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Research Article

Knowledge and Perceptions of Marital Rape among Women in Oyo State, Nigeria

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ABSTRACT

Marital rape is a serious public health problem affecting many women worldwide. In Nigeria, there is dearth of evidence-based information on issues relating to knowledge and perceptions of marital rape among women. This study was therefore designed to assess the knowledge and perceptions about marital rape among married women in Oyo State, Nigeria. The cross-sectional survey was conducted among 1200 women aged 18-60 years who were ever-married. Participants were recruited using a multi-stage random sampling technique. A validated semi-structured questionnaire which contained a-8 point knowledge of health consequences of marital rape and a-20 point marital rape perception scales was used for data collection. Data were analyzed using descriptive statistics and Chi-square test. Respondents' mean age was 36.6 ± 9.6 years, while their husbands' mean age was 42.1 ± 10.3 years. Mean knowledge score was 3.9±2.2 and 23.4% had poor knowledge of marital rape. Respondents who had poor knowledge who were aged ≤24 years, 25–49 years and ≥50 years were 31.6%, 25.3% and 9.6%, respectively (P≤0.05). Mean perception score was 8.9 ± 3.6, and 69.8% had supportive perceptions relating to marital rape. A higher proportion of respondents with marriage duration of >20 years (84.6%) had marital rape supportive perception compared with those with marriage duration of 0-10 years (64.9%) (P≤0.05). Knowledge of marital rape remains inadequate, especially among younger women. Furthermore, many women had supportive perceptions for marital rape, a situation which can adversely hinder adopting appropriate preventive behaviours. Multiple community-based health educational interventions have potentials for addressing the phenomenon.

Keywords: *Marital rape, Marital rape-related knowledge, Marital rape perception, Married women*

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INTRODUCTION

Violence against women is widespread public health as well as a fundamental violation of women's human rights (WHO, 2013). Globally, one-fifth of all women have experienced rape and other forms of violent behaviours or assaults (Garcia-Moreno et al, 2011). According to a World Health Organization (WHO) report, the global prevalence of physical and sexual intimate partner violence among all ever-partnered women was 30.0%, while the prevalence for Africa region alone was put at 36.6% (WHO, 2013). Rape is one of the most brutalising and traumatic forms of violent acts that can be experienced by women of various categories and status (Akinlusi et al, 2014).

Rape is the act of forcing another person to engage in sex against his or her wish through violence, threats, verbal insistence, deception and other various manipulative means (Heise et al, 1995). Researches have shown that the majority of rape cases against women are perpetrated by men known to the victims, who are either husbands, intimate partners or acquaintances (Center for Law Enforcement Education in Nigeria, 2014; Ogunwale et al, 2012; Shaahu etal, 2004).

Marital rape which is also known as spousal rape is a form of rape perpetrated against a spouse by the husband or spouse. It occurs when one spouse forces the other to take part in certain sexual acts without the other's consent. It can be succinctly described as unwanted sexual intercourse carried out by a spouse with the use of force, threat or any other coercive means (Ambekar, 2009; Bergen, 2006; Monisola et al, 2013). It is a form of intimate partner violence where one spouse attempts to establish dominance and control over the other (Obidimma et al, 2015). It has been reported that marital rape had received relatively less attention in research, law

reform efforts and enforcements (Ashiru et al, 2015). Only recently, marital rape became dully recognised as criminal behaviour in Nigeria under the Violence Against Person Prohibition (VAPP) Act which came into being in 2015. Several authors such as Monisola et al (2013), Emeka et al (2015) and Ashiru et al (2015) have argued that the legal provisions on rape in Criminal and Penal Codes in Nigeria have not adequately captured marital rape.

Some studies on marital rape such as Uwaoma et al (2011) and Ashimolowo et al (2012) carried out in Nigeria, have noted that married women often experienced rape in the hands of their husbands. Marital rape poses serious health consequences to the health of women in the form of physical and vagina injuries, sexually transmitted infections, gynaecological complications and psycho-social consequences (Bergen, 2006; WHO, 2010). Experience of marital rape during pregnancy can be associated with several adverse pregnancy events- such as the risk of low birth infant, preterm delivery and neonatal death (Asling-Monemi et al, 2008; Bergen, 2006; Covington et al, 2001; Ntaganira et al, 2009).

Despite the reality of marital rape and some evidence-based data that corroborate it, many people in Nigeria are still cynical about the existence of rape in an intimate relationship. Marital rape is mostly under-recognised due to tacit cultural normalisation of sexual coercion in intimate relationships. A lot of women including most survivors of marital rape may not view forced sex from partners as a crime or problem that demand attention (Kung'u, 2011) and could consider the phenomenon as a private matter (Bennice et al, 2003).

