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Research

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Gender-based violence in a rural Nigerian community during the COVID-19 era: a call for policy action

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Abstract

Introduction: *gender-based violence (GBV) is a global pandemic which is deeply rooted in culture, hence the need to contextually understand its occurrence and patterns in rural settings. The objective of this study assessed respondents´ attitude, prevalence, the perceived risk factors, patterns and predictors of GBV in Ife-Odan, Osun State, Nigeria.* ***Methods:*** *cross-sectional study design was used and multi-stage sampling method employed to recruit 450 consenting adults. A pretested interviewer-administered, semi-structured questionnaire was used for data collection. Both descriptive and inferential statistics were carried out.* ***Results:*** *mean age (±SD) of the respondents was 30.73±7.0, 58.7% of them were females and 88.0% had negative attitude to GBV. Prevalence of any form of GBV was 16.2%. Predominant GBV types included intimate partner violence (IPV) (58.3%), female genital mutilation (FGM) (31.1%), Sexual violence (6.9%) and incest (3.4%). Perceived risk factors of GBV included cultural acceptance, substance abuse, lack of punishments for GBV offenders, indecent female dressing styles, social media influences, effects of COVID-19 lockdown and male dominance. However, gender (AOR=7.82; 95%CI=2.35-8.17), marital status (AOR=3.23;95%CI=1.82-3.78), religion (AOR=5.02;95%CI=1.78-9.63) and attitude (AOR=4.23; 95%CI=2.267-5.82) were the significant predictors of past GBV experiences in the study setting.* ***Conclusion:*** *gender-based violence (GBV) is prevalent in the study setting, with IPV being the most common. There is need for policymakers to focus on cultural transformation by designing a robust awareness campaign against GBV in rural Nigerian communities. Traditional and religious leaders should be sensitized and involved in the campaign programs using all available channels of communication. Laws prohibiting perpetration of GBV need to be fully implemented.*

Introduction

Gender-based violence (GBV) is a global pandemic considered to be one of the most oppressive features of gender inequality [1]. It reinforces the existing gender imbalances between men and women, especially in developing countries [1]. Gender-based violence (GBV) equally violates the fundamental human rights of victims, posing a significant impediment to the realization of equal participation of women and men in social, economic, and political spheres [1]. Gender-based violence (GBV) refers to harmful acts directed at an individual based on their gender, which is rooted in gender inequality, the abuse of power and harmful norms [2]. Gender-based violence (GBV) is used interchangeably with "Violence Against Women (VAW)" which encompasses all acts of violence including rape, attempted rape, sexual assault, sexual abuse, sexual exploitation and harassments, spousal abuse and sex trafficking [3]. Thus, GBV can take many forms including physical, sexual, or psychological intimate partner violence (IPV), child marriage, sex trafficking, honour-killings, sex-selective abortion female genital mutilation (FGM), sexual harassment and abuse and digital violence such as cyberbullying [4].

The burden of GBV is huge globally, compromising the health, dignity, security and autonomy of its victims, yet most cases go unreported [5]. According to the WHO, over 736-852 million (roughly 1 in 3) women have experienced one form of GBV or another worldwide. An average of 31% of women globally are estimated to have experienced IPV and about 6% of them are subjected to non-partner violence [6]. The report also revealed that 16% of adolescents and young women experienced IPV in 2018 [6]. A 2020 meta-analyse in sub-Saharan Africa by Muluneh *et al*. revealed the pooled prevalence of IPV among women to be as high as 44%, with a one-year pooled prevalence estimated at 35.5% and non-IPV pooled prevalence at 14% [7]. Gender-based violence (GBV) has been estimated

to cost up to 3.7% of GDPs in some countries [1]. In Nigeria, the burden of GBV is also astronomical. Above a quarter (28%) of Nigerian women aged 15-49 years have experienced some forms of physical or sexual violence according to the Nigeria demographic and health survey (NDHS) in both 2008 and 2013. Painfully, this figure rose to 31% in 2018 [8]. The prevalence of FGM was as high as 20% while 19% of Nigerian girls were married by age 15 years, and 43% of them by age 18 years [8].

