Assessment of Gender Based Violence in Ibadan, Oyo State, Southwest Nigeria

Taiwo Iyabode OLARINDE
LCU/PG/001675

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2025

Certification

This is to certify that Taiwo Iyabode OLARINDE with Matriculation Number LCU/PG/001675 carried out this research work titled "**Assessment of Gender based Violence in Oyo State, Ibadan, Southwest Nigeria**" in the Department of Public Health, Faculty of Basic Medical and Applied Sciences, Lead City University, Ibadan, Oyo State, for the award of **Doctor of Philosophy Degree (PhD) in Public Health (Maternal and Child Health)** and this has not been previously submitted.

_____ _____

Prof Oliver C. Ezechi — Date

(Supervisor)

_____ _____

Dr. Folahanmi T. Akinsolu — Date

(Co-Supervisor)

_____ _____

Dr. Folahanmi T. Akinsolu — Date

(Head of the Department)

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Dedication

I dedicate this research to God Almighty, who has been my help in ages past and to all women, men and adolescents out there, who have experienced one form of abuse or the other.

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First, my gratitude goes to the Executive Secretary of the Oyo State Primary Healthcare Board, Dr Muideen Olatunji, and his team for the baseline information and support provided throughout this work together with the LGA Health Educators across the 11 LGAs of Ibadan.

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Abstract

Gender-based violence (GBV) is any harmful intimate relationship behaviour, directed at an individual based on their gender, that includes physical aggression, sexual assault, controlling behaviours, and psychological exploitation. Predominant among women and adolescents, males, particularly adult men and younger boys, also experience GBV, but societal norms of manliness frequently obscure their pain. There is paucity of research in the region that assessed the prevalence of GBV among men; greater dearth that further delineated between pregnant and non-pregnant women and between in-school and out-of-school adolescents. As such, the magnitude and patterns of Gender-based Violence most especially among men, adolescents and pregnant women in the State remains debatable. This study sought to assess the pattern, prevalence and determinants of GBV among men, women and adolescents in Ibadan. The study further assessed the healthcare workers' knowledge and attitude about GBV and identified the category of services offered to GBV survivors in health facilities within the State. This descriptive, cross-sectional study had structured questionnaires hosted on Kobo. SPSS 29 was deployed for data analysis. Inferential statistics examined data categories' relationships. Logistic regression determined independent predictors of GBV, at a p-value of 0.05. The research covered all 11 Ibadan LGAs. A total of 11,332 respondents comprising 2,951 adult men, 1,622 pregnant women, 1,911 non-pregnant women, 3,562 adolescents, and 1,286 healthcare providers were sampled. GBV prevalence was determined at 23.8% among female respondents The study revealed sociodemographic variables such as age, employment status, education level number of children and years of marriage as key determinants among women ($p<0.001$). Younger women (20-29 years) were at double risk of GBV when compared with other age groups (OR= 2.15, $p<0.001$). Women without children (38%) or with1-2 children (50.5%) were less likely to experience GBV when compared with women with 6-9 children (55%). Up to 11% of the pregnant women reported being currently physically abused by their partners, with 6% reporting sexual assaults. Pregnant women (30-39 years) were atleast seven times more likely to experience GBV than other age groups (OR= 7.476, $p=0.026$) More than half, (53.8%) of the surveyed adolescents experienced varying degrees of physical abuse from their partners, with younger adolescents (ages 10-14) at double risk of abuse compared to older adolescents (ages 15-19)(OR=2.43). The prevalence of GBV was 15.36% among out-of-school and 3.06% among in-school adolescents respectively. Among the in-school and out-of-school adolescents, sociodemographic variables like residence (rural or urban), and gender, do not significantly predict GBV risk; however, younger age, education status and unemployment status are key GBV predictors among the adolescents. GBV prevalence among men was found to be 13.7%. The research findings indicate notable deficiencies in the knowledge of healthcare providers regarding GBV, as well as insufficient long-term support for survivors. GBV persists in Ibadan with age, professional level, education, alcohol and drug use identified as strong predictors. Interventions for GBV survivors should be designed with a focus on individual-specific, client-centred approaches. Long-term support and empowerment strategies should be integrated into school and health facilities curricula for survivors of gender-based violence.

Keywords: Gender-based Violence, Nigeria, Men, Women, Adolescents, Healthcare providers

Word Count:500

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List of Acronyms

Abbreviation	Meaning
AOR	Adjusted Odds Ratio
ARI	Acute Respiratory Infections
CI	Confidence Interval
CEDAW	Committee For the Elimination of All Forms of Violence Against Women
DV	Domestic Violence
DPRS	Directorate of Planning Research and Statistics
ECOSOC	Economic and Social Council
GBV	Gender-based Violence
IPV	Intimate Partner Violence
IPVAW	Intimate Partner Violence Against Women
LBW	Low Birth Weight
LCU	Lead City University
LGA	Local Government Area
NBS	National Bureau of Statistics
NPC	National Population Commission
NPSV	Non-Partner Sexual Violence
PPD	Post-Partum Depression
SAC	School Age Children
SDG	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SMOH	State Ministry of Health
SPHCB	State Primary Healthcare Development Board

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UNFPA	United Nations Funds for Population and Development
US	United States
VAWG	Violence against women and girls
WHO	World Health Organization

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Chapter One
Introduction

1.1 Background to the Study

Gender-based violence (GBV) represents a critical international health crisis and is a stark expression of the power imbalance between genders. It serves as a major impediment to the ability of men and women to participate equally in the social, governmental, and economic aspects of life[1]. WHO identifies GBV within a close partnership as any conduct involving physical assault, forced sexual activity, emotional mistreatment, or controlling actions[3].

Such aggression commonly occurs between individuals involved in a romantic or sexual relationship, with females typically being the party subjected to the harm[4]. Globally, violence stemming from gender is understood to be a significant threat to public well-being and an urgent matter of fundamental human rights[5].

GBV, which is also termed Gender oppression through violence, includes all forms of abuse and mistreatment, including affection withholding, sexual, domestic assault, and gaslighting —forced upon someone against their consent, which is based on the culturally defined roles and differences between men and women.

Almost thirty years, the United Nations has consistently developed and revised its characterizations of GBV. The Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), during its 11th session, classified GBV as a form of prejudice that profoundly obstructs a woman's ability to access her rights and liberties on an equal basis with men[18].

The first article within the Declaration on the Elimination of Violence against Women, established by UN General Assembly resolution 48/104 on

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December 20, 1993, characterizes as "Any act of violence that results in, or is likely to result in, psychological, domestic assaults, or sexual harm or suffering to women, encompassing, but not restricted to, menacing conduct, coercion, or illegal confinement, happening in both private and public spheres"[18].

The most thorough definition that frames gender-based violence as a tool for subjugation and harm was put forth by the Economic and Social Council's (ECOSOC) Humanitarian Affairs Segment during 2006, portraying it as "Any harmful act committed against a person's volition and based on socially constructed differences between males and females." The consequences of these acts manifest physically and mentally, leading to enduring negative impacts on those who have experienced the violence and the societies they live in[18].

Universally, females possess diminished authority compared to males when it comes to autonomy over their own bodies, access to assets, and the power to make choices. Cultural standards that approve of male aggression as a method for asserting authority, enforcing order, and maintaining power intensify the disparities between genders and sustain the cycle of gender-based violence. On a worldwide scale, females, with a specific emphasis on those in their teenage years, face the greatest vulnerability[19].

Violence based on gender involves cruel and damaging actions targeted at people because of their gender. Its foundations lie in the imbalance of power between genders, damaging societal standards, and the misuse of authority. This form of violence is a profound breach of basic human rights, a danger to physical well-being, and a critical issue of personal safety.

Disturbingly, projections indicate that a third of all women are expected to endure some form of sexual or physical assault during their lives[20,21].

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UNICEF has identified Gender-Based Violence as the most widespread and deeply ingrained, yet simultaneously most concealed, violation of human rights on a global scale[19]. This encompasses harm that is sexual, bodily, financial, or psychological in nature, inflicted because of socially constructed power disparities between men and women. Furthermore, it involves the menace of aggression, the use of force, and the restriction of freedom, regardless of whether these acts occur in a public or personal setting[19, 24].

The global pervasiveness of gender-based violence stems primarily from institutionalized gender disparity, which marginalizes females, young women, and other minority groups[24]. This system suppresses their ability to speak out, leading to their narratives being ignored and their fundamental human rights being readily stripped away[24].

While gender-based violence serves as a method to create, uphold, and continue imbalanced power structures between genders, it is evident that these power dynamics are concurrently influenced by additional factors of marginalization, including social status, caste, age, sexual orientation, and racial or ethnic background[22]. This brutal pattern of aggression is sustained by an absence of legal recourse, a scarcity of support systems, and limited financial independence, all of which contribute to the survivor's reliance on the person causing the harm. As an illustration, in the United States, a mere two percent of those who commit rape can expect to be imprisoned. Globally, those responsible for so-called "honour killings" seldom face legal consequences, which enables aggressive individuals and factions to persist in their misuse of authority, free from the worry of punishment[23].

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During 2019, the World Bank designated the issue of violence targeting women and girls as a crisis of worldwide pandemic proportions[21]. Data released in 2023 by the High Commissioner of UN for Refugee reveals that 1/3 women is projected to go through gender-based violence at some point in her life[20, 21]. It continues to be significantly under-documented, a consequence of the quietude, lack of legal consequences for perpetrators, humiliation, and social disgrace associated with it[25].

The UN defines Violence against Women and Girls (VAWG) as "any gender-related act that causes, or has the potential to cause, emotional trauma, bodily violation, or physical injury to women—including threats of such behavior, unjust restrictions on personal freedom, and acts of coercive control—whether in private settings or public spaces"[6]. VAWG presents itself through bodily, carnal as well as emotional means, exemplified by:

- Aggression within close partnerships (which encompasses physical assault, emotional mistreatment, rape within marriage, and the killing of women);
- Sexual violation and unwanted advances**,** which includes actions like rape, forced sexual contact, unwelcome propositions of a sexual nature, the sexual abuse of children, marriages entered into under duress, unwelcome attention in public spaces, persistent following or watching, and online persecution.
- The trade of human beings, involving practices of servitude and forced sexual acts.
- The procedure of female genital mutilation.
- Marriage involving minors.

The statistics on gender-based violence from the WHO and UNFPA for the year 2023 paint a stark and troubling picture:

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- More than a third of all women (35%) have been subjected to either sexual or physical aggression[24].
- Across the world, seven percent of women have been the victims of a sexual attack from someone other than a romantic partner[24].

- Globally, a significant portion of all murders of women, reaching as high as 38%, are carried out by a male partner[24].
- The practice of female genital mutilation or cutting has impacted 200 million women and girls worldwide[24].
- Females make up the overwhelming majority (90%) of individuals who have been raped[24].
- It is a shocking reality that 80% of adult survivors of rape knew their assailant, and for survivors who are minors, that number climbs to over 90%[26].
- In some parts of the world, a considerable number of women hold the view that violence from a husband is acceptable in particular situations. In countries like Ethiopia, Bhutan, India and Laos, this perspective is shared by more than 1/2 of the female population[26].
- More than 90% of offenders do not experience justice[26].
- Gender-based violence incurs significant economic costs, with pay losses equating to the annual military expenditures of all nations combined [26].

Violence and attacks have a profound impact on survivors and their families, incurring substantial community and income-related consequences. Patriarchal violence is a pervasive problem that affects everyone, either directly or through acquaintances[26]. In certain nations, abuse targeted at women is estimated to incur costs equivalent to 3.7% of GDP, surpassing the educational expenditures of some governments by more than double[24]. Gender-based violence frequently remains unrecognized, unaddressed, and unmitigated. A

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preliminary step towards rectifying the injustice of violence against women involves a deeper understanding of the various forms of violence women endure, followed by the exploration of optimal strategies to tackle each specific type of violence[26].

Gender-based violence inflicts deep and enduring harm, leaving survivors with dire immediate and lasting impacts on their physical and psychological state[19]. Victims, particularly women and girls, often face consequences such as unintended pregnancies, contraction of sexually transmitted infections like HIV, and serious bodily harm. Psychological trauma is also widespread, frequently appearing as post-traumatic stress disorder (PTSD), a diminished capacity to perform everyday activities, depression, anxiety, and thoughts of suicide[19].

The repercussions of this violence extend to increased rates of sickness and death, diminished personal and professional output, and a significantly lower quality of life. This form of violence encompasses a wide spectrum of abuse—including sexual, physical, mental, psychological, and financial damage—and can involve coercive tactics, threats, and manipulation in both public and private spheres[2]. Culturally, gender-based violence appears in various guises, from sexual assault and domestic abuse to child marriage, and non-consensual genital alteration[22].

Ultimately, the impact of gender-based violence is catastrophic, creating lifelong challenges for those who endure it and, in the most extreme cases, even resulting in fatality[19,20].

While females who experience gender-based violence may come forward to the authorities, it is contended that men who are victims encounter societal pressures that deter them from reporting. They face potential social disgrace tied to perceived failures in their manliness and other criticisms of their masculinity[2].

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In its foundational report on abuse and wellbeing, the World Health Organization highlighted that most experts concur that official data does not reflect the true number of male rape victim[22].

Prevalence of male victimization in sex-based violence is little documented and insufficiently examined both worldwide and within Nigeria.

Gender-based violence (GBV) endangers men's health. Society often recognizes gender-based violence against women more than that against men, hence inhibiting males from reporting their circumstances[2]. This is partly due to the widespread societal dominance of men in positions of authority[2]. Limited research has investigated the frequency, patterns, and correlations of gender-based violence among male victims in Nigeria.

About a third of adult females experience sexual or physical abuse in their lives, mainly by a relationship partner. The prevalence of gender-based violence serves as a sharp reminder of gender inequality and discrimination against women. Chronic exposure to gender-based violence (GBV) is a predictor of numerous acute and chronic diseases, as well as stress-related disorders in women[7].

Violence based on gender remains a major public health problem worldwide for expectant mothers. In the region of Sub-Saharan Africa, more than four out of ten women reported suffering mistreatment by their intimate partners[8]. Sex-based violence continues to be a global wellbeing concern that impacts the well-being of both mother and unborn child among pregnant women. It represents the main cause of recorded physical injury while expecting, with its frequency varying between different countries and within them. Numerous studies have shown that women who experienced gender-based violence before becoming pregnant often kept facing its consequences throughout their pregnancy. The

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specific demographic details, psychological and thought processes, and cultural backgrounds of a woman and her partner are the primary determinants of gender-based violence (GBV).

Violence against women before birth has been associated with negative pregnancy outcomes, including reduced infant birth weight[10]. The way that being subjected to gender-based violence during pregnancy can affect the results of

childbirth includes a combination of immediate and secondary biological effects on the developing fetus. Prenatal gender-based violence is a risk factor that can potentially be changed to prevent low birth weight (LBW). A detailed single-point-in-time study of 1180 expectant mothers getting prenatal services in Dar-es-Salaam, Tanzania, carried out by Mahenge and colleagues, found a significantly higher likelihood of anxiety, stress disorders, and signs of depression among females who had experienced sexual or physical violence based on their gender while pregnant.[11] Behaviors such as tobacco use, drinking alcohol, and not making sufficient use of maternity health services are linked to occurrences of gender-based violence[9].

Women frequently look for help and support after experiencing violence. The way women approach seeking healthcare for gender-based violence is determined by a variety of elements. Research carried out in 2019 by Olaoye et al. with women facing GBV in Isolo, Lagos State, Nigeria, showed that a large percentage of participants (59.5%) pointed to the dispositions, methods, and prejudices of healthcare staff as barriers to getting help. The participants experienced various forms of gender-based violence, which was associated with their less-than-ideal efforts to find support. This study, which focused on how healthcare providers manage patients affected by GBV, suggested that staff at

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medical facilities should undergo thorough training to better show compassion for survivors[12].

Even though it is a relatively new area of focus, the problem of violence in schools has drawn growing concern from both the scientific community and the public lately. Aggression amidst youth represents a significant worldwide problem and a critical public health challenge. This problem includes avoidable illness and death affecting both males and females in diverse cultural settings. Consequently, efforts to identify risk and safeguarding elements have intensified.

In Nigeria, there has been scarce investigation into the scope and dynamics of youth violence within school environments[13,14].

1.2 Statement of the Problem

Gender-based violence is globally known as a great threat to society wellness and a critical people's rights violation[5]. This study addresses Gender-based violence holistically, defining it as aggression intended to enforce and maintain power disparities rooted in restrictive gender norms; this definition includes violence directed at women, men, and adolescents of both genders.

The expression of gender-based violence is varied, ranging from the widespread issue of abuse by a close partner to violent acts carried out in online settings. These different types of violence often coexist and can intensify one another[26]. Furthermore, discrimination based on factors such as age, race, disability, socioeconomic standing, religion, or sexual orientation can also be a catalyst for such violent acts.

It is estimated that 1/3 of all women will be subjected to physical and/or sexual violence during their lives, most often by a partner[27]. Statistics from the UNFPA show that Oyo State has a gender-based violence prevalence rate of about 8%, while Gombe State reports the nation's highest rate at 36%, and Sokoto

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State the lowest at 3%[28]. By 2021, in Oyo State, Nigeria's fifth most populous state with over 8 million people, an estimated 17% of women have been abused physically. Supporting this, the Oyo State gender violence response team noted a sharp rise in females reporting violence, 122 cases in 2018 to 770 in 2020[28]. Additionally, data from 2018 indicated that a troubling 13.8% of Nigerian females aged 14-49 who had ever had a partner had suffered psychological, sexual abuse or physical abuse from that partner within the last year[29].

In Nigeria, educational achievement and employment status have been identified as key factors that influence the dynamics of gender-based violence[17,24,25,30,31,32]. Being a victim of GBV increases the risk for a wide range health problems, such as stress-related conditions in women[7]. The persistence of gender-based violence is unacceptable, especially when measured against Sustainable Development Goal (SDG) five, which is dedicated to achieving gender equality and empowering all women and girls[6].

Moreover, there has been increasing societal and scientific apprehension around this issue. Violence among youth constitutes a major public health concern and a pervasive issue globally. Studies show that a propensity for aggression and violent acts among adolescents is associated with a combination of influences from their surroundings, personal makeup, and specific circumstances. This issue has a deep and lasting effect on those who experience violence and their loved ones, resulting in considerable financial and societal burdens. In some nations, the economic toll of violence targeted at women is calculated to be as high as 4% of the gross domestic product, a figure that is more than twice the typical government budget for primary education[6].

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Neglecting to resolve this issue will incur substantial future costs. Research indicates that children exposed to violence are more likely to become either perpetrators or victims of gender-based violence[31,32].

A notable feature of sex-based violence is its disregard for social or economic boundaries, impacting women and girls across all strata; this issue necessitates attention in developing and established nations[33].

Gender-based violence directed at males is typically less acknowledged by society compared to GBV against women, hence hindering males' willingness to report their circumstances. This is also due to the cultural perception that males possess strength, making it difficult to regard them as victims[2]. The inquiry offers actual proof and foundational data inside our surroundings, so establishing a platform for developing preventive strategies. It also aids in the design of systems and solutions specifically aimed at effectively and suitably addressing the requirements of victims[2].

When subjected to gender-based violence, individuals naturally gravitate towards support from either official institutions or personal networks. In the context of Nigeria, the ways in which mothers pursue healthcare are shaped by a variety of interlinked influences. There is a notable gap in academic literature exploring how societal conventions and the power dynamics between genders—specifically the social tolerance of intimate partner violence against women (IPVAW)—impact a woman's autonomy in decision-making, her patterns of seeking health support, and her overall welfare[15].

1.3 Justification for the Study

The rising incidence of gender-based violence (GBV) necessitates a thorough examination of its causes, determinants, and exacerbating factors within the Nigerian context to develop effective ways to mitigate this issue. Moreover,

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the majority of research have extensively examined gender-based violence (GBV) in women, resulting in a disproportionate focus that neglects males as victims. Determining the prevalence of violence against females necessitates a community-oriented and multifaceted strategy. Continuous interaction with all stakeholders is essential. Effective programs tackle the root causes or risk factors of violence, including social construct related to gender roles or identities, and the permissibility of violence [24].

The issues pertaining to gender-based violence may not have been thoroughly examined, resulting in a general rise in GBV incidents in Nigeria. Moreover, the majority of research neglected to address men and adolescents as victims. In Nigeria, as in other regions, gender-based violence continues to impede women's autonomy and possibilities[33]. This study examined gender-based violence in Nigeria, focusing on men, adult non-pregnant women, pregnant women, and teenagers (both in-school and out-of-school), to comprehend the issue and suggest viable solutions to the increasing prevalence. This research examined the seeking of help behavior of abuse victims with the responses of medical providers in addressing gender-based violence in Ibadan. The study identified and presented novel, realistic, and repeatable techniques, methodologies, and tactics at both community and policy levels to address and mitigate the occurrence of GBV in Ibadan, Oyo State, Nigeria.

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1.4 Aim and Objectives of the Study

1.4.1 General Objective

The primary aim of this research was to assess gender-based violence in Ibadan, Oyo State, located in Southwestern Nigeria.

1.4.2 Specific Objectives

The precise aims of this research were to:

i. Assess the frequency, patterns, and predictors of gender-based violence among adult non-expectant women in Ibadan.

ii. Evaluate the frequency, patterns, and related risk factors of gender-based violence among pregnant women in Ibadan.

iii. Assess the frequency, patterns, and risk factors of gender-based violence among in and out-of-school adolescents in Ibadan.

iv. Evaluate the prevalence, patterns, and drivers of gender-based violence among adult males in Ibadan.

v. Assess the knowledge, attitudes, and practices of health workers regarding gender-based violence in Ibadan.

vi. Assess the knowledge and attitudes of female respondents regarding gender-based violence.

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1.5 Research Questions

The research was designed to find answers to the following questions:

1. What is the rate of occurrence and what are the determinants of gender-based violence affecting adult women who are not pregnant?
2. How widespread is gender-based violence among pregnant women, and what are the associated risk factors?
3. What are the impacts and risk factors connected to gender-based violence experienced by adolescents?
4. What is the frequency of gender-based violence among adult men, and what factors contribute to it?
5. What are the levels of awareness, perspectives, and professional conduct of healthcare workers in relation to gender-based violence?

6. What is the understanding and perspective of women study participants regarding gender-based violence (GBV)?

1.6 Hypotheses

The following Null Hypotheses(H0) were tested:

Ho1: Men with fewer socio-economic resources than their female partners are not likely to use physical violence and coercive control than men with resources equal to or greater than their female partners.

Ho2: Women with more significant economic resources are not likely to experience physical violence and coercive control within intimate partnerships.

Ho3: Individuals with more significant economic resources are not likely to experience gender-based violence within intimate partnerships.

Ho4: Older women are not likely to experience GBV from their partners

Ho5: Younger Adolescents are not likely to be at higher risk of GBV

1.7 Significance of the Study

This research sought to uncover the frequency, characteristics, and contributing factors of gender-based violence affecting victims such as women (both expectant and not), adolescents, and men. The goal was to illuminate the magnitude of this often-unreported problem to better inform advocacy for its prevention, intervention, and the restoration of survivors. More specifically, the investigation concentrated on identifying and detailing the patterns, prevalence, and underlying causes of gender-based violence experienced by adult females, regardless of pregnancy status, throughout the eleven Local Government Areas that constitute Ibadan. A comprehensive study of the factors influencing GBV

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among expectant and non-expectant women facilitated the identification of practical strategies to mitigate GBV within this demographic cohort. This research elucidated the prevalence and factors contributing to gender-based violence among adolescents as victims. According to the UNFPA population statistics portal, 12.6% of Nigerian teenagers aged 15-19 have encountered intimate relationship abuse, which encompasses rape as a type of gender-based violence[29]. The research aimed to validate, disprove, or challenge this data, particularly among young ones in Oyo State. What factors may have contributed to the maltreatment of adolescents? Are there modifiable factors contributing to GBV that may be managed or eliminated to prevent its recurrence among the state's in and out-of-school adolescents? This research elucidated this conundrum.

The investigation clarified the prevalence, characteristics, and underlying causes of gender-based violence (GBV) as experienced by men. Compared to the volume of work on female victims, there is a significant lack of research and academic literature concerning gender-based violence against males[13]. Reports

of such violence targeting male victims are less frequent, partly because societal norms surrounding masculinity often discourage men from admitting they are victims, leading to shame, embarrassment, and fear of being seen as weak.

A thorough examination of the elements that contribute to GBV among men is essential for devising programmatic and practical interventions to address this trend. This particular research initiative is designed to tackle the barriers and social stigma that men in Ibadan, Oyo State, Nigeria, face when reporting GBV. Consequently, the study's conclusions will be incomplete until it fully identifies the level of understanding and the perspectives of GBV survivors regarding the issue, in addition to the patterns of help-seeking behavior among those who have

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been abused. The methods by which survivors of gender-based violence sought care (including location, means, and sources) were also examined. Healthcare professionals are inherently equipped to handle incidents of abuse. Nevertheless, their methodologies for addressing diverse abuse scenarios within healthcare facilities remain ambiguous.

Accordingly, this investigation also sought to determine and clarify the understanding, perspectives, and professional conduct of healthcare providers in Ibadan concerning gender-based violence. A clear comprehension of this phenomena might prompt beneficial policy modifications in both the training curriculum for healthcare staff addressing victims of gender-based violence and the establishment of health facilities designed to manage such situations effectively. Survivors of gender-based violence will inherently seek assistance through either formal or informal avenues. This research analyzed and provided concrete, foundational data that illustrates how healthcare professionals interact with and manage cases involving survivors of gender-based violence. This will function as a framework for developing policies, devising preventive measures, and conceptualizing rehabilitation programs for survivors. It finally enabled the creation of mechanisms and solutions that effectively and suitably address the requirements of survivors.

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1.8 Scope of the Study

This research investigated the prevalence of gender-based violence across diverse groups in Ibadan, including adult men, pregnant women, non-pregnant women, and adolescents (both in and out-of-school). The study specifically analyzed the frequency, characteristics, and associated factors of this violence within the eleven (11) Local Government Areas that comprise Ibadan. Furthermore, it explored the conduct of healthcare providers toward these

survivors. The research made sure to include adolescents from both educational and non-educational settings.

1.9 Limitation of the Study

The study was restricted to the eleven LGAs in Ibadan. Nevertheless, the research's sampling technique and the number of participants were intentionally designed to compensate for this limitation. This approach ensured that the study's conclusions could be generalized and were reflective of the entire State and broader geographical region. The study did not encompass the justice-seeking and health seeking behavior of GBV victims. Further, this study did not assess the pregnancy outcome of abused pregnant women.

1.10 Operational Definition of Terms based on its usage in the body of work

Adolescents: This is the stage of life between childhood and adulthood, usually from ages 10 to 19.

Adult: A person more than 18 years of age

Child: A person less than 18 years of age.

Co-habiting: A male and a female living together in one room but not in any legal union

Formal Marriage: In a marriage or relationship consummated in a court of law, church or mosque with couples issued a marriage certificate.

Gender-based Violence: any behavior within an intimate relationship, inclusive of acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Healthcare Provider: A doctor, registered nurse (RN), community health extension worker (CHEW) or community health officer (CHO).

Pregnant Woman: A woman in any stage of gestation

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Chapter Two
Literature Review

Studies reveal an association between gender-based violence and a spectrum of societal, cultural, academic, and personal factors. The issue of gender-based violence represents a worldwide crisis, affecting countless people

long before the Covid-19 pandemic emerged. An exploration of the concepts "gender-based" and "violence" follows.

2.1 Empirical Studies

2.1.1Gender

Gender refers to the roles, characteristics, and opportunities that society assigns to women, girls, men, and boys. This includes the norms, actions, and expectations associated with being masculine or feminine, as well as the ways people of all genders interact with one another. Because it is a social concept, the meaning of gender varies across different cultures and can evolve over time[1].

The concept of gender creates a power structure, leading to disparities that overlap with other forms of social and financial inequality. Discrimination based on gender often combines with other grounds for prejudice, such as a person's financial status, disability, age, ethnic background, place of residence, sexual preference, and personal sense of gender[1].

Stated gender orientation is an individual's deep-seated, internal perception of their own gender, which might not align with their biological features or the sex they were assigned when born[1].

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2.1.2Adolescents

The United Nations (UN) defines an adolescent as any person between the ages of 10 and 19. This period marks a passage from childhood to adulthood,

characterized by significant physical and psychological changes. This age bracket aligns with the World Health Organization's classification of "young people or youths," which includes those from 10 to 24 years old[2].

Across many cultures and societies, the adolescent period is strongly linked to the onset of puberty and the bodily changes that result in the ability to reproduce. However, in different cultural contexts, the concept of adolescence is broader, incorporating mental, societal, and ethical development in addition to the biological aspects of growing up. Within these societies, the adolescent stage is considered to last from about age twelve to twenty, which is approximately the same as the teenage years[2].

Violence during adolescence refers to harmful actions or patterns of behavior that can begin during these formative years. A young person can be involved in such violence as a perpetrator, an observer, or a recipient of an aggressive act. Violent acts include the following:

- Harassment
- Engaging in physical altercations, such as kicking, punching, striking, or slapping
- Utilization of armaments include knives, firearms, or machetes. Certain violent acts may yield greater emotional than bodily damage. Others may result in grave, life-threatening injuries or fatalities[3].

Gender-based violence is a worldwide people's rights issue that stems from a variety of societal factors. Adults with young ages are identified as a group

with significant vulnerability; on a national scale, contributing elements include cultural norms, government policies, and established practices[4]. A

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comprehensive study involving 30 different nations found that an estimated 30% of adolescent girls and 31% of women at young ages reported having experienced physical or sexual intimate partner violence (IPV) at some point in their lives. This issue was most pronounced in the regions of Southern and Eastern Africa. The study also observed variations in violence patterns based on age across different countries, indicating that young adult women face a greater likelihood of recent (past-year) intimate partner violence than their older counterparts. The particular risk faced by youth changes from country to country, highlighting an interaction between age and location[4].

2.1.3Violence

The World Health Organization (WHO) defines violence as the "intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation"[5].

Fatalities resulting from interpersonal violence are only a small fraction of its total burden; for each death, there are many more episodes of violence that cause a variety of health wellbeing and social consequences[5]. An individual's prior experience with aggression elevates their risk of subsequently being either subjected to or committing violent acts. Violence between persons exhibits a distinct gender-based dimension, wherein males constitute the predominant share of fatalities, whereas violence targeting females is a widespread assault and

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human rights problem that originates from gender inequality and harmful gender customs[5].

The contributors to interpersonal violence are multifaceted and can be identified within personal, relational, environmental, and societal contexts.

The Sustainable Development Goals represent a potentially effective agenda for violence prevention, and their proper execution will substantially aid in mitigating all types of interpersonal violence. Violence prevention necessitates the collaboration of several sectors to execute evidence-based solutions that priorities inclusivity, human rights, equity, and a life-course perspective[5,6,7].

2.1.4 The indicators for "violence" under the Sustainable Development Goals (SDGs)

The subsequent SDG indicators have been employed to monitor violence pertaining to the SDG targets 3, 5, 8, 10, 11 and 16 [5,7,8]

3.5.2 The detriment of alcohol usage is defined nationally as the per capita intake of pure alcohol, measured in liters.

5.1.1 The establishment of legal structures aimed at implementing, advancing, and supervising equal treatment and the prohibition of discrimination on the grounds of sex.

5.2.1 The percentage of females, aged 16 and more, who have ever had an intimate partner and had sexual, mental, or have been physically abused by present or previous love partner within last one year, broken down by the specific form of violence and by age group.

5.2.2 Proportion of females aged above 15 years that encountered sexual assaults by non-intimate partners in the preceding year, categorized by age and location of incidence.

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5.3.1 Proportion of 20–24-year-old women that entered into a partnership or marriage prior to the ages of 15 and 18.

10.3.1 Percentage of the population indicating experiences of discrimination or harassment within the past year based on a banned ground under people's rights international rules.

11.7.2 The rate of people who have experienced harassment physically or sexually in the last one year, detailed by their gender, age, disability status, and where the event occurred.

16.1.1 The amount of people who experienced deliberate killing for every 100,000 people, broken down by gender and age.

16.13 The percentage of the entire people that has been subjected to physical, mental or sexual violence within the past year.

16.14 The percentage of people who feel secure when walking by themselves in the location where they reside.

16.21 The rate of children between the ages of 1 and 17 who have experienced any type of physical discipline and/or emotional aggression from their caregivers in the last month.

16.22 The number of human trafficking victims per hundred thousand people, classified by gender, age, and the specific type of exploitation involved.

16.31 The percentage of individuals who, after being victims of violence in the previous year, reported their victimization to the proper authorities or other formally recognized systems for resolving disputes.

Precise and dependable data on gender-based abuse of women are essential for enhancing our comprehension of its occurrence, characteristics, and effects, as well as for assessing variations across contexts and age groups, and for tracking temporal changes[9].

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2.1.5 Forms of Violence

Gender-based violence (GBV) is expressed in a multitude of ways, encompassing everything from the well-known problem of abuse between intimate partners to harmful conduct in digital settings. These diverse expressions of harm are not separate phenomena; in fact, different forms of abuse can occur concurrently and amplify one another's destructive effects.

Abuse can be perpetrated by anyone, including partners, family members, acquaintances, and strangers, and can occur in both private and public settings. Inequities associated with an individual's age, socioeconomic status, ability or disability, religion, and sexual orientation can potentially incite acts of violence. Consequently, although women encounter violence and prejudice due to their gender, certain individuals endure intersecting kinds of abuse. Ten Violence manifests differently in various contexts, with each type capable of occurring independently or concurrently[10].

All manifestations of violence are harmful and entail perilous repercussions for both survivors and victims.

Sexual Assault

Sexual violence is defined by WHO as "any intimate act, an attempt to procure a sexual act, unsolicited sexual advances or remarks, or trafficking acts, directed at an individual's sexuality through coercion, by any perpetrator, irrespective of their relationship to the victim, in any context, including but not limited to domestic and occupational environments [11]." Sexual violence is a widespread problem that covers a range of actions. It includes rape, which is defined as the penetration of the vulva or anus with a penis, another body part, or an object,

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compelled either by physical force or through coercion. The term also encompasses coerced physical intimacy, unsuccessful attempts at sexual

violation, and other forms of sexual misconduct that do not involve direct touch. In essence, sexual violence is classified as either rape or sexual assault[10].

Aggression / Physical Violence

WHO characterizes physical violence as "the intentional or calculated application of power or physical force, whether actual or threatened, against oneself, an individual, or a group or community, which either leads to or has a significant likelihood of leading to injury, psychological harm, maldevelopment, deprivation, or death"[10,11].

Economic Violence/ coercion

Any action or conduct that poses an economic danger or inflicts injury on an individual. Economic violence may manifest as the restriction or withholding of access to financial resources, education, employment opportunities, property damage, or failure to fulfil economic obligations, such as alimony[10 13].

Domestic violence

Domestic (Interpersonal) violence refers to violence occurring in intimate partnerships where individuals of any gender may be subjected to or responsible for acts of violence. Domestic violence extends beyond partner violence and includes abuse directed at those residing in the same household, such as siblings, children, or grandparents[11].

2.1.6 Violence Against Women and Girls (VAWG)

VAWG refers to any form of gender-motivated harm that causes, or has the potential to cause, sexual violation, bodily injury, or psychological trauma to women and girls. This includes unjust restrictions on freedom, coercive tactics,

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and threats of such actions—whether they occur in private settings or public environments[9,12,14].

VAWG impedes growth, peace, equality, and the realization of females' fundamental rights. The objective of the Sustainable Development Goals—to

ensure nobody is left behind—cannot be achieved without eradicating abuse against women and girls[15,16].

As a prevalent, devastating, and persistent infringement on human rights, VAWG frequently goes undocumented due to the surrounding quiet, social disgrace, lack of consequences for perpetrators, and feelings of embarrassment. VAWG generally manifests in physical, sexual, and psychological ways, which include[17]:

- Violence within intimate partnerships (psychological torment, bodily harm, the killing of women, spousal rape)
- juvenile matrimony

The term violence against women can be used interchangeably with gender-based violence when the intention is to target women for assistance or to emphasize that they are the demographic most vulnerable.

Violence against women manifests differently across the globe, yet it remains a universal phenomenon[11,18]. Additionally, one-fifth of women have faced sexual abuse during childhood. Such violent acts, intended to restrict women's autonomy and infringe upon their freedom, are frequently tolerated or anticipated by communities[19].

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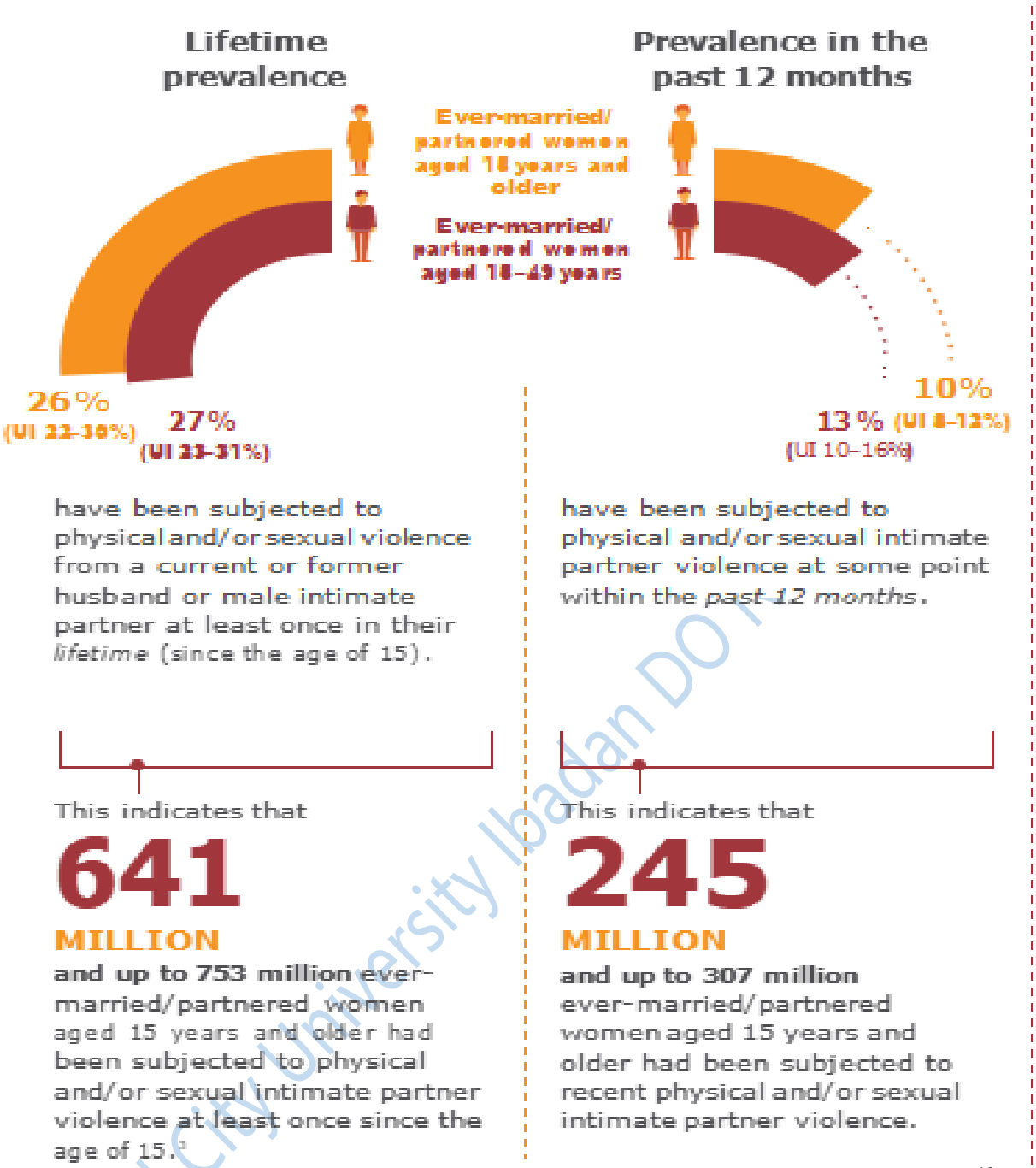


Figure 2.1: Worldwide report showing prevalence of violence against women[19]

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2.1.7 A Comparative Analysis of GBV and Non-Partner Sexual Violence.

Although female encounter various forms of violence, these two types constitute a significant fraction of the violence they face worldwide. The combined prevalence figures for the two categories of violence offer a more comprehensive understanding of the number of women who endure abuse throughout their lives, however, it fails to capture the complete magnitude of abuse experienced by women. partners, or both forms of abuse at least once since 15 years[19].