Anecdotal observations have shown that several women in Nigeria have several misconceptions about marital rape as well as perceptions that support or encourage marital rape. Additionally, it has been observed that there is lack of adequate knowledge of marital rape-related issues. Misconceptions and ignorance about marital rape issues can hinder women's disclosure or reporting of marital rape experiences to appropriate health authorities as well as serve as a disincentive towards the adoption of appropriate prevention and control measures. There is need for evidence-based data on women's knowledge of health burden of marital rape and perceptions of women relating to marital rape that could serve as useful baseline data for designing and implementing appropriate interventions that are useful in the prevention and control of marital rape. This explains why this study was designed to assess the knowledge and perceptions relating to marital rape among married women in Oyo State, Nigeria.

MATERIALS AND METHODS

The Study Design: The study was a descriptive cross-sectional survey. It investigated knowledge and perceptions relating to marital rape among married women in Oyo State, Nigeria.

The Study Population and Setting: Population for this study comprised all women who were married or were previously married in Oyo State, Nigeria. Oyo State is the fifth most populated State in Nigeria and the second most populated in the South West geopolitical zone (National Bureau of Statistics [NBS], 2012). Based on the Nigerian National Population Commission (NPC) census of 2006, Oyo State population for 2017 was projected at 7,594, 147 with female population constituting 49.9% (3,789,479) (NPC, 2006; 2013). The NPC projection for 2017 revealed that there were 1,623,440 that were ever married in Oyo State (NPC, 2006; 2013). The study was conducted between August – October 2017.

Sample size and Sampling procedure: The sample for the study was calculated to be 1,200 using sample size formula for a single cross-sectional survey recommended by Pourhoseingholi et al (2013). The respondents were recruited using multi-stage sampling technique involving five stages. The first stage involved the selection of two LGAs from each of the three senatorial districts in the State using simple random sampling method of balloting. This resulted into the selection of the six LGAs, namely: Akinyele, Oyo West, Ogbomoso South, Ogbomoso North, Ibadan North, Ibadan North East LGAs. The total sample size of 1200 was distributed proportionately among the six LGAs. The second stage was the selection of five wards from each of the six selected LGAs that were involved in the study. Altogether a total of 30 wards selected through balloting were used in the study. In the third stage four communities were selected from the lists of communities in each of the 30 wards visited through the balloting procedure. In total, 120 communities were selected to be involved in the study. The lists of the communities were obtained from 2015 Independent National Electoral Commission records. The fourth stage involved the selection of 10 houses/compounds where women who were ever married lived from each of the communities using systematic random sampling. This yielded a total of 1,200 houses selected from all the communities involved in the study. Systematic random sampling was used in selecting appropriate number of houses or compounds based on the total number of houses in a community. The list of houses compiled by National Population Census was used as the sampling frame. In case where such information was not available, enumeration of number of compounds/houses in a sub-area/street was carried out to have a provisional sampling frame. Recruitment of the eligible women from the 1200 houses visited constituted the fifth stage of the sampling process. Only one respondent was interviewed per house in order to ensure confidentiality of the information provided by the respondents. However, where two or more eligible women were met in a selected house, balloting was used to pick one of them for interview.

Instrument for Data Collection: A validated researcher-designed semi-structured questionnaire was used to facilitate the process of data collection for the study. The questionnaire was used to capture information about the respondents' socio-demographic characteristics, awareness of marital rape as well as 8-point knowledge of health consequences of marital rape and 20-point perceptions relating to marital rape scale.

Data Collection Procedure: The administration of the questionnaires was achieved through the help of 12 trained

female research assistants. All the research assistants were married women who were graduates with previous experience in the conduct of gender-based violence research. Notwithstanding their previous experience, they underwent a four-hour intensive training before the conduct of the study. The training comprised acquaintance with the data collection instrument, how to observe ethical considerations and obtain informed consent from participants as well as how to administer the instrument. There were also practical demonstrations and role-play on interviewing skills and processes. Additionally, the research assistants were involved in the pre-test of the instrument as well as community entry processes (establishing necessary contact, rapport and seeking cooperation to execute the study) that were carried out to ensure collection of quality data.

The questionnaires were administered on a one-on-one basis and under situations that guaranteed respondents' privacy. The respondents were interviewed in comfortable private places within their houses, compounds or neighbourhoods. The interviews lasted between 15 – 25 minutes. Written informed consent was obtained from the respondents prior to the commencement of the study.

