6% had been threatened with harm or death by their partners. Other severe forms of abuse, such as choking, strangulation, or suffocation attempts, were reported by 2.4% of the respondents. Meanwhile, 2.7% reported threats or assaults involving weapons and 1.5% indicated that their partner had harmed or threatened to harm a family pet.

Also on controlling behaviors, 8.8% of the adult male respondents indicated that their partners controlled their access to money while 5.3% of respondents reported being stalked, harassed, or constantly

contacted by their partners. Another 3.5% noted that the violence or controlling behavior in their relationship was worsening over time.

The background of the abusive partners reveals additional risk factors with approximately one-fifth (21.6%) of the partners being unemployed and 11.8% with financial difficulties. Although less common, mental health issues, including depression, were reported in 1.1% of cases and 1.5% of partners had substance abuse problems. Also, 1.5% of respondents mentioned that their partner had threatened or attempted suicide and 0.7% indicated that their partner had a history of violent offenses or was currently on bail or parole.

On presence of children in these households, fifteen percent (15%) of respondents reported having children who were less than 12 months apart in age. Additionally, 5.2% of respondents experienced physical violence in front of their children and 1.4% reported that their partner had threatened or harmed their children. Conflict regarding child custody or residency was reported by 2.4% of respondents, while 4.6% indicated the presence of children from previous relationships.

On issues of sexual assault within these relationships, while 2.6% of respondents reported that their partner had engaged in sexually abusive behavior, a smaller percentage (0.7%) noted that their partner had been arrested for sexual assault.

However, employment status showed a significant association with GBV threat ($p<0.001$) as significant higher proportion of individuals who were not currently employed reported experiencing GBV threats (56.7%) compared to those who were employed (33.5%). Similarly, education level was significantly associated with GBV threat ($p<0.001$) as higher proportion of individuals with primary education (47.7%) or secondary education (47.2%) were more likely to experience GBV threats compared to those with tertiary education (39.2%).

The number of children was also found to be a significant determinant ($p=0.033$). Those with no children reported the lowest incidence of GBV threat (27.7%), while the proportion slightly increased with the number of children, and particularly increased among those with more than eight children (50.9%). Years of marriage showed a strong association with GBV threat ($p<0.001$). Individuals married for 1-5 years had lower proportion of reported GBV threats (36%) compared to those married for more than 10 years (49.3%).

Age is shown to be a significant factor, with younger males (particularly those aged 20-29 and 30-39) having a higher likelihood of experiencing GBV threats compared to those aged 50 and above. Specifically, males aged 20-29 have an odds ratio of 2.603 ($p < 0.001$), meaning they are over 2.6 times more likely to experience GBV threats than those aged 50 and above. Similarly, those aged 30-39 have an odds ratio of 1.935 ($p < 0.001$), indicating a nearly doubled risk of GBV threat compared to those 50 years and above which is the reference category.

Also, currently employed individuals are less likely to experience GBV threats, with an odds ratio of 0.585 ($p = 0.005$), compared to those not employed in the last 12 months. On the other hand, those not currently employed but who were employed at some point have a higher likelihood of facing GBV threats, with an odds ratio of 1.516 ($p = 0.028$) when compared to those who have not been employed in the last 12 months.

Individuals with no formal education are less likely to experience GBV threats, with an odds ratio of 0.525 ($p = 0.001$), compared to those with tertiary education. However, the likelihood of experiencing GBV threats slightly increases as the education level rises to primary and secondary education, though these associations are not statistically significant. Also, adult male individuals with no children are less likely to experience GBV threats, with an odds ratio of 0.392 ($p = 0.014$), compared to those with more than eight children. Lastly, the duration of marriage is significantly associated with GBV threat risk. Those married for 1-5 years are less likely to experience GBV threats, with an odds ratio of 0.328 ($p < 0.001$), while those married for 6-10 years also have a reduced likelihood, with an odds ratio of 0.675 ($p = 0.001$). The partner's age ($p=0.500$) does not show a statistically significant association with GBV threats. Similarly, (partner's smoking habit does not show to have a significant association ($p=0.088$).

However, the partner's employment status reveals a significant relationship with GBV threats ($p < 0.001$). Partners who are not currently employed (55.1%) or have not been employed in the last 12 months (53.2%) have higher proportions of being associated with GBV threats when compared to those currently employed (31.1%). The partner's education level is also significantly associated with GBV threats ($p = 0.002$). Those whose partners had no formal education or only primary education were more likely to experience GBV threats compared to those with partners who had secondary or tertiary education. For instance, 40.8% of those with partners who had primary education reported GBV threats, compared to 47.0% for secondary education. Alcohol consumption by the partner is another significant factor ($p < 0.001$). Partners who consume alcohol are more likely to be associated with GBV threats, with 63.4% of those whose partners consume alcohol reporting GBV threats, compared to 42.3% of those whose partners do not consume alcohol.