Figure 2.2: GBV and NPSV among women worldwide[19]

2.1.8 Gender-Based Violence and domestic violence are analogous ideas frequently perceived as identical. Nonetheless, significant distinctions exist among them, each with different ramifications for governments, care providers, and survivors. Analyzing these distinctions is crucial for understanding how survivors encounter violence on a daily basis [11]. Research indicates that various socioeconomic, cultural, educational, and individual factors correlate with gender-based violence. Gender-based violence (GBV) constitutes a global pandemic, with numerous individuals having suffered from it even before the onset of Covid-19. International organizations have reported a rise in the prevalence of GBV during the pandemic. Having direct or indirect exposure to violence in childhood serves as a key indicator for an individual's likelihood of either perpetrating or being subjected to abuse in their adult years[21]. This association between past knowledge and abusive acts has led academics to

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suggest that mental constructs, like the acceptance of violence as a valid tool in family interactions, contribute to the intergenerational transfer of aggressive tendencies[26].

Research narratives and interviews revealed complex discourses surrounding these gender-related issues. In certain male-dominant cultures, greater educational attainment among women may increase their vulnerability to gender-based violence[9]. This observation is associated with the propensity of educated women to contest male authority[29]. Males exerted dominance over females in sexual relationships by suppressing discussions about condom use and participating in multiple sexual partnerships[21]. Females tolerated male dominance in sexual interactions to maintain those connections. Poor socioeconomic standing compels older men to exploit younger ladies in sexual encounters. Significant age disparities and the expectation to comply with their role in compensated sexual relations hindered younger girls from negotiating safe sex[27]. Moreover, healthcare practitioners exhibited bias and indifference in delivering medical services to emerging adults [27].

An integrated analysis of risk enhancers and protective barriers for gender-based violence indicates that the more modifiable predictors risk factors affecting women pertain to unplanned pregnancies and parental education levels below high school, which the authors linked to lower socioeconomic status[28]. Numerous studies have shown that inadequate educational attainment is a dangerous factor for both preparedness and victimization. Other characteristics connected to GBV include tribe, location, and the spouse taking alcohol. Respondents' spouses were mainly envious and demonstrated some type of controlling behaviour. Physical assault was the predominant form, and the

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majority of victims took no action. In certain male-dominant cultures, elevated educational attainment among women may increase their vulnerability to gender-based violence[29]. This observation is associated with the propensity of educated women to contest male authority[29,32]. Contemplating the risk factors linked to GBV underscores the necessity of comprehending how particular elements trigger incidents of GBV [21,15].

The UN characterizes gender-based violence as "any behavior related to violence predicated on sex that results in acts of coercion, assault, or emotional trauma targeting women, occurring in either private or public spheres[11]"

Sex-based violence is a more comprehensive term than violence against females. Gender-based violence may encompass abuse against men, contingent upon the abuse stemming from perceptions of male gender identity or expression Gender-based violence may also encompass violence suffered by those who do not comply to traditional gender norms. Acknowledging abuse against sex non-conforming individuals is critical, as their way to care and support services is often hindered by stigma, discrimination, and systemic bias related to their identity or expression[11]. Moreover, perceptions of gender differ markedly around the globe, rendering the man-woman dichotomy prevalent in Western society inapplicable to several other cultures. Western operatives functioning in sensitive international contexts must acknowledge and accommodate these disparities to effectively tackle matters of gender-based violence[11]. The normalization of aggression directed at a specific gender cultivates a power disparity between the sexes, which consequently obstructs the potential of young women to achieve their aspirations. Harmful acts against females are a fundamental transgression of basic human dignities on an international level. Every woman and girl holds an inherent entitlement to safety and must possess the freedom to follow

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meaningful educational and career paths, seize opportunities for growth, and form healthy relationships[11].

2.2 Types of Gender-based Violence

Harm rooted in gender identity can manifest in numerous ways. It is a form of aggression that is intrinsically linked to the gender of the individual being targeted. The very identity of the person attacked is what defines the incident as gender-based. This type of violence can happen anywhere, from private spaces like the home to public areas such as city streets, commercial centers, professional environments, and even in temporary shelters for displaced people or refugees. It can appear as public transgressions—like unwanted touching, catcalling, or intrusive advances—or as intimate violations, including sexual assault within a marriage and abuse by a partner. Numerous manifestations of gender-based violence have been contested as cultural practices within particular civilizations[18].

Intimidating a woman to manipulate her actions can swiftly escalate into sexual coercion or physical violence. These actions profoundly erode and restrict women's agency. Furthermore, if a woman resists the assault, she may face increased violence as retaliatory retribution. Such situations can escalate to a fatal conclusion where a woman is either murdered by her intimate partner or is driven to end her own life as a final escape from the persistent abuse. Worldwide, a concerning 48% of females between the ages of 16 and 20 accept that a spouse is entitled to inflict physical harm upon their wife[18].

Financial and psychological abuse resulting from gender-based violence Emotional, psychological, or economic violence frequently accompanies sexual abuse and physical abuse. Economic abuse, manifested through the withholding

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of funds or the appropriation of a woman's earnings, serves as a mechanism for exerting control over women. This renders women reliant on their relationships for housing, sustenance, and other essentials, so perpetuating their involvement with their abusers. Globally, females are transported or kidnapped to satisfy

tourisms with sex, gender disparities, and humanitarian disasters. Females frequently possess minimal safeguards and are constrained by public and financial limitations, thereby diminishing their capacity to extricate themselves from their circumstances.

Coerced unions, particularly those involving minors, are a reality for one-fifth of the female population globally and for two-fifths of females in nations that are just developing[18]. Adolescent pregnancy, the primary reason for death among young women aged 16 to 20, is deeply intertwined with the practice of minor marriage. A staggering ninety percent of mothers below the age of 19 who pass away from complications related to pregnancy or delivery were already married. In some instances, young women are given in marriage to adhere to long-standing cultural norms. In other situations, households facing desperate circumstances erroneously believe that arranging a marriage for their daughters or even using them in an exchange is the best course of action to evade hunger.

Honour crimes are acts of violence committed against women by their own male relatives—such as dads, brother, or uncle—as retribution for what is considered a stain on the family's reputation. Paradoxically, these punishments are often inflicted upon women who have been subjected to sexual assault themselves. For example, there have been cases where women were brutally killed for conceiving a child outside of marriage after being sexually violated. These 'honor' killings are particularly widespread in Yemen, a nation grappling with the world's most severe humanitarian crisis fueled by conflict and famine[18].

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Female genital mutilation (FGM) is a procedure that involves the complete or partial excision of the outer female sexual organs or other intentional damage to the female reproductive organs for reasons unrelated to health[18]. This ritual is performed for a variety of motivations: to satisfy cultural ideals of making girls "neat" or "pure," to curb female sexuality, or as a mandatory condition for

matrimony. Recently, medicalized female genital mutilation, conducted by health professionals in hospitals or clinics, has proliferated in certain regions despite the absence of medical or other rationale for the practice. Prevalent globally and impacting 200 million women and girls currently, it exemplifies profound gender inequity[18].

Harassment: Every day, females confront the constant menace of unwanted sexual attention in public spaces, on their journeys to their occupations or places of learning, and while using shared transport systems. This intimidation can take various forms, including offensive remarks, intrusive advances, lecherous gazes, or physical touch without permission. Such experiences are humiliating, demoralizing, and terrifying; it is impossible to foresee whether an improper remark will escalate into a genuinely hazardous situation[18].

2.3 Violence against Men

Male violence is directed not only at preserving male dominance over women but also at reinforcing power hierarchies among males, operating within hierarchies shaped by socially constructed gender roles. Study indicates that men's experiences of coerced sexual encounters are reported even less frequently than those of women[10]. The susceptibility of men to coerced sexual acts is linked to particular demographics of men and boys, certain circumstances (war situations), and particular environments (such as penitentiaries and the armed forces)[10,21].

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2.4 Review of Emperical Studies

In Lagos State, Nigeria, over two-thirds of females have encountered domestic abuse. In southeastern Nigeria, 60% of participants indicated experiencing familial abuse, with 82% of the individuals affected being female partners and 8% male. Subsequent research in Lagos State indicated that the lifetime prevalence of gender-based violence (GBV) was 73.3%. The primary

predictors of gender-based violence included employment status, exposure to parental abuse, with spouse who consumes alcohol, and engaging with several mates [37].

A study by Olumide Abiodun et al. in Ogun State, southwestern Nigeria, identified the occurrence of lifetime GBV among gravid HIV-positive women as 24.02%[39].

A younger age, prior experiences of gender-based violence (GBV) in partnerships, and having several sexual partners were associated with experiencing GBV in the past year ($p < .05$). The spouses' age, alcohol consumption, and current smoking status were correlated with the occurrence of gender-based violence in the past year ($p < .05$). Following statistical modeling approach examining the influence of respondents' age, with adjusted comparative likelihood values AOR= 0.892, 95% confidence interval [CI] = [0.821, 0.99]), prior experience of gender-based violence (GBV) in a relationship (AOR = 12.751, 95% CI = [4.30, 39.318]), and partners' current smoking status (AOR = 4.974, 95% CI = [1.352, 18.97]) were found to be significantly associated with the occurrence of GBV in the past one year[39].

A study confirmed that individuals who encountered gender-based violence were more likely to suffer from depression than those who did not go

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through such violence. Logistic analysis indicated that GBV independently forecasted post-partum depression in participants (OR 4.8, CI 1.91-12.5)[40].

A survey regarding women's attitudes towards wife-beating in Nigeria revealed that 65.4% of ever-married women and 51.4% of unmarried women indicated approval of wife-beating[22]. The "evolving nature of GBV over time" is highlighted, as numerous older women encounter shifts in the violence[23]. At the federal level, 17 % of participants in Nigeria population and health study reported experiencing gender-based violence (GBV), with the South-South area exhibiting

the greatest frequency at 28% [24]. The primary drivers of GBV at the national stratum and in various regions included elevated alcohol use by certain husbands, an increased quantity of polygamous partners, increasing number of births, socio-economic status marker, and low women literacy rate[24]. Moreover, research indicates that women's propensity to negotiate safer sex significantly contributes to the variety in experiences of bodily harm, sexual assaults and mental cruelty. Other contributions indicate that targeted interventions may be necessary to enhance women's negotiation abilities in order to mitigate the risk of violence perpetrated by husbands[25]. The likelihood of physical violence events was almost five times more for individuals aged 55 years and older compared to those aged 15-24 years[26].

A separate study examining the correlation between psychiatric illness, gender-based violence (GBV) among expectant women, and spouse alcohol consumption in Nigeria revealed a year prevalence of GBV at 25.8%, with abuse emotionally being the most prevalent form at 90%. Forty-six participants (12 %) exhibited indications of possible psychological illness[30]. Factors predicting gender-based violence included partner alcohol consumption throughout the preceding 12 months[32].

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Research indicated that use of alcohol by expectant women and their husbands affected the incidence of gender-based violence[33]. Expectant women who experienced violence domestically tended to get assistance from relatives and friends rather than notifying organisations dedicated to addressing violence. It is imperative to screen all pregnancies at different intervals, as certain women may not report instances of abuse. Gender-based violence screening should be conducted during the initial prenatal appointment, at least once every trimester, and during the postpartum examination[33].

A poll done in 2018 indicated that 4.69% of the partners surveyed have encountered various manifestations of gender-based assaults, including emotional, physical, and sexual molestations[77].

Of the females who encountered bodily harm, 21.5% sustained merely wounds, 9% suffered nothing less than an instance of injuries in the eye, or dislocations, and 3.7% reported one or more instances of cuts, fractures, or dental problems[77]. This highlights the necessity for men to attain a specific degree of maturity prior to marriage, as this may contribute to a reduction in GBV in Nigeria[35].

A 2020 follow-up study indicated that women who have encountered any form of gender-based violence were strongly affected by their education, occupation, number of living children, and duration of marriage in their decision to cease contraception while being at risk of pregnancy[36].

A 2018 study examined the impact of women's status and community norms, corroborating findings from another study, which revealed that nearly 25% of women in Nigeria reported experiencing intimate partner abuse[44,45]. An elevated position of women diminished the likelihood of gender-based violence

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(Odds ratio = 0.47; 95% CI = 0.32–0.71). Societal expectations among men that allows for gender-based violence against the feminine gender undermined the protective influence of elevated women's status against such violence, resulting in tilted odds (OR = 1.89; 95% CI = 1.26–2.83). Ultimately, in addition to women's status, community norms regarding gender-based violence are a critical component in its prevalence. Research conducted in Sokoto, northwest Nigeria, indicated that as many as 83.5% of participants in a survey on gender-based violence were in monogamous relationships. Seventy-five percent (75%) of the individuals were Muslims, predominantly from metropolitan regions; 72.1% possessed a university or Higher National Diploma (HND) degree, and 36.4%

held such qualifications. The majority answered questions related to GBV accurately; in total, up to 98% possessed substantial understanding about GBV. Approximately 33% of respondents reported experiencing gender-based violence during pregnancy, and up to 61.7% of these individuals indicated that they took no action due to fear. Certain controlling behaviours exhibited by male partners encompassed consistently seeking permission prior to engaging with friends and family, as well as exerting control over financial matters. Among breastfeeding mothers, those who encountered gender-based violence had a 27% diminished probability of practicing Exclusive Breastfeeding compared to mothers who did not encounter GBV[34]. A unit dosage of maternal GBV experience correlated with a 5% decrease in the chance of exclusive breastfeeding practice. Of the three categories of gender-based violence, physical gender-based violence exhibited the greatest effect size. Physical gender-based violence (GBV) correlated with a 37% diminished probability of exclusive breastfeeding (EBF) practice, whilst psychological GBV correlated with a 34% diminished probability of EBF practice in comparison to the respective reference groups. Conversely,

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individuals who reported experiencing sexual gender-based violence were equally likely to breastfeed as those who did not[18]. Consequently, maternal GBV correlates with exclusive breastfeeding behaviors. In Abuja, north-central Nigeria, 30 % of polled females reported experiencing gender-based violence in the recent years, with 6.2% indicating intimate partner assault during the early pregnancy. Sexual partners constituted the primary perpetrators of gender-based violence (65.7%), whilst 34.3% were inflicted by individuals other than their sexual relationships. In the current pregnancy, 56.6% of respondents experienced abuse once, whereas 44.4% had multiple instances of abuse. Gender-based violence correlated with elevated probabilities of caesarean section ($p = 0.001$), heightened risk of lower birth weight infants ($p = 0.014$), and maternal problems

during pregnancy ($p = 0.030$). The incidence of gender-based violence during pregnancy in Abuja is significant, resulting in adverse mother and fetal outcomes. Women subjected to mental cruelty are predictably less inclined to utilize institutional delivery services, hence facing a heightened risk of reproductive problems[32]. In Ethiopia, 20% of pregnant women encountered gender-based violence, which is significantly correlated with sadness[41]. A statistically significant correlation was shown between gender-based violence (GBV) and post-partum depression (PPD) in Makurdi, Benue State[43]. The incidence of postpartum depression (PPD) and gender-based violence (GBV) was significant, impacting nearly 25% of postpartum mothers in Makurdi. Consequently, GBV was identified as a contributing factor to the onset of PPD, underscoring the necessity for clinicians to screen for these disorders[46].

A study involving dating students at a Nigerian university demonstrated that age, attitudes towards alcohol, and self-esteem directly influence students' perceptions of psychological abuse, control, and physical violence, respectively.

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Age and self-esteem significantly influence pupils' attitudes on psychological control. Consequently, younger age, low self-esteem, and acceptance of alcohol consumption directly influence university students' attitudes towards gender-based violence. These findings underscore the significance of maturity, alcohol risk reduction interventions, and assertiveness skills in altering attitudes towards participation in gender-based violence[47].

Adolescents from Nigeria exhibited a higher propensity for exposure to gender-based violence and familial violence, as well as a greater likelihood of endorsing violence against women compared to their counterparts from South Africa[48]. Male adolescents had a higher propensity to endorse violence against women (VAW) compared to their female counterparts. Likewise, advanced age, male gender, Nigerian nationality, being in a relationship, and increased exposure to familial violence correlated with a larger support of violence against women[48]. In Borno State, economic causes, male hegemony, and cultural influences appear to be the primary contributors to the rising incidence of GBV. The anomaly of GBV has been identified as a great concern of public-health that necessitates immediate intervention. The government must provide soft loans to low-income households to encourage their participation in economic activities, such as small and medium-sized firms, thereby reducing the incidence of gender-based violence[49]. Incorporating the human security perspective into policies is crucial for eliminating these abuses[50].

Gender-based violence (GBV) against pregnant women is a significant issue due to its harmful effects on pregnancy, including antepartum hemorrhage, intrauterine growth restriction, trauma, perinatal mortality, abortion/miscarriage, low birth weight, premature delivery, and the risk of homicide[51]. In Sub-Saharan Africa, around 40% of women have disclosed instances of violence by their

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romantic partners. The incidence of domestic violence during pregnancy in Nigeria varies from 2.3% to 44.6%, while lifetime prevalence rates range from 33.1% to 63.2%[51].

In Egypt, among ever-married males, 77.1% endorsed gender-based violence (GBV), 82.2% had spouses married before the age of 18, 81.8% resided in rural areas, 88.4% had parents who did not respond to mistakes, and 83.9% of those with a favorable disposition towards divorce accepted GBV, exhibiting a statistically significant difference. Moreover, substantial indicators for endorsing gender-based violence were rural residency, a disposition that prompts husbands to divorce their spouses, and parental reactions to errors[52]. The notable correlations of married men's acceptance of gender-based violence included rural residency, respondents' attitudes towards divorcing their wives, and inadequate parental responses to mistakes[54].

A study in Ethiopia revealed that the incidence of gender-based violence (GBV) among pregnant women was notably high, with just over 25% of pregnant women encountering GBV throughout their pregnancy, mirroring the trend observed in Nigeria[55]. The educational levels of mothers, the educational levels of intimate partners, and the alcohol consumption of intimate partners were significantly correlated with gender-based violence among pregnant women [53]. Viewing violence or coercion as a method for resolving interpersonal disputes, favorable attitudes towards domestic abuse, recognition of violence as a manifestation of masculinity, and rigid gender role distinctions were positively correlated with gender-based violence during pregnancy [56,57,58]. A research among pregnant women visiting ante-natal clinics in various Ethiopian states indicated a 41.1% prevalence of gender-based violence during their current

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pregnancy. The prevalence rates of sexual, physical, and psychological violence were 19.8%, 29.1%, and 21%, respectively[54].

A cross-country survey encompassing 16 sub-Saharan African nations revealed that 20.2% of women were in polygamous marriages, with figures varying from 40% in Chad to 1.6% in South Africa. The incidence of gender-based violence (GBV) was 30.7% throughout the 16 nations, with a maximum of 44% in Uganda and a minimum of 12.7% in South Africa. The prevalence of gender-based violence was elevated among women in polygamous unions in Angola, Burundi, Ethiopia, Uganda, Malawi, Mozambique, Zambia, and Zimbabwe. Nevertheless, the rates were diminished among women in polygamous unions in Cameroon and Nigeria, a trend that remained consistent even after adjusting for education level, residential location, socioeconomic status, media exposure, and the rationalization of violence. This research demonstrated a substantial correlation between polygyny and gender-based violence. Gender-based violence in Africa (Sub-Sahara) is intertwined with the

socio-cultural guidelines and religious dictums and traditions prevalent in the region[60]. The findings suggest that family structures predispose women to gender-based violence. A study done in Zimbabwe found no significant correlation between women's educational achievement and gender-based violence[61].

Gender-based violence is widespread in the United States, with around 25% of surveyed women and 7.6% of surveyed men reporting experiences of rape or sexual assault by a date, past or current spouse, or cohabiting partner at some point in their lives. Additionally, 1.5% of surveyed women and 0.9% of surveyed men reported experiencing physical assault or rape by a partner in the preceding 12 months[68]. Women face a far higher risk of intimate relationship violence

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compared to men. This, however, contradicts findings from the National Family Violence Survey, which consistently indicates that men and women are equally susceptible to physical violence by an intimate partner. Research is required to ascertain the impact of various survey methodology on the responses of women and men about gender-based violence[68].

Recent data from a population-based, random-digit-dial telephone survey initiated in the US in 2010 and currently ongoing indicates that slightly above a third of women (37.3%) and men (30.9%) had encountered stalking, physical assaults, or sexual violence by a spouse/partner, with 23.2% of women and 13.9% of men having endured brutal physical or sexual assaults by an intimate-partner. The poll evaluated the prevalence of subsequent repercussions of violence, injury requirement for medical attention, or post-traumatic stress symptoms. A fourth of women and one in ten males reported experiencing at least one consequence of violence. The prevalence estimates have remained largely constant since 2010, highlighting an opportunity to prevent this significant public health concern[69]. Moreover, while gender-based violence transpires across all

social strata, locales, and cultural contexts, prevalence estimates differ dependent on demographic variables. The prevalence is greatest among young adults aged 18 to 24 in comparison to other age groups. An intersection between intimate partner abuse and human trafficking has been noted; traffickers may initially present themselves as affectionate, romantic partners before employing coercive and controlling strategies akin to those utilized by perpetrators of intimate partner violence[69].

In Saudi Arabia, a West Asian nation, the predominant effects of domestic violence on women were medical or behavioral issues (72%) and psychiatric disorders (58%). The predominant responses to gender-based violence were

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pursuing isolation (56%) and inaction (41%). Over 90% of children of battered women experience psychiatric or behavioral issues. In conclusion, gender-based violence against Saudi women is significant, and the response is predominantly passive. Fostering a society intolerant of domestic violence and ensuring accessible, effective, and reliable social services for victimized women are imperative[70].

In Peru, South America, emotional distress, suicidal ideation, or attempts were more prevalent among women who had experienced sexual or physical assault compared to those without such experiences. The incidence of injury among women who have suffered gender-based violence (GBV) ranges from 18.9% in Ethiopia to as high as 55.1% in Peru, with assaulted women being doubly likely to report or experience deteriorated health, alongside other physical and mental health issues, compared to non-abused women[71].

A study in India, a South Asian nation, investigated the relationship between gender-based violence and child mortality and morbidity. The morbidity and mortality rates were elevated among children whose mothers experienced physical, emotional, or sexual assault from their partners compared to those

whose mothers did not experience any violence. Multivariate analysis indicated that maternal exposure to physical and sexual violence substantially elevated the risks of childhood diarrhea and fever, while emotional violence correlated with a heightened probability of diarrhea, fever, and acute respiratory infection (ARI) in the preceding two weeks among children under five. Furthermore, preliminary research indicated that women's experiences of physical and emotional violence correlated with heightened probabilities of baby and under-five death. The connections were inconsequential in the adjusted analysis. No significant correlation was seen between maternal exposure to GBV and child mortality

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(ages 1 to < 5 years) [74]. No significant correlation was identified between maternal exposure to GBV and child mortality in the age group of 1 to less than 5 years[75]. Rural residency, lower educational attainment of partners, frequent alcohol consumption by partners, early commencement of antenatal care, the age of women between 17 and 26 years, and the selection of partners solely by women were statistically significant factors correlated with gender-based violence against pregnant women. A comparable study involving ever-married women in Ethiopia indicated that more than 30% of participants experienced gender-based violence (GBV). Residing in rural regions, experiencing divorce, possessing primary and secondary education, being aged 25 to 39, and facing poverty were indicators of gender-based violence against women in Ethiopia[73].

In the Gambia, women married between the ages of 18 and 24, who cohabited with three to four or five or more children, experienced parental violence, had partners with primary education, faced accusations of infidelity, and dealt with partners' alcohol usage, are more likely to report gender-based violence (GBV)[59]. Unemployed women were seen to be less inclined to report gender-based violence. In conclusion, the data indicate a significant prevalence of gender-based violence (GBV) among Angolan women, with the husband's

alcohol use, women's religious affiliation, the frequency of spousal church attendance, and age disparity identified as the primary predictors of GBV or intimate partner violence. Non-pregnant women who encountered emotional and sexual gender-based violence exhibited heightened likelihood of healthcare visits in the last year. Individuals who endure emotional and sexual gender-based violence may be at an increased risk for medical disorders and should therefore receive particular attention in primary care environments [62,63].

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A 2018 study by Sally et al. in South Africa corroborated a pattern observed in other African nations[63]. Qualitative research of 95 counselling case notes indicated that domestic violence within households extended beyond intimate relationships, with respondents frequently perceiving such violence as 'normal' behaviour.[64]

Male teenagers were more likely to endorse violence against women (VAW) than their female counterparts. Adolescents from Nigeria had a higher propensity for exposure to gender-based violence and familial violence, as well as a greater likelihood of endorsing violence against women compared to their South African counterparts. Gender-based violence has been identified as a public health concern necessitating immediate intervention.

2.5 Conceptual Model

2.5.1 Theoretical Frameworks for the Causation and Determinants of Gender-Based Violence

Causation theories seek to elucidate and forecast the motivations, situations, and other aspects that define persons who commit and suffer from abuse and violence in intimate relationships. We will now analyze several of these prevalent theories.

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2.5.1 Historical Theories

The historical theories or frameworks for comprehending the causes of gender-based violence are categorized into numerous distinct classifications.

The amalgamation of scholarship from diverse disciplines resulted in more thorough and modern elucidations of gender-based violence (GBV), including theories that articulate gender-based disparities rooted in systems of oppression

and power, as well as socio-cultural models derived from numerous conventional ideas[83]. Nonetheless, the historical theories must comprehensively elucidate the reasons behind an individual's perpetration of gender-based violence[83].

2.5.2 The Modern Theories

This leads us to the modern notions of Gender-Based Violence. The Socio-Cultural Model, a multifactorial framework for Gender-Based Violence (GBV), integrates components of family systems theory, social learning theory, social structures, and cultural influences, initially formulated by Murray Straus and his associates[83]. This socio-cultural paradigm situates familial violence within the framework of pervasive societal violence, the patriarchal structure of our society and familial structures, and prevailing cultural norms[83].

2.5.3 The Feminist Theory and Feminist Intersectionality

The feminist theory of gender-based oppression has developed to incorporate other elements and complexities that intersect with gender, affecting impoverished women and other vulnerable groups in their pursuit of fair power dynamics with their partners and society. A significant portion of this study originated from social scientists, domestic violence advocates, and minority women who framed violence against women (VAW) as a multifaceted issue beyond mere gender considerations. Black Feminist Theory arose as a response to the predominantly liberal feminist and the largely African American male civil rights movement, both of which failed to adequately typify the experiences of black women. Black Feminist Theory conceptualizes the interplay of gender, race, and class as components of a comprehensive structure of domination [88]. Likewise, Chicanas and Latinas perceived that their issues were insufficiently reflected by both the Chicano and women's movements. Chicana Feminist Theory elucidates the interplay among race/ethnicity, socioeconomic class, linguistics, and

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nationalism. Chicana feminists emphasized culturally specific strategies, including the necessity to contest traditional and exaggerated gender roles within Latino households, while maintaining robust family structures and recognizing the essential contributions of women in domestic spheres[85]. Indigenous feminists, including Native Americans, assert that postcolonial frameworks highlighting historical trauma and diverse tribal traditions in gender relations are crucial for comprehending the elevated incidence of gender-based violence among indigenous populations globally[89].

Feminist scholars and activists have broadened the scope of intersectionality theory to encompass additional socially created identities and social positions that marginalize individuals, such as disability, beyond race, class, and gender. Social justice frameworks concerning women with disabilities differentiate between the biological condition of impairment and the social construct of disability, which embodies socio-cultural and environmental constraints rather than personal limits. Nixon[90] contended that women with disabilities who experience abuse or are susceptible to it may be rendered voiceless or invisible due to the intersecting dimensions of oppression related to social identity, such as disablism, sexism, ageism, and systemic oppression by institutions, social movements, and society at large.

Feminist intersectionality is predicated on the premise that each social group possesses distinct characteristics; that individuals occupy positions within social frameworks that shape power dynamics; and that interactions among various social

identities, such as race, gender, and class, yield compounded detrimental effects on health and well-being[83]. Feminist intersectionality is a framework aimed at achieving social justice, leading to societal inequities and social injustice[88,91,92]. Health inequalities, defined as discrepancies in access to and quality of health care among

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marginalized racial, ethnic, and socioeconomic groups, exemplify social inequality. Feminist theorists in nursing and other social sciences advocate for feminist intersectionality to achieve a more thorough understanding of the compounded effects of social inequalities faced by vulnerable and marginalized groups, thereby informing research and the development of interventions to address health disparities[93]. Intersectionality functions on two levels: (i) as an analytical tool for examining structural oppression and (ii) as a framework for comprehending how people' intersecting identities shape their experiences[94]. Although these levels may be regarded independently, they are interconnected and interdependent. The application of intersectionality to gender-based violence (GBV) entails: (i) analyzing how structural inequities facilitate and perpetuate GBV, and (ii) investigating the impact of marginalized social identities on women's reactions to GBV, which are intrinsically connected to the responses of support professionals and social agencies to women encountering GBV[84,87,95,99].

The initial study examines the inquiry, "What aspects of our society contribute to the prevalence, persistence, and intractability of GBV?" The second study offers many perspectives to evaluate women's reactions to gender-based violence. For instance, how does the inclusion of disability, or any other marginalized social identity, as an analytical lens enhance our comprehension of gender-based violence and a woman's reaction to it? How does identifying this woman as a migrant inform our understanding of her unique risks and lived experience? Could her employment status present additional challenges? What support strategies—spanning personal care, institutional frameworks, community engagement, and

policy reform—can nurses draw upon when aiding women affected by gender-based and other forms of violence[83]?

2.5.4 The Social Ecological Model (SEM)

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The SEM posits that the causes of violence against women and girls are many and multifaceted, encompassing interpersonal, relational, community, and social issues. The social-ecological paradigm identifies gender inequality as the fundamental cause of gender-based violence, manifested via the disproportionate allocation of power and resources between men and women. Gender-based violence, discrimination, and inequality can manifest through several means. This includes discriminatory legislation, such as inequitable access to social, intellectual, political, and economic power, as well as socially manufactured or misconceived notions of masculinity and femininity, along with gender roles and stereotypes[80]. Besides the fundamental causes of gender-based violence, individual-level influences and relationship-level dynamics might influence the likelihood of a female gender encountering assault. The determinants encompass age, educational attainment, substance usage, poverty, tolerance of violence, unemployment, and depression, among others. This study employs the social-ecological model to examine the extent and prevalence of gender-based violence threats in Oyo State. This paradigm posits that individual, interpersonal, community, and policy-level elements might influence a woman or girl's experience of gender-based violence (GBV). The overarching policies designed to prevent gender-based violence (GBV), the current punitive measures for GBV offenders, the mechanisms in place at workplaces and educational institutions to dissuade perpetrators, as well as the academic, economic, and societal status, can all predispose a woman or girl to experience GBV. Conversely, it is posited that socioeconomic circumstances significantly influence the experience of gender-based violence among males.

2.5.5 The Socio-Cultural Framework (SCF)

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The socio-cultural framework situates family violence within a broader context of pervasive violence in our culture, wherein the patriarchal structure of society and familial systems, along with cultural norms, validate violence against family members. This concept posits that familial relationships intrinsically result in violent behaviors, mostly owing to the expression of societal influences within family structure, parental conduct, childrearing practices, and individual interactions[87]

2.5.6 Conceptual Framework

To achieve a comprehensive understanding of the origins and determinants of gender-based violence, it is essential to combine the relevant theories and frameworks. Consequently, for this study, the author will employ the WHO Ecological Framework.

2.5.7 Ecological Framework

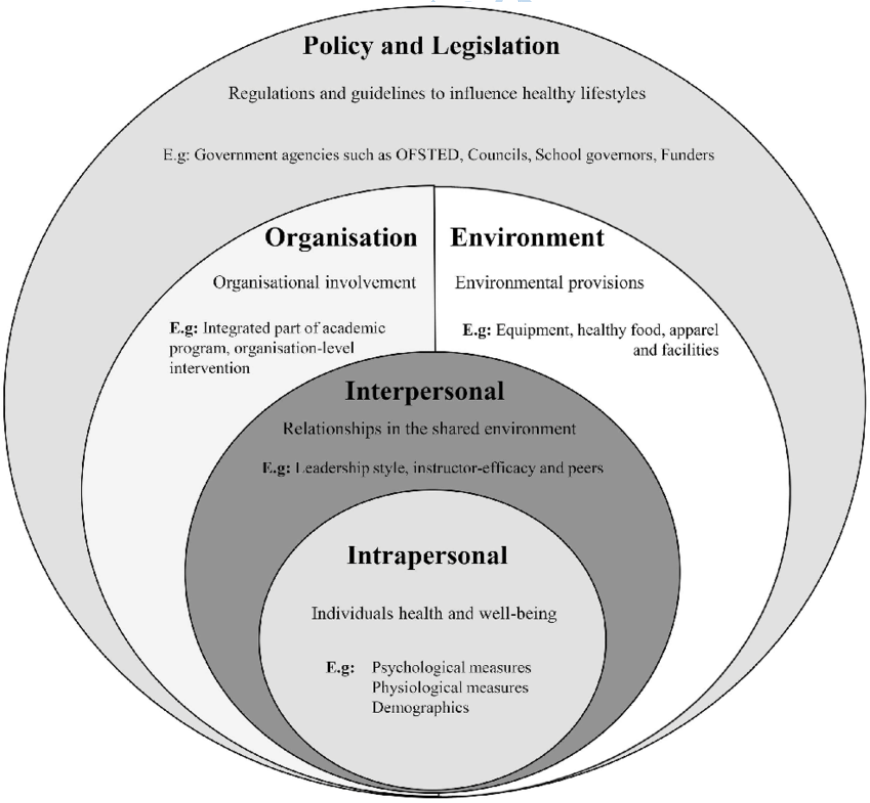


Figure 2.3: The WHO Ecological Framework[83]

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The Ecological Framework

The WHO applies an ecological framework to elucidate the origins and factors of gender-based violence[83]. An ecological framework characterizes violence as a worldwide public health issue. The framework incorporates research findings and theories from various disciplines, particularly feminist theories, to elucidate the origins of gender-based violence (GBV). Within the ecological paradigm, gender-based violence (GBV) is perceived as a complex phenomenon arising from the dynamic interactions among individuals, relationships, communities, and societal factors that affect an individual's likelihood of perpetrating or experiencing violence.

Intrapersonal Factors

At the individual level, both perpetrators and victims of abuse and violence exhibit biological and personality qualities, as well as a personal history that influence their behaviours and relationships with intimate partners and the wider community.

Factors at the individual level related to the perpetration of gender-based violence (GBV) include:

i. Demographic variables such as age, education, and income;
ii. Exposure to domestic violence throughout childhood;
iii. Experiencing physical or sexual abuse in childhood; and
iv. Substance use.

A personal history of various interpersonal traumas, such as gender-based violence, child abuse, and rape, correlates with post-traumatic stress disorder and other detrimental health effects for victims; hence, cumulative trauma serves as an individual component affecting women's reactions to gender-based violence[83]. Societal norms may impact on the family's perceptions and acceptance of gender-based violence (GBV). A family residing in a community that perceives women

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as "slaves" will certainly rear male offspring who adopt the same mentality. The standards of parental conduct and procreation additionally affect an individual at the intrapersonal level. The standards and parenting methods of parents, along with their observable interactions, may influence a child's susceptibility to gender-based violence in adulthood. The attitudes and behaviors of parents regarding GBV ultimately influence their children's perspectives and actions towards GBV in adulthood. The second tier of influence encompasses intimate interactions with partners, family members, and peers that may impact the likelihood of an individual committing or falling victim to violence. Various elements of relational dynamics, particularly regarding familial composition and operation, have been recognized as risk factors for the emergence of gender-based violence (GBV). These encompass:

i. Male economic and decision-making dominance within the family,

ii. Male control over income and resources in the family, and

iii. Marital discord, particularly in partnerships characterized by asymmetrical power dynamics.

The influence of role models and peers on gender-based violence (GBV) significantly affects an individual's likelihood of experiencing or participating in GBV. Peer interactions can exert a binding influence, whether intentionally or unintentionally. Consequently, peers who participate in or endorse gender-based violence (GBV) significantly affect their associates to either adopt GBV behaviors or refrain from them if their peers do not engage in such conduct. Peer pressure significantly influences the formation or maintenance of behavior. Culture, as a way of life, significantly influences an individual's propensity to engage in gender-based violence (GBV). Individuals come to recognize the

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cultural inclinations within a culture; behaviors are established and decisions are made, including preferences for participating in gender-based violence. The

cultural perspective on gender-based violence (GBV) can influence an individual's likelihood of participating in such behavior. The tertiary level of factors encompasses the community, comprising environments such as neighborhoods, educational institutions, and workplaces. Research indicates that communities characterized by significant social disorganization, such as residential mobility, elevated population densities, and insufficient cohesion among people, correlate with increased levels of violence. Poverty within the community, unemployment, and the presence of alcohol outlets have been recognized as risk factors for both the perpetration of violence and victimization by violence. According to social disorganization theory, poverty at the community level may underpin significant stress and conflict among intimate partners, such that community poverty emerges at the relationship level [84]. The societal stigmatization encountered by GBV survivors hinders the timely reporting of GBV incidents by these individuals. The manner in which healthcare providers engage with GBV survivors can influence their likelihood of seeking care at a health facility or reporting the incident. The presence of a curriculum for healthcare personnel on managing GBV survivors influences the recorded incidence of GBV. The final strata of elements is the societal stage. This encompasses extensive societal factors that foster or inhibit violence at the community, relational, and individual levels, including the regulations, norms, and social expectations that dictate personal conduct and social inequalities among groups, such as patriarchal structures, oppression, poverty, sexism, and health disparities. [85]. For instance, sources of support and institutional help may be inaccessible to socially marginalized women, rendering them susceptible to

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gender-based violence and affecting their reactions to such abuse. This ecological perspective on violence synthesizes research from multiple disciplines into a cohesive framework that enhances our comprehension of the context, causes, and

effects of gender-based violence on women and their surrounding environment. The ecological model for GBV intervention necessitates the formulation of methods that address various levels, specifically individual, family, community, and society[83]. The current punitive measures for GBV perpetrators may act as a deterrence or, conversely, fail to dissuade individuals from committing GBV. In the absence of a definitive, stringent, and enforced penalty for GBV offenders, certain individuals may be incentivized to commit GBV, confident in their ability to evade consequences. This increases the prevalence of gender-based violence.

Further at the intrapersonal level, low educational attainment or poor education limits awareness of rights, healthy relationships and conflict resolution skills. Economic stress can lead to frustration and dominance behaviors in men and dependency or tolerancy of abuse in women. Also, acceptance of male superiority and rigid gender norms encourage male dominance and female subordination. Depression, stress or trauma from previous violence can perpetrate cycles of abuse.

Interpersonal Relationship Factors

This level focuses on family, intimate and peer relationships where GBV often occurs. Key factors include:

i. Marital Conflict and power imbalance: Unequal decision making and communication patterns lead to coercion and violence.
ii. Economic dependence: Women who rely financially on partners may remain in abusive relationships due to fear of poverty

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iii. Infidelity and mistrust: Jealousy or suspicion often triggers violent confrontations

iv. Peer Influence: Men whose peers condone violence or misogyny are more likely to perpetrate GBV[83].

v. Family Support Systems: Weak or unsupportive families discourage victims from seeking help.

vi. Male entitlements: Societal socialization that teaches men to view women as property fuels control and violence. For example, in settings where divorce is frowned upon, extended families often pressure women to endure violence rather than seek justice.

Organizational/ Community Factors

This level captures the institutional and community contexts that influence how GBV is tolerated, reported or addressed. It includes :

Weak Institutional Response: Police, health workers or community leaders may trivalize GBV, thereby discouraging survivors from reporting.

Workplace or School cultures: In institutions lacking gender-sensitive policies, sexual harassment and coercion can go unchecked

Religious and traditional Norms: Misinterpretation of religious doctrines can justify male dominance and discourage separation from abusive partners. When community leaders prioritize reconciliation over justice in domestic abuse cases, it reinforces that GBV is a private issue

Community Acceptance of Violence: In some cultures, wife-beating is viewed as discipline rather than abuse.

Limited Community Support Structures: Absence of shelters, legal aid, or counselling services increase victim's vulnerability.

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Neighborhood Insecurity: Poor lighting, inadequate policing and social disorder increase exposure to assault.