Validity and Reliability: The design of this research instrument was based on the research objectives and relevant literature. The tool was subjected to scrutiny and constructive criticism by five experienced researchers in the fields of public health. The instrument was pre-tested among 120 ever-married women (10% of the study sample) in Osun State, which shares similar characteristics with the study area. The reliability of the instrument was ascertained with the use of Cronbach's Alpha coefficient technique in International Business Machine Corporation [IBM/Statistical Package for Social Sciences [SPSS] (IBM/SPSS), which yielded a coefficient value of 0.9.

Data Analysis: The copies of the questionnaire were checked for completeness, and a serial number was given to each for easy identification and recall. A coding guide was developed based on the variables and responses teased out from the questionnaires. This coding code was used to aid data entry into a computer. Knowledge scores of ≤2, 3- 5 and ≥6 were rated as poor, fair and good knowledge of health consequences of marital rape respectively. Perceptions scores of ≤10 and >10 were classified as supportive perception and non-supportive perceptions of marital rape, respectively. The IBM SPSS software (version 20.3) was used to facilitate data analysis. Descriptive statistics including mean, frequency distribution, percentages and charts were used to present univariate data. Chi-square statistics was used to test the association between dependent and independents variables at a level of significance set at 0.05.

Ethical Issues/Approval: Approval to conduct the study was obtained from the Oyo State Ministry of Health Ethics Review Committee (AD 13/479/065). The investigators sought for informed consent from the respondents making them to fill the informed consent form after they had been informed about the objectives of the study, that the data collected will be used for research purposes, that confidentiality will be maintained and that participation was voluntary.

RESULTS

Respondents' Socio-demographic characteristics: Table 1 shows the essential socio-demographic characteristics of the respondents. The ages of respondents ranged from 18 – 60 years with a mean age of 36.6 ±9.6 years. Sixty-five per cent of the respondents were Christians, and 32.8% were believers of the Islamic faith. Yorubas constituted the majority of the respondents (76.8%), while those that were Igbos and Hausas were 15.8% and 6.8% respectively. Respondents with tertiary education had the highest proportion with 42.3%, followed by those with secondary education with 41.3%. Respondents who had ever married a single husband constituted 91.2% of the study population. Respondents who were employed or working were 84.2%.

Table 1:
Descriptive statistics showing socio-demographic information of respondents

	Characteristics	№	%
***Age in years**	≤24	57	4.8
	25 – 49	977	81.4
	≥50	166	13.8
Marital Status	Married	993	82.8
	Widow	88	7.3
	Divorce	119	9.9
Religion	Christian	780	65.0
	Islam	394	32.8
	Traditional	26	2.2
Ethnicity	Yoruba	921	76.8
	Igbo	190	15.8
	Hausa	82	6.8
	Others	7	0.6
Respondents' Educational Status	No formal Education	89	7.4
	Primary Education	109	9.1
	Secondary Education	495	41.2
	Tertiary Education	507	42.3
Family type	Monogamy	998	83.2
	Polygamy	202	16.8
Number of husbands ever married[β]	One	1094	91.2
	Two	94	7.8
	Three	12	1.0
Duration of marriage^	≤10 years	703	58.6
	11 – 20 years	302	25.2
	≥20 years	195	16.2
Employment Status	Working/Employed	1010	84.2
	Not working/Unemployed	190	15.8

**Mean age of respondents = 36.6±9.6, median -35.0, range – 18 – 60 years.*
[β]Mean number of husband 1.1 ±0.29, median- 1.0, range – 1 – 3.
^Mean duration of marriage =1.58 ±0.76, median- 1.0, range – 1 – 3.

Awareness related issues and sources of information: Table 2 presents results relating to awareness of marital rape. About three-quarter (75.8) of the respondents had heard of marital rape. Radio (29.8%) was the most common source of informationabout marital rape, followed by television (24.0%) and friends (17.7%). Among those who had heard about marital rape, 72.4% of them reported that they hear about it sometimes (occasionally) from their various sources of

information. Only a few (17.0%) respondents had attended any lecture or educational programme on rape.

Table 2:
Awareness of Marital Rape (N=1200)

Characteristics	№	%
Ever heard of marital rape		
Yes	910	75.8
No	290	24.2
Sources of information on marital rape+ (N= 910)		
Radio	567	29.8
Television	457	24.0
Friend	337	17.7
Internet	150	7.9
Lecture	69	3.6
Book	61	3.2
Church/Mosque	44	2.3
Neighbourhood	15	0.8
*Others	5	0.5
Frequency of hearing of marital rape (N=910)		
Sometimes	659	72.4
Often	251	27.6
Ever attended any lecture or educational session on rape		
Yes	204	17.0
No	996	83.0

** Others- Patient – 0.1%, film – 0.1%, spouse– 0.1%, hospital-– 0.1%, personal- – 0.1%,*
+Multiple responses were present

Knowledge of possible health consequences of marital rape: Respondents had a mean knowledge score of 3.9 ±2.2. The proportion of respondents with good, fair and poor knowledge scores relating to marital rape are shown in Figure 1. About half of the respondents (50.3%) had a fair knowledge of the health consequences of marital rape. Those who had good knowledge of the health consequences of marital rape constituted 26.3%, while 23.4% had poor knowledge of the phenomenon.

