Factors Associated with Knowledge and Attitude of Pregnant Women towards Gender-Based Violence in Benin City, Edo State

***Obi AI,[1-3] Odinkemere OC,[2] Eriki OJ,[1] Imadojiemu OM,[1] Adayonfo OE,[4] Obi JN,[5] Obi RU[6]**

ABSTRACT

Gender-based violence (GBV) is a global public health problem with deep cultural roots especially in developing countries like Nigeria. This study assessed knowledge and attitude of pregnant women towards GBV in Benin City, to help curb this public health menace. A facility-based analytical cross-sectional study was conducted. Pre-tested semi-structured questionnaires were interviewer-administered to 500 respondents attending antenatal (ANC) clinics in Benin City, Edo state. Data collected were analysed using SPSS version 24.0 statistical software with statistical significance set at p<0.050 and 95% Confidence Interval. The mean age of the respondents studied was 30.2 ± 4.9 years, 462(92.4%) of them were aware of the term GBV, with media 293(63.4%), friends 251(54.3%) and family members 187(40.5%) reported as the main sources of information. Two hundred and ten (45.5%) and 334(73.3%) of respondents had good knowledge and negative attitude towards GBV respectively. The increasing level of education (p=0.009) and occupation (p<0.001) were significant factors associated with knowledge of GBV while employment status (p = 0.010) and level of knowledge of GBV (p<0.001) were significant factors associated with attitude towards GBV. Gaps exist between knowledge and attitude towards GBV among pregnant women in Benin City. Sensitization and awareness creation on GBV during and outside the routine ANC visits can help bridge this gap to promote better knowledge and attitudinal change about GBV among respondents.

Keywords: Antenatal clinic, awareness, Benin City, Edo State, gender-based violence, pregnant women

INTRODUCTION

Gender-based violence (GBV) is a grave public health concern that has very strong and deep cultural roots across developing countries including Nigeria.[1-6] The prevalence of gender-based violence (GBV) cuts across social classes, ethnic groups, cultures and religions as well as socioeconomic, educational or developmental backgrounds, with grave physical, psychosocial and economic implications to the victim's health, well-being and that of society at large.[1-3]

Department of Community Health,[1] University of Benin, Benin City, PMB 1154, Edo State, Nigeria. Department of Community Health,[2] University of Benin Teaching Hospital, Benin City, PMB1111,Edo State, Nigeria. Centre of Excellence for Reproductive Health Innovation (CERHI),[3] University of Benin, Benin City, Edo State, Department of Mental Health,[4] University of Benin, Benin City, PMB 1154, Edo State, Nigeria. Federal Neuropsychiatric Hospital,[5] Benin City Edo State. Department of Sociology and Anthropology,[5] University of Benin, Benin City, Edo State.

*Corresponding author: andrew.obi@uniben.edu
Date manuscript was received: 14/3/2023
Date manuscript was accepted: 15/6/2023

According to the United Nations (UN) Declaration on the Elimination of Violence against Women (DEVAW), GBV is any act of physical, sexual and psychological violence against an individual and can be perpetuated at family or community levels.[4-6] These acts of violence can include but are not limited to spousal battering, sexual abuse of female children, dowry-related violence, all forms of rape including marital rape, traditional practices harmful to women such as female genital mutilation, non-spousal violence; sexual harassment and intimidation; trafficking in women, forced prostitution and violence perpetrated or condoned by the state such as rape in war settings.[4-6] Gender-based violence has been described as the most widespread and socially tolerated form of human rights violations with rising source of concern globally.[3] These observations and concerns led the Federal Government of Nigeria, in 2015 to enact the Violence Against Persons Prohibitions Act (VAPPA).[7]