Environmental / Societal Factors

These are broader cultural, economic and social systems that shape gender relations and power structures. Key factors include:

i. Patriarchy and Gender inequality: Societies that privilege men in decision making and economic control perpetuate gender hierarchies and normalize violence[84].

ii. Cultural tolerance of violence: Proverbs and sayings such as " a man must discipline his wife" reflect deep rooted acceptance of violence

iii. Harmful traditional practices: Practices like female genital mutilation, early marriage and widow inheritance reinforce control over women's bodies

iv. Media and popular culture: Sexual objectification of women and glorification of aggression in media sustain negative stereotypes

v. Economic Instability and Conflicts: Wars, displacement, and disasters heighten women's risk of sexual violence. During conflicts, sexual violence is often used as a weapon to assert dominance and terrorize communities.

vi. Urban Insecurity: Poorly designed public spaces and weak law enforcement expose women to harassment and assault.

vii. Social Stigma: Societal shaming of survivors suppresses reporting and fuels silence

Policy/ Legislation Factors

This level highlights the role of laws, political systems, and governance in either protecting against or perpetuating GBV:

i. Weak Legal Frameworks: Many countries lack clear laws criminalizing domestic violence or marital rape[87].

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ii. Poor Enforcement: Corruption, delays and lack of sensitivity training among police and judges reduce the effectiveness of existing laws.

iii. Inadequate Funding: Without sufficient budgetary allocation, GBV response services remain ineffective.

iv. Lack of monitoring system: Absence of national GBV databases hinders tracking and prevention efforts.

v. Limited Political Will: When leaders fail to prioritize GBV, it remains low on policy agendas

vi. Failure to domesticate international treaties: Non implementation of instruments like CEDAW and the Maputo Protocol leaves women legally vulnerable. Some States in Nigeria are yet to domesticate the Violence Against Persons (Prohibition) act (VAPP) leaving women without comprehensive legal protection

Summarily efforts must focus on empowering individuals through education and economic support, promoting equitable relationships, strengthening institutions, transforming cultural norms and enforcing protective laws and policies. Only through an integrated approach can the cycle of GBV be broken sustainably

2.6 Summary of Literature Reviewed

Although the determinants of gender-based violence differ in intensity and scale across regions and continents, the prevalence of GBV remains unacceptably elevated. The majority of studies predominantly examined women as victims, with just a limited number addressing males and adolescents as victims of gender-based violence (GBV). There seems to be a lack of research examining the attitudes, knowledge, and competencies of healthcare providers in managing GBV cases. The increasing social consciousness regarding gender-based violence, exemplified by the tragic case of the 40-year-old renowned

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Nigerian gospel singer Osinachi, who was violently killed by her husband, has led to public outcries over occurrences of GBV in Nigeria; regrettably, this reflects the ongoing prevalence of this societal issue. The mindset and attitude of healthcare providers towards managing victims of GBV in Nigeria is also problematic. Moreover, few studies on gender-based violence have sought to differentiate between in-school adolescents and out-of-school adolescents, as well as between pregnant and non-pregnant women. This research aims to evaluate the prevalence and patterns of gender-based violence among male

victims, pregnant and non-pregnant women, as well as in-school and out-of-school teenagers, from which significant insights might be gleaned. The study illuminates the GBV services offered by health facilities and examines the competence and expertise of healthcare practitioners in managing GBV cases in southern Nigeria. This study did not aim to investigate pregnancy outcomes in pregnant women who have experienced abuse.

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Chapter Three
Methodology

This chapter will distinctly describe the research methodology, delineate the study's limitations, and specify the scope of the research in relation to its geographic location. The approaches for data collection and analysis will also be explored.

3.1 Research Design

Research design was cross-sectional with a quantitative approach. This study employed a research methodology centered on collecting numerical data from a specific group at a single point in time. This approach was chosen to analyze the intended demographic, using statistical information to measure the scale of Gender-Based Violence in Ibadan and identify its underlying drivers. The research also delved into the origins of GBV and its consequences, paying particular attention to the effects on women, men, and

young people. The chosen research framework provided significant understanding of the common GBV-related conduct among the local inhabitants, and these findings were then used to infer trends for the broader population of Oyo State. In essence, this methodological choice delivered a clear snapshot of the prevailing GBV situation in the state, with the goal of facilitating the development of informed policies and data-supported decisions. The research spanned between 2022 and 2024.

3.2 Study Area

The study area included the eleven LGAs that make up Ibadan Metropolis, consisting of Ibadan North, Ibadan North-East, Ibadan South-East, Ibadan South-West, Akinyele, Lagelu, Ido, Ona-Ara, Oluyole, Ibadan North-West, and Egbeda.

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Figure 3.1: Map of Oyo State showing the LGAs[8]

Oyo State was established in 1976, having been created from the former Western State. It earned the sobriquet "The Pace Setter State" due to being the site of several 'FIRSTS' in various human endeavors. These include the first Nigerian

University (The University of Ibadan); the first national stadium in Africa (The 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 (The University College Hospital, Ibadan); the first high-rise building in Nigeria (The Cocoa House, Ibadan); and the first five-star hotel in Nigeria (The Premier Hotel, Ibadan).

In 1991, Osun State was carved out of the old Oyo State. Ibadan continues to serve as the State's administrative headquarters, a role it has held since the Western region era, and is renowned as Africa's largest indigenous city. The State shares borders to the North with Kwara State, to the South with Ogun State, to the East with Osun State, and to the West with the Benin Republic, providing unique possibilities for cross-border commerce. The terrain is divided into four roughly equal sections by latitude 80°N and longitude 40°E. Oyo State covers a land area of 27,149 KM2. The projected

population for the State in 2022 was 9,546,933, with an estimated 477,347 expectant women[1].

The State has thirty-three LGAs, with 33% classified as urban and 66% as rural[1]. There are a total of 351 electoral wards[1]. The majority of the State's residents are farmers, small traders, and artisans, with a smaller segment employed as civil servants. Like other states in the Federation, Oyo has three senatorial districts: Oyo North (with thirteen LGAs), Oyo Central (with eleven LGAs), and Oyo South (with nine LGAs)[2]. The State government comprises a 32-member cabinet in the State House of Assembly, 14 members in the Federal House of Representatives, and three Senators in the National Assembly. Oyo State is predominantly agrarian, with approximately

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60–70% of the productive workforce engaged in agriculture, primarily in the northern part of the State[3]. The remaining productive workforce is distributed among those in the informal sector, the civil service, mining activities in the northern region of the State, and pockets of Fast-Moving Consumer Goods (FMCG) industries mainly operating in Ibadan. Manufactured goods include biscuits, vegetable oil, and plastics[3].

Consistent with the trend in other states within the Western geo-political region, the level of absolute poverty stands at 29.4%, with relative poverty recorded at 9.8%[1]. It is important to note, however, that the criteria for measuring poverty change depending on the specific area and type of community. The ongoing economic downturn is expected to have driven these figures upward. Furthermore, the state's key metrics include a Gross Domestic Product per person of US $34.5, an educational attainment score of 0.8523, a gender disparity measure of 0.418, and an overall human development score of 0.4765[1].

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Ibadan city

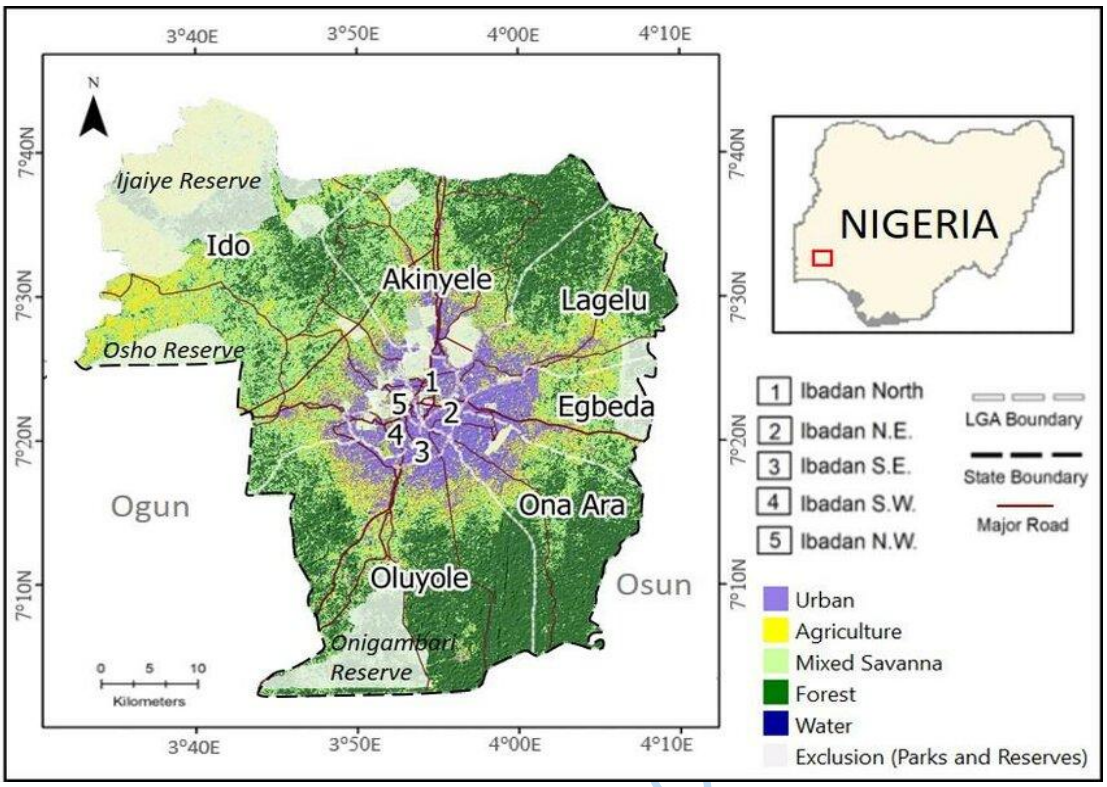


Figure 3.2: Map of Ibadan showing the 11 Local Government Areas[9]

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 approximately 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 lies 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 stands today. The major inhabitants of the city are the Yorubas, as well as various ethnic groups (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

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estimated area of 6,800 km² (2,600 sq. mi)[1]. Ibadan City is the study site for this research.

3.3 Population and Sample

The research was designed to include participants from several distinct groups: pregnant mothers, women who were not pregnant, men, in-school adolescents, out-of-school adolescents, and medical and healthcare providers. For the purposes of this study, these groups were defined as follows:

Pregnant women: Any woman currently expecting a child, regardless of the trimester.

Non-pregnant women: Any woman not currently expecting a child.

Men: Adult individuals who identify as the male gender.

Adolescents: Individuals in the transitional phase of life from childhood to adulthood, generally between the ages of 10 and 19.

Healthcare workers: Professionals delivering medical care, specifically doctors, registered nurses (RNs), community health extension workers (CHEWs), or community health officers (CHOs).

3.4 Sample Size Determination

The required number of participants was established by utilizing the Raosoft online sample size calculator[2]. The formulas for determining the sample size (n) and the margin of error (E) are presented as:

$$\mathbf{E}. = \sqrt{\frac{(N-n)x}{n}\ (N-1)}$$

In this equation, 'N' stands for the overall size of the population, 'r' signifies the expected percentage of a particular response under investigation, and 'Z(c/100)' represents the critical Z-score for a given confidence level, 'c'.

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The Raosoft sample size calculator was employed based on the following set of criteria:

- An estimated target population in Ibadan of more than 20,000 people.
- A confidence level of 95% with a margin of error of 2.5%.
- An assumed response distribution of 50% to maximize sample robustness, which initially indicated a need for 1,428 participants.
- 30% attrition rate.
- Therefore, the adjusted minimum sample size for the research was established at 1,857 individuals for each designated population category based on the raosoft calculation.

In the end, a total of 11,332 individuals participated in the study. This group was composed of 1622 expectant mothers, 1,911 non-expectant women, 3,562 adolescents, 2,951 adult males, and 1,286 healthcare professionals.

3.5 Sampling technique

A multi-staged sampling technique was employed, carried out through the subsequent phases:

Phase 1:

The process began with the complete and inclusive selection of all eleven Local Government Areas located in Ibadan.

Phase 2:

Next, from the comprehensive list of political wards in each of the 11 LGAs, five wards were chosen at random, which brought the total number of selected wards to 55.

Phase 3:

Following that, a roster of all communities within the chosen wards was acquired from the State Ministry of Lands and Housing. From each of the 55 wards, five communities were selected using a lottery-style draw, which resulted in a target of 275 communities for the study.

Phase 4

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In this phase, an exhaustive attempt was made to contact every household, residence, secondary school, and healthcare center within the selected communities.

Phase 5

In the concluding phase, all adult men, pregnant women, non-pregnant women, adolescents, and healthcare providers who satisfied the study's eligibility criteria were recruited. This recruitment continued until the required sample number for each LGA was reached. The allocation of the sample size was not evenly divided among the LGAs but was instead calculated proportionally based on the projected population data for the year 2022.

3.6 Inclusion Criteria

Individuals enrolled in the study were able to provide consent and are resident, schooling or working within the study area. Adult males and females included in the study were 18 years and above, while adolescents included in the study were between 10-19 years of age and were also resident, schooling or working within the study site

3.7 Research Instrument

The primary tool for gathering data was a carefully organized survey, created specifically for this study and administered digitally using the KoboCollect platform. Its development was guided by an extensive review of existing academic literature, leading to the adaptation of several established instruments. This resulted in a composite, structured questionnaire that integrated components from the following sources:

3.7.1 Informed Consent Document: This section was dedicated to formally requesting and recording each participant's voluntary agreement to take part in the research. The informed consent document was developed by the researcher.

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3.7.2 Socio-Demographic Profile Section[3]: This part of the questionnaire was modeled after an instrument used in a 2021 Turkish study by Yasemin Erkal Aksoy and colleagues, which investigated factors influencing distress during pregnancy and intimate partner violence. Its purpose was to collect data on the participants' background characteristics.

3.7.3 Domestic Violence Safety Assessment Tool (DVSAT)[4]: This tool, originally created by the New South Wales Bureau of Crime Statistics and Research for use by both governmental and non-governmental support services, was incorporated into the questionnaire. It had been previously utilized in a 2018 study by Claire Ringland[4] to evaluate the likelihood of recurring intimate partner violence. The DVSAT is specifically tailored for situations of domestic abuse and functions by asking a series of yes/no questions, which are then scored to gauge a participant's vulnerability to future GBV and repeated abuse.

3.7.4 Danger Assessment (DA) Instrument[5]: The DA is a specialized tool created to evaluate the probability of fatal or near-fatal outcomes in instances of gender-based violence. It was first developed and validated in a 2008 study focused on creating a risk assessment for intimate partner femicide[5]. Its inclusion in this research served to measure the potential for severe, life-threatening harm in cases of GBV[4].

3.7.5 Revised Tilburg Pregnancy Distress Scale (TPDS-R)[3]: This scale was included to measure distress specifically related to pregnancy. It was first used in a 2012 longitudinal study by Yasemin Erkal Aksoy et al. that examined the link between a woman's autonomy in sexual matters and her experience of GBV. Originally a 16-question tool, the revised TPDS-R is a more comprehensive and effective instrument for identifying expectant mothers who are at risk of experiencing significant pregnancy-related distress[6].

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3.7.6 UNFPA GBV Assessment and Situational Analysis Tools[7]: This set of resources was a collaborative effort by the UNFPA, International Medical Corps, the Global Protection Cluster, and the Australian Government. Designed for field use and continuous improvement, these tools provide a tested foundation that researchers can adapt to specific contexts. For this study, the previously validated "GBV Assessment" and "Intimate Partner Violence Screening tool" forms were modified. They were chosen for their effectiveness in asking probing questions to gauge a respondent's predisposition to GBV, exploring topics like community dynamics and the help-seeking behaviors of survivors[7].

3.7.7 Adapted Instrument for Assessing Violence Against Women in Low-Income Settings[7]: This component was derived from literature focused on evaluating assault against women in economically disadvantaged regions. Its internal consistency was confirmed using Cronbach's alpha in a 2019 study by Agumasie Semahegn and colleagues[8]. Cronbach's alpha is a statistical measure of how closely related a set of items are. The tool itself evaluates a woman's level of independence in household decisions and her views on unfair gender-based social rules. It also included a scale to assess an intimate partner's potential physical, psychological, and sexual reactions in certain situations and explored attitudes regarding the justification of violence against a wife[8]. For this research, the reliability of the tool's variables was verified by ensuring the Cronbach's alpha coefficient met the standard minimum threshold of 0.7.

3.7.8 Customized Survey Tool for Healthcare Professionals: A specific questionnaire was created from the domestic violence healthcare providers' survey questionnaire (DVHPSS) to gauge the perspectives and reactions of medical personnel when dealing with survivors of GBV[11]. This survey underwent a validation and pre-testing phase to ensure its effectiveness before being used in the main study.

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3.8 Accuracy of the Research Instrument

The concept of validity centers on a tool's accuracy—specifically, its ability to measure precisely what it is intended to measure. While the individual sections of the survey were based on previously validated instruments, the complete, combined questionnaire underwent a preliminary testing phase before its full-scale implementation.

This preliminary trial was conducted in East of Ibarapa (which adjoins Ido LGA) and Afijio LGA (which adjoins Akinyele LGA), two areas adjacent to the primary study region of the eleven core Ibadan LGAs. The trial involved a sample of 200 women, 200 adolescents, 200 men, and 100 healthcare professionals. Feedback from this trial was used to refine the questionnaire, ensuring all terms were culturally and locally appropriate. Additionally, this pilot test helped establish the average time needed to complete the survey, which was crucial for planning the daily workload of the research assistants.

3.9 Reliability of the Research Instrument

The dependability of a research instrument refers to its consistency, its capacity to produce similar outcomes when used repeatedly under the same conditions. To confirm this, every component of the adapted survey was subjected to a test-retest reliability assessment. This method involved giving the questionnaire to the same group of participants on two separate occasions. This procedure assesses the instrument's external consistency by statistically correlating the results from the first and second administrations to confirm the tool's stability over time. This particular reliability testing method was chosen because the study was measuring traits and variables that are not expected to change significantly over a short period.

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3.10 Validity of the Research Instrument

Before its use in the main study, the adapted questionnaire underwent a final re-validation and pre-testing stage. This process involved confirming the instrument's internal consistency and then conducting a pilot test in the Akinyele and Ibarapa East LGAs prior to the main research rollout.

The test-retest procedure for this re-validation was carried out with a group separate from the main study participants, consisting of hundred non-pregnant women, hundred pregnant women, hundred adolescents, hundred men, and fifty healthcare providers. The instrument's reliability was quantified using a Cronbach's alpha calculation. The analysis yielded a Cronbach's alpha coefficient of 0.70, meeting the established threshold, and showed an item-total score correlation of 0.20 for each component[6]. During data collection, the questionnaires were completed in two ways: some were filled out directly by the participants, while others were administered by an interviewer.

The test-retest method was applied to evaluate the external validity of the research instruments.

A preliminary trial of the validated instruments was performed to help find and correct any confusing language, potential biases, or other shortcomings before the main study began. This pilot test was carried out in the Ido, Akinyele, Ona Ara, and Oluyole LGAs, with a group consisting of two hundred males, two hundred females, 200 adolescents, and 100 medical professionals. The questions within the survey were also meticulously crafted to ensure they were not phrased in a way that would influence the answers or be unclear.

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3.11 Data Analysis and Management

3.11.1 Data Collection Process

The study utilized a quantitative methodology for gathering data. The survey was digitized and administered using the KoboCollect application. The data was collected by the lead researcher with the help of twenty-two trained research assistants, who explained the survey and recorded the responses from consenting individuals at schools, health clinics, government hospitals, and within the communities.

These research assistants were brought in from the health promotion and education department of the University College Hospital (UCH) and were aided by local contact persons in each of the study's LGAs. These local contacts were instrumental in gaining entry into the communities and mobilizing participants for the study.

Participants who were literate and willing were given the option to fill out the KoboCollect survey themselves. The questionnaires for healthcare providers were completed through a mix of direct interviews and self-administration.

3.11.2 Data Processing and Analysis

The data for the study was collected using composite, semi-structured questionnaires that were filled out by both the participants themselves and by interviewers. All data was analyzed using SPSS Version 29.

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A summary of the findings is laid out in frequency tables and charts. For making inferences, the Chi-square test was used to check for significant associations between different categories of non-numerical data.

3.11.3 Outcome variables measurement

Study design was cross-sectional with a quantitative approach. Data analysis was done using descriptive statistics, logistics regression and chi square. A logistic regression analysis was also performed to identify the independent factors that contribute to GBV. Throughout the analysis, the threshold for statistical significance (p) was established at $p < 0.05$, which corresponds to a 95% confidence interval

3.12 Ethical Protocol

To ensure the research was conducted responsibly, formal ethical clearance was secured from multiple bodies. Approval was granted by the ethics committee of Lead City University(Reference No: LCU-REC/22/168) and the research ethics committee within the State Ministry of Health's directorate of planning, research, and statistics (Reference No: AD13/479/44573^{B}). Furthermore, the necessary ethical permissions were also obtained from the State Ministry of Education (Reference No EDU/1650T^{3}VOL III/97) before any data was collected, documented written consent was secured from every participant involved in the study.

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Endnotes

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Chapter Four

Results and Discussion of Findings

This section of the report details the results, structured to answer each of the initial research questions based on the information gathered from the participant groups. The findings shed light on the impact and the contributing factors of gender-based violence (GBV) as it appears in various demographic segments. Furthermore, the analysis explores the levels of awareness, common viewpoints, typical behaviors, and the patterns of seeking assistance related to GBV in Ibadan.

The first research inquiry centered on understanding the extent and underlying factors of gender-based violence (GBV) among adult women who were not pregnant. Data from 1,911 women who provided the necessary information indicated the frequency of GBV within this group and pointed to various social and demographic elements linked to a heightened risk. The investigation delves into crucial determinants like age and educational background to comprehend the root causes of violence against adult women.

The second area of investigation examined the prevalence and contributing risk factors of GBV specifically among pregnant women. Based on the responses of 1,622 women who filled out the questionnaire, the findings underscore the distinct vulnerabilities that pregnant women face concerning GBV. Research indicates that violence experienced before pregnancy is a strong predictor of violence during pregnancy. This analysis

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looks into how socio-demographic characteristics affect the likelihood of violence during this period. Factors such as lower education levels, unintended pregnancies, and a partner's substance abuse have been identified as significant predictors of domestic violence during pregnancy.

The third research question delved into the prevalence and risk factors for gender-based violence (GBV) among adolescents. Based on a sample of 3,562 young people,

including those both in and out of school, the study determined the frequency of GBV in this demographic and pinpointed the specific vulnerabilities they face. Various socio-demographic elements were examined to create a thorough picture of GBV in adolescence.

The fourth inquiry assessed the scope and contributing factors of GBV among adult men. Out of a sample of 2,951 men, the findings indicated the occurrence of GBV in men and the determinants that may lead to such violence. This part of the study brings attention to the often-neglected topic of male victimization in GBV and investigates its socio-demographic roots.

The fifth research question centered on the awareness, attitudes, and practices of 1,286 healthcare workers concerning GBV. This section investigated the level of knowledge among these professionals, their perspectives on victims of GBV, and the methods they use to handle GBV cases within healthcare settings.

The sixth research question examined the knowledge and attitudes of respondents in Ibadan regarding GBV, specifically addressing whether they believe GBV can be justified.

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4.1 Objective 1: Prevalence, Pattern and Determinants of GBV Among Adult Non-pregnant women in Ibadan

Table 4.1a: Sociodemographic Characteristics of Non pregnant Adult women in Ibadan **N=1911**

Variables	Frequency (n)	Percentage (%)
Age(Yrs)		
20-29	746	39.1
30-39	619	32.4
40-49	331	17.3
≥50	215	11.2
Mean (SD)	34.7 (11.3)	
Level of Education		
No formal educ	108	5.7
Pri educ	194	10.1
Sec educ	1118	58.5
1st degree	377	19.7
PGD	114	6.0
Status of employ		
Currently Employed	897	46.9
Not currently employed	903	47.3
Not employed in last 1yr	110	5.8
Occupation		
Professional/Mgt	176	9.2
Cleric	93	4.9
Sales/services	686	35.9
Skilled	490	25.6
Not-skilled	90	4.7
Agricultur/Farmer	62	3.3
Apprentice	157	8.2
Student	94	4.9
Housewife	63	3.3
Marital Status		
Never married	297	15.5

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	Married	1356	71.0
	Living together	104	5.4
	Divorced	34	1.8
	Separated	52	2.7
	Widowed	68	3.6
	Residence		
	Rural	542	28.4
	Urban	1369	71.6
	Number of children		
	None	440	23.0
	1-2	598	31.3
	3-4	653	34.2
	5-8	218	11.4
	>8	3	0.2
	Years of union		
	≤5 years	893	46.7
	6 -10 years	404	21.1
	>10 years	614	32.1

Source: Researcher's Field Survey 2023

The sociodemographic characteristics of the adult, non-pregnant female population totaling 1911 are expatiated on in table 4.1a. Descriptions were in terms of age, education, employment, occupation, marital status, residence, number of children, and years of union.

The demographic breakdown by age reveals a predominantly young group of participants, with an average age of 34.7 years and a standard deviation of 11.3 years. The largest cohort was the 20-29 age group, making up 39% of the respondents, followed closely by the 30-39 age group at 32%.

Regarding educational background, the majority of the females had achieved a secondary education or higher. Specifically, 59% had completed secondary school, and an additional 19.7% possessed a first degree. In contrast, very small proportions of the sample had either no formal schooling (5.8%) or had earned a postgraduate degree (6.0%). Regarding employment, the respondents were almost evenly divided, with 47 % currently holding a job and 47.2% without one. A smaller group, representing 5.8%, had been unemployed for the past year.

The professional landscape of the participants is diverse. The largest segment is involved in sales and service industries, accounting for 35.9% of the respondents, while

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another significant portion (25.6%) consists of skilled laborers. Fewer individuals hold managerial or professional positions (9.2%) or are engaged in unskilled labor (4.7%). In terms of marital status, a significant majority of the women, 71%, were married. A smaller percentage were single (15.5%), and the remainder were distributed among other relationship statuses, including cohabitation (5.4%), divorce (1.8%), separation (2.7%), or widowhood (3.6%). The data also shows that most participants (71.6%) lived in urban settings. When it comes to family size, just over a third of the women (34.2%) had three to four children, whereas an extremely small fraction (0.2%) had more than eight.

Finally, looking at the duration of marriage for those in a union, 46.7%—nearly half—have been married for five years or fewer. Meanwhile, almost one-third (32.1%) have been married for over a decade.

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Table 4.1b: Sociodemographic Characteristics of Partner/Spouses of Adult, non-pregnant women in Ibadan

Variables	N = 1911 Frequency (n)	Percentage (%)
Age in years		
20-29	420	22.0
30-39	567	29.6
40-49	546	28.6
≥50	378	19.8
Mean (SD)	37.6 (18.8)	
Level of educ		
No formal	182	9.5
education	153	8.0
Pry	972	50.9
Sec	444	23.2
1st degree	160	8.4
PGD		
Status of employment		
Actively	982	51.4
working	796	41.7
Temporarily	132	6.9
out of work		

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	Unemployed over a year		
	Occupational category	323	16.9
	White collar	142	7.4
	worker	422	22.1
	Religious	527	27.6
	leader	284	14.8
	Retail or	112	5.9
	service	48	2.5
	worker	52	2.7
	Trained tradesperson		
	Unskilled		
	Agriculture/Farmer		
	Learner		
	Student		
	Knows how much a spouse earns	440	23.0
	Yes	1471	77.0
	No		
	Partner Smokes	137	7.2
	Yes	1640	85.8
	No	134	7.0
	Don't Know		
	Partner engages in substance abuse	22	1.1
	Yes	1728	90.5
	No	161	8.4
	Don't Know		
	Partner Consumes Alcohol	439	22.9
	Yes	1354	70.9
	No	118	6.2
	Don't Know		

Source: Researcher's Field Survey 2023

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Table 4.1b details the profile of the spouses of the adult, non-pregnant women who participated in the study. The age data reveals that a considerable portion of these partners are in the younger age brackets. Specifically, 23% are between 20 and 30 years old, while the largest group, at 29%, falls within the 30 to 39 age range. The average age for spouses is 37.6 years, and a standard deviation of 18.8 years points to a broad spectrum of ages within the group.

The level of education of the spouses is evenly dispersed, 50.9% completed secondary education and around 23.2% holding a first degree. A minority either no formal education (9.5%) or holds a postgraduate degree (8.4%). Concerning employment status, 51.4% of the partners are presently employed, 41.7% are unemployed, and a minority, 6.9%, have not been employed in the past 12 months. Their professions are diverse, with the predominant sectors being skilled labour (28%) and retail (22.1%), while a lesser percentage is involved in professional positions (16.9%) or unskilled labour (14.8%).

The findings reveal a significant lack of financial transparency, with the vast majority of adult women (77.0%) reporting that they do not know their partner's income[1]. Additionally, the study documented the prevalence of certain lifestyle habits among the partners, noting that 22.9% consume alcohol, 7.2% smoke, and 1.1% use hard drugs.

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Table 4.1c: Danger Assessment in Abusive Relationship among Adult Non-pregnant Females living in Ibadan

N = 1911

Risk indicator	Frequency (%)	Percentage (%)
Partner ever threatened to harm or kill you	86	4.5
Partner ever used physical violence against you	195	10.2
Partner ever choked, strangled or suffocated you or attempted to do any of these things	64	3.4
Partner ever threatened or assaulted you with any weapon (including knives and/or other objects)	58	3.0
Partner ever harmed or killed a family pet or threatened to do so	30	1.5
Partner ever been charged with breaching an apprehended domestic violence order	26	1.4
Relationship between client and partner		
Violence or controlling behaviour from partner is becoming worse or more frequent	77	4.0
Partner stalked, constantly harassed or texted/ emailed you	101	5.3
Partner control access to money	126	6.6
There has been a recent separation (in the last 12 months) or one imminent	93	4.9
Background of partner		
Partner or the relationship have financial difficulties	276	14.4
Partner is unemployed	382	20.0
Partner has mental health problems (including undiagnosed conditions) and/or depression?	22	1.2
Partner have a problem with substance abuse such as alcohol or other drugs	62	3.2
Partner ever threatened or attempted suicide	23	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	15	0.8
Partner has access to firearms or prohibited weapons	14	0.8
Information about Children's risk		
Household has children who are less than 12 months apart in age	310	16.2
Partner ever threatened or used physical violence toward me at any time	116	6.1
Partner ever harmed or threatened to harm your children	44	2.3
There is conflict between me and partner regarding child contact or residency issues and/or current Family Court proceedings	22	1.2
There are children from a previous relationship present in the household	102	5.4
Sexual assault		
Partner has ever done things to me, of a sexual nature, that made me feel bad or physically hurt me	73	3.8

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Partner has ever been arrested for sexual assault	26	1.3

Source: Researcher's Field Survey 2023

Table 4.1c provides a breakdown of the risk factors for violence relationships identified amidst the non-expectant women surveyed in Ibadan. The findings indicate that as many as one in ten participants (10%) have experienced bodily harm from their spouse[2]. Financial abuse was also reported, with 6.7% of the women stating their spouses limited their financial access. Furthermore, economic instability appears to be a significant factor, as 15% of the couples were experiencing financial strain, and 21% of the partners were unemployed. Lastly, 6.2% of the women reported that their partner had ever made threats or acted violently towards them at some point. Infrequently reported indicators, as illustrated in the table, pertain to sexual assaults, with approximately 3.8% of respondents stating they experienced sexual actions from their partner that elicited negative feelings or resulted in physical harm, while 3.4% reported instances of choking, strangling, or suffocation by their partners or attempts thereof. Furthermore, the table indicates an increased danger in partnerships, as 4.0% of respondents noted a deterioration in aggression or controlling behaviour from their partner[2]. 16.2% of respondents reported households with children fewer than 12 months apart in age.

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Table 4.1d: Sociodemographic determinants of GBV threat among adult, non-pregnant women

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Age Group(Yrs)				
20 - 29	418 (56.1)	328 (43.9)	16.643	0.001*
30 – 39	297 (48.0)	321(52.0)		
40 - 49	152(45.9)	179 (54.1)		
≥50	110 (51.1)	105 (48.9)		
Status of employment				
Actively working	539 (60.1)	358 (39.9)	80.679	<0.001*
Temporarily out of work	374 (41.5)	528 (58.5)		
Unemployed for over a year.	63(57.2)	47 (42.8)		
Residence				
Rural	263 (48.6)	278 (51.4)	2.428	0.119
Urban	713 (52.1)	655 (47.9)		
Level of educ				
No formal education	63 (58.5)	45 (41.5)	32.773	<0.001*
Primary	86 (44.6)	107 (55.4)		
Secondary	533 (47.7)	584 (52.3)		
Tertiary	294 (59.9)	197 (40.1)		
No of Children				
None	277 (63.0)	162 (37.0)		
1-2	296 (49.5)	302 (50.5)	43.997	<0.001*
3-4	303 (46.4)	350 (53.6)		
5-8	98 (45.2)	120 (54.8)		
>8	2 (75.0)	1 (25.0)		
Years of Union				
1-5	520 (58.2)	373 (41.8)	42.567	<0.001*
6-10				

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	184 (45.5)	220 (54.5)
>10		
	272 (44.5)	341 (55.5)

Source: Researcher's Field Survey 2023

Table 4.1d delineates the socio-demographic factors associated with the risk of gender-based violence (GBV) among adult non-pregnant women in Ibadan. Factors such as age, job situation, level of schooling, number of children, and length of the marital union are identified as contributing influences. A notable correlation exists between age and the risk of gender-based violence (GBV), with a lesser percentage of younger women aged 20-29 years (43.9%) facing this threat compared to older women aged 40-49 years (54.1%) ($p=0.001$). working women face a lower threat level (39.9%) compared to those who have not been working in the past 12 months (42.8%) or those who are now out of jobs (59%). Females possessing a university education have a reduced risk of gender-based violence at 40.1%, in contrast to those with secondary education at 52.3% and primary education at 56%. Likewise, both the number of children and duration of marriage are highly correlated with the threat of gender-based violence ($p<0.001$)[3]. Women without children (38%) or with a limited number of children (1-2) (50.5%) are less susceptible to threats than those with 6-9 children (55%) and those with fewer children (42%). Women who have been married for more than ten years face a higher likelihood of risk, with 55.5% affected

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Table 4.1e: Logistic Regression model on determinants of GBV threat among adult non-pregnant women

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				
Actively working	0.707	0.070	0.487	1.028
Temporarily out of work	1.636	0.009	1.132	2.367
Unemployed for over a year (RC).	1.000			
Academic background				
No schooling	0.806	0.291	0.540	1.203
Basic education	1.236	0.209	0.888	1.721
High school level	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	1,558	0.715	0.144	16.812
1-2	2.869	0.383	0.268	30.697
3-4	2.825	0.389	0.267	29.934
5-8	3.082	0.350	0.291	32.602
>8	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			

Source: Researcher's Field Survey 2023

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The statistical analysis presented in Table 4.1e identifies key demographic predictors associated with the likelihood of GBV among non-expectant women in Ibadan.

A strong connection exists between age and vulnerability to GBV. When measured against women aged 50 and older, younger women demonstrated a significantly increased probability of experiencing abuse[3]. This risk was highest for women in the 20-29 age bracket (OR = 2.15, p = 0.001), and remained substantially elevated for those aged 30-39 (OR = 1.867, p = 0.001) and 40-49 (OR = 1.568, p = 0.009).

Current employment status also emerged as a critical factor. Women who are presently unemployed showed a significantly higher likelihood of facing threats of violence (OR = 1.636, p = 0.009) compared to the baseline group of women who had not worked in the past year. Furthermore, higher education appears to be a protective element; women with a secondary education were more likely to experience GBV (OR = 1.240, p = 0.041) than those who held a university degree.

Finally, the length of a marriage was also a significant predictor. female in marriages of five years or less had a substantially lower risk of experiencing GBV (OR = 0.507, p < 0.001) when contrasted with women who had been married for over ten years.

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Table 4.1f: Partner's characteristics and GBV threat among Partners of adult non-pregnant women in Ibadan

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Age of Partner (Yrs)				
20 - 29	266 (63.4)	153 (36.6)	40.878	<0.001*
30 – 39	267 (47.2)	299 (52.8)		
40 – 49	261 (47.7)	286 (52.3)		
≥50	183 (48.3)	195 (51.7)		
Employment Status of partner				
Actively working	582 (59.2)	401 (40.8)	96.206	<0.001*
Temporarily out of work	313 (39.3)	483 (60.7)		
Unemployed for over a year	82 (62.4)	50 (37.6)		
Spouse's education level				
No schooling	156 (85.5)	26 (14.5)	141.953	<0.001*
Basic education	71 (46.6)	82 (53.4)		
High school level	422 (43.4)	550 (56.6)		
Tertiary	328 (54.4)	275 (45.6)		
Spouse drinks alcohol				
No	752 (55.6)	602 (44.4)	128.783	<0.001*
Yes	138 (31.4)	301 (68.6)		
I don't know	87 (73.6)	31 (26.4)		
Partner smokes				
No	842 (51.3)	798 (48.7)	40.657	<0.001*
Yes	45 (32.7)	92 (67.3)		
I don't know	90 (67.3)	44 (32.7)		
Spouse takes hard drug				
Yes	6 (25.9)	16 (74.1)	13.721	0.001*

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No				
	874 (50.6)	854 (49.4)		
I don't know				
	10 (60.2)	64 (39.8)		
Know partner's income				
No	766 (52.1)	705 (47.9)	2.968	0.085
Yes	210 (47.9)	229 (52.1)		

Source: Researcher's Field Survey 2023

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Table 4.1f presents the partner's characteristics and GBV threat among Partners of adult non-pregnant women in Ibadan. A statistically significant link was found between the partner's age and the likelihood of experiencing GBV ($p < 0.001$). Women whose partners were aged 30–39 (53%), 40–49 (52%), and 50 years or older (51.5%) reported higher rates of GBV compared to those with partners aged 20–29 (37%). The employment status of the partner also played a role: women with working partners reported lower exposure to GBV (40.8%) than those whose partners were jobless (60.7%)[3]. Interestingly, women whose partners had not been employed in the past year showed a lower incidence (37.6%) of GBV. Educational background of the partner was another influential factor. Women whose partners had no formal schooling experienced the lowest rates of GBV (15.1%), while those with partners who had completed primary (53.4%), secondary (56.6%), or tertiary education (46%) reported significantly higher rates. Substance use by the partner, including alcohol consumption, tobacco use, and illicit drug intake, was strongly associated with increased GBV risk. Women whose spouses drank alcohol (68.6%), smoked (67.3%), or used hard drugs (74%) were substantially more likely to experience GBV than those whose partners refrained from such behaviors.

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Table 4.1g: Logistic Regression model on partners' characteristics and GBV threat among Adult non-pregnant women in Ibadan

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age Group(Yr)				
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			
Status of employment				
Actively working	0.516	0.001	0.347	0.768
Temporarily out of work	1.661	0.012	1.119	2.464
Unemployed for over a year (RC)	1.000			
Academic level				
No schooling	0.182	<0.00	0.116	0.285
Basic education	0.845	1	0.593	1.205
High school level	1.119	0.352	0.913	1.371
Tertiary (RC)	1.000	0.280		
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			
Consumes 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 partner's income				
No	0.723	0.004	0.580	0.901
Yes	1.000			

Source: Researcher's Field Survey 2023

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The statistical model detailed in Table 4.1g examines partners' characteristics and GBV threat among Adult non-pregnant women in Ibadan. A spouse's employment situation was a key factor. When measured against the baseline group of partners who had not worked in the previous 12 months, those who were currently employed were associated with a significantly lower likelihood of GBV threats (OR = 0.516, p = 0.001). In contrast, partners who were presently unemployed were linked to a substantially higher probability of such threats[4].

Interestingly, a partner's educational background showed a strong inverse relationship with violence. Men with no formal education were associated with a dramatically lower chance of GBV threats (OR = 0.182, $p < 0.001$) compared to the reference group of partners holding a tertiary degree.

Furthermore, the data revealed that spouses who drink alcohol were connected to a lower probability of GBV threats (OR = 0.21, $p < 0.001$) when contrasted with the baseline group where the woman was unaware of her spouse's alcohol habits. Similarly, a woman's knowledge of her partner's finances was a significant variable; women who did not know their partner's income had a considerably lower probability of facing gender-based violence (OR = 0.73, p = 0.004) than their counterparts who were informed about their partner's earnings.