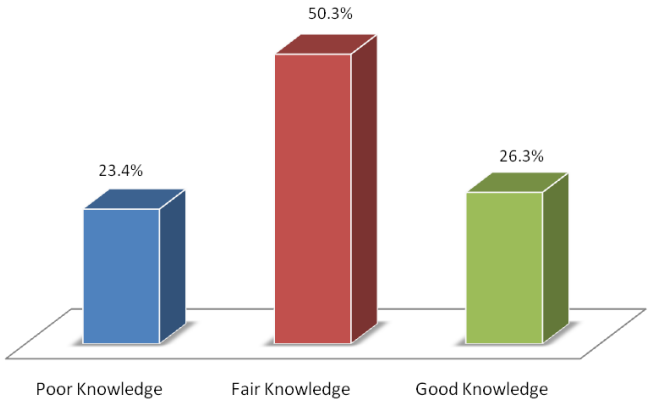

Figure 1:
Respondents' level of knowledge of health consequences of marital rape (N = 1200).
Mean knowledge of respondents 3.92 ± 2.2, median – 4, range – 0 - 8

As shown in Table 3, body injury and body pain had the highest proportions among the physical health consequences of marital rape mentioned by the respondents with 38.5% and 37.0% respectively. Table 3 also shows the psychological health consequences of marital rape mentioned by the respondents. Depression had the highest proportion with 49.6%, followed by thinking, anger and fear of sex with 10.5%, 8.9% and 7.7% respectively. As reflected on Table 3, divorce/separation with 47.9% topped the list of the significant social health consequences of marital rape mentioned by the respondents followed by disagreement and strained relationship/reduced love for husband which constituted 22.5% and 10.4% respectively. Among the sexual health-related health consequences of marital rape mentioned by the respondents, sexually transmitted diseases including HIV had the highest proportion being 30.2%, followed by unwanted pregnancy and vagina injury with the proportions of 27.9% and 18.2%, respectively.

Table 3:
Knowledge of possible health consequences of marital rape (N= 1,200)

		№	%
Physical health consequences of marital rape	Body injury	403	38.5
	Body pain	387	36.8
	Weakness of the body	104	10.0
	Sickness	91	8.7
	Death	26	2.5
	Internal injury/bleeding	25	2.4
	Disability	6	0.6
	Loss of consciousness	3	0.3
Psychological health consequences of marital rape	Sadness (Depression)	596	49.6
	Thinking	126	10.5
	Anger	107	8.9
	Fear of sex	92	7.7
	Hatred	73	6.1
	Post Traumatic Stress Disorder (PSTD)	73	6.1
	Become violent	45	3.7
	Mental disorder	21	1.7
	Low self esteem	20	1.7
	Worry	20	1.7
	Suicidal ideation	17	1.4
	Others+	10	0.9
Social health consequences of marital rape	Divorce/Separation	457	47.9
	Disagreement	215	22.5
	Strained relationship/reduced love	99	10.4
	Isolation(keeping to one's self)	82	8.5
	Stigmatization	68	7.1
	Lack of trust	18	1.9
	Others++	16	1.7
Sexual health consequences of marital rape	Sexually transmitted diseases (including HIV)	451	30.2
	Unwanted pregnancy	415	27.9
	Vagina injury (including vagina bleeding)	270	18.2
	Miscarriage	263	17.7
	Unable to enjoy sex	54	3.6
	Vagina pain	35	2.4

*****Multiple responses present*

+Others- Loss of focus (0.5%), use of drugs (0.2%), self blame (0.%), change of mood (0.1)
++Others – Feel neglected (1.2%), bad influence on children (0.5%)

Table 4 shows respondents' knowledge of marital rape by selected socio-demographic characteristics. The distribution of respondents with good knowledge of marital rape among those aged ≤24, 25 – 49 and ≥ 50 years were 17.5%, 26.2% and 30.1% respectively. Good knowledge of marital rape increased significantly with the age of respondents. Overall there was a significant association between knowledge of marital rape and age of respondents (See table 4 for details). The distribution of respondents with a good of marital rape among those with non-formal education, primary, secondary and tertiary education was 24.7%, 11.9%, 27.5%, 28.6% respectively. There was a significant association between knowledge of marital rape and the level of education of respondents (See table 4 for details). More proportion of believers of African traditional religion (53.8%) had good knowledge of marital rape compared with Christians (22.7%) and adherents of Islamic religion (22.8%). Overall, there was a significant association between respondents' religion and the knowledge of marital rape (Table 4). More respondents with a monogamous relationship (27.3%) had poor knowledge of marital rape than those in polygamous families (49.1%). There was, however, no significant association between respondents' family type and knowledge of marital rape.