In trying to stem the tides of GBV, the Nigerian government has taken some proactive measures. One of such measures was the enactment of the Violence Against Persons Prohibition (VAPP) Act in 2015 [9]. The Act has the central goal of eradicating all forms of violence in both private and public realms, and to provide helps for victims of GBV. Nigeria is also a signatory to the Convention on the Elimination of All forms of Discriminations Against Women (CEDAW) and the Beijing Platform of Action against gender inequality [10,11]. Nigerian has also signed into law the Child Right Act (CRA) which prohibits any form of harmful practices against Nigerian children and discourages child marriage in the strongest term [12]. In spite of these actions of the Nigerian government, the burden of GBV is still humongous and only 15 out of 36 states had adopted the VAPP act as of 2021.

Meanwhile, recent evidences show that the prevalence of GBV has risen significantly since the onset of COVID-19 pandemic in 2020. A UNFPA data showed a sharp increase in GBV reported cases between March and April 2020 in Nigeria. Most cases of GBV were reported in south-Western Nigeria. In the region, the number of cases jumped from 91 in March to 296 in April 2020 [13]. In Osun State, where the current study was conducted, the number of GBV cases also increased exponentially during the period. Yet, no study has been conducted in rural areas of Osun State to understand the true burden and the associated factors of GBV post-COVID-19 lockdown. Continued perpetration of GBV poses a formidable threat to the actualization of the Sustainable Development Goals (SDGs) 5 and 3 in Nigeria. It thus becomes imperative to contextually analyse GBV experiences in rural Nigeria since most rural communities have distinct socio-cultural attributes which could negatively impact on GBV perpetration when compared to urban areas where most past studies have been conducted [14,15]. This study generates comprehensive, evidence-based information to bridge the existing gap in knowledge regarding GBV in rural Nigeria. Study objectives were to assess attitude towards, perceived risk factors, prevalence, patterns and determinants of GBV in a rural Nigerian Community. The information can be used by policymakers, to formulate and implement cost-effective interventions to reduce the burden of GBV in Nigeria in the COVID-19 era.

Methods

Study design: this study utilized cross-sectional study design.

Study setting: the study was carried out in Ife-Odan, a community located in Ejigbo Local Government Area (LGA), Osun state, Nigeria, with a projected population of about 3,000 inhabitants [16]. The predominant religions of the Ife-Odan inhabitants are Christianity, Islam and Traditional religions. The main tribe is Yoruba ethnic group and the majority of the people are peasant farmers, petty traders and artisans.

Study population: the study population was adult males and females who were residents of Ife-Odan community of Osun State and gave their consent.

Inclusion and exclusion criteria

Inclusion criteria: all consenting adults who were permanent resident of Ife-Odan community were included in the study.

Exclusion criteria: all potential respondents who had not resided in the community for at least 6-months or were adjudged to have illnesses (such as mental issues) which may prevent them

from giving valid responses to our questions were excluded from the study.

Sampling approach: a multistage sampling technique was applied in this study. In the first stage, Ejigbo LGA was selected amongst the 30 LGAs in Osun State using the simple random sampling method (by balloting). Secondly, Ife-Odan was selected from the list of 10 electoral wards/EAs in Ejigbo LGA through balloting. In the next stage, three out of the six main streets in Ife-Odan were chosen to use simple random sampling technique (balloting). A systematic random sampling method was then used to recruit households into the study from the chosen streets. The sampling interval was calculated by dividing our estimated sample size by the number of households on each of the selected streets. The first household was selected by spinning a bottle at the middle of the street. Subsequently, every n^{th} household was selected until the houses on the street were exhausted. Using our stated inclusion/exclusion criteria, eligible respondents were chosen from selected households. In households with more than one eligible respondent (e.g. both husband and wife present), one was chosen to use a simple random method (balloting).