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

Table 4.2a: Sociodemographic Characteristics of Pregnant Women in Ibadan

N=1622

Variables	Frequency (n)	Percentage (%)
Age Group (Yrs)		
20-29	833	51.4
30-39	702	43.3
40-49	82	5.0
≥50	5	0.3
Mean (SD)	29.8 (5.8)	
Level of Educ		
No formal education	56	3.5
Primary	177	10.9
Secondary	982	60.5
First degree	309	19.0
PGD	98	6.1
Status of employment		
Currently Employed	760	46.8
Not currently employed	780	48.1
Not employed in last 12 months	82	5.1
Occupation		
Professional/Management	125	7.7
Cleric	91	5.6
Sales/services	533	32.9
Skilled	586	36.2
Unskilled	58	3.6
Agriculture/Farmer	26	1.6
Apprentice	118	7.3
Student	42	2.6
House-wife	41	2.5
Marital Status		
Never married	50	3.1
Married	1470	90.7
Living together	86	5.3
Divorced	2	0.1
Separated	14	0.8
Residence		
Rural	491	30.3
Urban	1130	69.7
No of children		
None	252	15.5
1-2	947	58.4
3-4	375	23.1
5-8	47	2.9
Years of Union		
≤5 years	999	61.6
6 -10 years	425	26.2
>10 years	198	12.2

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Source: Researcher's Field Survey 2023

Table 4.2a delineates the features of a cohort of 1622 expectant females in Ibadan. Over fifty percent of expectant women (51.6%) are aged between 20 and 29 years, with a mean age of 29.6 years and a standard deviation of 5.6 years. A portion of individuals is within the 30-39 age bracket (43.3%), whereas a small minority is aged 40 years and older. A majority of women have achieved a minimum of secondary education (60.5%), with a significant proportion holding a bachelor's degree (19.0%). A mere 3.5% lack formal education, whereas 6.1% have engaged in postgraduate courses. The employment status indicates a virtually equal distribution, with 46.8% currently employed and 48.1% not employed, although a minor fraction (5.1%) has experienced unemployment during the past year. The predominant group engaged in trained personnel (36.2%) and retail and customer service (32.9%). A lesser proportion is employed in professional or managerial positions (8%) or participates in unskilled labour (3.6%). The majority of expectant women are married (91%), whereas a tiny percentage cohabitate with a partner (5.3%) or are unmarried (3.1%). A significant majority live in metropolitan regions (69.7%), and the majority of women have 1-2 children (58.4%), but a lesser percentage have three or more children. A significant percentage of women have been married for five years or fewer (62%), whereas a lesser proportion have been married for over a decade (13.1%).

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Table 4.2b: Sociodemographic Characteristics of Partner/Spouses of Pregnant Women in Ibadan **N = 1622**

Variables	Frequency (n)	Percentage (%)
Age Group (yrs)		
20-29	324	20.0
30-39	857	52.8
40-49	390	24.1
≥50	50	3.1
Mean (SD)	35.1 (7.9)	
Educational Attainment		
Without Formal Schooling	43	2.7
Primary Schooling	90	5.5
Secondary Schooling	916	56.5
Undergraduate Degree	425	26.2
Postgraduate Qualification	148	9.1
Work Status		
Presently Working	942	58.1
Unemployed at Present	640	39.5
Jobless for the Last Year	38	2.4
Vocation		
Professional/Technical	248	15.3
Religious Clergy	148	9.1
Commercial and Service Sector	382	23.6
Skilled Labor	531	32.8
Unskilled Labor	163	10.1
Farming and Agriculture	82	5.1
Trainee	48	3.0
Student	18	1.1
Knows partner's income		
Yes	545	33.6
No	1077	66.4
Smokes		
Yes	107	6.6
No	1437	88.7
Don't Know	77	4.7
Takes hard drugs		
Yes	23	1.4
No	1503	92.7
Don't Know	95	5.9
Drinks Alcohol		
Yes	526	26.2
No	1133	69.9
Don't Know	63	3.9

Source: Researcher's Field Survey 2023

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Table 4.2b presents a demographic profile of the partners of the pregnant women surveyed in Ibadan.

Regarding age, the largest cohort of spouses falls within their thirties, with 52.8% being between 30 and 39 years old. The average age is 35.1 years, which suggests that most couples are in their middle adult years. Fewer partners were in the 20-29 age bracket (20.0%) or were 50 years or older (3.1%).

In terms of educational attainment, a majority of the men (56.5%) have completed at least their secondary schooling. A notable portion holds an undergraduate degree (26.2%), while a smaller number have pursued postgraduate qualifications (9.1%). Only a small minority (2.7%) have no formal schooling.

Looking at employment, most partners (58.1%) are currently working. However, a substantial 39.5% are presently without a job, and a small fraction (2.4%) have been unemployed for the entire past year. The professional landscape is diverse, with skilled trades (32.8%) and roles in sales or services (23.6%) being the most common occupations. Fewer men are employed in professional fields (15.3%) or as unskilled laborers (10.1%).

In relation to personal habits, approximately one in four partners (26.2%) drinks alcohol, while a smaller percentage (6.6%) smokes. The use of hard drugs is rare, with 92.7% of the men not partaking in such substances. Finally, a significant finding is the lack of financial transparency, as a substantial majority of the women (66.4%) reported not knowing their partner's income.

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Table 4.2c: Danger Assessment in Abusive Relationship among Pregnant Women living in Ibadan

N = 1622

Risk indicator	Frequency (n)	Percentage (%)
Has your partner ever made verbal threats of physical injury or death towards you?	64	3.9
Have you ever been subjected to physical battery by your partner?	179	11.0
Has your partner ever attempted to asphyxiate you by choking, strangling, or suffocating you?	56	3.5
Have you ever been menaced or attacked by your partner with a weapon or other object?	35	2.2
Has your partner ever injured or killed a pet, or made threats to do so?	26	1.6
Has your partner ever faced legal consequences for violating a protective order?	23	1.4
Relationship between client and partner		
Has your partner ever made verbal threats of physical injury or death towards you?	74	4.6
Have you ever been subjected to physical battery by your partner?	158	9.7
Has your partner ever attempted to asphyxiate you by choking, strangling, or suffocating you?	219	13.5
Have you ever been menaced or attacked by your partner with a weapon or other object?	66	4.0
Background of partner		
Is the relationship or your partner experiencing significant financial strain?	278	17.2
Is your partner currently without a job?	346	21.3
Does your partner struggle with mental health challenges, such as depression, whether diagnosed or not?	26	1.6
Does your partner have issues with substance dependency, such as alcohol or other drugs?	62	3.8
Has your partner ever expressed suicidal intentions or made a suicide attempt?	24	1.5
Is your partner involved with the criminal justice system for violent acts (e.g., currently on bail/parole, or has a history of incarceration)?	19	1.2
Does your partner have the ability to obtain firearms or other illegal weapons?	21	1.3

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Information about Children's risk		
Are there children in the home with an age gap of less than one year?	892	56.8
Has your partner ever made threats of physical harm or acted violently toward you?	161	9.9
Has your partner ever injured your children or made threats to do so?	46	2.8
Are there ongoing disputes over child residency or visitation, possibly involving formal legal proceedings?	26	1.6
Are children from a prior partnership living in the household?	96	5.9
Coercive or Unwanted Sexual Acts		
Partner has ever done things to me, of a sexual nature, that made me feel bad or physically hurt me	111	6.9
Partner has ever been arrested for sexual assault	34	2.1

Source: Researcher's Field Survey 2023

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Table 4.2c delineates a risk evaluation of abusive relationships among pregnant women residing in Ibadan. A considerable number of women have encountered extreme types of abuse[4]. Specifically, 11% of women indicated that their spouses had used physical violence against them, and 3.9% had experienced threats of harm or death. Furthermore, 3.5% of respondents indicated experiences of choking, strangulation, or suffocation, while 2.2% reported threats or assaults employing weapons. Partners manage the finances of pregnant women, as 13.5% of women report that their partner regulates access to funds. Additionally, 9.7% indicated experiencing stalking, harassment, or persistent communication from their spouse by text, email, or alternative methods.

Pregnant women said that 21.3% of their partners were unemployed and 17.2% had financial hardships. A minority of partners experienced mental health disorders (1.6%) or drug misuse problems (3.8%). A significant majority (56.8%) of households have children less than 12 months apart in age. Additionally, 9.9% of women reported experiencing physical violence from their partners, while 2.8% indicated that their partners had harmed or threatened to harm their children. Furthermore, 6.9% of women reported being subjected to sexual acts by their partners that caused them distress or physical harm, and 2.1% of partners had been arrested for sexual assault[4].

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Table 4.2d: Sociodemographic determinants of GBV threat among Pregnant Women

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Age grouped (Yrs)				
20 - 29	254 (30.5)	578 (69.5)	13.698	0.003*
30 – 39	172 (24.5)	530 (75.5)		
40 - 49	19 (23.5)	62 (76.5)		
≥50	3 (66.7)	2 (33.3)		
Employment status				
Currently employed	238 (31.3)	521 (68.7)	11.683	<0.001*
Not currently employed	191 (24.5)	589 (75.5)		
Not employed in last 12 months	20 (24.3)	62 (75.7)		
Residence				
Rural	133 (27.0)	358 (73.0)	0.181	0.671
Urban	316 (28.0)	814 (72.0)		
Education level				
No formal education	13 (22.9)	43 (77.1)	5.326	0.149
Primary	42 (24.0)	134 (76.0)		
Secondary	267 (27.2)	714 (72.8)		
Tertiary	126 (31.0)	281 (69.0)		
Number of Children				
None	79 (31.4)	173 (68.6)	9.964	0.019*
1-2	271 (28.6)	676 (71.4)		
3-4	91 (24.3)	284 (75.7)		
5-8	7 (15.3)	40 (84.7)		
Years of Marriage				
1-5	300 (30.0)	698 (70.0)	10.267	0.006*
6-10	106 (25.0)	318 (75.0)		

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>10	42 (21.4)	156 (78.6)		

Source: Researcher's Field Survey 2023

Table 4.2d delineates the sociodemographic factors influencing the threat of gender-based violence among pregnant women. Age markedly affects the risk of gender-based violence (GBV) among pregnant women, with younger women aged 20-29 (69.5%) and 30-39 (75.5%) more likely to indicate vulnerability to GBV, whereas women aged 50 and beyond exhibit a reduced risk (33.3%) ($p = 0.003$).

Women who are unemployed or have not held employment in the past 12 months are more susceptible to experiencing gender-based violence (75.5%) than those who are now employed (68.7%) ($p<0.001$). The quantity of offspring a woman possesses is another critical determinant in the threat of gender-based violence (GBV)[5]. Women without children (68.6%) or with a limited number of children (1-2) (71.4%) are less susceptible to experiencing gender-based violence (GBV) than those with 5-8 children (84.7%) ($p = 0.019$).

The length of marriage demonstrates a notable correlation with the threat of gender-based violence (GBV). Women married for over 10 years are more susceptible to experiencing gender-based violence (GBV) at a rate of 78.6%, in contrast to 70.0% among those married for 1-5 years ($p = 0.006$).

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Table 4.2e: 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			

Source: Researcher's Field Survey 2023

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Table 4.2e presents a logistic regression analysis detailing the drivers of gender-based violence threats among pregnant women. Age demonstrates a notable correlation with the probability of gender-based violence during pregnancy. Women aged 30-39 possess an odds ratio of 7.476 ($p = 0.026$), signifying that they are around 7.5 times more susceptible to the risk of gender-based violence. Women aged 40-49 exhibit an odds ratio of 6.199 ($p = 0.046$), indicating an elevated risk compared to the reference group (≥50 years). Additional variables, including employment position, educational attainment, place of residence, number of offspring, and duration of marriage, do not exhibit statistically significant correlations with the likelihood of gender-based violence (GBV) among pregnant women[5].

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Table 4.2f: 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 Group (Yrs)				
20 - 29	102 (31.4)	222 (68.6)	14.897	0.002*
30 – 39	246 (28.8)	610 (71.2)		
40 – 49	83 (21.3)	307 (78.7)		
≥50	18 (34.9)	33 (65.1)		
Employment Status of partner				
Currently employed	280 (29.7)	662 (70.3)	6.765	0.034*
Not currently employed	162 (25.2)	479 (74.8)		
Not employed in last 1 year	7 (18.8)	31 (81.2)		
Partners education level				
No formal education	12 (27.8)	31 (72.2)	3.782	0.286
Primary	20 (22.3)	70 (77.7)		
Secondary	246 (26.8)	670 (73.2)		
Tertiary	171 (29.9)	401 (70.1)		
Partner consumes alcohol				
Yes	138 (31.4)	301 (68.6)	128.783	<0.001*
No	752 (55.6)	602 (44.4)		
I don't know	87 (73.6)	31 (26.4)		
Partner smokes			11.382	<0.001*
Yes	21 (19.4)	86 (80.6)		
No	398 (27.7)	1040 (72.3)		
I don't know	30 (39.6)	46 (60.4)		

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Partner takes hard drug				
Yes	6 (27.6)	17 (72.4)	1.145	0.565
No	412 (27.4)	1091 (72.6)		
I don't know	30 (31.9)	65 (68.1)		
Know partners' income				
			0.003	0.960
No	298 (27.7)	778 (72.3)		
Yes	150 (27.6)	394 (72.4)		

Source: Researcher's Field Survey 2023

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Table 4.2f depicts partners' characteristics and GBV threat among partners of pregnant women in Ibadan. A notable correlation exists between the partner's age and the risk of GBV ($p = 0.002$), suggesting that younger partners, especially those aged 20-29 (68.6%), are linked to a diminished risk of GBV relative to older cohorts. A notable correlation exists between the partner's employment position and the risk of gender-based violence ($p = 0.034$)[5]. Partners who are either now unemployed or have not been employed in the past 12 months exhibit a higher likelihood of being linked to the threat of gender-based violence (81.2%). An relationship exists between a partner's alcohol use and the risk of gender-based violence ($p < 0.001$). Individuals who consume alcohol are more likely to be linked to an increased risk of gender-based violence (68.6%) compared to those who abstain (44.4%)[5]. Smoking is substantially correlated with the risk of gender-based violence ($p < 0.001$). Individuals who smoke (80.6%) are more likely to be associated with the threat of gender-based violence (GBV) than non-smokers (72.3%).

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Table 4.2g: 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	0.504	0.078	0.235	1.079
Not currently employed	0.634	0.244	0.295	1.364
Not employed in the last 12 months (RC)	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	0.953	0.685	0.755	1.203
Yes (RC)	1.000			

Source: Researcher's Field Survey 2023

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Table 4.2g presents a logistic regression study that investigates the impact of partner characteristics on the risk of gender-based violence among pregnant women. The odds ratios demonstrate a substantial correlation between the partner's age and the risk of gender-based violence (GBV)[6]. Partners aged 40-49 exhibit an odds ratio of 2.064 ($p = 0.015$), indicating a greater likelihood of association with GBV compared to those aged 50 and older, who represent the reference category. Individuals aged 30-39 exhibit a stronger yet less significant association (OR = 1.431, p = 0.208).

In terms of alcohol consumption, partners who use alcohol exhibit a markedly elevated odds ratio of 0.246 ($p < 0.001$), signifying a considerable correlation with the threat of gender-based violence compared to individuals with an unknown alcohol consumption status.

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Objective 3: Prevalence, Pattern and Determinants of GBV among Adolescents in Ibadan

Table 4.3a: Sociodemographic Characteristics of Adolescents in Ibadan

N=3562

Variables	Frequency (n)	Percentage (%)
Age(Yrs)		
Minimum	10	
Maximum	19	
Mean (SD)	15.1 (1.8)	
Level of educ		
No formal education	187	5.3
Primary	743	20.9
Secondary	2602	73.1
First degree	13	0.4
PGD	16	0.4
Status of Employment		
Currently Employed	214	6.0
Not currently employed	1980	55.6
Not employed in last 12 months	1367	38.4
Occupation		
Professional	6	0.2
Cleric	5	0.1
Sales/services	62	1.7
Skilled	71	2.0
Unskilled	83	2.3
Agriculture/Farmer	11	0.3
Apprentice	947	26.6
Student	2319	65.1
Housewife	58	1.6
Status of marriage		
Never married	3450	96.9
Married	62	1.7
Living together	45	1.3
Divorced	1	0.0
Separated	5	0.1
Residence		
Rural	1086	30.5
Urban	2476	69.5
No of children		
None	3474	97.5
1	75	2.1
2	13	0.4
Gender		
Male	1489	41.8
Female	2073	58.2

Source: Researcher's Field Survey 2023

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Table 4.3a delineates the socio-demographic attributes of adolescents in Ibadan. The sample comprised 3.562 adolescents with a mean age of 15.1 years, spanning from 10 to 19 years. The predominant educational attainment among participants was secondary education completion (73.1%), while approximately one-fifth (20.9%) had only completed primary education. Those who achieved a first degree or postgraduate studies constituted a mere 0.4% each, and 5.3% of the adolescents had no formal education. Regarding employment, over half of the adolescents were not now employed (55.6%), while 38.4% had not been employed in the past 12 months, and only a minor percentage (6.0%) were presently worked. The occupational distribution indicates that a predominant 65.1% of adolescents are classified as students. A few participated in apprenticeships (26.6%), with even fewer engaged in unskilled (2.3%) and skilled (2.0%) positions, as well as other sectors such as sales/services (1.7%) and agriculture/farming (0.3%). A negligible proportion identified as professionals (0.2%) or clerics (0.1%). The majority of adolescents had never been married (96.9%), with only 1.7% now married and 1.3% cohabiting with a partner. Occurrences of divorce and separation were exceedingly uncommon, comprising less than 0.2% of the sample. Moreover, a significant proportion of the adolescents inhabited metropolitan regions (69.5%), whereas 30.5% dwelt in rural locales. Concerning the number of children, nearly all adolescents were childless (97.5%), with merely 2.1% having one child and a minimal 0.4% having two children. The gender distribution in the sample indicated a minor predominance of females (58.2%) compared to males (41.8%).

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Table 4.3b: Sociodemographic Characteristics of Adolescents' Partner/Spouses

N = 262

Variables	Frequency (n)	Percentage (%)
Age (years)		
Minimum	14	
Maximum	55	
Mean (SD)	17.1 (10.1)	
Education level		
No formal education	15	5.8
Primary	15	5.8
Secondary	196	74.9
First degree	9	3.4
PGD	9	3.4
Not Available	18	6.7
Employment Status		
Currently Employed	76	29.1
Not currently employed	133	50.8
Not employed in last 12 months	23	8.9
Not Applicable	30	11.3
Occupation		
Professional	2	0.6
Sales/services	44	16.8
Skilled	58	22.0
Unskilled	24	9.2
Agriculture/Farmer	6	2.4
Apprentice	46	17.4
Student	48	18.3
Housewife	8	3.1
Not Applicable	26	10.1
Know partner income		
Yes	20	7.6
No	208	79.5
Not Applicable	34	12.9
Smokes		
Yes	20	7.6
No	33	12.5
Don't Know	209	79.9
Consumes hard drugs		
Yes	26	10.1
No	10	3.7
Don't Know	226	80.2
Drinks Alcohol		
Yes	14	5.5
No	82	31.5
Don't Know	165	63.0

Source: Researcher's Field Survey 2023

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Table 4.3b delineates the attributes of the partners or wives of the adolescent participants, comprising a total of 262 persons. The ages of these partners varied from 14 to 55 years, with an average age of 17.1 years. Regarding educational achievement, spouses had completed secondary education (74.9%), whereas a lesser proportion had only elementary education (5.8%) or no formal education (5.8%). A few engaged in higher education, with 3.4% possessing a first degree or postgraduate diploma, while 6.7% had undisclosed educational backgrounds. Employment status among the couples varied, with little over half (50.8%) being unemployed. Approximately 29.1% were presently employed, whereas 8.9% had not been employed in the preceding 12 months, and 11.3% were classified as "not applicable." The occupational distribution among the partners indicated that the predominant group was involved in skilled labour (22.0%), succeeded by those in sales or services (16.8%) and apprenticeships (17.4%). Additional significant jobs comprised students (18.3%), unskilled labourers (9.2%), and a minor fraction of professionals (0.6%). Furthermore, a portion of partners was classified as housewives (3.1%), while another segment (10.1%) had vocations deemed inapplicable.

The research additionally examined the financial transparency of the couples and their substance use. A significant proportion of the adolescent participants (79.5%) indicated that they were unaware of their partners' earnings, whereas merely 7.6% possessed knowledge about their partner's income. Substance use among partners was documented, with 7.6% identified as smokers and 10.1% as users of illicit drugs. Nonetheless, the overwhelming majority of individuals (79.9% and 80.2%, respectively) were either oblivious to or did not recognise their partner's smoking or substance use behaviours. Alcohol usage was seen in

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31.5% of the partners, although a substantial proportion of participants (63.0%) were uncertain about their partner's alcohol consumption[6].

Table 4.3c: Pattern of GBV among Adolescents

Variables	Frequency (n)	Percentage (%)
No of times slapped and/or pushed without injuries/lasting pain		
0	2	15.4
1	7	53.8
2	1	7.7
3	2	15.4
8	1	7.7
No of times punched/kicked/bruised/cut you with continued pain		
0	9	69.2
1	2	15.4
2	1	7.7
4	1	7.7
No of times ex/partner beat you up with severe confusions, burns etc		
0	11	84.6
1	1	7.7
5	1	7.7
No of times ex/partner threatened to use weapon causing injury		
0	10	76.9
2	3	23.1
No of times weapon was used causing wounds		
0	10	76.9
1	1	7.7
2	2	15.4

Source: Researcher's Field Survey 2023

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Table 4.3c delineates the pattern of Gender-Based Violence (GBV) among adolescents, emphasising the kind, frequency, and intensity of the diverse forms of abuse encountered by the participants during the last year. Concerning events in which participants were slapped or shoved without incurring injuries or enduring pain, a majority (53.8%) indicated having encountered this form of abuse at least once, while 15.4% reported encountering it three times, and a further 7.7% stated it occurred eight times over the last year. In the context of more serious physical violence, like being punched, kicked, bruised, or cut with persistent pain, 69.2% of participants indicated they had never had such experiences, while 15.4% reported having it once, and smaller proportions reported it occurring twice or four times. Regarding more extreme manifestations of violence, like physical assault resulting in significant contusions, burns, or other grave injuries, 84.6% of the participants indicated that they had never had such experiences. Nonetheless, 7.7% encountered this form of violence once, while an additional 7.7% experienced it five times during the review year[7]. Furthermore, 23.1% of participants indicated that their former or present partner had threatened to employ a weapon against them, resulting in injury, whereas 76.9% did not encounter such threats. Concerning the utilisation of a weapon that resulted in injuries, 15.4% indicated this event occurred twice, and 7.7% reported it occurring once, whereas the majority (76.9%) had not encountered this type of violence.

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Table 4.3d: Danger Assessment in Abusive Relationship among Adolescents N=262

Statements	Freq (%)	Score
1. Partner is constantly jealous and/or possessive of you	94 (36.1)	4
2. Partner tries to isolate you socially	50 (19.3)	3
3. Physical violence increased in severity or frequency over the past year	29 (11.0)	2
4. Partner threatened you with a gun over the past year	10 (4.0)	2
5. Have lived with partner in the past year	62 (23.5)	2
6. Partner had ever threatened to abuse a previous intimate partner/family/friends	24 (9.2)	2
7. Partner uses illegal drugs	14 (5.2)	1
8. Partner is an alcoholic or problem drinker	34 (12.8)	1
9. Partner tries to control/limit my spirituality	34 (13.1)	1
10. Partner constantly blames you or put you down	30 (11.3)	1
11. Partner destroyed/threatened to destroy something that belongs to me	22 (8.6)	1
12. Partner has threatened to harm		
➢ Pet	79 (30.3)	1
➢ Elderly family member	22 (8.6)	1
➢ Person I care for with a disability	4 (1.5)	1
13. Partner has ever violated a restraining order	22 (8.6)	1
14. Partner stalks you (follow/spy/drops threatening message etc)	31 (11.9)	1
15. If abused by partner, and calls for help, people will not take me seriously	34 (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	19 (7.3)	1
17. Will keep serious difficulty with partner a secret out of fear or shame	30 (11.3)	1
18. I have threatened or tried to kill myself	11 (3.7)	--

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TOTAL OBTAINABLE SCORE	28

Source: Researcher's Field Survey 2023

The evaluation of risk in adolescents' abusive relationships, as indicated in table 4.3d, demonstrates that a significant 36.1% claimed their partner exhibited persistent jealousy or possessiveness, which received the highest rating of 4 on the danger scale. Furthermore, 19.3% of the adolescents reported that their partners attempted to socially isolate them, resulting in a score of 3. Eleven percent of respondents reported an increase in the severity or frequency of physical violence during the last year, which, albeit being lower in frequency, nevertheless constitutes a significant warning indicator with a score of 2. 4.0% of participants reported the threat of violence involving a weapon, specifically a firearm, which received a score of 2. Living with a partner in the last year, reported by 23.5%, was correlated with an elevated risk score of 2. Additional alarming behaviours encompass the partner's history of threatening former intimate partners, friends, or family members, indicated by 9.2%, with the partner's substance misuse problems, including illegal drug usage (5.2%) and alcoholism (12.8%). Moreover, 30.3% of teens indicated that their spouse had threatened to inflict damage on a pet, an older family member, or an individual with a disability that they care for[8].

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Table 4.3e: Sociodemographic characteristics and GBV risks among Adolescents in Ibadan

Variables	Danger of GBV		CHI^2	P-VALUE
	NO	YES		
Age (Yrs)				
10 – 14	10 (40.6)	15 (59.4)	5.896	0.021*
15 – 19	148 (62.7)	88 (37.3)		
Employment Status				
Currently employed	32 (71.4)	13 (28.6)	11.996	0.002*
Not currently employed	88 (53.4)	77 (46.6)		
Not employed in last 12 months	38 (73.8)	14 (26.2)		
Education level				
No formal education	10 (50.0)	10 (50.0)	4.189	0.247
Primary	19 (55.8)	15 (44.2)		
Secondary	127 (63.1)	74 (36.9)		
Tertiary	2 (33.3)	3 (66.7)		
Gender				
Male	37 (55.4)	30 (44.6)	1.225	0.268
Female	122 (62.3)	73 (37.7)		
Residence				
Rural	70 (58.8)	49 (41.2)	0.353	0.552
Urban	89 (62.0)	54 (38.0)		

Source: Researcher's Field Survey 2023

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The analysis of sociodemographic characteristics and their association with the risk of gender-based violence (GBV) among adolescents in Ibadan (Table 4.3e) 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[9]. 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).

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Table 4.3f: Logistic Regression model on sociodemographic determinants of GBV risks among Adolescents

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grp)Yrs				
10 - 14	2.430	0.026*	1.114	5.298
15 - 19 (Reference Category)	1.000			
Status of employment				
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			
Level of educ				
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			

Source: Researcher's Field Survey 2023

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The logistic regression analysis of sociodemographic determinants of gender-based violence (GBV) risks among adolescents identified age and employment status as influential factors in the likelihood of experiencing GBV (Table 4.3f). Age emerged as a critical factor, with adolescents aged 10-14 years exhibiting a 2.43-fold increased likelihood of being at risk for GBV relative to those aged 15-19 years, as evidenced by an odds ratio (OR) of 2.430 and a p-value of 0.026. Adolescents not currently employed exhibited a 2.825-fold increased likelihood of experiencing GBV compared to those who had not been employed in the past 12 months, with a statistically significant p-value of 0.002.

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Table 4.3g: Partners' characteristics and GBV risk among Adolescents in Ibadan

Variables	Danger of GBV		CHI^2	P-VALUE
	NO	YES		
Age (Yrs)				
10 – 14	154 (61.7)	96 (38.3)	3.777	0.090
15 – 19	4 (35.7)	7 (64.3)		
Employment Status				
Currently employed	51 (67.4)	25 (32.6)	3.940	0.135
Not currently employed	74 (55.4)	59 (44.6)		
Not employed in last 12 months	34 (63.6)	19 (36.4)		
Education level				
No formal education	18 (56.1)	14 (43.9)	8.628	0.033*
Primary	5 (31,6)	10 (68.4)		
Secondary	126 (64.1)	70 (35.9)		
Tertiary	10 (54.5)	8 (45.5)		
Know Partners' earning				
No	143 (59.3)	98 (40.7)	2.705	0.135
Yes	15 (76.0)	5 (24.0)		
Takes alcohol				
Yes	10 (66.7)	5 (33.3)	8.563	0.014*
No	79 (68.8)	36 (31.2)		
I don't know	70 (52.7)	62 (47.3)		
Smokes				
Yes	13 (64.0)	7 (36.0)	3.893	0.143
No	46 (69.0)	21 (31.0)		
I don't know	99 (56.9)	75 (43.1)		
Hard drugs				
Yes	18 (66.7)	9 (33.3)	6.229	0.044*
No	34 (73.7)	12 (26.3)		
I don't know	107 (56.5)	82 (43.5)		

Source: Researcher's Field Survey 2023

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Table 4.3g presents an analysis of partners' characteristics and their correlation with the risk of gender-based violence (GBV) among adolescents in Ibadan. It indicates that education level, alcohol consumption, and the use of hard drugs among partners significantly influence GBV risks[10].

The educational attainment of a partner significantly influences the risk of gender-based violence (GBV). Adolescents with partners possessing only primary education demonstrated an increased risk of gender-based violence (GBV), with 68.4% of these cases reporting GBV, in contrast to 31.6% who did not ($p = 0.033$). This indicates that reduced educational attainment among partners may correlate with an increased risk of gender-based violence (GBV).

The partner's alcohol consumption was significantly linked to the risk of gender-based violence (GBV). Adolescents uncertain about their partner's alcohol consumption reported a higher incidence of gender-based violence (GBV) at 47.3%, compared to 31.2% among those aware their partner did not consume alcohol and 33.3% among those who knew their partner did consume alcohol. $p = 0.014$.

The consumption of hard drugs by partners demonstrated a significant correlation with the risk of gender-based violence (GBV). Adolescents with partners who used hard drugs experienced a greater prevalence of gender-based violence (GBV) at 33.3%, in contrast to those whose partners did not use such substances (26.3%) or those who were uncertain (43.5%) ($p=0.044$).

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Table 4.3h: Logistic Regression model on partners' characteristic determinants of GBV risks among Adolescents

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grp)Yr				
10 – 14	0.389	0.115	0.120	1.259
15 - 19 (Reference Category)	1.000			
Status of employ				
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 1 yr (RC)	1.000			
Level of educ				
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 partner's income				
Yes	2.068	0.159	0.753	5.681
No	1.000			
Drinks 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			

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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			

Source: Researcher's Field Survey 2023

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Table 4.3h presents the logistic regression analysis regarding partners' characteristics and their correlation with the risk of gender-based violence among adolescents. The associations lacked statistical significance. The age of the adolescent, classified as 10-14 years compared to 15-19 years, did not demonstrate a significant impact on the risk of gender-based violence (GBV), with an odds ratio (OR) of 0.389 and a p-value of 0.115. The employment status of the partner was not identified as a significant predictor of GBV risk. Partners not currently employed exhibited an odds ratio of 1.300 in comparison to their employed counterparts, with a p-value of 0.472. Furthermore, characteristics of the partner, such as educational attainment, awareness of the partner's income, substance use, and use of hard drugs, did not achieve statistical significance[11].

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Disaggregation between in-school and out-of-school adolescents

Objective 3(cont'd): Prevalence, Pattern and Determinants of GBV Among Adolescents

Table 4.3i: Sociodemographic Characteristics of In and Out-of-school Adolescents in Ibadan

N=3562

Variables	In-School (2319) (n/%)	Out-of-school (1243) (n/%)
Age		
Minimum	10	10
Maximum	19	19
Mean (SD)	14.6 (1.6)	16.0(1.8)
Level of educ		
No formal education	19 (0.8)	168 (13.5)
Primary	491 (21.2)	252 (20.3)
Secondary	1787 (77.1)	815 (65.6)
First degree	22 (0.9)	7 (0.6)
Status of employment		
Currently Employed	41 (1.8)	173 (13.9)
Not currently employed	1384 (59.7)	596 (48.0)
Not employed in last 12 months	894 (38.5)	474 (38.1)
Occupation		
Professional	0 (0.0)	6 (0.5)
Cleric	0 (0.0)	5 (0.4)
Sales/services	0 (0.0)	62 (5.0)
Skilled	0 (0.0)	71 (5.7)
Unskilled	0 (0.0)	83 (6.7)
Agriculture/Farmer	0 (0.0)	11 (0.9)
Apprentice	0 (0.0)	947 (76.2)
Student	2319 (100.0)	0 (0.0)
Housewife	0 (0.0)	58 (4.6)
Marital Status		
Never married	2298 (99.1)	1151 (92.7)
Married	18 (0.8)	44 (3.5)
Living together	2 (0.1)	
Divorced	1 (0.0)	43 (3.5)
Separated		0 (0.0)
		4 (0.3)
Residence		
Rural	699 (30.1)	387 (31.2)
Urban	1621 (69.9)	855 (68.8)
No of children		
None	2314 (99.8)	508 (40.9)
1	5 (0.2)	70 (5.7)
2	0 (0.0)	13 (1.0)
Gender		

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Male	981(42.3)	508(40.9)
Female	1338 (57.7)	734 (59.1)

Source: Researcher's Field Survey 2023

The sociodemographic characteristics of adolescents in Ibadan reveal differences between in-school and out-of-school adolescents(Table 4.3i). A total of 2,319 in-school and 1,243 out of school adolescents were sampled.

The mean age for both groups is approximately 14.6 years, with a minimum of 10 years and a maximum of 19 years. A majority of in-school adolescents have completed secondary education (77.1%), whereas a notable percentage of out-of-school adolescents participate in apprenticeships (26.6%) or unskilled labour (2.3%), highlighting a disparity in educational and employment prospects. Employment patterns vary between the two groups. Among in-school adolescents, a mere 1.8% were currently employed, while the entirety (100%) identified as students. In contrast, out-of-school adolescents demonstrate a broader spectrum of occupations, with a significant proportion serving as apprentices (26.6%), participating in unskilled labour (2.3%), or working in sales/services (1.7%).

In terms of marital status, the majority of adolescents are unmarried (96.9%), while a minor percentage are married (1.7%) or cohabiting (1.3%). The majority of participants, 69.5%, reside in urban areas, whereas 30.5% live in rural locations. Furthermore, a significant majority of adolescents (97.5%) do not have children, highlighting their developmental stage.

The gender distribution indicates a greater proportion of females (58.2%) compared to males (41.8%) among the surveyed adolescents. The observed gender imbalance, along with the urban concentration of participants, indicates

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possible effects on educational, employment, and marital trends within this population (Table 4.3.9).

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Table 4.3j: Sociodemographic Characteristics of Adolescents' Partner/Spouses

N = 262

Variables	In-School (71) (n/%)	Out-of-school (191) (n/%)
Age (years)		
Minimum	0	0
Maximum	36	55
Mean (SD)	9.6 (10.8)	18.8 (9.4)
Level of educ		
No formal education	2 (2.2)	14 (7.1)
Primary	2 (2.2)	14 (7.1)
Secondary	38 (66.3)	149 (78.2)
First degree	2 (4.5)	6 (2.9)
PGD	2 (3.4)	12 (21.3)
Not Available		6 (3.4)
		2 (1.3)
Status of employment		
Currently Employed	10 (13.5)	83 (35.0)
Not currently employed	38 (52.8)	119 (50.2)
Not employed in last 12 months	2 (3.4)	26 (11.0)
Not Applicable	22 (30.3)	7 (3.8)
Occupation		
Professional	0 (0.0)	2 (0.8)
Sales/services	7 (6.8)	39 (20.6)
Skilled	6 (9.1)	51 (26.9)
Unskilled	1 (1.1)	23 (12.2)
Agriculture/Farmer	0 (0.0)	6 (3.4)
Apprentice	6 (8.0)	40 (21.0)
Student	30 (43.2)	18 (9.2)
Housewife	2 (2.3)	6 (3.4)
Not Applicable	21 (29.5)	5 (2.5)
Knows partner income		

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Yes	45 (65.9)	163 (87.6)
No	3 (4.7)	17 (9.0)
Not Applicable	20 (29.4)	6 (3.4)
Smokes		
Yes	3 (4.5)	17 (8.9)
No	5 (6.7)	28 (14.8)
Don't Know	63 (88.8)	145 (76.4)
Takes hard drugs		
Yes	5(6.7)	22 (11.6)
No	2 (2.2)	8 (4.4)
Don't Know	65 (91.1)	160 (84.0)
Consumes Alcohol		
Yes	4 (5.6)	10 (5.5)
No	7 (10.1)	75 (39.7)
Don't Know	60 (84.3)	104 (54.9)

Source: Researcher's Field Survey 2023

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The sociodemographic characteristics of adolescents' partners or spouses exhibit notable differences between in-school and out-of-school individuals(Table 4.3j). The data indicates that a significant majority of partners/spouses in both groups have attained secondary education, with 66.3% of partners of in-school adolescents and 78.2% of partners of out-of-school adolescents having completed secondary school. A greater proportion of out-of-school partners/spouses (7.1%) lack formal education compared to those who are in school (2.2%).

The employment status varies between the two groups. Of the partners of in-school adolescents, 13.5% are currently employed, 52.8% are not employed, and 30.3% fall under the "Not Applicable" category, likely representing students or housewives. In contrast, the partners or spouses of most out-of-school adolescents are engaged in skilled occupations (22%) or sales/service roles (16.8%), with 17.4% categorised as apprentices.

Patterns of substance use among partners and spouses reveal troubling trends. About 10% of partners or spouses of out-of-school adolescents use hard drugs, in contrast to 3.7% of partners of in-school adolescents. Alcohol consumption rates are significantly elevated among out-of-school partners (31.5%) in contrast to in-school partners (5.5%). Furthermore, only 7.6% of adolescents are aware of their partner's or spouse's earnings, indicating a lack of financial transparency in relationships. Most partners or spouses do not smoke (79.9%), although smoking is more common among the out-of-school group (12.5%) than the in-school group (7.6%). Table 4.3j.

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Table 4.3k: Pattern of GBV among Adolescents

Variables	In-School (3) (n/%)	Out-of-School (10) (n/%)
Number of times slapped and/or pushed without injuries/lasting pain		
0	1 (33.3)	1 (10.0)
1	1 (33.3)	5 (60.0)
2		1 (10.0)
3	1 (33.3)	1 (10.0)
8		1 (10.0)
Number of times punched/kicked/bruised/cut you with continued pain		
0	2 (66.7)	6 (70.0)
1		2 (20.0)
2	1 (33.3)	1 (10.0)
4		0 (0.0)
Number of times ex/partner beat you up with severe confusions, burns etc		
0	2 (66.7)	7 (90.0)
1	1 (33.3)	0 (0.0)
5	0 (0.0)	1 (10.0)
Number of times ex/partner threatened to use weapon causing injury		
0	1 (33.3)	7 (90.0)
2	2 (66.7)	1 (10.0)
Number of times weapon was used causing wounds		
0	2 (66.7)	6 (80.0)
1	0 (0.0)	1 (10.0)
2	1 (33.3)	1 (10.0)

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Source: Researcher's Field Survey 2023

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The data presented in Table 4.3k illustrates the disparities in gender-based violence (GBV) experiences between in-school and out-of-school adolescents. Out-of-school adolescents experience higher rates of gender-based violence, with reported variations in severity and frequency across different abuse types. Sixty percent of out-of-school adolescents reported experiencing slapping or pushing without lasting injuries at least once, in contrast to 33.3% of in-school adolescents. Significantly, in-school adolescents did not report experiencing this more than once, while out-of-school adolescents indicated multiple occurrences. In instances of severe physical violence, including punching, kicking, or inflicting bruises or cuts, 33.3% of in-school adolescents reported such experiences, whereas 30% of out-of-school adolescents indicated at least one occurrence, with 10% experiencing it on two occasions. In instances of extreme violence, including severe injuries such as burns or contusions, 10% of out-of-school adolescents reported experiencing such incidents, whereas no in-school adolescents reported similar experiences. A small percentage of both groups reported the use of weapons or threats thereof, with out-of-school adolescents indicating a higher incidence of such threats at 10%.