Table 4:
Level of knowledge of the health effects of marital rape by selected demographic characteristics (N =1200)

Variables	Level of knowledge				Chi-square (χ^2)
	Poor	Fair	Good	Total	
	No. (%)	No. (%)	No. (%)	No. (%)	
Age (in years)					
≤24 years	18 (31.6)	29 (50.9)	10 (17.5)	57 (100.0)	χ^2=23.0
25 – 49 years	247 (25.3)	474 (48.5)	256 (26.2)	977 (100.0)	p= 0.000*
≥ 50 years	16 (9.6)	100 (60.2)	50 (30.1)	166 (100.0)	d= 4
Educational Status					
Non-formal Edu.	26 (29.2)	41 (46.1)	22 (24.7)	89 (100.0)	χ^2=30.3
Primary	43 (39.4)	53 (48.6)	13 (11.9)	109 (100.0)	p= 0.000*
Secondary	119 (24.0)	240 (48.5)	136 (27.5)	495 (100.0) 507	d= 6
Tertiary	93 (18.3)	269 (53.1)	145 (28.6)	(100.0)	
Religion*					
Christian	178 (22.8)	390 (50.0)	212 (27.2)	780 (100.0)	χ^2=14.06
Islam	101 (25.6)	203 (51.5)	90 (22.8)	394 (100.0)	p= 0.007*
Traditional	2 (7.7)	10 (38.5)	14 (53.8)	26 (100.0)	d= 4
Family type					
Monogamy	272 (27.3)	492 (49.5)	232 (23.2)	998 (100.0)	χ^2=2.7
Polygamy	44 (21.8)	109 (54.0)	49 (24.3)	202 (100.0)	p= 0.27
					d= 2

Note: *** = <0.05**

Perception of marital rape: Information on the perception scores of respondents and the proportion of respondents with supportive and non-supportive perceptions relating to marital rape are shown in Figure 2. Respondents' perceptions scores ranged from 0-19, with a mean score of 8.9 ± 3.6. Respondents who had supportive perception relating to marital rape were 69.8%.

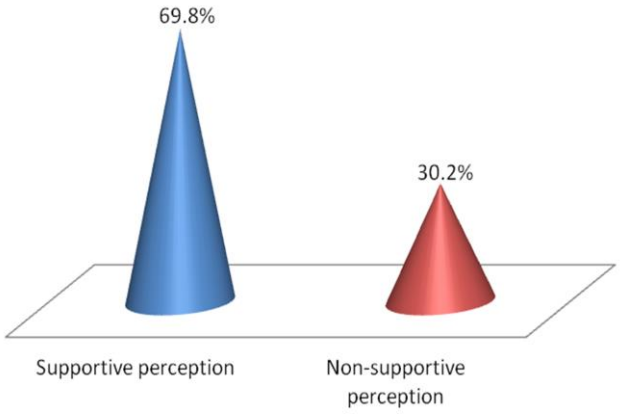

Figure 2:
Categorisation of respondents' perception of marital rape

Mean perception of respondents 8.9 ± 3.6, median – 9.0, range – 0 - 20

Tables 5 (5a & 5b) presents respondents' specific perceptions relating to marital rape. The perception that being subjected to forced or unwanted sexual intercourse by one's husband is not a pleasant experience was shared by 83.7% of the respondents. Most of the respondents, 71.2%, opined that a man who subjects his wife to forced sexual intercourse should be blamed for such an act. The perception that experience of forced or unwanted sexual intercourse by one's husband can seriously affect the sexual desire of a woman was supported by 67.3% of the respondents.

More than half (54.3%) of the respondents shared the perception that married women do not have the right to refuse sex from their husbands. Forty-five per cent of the respondents opined that a woman who experiences rape (forced or unwanted sex) in the hand of her husband should not inform anyone. The view of 44.2% of the respondents was that being subjected to forced or unwanted sexual intercourse by one's husband should not be regarded as rape. Forty-two per cent of the study respondents perceived that a woman should tolerate marital rape for the sake of the marriage. Similarly, 37.7% of the respondents acknowledged that there is nothing a woman

can do to prevent being raped (subjected to forced or unwanted sex) by her husband (Table 5b).