In sub-Saharan Africa including Nigeria, lack of awareness, poor knowledge of GBV and cultural factors perpetuate these mistreatments perpetrated against women

especially by male partners. They are often not seen or identified as GBV rather, they have been reported as justifiable punishments for a woman's transgression of her normative roles in society, as well as for disobedience, adultery and disrespecting her husband's relatives.[8-10] Domesticating international, regional and national laws as well as enforcing them have remained an issue in cultural settings where GBV is encouraged.[9-10] This implies that these ineffectively implemented laws if well executed will go a long way to influence positively and negatively the incidences of gender violence against women. Furthermore, men must be aware and imbibe good knowledge on GBV to help influence appropriate behavioral and attitudinal changes to influence actions and interventions against gender-based violence in women.[9-10]

Consequently, majority of GBV survivors in sub-Saharan Africa find it difficult to identify with the reality of the problems of GBV and services available for treatment and rehabilitation.[11]

In Nigeria, a total of 42% of women justified GBV with at least one reason.[11] This positive attitude towards issues of GBV especially among victims and stakeholders in our society is invariably perpetuating the act of GBV impeding mitigation measures. [2,10-11] GBV is a stumbling block to attaining gender equality, but women who are the major victims of GBV sadly also justify these acts[1-8] These attitudes sprout from long-term deep cultural practices, beliefs and teachings have made women accept certain forms of GBV as 'normal'.[9-10]

GBV is preventable, the World Health Organization (WHO) and other health bodies are committed to promoting gender equality and human rights across all sectors by working with partners, Governments and communities to address GBV and implement quality programming to prevent, mitigate and respond, to stem this growing societal evil.[4-6] In other to take the necessary precautions to create a healthy environment for woman, it is therefore important to determine how the behaviour of violence is primarily perceived in a particular society, as well as the attitude of the society towards violence.[11-12]

GBV also impacts seriously the reproductive health and life of a woman; resulting in unwanted pregnancies, adolescent pregnancies, sexually transmitted infections, chronic pain etc with potential risks for adverse birth outcomes.[10-12]

Abuse during pregnancy poses immediate risks to the mother and unborn child, such as bleeding, foetal demise etc. and also increases chronic problems such as depression, substance abuse, lack of access to prenatal care, suicidal tendencies and poor maternal weight gain.[2,4,11-12] Children of abused women have a higher risk of death before reaching age five and violence during pregnancy is associated with low birth weight of babies.[2,4,11-12]

Gender-based violence has financial implications due to health care, civil, legal cost and fees with loss of productivity, in addition to contributory implications on maternal mortality rate.[1-3,10-12] Furthermore, though legislations exist to prevent and address gender-based violence at both international and national levels, these laws are not uniformly enforced. Meanwhile, the involvement of the health sector in responding to the increasingly recognized health consequences remains inadequate in many countries. This study assessed knowledge and attitude of pregnant towards GBV in Benin City, to raise awareness on the need to curb this public health challenge.

MATERIALS AND METHODS

This study was carried out in two selected hospitals (one tertiary, one secondary) that provide Antenatal care services in Egor and Oredo Local Government Areas (LGA) respectively in Benin City, Edo State, Southern Nigeria.[13] Benin City hosts, diverse ethnic groups with Benin, English and pidgin English languages as the commonly spoken languages, christianity remains the dominant religion with Islam and traditional religions also practised.[13-14] The people are majorly civil servants and traders.[13]

A community-based cross-sectional analytical study design was utilised for the study between July 2015 to July 2016.

Structured pre-tested questionnaires were administered to 500 consenting pregnant women (between the ages of 15-49 years) attending antenatal clinics in the University of Benin Teaching Hospital (UBTH) and Central Hospital Benin City, Edo State. Minimum sample size was calculated using the Cochran formula[15] for an analytical study based on a 36% prevalence support towards GBV from a previous study.[16]