Sample size determination: the minimum sample size for the study was calculated using the Leslie Kish formula for a population with less than 10,000 inhabitants. Standard normal deviate of 95% (1.96) was used and the tolerable margin of error was set at 5%. Based on reports from 2018 NDHS [7], 36% of our respondents were assumed to have experienced one form of GBV or another before our survey. A 10% non-response rate was envisaged and corrected. Appropriate adjustment was made to account for the small population size of the study setting. Also, possible cluster effect was corrected for, by multiplying the estimated sample size by 1.2. Thus, the minimum sample size estimated for the study was 442, but a total of 450 people participated in the study.

Pretesting: the questionnaire was pretested in Oke Moro, Ejigbo, Osun state, a community which was different from the ones used for the main study. Fifty respondents were selected for this exercise using a convenience sampling method. The exercise assisted us to assess the internal validity of our instrument. It also helped us to know if the questions on the questionnaire were good enough to elicit the desired responses from our respondents. Ambiguous questions were either rephrased or removed entirely in line with our study objectives.

Data collection process: the tool for data collection was an interviewer-administered, semi-structured questionnaire, which was developed after reviewing extant literatures. The questionnaire had four sections which sought information on socio-demographic characteristics of respondents, pattern of gender-based violence in the community, perceived risk factors of GBV, attitude of respondents towards GBV and respondents´ experiences of GBV in the community. The questionnaire was translated to Yoruba language for our respondents who preferred communicating in their local language. Back translation into English language was carried out to preserve the original meanings of the questions asked. Data collection was carried out by a group of 14 final year medical students of Bowen University, Iwo, who were on their rural posting and were appropriately trained on questionnaire administration to people with no or little educational exposures. They were supervised by the principal investigator to ensure data accuracy and completeness.

Data analyses: each completed questionnaire was edited daily on the field before entering into Statistical Package for the Social Sciences (SPSS) version 20 for analysis. Both descriptive and inferential statistics were carried out. Chi-Squared Test was used to compare the relationships between categorical variables. Stepwise binary logistic regression was built at the multivariate level. Variables imputed into the model were selected based on whether they were significant at

the bi-variate level or had been reported as significant predictors in past studies. To identify significant determinants of GBV occurrence in the study setting, 95% Confidence Intervals (CIs) were obtained and Adjusted Odds Ratio estimated at $p<0.05$. Attitude of respondents towards GBV was assessed by asking 10 positively-phrased questions on a 5-point Likert´s scale, ranging from Strongly agree (5 points) to Strongly Disagree (1 point). The maximum obtainable point was 50. Respondents who scored less than 30 points were categorized as having positive attitude (approved of GBV) while those who scored at least 30 points were classified as having negative attitude.

Ethical consideration: approval to conduct the study was obtained from the Ethical Review Board of Bowen University Teaching Hospital Ethical Review Board. Written informed consents were obtained from each study participants after the study objectives had been clearly explained to them. Participation was entirely voluntary, and respondents were allowed to opt any stage they were no longer comfortable with the interview. Confidentiality of the information from each respondent was assured by making the questionnaire anonymous, using codes rather than personal identifiers. Data were also saved in computers which were only assessable to the principal investigator. Victims of GBV encountered on the filed were counselled and referred to the nearest healthcare facilities for better evaluation and managements.

Results

Participants: a total of 450 of the administered 470 questionnaires were returned satisfactorily completed (96.0% response rate). As shown in Table 1, mean age (±SD) of the respondents was 30.73±7.0. More than a quarter (34.2%) of the respondents were 20-29 years old, while 58.7% of them were females. Most (62.0%) of the respondents were Christians, and above average (59.6%) of them attained secondary education. Almost all (99.6%) of the respondents were of Yoruba ethnic group and 56.6% of them were married. While 66.4% of the respondents belonged to a monogamous family setting, almost three-quarter (73.6%) of them earned less than the national minimum wage of 30,000.00 Naira monthly.