Table 5a: Perceptions relating to Marital Rape

*Marital rape-related perceptions	Pattern of response		
	Agree No. **(%)**	**Undecided** No. **(%)**	**Disagree** No. **(%)**
Being subjected to forced or unwanted sexual intercourse by one's husband is not a pleasant experience	1004 (83.7)β	50 (4.2)	14 6(12.2)
Being subjected to forced or unwanted sexual intercourse by one's husband is not as serious as being raped by a stranger	545 (45.4)	223 (18.6)	432 (36.0)β
A woman who is being subjected to forced or unwanted sexual intercourse by her husband is likely to have caused it	411 (34.2)	205 (17.1)	584 (48.7)β
A man who subjects his wife to forced sexual intercourse should be blamed for such an act	854 (71.2)β	156 (13.0)	190 (15.8)
Experience of forced or unwanted sexual intercourse by one's husband can seriously affect the sexual desire of a woman	808 (67.3)β	186 (15.5)	206 (17.2)
One factor that promotes the rape of a woman by the husband is the belief that a woman should always submit to the sexual request or advances of her husband	548 (45.7)β	220 (18.3)	432(36.0)
'The belief that women are properties of men may be the reason why some men have forced or unwanted sexual intercourse with their wives.	435 (36.2)	204 (17.0)	561 (46.8)β
A woman who often suffered rape (situation of forced or unwanted sexual intercourse) in the hands of her husband should file for divorce	508 (42.3)β	254 (21.2)	438 (36.5)
The stigma that follows the reporting of a case of "marital rape" may be worse than the rape itself	642 (53.5)	276 (23.0)	282 (23.5) β
A woman who experiences rape (forced or unwanted sex) in the hands of her husband should inform the social welfare office	465 (38.8)β	206 (17.1)	529 (44.1)

β- correct/appropriate perception

Table 5b: Perceptions relating to Marital Rape

*Marital rape-related perceptions	Pattern of response		
	Agree No. **(%)**	**Undecided** No. **(%)**	**Disagree** No. **(%)**
Being subjected to forced or unwanted sexual intercourse by one's husband is a common phenomenon which any woman should not worry herself too much about	388 (32.3)	216 (18.0)	596 (49.7)β
Being subjected to forced or unwanted sexual intercourse by one's husband should not be regarded as rape	530 (44.2)	233 (19.4)	437 (36.4)β
A woman should tolerate marital rape for the sake of the marriage	508 (42.3)	214 (17.8)	478 (39.9)β
It is better for a woman who experience marital rape not to inform anyone	575 (47.9)	205 (17.1)	420 (35.0)β
It is not appropriate to report one's husband because of experience of marital rape	543 (45.2)	234 (19.5)	423 (35.3)β
The stigma that follows the reporting of a case of "marital rape" may be worse than the rape itself	642 (53.5)	276 (23.0)	282 (23.5)β
Married women do not have the right to refuse sex from their husbands	651 (54.3)	177 (14.7)	372 (31.0)β
A married women should not leave her husband because of experience of marital rape	607 (50.6)	213 (17.7)	380 (31.7)β
A woman who experiences rape (forced or unwanted sex) in the hands of her husband should not inform anyone	546 (45.5)	184 (15.3)	470 (39.2)β
A woman who experiences rape (forced or unwanted sex) in the hands of her husband should just endure it	489 (40.8)	228 (19.0)	483 (40.2)β
There is nothing a woman can do to prevent being raped (subjected to forced or unwanted sex) by her husband	452 (37.7)	163 (13.6)	585 (48.8)β

β- correct/appropriate perception-

Table 6 shows respondents' perception of marital rape by selected socio-demographic characteristics. The proportions of respondents who had marital rape supportive perception among those aged ≤24, 25 – 49 and ≥ 50 years were 59.6%, 67.9% and 84.9% respectively. Marital rape supportive perception was significantly associated with increasing age of respondents. The distribution of respondents with marital rape supportive perception among those with non-formal education, primary, secondary and tertiary education were 80.9%, 74.3%, 68.5%, 68.2% respectively. There was, however, no significant association between perception of marital rape and level of education of respondents (See table 6 for details). The distribution of respondents with marital rape supportive perception among those who were Christians,

Islam and adherents of African Traditional Religion were 70.1%, 69.0% and 73.1% respectively. Overall there was a significant association between perception of marital rape and religion of respondents (See table 6 for details).