Drug use by the partner show a statistically significant association with GBV threat ($p = 0.031$). Partners who take hard drugs are more likely to be linked to GBV threats, with 56.2% of those whose partners use drugs reporting GBV threats, compared to 43.7% of those whose partners do not use drugs. Employment

status, demonstrates a significant association with GBV threats as partners who are currently employed are significantly less likely to be associated with GBV threats, with an odds ratio of 0.355 ($p < 0.001$), compared to those not employed in the last 12 months.

Logistics regression reveals that education level also plays a significant role in GBV threats. The odds ratios for partners with no formal education and primary education relative to those with tertiary education are 0.543 ($p = 0.001$) and 0.590 ($p < 0.001$) respectively.

Alcohol consumption by the partner shows a strong and significant association with GBV threats. Partners who consume alcohol have an odds ratio of 0.236 ($p < 0.001$), and those whose alcohol consumption status is unknown have an odds ratio of 0.411 ($p < 0.001$). Both groups are significantly associated with a lower likelihood of GBV threats compared to partners who do not consume alcohol.

Adolescents

Majority of the adolescents identified as students (65.1%). A smaller percentage was involved in apprenticeships (26.6%) and even fewer worked in unskilled (2.3%) and skilled (2.0%) jobs or other occupations such as sales/services (1.7%) and agriculture/farming (0.3%). A minimal number reported being professionals (0.2%) or clerics (0.1%).

The adolescents had mostly never been married (96.9%), with only 1.7% being married and 1.3% living together with a partner. Instances of divorce and separation were extremely rare, accounting for less than 0.2% of the sample. Additionally, the majority of the adolescents resided in urban areas (69.5%), while 30.5% lived in rural areas.

Regarding the number of children, almost all adolescents had no children (97.5%), with only 2.1% having one child and a negligible 0.4% having two children. Gender distribution in the sample showed a slight predominance of females (58.2%) over males (41.8%). Regarding incidents where participants were slapped or pushed without sustaining injuries or lasting pain, a majority (53.8%) reported experiencing this type of abuse at least once, while 15.4% experienced it three times, and another 7.7% reported experiencing it eight times within the past year.

Similarly, when examining more severe physical violence, such as being punched, kicked, bruised, or cut with continued pain, 69.2% of the adolescents reported never experiencing this, while 15.4% experienced it once, and smaller percentages reported experiencing this twice or four times within the past year.

When it came to more severe forms of violence, such as being beaten up with severe contusions, burns, or other serious injuries, 84.6% of the respondents reported that they had never experienced this. However, 7.7% experienced this type of violence once, and another 7.7% experienced it five times under the review year. Additionally, 23.1% of the adolescents reported that their ex-partner or current partner had threatened to use a weapon against them, causing injury, while 76.9% did not experience such threats. Finally, regarding the actual use of a weapon that caused wounds, 15.4% reported this occurrence twice, and 7.7% reported it happening once, with the majority (76.9%) not having experienced this form of violence. The study indicated that age was significantly associated with the risk of GBV. Specifically, adolescents aged 10-14 years were more likely to be at risk, with 59.4% of this age group experiencing GBV, compared to 37.3% in the 15-19 age group ($p= 0.021$).

Employment status also showed a significant association with GBV risk. Adolescents who were not currently employed had a higher risk of GBV, with 46.6% reporting such experiences, compared to 28.6% of those currently employed and 26.2% of those not employed in the last 12 months ($p=0.002$).

In contrast, educational level, gender and residence did not show significant associations with GBV risk. Although there were differences in the percentages of adolescents experiencing GBV across various education levels, these differences were not statistically significant ($p = 0.247$). Similarly, gender did not significantly impact the risk of GBV, with both males and females reporting similar experiences ($p = 0.268$). Residence, whether rural or urban, did not significantly affect GBV risk among adolescents in the study. The findings indicated that 58.8% of rural adolescents and 62.0% of urban adolescents reported GBV risk, with no significant difference between the two groups ($p = 0.552$). The logistic regression analysis on the sociodemographic determinants of gender-based violence (GBV) risks among adolescents identified age and employment status as factors influencing the likelihood of experiencing GBV. Age was a significant determinant, with adolescents aged 10-14 years being 2.43 times more likely to be at risk of GBV compared to their older counterparts aged 15-19 years, as indicated by an odds ratio (OR) of 2.430 and a p-value of 0.026.