Attitude of respondents to GBV: as almost all the respondents had heard about GBV, Table 2 revealed that 52.7% of them strongly agreed that men are socially superior to women and have the right to assert power over them. However, 43.1% of the respondents strongly disapproved of early girl child marriage. Not less than 15.8% of the respondents strongly agreed that FGM should continue because it prevents promiscuity in girls. Almost half (47%) of the respondents strongly agreed that women should be blamed for the rise of sexual violence like rape and incest in Nigeria because of their indecent dressing. Overall, majority (88.0%) of the respondents had negative attitude to GBV.

Prevalence, pattern and risk factors of GBV in the study setting: Table 3 shows that 16.2% of the study participants had experienced one form of GBV or another prior to the survey. Most common type of GBV ever experienced by our study participants was IPV; reported by 58.3% of them. However, not less than 31.1% of the respondents had experienced FGM, 6.9% were victims of sexual violence while 3.4% of them were victims of incest (Figure 1). Almost a quarter (24.0%) of GBV victims experienced IPV within a month prior to the survey. Figure 2 revealed the most important risk factors of GBV perceived by study participants. They included cultural acceptance (29.1%), substance abuse (94.2%), lack of punishments of GBV offenders (89.5%), indecent female dressing pattern (84.1%), effects of social media (80.4%), effects of COVID-19 Lockdown (62.6%) and male dominance (66.4%).

Predictors of GBV experiences by the respondents: from Table 3, the proportion (20.4%) of the respondents who had experienced GBV was significantly higher among those aged 30-39 years

compared with people in other age categories (p=0.043). Also, females constituted a significantly higher proportion (20.6%) of those who have been victims of GBV compared to men (p=0.003). Respondents who were traditional worshipers had a significantly higher proportion (45.5%) of those who had experienced GBV in the study population (p=0.029). Additionally, separated persons had a significantly higher proportion (75.0%) of GBV victims in the study setting (p=0.001). Respondents who approved of GBV (had positive attitude) constituted significantly higher percentage (26.4%) of GBV victims among our study participants (p=0.034). After controlling for possible effects of confounders at the multivariate level, gender, religion, marital status and attitude remain significant determinants of GBV perpetration in the study setting. Women were eight times more likely to have experienced GBV when compared to men (AOR=7.820; 95%CI=2.345-8.167). Similarly, traditional religionist were 5 times more likely to have experienced GBV compared to other religion practitioners (AOR=5.021; 95%CI= 1.781-9.630). Separated couples were three times more likely to have experiences GBV compared to those with different marital statuses (AOR=3.23, 95% CI=1.820-3.781). Also, those who had positive attitude to GBV had significantly higher odds of GBV experiences when compared to those who disapproved of it (AOR=4.23; 95%CI=2.267-5.817) (Table 4).

Discussion

The current study examined attitude, patterns, prevalence, perceived risks and determinants of GBV in a rural Nigerian community. More than half of the respondent were of the opinion that men are socially superior to women and have the right to assert power over them. This is in line with reports by the World Bank in 2019 in which males were clearly perceived as the superior sex and some respondents used religious and cultural arguments to justify the man´s superiority and woman´s subservience [1]. Studies have shown that patriarchal family system, male dominance and gender stereotype are major reasons for GBV perpetration in many cultures [17,18]. For GBV burden to be lessened, this gender norm has to be transformed to ensure equity in power-sharing between males and females in the community. Some of the respondents in the current study strongly approved of FGM. A 2017 study by Abathun *et al*. in Eastern Ethiopia, revealed an 18% approval rate for FGM [19]. Another study conducted by Ankita *et al*. in both Nigeria and Kenya revealed majority disapproval of FGM with some study participants justifying continued practice as a means of curbing premarital sex in girls, which was also stated as one of the main FGM justification in the current study [20]. Hence, the fights against the dehumanizing FGM have to be intensified in rural Nigerian communities.