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Table 4.3l: Danger Assessment in Abusive Relationship among Adolescents

N = 262

Statements	In-School (71) (n/%)	Out-of-school (191) (n/%)	Score
1. Partner is constantly jealous and/or possessive of you	9 (12.4)	86 (45)	4
2. Partner tries to isolate you socially	4 (5.6)	46 (24.4)	3
1. Physical violence increased in severity or frequency over the past year	2 (3.4)	26 (13.9)	2
1. Partner threatened you with a gun over the past year	0 (0.0)	10 (5.5)	2
2. Have lived with partner in the past year	2 (2.2)	60 (31.5)	2
3. Partner had ever threatened to abuse a previous intimate partner/family/friend	2 (3.4)	22 (11.3)	2
4. Partner uses illegal drugs	1 (1.1)	13 (6.7)	1
5. Partner is an alcoholic or problem drinker	3 (3.4)	31 (16.4)	1
6. Partner tries to control/limit my spirituality	4 (5.6)	30 (16.0)	1
7. Partner constantly blames you or put you down	5 (6.7)	25 (13.0)	1
8. Partner destroyed/threatened to destroy something that belongs to me	2 (2.2)	21 (10.9)	1
9. Partner has threatened to harm:			
Pet	22 (31.5)	57(29.8)	1
Elderly family member	13 (18.0)	10 (5.0)	1

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Person I care for with a disability	2(2.2)	2(1.3)	1
10. Partner has ever violated a restraining order	2(2.2)	21(10.9)	1
11. Partner stalks you (follow/spy/drops threatening message etc)	3(4.5)	28(14.7)	1
12. If abused by partner, and calls for help, people will not take me seriously	6(7.9)	28(14.7)	1
13. Fear of reinforcing negative stereotypes about sexual relationships and/or being discriminated against will prevent me from seeking help if being abused by partner	2(2.2)	18(9.2)	1
14. Will keep serious difficulty with partner a secret out of fear or shame			1
15. I have threatened or tried to kill myself			--
TOTAL OBTAINABLE SCORE			**28**

Source: Researcher's Field Survey 2023

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The table (4.3l) on danger assessment in abusive relationships among adolescents illustrates a distinction between in-school and out-of-school adolescents concerning their exposure to different abusive behaviours.

Prevalence of GBV was determined to be 15.56% among out of school adolescents and 3.06% among their in-school counterparts. Adolescents who are out of school consistently report elevated rates of dangerous and abusive behaviours from their partners in comparison to their in-school counterparts. A significant finding indicates that out-of-school adolescents report substantially higher rates of jealousy and possessiveness from their partners, with 45% exhibiting this behaviour compared to merely 12.4% of in-school adolescents[9]. Social isolation, a significant factor in abusive relationships, is more prevalent among out-of-school adolescents (24.4%) compared to in-school adolescents (5.6%).

Out-of-school adolescents exhibit a higher prevalence and severity of physical violence, with 13.9% indicating an increase in such incidents over the past year, in contrast to 3.4% of in-school adolescents. Furthermore, 5.5% of out-of-school adolescents indicated that they had been threatened with a firearm by their partner, a behaviour not observed among in-school adolescents. Substance abuse and controlling behaviours are more prevalent among partners of out-of-school adolescents[12]. For example, 16.4% of out-of-school adolescents indicated that their partner is an alcoholic or problem drinker, whereas only 3.4% of in-school adolescents reported the same. Out-of-school adolescents are more likely to indicate that their partner attempts to control their spirituality, with rates of 16% compared to 5.6%, respectively.

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Table 4.3m: Sociodemographic characteristics and GBV risks among in-school Adolescents in Ibadan N=2319

Variables	Danger of GBV		CHI²	p-VALUE
	NO	YES		
Age (Yrs)				
10 – 14	10 (50.0)	10 (50.0)	0.004	0.949
15 – 19	26 (49.2)	26 (50.8)		
Employment Status				
Currently employed	2 (40.0)	2 (60.0)	1.371	0.591
Not currently employed	25 (47.0)	28 (53.0)		
Not employed in last 12 months	9 (61.1)	6 (38.9)		
Education level				
Primary	2 (37.5)	4(62.5)	0.961	0.694
Secondary	32(51.3)	30(48.7)		
Tertiary	1(33.3)	2(66.7)		
Gender				
Male	14(51.4)	14(48.6)	0.091	0.762
Female	21(48.1)	22(51.9)		
Residence				
Rural	15(43.2)	20(56.8)	1.363	0.243
Urban	20(55.6)	16(44.4)		

Source: Researcher's Field Survey 2023

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Table 4.3m illustrates the relationship between sociodemographic characteristics and the risk of gender-based violence (GBV) among in-school adolescents in Ibadan. The findings are presented with chi-square (χ^2) and p-values, indicating statistical significance regarding the associations between the variables and GBV risk. Adolescents aged 10–14 years and those aged 15–19 years exhibit nearly equivalent risks of gender-based violence (GBV), with 50.0% of younger adolescents and 50.8% of older adolescents reporting experiences of GBV. The chi-square value of 0.004 and a p-value of 0.949 suggest an absence of a statistically significant relationship between age and the risk of GBV.

A slight variation in GBV risk is observed based on employment status, with individuals "currently employed" or "not employed in the last 12 months" exhibiting differing levels of risk; however, these differences are not statistically significant ($\chi^2 = 1.320$, $p = 0.520$). Adolescents possessing secondary education exhibit the highest prevalence of gender-based violence (51.3%), while those with primary education demonstrate a prevalence of 62.5%[12]. The p-value of 0.650 indicates a lack of significant association between education level and GBV risk. The distribution of GBV risk varies marginally between males (48.6%) and females (51.9%), with a chi-square value of 0.091 and a p-value of 0.762, suggesting that gender does not significantly influence GBV risk among in-school adolescents. Adolescents living in rural regions exhibit a marginally elevated risk of gender-based violence (56.8%) relative to their urban counterparts (44.4%). The observed difference lacks statistical significance ($\chi^2 = 1.363$, $p = 0.243$).

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Table 4.3n: Sociodemographic characteristics and GBV risks among out-of-school Adolescents in Ibadan **N=1243**

Variables	Danger of GBV		CHI^2	p-VALUE
	NO	YES		
Age (Yrs)				
10 – 14	1(12.5)	6(87.5)	9.879	0.002*
15 – 19	122(66.)	62(33.)		
Employment Status				
Currently employed	30(74.5)	10(25.)	10.390	0.006*
Not currently employed	63(56.4)	49(43.)		
Not employed in last 1 yr	30(78.7)	8(21.)		
Educ level				
No formal education	10(50.0)	10(50.)	5.129	0.163
Primary	17(60.0)	11(40.)		
Secondary	95(68.)	44(31.)		
Tertiary	1(33.3)	2(66.7)		
Gender				
Male	22(58.3)	16(41.7)	1.069	0.193
Female	101(66.)	52(33.7)		
Residence				
Rural	54(65.4)	29(34.6)	0.037	0.847
Urban	69(64.2)	38(35.8)		

Source: Researcher's Field Survey 2023

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Table 4.3n presents the relationship between sociodemographic characteristics and the risk of gender-based violence (GBV) among out-of-school adolescents in Ibadan. The results are reported using chi-square (χ^2) values and p-values to evaluate the statistical significance of the observed relationships. Adolescents between the ages of 15 and 19 demonstrate a significantly higher risk of gender-based violence compared to those aged 10 to 14. Among younger adolescents, 87.5% reported experiencing gender-based violence (GBV), whereas the prevalence in older adolescents was 33.5%. The chi-square statistic of 9.879 and the p-value of 0.002 indicate a statistically significant association between age and the risk of gender-based violence (GBV). Similarly, individuals who are "currently employed" (25.5%) and those "not employed in the last 12 months" (21.3%) demonstrate lower risks of experiencing GBV in comparison to individuals who are "not currently employed" (43.6%). The relationship demonstrates statistical significance, as evidenced by a chi-square value of 10.390 and a p-value of 0.006. Among adolescents with secondary education, 68.4% represent those who did not encounter gender-based violence (GBV). The proportion decreases to 31.6% among individuals who experienced GBV. A slight disparity in GBV risk is observed, with males at 41.7% and females at 33.7%. Furthermore, adolescents residing in rural regions encounter a gender-based violence risk of 34.6%, whereas their urban counterparts face a similar risk of 35.8%. The chi-square value of 0.037 and p-value of 0.847 suggest no significant association between residence and GBV risk[12].

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Table 4.3o: Logistic Regression model on Sociodemographic Determinants of GBV risks Among In-School Adolescents

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
10 - 14	1.057	0.913	0.390	2.863
15 - 19 (Reference Category)	1.000			
Employment Status				
Currently employed	2.407	0.405	0.305	19.005
Not currently employed	1.712	0.336	0.573	5.114
Not employed in the last 12 months (RC)	1.000			
Education level				
Primary	0.899	0.942	0.051	15.924
Secondary	0.460	0.543	0.038	5.627
Tertiary (RC)	1.000			
Residence				
Rural	1.563	0.313	0.656	3.726
Urban	1.000			
Gender				
Male	0.959	0.927	0.394	2.337
Female	1.000			

Source: Researcher's Field Survey 2023

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Table 4.3o: The logistic regression analysis of sociodemographic factors influencing GBV risk in in-school adolescents reveals no significant associations among the examined variables. Age is not a significant predictor of GBV risk, as adolescents aged 10-14 years exhibit an odds ratio (OR) of 1.057 relative to those aged 15-19 (p = 0.913), suggesting no substantial difference between the age groups (Table 4.3.15). Employment status does not exhibit a significant correlation with the risk of gender-based violence (GBV). Adolescents who are currently employed (OR = 2.407, p = 0.405) or not currently employed (OR = 1.712, p = 0.336) do not exhibit a statistically significant increased risk of gender-based violence compared to those who have not been employed in the past 12 months. The variables of education level, residence, and gender do not yield statistically significant results. Adolescents with primary education (OR = 0.899, p = 0.942) or secondary education (OR = 0.460, p = 0.543) do not exhibit a statistically significant difference in the likelihood of experiencing GBV when compared to their counterparts with tertiary education. The odds of gender-based violence are not significantly influenced by rural residence (OR = 1.563, p = 0.313) or by male gender (OR = 0.959, p = 0.927).

The model indicates that sociodemographic variables such as age, employment status, education, residence, and gender do not significantly predict GBV risk among in-school adolescents.

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Table 4.3p: Logistic Regression model on sociodemographic determinants of GBV risks among Out-of-School Adolescents

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (grouped)				
10 - 14	13.957	0.017*	1.599	121.803
15 - 19 (Reference Category)	1.000			
Employment Status				
Currently employed	1.496	0.432	0.548	4.083
Not currently employed	3.512	0.004*	1.497	8.239
Not employed in the last 12 months (RC)	1.000			
Education level				
No formal education	1.060	0.968	0.060	18.831
Primary	0.525	0.655	0.031	8.855
Secondary	0.329	0.429	0.021	5.174
Tertiary (RC)	1.000			
Residence				
Rural	0.795	0.449	0.439	1.439
Urban	1.000			
Gender				
Male	1.504	0.252	0.748	3.026
Female	1.000			

Source: Researcher's Field Survey 2023

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The logistic regression model evaluating sociodemographic factors influencing GBV risk in out-of-school adolescents indicates significant correlations with age and employment status(Table 4.3p). Adolescents aged 10-14 years exhibit a significantly elevated risk of experiencing gender-based violence (GBV) relative to those aged 15-19, with an odds ratio (OR) of 13.96 ($p = 0.017$). Employment status influences the risk of gender-based violence (GBV), with individuals not currently employed exhibiting a significantly higher risk (OR = 3.51, $p = 0.004$) in comparison to those who have not been employed in the past 12 months (Table 4.3p).

Other sociodemographic factors, such as education level, residence, and gender, did not show a significant association with the risk of gender-based violence (GBV). Adolescents with lower education levels (no formal, primary, or secondary education) exhibited no statistically significant difference in the risk of gender-based violence compared to their counterparts with tertiary education[9]. Adolescents living in rural areas and male adolescents exhibited marginally lower or higher odds of experiencing GBV; however, these results lacked statistical significance.

Younger age and unemployment are significant predictors of heightened GBV risk among out-of-school adolescents, whereas factors such as education, residence, and gender do not exhibit a notable association in this model[12].

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Table 4.3q: Partners' characteristics and GBV risk among In-School Adolescents in Ibadan

Variables	Danger of GBV		CHI^2	P-VALUE
	NO (43)	YES (44)		
Age Grp (Yrs)				
<20	26 (48.5)	28 (51.5)	15.563	<0.001*
20 -29	6 (53.3)	6 (46.7)		
≥ 30	2 (50.0)	2 (50.0)		
Status of employment				
Currently employed	5 (50.0)	5 (50.0)	2.232	0.328
Not currently employed	16 (42.6)	21 (57.4)		
Not employed in last 12 months	14 (60.0)	10 (40.0)		
Level of educ				
No formal education	11 (66.7)	6 (33.3)	4.157	0.206
Primary	1 (50.0)	1 (50.0)		
Secondary	21 (45.8)	26 (54.2)		
Tertiary	2 (28.6)	4 (71.4)		
Know Partners' earning				
No	34 (49.4)	34 (50.6)	0.001	1.000
Yes	2 (50.0)	2 (50.0)		
Takes alcohol				
Yes	2 (60.0)	2 (40.0)	9.576	0.006*
No	20 (67.6)	10 (32.4)		
I don't know	13 (34.0)	25 (66.0)		
Smokes				
Yes	2 (50.0)	2 (50.0)	6.396	0.025*
No	18 (65.7)	10 (34.3)		
I don't know	15 (38.0)	25 (62.0)		
Hard drugs				
Yes	4 (83.3)	1 (16.7)	12.711	0.001*
No	17 (70.0)	7 (30.0)		

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I don't know	14 (34.0)	28 (66.0)

Source: Researcher's Field Survey 2023

Table 4.3q illustrates the relationship between partner characteristics and the risk of gender-based violence (GBV) among in-school adolescents in Ibadan. The variables are analysed through chi-square (χ^2) tests, utilising p-values to assess the statistical significance of the associations. The analysis reveals a notable correlation between the partner's age and the risk of gender-based violence, indicated by a chi-square value of 15.563 and a p-value below 0.001. Adolescents with partners under 20 years exhibit a marginally elevated risk of gender-based violence (51.5%) relative to those with partners aged 20-29 (46.7%) and those aged 30 or older (50.0%). The relationship between a partner's alcohol consumption and the risk of gender-based violence is significant (exact = 9.576, p = 0.006). Adolescents unaware of their partners' alcohol consumption status exhibit a higher risk of gender-based violence (66.0%) compared to those with non-drinking partners (32.4%) or those whose partners consume alcohol (40.0%). Partner smoking habits exhibit a significant correlation with the risk of gender-based violence (Exact = 6.396, p = 0.025). Adolescents with non-smoking partners exhibit a lower risk of GBV at 32.4%, in contrast to those with smoking partners at 50.0% and those with unknown smoking habits at 62%. Additionally, partner use of hard drugs demonstrates a highly significant association with GBV risk (Exact = 12.711, p = 0.001). Adolescents with partners who do not engage in hard drug use exhibit a lower incidence of gender-based violence (30.0%) compared to those unaware of their partners' hard drug use (66%).

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Table 4.3r: Partners' characteristics and GBV risk among Out-of-School Adolescents in Ibadan

Variables	Danger of GBV		CHI^2	P-VALUE
	NO	YES		
Age (Yrs)				
<20	34 (52.4)	31 (47.6)	15.563	<0.001*
20 -29	86 (73.8)	30 (26.2)		
≥ 30	2 (30.0)	6 (70.0)		
Employment Status				
Currently employed	46 (69.9)	20 (30.1)	1.953	0.377
Not currently employed	58 (60.5)	38 (39.5)		
Not employed in last 12 months	19 (66.7)	10 (33.3)		
Education level			14.890	0.002*
No formal education	7 (45.0)	9 (55.0)		
Primary	4 (29.4)	10 (70.6)		
Secondary	104 (69.9)	45 (30.1)		
Tertiary	8 (66.7)	4 (33.3)		
Know Partners' earning				
No	110 (63.1)	64 (36.9)	2.662	0.150
Yes	13 (81.0)	3 (19.0)		
Takes alcohol			2.078	0.389
Yes	7 (69.2)	3 (30.8)		
No	59 (69.2)	26 (30.8)		
I don't know	57 (60.2)	38 (39.8)		
Smokes				
Yes	11 (66.7)	6 (33.3)	1.321	0.515
No	28 (71.4)	12 (28.6)		
I don't know	84 (62.5)	50 (37.5)		

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Hard drugs				
Yes	14 (63.0)	8 (37.0)	2.279	0.320
No	17 (77.8)	5 (22.2)		
I don't know	93 (63.0)	54 (37.0)		

Source: Researcher's Field Survey 2023

Table 4.3r illustrates the relationship between partner characteristics and the risk of gender-based violence (GBV) among out-of-school adolescents in Ibadan. Chi-square (χ^2) and p-values serve to evaluate the statistical significance of these relationships. A significant association exists between partner age and the risk of GBV, indicated by a chi-square value of 15.563 and a p-value of less than 0.001. Adolescents with partners aged 20-29 exhibit the lowest risk at 26.2%, in contrast to those with partners younger than 20, who face a risk of 47.6%, and those with partners aged 30 and above, who have a risk of 70.0%. A notable correlation is observed between the partner's educational attainment and the risk of gender-based violence ($\chi^2 = 14.890$, $p = 0.002$). Adolescents with partners possessing secondary education (30.1%) or tertiary education (33.3%) exhibit a reduced risk of gender-based violence (GBV) in comparison to those with partners lacking formal education (55.0%) or having only primary education (70.6%).

Additional factors, including employment status, alcohol consumption, smoking habits, and drug use, do not exhibit significant correlations with the risk of gender-based violence.

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Table 4.3s: Logistic Regression model on partners' characteristic determinants of GBV risks among In-School Adolescents

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (Yrs)				
<20	3.811	0.995	0.120	1.259
20 -29	1.682	0.994	0.595	2.568
≥ 30 (Reference Category)	1.000			
Employment Status				
Currently employed	0.782	0.816	0.098	6.219
Not currently employed	0.565	0.482	0.115	2.775
Not employed in the last 12 months (RC)	1.000			
Education level				
No formal education	3.933	0.991	1.407	6.537
Primary	3.083	0.995	1.911	7.060
Secondary	6.597	0.991	0.407	13.468
Tertiary (RC)	1.000			
Knows partners' earnings	2.102	0.623	0.109	40.625
Yes	1.000			
No				
Takes alcohol				
I don't know	2.834	0.992	0.109	2.921
Yes	0.943	0.999	0.245	3.466
No	1.000			
Smokes				
I don't know	3.001	0.988	1.092	14.274
Yes				
No	0.737	0.675	0.045	3.810
	1.000			
Hard drugs				
I don't know				
Yes	2.016	0.079	0.896	7.623
No				
	1.340	0.501	0.454	5.027
	1.000			

Source: Researcher's Field Survey 2023

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The logistic regression model presented in Table 4.3s examines the impact of partner characteristics on the risk of gender-based violence among adolescents attending school. The partner's age does not have a significant effect on the risk of gender-based violence (GBV). Adolescents with partners under 20 years or aged 20-29 years exhibit odds ratios of 3.811 and 1.682, respectively, in comparison to those with partners aged 30 and above; however, these findings lack statistical significance ($p = 0.995$ and $p = 0.994$). In terms of employment status, partners who are either currently unemployed or have not been employed in the past 12 months do not have a significant impact on GBV risk, as indicated by odds ratios of 0.782 and 0.565, respectively. The associations lack statistical significance, evidenced by p-values of 0.816 and 0.482.

The educational level of the partner yields more significant findings. The odds ratio for partners with secondary education is 6.597; however, this finding is not statistically significant ($p = 0.991$). Lower educational levels, such as no formal education and primary education, exhibit increased but statistically non-significant odds ratios of 3.933 and 3.083, respectively ($p = 0.991$ and $p = 0.995$).

Factors related to substance use, including alcohol consumption, smoking, and the use of hard drugs, do not exhibit significant associations with the risk of gender-based violence. Partners who consume alcohol or hard drugs exhibit odds ratios of 2.834 and 2.016, respectively; however, these findings lack statistical significance ($p = 0.992$ and $p = 0.079$). Smoking does not have a

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significant impact on GBV risk, as indicated by an odds ratio of 3.001 for partners with unknown smoking habits ($p = 0.988$)[7].

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Table 4.3t: Logistic Regression model on partners' characteristic determinants of GBV risks among Out-of-School Adolescents

Variables	Odds Ratio	p-value	Confidence Interval	
			Lower	Upper
Age (Yrs)				
<20 (Reference Category)	1.000			
20 -29	2.740	0.006	1.745	2.291
≥ 30	1.220	0.222	0.596	2.548
Employment Status				
Currently employed (RC)	1.000			
Not currently employed	0.820	0.413	0.405	0.984
Not employed in the last 1 year	0.700	0.482	0.352	2.637
Educ level				
No formal education (RC)	1.000			
Primary	0.020	0.985	0.002	1.549
Secondary	2.440	0.015	1.477	3.719
Tertiary	1.900	0.057	1.315	5.496
Knows partners' earnings				
Yes (RC)	1.000			
No	1.420	0.156	0.137	3.419
Drinks alcohol				
I don't know (RC)	1.000			
Yes	0.400	0.686	1.182	3.795
No	1.210	0.225	0.300	4.285
Smokes				
I don't know (RC)	1.000			
Yes	3.025	0.699	0.384	4.164
No	1.309	0.758	0.196	3.276
Hard drugs				
I don't know (RC)	1.000			
Yes	3.008	1.39	0.698	12.956
No	4.339	0.067	0.903	20.852

Source: Researcher's Field Survey 2023

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Table 4.3t presents a logistic regression model that examines the characteristics of partners as factors influencing the risk of gender-based violence among out-of-school adolescents. The data indicates a notable correlation between partner age and the risk of gender-based violence (GBV). Adolescents with partners aged 20-29 years exhibit a significantly elevated risk (OR = 2.740, p = 0.006) in comparison to those with partners under 20, which serves as the reference category. Partners aged 30 and above do not exhibit a significant association with the risk of GBV (OR = 1.220, p = 0.222). The partner's education level also demonstrates significant effects. Partners with secondary education demonstrate an increased risk of gender-based violence (OR = 2.440, p = 0.015), whereas those with tertiary education also show a significant risk (OR = 1.900, p = 0.057). Primary education is not statistically significant (OR = 0.020, p = 0.985).

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Objective 4: Prevalence, Pattern and Determinants of GBV Among Adult Men in Ibadan

Table 4.4a: Sociodemographic Characteristics of Adult Male

N=2951

Variables	Frequency (n)	Percentage (%)
Age (Years)		
20-29	815	27.6
30-39	969	32.8
40-49	739	25.1
≥50	427	14.5
Mean (SD)	37.6 (11.6)	
Education level		
No formal education	172	5.8
Primary	300	10.2
Secondary	1622	55.0
First degree	665	22.5
PGD	191	6.5
Employment Status		
Currently Employed	1417	48.0
Not currently employed	1370	46.4
Not employed in last 12 months	163	5.5
Occupation		
Professional/Management	383	13.0
Cleric	218	7.4
Sales/services	682	23.1
Skilled	870	29.5
Unskilled	207	7.0
Agriculture/Farmer	178	6.0
Apprentice	196	6.6
Student	200	4.1
Housewife	97	3.3
Marital Status		
Never married	496	16.8
Married	2168	73.5
Living together	154	5.2
Divorced	43	1.5
Separated	54	1.8
Widowed	35	1.2
Residence		
Rural	840	28.5
Urban	2110	71.5
Number of children		
None	510	17.3
1-2	1016	34.4
3-4	993	33.6
5-8	366	12.4
>8	65	2.2
Years of Marriage		
≤5 years	910	37.1
6 -10 years	653	26.6
>10 years	891	36.3

Source: Researcher's Field Survey 2023

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Table 4.4a presents the sociodemographic characteristics of adult males in Ibadan. The study population primarily consists of middle-aged individuals, with a mean age of 37.6 years. The majority of respondents belong to the 30-39 age group (32.8%), followed by the 20-29 age group (27.6%) and the 40-49 age group (25.1%). A minority of the population is aged 50 and above, comprising 14.5%. The majority of respondents have achieved at least secondary education, with over half (55%) possessing this qualification. A significant percentage possesses a first degree (22.5%), whereas a lesser proportion has attained a postgraduate degree (6.5%). Additionally, a minority lacks formal education (5.8%) or has completed only primary education (10.2%). The employment status of respondents shows that approximately 48% are currently employed, while 46.4% are not employed. A minority of the group indicated that they had not been employed in the past 12 months (5.5%). In terms of occupation, the predominant job categories are skilled labour (29.5%) and sales/services (23.15%), while professional or management positions account for a smaller proportion (13%). A smaller proportion of adult males is employed in clerical positions (7.4%), unskilled jobs (7%), agriculture (6%), or apprenticeships (6.6%). The population comprises a small percentage of students (4.1%) and housewives (3.3%). A significant majority of respondents are married, accounting for 73.5% of the total population surveyed. A minority has never married (16.8%), with even fewer cohabiting (5.2%), divorced (1.5%), separated (1.8%), or widowed (1.2%). The residence distribution indicates that a majority of individuals reside in urban areas (71.5%), while a minority live in rural locations (28.5%). The majority of respondents report having one to four children, with the largest proportion (34.4%) indicating they have 1-2 children. A significant proportion

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of individuals have no children (17.3%), whereas a minor percentage has more than four children (16.6%). Among married individuals, the majority have been married for five years or less (37.1%), while a significant portion has been married for more than ten years (36.3%).

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Table 4.4b: Sociodemographic Characteristics of Partner/Spouses of Adult males

N = 2454

Variables	Frequency (n)	Percentage (%)
Age (years)		
20-29	962	39.2
30-39	917	37.4
40-49	398	16.2
≥50	177	7.2
Mean (SD)	33.2 (10.6)	
Education level		
No formal education	110	5.6
Primary	298	12.2
Secondary	1485	60.5
First degree	391	15.9
PGD	141	5.7
Employment Status		
Currently Employed	1099	44.8
Not currently employed	1218	49.6
Not employed in last 12 months	137	5.6
Occupation		
Professional	198	8.1
Cleric	135	5.5
Sales/services	899	36.6
Skilled	713	29.0
Unskilled	221	9.0
Agriculture/Farmer	85	3.5
Apprentice	154	6.3
Student	50	2.0
Knows how much partner earns		
Yes	20	7.6
No	208	79.5
Not Applicable	34	12.9
Smokes		
Yes	41	1.7
No	2308	94.0
Don't Know	106	4.3
Takes hard drugs		
Yes	13	0.5
No	2331	95.0
Don't Know	110	4.5
Consumes Alcohol		
Yes	221	9.0
No	2110	87.1
Don't Know	95	3.9

Source: Researcher's Field Survey 2023

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Table 4.4b outlines the sociodemographic characteristics of the partners of adult males, indicating a predominantly younger demographic. The average age of the partners is 33.2 years, accompanied by a standard deviation of 10.6 years. The predominant age group among partners is 20-29 years, representing 39.2% of the population, followed by those aged 30-39 at 37.4%. A lesser proportion is found in the 40-49 age range at 16.2%, and the smallest group consists of individuals aged 50 years or older at 7.2%.

A substantial majority of the partners, comprising 60.5% of the population, have completed secondary education. A smaller yet significant percentage has attained a first degree (15.9%), whereas individuals with no formal education or only primary education constitute 5.6% and 12.2%, respectively. Furthermore, 5.7% have engaged in postgraduate education. The employment status of the partners is relatively balanced, with 44.8% currently employed and 49.6% not employed. A minor proportion (5.6%) has remained unemployed over the past 12 months. The predominant occupations are sales/services, comprising 36.6%, and skilled labour, accounting for 29.0%. A smaller proportion of individuals are engaged in professional roles (8.1%), unskilled jobs (9%), clerical positions (5.5%), or agriculture (3.5%). Additionally, a minority are involved in apprenticeships (6.3%) or are still pursuing their studies (2%).

Regarding awareness of partners' income, smoking habits, drug use, and alcohol consumption. Approximately 79.5% of partners are unaware of their partners' earnings. Regarding health-related behaviours, a significant majority do not smoke (94.0%) or use hard drugs (95.0%). Nonetheless, 9.0% engage in alcohol consumption, while a minor portion of the population either remains unaware or declines to reveal their behaviours related to smoking (4.3%), drug use (4.5%), and alcohol intake (3.9%).

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Table 4.4c: Danger Assessment in Abusive Relationship among Adult male living in Ibadan

N = 2454

Risk indicator	Frequency (n)	Percentage (%)
Partner ever threatened to harm or kill you	70	3.6
Partner ever used physical violence against you	174	7.1
Partner ever choked, strangled or suffocated you or attempted to do any of these things	60	2.4
Partner ever threatened or assaulted you with any weapon (including knives and/or other objects)	66	
Partner ever harmed or killed a family pet or threatened to do so	38	2.7
Partner ever been charged with breaching an apprehended domestic violence order	31	1.3
Relationship between client and partner		
Violence or controlling behavior from partner is becoming worse or more frequent	86	3.5
Partner stalked, constantly harassed or texted/ emailed you	131	5.3
Partner control access to money	216	8.8
There has been a recent separation (in the last 12 months) or one imminent	111	4.5
Background of partner		
Partner or the relationship have financial difficulties	289	11.8
Partner is unemployed	530	21.6
Partner has mental health problems (including undiagnosed conditions) and/or depression?	28	1.1
Partner have a problem with substance abuse such as alcohol or other drugs	38	1.5
Partner ever threatened or attempted suicide	37	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	16	0.7
Partner has access to firearms or prohibited weapons	20	0.8
Information about Children's risk		
Household have children who are less than 12 months apart in age	368	15.0
Partner ever threatened or used physical violence toward me at any time	128	5.2
Partner ever harmed or threatened to harm your children	34	1.4
There is conflict between me and partner regarding child contact or residency issues and/or current Family Court proceedings	59	2.4
There are children from a previous relationship present in the household	114	4.6
Sexual assault		
Partner has ever done things to me, of a sexual nature, that made me feel bad or physically hurt me	63	2.6
Partner has ever been arrested for sexual assault	17	0.7

Source: Researcher's Field Survey 2023

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The table provides an evaluation of risk in abusive relationships among adult males residing in Ibadan (Table 4.4c). Among respondents with partners or spouses, 7.1% reported experiencing physical violence from their partners, indicating it as the most prevalent form of abuse in this category. Furthermore, 3.6% reported being threatened with harm or death by their partners. Severe forms of abuse, including choking, strangulation, or suffocation attempts, were reported by 2.4% of respondents. Additionally, 2.7% reported experiencing threats or assaults involving weapons, while 1.5% indicated that their partner had harmed or threatened to harm a family pet. Regarding controlling behaviours, 8.8% of respondents reported that their partners restricted their access to finances, while 5.3% indicated experiencing stalking, harassment, or persistent contact from their partners. Additionally, 3.5% reported that the violence or controlling behaviour in their relationship was deteriorating over time.

The background of abusive partners indicates further risk factors, with approximately 21.6% being unemployed and 11.8% experiencing financial difficulties. Mental health issues, including depression, were reported in 1.1% of cases, while 1.5% of partners exhibited substance abuse problems. Additionally, 1.5% of respondents reported that their partner had threatened or attempted suicide, while 0.7% indicated that their partner had a history of violent offences or was currently on bail or parole.

Fifteen percent of respondents indicated that they had children whose ages were less than 12 months apart. Furthermore, 5.2% of respondents reported experiencing physical violence in the presence of their children, while 1.4%

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indicated that their partner had threatened or harmed their children. Conflict over child custody or residency was reported by 2.4% of respondents, whereas

4.6% noted the existence of children from prior relationships.

In conclusion, regarding sexual assault in these relationships, 2.6% of respondents indicated that their partner had exhibited sexually abusive behaviour, whereas a lesser percentage, 0.7%, reported that their partner had been arrested for sexual assault.

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Table 4.4d: Sociodemographic determinants of GBV threat among adult male

Variables	At threat of GBV		CHI^2	P-VALUE
	NO	YES		
Age grouped (Yrs)				
20 - 29	214 (55.2)	174 (44.8)	3.156	0.368
30 – 39	495 (54.0)	422 (46.0)		
40 – 49	419 (57.7)	240 (56.7)		
≥50	240 (56.7)	183 (43.3)		
Employment status				
Currently employed	838 (66.5)	422 (33.5)	159.807	<0.001*
Not currently employed	471 (43.3)	618 (56.7)		
Not employed in last 12 months (RC)	59 (55.6)	47 (44.4)		
Residence				
Rural	386 (55.3)	312 (44.7)	0.105	0.746
Urban	982 (55.9)	774 (44.1)		
Education level			23.613	<0.001*
No formal education	85 (65.8)	44 (34.2)		
Primary	139 (52.3)	127 (47.7)		
Secondary	710 (52.8)	635 (47.2)		
Tertiary	434 (60.8)	280 (39.2)		
Number of Children				
None	48 (72.3)	18 (27.7)	10.466	0.033*
1-2	554 (55.7)	441 (44.3)		
3-4	542 (55.3)	439 (44.7)		
5-8	201 (54.9)	165 (45.1)		
>8	22 (49.1)	23 (50.9)		
Years of Marriage				

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1-5	582 (64.0)	328 (36.0)	49.757	<0.001*
6-10	334 (51.1)	320 (48.9)		
>10	452 (50.7)	439 (49.3)		

Source: Researcher's Field Survey 2023

Table 4.4d analyses the association between sociodemographic characteristics and the threat of Gender-Based Violence (GBV) among adult males in Ibadan, contrasting individuals who reported experiencing GBV threats with those who did not. The analysis revealed no significant correlation between age group and the experience of GBV threats (p=0.368), nor between residence and GBV threats (p=0.746).

Employment status demonstrated a significant correlation with the threat of gender-based violence (GBV) (p<0.001), with a notably higher percentage of unemployed individuals reporting GBV threats (56.7%) compared to their employed counterparts (33.5%). Education level was significantly correlated with the threat of gender-based violence (GBV) (p<0.001). A higher proportion of individuals with primary education (47.7%) or secondary education (47.2%) reported experiencing GBV threats compared to those with tertiary education (39.2%).

The quantity of children was identified as a significant determinant (p=0.033). Individuals without children reported the lowest incidence of gender-based violence (GBV) threat at 27.7%[6]. This proportion increased slightly with the number of children, notably rising to 50.9% among those with more than eight children. Finally, the duration of marriage demonstrated a significant correlation with the threat of gender-based violence (p<0.001). Individuals married for 1-5 years reported a lower proportion of GBV threats (36%) compared to those married for over 10 years (49.3%).

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Table 4.4e: 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	0.585	0.005	0.403	0.849
Not currently employed	1.516	0.028	1.047	2.196
Not employed in the last 12 months (RC)	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	0.392	0.014	0.185	0.829
1-2	0.925	0.788	0.525	1.630
3-4	0.782	0.391	0.446	1.371
5-8	0.780	0.406	0.434	1.401
>8	1.000			
Years Married				
1-5	0.328	<0.001	0.251	0.429
6-10	0.675	0.001	0.536	0.850
	1.000			

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>10	

Source: Researcher's Field Survey 2023

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The logistic regression model outlined in the table evaluates the sociodemographic factors influencing the threat of Gender-Based Violence (GBV) among adult males in Ibadan (Table 4.4e). Age is a significant factor, as younger males, particularly those aged 20-29 and 30-39, exhibit a higher likelihood of encountering threats of gender-based violence compared to individuals aged 50 and older. Males aged 20-29 exhibit an odds ratio of 2.603 ($p < 0.001$), indicating they are more than 2.6 times as likely to encounter GBV threats compared to individuals aged 50 and older. Individuals aged 30-39 exhibit an odds ratio of 1.935 ($p < 0.001$), suggesting a nearly doubled risk of experiencing GBV threats in comparison to those aged 50 and older. Currently employed individuals exhibit a reduced likelihood of experiencing GBV threats, evidenced by an odds ratio of 0.585 ($p = 0.005$), in contrast to those who have not been employed in the past 12 months. Conversely, individuals who are not currently employed but have had employment experience are more likely to encounter threats of gender-based violence (GBV), exhibiting an odds ratio of 1.516 ($p = 0.028$) relative to those who have not been employed in the past 12 months. Individuals lacking formal education exhibit a reduced likelihood of encountering GBV threats, evidenced by an odds ratio of 0.525 ($p = 0.001$), in contrast to those possessing tertiary education. The probability of encountering GBV threats marginally increases with higher education levels, specifically at the primary and secondary stages; however, these associations lack statistical significance. Individuals without children exhibit a reduced likelihood of experiencing GBV threats, evidenced by an odds ratio of 0.392 ($p = 0.014$), in comparison to those with more than eight children.

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The length of marriage is significantly correlated with the risk of experiencing gender-based violence (GBV). Individuals married for 1-5 years exhibit a lower probability of experiencing GBV threats, indicated by an odds ratio of 0.328 ($p < 0.001$). Similarly, those married for 6-10 years also demonstrate a decreased likelihood, with an odds ratio of 0.675 ($p = 0.001$)[8].

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Table 4.4f: 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	551 (57.3)	411 (42.7)	2.366	0.500
30 – 39	502 (54.8)	414 (45.2)		
40 – 49	214 (53,8)	184 (46.2)		
≥50	100 (56.6)	77 (43.4)		
Partner's Employment Status				
Currently employed	757 (68.9)	342 (31.1)	173.669	<0.001*
Not currently employed	547 (44.9)	671 (55.1)		
Not employed in last 12 months	64 (46.8)	73 (53.2)		
Partner's education level				
No formal education	86 (62.4)	52 (37.6)	14.921	0.002*
Primary	177 (59.2)	121 (40.8)		
Secondary	787 (53.0)	698 (47.0)		
Tertiary	318 (59.7)	214 (40.3)		
Partner consumes alcohol				
Yes	81 (36.6)	140 (63.4)	45.135	<0.001*
No	1233 (57.7)	905 (42.3)		
I don't know	53 (56.3)	42 (43.7)		
Partner smokes				
Yes	18 (45.1)	22 (54.9)	4.871	0.088
No	1298 (56.2)	1010 (43.8)		
I don't know	52 (49.2)	53 (50.8)		
Partner takes hard drug				

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Yes	6 (43.8)	7 (56.2)	6.969	0.031*
No	1312 (56.3)	1019 (43.7)		
I don't know	50 (45.7)	60 (54.3)		

Source: Researcher's Field Survey 2023

Table 4.4f illustrates the correlation between different partner characteristics and Gender-Based Violence (GBV) threats among adult males in Ibadan. The partner's age (p=0.500) does not demonstrate a statistically significant correlation with GBV threats. In a similar vein, the partner's smoking habit does not exhibit a significant association (p=0.088).

The partner's employment status demonstrates a significant correlation with threats of gender-based violence ($p < 0.001$). Individuals who are not currently employed (55.1%) or have not been employed in the past 12 months (53.2%) exhibit higher rates of association with GBV threats compared to those who are currently employed (31.1%).

The partner's educational attainment is significantly correlated with threats of gender-based violence ($p = 0.002$). Individuals with partners lacking formal education or possessing only primary education exhibited a higher likelihood of encountering threats of gender-based violence compared to those with partners who attained secondary or tertiary education. For example, 40.8% of individuals with partners who had primary education reported threats of gender-based violence, in contrast to 47.0% among those with partners who had secondary education.

The partner's alcohol consumption is a significant factor ($p < 0.001$). Individuals with partners who consume alcohol exhibit a higher likelihood of experiencing threats of gender-based violence (GBV), with 63.4% reporting such threats compared to 42.3% among those whose partners abstain from alcohol

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consumption.

The partner's drug use demonstrates a statistically significant correlation with the threat of gender-based violence ($p = 0.031$). Individuals with partners who consume hard drugs exhibit a higher association with threats of gender-based violence (GBV), with 56.2% of those reporting such threats compared to 43.7% among those whose partners do not engage in drug use[7].

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Table 4.4g: 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	0.355	<0.001	0.255	0.494
Not currently employed	1.058	0.732	0.767	1.460
Not employed in the last 12 months (RC)	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				

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Yes	1.207	0.687	0.482	3.022
No	0.859	0.635	0.459	1.607
Don't know				
Takes hard drugs				
Yes	1.455	0.555	0.418	5.061
No	0.816	0.715	0.274	2.430
Don't know	1.000			

Source: Researcher's Field Survey 2023

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The logistic regression model examines the influence of different partner characteristics on the probability of adult males encountering Gender-Based Violence (GBV) threats (Table 4.4g).

The employment status shows a notable correlation with threats of gender-based violence (GBV), as individuals who are currently employed exhibit a significantly lower likelihood of experiencing GBV threats, indicated by an odds ratio of 0.355 ($p < 0.001$), in comparison to those who have not been employed in the past 12 months.