Similarly, adolescents who were not currently employed were 2.825 times more likely to experience GBV compared to those who had not been employed in the last 12 months, with a statistically significant p-value of 0.002. Educational level of the partner significantly impacts the risk of GBV. Adolescents whose partners had only primary education exhibited a higher risk of GBV, with 68.4% of such cases reporting GBV compared to 31.6% who did not ($p = 0.033$). This suggests that lower educational attainment among partners may be associated with a heightened risk of GBV.

Similarly, the partner's consumption of alcohol was significantly associated with GBV risk. Adolescents who were unsure if their partner consumed alcohol were more likely to report GBV (47.3%) compared to those who knew their partner did not consume alcohol (31.2%) or those who knew their partner did (33.3%). (p=0.014).

The use of hard drugs by the partners also showed a significant relationship with GBV risk. Adolescents whose partners used hard drugs reported a higher incidence of GBV (33.3%) compared to those whose partners did not (26.3%) or those who were unsure (43.5%) (p-0.044).

Healthcare workers

A total 647 health facilities were captured in the study, with only 22% reporting GBV cases within the past 6 months. In terms of health facility distribution, most workers are employed in Primary Health Clinics/Centers (50.5%), followed by General Hospitals (34.2%). Gender distribution shows a predominance of female healthcare workers (83.4%), while males constitute only 16.6%. Professionally, the largest groups are Nurses/Midwives (34.7%) and Health Assistants and CHEWs (17.1%). Out of a total of 1,286 respondents, 1,001 (77.7%) express a positive attitude towards the urgent treatment of GBV survivors while, 285 (22.3%) have a negative attitude. Out of the 638 respondents, only 24.1% (154) correctly knew the meaning of GBV, while a majority 75.9% (484) did not, indicating a significant gap in basic understanding of GBV among HCWs.

When asked to identify the common types of GBV, 77.4% of respondents identified only one type, and 17.1% identified two types, while only 1.4% could identify four types. A small fraction (2.2%) of HCWs could identify three types, with just 0.2% identifying all five common types of GBV, demonstrating limited and significant gap in knowledge of the different forms of GBV among HCWs.

Medical care is the most frequently provided service, representing 81.5% (527 out of 647) of the total services offered. Counselling and psychological support follows with 54.4% (352), while referral services accounting for 42.7% (276). Screening and assessment services make up 28.9% (187), showing that health facilities prioritize medical treatment, mental health support, and referrals for survivors.

On the lower end, follow-up care is provided in 19.2% (124) of cases**,** education and prevention in 16.4% (106), and documentation and reporting in only 12.4% (80). The least common service is advocacy and empowerment**,** offered in just 24 (3.7%) of the health facilities sampled. These figures suggest that while immediate care is prioritized, there may be gaps in long-term support and empowerment initiatives for GBV survivors.

Further, a notable percentage of caregivers reported that health facilities provide STI-related services, with 43.3% referring victims to an STI/STD clinic, 39.3% giving prophylactic treatment and 4.9% sending swabs for STI tests, though 31.1% do not offer any such services. Most (73.6%) of facilities offer counselling to survivors, but only 21.3% refer victims to other service providers, like police or court. The low referral rate recorded might not be unconnected to the poor attitude of HCWs to GBV survivors and the gap in knowledge of GBV identified among the sampled HCW respondents.

Only 5.9% of facilities collect physical evidence and 11.9% use a pre-packaged rape kit for examination, though just 5.7% have a steady supply of kits. Less than half (44.7%) of HCW reported that facilities keep records of examined GBV cases, but less than a third have specific forms (29.7%) or protocols/guidelines (23.2%) for GBV case management, further underscoring the low prioritization of GBV management in health facilities.

General Discussion

Objective 1: Determine the prevalence, pattern, and determinants of GBV among adult non-pregnant females in the city of Ibadan.

Up to a tenth adult non-pregnant female respondents reported that their partner ever used physical violence against them. Slightly less (6.6%) of the women reported their partners controlled their access to money, while 3.8% of respondents reported being subjected to sexual actions by their partner that made them feel bad or caused physical harm. A smaller proportion (3.4%) indicated that their partners choked, strangled, or suffocated them or attempted to do so. It follows that physical violence appears to be the most prevalent form of GBV among adult non-pregnant females in Ibadan. Economic violence is the third most reported form of GBV while sexual abuse alongside choking, strangling/suffocation were also frequently reported. Literature affirms that economic violence, though less visible, as the prevalent form of GBV after sexual abuse and physical violence[1]. Cumulatively, the prevalence of GBV among adult non-pregnant females was 23.8%. This finding aligns with studies conducted by Benabo et al. in 2018 and Oluyemisi et al in 2020 which demonstrated that almost a quarter of women in Nigeria reported having ever experienced intimate partner violence[2, 3].