Ethical approval was sought and obtained from the Research and Ethics Committee, College of Medical Sciences, University of Benin, Benin City, Edo state. Furthermore, institutional approval was obtained from the management of University of Benin Teaching Hospital and Central Hospital Benin City, with informed consent sort from the individual respondents before commencement of the study. A systematic random sampling technique was used to select participants from the health facilities selected until the desired sample size was obtained. Knowledge of GBV was assessed using 39 questions under 7 domains, with a Cronbach's alpha score of 0.781. A score of "1" was given for every correct response and "0" for incorrect response, unanswered variables also attracted a score of "0", given a total aggregate score of 39. A percentage composite score of greater than or equal to 50% was categorized as good knowledge, while less than 50% was categorized as poor knowledge. Attitude towards GBV was assessed based on 9 questions scoring system, with a Cronbach's alpha score of 0.650. A score of "1" was allotted for each appropriate response and "0" for every inappropriate response, giving a total aggregate score of "9". An aggregate score of greater than or equal to 50% was categorised as positive attitude (supportive of GBV) while less than 50% was categorised as negative attitude (not supportive of GBV). Data collected were analysed using SPSS version 20.0 statistical software with statistical significance set at p<0.050 and 95% Confidence Interval.

RESULTS

A total of 500 respondents participated in the study with mean age of 30.2 ± 4.9 years, Benin 228(45.6%) was the predominant ethnic group with Christianity 478(95.6%) as the major religion among respondents. Four hundred and seventy (94.0%) of the respondents were married. Three hundred and fourteen (62.4%) and 177(35.4%) respondents had a tertiary level of education and were in the skilled level 2 occupational class. Finally, concerning employment status, the majority of 308(79.4%) of respondents were employed while 192(20.6%) were unemployed.

Four hundred and sixty-two (92.4%) of respondents were aware of the term GBV (Table 1).

In terms of factors promoting GBV, respondents reported use of alcohol 457(91.4%), psychological problems in the perpetrator 373(74.6%), and multiple sexual partners 270(54.0%) among others as possible factors promoting GBV. In relation to consequences of GBV in pregnancy, miscarriage 437(87.4%), depression 345(69.0%), among others were reported respectively (Table 2). Two hundred and fifty-two (54.5%) respondents studied had poor knowledge of GBV while 210(45.5%) had good knowledge of GBV (Figure 1). Furthermore, increasing level of education (p=0.009) and occupational status (p<0.001) were associated with knowledge of GBV (Table 3).

Three hundred and fifty-nine 359(77.8%) of respondents agreed that GBV was mostly perpetuated by husbands while 441(95.6%) agreed that GBV should be discouraged. Similarly, 416(90.2%) of respondents disagreed that GBV should be excused if the perpetrator is under the influence of alcohol. Four hundred and three (87.4%) of them disagreed that it is usual for a husband to force his wife to have sex even if led on while 98(21.4%) agreed that GBV should not be disclosed because it is a family matter. Furthermore, 448(89.6%) agreed that perpetrators of GBV should be penalized while 387(77.4%) agreed that GBV should be discussed in antenatal clinics. (Table 4).

Three hundred and thirty-four (72.3%) of respondents studied had negative attitudes towards GBV while 128(27.7%) had positive attitudes towards GBV. Finally, level of education (p<0.001), employment status (p=0.010) and level of knowledge of GBV (p<0.001) were identified as significant factors influencing attitude towards GBV (Table 5).

Table 1: Awareness and source of information on gender-based violence among respondents.

Variable	Frequency	Percent (%)
Awareness of GBV (n=500)		
Yes	462	92.4
No	38	7.6
Source of information *(n=462)		
Media	293	63.4
Friends	251	54.3
Family members	187	40.5
Religious places	120	26.0
Health workers	112	24.2
Books	110	23.8
Schools	98	21.2
Others	2	0.4

Others - Magazines, Personal experience

Table 2: Knowledge of gender-based violence among respondents.