The level of education significantly influences the threats associated with gender-based violence (GBV). The odds ratios for partners lacking formal education and those with primary education, compared to partners with tertiary education, are 0.543 ($p = 0.001$) and 0.590 ($p < 0.001$), respectively.

The consumption of alcohol by a partner is significantly associated with threats of gender-based violence (GBV). Partners who consume alcohol exhibit an odds ratio of 0.236 ($p < 0.001$), while those with an unknown alcohol consumption status show an odds ratio of 0.411 ($p < 0.001$). Both groups exhibit a significant association with a reduced likelihood of experiencing GBV threats in comparison to partners who do not engage in alcohol consumption.

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

Table 4.5a 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

Source: Researcher's Field Survey 2023

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Table 4.5a summarises the characteristics of healthcare workers in Ibadan, based on a sample size of 1,286. The workforce predominantly comprises individuals aged 35-44 years, accounting for 38.2%, with a mean age of 37.7 years (SD = 8.9). Only 2.7% of the population is aged 55 years or older. Health facility distribution indicates that the majority of workers are employed in Primary Health Clinics/Centres (50.5%), with General Hospitals employing 34.2% of workers. The gender distribution indicates a majority of female healthcare workers at 83.4%, with males representing only 16.6%. The predominant professional groups are Nurses/Midwives, comprising 34.7%, and Health Assistants and Community Health Extension Workers (CHEWs), accounting for 17.1%.

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Distribution of Healthcare providers according to GBV awareness

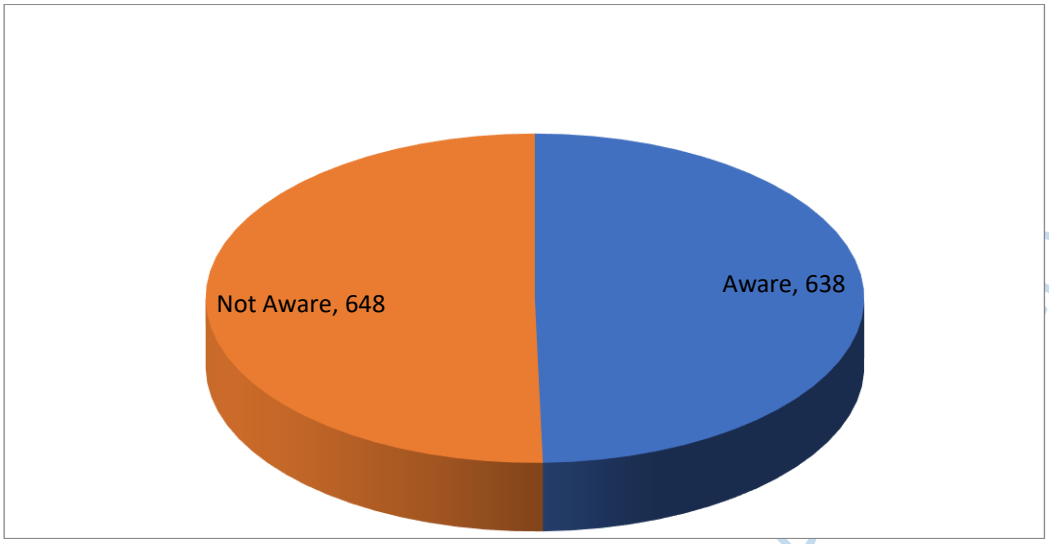


Figure 4.1: Distribution of Healthcare providers according to GBV awareness
Source: Researcher's Field Survey 2023

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Figure 4.1 illustrates the awareness of healthcare providers regarding gender-based violence (GBV), revealing a nearly equal distribution between those who are aware and those who are not. Among 1,286 healthcare providers, 638 (49.6%) are aware of gender-based violence (GBV), whereas 648 (50.4%) lack awareness.

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Attitude towards urgent treatment of GBV survivors/victims

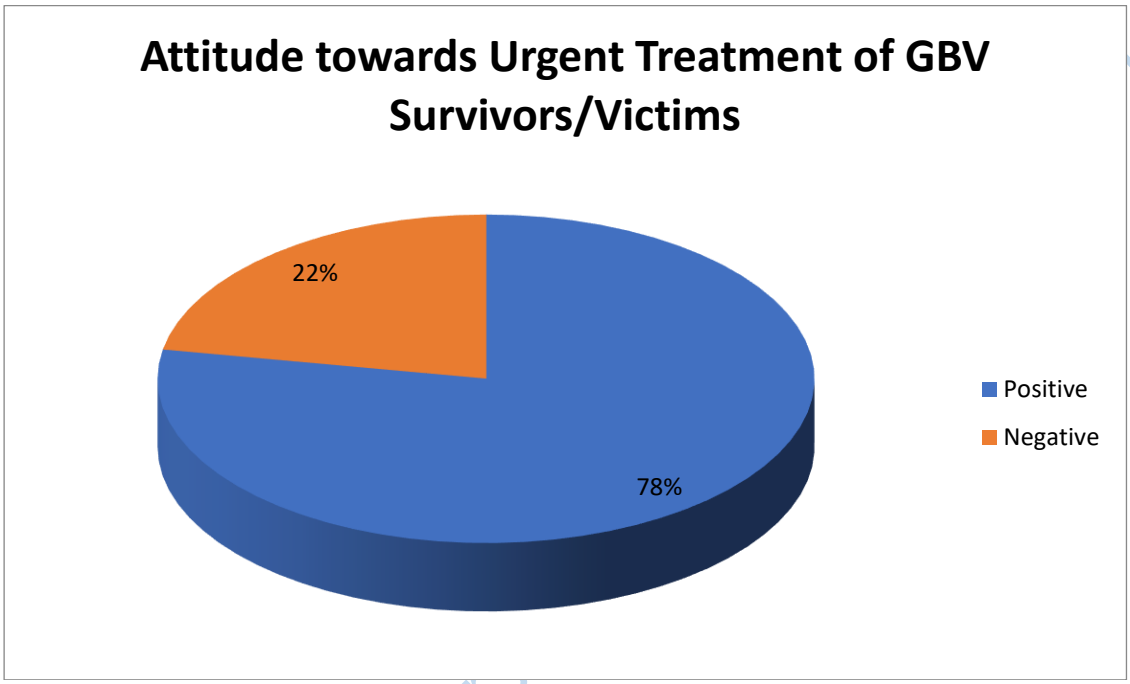


Figure 4.2: Attitude towards urgent treatment of GBV survivors/victims
Source: Researcher's Field Survey 2023

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The pie chart (Fig. 4.2) illustrates that healthcare providers predominantly hold a positive stance towards the urgent treatment of GBV survivors/victims. Among 1,286 respondents, 1,001 (77.7%) demonstrate a positive attitude towards the urgent treatment of GBV survivors, whereas 285 (22.3%) exhibit a negative attitude.

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Table 4.5b Knowledge of GBV among HCW in Ibadan

S.No		N = 638 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)	

Source: Researcher's Field Survey 2023

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Table 4.5b illustrates the awareness of gender-based violence (GBV) among healthcare workers (HCWs) in Ibadan. Among the 638 respondents, only 24.1% (154) accurately understood the meaning of GBV, whereas a majority, 75.9% (484), lacked this knowledge, highlighting a considerable deficiency in the fundamental comprehension of GBV among healthcare workers.

In response to enquiries regarding the common types of gender-based violence (GBV), 77.4% of participants identified a single type, 17.1% recognised two types, and merely 1.4% were able to identify four types. A limited proportion (2.2%) of healthcare workers were able to identify three types of gender-based violence (GBV), with only 0.2% recognising all five common types, indicating insufficient knowledge regarding the various forms of GBV.

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Distribution of HCW according to treatment of GBV survivors at health facilities

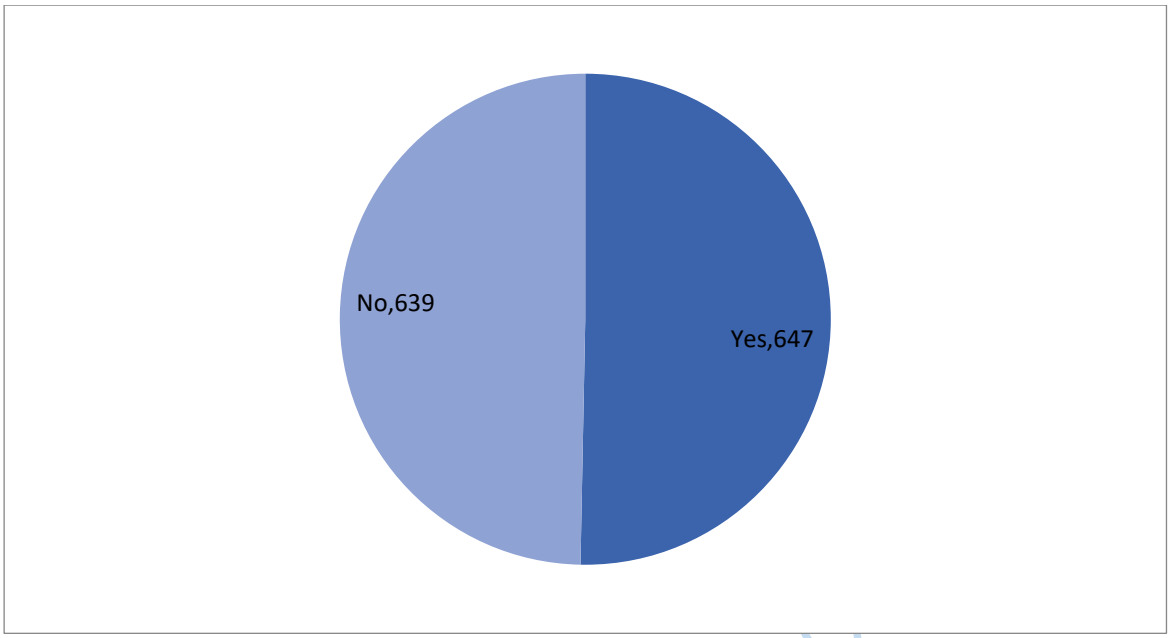


Figure 4.3: Pie-chart showing distribution of HCW by involvement in treatment of GBV survivors at health facilities
Source: Researcher's Field Survey 2023

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The pie chart illustrates a nearly equal distribution of healthcare workers (HCWs) treating gender-based violence (GBV) survivors, with 50.3% engaged in care and 49.7% not involved. This indicates a balanced, albeit slightly greater, involvement in GBV survivor treatment across health facilities (Table 4.3).

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Distribution of Services Offered to GBV Survivors at health facilities in Ibadan

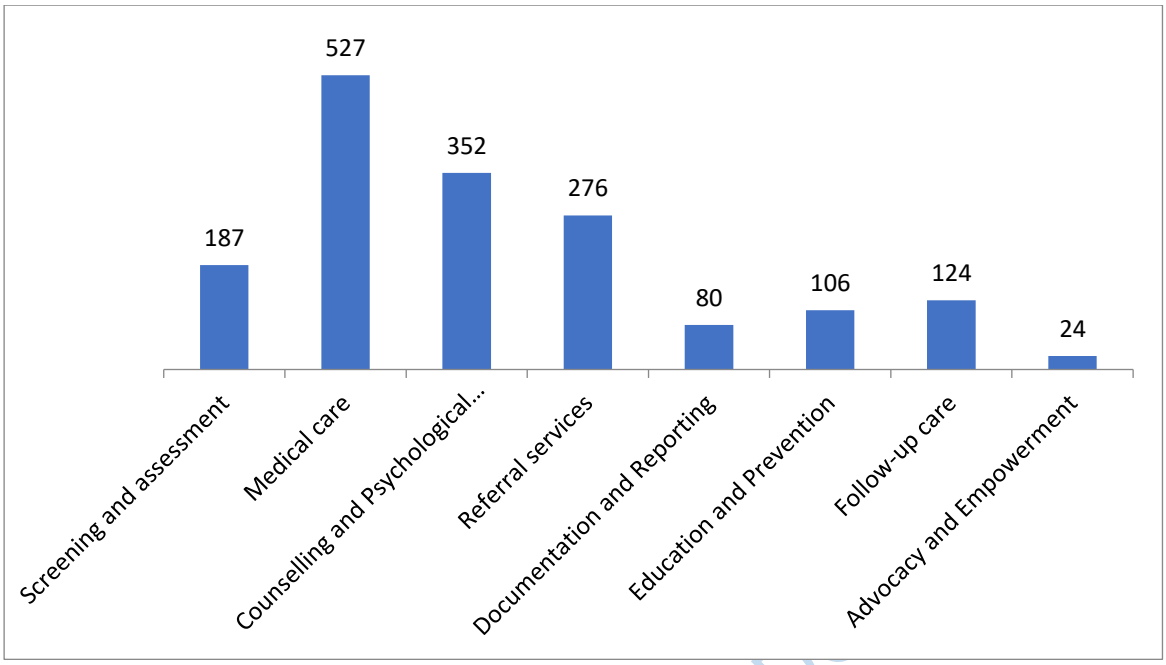


Figure 4.4: Bar-chart distribution of Services Offered to GBV Survivors at health facilities in Ibadan

Source: Researcher's Field Survey 2023

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Figure 4.4 presents a bar chart depicting the various services provided to GBV survivors at health facilities in Ibadan. Medical care constitutes the predominant service, accounting for 81.5% (527 of 647) of the total services provided. Counselling and psychological support constitutes 54.4% (352), whereas referral services represent 42.7% (276). Screening and assessment services constitute 28.9% (187), indicating that health facilities prioritise medical treatment, mental health support, and referrals for survivors. Follow-up care is provided in 19.2% (124) of cases, education and prevention in 16.4% (106), and documentation and reporting in 12.4% (80). Advocacy and empowerment represent the least common service, provided in only 3.7% (24) of cases. The data indicate that, although immediate care is emphasised, there may be deficiencies in long-term support and empowerment programs for survivors of gender-based violence (GBV).

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Facilities Providing Post-Exposure Prophylaxis (PEP) Services in Ibadan (%)

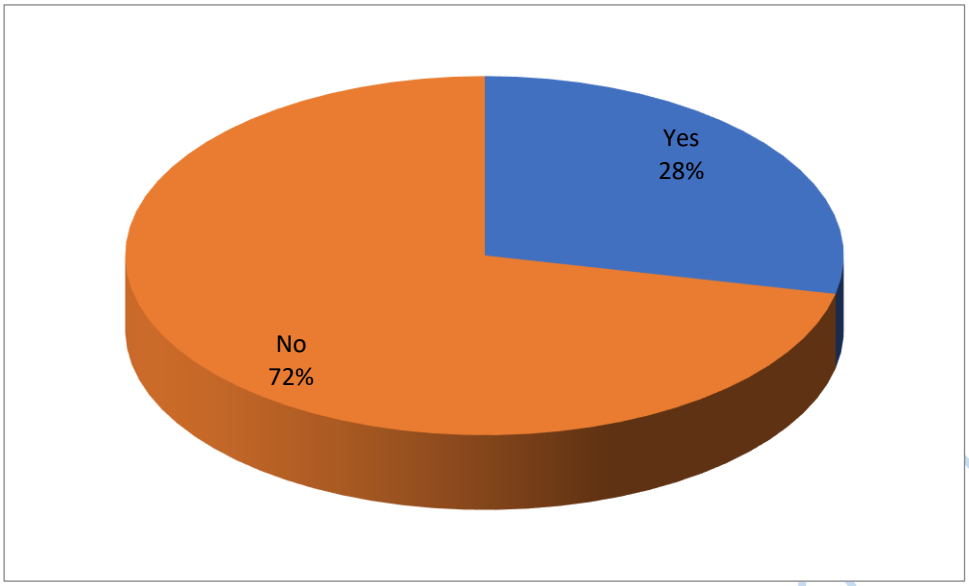


Figure 4.5: Proportion of Facilities Providing Post-Exposure Prophylaxis (PEP) Services in Ibadan (%)
Source: Researcher's Field Survey 2023

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The pie chart indicates that a significant proportion of facilities in Ibadan (71.6%) do not offer Post-Exposure Prophylaxis (PEP) services, while only 28.4% provide these services (Table 4.5).

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Table 4.5c GBV Services Offered to Survivors at Health Facilities in Ibadan

N=647

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

Source: Researcher's Field Survey 2023

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Table 4.5c displays the findings regarding the availability of gender-based violence services provided to victims at health facilities in Ibadan. A significant proportion of carers indicated that health facilities offer STI-related services: 43.3% refer victims to a STI/STD clinic, 39.3% provide prophylactic treatment, and 4.9% send swabs for STI testing, while 31.1% do not offer any such services. A majority of facilities (73.6%) provide counselling services to survivors; however, only a minority (21.3%) make referrals to external service providers, such as law enforcement or judicial systems. The data indicates that merely 5.9% of facilities gather physical evidence, while 11.9% utilise a pre-packaged rape kit for examinations; however, only 5.7% maintain a consistent supply of these kits. Only 44.7% of healthcare workers indicated that facilities maintain records of examined gender-based violence cases. Furthermore, less than one-third reported the existence of specific forms (29.7%) or protocols/guidelines (23.2%) for managing GBV cases.

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

Table 4.6a: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

Source: Researcher's Field Survey 2023

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Table 4.6a displays the knowledge and attitudes of adult female respondents regarding perceived justifiable reasons for gender-based violence (GBV) by partners in a relationship. Research findings demonstrate that the majority of adult females do not view the reasons for gender-based violence as justifiable; however, a minority of respondents maintain beliefs that may contribute to the continuation of such violence. Among the 2,388 sampled adult females, only 2.9% endorsed the notion that a husband is justified in physically assaulting his wife for leaving without notification, whereas a significant majority, 97.1%, opposed this view[6]. In a similar vein, 3.1% of respondents considered neglecting children a justifiable reason for violence, while 96.9% opposed this view. In other contexts, 2.4% of respondents indicated that arguing with a husband could warrant violence, whereas 97.6% expressed disagreement. In response to the question of whether burning food constitutes a justifiable reason, 3.1% of participants expressed agreement, whereas 96.9% disagreed. Ultimately, 4.4% of adult females considered the refusal of sexual relations with their husbands as a justification for gender-based violence, while 95.6% opposed this rationale.

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Distribution of adult female according to GBV practice and justification for GBV

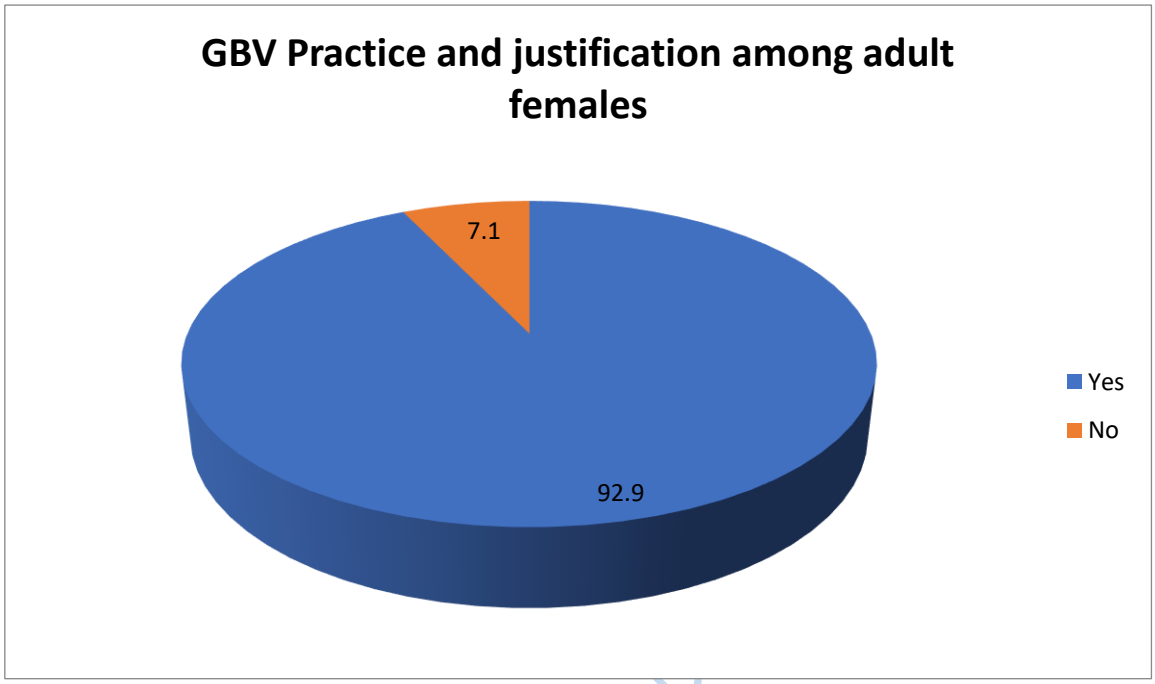


Figure 4.6: Percentage distribution of adult females according to GBV practice and justification

Source: Researcher's Field Survey 2023

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Most adult females (92.9%) do not subscribe to any justification for gender-based violence (GBV) practices, whereas 7.1% continue to justify GBV practices within relationships (Fig. 4.6).

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Table 4.6b Post-Exposure Prophylaxis Offered to GBV Survivors 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	83	35.8
All drugs given at one time	84	36.2
Seven-day supply given	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

Source: Researcher's Field Survey 2023

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Table 4.6b presents the distribution of Post-Exposure Prophylaxis (PEP) methods available to GBV victims at health facilities in Ibadan. Only 232 of the sampled 647 (36%) health facilities reported offering PEP. Among the 232 facilities offering PEP, 36.2% administer all medications simultaneously, 35.8% employ a Directly Observed Treatment Short-course (DOTS) method for the initial drug followed by the remaining medications, and 28.0% provide a seven-day supply at once.

In the context of HIV testing prior to the initiation of PEP, 65.1% of facilities mandate consent for testing, whereas 34.9% do not, demonstrating a predominant compliance with HIV testing protocols. The PEP regimen exhibits variability, with 50.4% of facilities prescribing Tenofovir, 43.1% prescribing Abacavir, and 17.2% each for Raltegravir and Dolutegravir. Other medications, including Lamivudine, account for 25.0%, while additional treatments constitute 3.0%.

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Table 4.6c: Prevalence of reported GBV cases at health facilities in Ibadan in the last 6 months (n=647)

	None (n/%)	One (n/%)	2 – 5 (n/%)	>5 (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)

Source: Researcher's Field Survey 2023

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The table (4.6c) displays the prevalence of reported GBV cases at health facilities in Ibadan categorised by various classifications. A total of 647 health facilities were included in the study. In the past six months, among male adult survivors (≥18 years), 77.0% of facilities reported no cases, 15.6% reported between 2-5 cases, and 4.5% reported more than 5 cases. In comparison, female adults were reported more frequently, with 68.0% of facilities indicating no cases, 17.6% reporting between 2-5 cases, and 6.2% observing more than 5 cases. This suggests that female adults are more frequently identified as survivors of gender-based violence compared to male adults. On average, 80.2% of facilities reported no male adult GBV survivors monthly, while 14.4% managed between 2 and 5 cases. Among female adults, 74.8% of facilities reported no cases, while 19.3% reported an average of 2-5 cases. In 2023, 64.1% of facilities indicated no male adult cases, whereas 31.8% reported 2-5 cases among female adults, reflecting a higher incidence among females. In the population of children under 18 years, 80.5% of facilities indicated the absence of male child cases in the past six months, whereas 76.8% reported no female child cases. Female children were observed more frequently, with 8.2% of facilities reporting more than 5 cases.

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End Notes

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Chapter Five

Conclusion

5.1 Summary of Main Findings

A total of 11,332 individuals participated in the study, including 1622 expectant women, 1911 non-expectant women, 3562 adolescents, 2951 adult males, and 1,286 medical providers.

5.1.1 Non-Pregnant Adult Females

In a sample of adult non-pregnant females, up to 10% reported experiencing physical violence from their partners. Additionally, 6.6% indicated that their spouses restricted their ability to manage their own money, and 3.8% of individuals indicated they had endured sexual encounters that were either psychologically damaging or resulted in physical injury. Additionally, 3.5% of respondents reported that their spouses had either attempted to or had successfully choke or smothered them. A strong connection exists between a woman's age and her vulnerability to gender-based violence. Data shows a statistically significant trend ($p=0.001$) where a smaller percentage of women in the 20-29 age bracket (44.9%) are at risk compared to those in the 41-50 age range (53.1%). Interestingly, some research indicates that younger women, particularly adolescents, can face a higher risk of intimate partner violence.

A woman's employment status is a significant factor in her risk of experiencing GBV ($p<0.001$). Those who are employed show a lower level of threat (39.9%) when contrasted with women who have not been employed in the last year (43.8%) or are

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without a job at the moment (57.5%). Economic empowerment is often cited as a factor that can reduce a woman's vulnerability to violence.

Educational level also plays a crucial role in the likelihood of a woman facing GBV ($p<0.001$). Females with a university-level education have a notably lower risk at 40.1%, compared to those who have completed secondary education (52.3%) or only primary education (55.4%). Lower educational attainment is frequently identified as a risk factor for experiencing GBV.

There is a significant statistical link ($p<0.001$) between the number of children a woman has, the length of her marriage, and her risk of experiencing gender-based violence. The likelihood of being at risk is lower for women who have no children (36.0%) or a small number of children (51% for 1-2 children) compared to those with a larger family of 5-8 children (54.8%). Similarly, women with five or fewer children have a risk rate of 42%. Furthermore, women in marriages that have lasted for more than a decade experience a higher prevalence of gender-based violence, at a rate of 55.5%. Studies have shown a correlation between the number of children and the duration of a marriage with the incidence of domestic violence. The progression of logistics indicates a notable correlation with the risk of gender-based violence (GBV). When compared to women aged 50 and over (the baseline group), younger women show a markedly increased risk of experiencing gender-based violence (GBV). Specifically, women aged 20-29 have more than double the odds (OR = 2.155, p = 0.001), those aged 30-39 have nearly double the odds (OR = 1.870, p = 0.001), and women aged 40-49 have over one and a half times the odds (OR = 1.570, p = 0.009) of facing GBV. This aligns with broader findings that younger women,

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particularly adolescents and young adults, are at a higher risk for intimate partner violence.

A woman's employment situation significantly correlates with her risk of experiencing GBV. Women who are unemployed at the moment have very high chance

of being threatened with gender-based violence (OR = 1.640, p = 0.009) than those who have been unemployed within a year (the reference group).

Educational attainment is another critical factor. Using women with tertiary education as the reference point, those with only a secondary education are more likely to experience GBV (OR = 1.241, p = 0.041). This is consistent with research showing that higher levels of education can act as a protective factor against gender-based violence.

The duration of a marriage also shows a significant relationship with the risk of GBV. Females who have been married for a shorter period (1-5 years) have a lower risk of experiencing violence (OR = 0.51, $p < 0.001$) compared to those who have been married for over a decade. However, some studies indicate that delaying marriage is associated with a reduced risk of intimate partner violence.

There is a notable link between a companion's age and the likelihood of GBV. The occurrence of GBV is higher for women whose spouses are in the 31-40 age group (53%), the 41-50 age group (52%), and those aged 51 and older (51.7%), as opposed to women with partners aged 20-30 (36.6%). Women with employed spouses face a lower threat level (40.8%) compared to those with unemployed partners (60.7%). Partners who have not been employed in the past 12 months exhibit a reduced risk of gender-based violence (37.6%) ($p<0.001$). Women with partners lacking formal

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education face a lower risk of gender-based violence (GBV) at 14.5%, in contrast to those with companions who have primary (53.5%), secondary (57.1%), or tertiary education (46.1%) (p<0.001).

The partner's consumption of alcohol, smoking, and use of hard drugs are significantly correlated with an increased risk of gender-based violence (all p-values < 0.001). Females with spouses who drink alcohol (69.2%), smoke (67%), or use hard drugs (74.1%) experience a markedly increased risk of gender-based violence in comparison to those whose partners abstain from these activities. Individuals who are currently employed exhibit markedly reduced odds of being linked to threats of gender-based violence (GBV) (OR = 0.516, p = 0.001) in comparison to those who have not been employed in the preceding 12 months (reference category). Conversely, individuals who are currently unemployed demonstrate significantly increased odds (OR = 1.661, p = 0.012). Individuals without formal education exhibit markedly reduced odds of experiencing GBV threats (OR = 0.182, p < 0.001) in comparison to those possessing tertiary education (reference category). Partners who consume alcohol exhibit reduced odds (OR = 0.205, p < 0.001) of being linked to threats of gender-based violence compared to those unaware of their partner's alcohol consumption status (reference category). Women unaware of their partner's earnings exhibit markedly reduced odds of experiencing gender-based violence (OR = 0.723, p = 0.004) in comparison to those who are informed. Research on the knowledge and attitudes of adult females regarding perceived

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justifiable reasons for gender-based violence (GBV) by partners reveals that the majority do not find these reasons acceptable. However, a minority of respondents continue to hold beliefs that may contribute to the perpetuation of violence. Among the 2,388 adult females surveyed, only 2.9% endorsed the view that a husband is justified in physically assaulting his wife for going out without prior notification, whereas a significant majority, 97.1%, opposed this notion. In a similar vein, 3.1% of respondents considered the neglect of children to be a justifiable reason for violence, while 96.9% opposed this view. In other contexts, 2.4% of respondents indicated that arguing with a husband could warrant violence, whereas 97.6% expressed disagreement. In response to the question of whether burning food constitutes a justifiable reason, 3.1% of participants agreed, whereas 96.9% disagreed. In conclusion, 4.4% of adult females considered the refusal of sex with their husband as a justification for gender-based violence, while 95.6% opposed this justification.

5.1.2 Adult Pregnant Females

Age is a significant factor in the risk of gender-based violence (GBV) among pregnant women. Specifically, younger women aged 20-29 (69.5%) and those aged 30-39 (75.5%) are more likely to report being at risk of GBV, whereas women aged 50 and above show a reduced risk (33.3%) ($p = 0.003$). Women who are not currently employed or have not been employed in the past 12 months exhibit a higher likelihood of experiencing gender-based violence (75.5%) in comparison to their currently employed counterparts (68.7%) ($p<0.001$). The number of children a woman has constitutes a significant factor in the threat of gender-based violence (GBV). Women without children (68.6%) or with fewer children (1-2) (71.4%) exhibit a lower likelihood of experiencing gender-based violence (GBV) compared to those with 5-8 children (84.7%) ($p = 0.019$).

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The length of marriage demonstrates a notable correlation with the threat of gender-based violence (GBV). Pregnant women married for over 10 years exhibit a higher likelihood of experiencing gender-based violence (GBV) at 78.6%, in contrast to those married for 1-5 years, who report a rate of 70.0% (p = 0.006). Eleven percent of pregnant women reported experiencing physical violence from their partners, regardless of their physiological status, while 3.9% reported being threatened with harm or death. Furthermore, 3.5% of respondents indicated experiences of choking, strangulation, or suffocation, while 2.2% reported threats or assaults

involving weapons. Up to 13.5% of pregnant women report that their partner exercises control over financial resources. Logistic regression indicates that age is significantly associated with the risk of gender-based violence during pregnancy. Women in the age group of 30-39 exhibit an odds

ratio of 7.476 (p = 0.026), suggesting they are roughly 7.5 times more likely to be at risk of gender-based violence. Women aged 40-49 exhibit an odds ratio of 6.199 (p = 0.046), indicating an elevated risk compared to the reference group (≥50 years).

A significant association exists between the partner's age and the risk of GBV (p = 0.002), suggesting that younger partners, especially those aged 20-29 (68.6%), are linked to a reduced risk of GBV in comparison to older age groups. The partner's employment status is significantly related to the threat of gender-based violence (p = 0.034). Individuals who are not presently employed or have not been employed in the past 12 months exhibit a higher likelihood of being linked to the threat of gender-based violence (81.2%).

An association exists between the alcohol consumption of pregnant women's partners

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and the risk of gender-based violence ($p < 0.001$). Individuals who consume alcohol are more likely to be linked to an increased risk of gender-based violence (68.6%) in comparison to those who abstain (44.4%). Smoking is significantly correlated with the risk of gender-based violence ($p < 0.001$). Individuals with smoking partners (80.6%) exhibit a higher likelihood of experiencing threats of gender-based violence (GBV) compared to those with non-smoking partners (72.3%). Research findings reveal that the majority of adult pregnant females do not deem any reasons justifiable for gender-based violence; however, a minority of respondents maintain beliefs that may contribute to the perpetuation of such violence. Among the 2,027 pregnant women surveyed, only 3.1% endorsed the notion that a husband is justified in physically disciplining his wife for leaving without notification, whereas a significant majority, 96.9%, opposed this view. In a similar vein, 3.6% of respondents considered neglecting children a justifiable reason for violence, while 96.4% opposed this view.

In other contexts, 3.2% of respondents concurred that conflict with a spouse could warrant violence, whereas 96.8% opposed this view. In response to the question of whether burning food constitutes a justifiable reason, 4% expressed agreement, whereas 96% disagreed. Ultimately, 4.9% of adult females considered the refusal of sex with their husband as a justification for gender-based violence, while 95.1% dismissed this justification.

5.1.3 Adult Male Population

Among adult male respondents with partners or spouses, 7.1% reported experiencing physical violence from their partners, identifying it as the most prevalent form of abuse in this group. Furthermore, 3.6% reported having been threatened with harm or death by their partners. Severe forms of abuse, including choking,

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strangulation, or suffocation attempts, were reported by 2.4% of respondents. Additionally, 2.7% reported experiencing threats or assaults involving weapons, while 1.5% indicated that their partner had harmed or threatened to harm a family pet. Regarding controlling behaviours, 8.8% of adult male respondents reported that their partners restricted their access to finances, while 5.3% indicated experiencing stalking, harassment, or persistent contact from their partners. Additionally, 3.5% reported that the violence or controlling behaviour in their relationship was deteriorating over time. The background of abusive partners indicates further risk factors, with approximately 21.6% being unemployed and 11.8% experiencing financial difficulties. Mental health issues, including depression, were reported in 1.1% of cases, while 1.5% of partners

exhibited substance abuse problems. Additionally, 1.5% of respondents reported that their partner had threatened or attempted suicide, while 0.7% indicated that their partner had a history of violent offences or was currently on bail or parole. Fifteen percent (15%) of respondents indicated that they had children whose ages were less than 12 months apart. Furthermore, 5.2% of respondents reported experiencing physical violence in the presence of their children, while 1.4% indicated that their partner had threatened or harmed their children. Conflict over child custody or residency was reported by 2.4% of respondents, whereas 4.6% indicated having children from prior relationships. Regarding sexual assault in these relationships, 2.6% of respondents indicated that their partner had exhibited sexually abusive behaviour, whereas a lesser percentage (0.7%) reported that their partner had been arrested for sexual assault. Employment status demonstrated a significant association with the threat of gender-based violence (GBV) ($p<0.001$), with a notably higher proportion of individuals not currently employed reporting experiences of GBV threats (56.7%) compared to their

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employed counterparts (33.5%). Education level was significantly correlated with the threat of gender-based violence (GBV) ($p<0.001$), with a higher proportion of individuals possessing primary education (47.7%) or secondary education (47.2%) more likely to encounter GBV threats than those with tertiary education (39.2%). The quantity of children was identified as a significant determinant ($p=0.033$). Individuals without children reported the lowest incidence of gender-based violence (GBV) threat at 27.7%. This proportion increased slightly with the number of children, notably rising to 50.9% among those with more than eight children. The duration of marriage demonstrated a significant correlation with the threat of gender-based violence ($p<0.001$). Individuals married for 1-5 years reported a lower proportion of GBV threats (36%) compared to those married for over 10 years (49.3%).

Age is a significant factor, with younger males, particularly those aged 20-29 and 30-39, exhibiting a higher likelihood of encountering GBV threats compared to individuals aged 50 and older. Males aged 20-29 exhibit an odds ratio of 2.603 ($p < 0.001$), indicating they are more than 2.6 times as likely to encounter GBV threats compared to individuals aged 50 and older. Individuals aged 30-39 exhibit an odds ratio of 1.935 ($p < 0.001$), signifying a nearly doubled risk of experiencing GBV threats in comparison to the reference category of individuals aged 50 and above. Currently employed individuals exhibit a reduced likelihood of experiencing GBV threats, evidenced by an odds ratio of 0.585 ($p = 0.005$), in comparison to those who have not been employed in the past 12 months. Conversely, individuals who are not currently employed but have had employment experience are more likely to encounter threats of gender-based violence (GBV), exhibiting an odds ratio of 1.516 ($p = 0.028$) relative to those who have not been employed in the past 12 months. Individuals lacking formal education exhibit a reduced likelihood of encountering

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GBV threats, evidenced by an odds ratio of 0.525 ($p = 0.001$), in contrast to those possessing tertiary education. The probability of encountering GBV threats marginally increases with higher education levels, specifically at the primary and secondary stages; however, these correlations lack statistical significance. Adult males without children exhibit a reduced likelihood of experiencing GBV threats, indicated by an odds ratio of 0.392 ($p = 0.014$), in comparison to those with more than eight children. The length of marriage is significantly correlated with the risk of gender-based violence (GBV) threats. Individuals married for 1-5 years exhibit a lower probability of experiencing GBV threats, indicated by an odds ratio of 0.328 ($p < 0.001$). Similarly, those married for 6-10 years also demonstrate a decreased likelihood, with an odds ratio of 0.675 ($p = 0.001$). The partner's age ($p=0.500$) does not demonstrate a statistically significant correlation with GBV threats. Likewise, the partner's smoking habit does not exhibit a significant association ($p=0.088$).

The partner's employment status demonstrates a significant correlation with threats of gender-based violence ($p < 0.001$). Individuals who are not currently employed (55.1%) or have not been employed in the past 12 months (53.2%) exhibit higher rates of association with GBV threats compared to those who are currently employed (31.1%). The partner's educational attainment is significantly correlated with threats of gender-based violence ($p = 0.002$). Individuals with partners lacking formal education or possessing only primary education exhibited a higher likelihood of encountering threats of gender-based violence compared to those with partners who attained secondary or tertiary education. For example, 40.8% of individuals with partners who had primary education reported threats of gender-based violence, in contrast to 47.0% for those with partners who had secondary education. The partner's alcohol consumption is a significant factor ($p < 0.001$). Individuals with partners who

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consume alcohol exhibit a higher likelihood of experiencing threats of gender-based violence (GBV), with 63.4% reporting such threats, in contrast to 42.3% among those with non-drinking partners.

Partner drug use demonstrates a statistically significant correlation with the threat of gender-based violence ($p = 0.031$). Individuals with partners who engage in substance abuse are at a higher risk of experiencing gender-based violence (GBV) threats, with 56.2% of those whose partners use drugs reporting such threats, in contrast to 43.7% of those whose partners abstain from drug use. Employment status shows a notable correlation with threats of gender-based violence (GBV), as individuals who are currently employed exhibit a significantly lower likelihood of experiencing GBV threats, reflected by an odds ratio of 0.355 ($p < 0.001$), in contrast to those who have not been employed in the past 12 months.

Logistic regression indicates that education level significantly influences threats of gender-based violence (GBV). The odds ratios for partners lacking formal education and those with primary education compared to partners with tertiary education are 0.543 ($p = 0.001$) and 0.590 ($p < 0.001$), respectively. The partner's alcohol consumption exhibits a robust and significant correlation with threats of gender-based violence (GBV). Partners who consume alcohol exhibit an odds ratio of 0.236 ($p < 0.001$), while those with an unknown alcohol consumption status present an odds ratio of 0.411 ($p < 0.001$). Both groups exhibit a significant association with a reduced likelihood of experiencing GBV threats in comparison to partners who do not engage in alcohol consumption.

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5.1.4Adolescents

A significant proportion of the adolescents were identified as students, accounting for 65.1%. A minority participated in apprenticeships (26.6%), with even

fewer engaged in unskilled (2.3%) and skilled (2.0%) positions, as well as other sectors such as sales/services (1.7%) and agriculture/farming (0.3%). A small proportion identified as professionals (0.2%) or clerics (0.1%).
The majority of adolescents had never been married (96.9%), while 1.7% were married and 1.3% cohabited with a partner. Divorce and separation instances were notably infrequent, comprising less than 0.2% of the sample. The majority of adolescents lived in urban areas (69.5%), whereas 30.5% resided in rural areas.
In terms of childbearing, the vast majority of adolescents were childless (97.5%), while 2.1% had one child and a minimal 0.4% had two children. The sample exhibited a marginal predominance of females (58.2%) compared to males (41.8%). In incidents involving participants who were slapped or pushed without incurring injuries or enduring lasting pain, a majority (53.8%) indicated that they had encountered this form of abuse at least once. Additionally, 15.4% reported experiencing it three times, while another 7.7% stated that they had faced it eight times over the past year.