There is a significant relationship between age and the threat of GBV, with a lower proportion of younger women aged 20-29 years at threat (43.9%) of GBV compared to older age groups like women aged 40-

49 years (54.1%) (p=0.001). The phenomenon of younger aged women being more at risk of GBV was also reported by Olumide Abiodun et al in a study conducted in Ogun State, South Western Nigeria[4]. Logistics regression further reveals age has a significant association with the threat of GBV as women aged 20-29 years (OR = 2.154, p = 0.001), 30-39 years (OR = 1.867, p = 0.001), and 40-49 years (OR = 1.568, p = 0.009) are at significantly higher risk of GBV compared to those aged 50 years and above (reference category).

Women who are currently employed are less likely to be at threat (39.9%) compared to those who are not employed in the last 12 months (42.8%) or currently unemployed (58.5%) (p<0.001), with logistics regression showing that women who are not currently employed have significantly higher odds of GBV threat (OR = 1.636, p = 0.009) compared to those who have not been employed in the last 12 months (reference category). Women with tertiary education have lower proportion at threat of GBV (40.1%) compared to those with secondary education (52.3%) or primary education (55.4%) (p<0.001). Logistics regression affirms this as women with tertiary education (reference category) were found to be less likely to be at threat of GBV compared to those with secondary education (OR = 1.240, p = 0.041). Findings from this study also re-affirms the Nigeria demographic and health survey that revealed wealth index and low level of women's education as a significant determinant of GBV among women in Nigeria[5].

Similarly, both the number of children and years of marriage are significantly associated with GBV threat (p<0.001). Women with no children (37.0%) or fewer children (1-2) (50.5%) are less likely to be at threat compared to those with 5-8 children (54.8%) and those whose children are five or less (41.8%). The NDHS also revealed increased parity as a determinant of GBV[5]. Women who have been married longer (more than 10 years) are more likely to be at threat (55.5%). In the same vein, years married show significant associations with the threat of GBV. Women with shorter marriages (1-5 years, OR = 0.507, p < 0.001) are associated with a lower threat of GBV compared to marriages lasting more than 10 years.

There is a significant association between a partner's age and the threat of GBV (p<0.001). The threat of GBV is higher among women whose partners are aged 30-39 years (52.8%), 40-49 years (52.3%), and 50 years and above (51.7%), compared to those with younger partners aged 20-29 years (36.6%). Women whose partners are currently employed are less likely to be at threat (40.8%) compared to those whose partners are not currently employed (60.7%). Interestingly, partners not employed in the last 12 months are associated with a lower threat (37.6%) of GBV (p<0.001). Women whose partners have no formal education are less likely to be at threat of GBV (14.5%) compared to those whose partners have primary (53.4%), secondary (56.6%), or tertiary education (45.6%) (p<0.001). Partners who are currently employed have significantly lower odds of being associated with GBV threat (OR = 0.516, p = 0.001) compared to those who were not employed in the last 12 months (reference category) while partners who are currently not employed have significantly higher odds (OR = 1.661, p = 0.012). Partners with no formal education have significantly lower odds of being associated with GBV threat (OR = 0.182, p < 0.001) compared to those with tertiary education (reference category).

The consumption of alcohol, smoking, and taking hard drugs by the partner are all significantly associated with a higher threat of GBV (all p-values < 0.001). Women whose partners consume alcohol (68.6%), smoke (67.3%), or take hard drugs (74.1%) face a significantly higher threat of GBV compared to those whose partners do not engage in these behaviors. The NDHS also established a high significance between high levels of alcohol intake by husbands and risk of GBV[5]. Moreso, partners who consume alcohol have lower odds (OR = 0.205, p < 0.001) of being associated with GBV threat compared to those who do not know their partner's alcohol consumption status (reference category). Women who do not know their partner's earnings have significantly lower odds of being at threat of GBV (OR = 0.723, p = 0.004) compared to those who do know.

Summarily, the study reveals the prevalence of GBV among adult non-pregnant females as 23.8%; while physical violence, sexual violence and economic violence were identified as the most common forms of GBV among the study population. The trend in GBV puts younger aged women at a higher risk when compared with older women aged 50 years and above. Also, women who are not currently employed have a significantly higher odds of GBV threat when compared to those employed.