Table 6:
Perception of marital rape by selected demographic characteristics

Variables		Categorisation of Perception			Chi-square (χ^2)
		Marital rape Supportive perception No. (%)	**Marital rape Non-supportive perception** No. (%)	**Total** No. (%)	
Age (in years)	≤24 years	34 (59.6)	23 (40.4)	57 (100.0)	χ^2=23.0
	25 – 49 years	663 (67.9)	314 (32.1)	977 (100.0)	p= 0.000*****
	≥ 50 years	141 (84.9)	25 (15.1)	166 (100.0)	d= 2
Educational Status	Non-formal Edu.	72 (80.9)	17 (19.1)	89 (100.0)	χ =7.27
	Primary	81 (74.3)	28 (25.7)	109 (100.0)	p= 0.06
	Secondary	339 (68.5)	240 (31.5)	495 (100.0)	d= 3
	Tertiary	346 (68.2)	161 (31.8)	507 (100.0)	
Religion*	Christian	547 (70.1)	233 (29.9)	780 (100.0)	χ^2=0.28
	Islam	272 (69.0)	121 (31.0)	394 (100.0)	p= 0.87
	Traditional	19 (73.1)	7 (26.9)	26 (100.0)	d= 2
Family type	Monogamy	693 (69.4)	305 (30.6)	998 (100.0)	χ^2=0.44
	Polygamy	145 (71.8)	57 (28.2)	202 (100.0)	p= 0.51
					d= 1
Duration of Marriage	0 – 10 years	456 (64.9)	247 (35.1)	703 (100.0)	χ^2=29.0
	11 – 20 years	217 (71.9)	85 (28.1)	302 (100.0)	p= 0.000*****
	>20 years	165 (84.6)	30 (15.4)	195 (100.0)	d= 2
Employment Status	Employed	698 (69.1)	312 (30.9)	1010 (100.0)	χ^2=1.59
	Unemployed	140 (73.7)	50 (26.3)	190 (100.0)	p= 0.21
					d= 1

Note: **** - <0.05***

More respondents who were in polygamous unions (71.8%) had marital rape supportive perception compared with those in monogamous relationships (69.4%). There was, however, no significant association between respondents' family type and perception of marital rape. The proportions of respondents who had marital rape supportive perception among those whose marriage duration was ≤10, 11 – 20 and > 20 years were 64.9%, 71.9% and 84.6%, respectively. Marital rape supportive perception was significantly associated with increasing duration of marriage age. More respondents (73.7%) who were unemployed had marital rape supportive perception that those who were employed (69.1%). Overall, there was no significant association between perception of marital rape and the employment status of respondents.

DISCUSSION

The study revealed that body injuries, body pain and body weakness were the major physical health consequences of marital rape mentioned by the respondents. The health consequences mentioned by the respondents are in tandem with some of the major health consequences noted in previous studies and reports (Bennice et al, 2003; Mahoney et al, 2007; WHO, 2010). According to the WHO (2010), survivors of marital rape often suffer severe physical injuries. The chance of physical injuries may increase if marital rape experience is accompanied by physical violence. Reports had it that most women raped in marriage also experience severe forms of physical abuse (Bergen, 2006; Eby et al., 1995; Mahoney et al, 2007).

Depression, thinking, anger and fear of sex were the major psychological health consequences of marital rape mentioned by many respondents. This is not different from what previous studies such as Plichta et al (2001), Mahoney et al (2007) and WHO (2010) documented as psychological consequences of marital rape. Specifically, the WHO (2010) and Black et al (2011) mentioned that serious psychological disorders such as depression, anxiety, negative feelings about sex as well as increased risks of PSTD are the major possible adverse psychological complications of marital rape. Marital rape can result in debilitating psychological trauma that is worse more than other forms of rape involving non-partners (Russell, 1990, Burgen, 2006). Disagreement, strained relationship and divorce were among the major social health consequences of marital rape mentioned by respondents. Similar adverse social health consequences have been reported by the WHO (2010). According to the report, marital rape could lead to couple separation and strained relationship (WHO, 2010). Beyond the effect of marital rape on women, it can also affect the family relationship and have a negative influence on the children. An earlier study conducted by Russell (1990) noted that children whose parents are involved in marital rape turn out to be more violent.

Among the sexual health-related consequences of marital rape mentioned by the respondents were STIs, unwanted pregnancy and vagina injury. Previous studies such as Maman et al. (2000), Krug et al. (2002) and WHO (2010) pointed out that women who are subjected to rape by their partners most of the time experience vagina injuries and have increased risk of contracting sexually transmitted infections including HIV.