Variable	Frequency(n=462)	Percent (%)
What is gender-based violence*		
Physical violence	394	78.8
Sexual Violence	322	64.4
Psychological violence	209	41.8
Robbery	34	6.8
Reckless driving	16	3.2
Factors that promote GBV*		
Alcohol	457	91.4
Psychological problem	373	74.6
Substance use	294	58.8
Having multiple sexual partners	270	54.0
Low LOE of husband	232	46.4
Positive HIV status of a woman	98	19.6
Positive HIV status of man	99	19.8
Eating too much	48	9.6
No male heir	1	0.2
Categories of GBV*		
Physical violence	455	91.0
Sexual assault	427	85.4
Emotional violence	342	68.4
Denial of resources	233	46.6
Denial of opportunities	203	40.6
Place of occurrence of GBV*		
Home	441	88.2
Office	269	53.8
Parties	269	53.8
Market	173	34.6
Hospital	168	33.6
School	2	0.4
Anywhere	2	0.4
Perpetrators of GBV*		
Husband	414	82.8
In-laws	306	61.2
Employers	225	45.0
Neighbours	153	30.6
Children	19	3.8
Society	1	0.2
Consequences of GBV in pregnancy*		
Miscarriages	437	87.4
Depression	345	69.0
Premature labour	324	64.8
Trauma	323	64.6
Suicidal ideation	228	45.6
Low birth weight, illness	147	29.4
Under-five mortality	118	23.6

*Multiple response questions

Table 3: Factors associated with knowledge of GBV

Domains	Knowledge of GBV (n= 462)		Test statistics	p-value
	Poor Freq. (%)	Good Freq. (%)		
Age group (years)				
15-19	2(100.0)	0(0.0)		
20-24	21(51.2)	20(48.8)		
25-29	108(52.4)	98(47.6)	χ^2=4.064	0.540
30-34	72(60.0)	48(40.0)		
35-39	40(54.1)	34(45.9)		
≥40	9(47.4)	10(52.6)		
Marital status				
Never married	14(51.9)	13(48.1)		
Ever married	238(54.7)	197(45.3)	χ^2=0.084	0.772
Parity				
Nullipara	22(51.2)	21(48.8)		
Multipara	227(54.8)	187(45.2)	χ^2=0.272	0.873
Grand-multipara	3(60.0)	2(40.0)		
Religion				
Christianity	239(53.8)	205(46.2)		
Islam	11(68.8)	5(31.3)		
ATR*	2(100.0)	0(0.0)	χ^2=3.061	0.216
Level of education				
No formal education	5(71.4)	2(28.6)		
Primary	15(83.3)	3(16.7)	χ^2=11.505	0.009
Secondary	80(60.6)	52(39.4)		
Tertiary	152(49.8)	153(50.2)		
Employment status				
Unemployed	49(53.3)	43(46.7)		
Employed	104(52.0)	96(48.0)		
Self-employed	99(58.2)	71(41.8)		
Occupational classification				
level 0	22(37.3)	37(62.7)		
level 1	54(71.1)	22(28.9)		
level 2	84(50.0)	84(50.0)	χ^2=22.346	<0.001
level 3	22(44.9)	27(55.1)		
level 4	70(63.6)	40(36.4)		

Table 4: Attitude of respondents towards GBV

Variable	Attitude towards GBV (n=462)		
	Agree Freq. (%)	Indifferent Freq. (%)	Disagree Freq. (%)
GBV is mostly perpetuated by the husband	359(77.8)	10(2.2)	92(20.0)
GBV should be encouraged	20.(4.4)	0.(0.0)	441(95.6)
GBV perpetrators should be excused if under the influence of alcohol	45.(9.8)	0.(0.0)	416(90.2)
GBV should be excused if the victim is HIV^+	41.(9.0)	1.(0.2)	419.(90.8)
It is usual for a husband to force his wife to have sex if led on	58(12.6)	0.(0.0)	403(87.4)
GBV is a private and a family matter and should not be disclosed	98(21.4)	277.(60.0)	85.(18.6)
The legal system treats victims badly	180.(39.0)	231.(50.0)	50.(11.0)
Government policies have been put in place to combat GBV	226.(49.0)	4.(1.0)	231.(50.0)
Perpetrators of GBV should be penalized	413.(89.6)	46.(10.0)	2.(0.4)