Objective 2: Assess the prevalence, pattern, and associated risk factors of GBV among pregnant women in the city of Ibadan

Among pregnant women, age significantly influences the threat of GBV as younger women aged 20-29 (69.5%) and 30-39 (75.5%) are more likely to report being at risk of experiencing GBV while women aged 50 and above appear to have a lower risk (33.3%) (p = 0.003). Age shows a significant association with the risk of GBV during pregnancy. Logistics regression revealed women aged 30-39 had an OR of 7.476 (p = 0.026), indicating that they are approximately 7.5 times more likely to be at risk of GBV. Similarly, women aged 40-49 have an OR of 6.199 (p = 0.046), suggesting a higher risk relative to the reference group (≥50 years). There was a significant association between the pregnant women partner's age and the threat of GBV (p = 0.002) as

younger partners, particularly those aged 20-29 (68.6%), were found to be associated with a lower threat of GBV compared to older age groups. Further, a significant relationship was established between the partner's employment status and the threat of GBV (p = 0.034) as partners who are not currently employed or were not employed in the last 12 months are more likely to be associated with GBV threat (81.2%). Findings indicate that most adult pregnant females do not consider any reasons justifiable for GBV, although a small percentage of respondents still hold beliefs that could perpetuate violence. Out of the 2,027 sampled pregnant women, only 3.1% agreed that a husband is justified in beating his wife if she goes out without informing him, 3.6% felt neglecting the children justify GBV, 3.2% agree that arguing with the husband justifies GBV while 4.9% are of the view that refusing sex with husband justifies GBV.

Objective 3 Determine the prevalence, pattern, and risk factors of GBV among adolescents in the city of Ibadan

Majority of the adolescents identified as students and in-school (65.1%). A smaller percentage was involved in apprenticeships (26.6%) and even fewer worked in unskilled (2.3%) and skilled (2.0%) jobs or other occupations such as sales/services (1.7%) and agriculture/farming (0.3%). A minimal number reported being professionals (0.2%) or clerics (0.1%). Thus 34.9% of respondents were out of school adolescents.

Typically, the adolescents had mostly never been married (96.9%), with only 1.7% being married and 1.3% living together with a partner. Instances of divorce and separation were extremely rare, accounting for less than 0.2% of the sample. Additionally, the majority of the adolescents resided in urban areas (69.5%), while 30.5% lived in rural areas.

Expectedly, almost all adolescents had no children (97.5%), with only 2.1% having one child and a negligible 0.4% having two children. Gender distribution in the sample showed a slight predominance of females (58.2%) over males (41.8%). Regarding incidents where participants were slapped or pushed without sustaining injuries or lasting pain, a majority (53.8%) reported experiencing this type of abuse at least once, while 15.4% experienced it three times, and another 7.7% reported experiencing it eight times within the past year. This implies that more than four-fifth of the adolescent respondents had been slapped or pushed with minimal injuries sustained, within the past year.

Similarly, when examining more severe physical violence, such as being punched, kicked, bruised, or cut with continued pain, 69.2% of the participants reported never experiencing this, while 15.4% experienced it once, and smaller percentages reported experiencing this twice or four times.

When it came to more severe forms of violence, such as being beaten up with severe contusions, burns, or other serious injuries, 84.6% of the participants reported that they had never experienced this. However, 7.7% experienced this type of violence once, and another 7.7% experienced it five times under the review year. Additionally, 23.1% of the participants reported that their ex-partner or current partner had threatened to use a weapon against them, causing injury, while 76.9% did not experience such threats. Finally, regarding the actual use of a weapon that caused wounds, 15.4% reported this occurrence twice, and 7.7% reported it happening once, with the majority (76.9%) not having experienced this form of violence. The study indicated that age was significantly associated with the risk of GBV. Specifically, adolescents aged 10-14 years were more likely to be at risk, with 59.4% of this age group experiencing GBV, compared to 37.3% in the 15-19 age group (p= 0.021).

Employment status also showed a significant association with GBV risk. Adolescents who were not currently employed had a higher risk of GBV, with 46.6% reporting such experiences, compared to 28.6% of those currently employed and 26.2% of those not employed in the last 12 months (p=0.002).

In contrast, educational level, gender and residence did not show significant associations with GBV risk among the adolescents. Although there were differences in the percentages of adolescents experiencing GBV across various education levels, these differences were not statistically significant (p = 0.247). Similarly, gender did not significantly impact the risk of GBV, with both males and females reporting similar experiences (p = 0.268). Residence, whether rural or urban, did not significantly affect GBV risk among adolescents in the study. The findings indicated that 58.8% of rural adolescents and 62.0% of urban adolescents reported GBV risk, with no significant difference between the two groups (p = 0.552). The logistic regression analysis on the sociodemographic determinants of gender-based violence (GBV) risks among adolescents identified age and employment status as factors influencing the likelihood of experiencing GBV (Table 4.3.6). Age was a significant determinant, with adolescents aged 10-14 years being 2.43 times more likely to be at risk of GBV compared to their older counterparts aged 15-19 years, as indicated by an odds ratio (OR) of 2.430 and a p-value of 0.026.