Level of knowledge of marital rape significantly increased with the age of respondents. Older people may have been exposed to more relevant educational opportunity that gave them better insights about rape-related issues. Another

possible explanation is that more older people might have experienced marital rape or may know individuals who have experienced it. From the present study, it was observed that the level of knowledge of marital increased along with their educational status. Higher educational attainment, such as tertiary education, could have provided exposure to various relevant curricular and co-curricular learning opportunities over the years, which might have accounted for this knowledge differential among the respondents. Also, knowledge of marital rape significantly increased with respondents' duration in marriage. It is expected that people who have been married for a long time have acquired some experiences and learnt about various sexual-related issues compared with women who have been married for a short duration.

The findings relating to the supportive perceptions about marital rape reported in this study were similar to the pattern of results reported in previous studies such as Fero et al. (2008) and Tegbar et al. (2010). Some respondents considered marital rape as a normal phenomenon and opined that it should not be seen as a serious offence. Previous studies had documented that marital rape is less likely than rape perpetrated by strangers or acquaintances to be accurately labelled as rape (Kirkwood et al, 2001) or to be perceived as a serious offence (Monson et al, 1996; Monson et al., 2000). Walby et al (2004) similarly noted that women who experience sexual abuse in the hands of intimate partners are likely to classify their experience as rape if they suffer serious physical injuries. There is a need to design behavioural change communication interventions that can change women's negative perceptions about marital rape.

Supportive perception for marital rape increased significantly with the age of respondents as more of older persons had supportive perception. This finding is in tandem with the previous studies which earlier noted that age was a predictor of people's perceptions of rape (Ferro et al, 2008; Kalra et al, 1998; Nagel et al., 2005). Research has explained that younger respondents are more sympathetic toward and less likely to blame rape victims than are older respondents (Kalra et al., 1998; Nagel et al., 2005). The results which show that more of older people have more of supportive perception for marital rape may not be unconnected with the fact that older people are generally more accustomed with societal beliefs and attitudes than younger people. It is also possible that older women might have considered marital rape as tolerable behaviour because of the idea or the notion of marital rape as a foreign concept. In contemporary Nigeria, older people that are usually less inclined to issues viewed as foreign ideology. The finding which revealed that women who had stayed longer in their marriages had marital rape supportive perception more than those who have spent lesser years in their marital relationships is not surprising. The increasing length of stay in a marriage coupled with women's quest always to safeguard their marriages which they have invested so much in and in the interest of their children may have accounted for the differentials perception differentials among the respondents.

Findings from this study have implications for health promotion and education. Several combinations of health education strategies which include public enlightenment, training, and counselling of women as well as advocacy to religious and community leaders have huge potentials in addressing the phenomenon.

Public enlightenment campaigns can be used to create awareness and influence knowledge and cultural beliefs relating to marital rape. It has the potential to reach large numbers of people, including women and significant others such as spouses and relatives that can help in the prevention and control of marital rape among women. Public enlightenment techniques that can be used include handbills, documentaries, and jingles.

Training interventions could serve as effective strategies for addressing perceptions that promote marital rape and for upgrading women's knowledge of marital rape-related issues. Emphasis should be placed on various health consequences that can be associated with marital rape and strategies that can be employed to control marital rape. More attention should be given to young women who have less knowledge of marital rape-related issues. This could be achieved, in part, by increasing their access to relevant youth-friendly training programmes and providing opportunities for them to gain experiences from older women. Older women who are experienced and knowledgeable could be trained to provide peer-led training and support for young women in addressing marital rape-related issues. Various fora for women such as ante-natal care and social and religious gatherings targeting women health-related issues may be used to promote peer-led educational activities focusing on promoting knowledge and perceptions that can help prevent marital rape. Additionally, educational interventions such as social media strategies or methods such as text messages can be implemented to target a large population of women, especially young women and provide them with robust learning opportunities.

Mobilising communities to promote knowledge and appropriate perceptions useful in addressing the problem of marital rape may be very useful. Community involvement in community health interventions that focus on issues relating to women's right and prevention of marital rape and other forms of domestic violence acts is particularly appealing. It holds the potential for success because it is based on the principle that it provides opportunities for community members to participate in the design, implementation, and evaluation of nutritional interventions.

Advocacy interventions that target custodians of tradition and customs have the potential of effectively addressing cultural beliefs and misconceptions that favour marital rape. Advocacy interventions can be made more effective when supported with locally generated data from systematically conducted studies.

Conclusion

In conclusion, many women had heard of marital rape through mass media and friends as being the major sources of information. However, only a few respondents had good knowledge of the health effects of marital rape. Many women had supportive perceptions for marital rape and did perceive marital rape as being a serious form of rape, a situation which can adversely affect health-seeking behaviour. Multiple community-based health educational interventions should be used to upgrade women's knowledge about the phenomenon and modify perceptions which tend to support marital rape

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