Table 5: Factors associated with attitudes of respondents towards GBV

Variable	Attitude towards GBV (n = 462)		Test statistics	p-value
	Positive Freq. (%)	Negative Freq. (%)		
Age group (years)				
15-19	2(100)	0(0.0)	χ^2 = 10.382	0.065
20-24	7(17.1)	34(82.9)		
25-29	50(24.3)	156(75.7)		
30-34	34(28.3)	86(71.7)		
35-39	13(17.6)	61(82.4)		
$\geq$ 40	5(26.3)	14(73.7)		
Marital status				
Never married	7(25.9)	20(74.1)	χ^2 = 0.057	0.812
Ever married	104(23.9)	331(76.1)		
Parity				
Nullipara	11(25.6)	32(74.4)	χ^2=3.682	0.159
Multipara	97(23.4)	317(76.6)		
Grand multipara	3(60.0)	2(40.0)		
Level of Education				
No formal education	4(57.1)	3(42.9)	χ^2= 24.401	<0.001
Primary	10(55.6)	8(44.4)		
Secondary	42(31.8)	90(68.2)		
Tertiary	55(18.0)	250(82.0)		
Occupational Classification				
level 0	10(16.9)	49(83.1)		
level 1	20(26.3)	56(73.7)		
level 2	49(29.2)	119(70.8)		
level 3	8(16.3)	41(83.7)		
level 4	24(21.8)	86(78.2)		
Employment status				
Unemployed	20(21.7)	72(78.3)	χ^2= 9.187	0.010
Employed	37(18.5)	163(81.5)		
Self-employed	54(31.8)	116(68.2)		
Level of knowledge on GBV				
Good	24 (11.4)	186 (88.6)	χ^2 = 33.472	<0.001
Poor	87(34.5)	165 (65.5)		

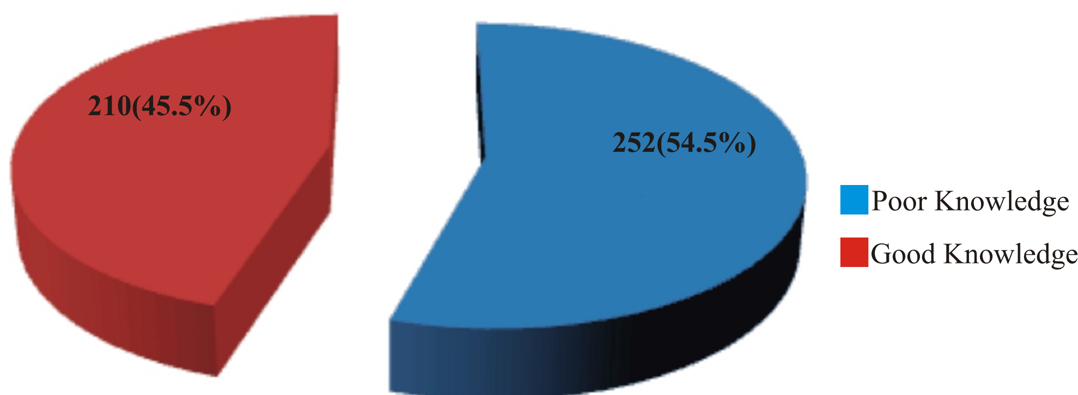

Figure 1: Level of knowledge of gender-based violence

DISCUSSION

The mean age and employment status of the study population are reflective of a young and economically active population. This finding is in keeping with a similar study done in Oleh, Nigeria[16] where the mean age of the respondents was 28 + 4.3 years.

This age group is reflective of persons who are either in active relationships/married and or in the reproductive age. They are also likely to share their thoughts on the subject of GBV possibly due to previous experience.

This observation was further buttressed in this study as majority (94.0%) of the respondents were married. This finding is in keeping with a study conducted in Zaria, Nigeria[17] where 93.9% of respondents were married. Over half of the respondents were Benin and practiced Christianity, this may be in keeping with the study location, as Christianity is the predominant religion practiced in the study area.[13-14]

Furthermore, about 82.2% of respondents had completed tertiary level of education, this is slightly in contrast with findings from study done in Abuja[18] and Edo State, Nigeria[19] where two-thirds had completed tertiary education. This suggests that a woman's level of education may be a contributory factor that predisposes her to GBV. This finding was supported by reports from Nigeria Demographic and Health Survey (NDHS)[14] and a study done in china[20] on education, perception factors and prevention of intimate partner violence. The high tertiary educational status of respondents in this study may be in keeping with study location which is predominantly made up of civil servants. Education increases the employability chance of individuals which may in turn expose them to additional information to understand issues surrounding GBV.