Similarly, adolescents who were not currently employed were 2.825 times more likely to experience GBV compared to those who had not been employed in the last 12 months, with a statistically significant p-value of 0.002. Educational level of the partner significantly impacts the risk of GBV. Adolescents whose partners had only primary education exhibited a higher risk of GBV, with 68.4% of such cases reporting GBV

compared to 31.6% who did not (p = 0.033). This suggests that lower educational attainment among partners may be associated with a heightened risk of GBV.

Similarly, the partner's consumption of alcohol was significantly associated with GBV risk. Adolescents who were unsure if their partner consumed alcohol were more likely to report GBV (47.3%) compared to those who knew their partner did not consume alcohol (31.2%) or those who knew their partner did (33.3%). (p=0.014).

The use of hard drugs by the partners also showed a significant relationship with GBV risk. Adolescents whose partners used hard drugs reported a higher incidence of GBV (33.3%) compared to those whose partners did not (26.3%) or those who were unsure (43.5%) (p-0.044).

Objective 4 Assess the prevalence, pattern, and determinants of GBV among adult men in the city of Ibadan

Among respondents who identified as males and who had partners/spouses, 7.1% reported experiencing physical violence from their partners, making it the most common form of abuse in the section. Additionally, 3.6% had been threatened with harm or death by their partners. Other severe forms of abuse, such as choking, strangulation, or suffocation attempts, were reported by 2.4% of the respondents. Meanwhile, 2.7% reported threats or assaults involving weapons and 1.5% indicated that their partner had harmed or threatened to harm a family pet.

Also on controlling behaviors, 8.8% of respondents indicated that their partners controlled their access to money while 5.3% of respondents reported being stalked, harassed, or constantly contacted by their partners. Another 3.5% noted that the violence or controlling behavior in their relationship was worsening over time.

The background of the abusive partners reveals additional risk factors with approximately one-fifth (21.6%) of the partners being unemployed and 11.8% with financial difficulties. Although less common, mental health issues, including depression, were reported in 1.1% of cases and 1.5% of partners had substance abuse problems. Also, 1.5% of respondents mentioned that their partner had threatened or attempted suicide and 0.7% indicated that their partner had a history of violent offenses or was currently on bail or parole.

On presence of children in these households fifteen percent of respondents reported having children who were less than 12 months apart in age. Additionally, 5.2% of respondents experienced physical violence in front of their children and 1.4% reported that their partner had threatened or harmed their children. Conflict regarding child custody or residency was reported by 2.4% of respondents, while 4.6% indicated the presence of children from previous relationships.

Finally, on issues of sexual assault within these relationships, while 2.6% of respondents reported that their partner had engaged in sexually abusive behavior, a smaller percentage (0.7%) noted that their partner had been arrested for sexual assault. The analysis found no significant association between age group and the experience of GBV threats (p=0.368) and between residence and GBV threat (0.746).

However, employment status showed a significant association with GBV threat (p<0.001) as significant higher proportion of individuals who were not currently employed reported experiencing GBV threats (56.7%) compared to those who were employed (33.5%). Similarly, education level was significantly associated with GBV threat (p<0.001) as higher proportion of individuals with primary education (47.7%) or secondary education (47.2%) were more likely to experience GBV threats compared to those with tertiary education (39.2%).

The number of children was also found to be a significant determinant (p=0.033). Those with no children reported the lowest incidence of GBV threat (27.7%), while the proportion slightly increased with the number of children, and particularly increased among those with more than eight children (50.9%). Lastly, years of marriage showed a strong association with GBV threat (p<0.001). Individuals married for 1-5 years had lower proportion of reported GBV threats (36%) compared to those married for more than 10 years (49.3%).

Age is shown to be a significant factor, with younger males (particularly those aged 20-29 and 30-39) having a higher likelihood of experiencing GBV threats compared to those aged 50 and above. Specifically, males aged 20-29 have an odds ratio of 2.603 (p < 0.001), meaning they are over 2.6 times more likely to experience GBV threats than those aged 50 and above. Similarly, those aged 30-39 have an odds ratio of 1.935 (p < 0.001), indicating a nearly doubled risk of GBV threat compared to those 50 years and above.

Also, currently employed individuals are less likely to experience GBV threats, with an odds ratio of 0.585 (p = 0.005), compared to those not employed in the last 12 months. On the other hand, those not currently employed but who were employed at some point have a higher likelihood of facing GBV threats, with an odds ratio of 1.516 (p = 0.028) when compared to those who have not been employed in the last 12 months.