Less than half of the respondents in the current study strongly approved of child marriage, although almost all of them declined actual practice. Authors recommend a qualitative study to fully understand the current socio-cultural issues surrounding child marriage practices in South West Nigeria. Almost half of the respondents strongly agreed that women should be blamed for the rise of sexual violence like rape and incest in Nigeria because of their indecent dressing. This is in consonance with findings from a similar study by Akinade *et al*. in which indecent dressing of females was considered a risk factor for sexual violence [21]. However, sexual violence is a criminal act which must be condemned by all. Risk factors of GBV perceived by our respondents included cultural acceptance, substance abuse, lack of punishments for GBV offenders, indecent female dressing style, effects of social media, effects of COVID-19 lockdown and male dominance. Past studies have established strong linkage between substance abuse and perpetrations of selected GBV such as IPV and sexual abuse [22,23]. Thus, efforts at eradicating substance abuse by relevant agencies should be intensified to reduce the burden of IPV in Nigeria. Most of our respondents associated increased

GBV cases to effects of COVID-19 lockdown. This perception is supported by a UNFPA report on Nigeria, in which there was a 56% increase in the reported cases of GBV in Nigeria during the lockdown [13]. The lockdown could have increased the time periods in which spouses in abusive relationships cohabited, thereby increasing the chances of GBV occurrence.

The prevalence of GBV as revealed by the current study was 16.2%. This is in tandem with a similar study by Bhattacharjee et al. among Kenyan adults, in which the prevalence of lifetime experience of GBV was 18% [24]. Again, Shanko *et al*. in a study conducted in Ethiopia, revealed that about 19.6% of respondents had experienced IPV [25]. However, some studies have reported higher prevalence of sexual violence. According to the 2018 DHS reports for Nigeria, almost one in three (31%) women aged 15-49 had ever experienced physical violence, and 14% experienced physical violence within 12 months preceding the survey [8]. This discrepancy in figures could be due to the fact that NDHS was a national survey involving persons with different socio-cultural characteristics. Also, women were the only respondents in the DHS reports, but our study involved men with generally lower risks of being victims of GBV, possibly explaining the lower prevalence of sexual violence in the current study. Females were more likely to be victims of GBV compared to men in the current study. This is not an unusual finding, as several past studies have documented women as victims in most cases of GBV [5]. In many developing countries such as Nigeria, women are mostly weak and vulnerable in many respects. They often lack economic and educational powers to report abusive tendencies and actual perpetrations by their spouses. Moreover, culture in most rural Nigerian communities empowers men to exert dominance on women, who are mostly dependent on them for sustenance [26]. Women are usually not involved in decision-making regarding household wealth and are therefore prone to financial deprivation to further worsen the existing gender gap between them and their spouses. Hence, most women endure abusive relationships as a result of low economic powers and cultural acceptance of GBV [27]. Governments need to be more intentional at empowering Nigerian women both educationally and economically through social safety nets for those in the lower socio-economic ladder.

Respondents who were traditional worshipers had significantly higher odds of GBV experiences in the study population. This finding is not in disagreement with reports from other studies where religion has been reported as a strong predictor of GBV perpetration [28,29]. Traditional religion as reported in the current study is often associated with age-long traditions, beliefs and practices which may foster perpetration of many of the GBV. For instance, FGM is culturally allowed among traditional religionists in some communities in South-west Nigeria. Osun state where this study was conducted is adjudged to have one of the highest prevalence of FGM in Nigeria and many inhabitants of Ife-Odan community embrace tradition norms which may foster FGM practices [30]. Additionally, separated couples were more likely to have experienced GBV in the study setting. This finding is corroborated by reports from a study by Oladepo et al., in Ibadan, in which separated and divorced women were more likely to have experienced GBV [31]. The cause of the marital separation and divorce may have been due to IPV in the first place. Respondents who approved of GBV (had positive attitude) had significantly higher odds of GBV experiences. This might be due to the fact that violence is an acceptable means of settling spousal misunderstanding in some rural Nigerian communities and because spousal abuses are generally regarded as family matters, allowed by tradition in such communities [27].