In the context of severe physical violence, including actions such as being punched, kicked, bruised, or cut with ongoing pain, 69.2% of adolescents indicated that they had never encountered such experiences. Conversely, 15.4% reported experiencing it once, while smaller proportions noted occurrences of twice or four times within the previous year.

In instances of severe violence, including physical assault resulting in significant contusions, burns, or other serious injuries, 84.6% of respondents indicated that they had not encountered such experiences. In the review year, 7.7% of individuals experienced this type of violence once, while another 7.7% encountered it five times.

Furthermore, 23.1% of adolescents indicated that their ex-partner or current partner had threatened to use a weapon against them, resulting in injury, whereas 76.9% did

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not report experiencing such threats. In conclusion, 15.4% of respondents indicated that they had experienced the use of a weapon causing wounds on two occasions, while 7.7% reported it occurring once. The majority, 76.9%, had not encountered this type of violence. The research demonstrated a significant correlation between age and the risk of gender-based violence (GBV). Adolescents aged 10-14 years exhibited a higher risk of experiencing gender-based violence (GBV), with 59.4% affected, in contrast to 37.3% in the 15-19 age group (p= 0.021).

The employment status demonstrated a significant correlation with the risk of gender-based violence (GBV). Adolescents not currently employed exhibited a greater risk of gender-based violence (GBV), with 46.6% reporting such experiences, in contrast to 28.6% of those currently employed and 26.2% of those who had not been employed in the past 12 months (p=0.002). Conversely, educational level, gender, and residence did not exhibit significant correlations with the risk of GBV. Differences in the percentages of adolescents experiencing GBV across various education levels were observed; however, these differences were not statistically significant (p = 0.247). Gender did not have a significant effect on the risk of GBV, as both males and females reported comparable

experiences (p = 0.268). The study found that residence, whether rural or urban, did not have a significant impact on the risk of gender-based violence among adolescents. The results showed that 58.8% of rural adolescents and 62.0% of urban adolescents reported experiencing GBV risk, with no statistically significant difference between the two groups (p = 0.552). The logistic regression analysis of sociodemographic determinants of gender-based violence (GBV) risks among adolescents revealed that age and employment status are significant factors affecting the likelihood of experiencing GBV. Age emerged as a crucial factor, with adolescents aged 10-14 years

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exhibiting a 2.43-fold increased likelihood of being at risk of GBV in comparison to their older peers aged 15-19 years, as evidenced by an odds ratio (OR) of 2.430 and a p-value of 0.026.

Adolescents who were not currently employed exhibited a 2.825-fold increased likelihood of experiencing gender-based violence (GBV) compared to their peers who had not been employed in the preceding 12 months, with a statistically significant p-value of 0.002. The educational attainment of a partner significantly influences the risk of gender-based violence (GBV). Adolescents with partners possessing only primary education demonstrated an increased risk of gender-based violence (GBV), with 68.4% of these cases reporting GBV, in contrast to 31.6% who did not ($p = 0.033$). This indicates that reduced educational attainment among partners may correlate with an increased risk of gender-based violence (GBV).

The partner's alcohol consumption was significantly linked to the risk of gender-based violence (GBV). Adolescents uncertain about their partner's alcohol consumption reported a higher incidence of gender-based violence (GBV) at 47.3%, compared to 31.2% among those aware their partner did not consume alcohol and 33.3% among those who knew their partner did consume alcohol. $p = 0.014$. The consumption of hard drugs by partners demonstrated a significant correlation with the risk of gender-based violence (GBV). Adolescents with partners who used hard drugs exhibited a greater prevalence of gender-based violence (GBV) at 33.3%, in contrast to those with non-drug-using partners at 26.3%, and those uncertain about their partners' drug use at 43.5% ($p=0.044$).

An analysis of in-school versus out-of-school adolescents indicates that sociodemographic variables such as age, employment status, education, residence, and gender do not significantly predict the risk of gender-based violence among in-school

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adolescents. Younger age and unemployment are significant predictors of heightened GBV risk among out-of-school adolescents, whereas factors such as education, residence, and gender do not demonstrate statistical significance.

5.1.5 Healthcare Providers

A total of 647 health facilities were included in the study, with only 22% reporting cases of gender-based violence in the past six months. The distribution of health facilities indicates that the majority of workers are employed in Primary Health Clinics/Centers (50.5%), with General Hospitals employing 34.2% of workers. The gender distribution indicates a significant predominance of female healthcare workers at 83.4%, with males representing only 16.6% of the workforce. The predominant professional groups are Nurses/Midwives, comprising 34.7%, and Health Assistants and Community Health Extension Workers (CHEWs), accounting for 17.1%. Among 1,286 respondents, 1,001 (77.7%) demonstrate a positive attitude towards the urgent treatment of GBV survivors, whereas 285 (22.3%) exhibit a negative attitude. Among the 638 respondents, only 24.1% (154) accurately understood the meaning of GBV, whereas a majority, 75.9% (484), lacked this knowledge, highlighting a considerable deficiency in the fundamental comprehension of GBV among healthcare workers. In response to the inquiry regarding common types of gender-based violence (GBV), 77.4% of participants identified a single type, 17.1% identified two types, and merely

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1.4% were able to identify four types. A small percentage (2.2%) of healthcare workers (HCWs) were able to identify three types of gender-based violence (GBV), while only 0.2% could identify all five common types. This indicates a notable gap in knowledge regarding the various forms of GBV among HCWs. Medical care constitutes the predominant service, accounting for 81.5% (527 of 647)

of the total services provided. Counselling and psychological support constitute 54.4% (352), whereas referral services represent 42.7% (276).

Screening and assessment services constitute 28.9% (187), indicating that health facilities prioritise medical treatment, mental health support, and referrals for survivors.

Follow-up care is provided in 19.2% (124) of cases, education and prevention in 16.4% (106), and documentation and reporting in 12.4% (80). Advocacy and empowerment is the least common service, provided in only 24 (3.7%) of the sampled health facilities. The data indicate that, although immediate care is emphasised, there may be deficiencies in long-term support and empowerment programs for survivors of gender-based violence (GBV).

A significant proportion of carers indicated that health facilities offer STI-related services, with 43.3% referring victims to a STI/STD clinic, 39.3% providing prophylactic treatment, and 4.9% sending swabs for STI testing; however, 31.1% do not provide any such services. A majority of facilities (73.6%) provide counselling to survivors; however, only 21.3% make referrals to other service providers, such as law enforcement or judicial systems. The recorded low referral rate may be linked to the negative attitudes of healthcare workers towards gender-based violence survivors and the identified knowledge gap regarding GBV among the sampled healthcare worker respondents.

Only 5.9% of facilities collect physical evidence, and 11.9% utilise a pre-packaged rape kit for examinations; however, merely 5.7% maintain a consistent supply of these kits. Fewer than half (44.7%) of healthcare workers indicated that facilities maintain records of examined gender-based violence (GBV) cases. Additionally, less than one-third possess specific forms (29.7%) or

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protocols/guidelines (23.2%) for GBV case management, highlighting the inadequate prioritisation of GBV management in health facilities.

5.2 Overview of Discussion

5.2.1 Assess the prevalence, patterns, and determinants of gender-based violence among adult non-pregnant females in Ibadan.

Up to 10% of adult, non-pregnant female respondents indicated that their partner had employed physical violence against them at some point. A smaller proportion (6.6%) of women indicated that their partners restricted their access to financial resources, whereas 3.8% of respondents reported experiencing sexual actions from their partners that resulted in negative feelings or physical harm. A minority (3.4%) reported that their partners engaged in choking, strangling, or suffocating behaviours, or attempted such actions. Consequently, physical violence is identified as the most common form of gender-based violence among adult non-pregnant females in Ibadan. Economic violence ranks as the third most reported category of gender-based violence, with sexual abuse, choking, and strangling/suffocation also frequently documented. Literature indicates that economic violence, while less apparent, is the most common form of gender-based violence following sexual abuse and physical violence. The overall prevalence of gender-based violence among adult non-pregnant females was 23.8%. This finding is consistent with research by UNFPA. (2018) and Oluyemisi et al. (2020), which indicated that nearly 25% of women in Nigeria reported experiencing intimate partner violence[1,2].

The relationship between age and the threat of gender-based violence (GBV) is significant, as evidenced by a lower proportion of younger women aged 20-29 years at risk (43.9%) compared to older women aged 40-49 years (54.1%) (p=0.001). Olumide Abiodun et al. reported that younger women are at a higher risk of gender-based

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violence in a study conducted in Ogun State, South Western Nigeria[4]. Logistic regression indicates that age significantly correlates with the risk of gender-based violence (GBV). 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) exhibit a markedly higher risk of GBV in comparison to those aged 50 years and older, who serve as the reference category.

Employed women face a lower threat of gender-based violence (GBV) at 39.9% compared to those not employed in the past 12 months (42.8%) and currently unemployed individuals (58.5%) (p<0.001). Logistic regression analysis indicates that women not currently employed have significantly higher odds of experiencing GBV threat (OR = 1.636, p = 0.009) relative to those who have not been employed in the last 12 months, which serves as the reference category. Women possessing tertiary education exhibit a lower prevalence of being at risk of gender-based violence (GBV) at 40.1%, in contrast to those with secondary education at 52.3% and primary education at 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). The findings of this study further corroborate the Nigeria Demographic and Health Survey, which identified wealth index and low levels of women's education as significant determinants of gender-based violence among women in Nigeria[5].

The number of children and the duration of marriage are significantly correlated with the threat of gender-based violence (p<0.001). Women without children (37.0%) or with fewer children (1-2) (50.5%) exhibit a lower risk compared to those with 5-8 children (54.8%) and those with five or fewer children (41.8%). The NDHS indicated that increased parity is a determinant of gender-based violence. Women married for

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over 10 years face a higher risk, with 55.5% indicating potential threats. Similarly, the duration of marriage demonstrates notable correlations with the risk of gender-based violence (GBV). Women in marriages of shorter duration (1-5 years, OR = 0.507, $p < 0.001$) exhibit a reduced risk of gender-based violence compared to those in marriages exceeding 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 with partners lacking formal education experience a lower risk of gender-based violence (GBV) at 14.5%, in contrast to those with partners who have primary (53.4%), secondary (56.6%), or tertiary education (45.6%) ($p<0.001$). Partners currently employed exhibit significantly lower odds of experiencing GBV threat (OR = 0.516, $p = 0.001$) in comparison to those not employed in the preceding 12 months (reference category). Conversely, partners who are currently unemployed demonstrate significantly higher odds (OR = 1.661, $p = 0.012$). Individuals without formal education exhibit markedly reduced odds of being linked to the threat of gender-based violence (OR = 0.182, $p < 0.001$) when contrasted with those possessing tertiary education (reference category).

The partner's consumption of alcohol, smoking, and use of hard drugs are significantly correlated with an increased risk of gender-based violence (all p-values < 0.001).

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Women with partners who consume alcohol (68.6%), smoke (67.3%), or use hard drugs (74.1%) are at a markedly increased risk of gender-based violence compared to those whose partners abstain from these activities. The NDHS identified a significant correlation between elevated alcohol consumption by husbands and the risk of gender-based violence[5]. Furthermore, partners who consume alcohol exhibit reduced odds (OR = 0.205, $p < 0.001$) of being linked to GBV threat in comparison to those unaware of their partner's alcohol consumption status (reference category). Women unaware of their partner's earnings exhibit significantly lower odds of experiencing gender-based violence (OR = 0.723, $p = 0.004$) in comparison to those who are informed. A study conducted in Lagos, another southwestern state of Nigeria, identified significant predictors of gender-based violence among women, including employment status, having a partner who consumes alcohol, and having multiple sexual partners[6]. A systematic review and meta-analysis of risk and protective factors for gender-based violence (GBV) indicated that the most robust evidence for modifiable risk factors affecting women pertains to unplanned pregnancy and parental education levels below high school, which the authors linked to lower socioeconomic status. Numerous studies indicate that low educational attainment is a significant risk factor for both preparation and victimisation. Additional factors associated with gender-based violence include ethnicity, geographic location, and the partner's alcohol consumption. The partners of respondents predominantly displayed jealousy and engaged in controlling behaviours. Physical violence was the predominant form, and the majority of victims took no action in response. In certain male-dominant cultures, elevated educational attainment among women may increase their vulnerability to gender-based violence. This observation is associated with the propensity of educated women to contest male authority. The study indicates that the prevalence of gender-based violence (GBV) among adult non-pregnant females is 23.8%. It identifies physical violence, sexual violence, and

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economic violence as the most prevalent forms of GBV within the study population. Younger women are at a greater risk of gender-based violence compared to women aged 50 years and older. Women who are not currently employed exhibit significantly higher odds of experiencing threats of gender-based violence compared to their employed counterparts. The elevation of women's status appears to decrease the likelihood of gender-based violence, highlighting the importance of girl-child education and women's empowerment initiatives.

5.2.2 Evaluate the prevalence, patterns, and associated risk factors of gender-based violence among pregnant women in Ibadan.

In pregnant women, age is a significant factor affecting the risk of gender-based violence (GBV). Women aged 20-29 (69.5%) and 30-39 (75.5%) are more likely to report being at risk of GBV, whereas those aged 50 and above show a reduced risk (33.3%) ($p = 0.003$). Age demonstrates a notable correlation with the risk of gender-based violence during pregnancy. Logistic regression analysis indicated that women aged 30-39 had an odds ratio of 7.476 ($p = 0.026$), suggesting they are approximately 7.5 times more likely to be at risk of gender-based violence compared to the reference group. Women aged 40-49 exhibit an odds ratio of 6.199 ($p = 0.046$), indicating an elevated risk compared to the reference group (≥50 years). The findings indicate that younger pregnant women have a higher likelihood of experiencing gender-based violence (GBV).

A significant association was observed between the age of pregnant women's partners and the risk of gender-based violence (GBV) ($p = 0.002$). Younger partners, specifically those aged 20-29 (68.6%), exhibited a lower risk of GBV compared to

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older age groups. The likelihood of gender-based violence during pregnancy appears to rise with the increasing age of women's partners.

A significant relationship was identified between a partner's employment status and the risk of gender-based violence (GBV) ($p = 0.034$). Partners who are currently unemployed or have not been employed in the past 12 months are more likely to be associated with a threat of GBV (81.2%). This pattern resembles findings from Kenya, which identified the educational status of intimate partners as a predictor of gender-based violence in pregnant women[10,11,12].

5.2.3 Assess the prevalence, patterns, and risk factors associated with gender-based violence among adolescents in Ibadan.

A significant proportion of the adolescents were classified as students or in-school adolescents, accounting for 65.1%. A minority participated in apprenticeships (26.6%), with even fewer engaged in unskilled (2.3%) and skilled (2.0%) positions, as well as other fields such as sales/services (1.7%) and agriculture/farming (0.3%). A small proportion identified as professionals (0.2%) or clerics (0.1%).

As anticipated, the majority of adolescents had never been married (96.9%). Nonetheless, 1.7% indicated having been married, while 1.3% were cohabiting with a partner. Divorce and separation instances were notably infrequent, comprising less than 0.2% of the sample. In terms of childbearing, the vast majority of adolescents were childless (97.5%), while 2.1% had one child and a minimal 0.4% had two children. The sample exhibited a marginally higher proportion of females (58.2%) compared to males (41.8%). In incidents involving participants being slapped or pushed without resulting injuries or enduring pain, a majority (53.8%) indicated that they encountered this form of abuse at least once. Additionally, 15.4% reported experiencing it three times, while another 7.7% noted occurrences of eight times within the past year. In the context of

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severe physical violence, including actions such as being punched, kicked, bruised, or cut with ongoing pain, 69.2% of participants indicated that they had never encountered such experiences. Conversely, 15.4% reported experiencing it once, while smaller proportions noted occurrences of twice or four times. In instances of severe violence,

including physical assault resulting in contusions, burns, or other significant injuries, 84.6% of participants indicated that they had not encountered such experiences. In the review year, 7.7% of individuals experienced this type of violence once, while another 7.7% experienced it five times. Furthermore, 23.1% of participants indicated that their ex-partner or current partner had threatened to use a weapon against them, resulting in injury, whereas 76.9% did not encounter such threats. In conclusion, concerning the utilisation of a weapon that resulted in injuries, 15.4% indicated this event occurred twice, while 7.7% reported it occurring once. The majority, 76.9%, did not experience this type of violence. This result exceeded that reported in a study conducted in Sub-Saharan Africa (Kenya), which indicated a lifetime and recent sexual violence prevalence of 20.5% among adolescents, and 18.0% for the same cohort[10]. The research demonstrated a significant correlation between age and the risk of gender-based violence (GBV). Adolescents aged 10-14 years exhibited a higher risk of experiencing gender-based violence (GBV), with 59.4% affected, in contrast to 37.3% in the 15-19 age group (p= 0.021). The employment status demonstrated a significant correlation with the risk of gender-based violence (GBV). Adolescents not currently employed exhibited a heightened risk of gender-based violence (GBV), with 46.6% reporting such experiences, in contrast to 28.6% of those currently employed and 26.2% of those not employed in the preceding 12 months (p=0.002).

Conversely, educational level, gender, and rural/urban residence did not

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demonstrate significant associations with the risk of gender-based violence (GBV). Residence, whether in rural or urban areas, did not have a significant impact on the risk of gender-based violence among adolescents in the study. The logistic regression analysis of sociodemographic determinants of gender-based violence (GBV) risks among adolescents identified age and employment status as influential factors in the

likelihood of experiencing GBV. Age significantly influenced the risk of gender-based violence (GBV), with younger adolescents (10-14 years) exhibiting a 2.43-fold increased likelihood of risk compared to older adolescents (15-19 years), as evidenced by an odds ratio (OR) of 2.430 and a p-value of 0.026. Adolescents who were not currently employed exhibited a 2.825-fold increased likelihood of experiencing gender-based violence (GBV) compared to those who had not been employed in the preceding 12 months, with a statistically significant p-value of 0.002. The educational attainment of a partner significantly influences the risk of gender-based violence (GBV). Adolescents with partners possessing only primary education demonstrated an increased risk of gender-based violence (GBV), with 68.4% of these cases reporting GBV, in contrast to 31.6% who did not ($p = 0.033$). This indicates that reduced educational attainment among partners may correlate with an increased risk of gender-based violence (GBV).

Additionally, the consumption of alcohol by partners was significantly correlated with the risk of gender- based violence (GBV). Adolescents uncertain about their partner's alcohol consumption reported a higher incidence of GBV (47.3%) compared to those who were aware that their partner did not consume alcohol (31.2%) or those who knew their partner did consume alcohol (33.3%). $p = 0.014$. The consumption of hard drugs by partners demonstrated a significant correlation with the risk of gender-based violence (GBV). Adolescents with partners who used hard drugs

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exhibited a higher incidence of gender-based violence (GBV) at 33.3%, in contrast to those whose partners did not use hard drugs (26.3%) or those who were uncertain (43.5%) (p=0.044).

In summary, age, employment status, partner's educational level, partner's alcohol consumption, and partner's use of hard drugs were found to increase the likelihood of gender-based violence (GBV) occurrence among the sampled adolescents. Conversely, residence and the educational level of adolescents did not show a significant impact on the occurrence of GBV in this population. An analysis of in-school and out-of-school adolescents indicates that none of the sociodemographic variables—such as age, employment status, education, residence, or gender—serve as significant predictors of GBV risk among in-school adolescents. Younger age and unemployment are significant predictors of heightened GBV risk among out-of-school adolescents, whereas factors such as education, residence, and gender lack statistical significance.

5.2.4 To assess the prevalence, patterns, and determinants of gender-based violence among adult men in Ibadan.

Physical violence constituted the predominant type of abuse reported by male respondents from their partners, accounting for 7.1% of cases. Severe forms of abuse, including choking, strangulation, or suffocation attempts, were reported by 2.4% of respondents. In contrast, only 2.7% of male respondents reported experiencing threats or assaults involving weapons, while 1.5% indicated that their partner had harmed or threatened to harm a family pet. Approximately 8.8% of male respondents reported that their partners restricted their access to financial resources, a noteworthy finding in a predominantly male-dominated society such as Ibadan. Additionally, 3.5% reported that the violence or controlling

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behaviour in their relationship was deteriorating over time.

It is concerning that 5.2% of male respondents reported experiencing physical violence in the presence of their children, while 1.4% indicated that their female partners had threatened or harmed their children. It is essential to prioritise the management and resolution of gender-based violence issues among men. In conclusion, regarding sexual assault within these relationships, 2.6% of respondents indicated that their partner had exhibited sexually abusive behaviour, while a lesser

percentage (0.7%) reported that their partner had been arrested for sexual assault, marking a relatively uncommon event in this context.

The analysis revealed a significant association between employment status and the threat of gender-based violence (GBV) ($p<0.001$). A notably higher proportion of individuals not currently employed reported experiencing GBV threats (56.7%) compared to their employed counterparts (33.5%). Education level was significantly correlated with the threat of gender-based violence (GBV) ($p<0.001$). A higher proportion of individuals with primary education (47.7%) or secondary education (47.2%) reported experiencing GBV threats compared to those with tertiary education (39.2%).

The number of children emerged as a significant determinant of gender-based violence (GBV) ($p=0.033$). Men without children reported the lowest incidence of GBV threat at 27.7%, while this proportion increased with the number of children, notably rising to 50.9% among those with more than eight children. The economic responsibilities associated with maintaining a family, particularly when the spouse or partner serves as the primary breadwinner, may significantly contribute to this observed trend.

Finally, the duration of marriage demonstrated a significant correlation with the

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threat of gender-based violence ($p<0.001$). Individuals married for 1-5 years reported a lower proportion of GBV threats (36%) compared to those married for over 10 years (49.3%).

Age is a significant factor, as younger males, specifically those aged 20-29 and 30-39, exhibit a higher likelihood of encountering threats of gender-based violence compared to individuals aged 50 and older. Males aged 20-29 exhibit an odds ratio of 2.603 ($p < 0.001$), indicating they are more than 2.6 times as likely to encounter GBV threats compared to individuals aged 50 and older. Individuals aged 30-39 exhibit an odds ratio of 1.935 ($p < 0.001$), suggesting a nearly doubled risk of experiencing GBV threats in comparison to those aged 50 and older. A study in Sub-Saharan Africa identified age as a determinant of gender-based violence (GBV) in males, revealing that 18% of men aged 18-24 experienced sexual violence prior to turning 18.

Currently employed individuals exhibit a reduced likelihood of experiencing GBV threats, evidenced by an odds ratio of 0.585 ($p = 0.005$), in contrast to those who have not been employed in the past 12 months. Conversely, individuals who are not currently employed but have had employment experience are more likely to encounter threats of gender-based violence (GBV), exhibiting an odds ratio of 1.516 ($p = 0.028$) in comparison to those who have not been employed in the past 12 months. Individuals lacking formal education exhibit a reduced likelihood of encountering

GBV threats, evidenced by an odds ratio of 0.525 ($p = 0.001$), in contrast to those possessing tertiary education. The probability of encountering GBV threats marginally increases with higher education levels, specifically at the primary and secondary stages; however, these associations lack statistical significance. Individuals without children exhibit a lower likelihood of experiencing GBV threats, reflected in

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an odds ratio of 0.392 (p = 0.014), in comparison to those with more than eight children. The length of marriage is significantly correlated with the risk of gender-based violence (GBV) threats. Individuals married for 1-5 years exhibit a lower probability of encountering GBV threats, indicated by an odds ratio of 0.328 (p < 0.001). Similarly, those in marriages lasting 6-10 years also demonstrate a diminished likelihood, reflected by an odds ratio of 0.675 (p = 0.001). The partner's age (p=0.500) does not demonstrate a statistically significant correlation with GBV threats. Likewise, the partner's smoking habit does not demonstrate a significant association (p=0.088).

The employment status, education level, alcohol consumption, and drug use of partners all demonstrate a significant correlation with threats of gender-based violence (p < 0.001). Individuals who are not presently employed (55.1%) or have not been employed in the past 12 months (53.2%) exhibit higher rates of association with GBV threats compared to those who are currently employed (31.1%). The stress associated with managing a household, particularly in the context of increasing living costs, may contribute to this phenomenon. The partners of the male respondents are primarily female. This trend indicates that a female partner who is gainfully employed is less likely to engage in gender-based violence (GBV) with her spouse, suggesting that empowering women to achieve self-sufficiency may be an effective strategy to reduce GBV among men.

The partner's educational attainment is significantly correlated with threats of gender-based violence (p = 0.002). Individuals with partners lacking formal education or possessing only primary education exhibited a lower likelihood of encountering threats of gender-based violence compared to those with partners who had secondary or tertiary education.

The partner's alcohol consumption is a significant factor (p < 0.001). Individuals with

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partners who consume alcohol exhibit a higher likelihood of experiencing threats of gender-based violence (GBV), with 63.4% of this group reporting such threats, in contrast to 42.3% of individuals whose partners abstain from alcohol consumption. Alcohol consumption has been consistently identified as a predictor of gender-based violence.

This study demonstrated a statistically significant association between partner drug use and the threat of gender-based violence (GBV) ($p = 0.031$), consistent with findings from other studies conducted in Nigeria[6,13]. Individuals with partners who consume hard drugs exhibit a higher association with threats of gender-based violence (GBV), as evidenced by 56.2% of respondents reporting such threats in the context of drug use, in contrast to 43.7% among those with non-drug-using partners.

5.2.5 Assess the knowledge, attitudes, and practices of health workers regarding gender-based violence in Ibadan.

Healthcare respondents were predominantly employed in Primary Health Clinics/Centres (50.5%), with General Hospitals following at 34.2%. This supports the notion that primary healthcare centres are generally favoured as a point of care compared to other levels of care. The gender distribution indicates a significant predominance of female healthcare workers at 83.4%, compared to 16.6% for males, suggesting a greater involvement of women in healthcare professions. The predominant professional groups are Nurses/Midwives, comprising 34.7%, and Health Assistants and Community Health Extension Workers (CHEWs), accounting for 17.1%.

Among 1,286 healthcare worker respondents, 1,001 (77.7%) demonstrate a positive attitude towards the urgent treatment of GBV survivors, while 285 (22.3%) exhibit a negative attitude. Among the 638 respondents to this question, only 24.1%

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(154) accurately understood the meaning of GBV, whereas the majority, 75.9% (484), did not. The aforementioned findings correspond with a 2021 study regarding the sexuality of emerging adults in Nigeria, which identified healthcare workers as indifferent to providing services to emerging adults who have experienced gender-based violence. A notable gap in the fundamental understanding of gender-based violence exists among healthcare workers. Additionally, it is essential to address the potential negative attitudes of healthcare workers towards survivors of gender-based violence to enhance care-seeking behaviour among victims.

In response to enquiries regarding the common types of gender-based violence (GBV), 77.4% of participants identified a single type, 17.1% recognised two types, and merely 1.4% were able to identify four types. A limited proportion (2.2%) of healthcare workers could identify three types, with only 0.2% recognising all five common types of gender-based violence, indicating insufficient awareness of the various forms of GBV. Medical care constitutes the predominant service, accounting for 81.5% (527 of 647) of the total services provided. Counselling and psychological support constitute 54.4% (352), whereas referral services represent 42.7% (276). Screening and assessment services constitute 28.9% (187), indicating that health facilities prioritise medical treatment, mental health support, and referrals for survivors. Follow-up care is provided in 19.2% (124) of cases, education and prevention in 16.4% (106), and documentation and reporting in 12.4% (80). Advocacy and empowerment represent the least common service, provided in only 3.7% (24) of cases. The data indicate that, although immediate care is emphasised, there may be deficiencies in long-term support and empowerment programs for survivors of gender-based violence (GBV). Strategies designed to address the deficiencies in long-term support and empowerment for GBV survivors must be implemented as formal policies.

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A significant percentage of healthcare workers indicated that their health facilities offer STI-related services: 43.3% refer victims to a STI/STD clinic, 39.3% provide prophylactic treatment, and 4.9% send swabs for STI testing. However, 31.1% do not offer any such services. A majority of facilities (73.6%) provide counselling to survivors; however, only 21.3% facilitate referrals to additional service providers, such as law enforcement or judicial systems. Approximately 31.1% of health facilities do not provide services for survivors of gender-based violence.
In the past six months, among male adult GBV survivors (≥18 years), a significant majority of facilities (77.0%) reported no cases, while 15.6% reported between 2-5 cases, and 4.5% reported more than 5 cases. In comparison, female adults were reported more often, with 68.0% of facilities indicating no cases, 17.6% reporting between 2-5 cases, and 6.2% observing more than 5 cases. This suggests that female adults are more frequently identified as survivors of gender-based violence compared to male adults. The finding supports the WHO's landmark report on violence and health, which states 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"[16,17].

Monthly data indicates that 80.2% of facilities reported no male adult survivors of gender-based violence, whereas 14.4% managed between 2 to 5 cases. Among female adults, 74.8% of facilities reported no cases, while 19.3% observed an average of 2-5 cases. In 2023, 64.1% of facilities indicated no male adult cases, whereas 31.8% reported 2-5 cases among female adults, indicating a higher incidence among females. In the population of children under 18 years, 80.5% of facilities indicated no male child cases in the preceding six months, whereas 76.8% of facilities reported no female child cases. Female children were observed more frequently, with 8.2% of facilities reporting

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more than 5 cases. Data indicates that health facilities report a higher incidence of cases among children (under 18 years) and females compared to children and adult males.

5.2.6 Assess the knowledge and attitudes of respondents regarding gender-based violence in Ibadan.

The study assessed adult women's awareness and perceptions concerning socially accepted justifications for intimate partner violence in relationships. Research findings reveal that the majority of females do not deem any rationales considered valid for gender-based violence; however, a minority of respondents maintain beliefs that may contribute to the continuation of such violence. Among the 2,388 sampled women, only 2.9% endorsed the notion that a husband is justified in physically assaulting his wife for going out without prior notification, whereas a significant majority, 97.1%, opposed this view. In a similar vein, 3.1% of participants considered neglecting children a justifiable reason for violence, whereas 96.9% opposed this view.

Additionally, a mere 2.4% of respondents endorsed the notion that disagreement with a husband justifies violence, whereas an overwhelming 97.6% rejected such justification. In response to the question of whether burning food constitutes a justifiable reason, 3.1% of participants expressed agreement, whereas 96.9% disagreed. Ultimately, 4.5% of older women considered that denying their husbands sex warranted gender-based violence, while 95.6% dismissed this rationale.

Cultural and societal norms continue to affect the attitudes and beliefs of certain pregnant women. Findings indicate that while the majority of adult expectant women uniformly rejected all forms of justification for gender-based violence (GBV), a minority still maintain beliefs that may contribute to the perpetuation of violence. Consequently, 14.8% of the female respondents provided justifiable reasons for gender-based violence, predominantly among young adults[15,17].

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5.3Null Hypothesis

The study's Null Hypothesis indicated the following:

H1. Men with fewer socio-economic resources than their female partners are not likely to use physical violence and coercive control than men with resources equal to or greater than their female partners. The null hypothesis is rejected

H2. Women with more significant economic resources are not likely to experience physical violence and coercive control within intimate partnerships. The null hypothesis is upheld

H3. Individuals with more significant economic resources are not likely to experience gender-based violence within intimate partnerships. The null hypothesis is upheld

H4. Older women are not likely to experience GBV from their partners. The Null hypothesis was rejected as older women were demonstrated to be more at risk of experiencing GBV

H5. Younger Adolescents are not likely to be at higher risk of GBV leading to a rejection of the Null hypothesis as younger adolescents were more at risk.

5.4 Methodological Considerations

This research encountered several key methodological issues, including:

i. The ethical desk officer at the State Ministry of Education initially verbally requested that male in-school adolescents be excluded from this study as it was “unethical” to be

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asking them if they had partners or are being abused by their partners. Nonetheless, this verbal decline was overcome when the education officer responsible for granting ethical approval recognised the potential occurrence of gender-based violence among in-school male adolescents and the researcher committed to sharing the hard copy of the study's findings with the Ministry of Education.

ii. Inclusion of all 11 Local Government Areas in Ibadan in the study.

Additionally, despite being highly resource-intensive, all 11 LGAs in Ibadan were incorporated into the study to ensure a representative sample for the state and geographical region.

iii. Validity and Reliability of the Study Instrument

The tool pre-test, and pilot phase included a substantial sample size, comprising over 200 respondents in each category: men, women, adolescents, and healthcare providers.

iv. Statistical Tests

These were utilised as implemented in prior comparable studies.

v. Selection of data analysis technique

This was similarly implemented in other GBV studies.

5.5 Implications for Future Research

This study facilitates a comprehensive examination of pregnancy outcomes in abused pregnant women in Ibadan. It has highlighted the issue of men as victims of gender-based violence and the necessity for tailored interventions. The study established a clear framework and baseline for comprehensive investigations into

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gender-based violence incidents among both in-school and out-of-school adolescents. The aforementioned subjects may serve as topics for further investigation

5.6 Conclusion and Recommendation

The prevalence of gender-based violence (GBV) among non-pregnant women is 23.8%. Factors such as age, employment status, education level, drinking alcohol, and psychoactive drug use are significant determinants of GBV in the study area. Younger women and adolescents are at greater risk of experiencing GBV from their partners. The deceptive sense of elation and dizziness brought on by alcohol and substance use diminishes the cognitive clarity of the perpetrator, thereby increasing the likelihood of perpetrating abuse against the survivor. Additionally, an increase in the number of children within a marriage or union correlates with a higher likelihood of gender-based violence experienced by the woman. Respondents aware of their partner's income exhibited a lower likelihood of involvement in gender-based violence (GBV). Women should be empowered to engage in small or medium-scale ventures to reduce their dependency on spouses or partners. This could significantly reduce the likelihood of gender-based violence (GBV). Additionally, the regulation of alcohol and illicit

substances must be stringent to deter consumption and mitigate misuse. Pregnant women have been identified as victims of gender-based violence during pregnancy, with a significant number of cases remaining unreported. Women in their 30s who are pregnant exhibit an increased likelihood of experiencing gender-based violence, with the risk escalating as the age of the pregnant woman's partner increases. Pregnant women should be screened for gender-based violence during antenatal care booking to identify and mitigate occurrences of such violence during pregnancy. Long-term support and empowerment initiatives must be considered

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for pregnant women. Finally, a national justice system must be implemented to both blacklist offenders of gender-based violence and ensure their prosecution. This falls under the jurisdiction of the Federal and State Ministry of Justice.

Up to 7.36% of the surveyed adolescents indicated experiencing physical one form of abuse or the other from their partners, with younger adolescents (ages 10-14) exhibiting a higher risk of abuse compared to older adolescents (ages 15-19). Specifically, GBV prevalence was recorded at 15.36% among out of school adolescents and 3.06% among their in-school counterparts. Younger adolescents may be coerced into silence by their abusers, resulting in underreporting of the abuse. The disaggregation of in-school and out-of-school adolescents indicates that sociodemographic variables, including age, employment status, education, residence, and gender, do not significantly predict GBV risk among in-school adolescents. In contrast, younger age and unemployment are identified as key predictors of increased GBV risk among out-of-school adolescents, while education, residence, and gender lack statistical significance. It is advisable to enhance and intensify initiatives focused on girl-child education and women empowerment, as an elevated status of women markedly decreases the likelihood of gender-based violence (GBV). Additionally, spouses and partners should be gainfully employed and/or educated to mitigate the risk of gender-based violence within the household. The State and Federal Ministry of Education, the Ministry of Women Affairs and Community Development, and the Ministry of Labour and Productivity should be supported and enabled to lead initiatives in girl-child education and employment generation, respectively. Legislation and policy development are necessary to ensure the compulsory education of girls. Schools should create an environment that encourages adolescents to report any form of abuse without fear of intimidation or stigmatisation. The peer-educators approach can be

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implemented among in-school adolescents to facilitate the reporting of abuse cases. Professional work groups and associations should be required to inform relevant authorities, such as the Police and the Ministry of Women Affairs and Community Development, about instances of abuse among adolescents in apprenticeship programs. Men are not exempt from gender-based violence, with a notable percentage (13.7%) acknowledging experiences of physical and emotional abuse; 5.2% reported such abuse occurring in the presence of their children by their partners. Nevertheless, the majority of male abuse cases remain unreported, as indicated by hospital statistics. Some health facilities documented cases of gender-based violence (GBV) among women, whereas reports of GBV among men from healthcare providers were less frequent. This results in men enduring their suffering in silence, exacerbated by stigmatisation or, in some cases, increased violence from their partners. Men-centered gender-based violence care should be established at the grassroots level. Government agencies, parastatals, non-governmental organisations, and healthcare professionals should be trained to identify, understand, and address gender-based violence in men. Moreover, reports of gender-based violence should be free from any form of stigmatisation, regardless of the gender of the individual reporting.

The research findings indicate notable deficiencies in the knowledge of healthcare providers regarding GBV, as well as insufficient long-term support for survivors. Additionally, nearly one-third of healthcare providers exhibit negative attitudes towards GBV survivors. This is not acceptable. The research underscores the necessity for increased public awareness regarding gender-based violence (GBV) among the general population and emphasises the importance of encouraging men to report instances of GBV. Interventions for GBV survivors should be designed with a focus on individual-specific, client-centered approaches. Medical schools, nursing

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schools, colleges of health technology, and healthcare facilities should integrate long-term support and empowerment strategies into their curricula for survivors of gender-based violence. Medical treatment, mental health support, and referral systems require enhancement.

The justification for gender-based violence, as indicated by certain female respondents, constitutes a violation of fundamental human rights and is unequivocally unacceptable, necessitating urgent attention and intervention. Individual-focused counselling, which includes self-awareness and self-validation courses, serves as a strategy to address this anomaly.

This study has analysed the trends and patterns of gender-based violence among Ibadan's adult and teenage cohorts. The phenomenon is prevalent and continues to exist. Various factors contribute to the persistence of gender-based violence, including existing social norms and practices, poverty, the inability of spouses or partners to manage life's exigencies, negative attitudes of healthcare providers, a weak judicial system for apprehending and punishing offenders, inadequate legislation regarding the control and use of alcohol and drugs, and the fear of stigmatisation. It is essential to reduce the stigmatisation of GBV survivors to promote reporting and hold perpetrators accountable. In addition to the aforementioned recommendations, existing legislation should be reinforced and enforced, and appropriate penalties should be imposed on perpetrators of gender-based violence to deter others.

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End notes

1. United Nations funds for population development (UNFPA): *Violence against women – UNFPA's work to make gender-based violence a thing of the past*,UNFPA News, USA for UNFPA, 2023

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Appendix 1: Consent Form

Title of project: Assessment of gender-based violence in Ibadan, Oyo State, Southwest Nigeria

Name of Researcher: Taiwo.I. Olarinde

Institution: Lead City University, Ibadan

□ I have read and/or understood the information sheet for (version 1, 30 April 2022) the above study.

□I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

□I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason, without my medical care or legal rights being affected.

□ I understand that the researchers may look at relevant sections of my data collected during the study, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

□ I agree to take part in the above study.

_____ _____

Name of Participant: Signature & Date

_____ _____

Name of person taking consent: Signature& Date

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Appendix 2: Questionnaires for GBV (males)
Questionnaire 1: Domestic Violence assessment tool (DVAT), Adult Males

Domestic Violence Safety Assessment Tool (DVSAT)

Adapted Assessment tool for gender-based violence in Ibadan

My name is Taiwo Olarinde. I am a Ph.D student of the Department of Public Health, Lead City University, Ibadan, Oyo State.

I am conducting a research to assess the pattern and determinants of GBV in Ibadan, Oyo State, Nigeria.

This questionnaire is designed to obtain information on gender-based violence among adult males in Ibadan city.

Kindly complete the consent form prior to completing this questionnaire. You have the right to pull out of the research at any time you wish.

Please note that the information provided in this questionnaire will solely be used for research purpose and will be treated with utmost confidentiality.

Thank you for consenting to respond to this questionnaire.

Section 1: Client's ID

Client's Identification No: ..... Client's date of birth: .....

Completed by: ..... Signature: ..... Date: .....