Individuals with no formal education are less likely to experience GBV threats, with an odds ratio of 0.525 (p = 0.001), compared to those with tertiary education. However, the likelihood of experiencing GBV threats slightly increases as the education level rises to primary and secondary education, though these associations are not statistically significant. Also, individuals with no children are less likely to experience GBV

threats, with an odds ratio of 0.392 (p = 0.014), compared to those with more than eight children. Lastly, the duration of marriage is significantly associated with GBV threat risk. Those married for 1-5 years are less likely to experience GBV threats, with an odds ratio of 0.328 (p < 0.001), while those married for 6-10 years also have a reduced likelihood, with an odds ratio of 0.675 (p = 0.001). The partner's age (p=0.500) does not show a statistically significant association with GBV threats. Similarly, (partner's smoking habit does not show to have a significant association (p=0.088)

However, the partner's employment status reveals a significant relationship with GBV threats (p < 0.001). Partners who are not currently employed (55.1%) or have not been employed in the last 12 months (53.2%) have higher proportions of being associated with GBV threats when compared to those currently employed (31.1%).

The partner's education level is also significantly associated with GBV threats (p = 0.002). Those whose partners had no formal education or only primary education were more likely to experience GBV threats compared to those with partners who had secondary or tertiary education. For instance, 40.8% of those with partners who had primary education reported GBV threats, compared to 47.0% for secondary education.

Alcohol consumption by the partner is another significant factor (p < 0.001). Partners who consume alcohol are more likely to be associated with GBV threats, with 63.4% of those whose partners consume alcohol reporting GBV threats, compared to 42.3% of those whose partners do not consume alcohol.

Drug use by the partner show a statistical significant association with GBV threat (p = 0.031). Partners who take hard drugs are more likely to be linked to GBV threats, with 56.2% of those whose partners use drugs reporting GBV threats, compared to 43.7% of those whose partners do not use drugs. Employment status, demonstrates a significant association with GBV threats as partners who are currently employed are significantly less likely to be associated with GBV threats, with an odds ratio of 0.355 (p < 0.001), compared to those not employed in the last 12 months.

Education level also plays a significant role in GBV threats. The odds ratios for partners with no formal education and primary education relative to those with tertiary education are 0.543 (p = 0.001) and 0.590 (p < 0.001) respectively.

Alcohol consumption by the partner shows a strong and significant association with GBV threats. Partners who consume alcohol have an odds ratio of 0.236 (p < 0.001), and those whose alcohol consumption status is unknown have an odds ratio of 0.411 (p < 0.001). Both groups are significantly associated with a lower likelihood of GBV threats compared to partners who do not consume alcohol.

Objective 5 Determine health workers' knowledge, attitude, and practice of GBV in the city of Ibadan

In terms of health facility distribution, most workers are employed in Primary Health Clinics/Centers (50.5%), followed by General Hospitals (34.2%). Gender distribution shows a predominance of female healthcare workers (83.4%), while males constitute only 16.6%. Professionally, the largest groups are Nurses/Midwives (34.7%) and Health Assistants and CHEWs (17.1%). Out of a total of 1,286 respondents, 1,001 (77.7%) express a positive attitude towards the urgent treatment of GBV survivors while, 285 (22.3%) have a negative attitude. Out of the 638 respondents, only 24.1% (154) correctly knew the meaning of GBV, while a majority 75.9% (484) did not, indicating a significant gap in basic understanding of GBV among HCWs.

When asked to identify the common types of GBV, 77.4% of respondents identified only one type, and 17.1% identified two types, while only 1.4% could identify four types. A small fraction (2.2%) of HCWs could identify three types, with just 0.2% identifying all five common types of GBV, demonstrating limited knowledge of the different forms of GBV. Medical care is the most frequently provided service, representing 81.5% (527 out of 647) of the total services offered. Counselling and psychological support follows with 54.4% (352), while referral services accounting for 42.7% (276). Screening and assessment services make up 28.9% (187), showing that health facilities prioritize medical treatment, mental health support, and referrals for survivors.

On the lower end, follow-up care is provided in 19.2% (124) of cases, education and prevention in 16.4% (106), and documentation and reporting in only 12.4% (80). The least common service is advocacy and empowerment, offered in just 3.7% (24) of cases. These figures suggest that while immediate care is prioritized, there may be gaps in long-term support and empowerment initiatives for GBV survivors.

It shows that a notable percentage of caregivers reported that health facilities provide STI-related services, with 43.3% referring victims to an STI/STD clinic, 39.3% giving prophylactic treatment and 4.9% sending swabs for STI tests, though 31.1% do not offer any such services. Most (73.6%) of facilities offer counselling to survivors, but only 21.3% refer victims to other service providers, like police or court.

A total 647 Health facilities were captured in the study. Among male adult survivors (≥18 years) in the last six months, the majority of facilities (77.0%) reported no cases, with 15.6% seeing between 2-5 cases and 4.5% reporting more than 5 cases. Comparatively, female adults presented more frequently, with 68.0% of

facilities reporting no cases, 17.6% seeing between 2-5 cases and 6.2% seeing more than 5 cases. This indicates that female adults are more likely to present as GBV survivors than male adults.