In curbing the menace of GBV in Nigeria, authors recommend full implementation of the VAPP act. Also, there is urgent need to upscale the campaigns against continued perpetration of GBV, particularly in rural Nigeria. Such campaigns

should be made in local languages for easy understanding of the people, using the different media of communication. It should involve the main stakeholders in the communities, such as religious and community leaders. Moreover, there is need to increase the number of states and organizations providing 24-hour toll-free helplines for the care of GBV victims in Nigeria. Cybersecurity should be put in place to reduce exposures of young persons to age-inappropriate sexual contents. The Federal Ministry of Health should design cost-effective strategies to ensure that GBV victims (especially victims of IPV and sexual violence) receive prompt and immediate medical care. Above all, GBV victims are encouraged to speak up.

Study limitation :our study may not be totally free from self-reporting bias, in which fear of stigma and shame may have prevented our study participants from giving us their real-time GBV experiences. The fact that study objectives were clearly explained and confidentiality of given information was assured would have minimized this bias.

Conclusion

The burden of GBV is enormous in the study population, although respondents´ attitude was largely negative towards continued practices. IPV, FGM and sexual violence were the most predominant GBV types in the study setting. Thus, there is urgent need for more proactive measures to curtail this public health menace in order to meet the targets of SDGs 5 by 2030.

What is known about this topic

- *Gender-based violence is one of the most prevalent human rights violations globally;*
- *In spite of the interventions by national and international health agencies, the burden of GBV remains high in Nigeria.*

What this study adds

- *The current study provides information on pattern, burden and determining factors of GBV in rural Nigerian communities, post COVID-19 lockdown;*
- *This study also provides baseline data to inform policy formulation to curtail the high GBV prevalence in rural Nigerian communities.*

Competing interests

The authors declare no competing interests.

Authors' contributions

All the authors participated in proposal development but Ajibola Idowu conceived the idea. Olanrewaju Ismat Obisesan supervised the data collection process. All authors reviewed and approved the final version of the manuscript.

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Tables and figures

Table 1: socio-demographic characteristics of the respondents

Table 2: attitude of respondents to gender-based violence

Table 3: factors associated with experience of GBV among the respondents

Table 4: predictors of GBV perpetration in the study setting

Figure 1: types of GBV ever experienced by study participants

Figure 2: perceived risk factors of GBV amongst the respondents (multiple responses allowed)

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Table 1: socio-demographic characteristics of the respondents		
Variable	**Frequency N=450**	**Percent (%)**
Age (years)		
15-19	106	23.9
20-29	158	35.1
30-39	93	20.9
40-49	55	12.4
≥50	38	7.7
Mean age (SD)	30.73±7.0	
Religion		
Christianity	279	62.0
Islam	160	35.6
Traditional	11	2.4
Educational Level		
Nil formal education	22	4.9
Primary	72	16.0
Secondary	268	59.6
Tertiary	88	19.6
Marital status		
Single	190	42.3
Married	245	54.6
Divorced	2	0.4
Separated	4	0.9
Widowed	8	1.8
Family type		
Monogamous	292	66.4
Polygamous	148	33.6
Family monthly income naira		
≤30,000.00	284	73.6
30,000.00-100,000.00	84	21.8
≥100,000.00	18	4.7

Table 2: attitude of respondents to gender-based violence					
Variable	**SA Frequency (%)**	**A Frequency (%)**	**I Frequency (%)**	**D Frequency (%)**	**SD Frequency (%)**
Men are socially superior to women and have right to assert power over them	237(52.7)	101(22.4)	14(3.1)	42(9.3)	56(12.4)
A man has the right to correct or discipline a woman's behaviour if he considers it disrespectful or childish.	99(22.0)	96(21.3)	4(0.9)	112(24.9)	139(30.9)
Cutting of female genital parts should continue because it prevents promiscuity in girls	71(15.8)	50(11.1)	32(7.1)	140(31.1)	157(34.9)
Women should be blamed for the rise of sexual violence like rape and incest in Nigeria because of their indecent dressing and lack of submission/respect for men	211(47.0)	104(23.2)	8(1.8)	61(13.6)	65(14.5)
Violence is an acceptable means of settling disputes among partners in this community	15(3.3)	17(3.8)	10(2.2)	234(52.0)	174(38.7)
Every case of GBV should be reported to the law enforcement agents	44(9.8)	76(16.9)	16(3.6)	127(28.2)	187(41.6)
Sexual offenders should be punished by law	16(3.6)	16(3.6)	6(1.3)	124(27.6)	287(63.9)
In certain instances, it is culturally acceptable for men to have sexual relationships with their beautiful daughters/sisters	13(2.9)	18(4.0)	5(1.1)	106(23.6)	307(68.4)
Overall attitude	Frequency	Percent			
Positive	54	12.0			
Negative	396	88.0			
*SA=strongly agree, A=agree, I=indifference, D=disagree, SD=strongly disagree					