Over two third and half of the respondents studied were self-employed and in the upper socio-economic class respectively. This finding is slightly higher than findings reported in other Nigeria studies [21-22] where the higher the wealth status of pregnant women, the lower the likelihood of domestic violence.

The high level of awareness of GBV found among respondents studied is in keeping with the findings from the studies done in Zaria[17] and Abuja, Nigeria[18]. This confirms that the study population is not only educated but also well informed and knowledgeable about GBV. The high level of awareness and knowledge on GBV among a vast majority of respondents is possibly a reflection of the increasing sensitization of the general public on GBV through various media outlets such as internet, television, and radio, following the enactment of violence against people prohibition act in 2015. The findings reveal the important role the media holds in disseminating useful information about critical and useful information on GBV.

Although it was identified that the respondents had a high level of awareness of GBV, schools accounted for one of the least sources of information compared to mass media and friends. This finding is not good and should be reversed as the school is supposed to be a critical agent of socialization and character molding. Health education and teaching sessions in schools should be tailored to address GBV in a culturally sensitive manner. Furthermore, this study identified that knowledge of GBV increased significantly with level of education and occupational status of respondents. This finding is very important as education and occupational status of respondents is a leveler providing a huge opportunity to improve the knowledge base of respondents concerning GBV and other health matters. The level of knowledge on GBV is in contrast and lower than findings reported from studies in Sokoto and Kaduna Northern Nigeria[22-23].

Over two third of the respondents had a negative attitude towards GBV and were not in support of GBV. The level of education, employment status and knowledge of GBV were identified as significant factors influencing attitudes towards GBV among the study population. GBV has deep socio-cultural ties, as perpetrators see it as justifiable punishment for a woman's transgression of her normative roles in society, as well as for disobedience,

adultery and disrespecting her husband's relatives.[12,20,22,24]

This high level of negative attitude towards GBV identified in this study is encouraging and gives hope for the future. As more women become more empowered educationally and economically, they are expected to become more vocal in speaking out against GBV and their perpetrators which can progressively help reduce the vulnerability of sufferers, especially women and children to the risk factors of GBV. Appropriate attitudinal and behavioural changes can help address the deeply rooted socio-cultural notion among men and women on GBV in sub-Saharan Africa.

LIMITATIONS OF STUDY

Self-reporting and recall bias could have influenced the result findings; however, timelines were introduced to help minimize recall bias

CONCLUSION

Gaps exist between knowledge and attitude of pregnant women towards GBV in Benin City, Edo State. Even though knowledge was poor, the desired negative attitude was high. Optimization of routine ANC services for health education on GBV can provide proper information and orientation for the desired attitudinal changes against this societal menace.

CONFLICT OF INTEREST

We hereby declare that the study and manuscript submitted for publication are free of any form of interest and were fully funded by the Authors.

REFERENCES

1. Department of Justice, Equality and Law Reforms. National strategy on Domestic, sexual and gender-based violence 2010-2014.The National Office for the Prevention of domestic, sexual and gender-based violence, Dublin, 2010.
2. Aluko Y, Aluko-Arowolo S. The silent crime: a sociological Appraisal of Gender-Based Violence Experienced by women in Yoruba Culture of Nigeria. Paper presented at the fifth African Population Conference, Arusha, and Tanzania: December 2007; 10-14.
3. Ziad M, Suha K. School-related gender-based violence (SRGBV) in Lebanon. United Nations Educational Scientific and Cultural Organization [UNESCO]. 2012;225. Available at: www.unesco.org/beirut.
4. Nazanin M. Gender-Based Violence. Global Health Education Consortium 2009.
5. Inter-Agency Standing Committee (IASC). Guideline for integrating Gender-based violence Intervention in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery. 2015.Available at: www.gbvguidlines.org
6. Uwameiye BE, Iserameiya FE. Gender-based violence against women and its implication on the girl child education in Nigeria. International journal of academic research in progressive education and development. 2013; 2: ISSN: 2226-6348.
7. Violence against Persons (Prohibition) Act, 2015.Laws of the Federation of Nigeria
8. Osezua OC, Agholor HN. Patriarchy, cultural prejudices and spousal violence in the ancient city of Benin of southern Nigeria. Journal of international women's studies 2019;20:409-22.
9. Adika VO, Agada JJ, Bodise-Ere K, Ojokojo MEY. Men's attitude and knowledge towards gender-based violence against women in Yenagoa, Bayelsa State. Journal of Research in Nursing and Midwifery 2013;2:77-83.
10. Antai DE, Antai JB. Attitudes of women toward intimate partner violence: a study of rural women in Nigeria. The International Electronic