On monthly average, 80.2% of facilities reported no male adult GBV survivors, while 14.4% handled between 2-5 cases. For female adults, 74.8% of facilities reported no cases, with 19.3% seeing 2-5 cases on average. For 2023 as a whole, 64.1% of facilities reported no male adult cases, while 31.8% of facilities reported 2-5 cases among female adults, showing higher reporting for females.

Among children under 18 years, 80.5% of facilities reported no male child cases in the last six months, while 76.8% of facilities reported no female child cases. However, female children were more frequently seen, with 8.2% of facilities seeing more than 5 cases.

Objective 6 Determine the knowledge and attitude of respondents towards GBV in the city of Ibadan

Knowledge and attitudes of adult females on assumed justifiable reasons for gender-based violence (GBV) by partners in a relationship. Findings indicate hat most adult females do not consider the reasons justifiable for GBV, although a small percentage of respondents still hold beliefs that could perpetuate violence. Out of the 2,388 sampled adult females, only 2.9% agreed that a husband is justified in beating his wife if she goes out without informing him, while the vast majority (97.1%) disagreed. Similarly, 3.1% felt that neglecting children is a justifiable reason for violence, with 96.9% rejecting this notion.

Regarding other situations, 2.4% of respondents agreed that arguing with a husband could justify violence, while 97.6% disagreed. When asked if burning food was a justifiable reason, 3.1% agreed, while 96.9% did not. Finally, 4.4% of adult females believed that refusing sex with their husband justified GBV, with 95.6% rejecting this justification.

Among pregnant women, findings indicate that most adult pregnant females do not consider any reasons justifiable for GBV, although a small percentage of respondents still hold beliefs that could perpetuate violence. Out of the 2,027 sampled pregnant women, only 3.1% agreed that a husband is justified in beating his wife if she goes out without informing him, while the vast majority (96.9%) disagreed. Similarly, 3.6% felt that neglecting children is a justifiable reason for violence, with 96.4% rejecting this notion.

Regarding other situations, 3.2% of respondents agreed that arguing with a husband could justify violence, while 96.8% disagreed. When asked if burning food was a justifiable reason, 4% agreed, while 96% did not. Finally, 4.9% of adult females believed that refusing sex with their husband justified GBV, with 95.1% rejecting this justification.

End notes

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VI. Conclusion And Recommendation

Conclusion

Age, employment status, education level were strong significant factors that influence the occurrence of GBV in the study location, with younger adolescents and younger aged women at higher odds of receiving GBV from their partners. Further, the more the number of children in a marriage/union, the more likely the occurrence of GBV by the woman. Respondents that know their partners income were less likely to be involved in GBV, though the most common practice and norm is for both partners to keep each other in the dark as touching on finances. Pregnant women were also identified to suffer GBV in pregnancy, with most getting unreported.

Men are not excluded from GBV as a significant proportion admitted being abused physically and emotionally. However, most cases of male abuse never get reported as revealed by the hospital statistics. While most facilities reported cases among women, there were fewer reports of GBV among men by the healthcare

providers. This leaves the men suffering in silence due to stigmatization or worse still, more violence from their partners

Partner's behavior, such as alcohol consumption, and the use of hard drugs, were significant factors influencing GBV risks in Ibadan. The false euphoria and light headedness provided by alcohol and drugs clouds the abuser's judgement into violating a survivor.

The findings suggest significant gaps in the knowledge of healthcare providers and limited long-term support for survivors of GBV, with most healthcare providers displaying a negative attitude to GBV survivors.

The research highlighting the need for more public awareness, among the entire citizenry, about GBV and further torchlights the need to encourage the male gender to report GBV. Client-focused approaches, specific to individuals should be considered while designing interventions for GBV survivors.

Conclusion

This research has critically examined the trend and pattern of GBV among the adult and adolescent populations in Ibadan. The phenomenon is rife and persists. Social norms and practices, coupled with fear of stigmatization makes gender-based violence fester. There is a need to downplay on stigmatization of GBV survivors so as to encourage report and bring perpetrators to book.

Findings from this research have shed more light on GBV among men and generally on the determinants of gender-based violence in Ibadan, a better understanding of which will elicit protective policies for victims of GBV and more severe punishments for offenders. The research also present a blueprint for replication across all states of Nigeria and in sub-Saharan Africa.

Findings from this research will further stir up the consideration/inclusion/ review of relevant training modules in the curriculum of health-care providers such that they will be better positioned to manage GBV cases at their facilities.

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