Table 3: factors associated with experience of GBV among the respondents					
Variable	**Ever experienced GBV**		**Total**	χ^2	**p-value**
	Yes N=72 (16.0%)	No N=378(84.0%)			
Age (years)					
15-19	7(6.7)	98(93.30	105		
20-29	30(19.9)	121(80.1)	151	9.869	0.043*
30-39	19(20.4)	74(79.6)	93		
40-49	10(18.2)	45(81.8)	55		
≥50	6(15.8)	32(84.2)	38		
Gender					
Male	19(10.20	167(89.8)	186	8.619	0.003*
Female	54(20.6)	208(79.4)	262		
Religion					
Christianity	44(15.8)	234(84.2)	278	7.070	0.029*
Islam	24(15.1)	135(84.9)	159		
Traditional	5(45.5)	6(54.5)	11		
Marital status					
Single	18(9.5%)	171(90.5)	189		
Married	46(18.9)	198(81.1)	244	31.760	<0.001*
Divorced	1(50.0)	1(50.0)	2		
Separated	3(75.0)	1(25.0)	4		
Widowed	5(62.5)	3(37.5)	8		
Family type					
Monogamous	49(16.8)	242(83.2)	291	0.101	0.751
Polygamous	23(15.6)	124(84.4)	147		
Family monthly income(Naira)					
≤30,000.00	44(15.5)	239(84.5)	283		
31,000.00-100,000.00	24(28.6)	60(71.4)	84	9.432	0.009
>100,000.00	1(5.6)	17(94.4)	18		
Attitude to GBV					
Positive	14(26.4)	39(73.6)	53	4.514	0.034*
Negative	59(14.9)	336(85.1)	395		
*Significant at p<0.05 GBV=Gender-based violence					

Table 4: predictors of GBV perpetration in the study setting				
Variable	**B-coefficient**	**p-value**	**AOR**	**95%CI**
Age 30-39 (RC) others	-0.98	0.056	2.345	0.670-3.91
Sex male (RC) female	2.568	0.001*	7.820	2.345-8.167
Religion traditional (RC) others	1.034	0.026*	5.021	1.781-9.630
Marital status separated (RC) others	3.678	0.031*	3.23	1.820-3.781
Attitude to GBV positive negative (RC)	1.561	0.0342*	4.23	2.267-5.817
*Statistically significant at p<5%, RC=reference category, AOR=adjusted Oodds ratio, CI=confidence interval, GBV=gender based violence				