Journal of Rural and Remote Health Research, Education, Practice and Policy. 2008;26:245-51.

11. National Population Commission (NPC) [Nigeria} and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF.
12. Oshiname FO, Ogunwale AO, Ajuwon AJ. Knowledge and Perceptions of Date Rape among Female Undergraduates of a Nigerian University. African Journal of Reproductive Health. September 2013;17:137-48.
13. Edo State Government. Edo State Official Website. Available at www.edostategov.ng Accessed on 15th of January, 2023.
14. National Population Commission (NPC). Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International 2014.
15. Cochran WG. Sampling Techniques. Third Edition. New York: John Wiley & Sons, Inc.1977:149-56.
16. Awusi, VO, Okeleke VO, and Ayanwu BE. Prevalence of domestic violence during pregnancy in Oleh, a sub-urban Isoko Community, Delta State, Nigeria. Benin Journal of Postgraduate Medicine 2009;11:15-20.
17. Ameh N, Abdul M. Prevalence of domestic violence amongst pregnant women in Zaria, Nigeria. Annals of African Medicine 2003;3: 4-6.
18. Efetie E and Salami H. Domestic violence on pregnant women in Abuja, Nigeria. Tropical Journal of Obstetrics and Gynaecology 2007;27:379-82.
19. Oseni TIA, Salam TO, Ilori T, Momoh MO. Prevalence and pattern of intimate partner violence among men and women in Edo State, Southern Nigeria. Afr J Prim Health Care Fam Med. 2022 Aug 18;14: e1-e7. doi: 10.4102/phcfm. v14i1.3147. PMID: 36073121; PMCID: PMC9453150.
20. Wang L. Education, Perception Factors, and Prevention of Intimate Partner Violence: Empirical Research on Chinese University Students' Perceptions and Attitudes Concerning Intimate Partner Violence. Journal of Interpersonal Violence 2019;34:1611-32.
21. Oladepo O, Yusuf OB and Arulogun OS. Factors Influencing Gender Based Violence among Men and Women in Selected States in Nigeria. African Journal of Reproductive Health2011;15:78.
22. Nmadu AG, Jafaru A, Dahiru T, Joshua IA, Nwankwo B, Mohammed-Durosinlorun A. Cross-sectional study on knowledge, attitude and prevalence of domestic violence among women in Kaduna, north-western Nigeria. BMJ Open. 2022 Mar 8;12:e051626. doi: 10.1136/bmjopen-2021-051626. PMID: 35260449; PMCID: PMC8905932.
23. Oche OM, Adamu H, Abubakar A, Aliyu MS, Dogondaji AS. Intimate Partner Violence in Pregnancy: Knowledge and Experiences of Pregnant Women and Controlling Behavior of Male Partners in Sokoto, Northwest Nigeria. Int J Reprod Med. 2020 Mar 6;2020 :7626741. doi: 10.1155/2020/7626741. PMID: 32206671; PMCID: PMC7079217.
24. Basar F, Demýrcý N, Cýcek S, Yesýldere Saglam H. Attitudes Toward Violence Against Women and the Factors That Affect Them in Kutahya, Turkey. Afr J Reprod Health. 2019 ;23:16-26. doi: 10.29063/ajrh2019/v23i1.2. PMID: 31034168.