Section 2: Socio-demographic variables (Please tick as applicable)

1. Age:
   (a) 10-14 □ (b) 15-19□ © 20-24□ (d) 25-29□ (e) 30-34□
   (f) 35-39□
   (g) 40-44□ (h) 45-49□ (I) 50 and above□

2. Gender

a. Sex: Male □ b. Female □

3. Relationship status:

a. Never married □ b. Married □ c. Living together□ d. Divorced□ e. Separated □

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f. Widowed☐

2. Residence of respondent

a. Rural □ b. Urban □

3. Number of years for which you have been married (Please indicate) ……..

4. Educational status of respondent

a. No education□ b. Primary Education□ c. Secondary education□ d. First degree □ f. Post graduate degree□

6. Employment status of respondent

a. Currently employed □ b. Not currently employed□ c.Not employed within the last 12 months □

7. Occupation of respondent

a. Professional/Technical/Managerial □ b. Clerical □ c. Sales and services □ d. Skilled Manual□

e. Unskilled manual □ f. Agriculture/Farmer □ g. Apprentice □ h. Student □

i. Others (if others please specify……)

8 . Number of children alive (please indicate if applicable)……

Section 2: Information about spouse/intimate partner

9. Age of spouse/ intimate partner

(a) 10-14 □ (b) 15-19□ © 20-24□ (d) 25-29□ (e) 30-34□
(f) 35-39□ (g) 40-44□ (h) 45-49□ (i) 50 and above□

10. Educational status of spouse/intimate partner

a.No education□ b. Primary Education□ c. Secondary education□ d. First degree □ e. Post graduate degree□

11. Employment status of spouse/intimate partner

a. Currently employed □ b. Not currently employed□ c.Not employed within the last 12 months □

12. Occupational status of spouse/intimate partner

a. Professional/Technical/Managerial □ b. Clerical □ c. Sales and services □ d. Skilled Manual□ e. Unskilled manual □ f. Agriculture/Farmer □ g. Apprentice □ h. Student □
I. Full time house wife □ j. Others (if others please specify……)

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13. Do you know how much your spouse/partner earns? A. Yes □ b. No □

14. Does your spouse/partner consume alcohol? A. Yes □ b. No c. I don't know□

15. Does your spouse/ partner smoke? A. Yes □ b. No□ c. I don't know □

16. Does your spouse/partner take hard drugs (e.g Indian hemp, cocaine, heroin, marijuana, tramadol, codeine). A. Yes□ b. No□ c. I don't know □

Section 3: **Risk identification checklist for Violence towards respondent (Please tick as applicable)**

Risk indicator	**Yes**	**No**	**Unknown**	**Refused to answer**
1. Has your partner ever threatened to harm or kill you?	□	□	□	□
2. Has your partner ever used physical violence against you?	□	□	□	□
3. Has your partner ever choked, strangled or suffocated you or attempted to do any of these things?	□	□	□	□

5. Has your partner ever threatened or assaulted you with any weapon (including knives and/or other objects)? □ □ □ □

5. Has your partner ever harmed or killed a family pet or threatened to do so? □ □ □ □

6 ,Has your partner ever been charged with breaching an apprehended domestic violence order? □ □ □ □

Section 4: Relationship between client and partner (Please tick as applicable)

Risk indicator	Yes	No	Unknown	Refused to answer
8. Is the violence or controlling behaviour becoming worse or more frequent?	□	□	□	□
9. Has your partner stalked, constantly harassed or texted/ emailed you?	□	□	□	□
10. Does your partner control your access to money?	□	□	□	□
11. Has there been a recent separation (in the last 12 months) or is	□	□	□	□

one immine nt?

SECTION 5: Background of partner (Please tick as applicable)

12. Does your partner or the relation ship have financial difficult ies? □ □ □ □

13. Is your partner unempl oyed? □ □ □ □

14. Does your partner have mental health proble ms (includi ng undiagn osed conditi ons) and/or depress ion? □ □ □ □

15. Does your partner have a proble m with substan ce abuse such as alcohol □ □ □ □

or other drugs?				
16. Has your partner ever threatened or attempted suicide?	□	□	□	□
17. Is your partner 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?	□	□	□	□
18. Does your partner have access to firearms or prohibited weapon	□	□	□	□

s?

Section 6: Information about Children (Please tick as appropriate)

Risk indicator	Yes	No	Unknown	Refused to answer
18. Do you have children who are less than 12 months apart in age?	□	□	□	□
20. Has your partner ever threatened or used physical violence toward you at any time?	□	□	□	□
	□	□	□	□
21. Has your partner ever harmed or threatened to harm your children?				
22. Is there any conflict between you and your partner regarding child contact or residency issues	□	□	□	□

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and/or current Family Court proceedings?				
23. Are there children from a previous relationship present in the household?	□	□	□	□

SECTION 7: Sexual assault (Please tick as applicable)

24. Has your partner ever done things to you, of a sexual nature, that made you feel bad or physically hurt you?	□	□	□	□
25. Has your partner ever been arrested for sexual assault?	□	□	□	□

Total number of indicators= 25

1 or more 'yes' answers = at threat

12 or more 'yes' answers = at serious threat

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Appendix 3: Domestic Violence assessment tool (DVAT) (Pregnant and non-pregnant women)

Questionnaire 2: Domestic Violence assessment tool (DVAT) (Pregnant and non-pregnant women)

Domestic Violence Assessment Tool (DVAT)

Adapted Assessment tool for gender-based violence in Ibadan

My name is Taiwo Olarinde. I am a Ph.D. student of the Department of Public Health, Lead City University, Ibadan, Oyo State.

I am conducting research to assess the burden and determinants of GBV in Ibadan, Oyo State, Nigeria.

This questionnaire is designed to obtain information on gender-based violence among women in Ibadan city.

Kindly complete the consent form prior to completing this questionnaire. You have the right to pull out of the research at any time you wish.

Please note that the information provided in this questionnaire will solely be used for research purpose and will be treated with utmost confidentiality.

Thank you for consenting to respond to this questionnaire.

Section 1: Client's ID

Client's Identification No: .....

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Client's date of birth: .....

Completed by: .....

Signature: .....

Date: .....

Section 2: Socio-demographic variables (Please tick as applicable)

1. Age:
   (a) 10-14 □ (b) 15-19□ © 20-24□ (d) 25-29□ (e) 30-34□
   (f) 35-39□ (g) 40-44□ (h) 45-49□ (I) 50 and above□

2. Gender
   a. Male □ b. Female □
3. Relationship status:
   a. Never married □ b. Married □ c. Living together☐ d. Divorced☐ e. Separated ☐ f. Widowed☐

4. Residence of respondent
   a. Rural □ b. Urban □
6. Number of years for which you have been married (Please indicate) ……..

7. Educational status of respondent
   a. No education□ b. Primary Education□ c. Secondary education□ d. First degree □ f. Post graduate degree□

7. Employment status of respondent

   a. Currently employed □ b. Not currently employed□ c.Not employed within the last 12 months □

8. Occupation of respondent

   a. Professional/Technical/Managerial □ b. Clerical □ c. Sales and services □ d. Skilled Manual□

   e. Unskilled manual □ f. Agriculture/Farmer □ g. Apprentice □ h. Student □ I. Full-time house wife

   j. Others (if others please specify……)

9. Pregnant within the last 12 months: a. Yes □ b. No□

10. Number of children alive (please indicate if applicable)……

Section 2: Information about spouse/intimate partner of respondent (Please tick as applicable)

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11. Age of spouse/ intimate partner

(a) 10-14 □ (b) 15-19□ © 20-24□ (d) 25-29□ (e) 30-34□ (f) 35-39□
(g) 40-44□ (h) 45-49□ (I) 50 and above□

12 Educational status of respondent's spouse/intimate partner
b. No education□ b. Primary Education□ c. Secondary education□ d. First degree □ f. Post graduate degree□

13. Employment status of respondent's spouse/intimate partner
a. Currently employed □ b. Not currently employed□ c.Not employed within the last 12 months □

14. Occupation of respondent's spouse/intimate partner

a. Professional/Technical/Managerial □ b. Clerical □ c. Sales and services □ d. Skilled Manual□ e. Unskilled manual □ f. Agriculture/Farmer □ g. Apprentice □ h. Student □

i. Others (if others please specify……)

15. Do you know how much your spouse/partner earns? A. Yes □ b. No □

16. Does your spouse/partner consume alcohol? A. Yes □ b. No c. I don't know□

17. Does your spouse/ partner smoke? A. Yes □ b. No□ c. I don't know □

18. Does your spouse/partner consume **hard** drugs (e.g. Indian hemp, cocaine, heroin, marijuana, tramadol, codeine.snuff). A. Yes□ b. No□ c. I don't know □

Section 3: **Risk identification checklist (Please tick as applicable)**

Risk indicator	Yes	No	Unknown	Refused to answer
1. Has your partner ever threatened to harm or kill you?	□	□	□	□
2. Has your partner ever used	□	□	□	□

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physical violence against you?				
2. Has your partner ever choked, strangled or suffocated you or attempted to do any of these things?	□	□	□	□
4. Has your partner ever threatened or assaulted you with any weapon (including knives and/or other objects)?	□	□	□	□
5. Has your partner ever harmed or killed a family pet or threate	□	□	□	□

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ned to do so?				
6. Has your partner ever been charged with breaching an apprehended domestic violence order?	□	□	□	□

Section 4: Relationship between respondent and partner (Please tick as applicable)

Risk indicator	**Yes**	**No**	**Unknown**	**Refused to answer**
7. Is the violence or controlling behavior becoming worse or more frequent?	□	□	□	□
8. Has your partner stalked, constantly	□	□	□	□

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harassed or texted/ emailed you?				
9. Does your partner control your access to money?	□	□	□	□
10. Has there been a recent separation (in the last 12 months) or is one imminent?	□	□	□	□

SECTION 5: Background of partner (Please tick as applicable)

11. Does your partner or the relationship have financial difficulties?	□	□	□	□
12. Is your partner unemployed?	□	□	□	□

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13. Does your partner have mental health problems (including undiagnosed conditions) and/or depression?	□	□	□	□
14. Does your partner have a problem with substance abuse such as alcohol or other drugs?	□	□	□	□
15. Has your partner ever threatened or attempted suicide?	□	□	□	□
16. Is your partner currently on bail or parole, or has served a time	□	□	□	□

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of imprisonment or has recently been released from custody in relation to offences of violence?				
17. Does your partner have access to firearms or prohibited weapons?	□	□	□	□

Section 6: Information about Children (Please tick as applicable)

Risk indicator	Yes	No	Unknown	Refused to answer
18. Are you pregnant and/or do you have children who are less than 12 months apart in age?	□	□	□	□

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19. Has your partner ever threatened or used physical violence toward you while you were pregnant?	□	□	□	□
20. Has your partner ever harmed or threatened to harm your children?	□	□	□	□
21. Are there children from a previous relationship present in the household?	□	□	□	□

SECTION 7: Sexual assault (Please tick as appropriate)

22. Has your partner ever done things to you, of a sexual nature, that made you feel bad or physically hurt you?	□	□	□	□
23. Has your partner ever been arrested for sexual	□	□	□	□

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assault?

Total number of indicators= 23

1 or more 'yes' answers = at threat

12 or more 'yes' answers = at serious threat

Section 8: Women's decision-making autonomy (WDMA) on household matters

Women's decision-making autonomy on household matters (WDMAQ) (Please indicate 1 – husband, 2 – wife, and 3 – joint as applicable)		
Q1	Who is the head of the household?	Women decision making autonomy (Q1-Q13)
Q2	Who should decide on the household matters in your family?	
Q3	Who makes large household purchases?	
Q4	Who makes small daily household purchases?	
Q5	Who is the decision maker when you want to visit family, friends, or relatives?	
Q6	Who is the decision maker on contraceptive to have planned family service?	
Q7	Who is the decision maker on antenatal care service utilization?	
Q8	Who is the decision maker on vaccination service utilization?	
Q9	Do you discuss about family planning with your husband?	
Q10	Who in your family makes decisions about health care for yourself?	
Q11	Do you have an autonomy to decide by yourself and go to health care facility to seek care for you and your children?	
Q12	Who is the decision maker to seek health care when one of family member get sick?	
Q13	Who is the decision maker if you want to attend workshop?	
Section 9: Measures for gender inequity norms index assessment (GINQ)		
Measures for gender inequity norms index assessment		

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(GINQ) **(Please answer yes/no)**		
Q1	Is it fine for men to have more than one (sexual) partner?	Women's accepting attitude toward inequitable gender norm (Q1-Q6)
Q2	Is it a woman's duty to have sex with her spouse/partner even if she does not want to have?	
Q3	Is it more important for a woman to respect her spouse/partner than it is for a man to respect his spouse/partner?	
Q4	May a man beat his spouse/partner if she disobeys him?	
Q5	Can a man beat his spouse/partner if he believes she is having sex with another man?	
Q6	Is it more important for a boy to get an education than a girl?	
Section 10: Psychological intimate partner violence assessment scale (PsIPVQ)		
Psychological intimate partner violence assessment scale (PsIPVQ) **(Please answer yes or no)**		Psychological IPV (Q1-Q14)
Q1	Is/was he jealous or angry if you (talk/talked) to other men?	
Q2	Has he (insists/insisted) on knowing where you (are/were) at all time?	
Q3	Have you ever been insulted by your husband using abusive language that made you feel bad about yourself?	
Q4	Have you ever been threatened by your husband with an object such as a stick, belt, knife, gun, or other type of weapon, etc?	
Q5	Have you ever been created financial hardship/not trust you by your husband to making money available to you?	
Q6	Have you ever been frightened your husband by looking angrily at you?	
Q7	Have you ever expressed suspicion/accused him that he is unfaithful to you?	
Q8	Have you ever been ignored or shown indifference by your husband?	
Q9	Have you ever been deprived from privileges in the family by your husband?	
Q10	Have you ever been denied by your husband on your basic personal needs?	

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Q11	Have you ever been intentionally not involved by your husband on decision-making in the family?	
Q12	Has he belittled or humiliated you in front of other people?	
Q13	Has he done things to scare or intimidate you on purpose?	
Q14	Have you ever been restricted by your husband from going to your parent's home or other places like friends'/relatives' house, places of worship, etc?	

Section 11: Physical intimate partner violence assessment scale (PhIPVQ)		
Physical intimate partner violence assessment scale (PhIPVQ) (Please answer yes or no)		
Q1	Has he pushed or shoved you, shaken you, or thrown something at you?	Physical IPV (Q1-Q7)
Q2	Has he punched or hit you with his fist, or twisted your arm or with something that could hurt you?	
Q3	Has he slapped, kicked, dragged, or beaten you?	
Q4	Has he attacked you with a knife, gun, or other type of weapon?	
Q5	Have you ever been scalded or burnt purposefully by your husband?	
Q6	Has he ever choked you?	
Q7	What do you do in the event of an abuse? A.I go to thehHospital/ see a healthcare worker□ b.I tell my In-laws/ parents□ c. I report to the Pastor/Imam □ d. Traditional leader □ e. I pray about it □ f. I never report the abuse□ g. I report at the police station □ h. Others.(Please specify)	
Section 12: Sexual intimate partner violence assessment scale (SIPVQ)		
Sexual intimate partner violence a assessment scale (SIPVQ) (Please answer yes or no)		
SQ1	Have you ever been physically forced by your husband to have sex when you did not want to?	Sexual IPV (Q1-Q4)
Q2	Have you ever been intentionally denied or avoided sex by your husband?	
Q	Did you ever have sexual intercourse when you	

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3	didn't want because you were afraid of what he might do?	
Q 4	Has he forced you to do something sexual that you found degrading or humiliating?	
Section 13 Husbands can beat their wives if they have justifiable reasons (JWBQ) (Please answer yes or no)		
Husbands can beat their wives if they have justifiable reasons (JWBQ) (Please answer yes or no)		Women's accepting attitude of justified wife beating (Q1-Q5)
Q 1	If wife goes out without informing her husband?	
Q 2	If wife neglects the children?	
Q 3	If wife argues with her husband?	
Q 4	If wife burns the food?	
Q 5	If wife refuses to have sex with him?	

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Appendix 4: Questionnaire for Health Workers Knowledge and attitude to GBV Questionnaire 3:

Adapted GBV Assessment and situation aassessment tool to determine health workers' knowledge, attitude, and experience of GBV in Ibadan

My name is Taiwo Olarinde. I am a Ph.D student of the Department of Public Health, Lead City University, Ibadan, Oyo State.

I am conducting a research to assess the burden and determinants of GBV in Ibadan, Oyo State, Nigeria.

This questionnaire is designed to obtain information on health workers' knowledge, attitude,

and experience of GBV in Ibadan.

Kindly complete the consent form prior to completing this questionnaire. You have the right to pull out of the research at any time you wish.

Please note that the information provided in this questionnaire will solely be used for research purpose and will be treated with utmost confidentiality.

Thank you for consenting to respond to this questionnaire.

Section 1: Client's ID:

Health care provider's Name:

Sex: a. □Male b. □Female

Provider's age: (Please tick as appropriate)

(a) 15-19□ (b) 20-24□ (c) 25-29□ (d) 30-34□ (e) 35-39□

(f) 40-44□ (g) 45-49□ (h) 50 and above□

Provider's job title……

Brief description of provider's duties……

Contact details of respondent……..

Completed by: ……..

Signature……

SECTION 2: Structured Questionnaire for healthcare providers

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Health Services Structured Questionnaire

(As the interviewer, introduce yourself, explain the objectives of the interview and request the respondent's consent to be interviewed. (This is applicable if questionnaire is interviewer administered)

Date of interview: _____

Name of the health care facility:_____

Level of the health care facility:…….

☐ Health Post
☐ PHC
☐ Secondary heath care facility
☐ Tertiary health care facility
☐ Others(please specify)

Service provision

1. What do the words gender-based violence mean to you?

A. Physical Abuse of a partner
B. Sexual abuse/ rape
C. Financial deprivation
D. Emotional abuse
E. All of the above
F. I don't know

3. Does your facility treat survivors of gender-based violence (e.g., survivors of sexual violence)?

YES ☐ NO ☐

3, What are the most common types of violence that women and girls receive services for?

a. Physical ☐
b. Sexual☐
c. Emotional/ Psychological☐
d. Economic☐
e. Cultural☐
f. Cyber/online bullying☐
g. Others ☐

4. What kinds of GBV services are provided by your facility?

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Advocacy and empowerment ☐

Follow up Care ☐

Education and prevention ☐

Documentation and reporting ☐

Referral Services ☐

Counselling and psychological support ☐

Medical Care ☐

Screening and Assessment ☐

Others ☐

None ☐

5. Is post-exposure prophylaxis (PEP) provided to survivors? YES ☐ NO ☐

19. Does the survivor have to consent to getting an HIV test in order to receive PEP?
YES☐ NO ☐

20. Do you obtain consent from survivors/victims or parent/guardians of child survivors prior to starting the examination or collecting evidence? YES ☐ NO ☐

21.. Is consent verbal or written? A. VERBAL ☐ B. WRITTEN ☐

22. What pregnancy-related services do you routinely offer the patient after GBV incidence? (Please tick all that applies)

☐ None

☐ Emergency contraceptives (or morning-after pill)

☐ Pregnancy test

☐ Abortion counselling/information

☐ Other

10. What STI-related services do you offer the survivor after GBV? (Please tick all that applies)

a. None ☐

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b. Give prophylactic treatment (Ask what the treatment is) ☐

c. Refer to an STD/STI clinic ☐

d. Send swab to lab to test for STIs ☐

e. Others ☐

11. How often do you refer GBV survivors/victims for trauma/psychological counselling? Please indicate

12. Is it possible for survivors/victims to receive counselling in this facility? A. □ Yes b. □ No

13. Do you refer to other service providers, police and courts? A. □ Yes b. □ No

14. Do you refer GBV survivors to NGOs, support groups) a. Yes ☐ b. No ☐

15. Do you follow-up on survivors once they have left the health facility? A. YES☐ b. NO ☐

16. Do you collect physical evidence from survivors/victims (e.g., clothing, footwear, hair, fibers, or debris, etc.)?
A. □ Yes b. □ No

17. Do you use a pre-packaged rape kit when conducting the exam? A. □ Yes b. □ No

18. If so, do you have a steady supply of the pre-packaged rape kits? A. □ Yes b. □ No

19. Where do the kits come from? A. Police ☐ B. Government ☐ C. Facility procures ☐

20. Do you get them from the police? A. □ Yes b. □ No

Protocols/clinical management guidelines

21. Do you keep records of patients who have been examined after GBV? A. □ Yes b. □ No

22. Where do you keep the files related to cases of sexual violence? A. Facility ☐ B. Police☐

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C. Court ☐

23. Who keeps the key to these areas? A. Facility ☐ B. Police☐ C. Court ☐

24. Are there specific forms that you use? A. □ Yes b. □ No

25. Does this facility have protocols/guidelines for the management of rape survivors?
A. □ Yes b. □ No

26. Who makes the decision when reporting a case of sexual violence to the police(Please tick as appropriate)
a. □health care providers
b. □Survivors/victims of the violence,
c. □Parent/guardian)
d. □ Others

27. What do you do if you have a suspicion that a parent or guardian is involved in the sexual abuse of a child? A. Report to the spouse □ B. Report to the police□. C, Ignore□

Cases of sexual violence

28. How many adult survivors/victims (18 years and older) were examined/treated after sexual violence during the last five months?

# of males: # of females:

29. Or, on average, how many adult survivors/victims do you see each month? # of males:# of females:

30. How many did you see in 2023?(Please indicate) # of males: # of females:

31. How many child survivors/victims (17 years and younger) were examined/treated after child sexual abuse in the last six months? # of males: # of females:

32. What were the ages of the child survivors:
<5
5-9
10-14
15 and >

33. Or, on average, how many child survivors/victims do you see each month? # of males:# of females:

34. How many child survivors of gender based violence did you see in 2023?(Please specify)
# of males: # of females:

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Training

35. Have you or anyone else at this facility received formal training on the management of sexual violence /GBV?
A. □ Yes b. □ No

36. If yes, ask: how many different trainings have you attended,?(Please indicate)

37.What kinds of things were covered in the trainings that you attended? Check all that applies.

☐ Medical treatment

☐ PEP

☐ Using an evidence collection kit

☐ Completing the medico-legal form

☐ Laws (covering rape and sexual offences)

☐ Referrals to other services

☐ Giving evidence in court

☐ Counselling

☐ Did your training include meeting the needs of male survivors/victims?

☐ Did the training include meeting the needs of child survivors/victims?

Attitudes

38. How does the staff know if a woman has experienced GBV? A. Interaction with victim□. B, Staff asks questions□. C. Suspicion□

39. Do you think it is important to treat survivors/victims of GBV as urgent? A. □ Yes b. □ No

40. Do you think GBV always leaves obvious signs of injuries? A. YES□ B. NO□

Multi-sectoral services

41. How would you describe the relationship between this health facility and the closest police station over GBV cases? A. Good□. B. Bad□. C. Decline to comment□

42. How would you describe the relationship between this health care facility and NGOs over GBV cases? A. Good□. B. Bad□. C. Decline to comment□

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Appendix 5: DANGER ASSESSMENT for Adolescents
Questionnaire 4: DANGER ASSESSMENT for Adolescents

DANGER ASSESSMENT-Revised
For Use in Abusive Relationships

Adapted Assessment tool for gender-based violence among adolescents in Ibadan

My name is Taiwo Olarinde. I am a Ph.D student of the Department of Public Health, Lead City University, Ibadan, Oyo State.

I am conducting a research to assess the burden and determinants of GBV in Ibadan, Oyo State, Nigeria.

This questionnaire is designed to obtain information on gender-based violence among adolescents in Ibadan city.

Kindly complete the consent form prior to completing this questionnaire. You have the right to pull out of the research at any time you wish.

Please note that the information provided in this questionnaire will solely be used for research purpose and will be treated with utmost confidentiality.

Thank you for consenting to respond to this questionnaire.

Section 1: Client's ID

Client's Identification No: .....

Client's date of birth: .....

Completed by: .....

Signature: .....

Date: .....

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Section 2: Socio-demographic variables

1. Age: (Please indicate as applicable)
   (a) 10-14 □ (b) 15-19□
2. Gender.
   a Sex: Male □ b. Female □
3. Relationship status (please tick as applicable):
   a. Never married □ b. Married □ c. Living together☐ d. Divorced☐
   e. Separated ☐ f. Widowed☐

4. Residence of respondent (please tick as applicable)
a. Rural □ b. Urban □
5. Number of years for which you have been married/been in the relationship (Please indicate if applicable)……..

6. Educational status of respondent
   a. No education□ b. Primary Education□ c. Secondary education□ d. First degree □ e.. Post graduate degree□
   7. Employment status of respondent

   a. Currently employed □ b. Not currently employed□ c.Not employed within the last 12 months □

   8. Occupation of respondent

   a. Professional/Technical/Managerial □ b. Clerical □ c. Sales and services □ d. Skilled Manual□

   e. Unskilled manual □ f. Agriculture/Farmer □ g. Apprentice □ h. Student □ I. Full-time house wife

9. Number of children alive (please indicate if applicable)……

Section 2: Information about respondent's spouse/intimate partner

10. Age of spouse/ intimate partner of respondent (please tick as applicable)

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(a) 10-14 □ (b) 15-19□ © 20-24□ (d) 25-29□ (e) 30-34□
(f) 35-39□
(g) 40-44□ (h) 45-49□ (I) 50 and above□

11. Gender

A. Male □ b. Female □

12. Educational status of respondent's spouse/intimate partner

c. No education□ b. Primary Education□ c. Secondary education□ d. First degree □ f. Post graduate degree□

13.Employment status of respondent's spouse/intimate partner

a. Currently employed □ b. Not currently employed□ c.Not employed within the last 12 months □

14. Occupation of respondent's spouse/intimate partner

a. Professional/Technical/Managerial □ b. Clerical □ c. Sales and services □ d. Skilled Manual□

e. Unskilled manual □ f. Agriculture/Farmer □ g. Apprentice □ h. Student □

i. Others (if others please specify……)

15. Do you know how much your spouse/partner earns? A. Yes □ b. No □

16. Does your spouse/partner consume alcohol? A. Yes □ b. No c. I don't know□

17. Does your spouse/ partner smoke? A. Yes □ b. No□ c. I don't know □

18. Does your spouse/partner consume hard drugs (e.g Indian hemp, cocaine, heroin, marijuana, tramadol, codeine). A. Yes□ b. No□ c. I don't know □

SECTION 3: Risk assessment in abusive relationships

Several risk factors have been associated with increased risk of re-assault of victims in abusive relationships.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones, miscarriage
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

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Mark **Yes** or **No** for each of the following. ("S/he" refers to your male/female partner or ex-partner)

Yes	No		
____	__	1.	Is s/he constantly jealous and/or possessive of you?
____	__	2.	Does s/he try to isolate you socially?
____	__	3.	Has the physical violence increased in severity or frequency over the past year?
____	__	4.	Has s/he threatened you with a gun over the past year?
____	__	5.	Have you lived with him/her in the past year?
____	____	6.	Has s/he ever abused or threatened to abuse a previous intimate partner, or their family members or friends?
7.			Does s/he use illegal drugs, (by illegal drugs, I mean "uppers" or amphetamines, "meth," speed,
____	_____		angel dust, cocaine, "crack," street drugs or mixtures) or abuse prescription medication?
____	__	8.	Is s/he an alcoholic or problem drinker?
____	__	9.	Does s/he try to control/limit your spirituality?
____	__	10.	Does s/he constantly blame you and/or put you down?
____	__	11.	Has s/he destroyed or threatened to destroy things that belong to you?
____	__	12.	Has s/he threatened to harm a:
____	__	.	12a Pet?
____	_____		12b Elderly family member?
____	_____		12c Person you care for with a disability?
____	__	13.	Has s/he ever violated a restraining order?
___		14.	Does s/he stalk you, for example, follow or spy on you, leave threatening notes or messages on answering machine or cell phone, call you when you do not want her to?
___		15.	If you were being abused by her and tried to get help, do you think people would **not** take you seriously?
___		16.	If you were being abused by him/her, would fear of reinforcing negative stereotypes about sexual relationships and/or being discriminated against prevent you from seeking help, for example help from friends, domestic violence advocates, or health care providers?
___	___	17.	If you were having serious difficulties with him/her, would you keep it a secret out of fear or shame?
___	___	18.	Have **you** threatened or tried to kill yourself?
Total "Yes" Answers			

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment-Revised means in terms of your situation.

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Weighted Score for DA-R

Yes to Item 1 = 4 points Yes to Item 2 = 3 points Yes to Item 3 = 2 points Yes to Item 4 = 2 points Yes to Item 5 = 2 points Yes to Item 6 = 2 points

Yes to Items 7-17 = 1 point each

Item 18 is not scored, assessing her suicide attempt

Section 4

Danger Assessment

Calendar scale

2023 Calendar

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the last year when you were abused by your partner or ex-partner.

Write on that date how bad the incident was according to the following scale:

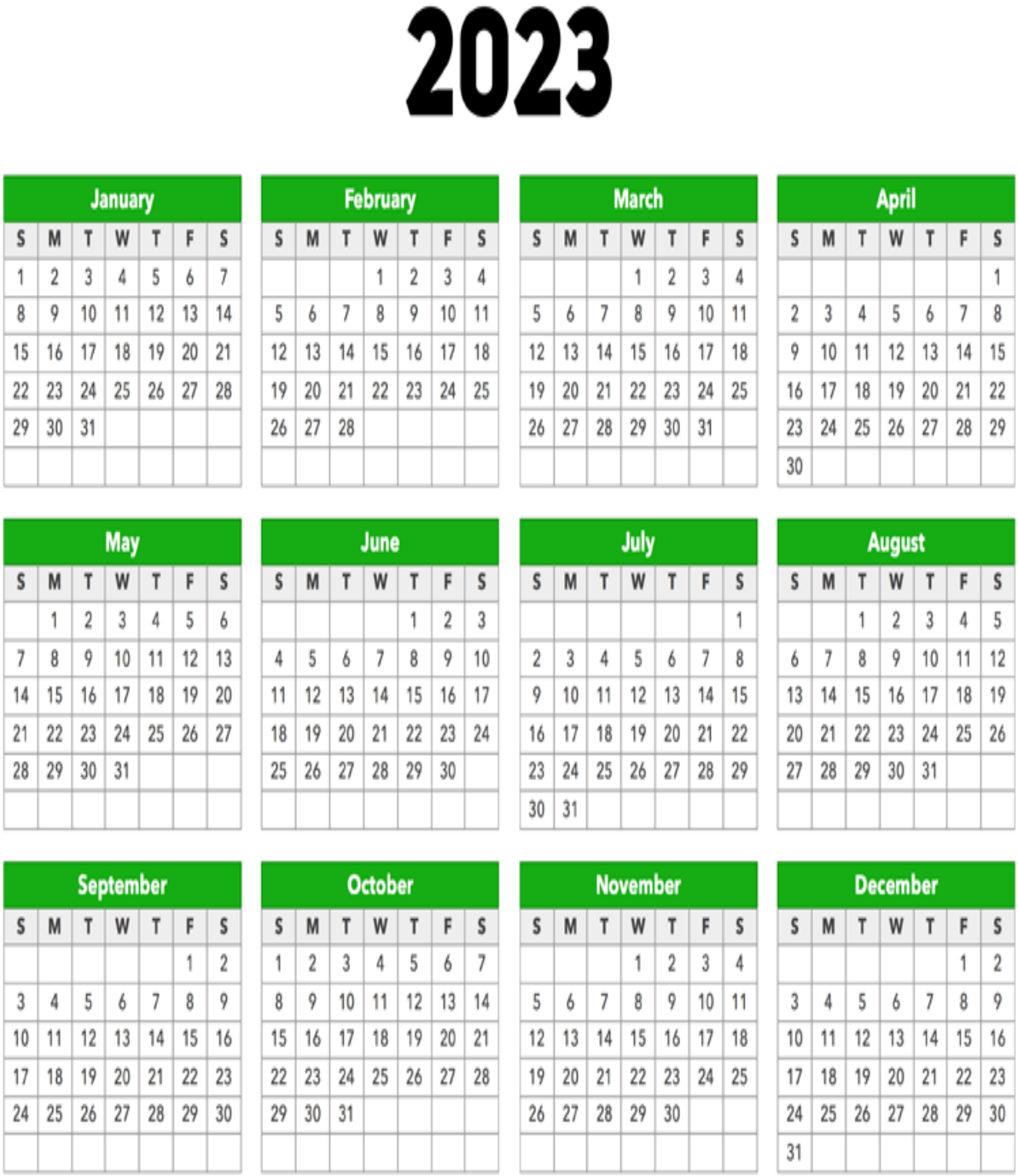
1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage, choking
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

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Appendix 6: 2023 Calendar

2023 Calendar



Appendix 7 Ethical Approval letters

MINISTRY OF EDUCATION
SCIENCE AND TECHNOLOGY
Ibadan, Oyo State, Nigeria
SECONDARY EDUCATION DEPARTMENT

Your Ref. No
All correspondence should be addressed to the Hon. Commissioner
Quoting
Our Ref. No. EDU1650T³VOLIII/97

Date 19th June, 2024

OLARINDE, TAIWO IYABODE,
Lead City University,
Ibadan,
Oyo State.

PERMISSION TO COLLECT DATA

I am directed to acknowledge the receipt of your letter on the above subject and inform you that the Honourable Commissioner has graciously approved your request to carry out research title "**Assessment of Gender-Based Violence in the city of Ibadan, Oyo State, South-West Nigeria**".

2. Please note that all data collected from the research should be used strictly for the same purpose and the findings be made available to the Ministry.

3. Thank you.

Akanji. O
For: Honourable Commissioner

Lead City University (LCU)

Motto: Knowledge for Self-reliance

Lagos - Ibadan Expressway, Toll Gate Area, Ibadan, Oyo State, Nigeria

Email: lcu.hrec@lcu.edu.ng

NHREC

University Research Ethics Committee

PROJECT TITTLE: **ASSESSMENT OF GENDER- BASED VIOLENCE IN THE CITY OF IBADAN, OYO STATE, SOUTHWEST NIGERIA**

PROJECT NUMBER: **LCU-REC/22/168.**

APPROVAL LETTER

The above named proposal has been adequately reviewed; the protocol and safety guidelines satisfy the conditions of *LCU-REC* policies regarding experiments that use human subjects.

Therefore, the study under its reviewed state is hereby approved by the LCU - Research Ethics Committee.

Prof. Olusola Ladokun .....

Name of LCU-REC Chairman *Signature of LCU-REC Chairman*

Dr. Folahanmi Akinsolu .....

Name of LCU-REC Secretary *Signature of LCU-REC Secretary*

This approval is given with the investigator's Declaration as stated below;

By signing below I agree/certify that:

1. I have reviewed this protocol submission in its entirety and that I am fully cognizant of, and in agreement with all submitted statements.

2. I will conduct this research study in strict accordance with all submitted statements except where a change may be necessary to eliminate apparent immediate hazard to a given research subject.
   - I will notify the REC promptly of any change in research procedures necessitated in the interest of the safety of a given research subject.
   - I will request and obtain REC approval of any proposed modification to the research protocol or informed consent document(s) prior to implementing such modifications.

TELEGRAMS.....

TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honorable Commissioner quoting

Our Ref. No. AD 13/479/ 44573[B]

2nd September, 2022

The Principal Investigator,
Department of Public Health,
Faculty of Basic Medical and Applied Sciences,
Lead City University,
Ibadan, Nigeria.

Attention: Olarinde Taiwo

ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Assessment of Gender-Based Violence in the City of Ibadan, Oyo State, Southwest Nigeria." has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

OYO STATE RESEARCH ETHICAL REVIEW COMMITTEE
Signature & Date
MINISTRY OF HEALTH

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State Research Ethics Review Committee

Bio-Data

A. Personal Data

Full Name	Taiwo Iyabode OLARINDE
Address	23B Dickson Omotosho Akinwole St, Alakia,Isebo
Mobile	234-8035505470
Email	tolarinde1@gmail.com
Date and Place of Birth	14th May 1978, Iseyin, Oyo State, Nigeria
Nationality	Nigerian
Next of Kin	Mr Olarinde Olaoye Samuel, 234-8037166400

B. Educational Background

School Attended	Date	Qualifications
• Omolayo Junior School First School Leaving Certificate Ibadan, Oyo State	1990	FSLC
• Basorun Ojoo High School,Ibadan	1990-1996	SSCE
• University of Ibadan, Nigeria	1996-2001	B.SC Human Nutrition
• University of Ibadan, Nigeria	2002-2008	Master in Public Health (MPH)

C. Work Experience

- State Program Manager and External Relations Focal Point
  Malaria Consortium
  Nigeria — July 2022-Date

- State Malaria Technical Lead
  US President's Malaria initiative for States
  Management Sciences for Health — Feb 2020- July 2022

- Ag State Malaria Elimination Program Manager
  Malaria Elimination Program
  Oyo State Ministry of Health — September 2017- Jan 2020

- State Coordinator
  Global Fund Malaria Programs
  Society for Family Health
  Oyo State — July 2009- September 2017

- Scientific Officer
  Food Water and Laboratory Services
  Oyo State Ministry of Health — January- June 2009

- Biology Instructor
  Teaching Service Commission
  Oyo State — November 2005- December 2008

- MPH Intern — May- July 2004

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Association for Reproductive and Family Health

Ikolaba, Ibadan

- National Youth Service Corp Member/State Athlete Dec 2001- December 2002
  River State Ministry of Health
  Port Harcourt

D. Professional Membership

- Fellow, African Institute of Public Health (FAIPH) Aug 2019-Date
- Member, Health Promotion and Education Alumni Association, Ibadan College of Medicine (HPEAAICM) 2008-Date

E. Publications

- Taiwo Olarinde, *Mass media influence on Adolescents' At-risk Practices in Egbeda LGA, Ibadan, Oyo State, Nigeria*
  A paper presented at the International HIV/AIDS Conference, 2010, Abuja, Nigeria.
- Taiwo Olarinde, *Rural-Urban differences in HIV/AIDs beliefs, knowledge and at-risk practices of Adolescents,* 2008, in Egbeda Local Government Area, Ibadan.
- Taiwo Olarinde, *Eating disorders among psychiatric patients* — A case study of the University College Hospital (UCH),2001, Ibadan.
- Taiwo Olarinde, Unlocking the potential of private sector health facilities in malaria control: Findings from a mapping study in Oyo State, south west Nigeria. An abstract accepted by the American Society of Tropical Medicine and Hygiene and presented at the 70th Annual Meeting, November 2021
- Taiwo Olarinde, Practical facility-level approaches to reduce malaria test positivity rates in Oyo State, Nigeria. An abstract submitted at the American Society of Tropical Medicine and Hygiene and presented at the 71st Annual Meeting, 2022
- Taiwo Olarinde, Oliver Ezechi, Folahanmi Akinsolu, Assessment of Gender-Based Violence in Ibadan, Oyo State, Southwest Nigeria. A paper accepted for presentation at the 2nd Lead City University Postgraduate Conference, October 2025
- Taiwo Olarinde, Oliver Ezechi, Folahanmi Akinsolu, Mofadeke Ajayi Prevalence, Patterns and Determinants of Gender-Based Violence: A Case study of Adult Males in Ibadan, Oyo State, Southwest Nigeria. A paper accepted for presentation at the 2nd Lead City University Postgraduate Conference, October 2025
- Taiwo Olarinde: Assessment of Gender Based Violence in Ibadan, Oyo State, South West Nigeria. A paper published in the IOSR journal of Health and Social Sciences, October 2024
- Adedapo Adeogun, Oladoyinbo A.O, Ladipo O.T, Olarinde T.I: Factors affecting willingness to use Indoor Residual Spraying among Pregnant women attending Ante-natal care in a hyperdemic State of West Africa. Journal of Medical Epidemiology, 2021

F. Major Conferences attended with Dates

- International HIV/AIDS Conference, 2010, Abuja, Nigeria
- American Society of Tropical Medicine and Hygiene, 70th Annual Meeting, November 2021
- 2nd Lead City University Postgraduate Conference, October 2025

G. References

- Dr Muideen .B Olatunji
  Executive Secretary
  Oyo State Primary Healthcare Board
  Oyo State
  Ibadan
  E.mail: tundeolatunji2002@yahoo.com
  Mobile: 08033521781

- Dr Chibuzo Oguoma
  Program Director (PF-SMC)
  Malaria Consortium
  Abuja
  Email:c.oguoma@malariaconsortium.org

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- Mr Olatunde Ogungbenro
  Territorial Manager, Society for Family Health, Ibadan
  E.mail: toogungbenro@yahoo.co.uk
  Mobile No: 08035769942

- Mrs Joke Ojo
  Finance and Admin Manager
  Management Sciences for Health
  Ibadan
  E.mail: jokeojo2@yahoo.com
  Mobile no: 08034756312

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Signature Date

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The University Compliance Certification

This is to certify that the Thesis by Taiwo Iyabode OLARINDE, with Matriculation Number LCU/PG/001675 in the Department of Public Health, Faculty of Basic Medical and Applied Sciences, Lead City University, Ibadan, is in full compliance with the University format and style of Thesis.

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Signature Date

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