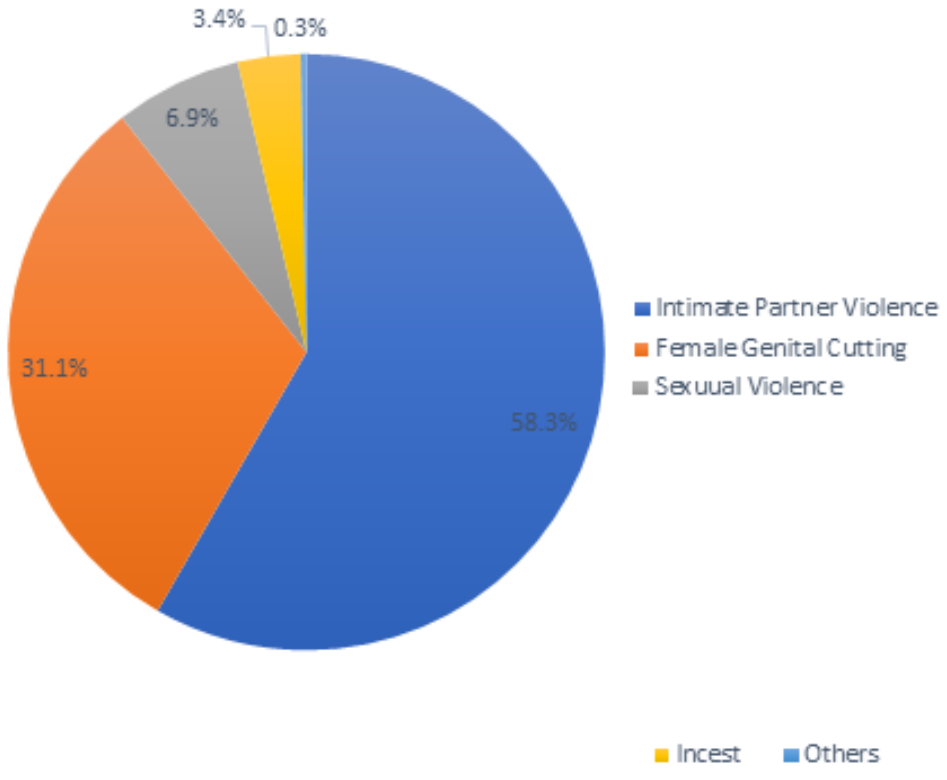

Figure 1: types of GBV ever experienced by study participants

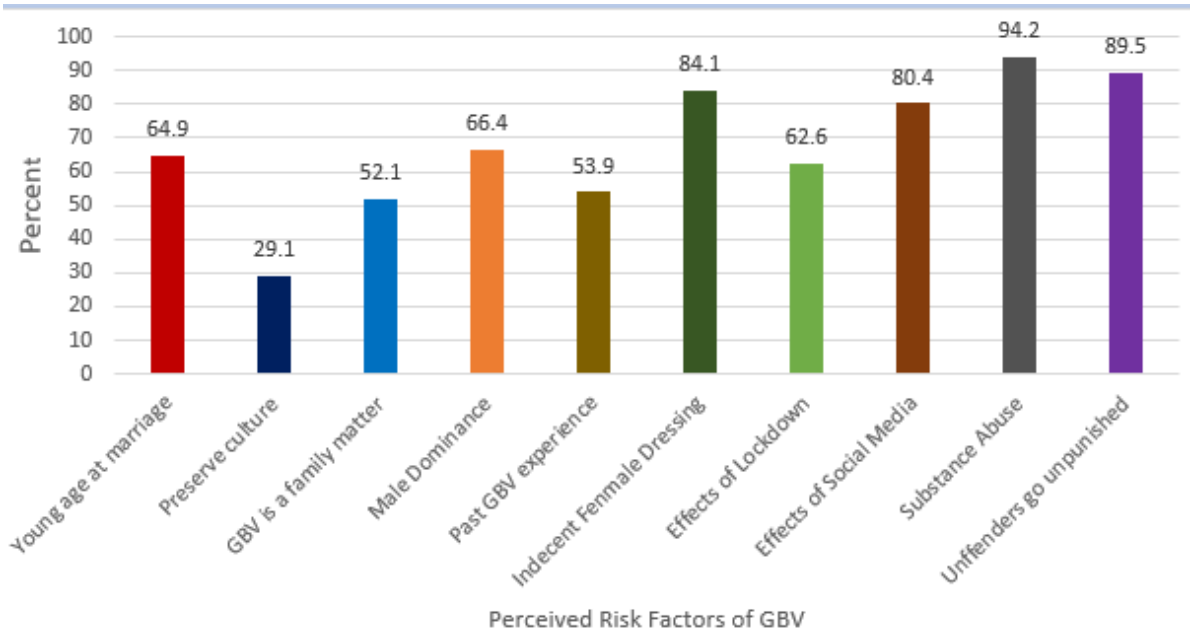

Figure 2: perceived risk factors of GBV amongst the respondents (multiple responses allowed)