

**KNOWLEDGE, PERCEPTIONS AND HELP-SEEKING BEHAVIOURS
TOWARDS MARITAL RAPE AMONG WOMEN IN
OYO STATE, NIGERIA**

OGUNWALE, AKINTAYO OLAMIDE
(02/250A076)
B.Sc. (Ed.) (Ilorin), M.P.H. (Ibadan)

**A THESIS SUBMITTED TO THE DEPARTMENT OF HEALTH PROMOTION AND
ENVIRONMENTAL HEALTH EDUCATION, FACULTY OF EDUCATION,
UNIVERSITY OF ILORIN, ILORIN, KWARA STATE, NIGERIA, IN PARTIAL
FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DOCTOR OF
PHILOSOPHY DEGREE IN HEALTH EDUCATION**

DR. O.L OLAITAN
SUPERVISOR

JULY, 2018

DECLARATION

I, Ogunwale Akintayo Olamide hereby declare that this dissertation entitled “Knowledge, Perceptions and Help-Seeking Behaviours of Marital Rape among women in Oyo State, Nigeria” is a record of my work. It has neither been presented nor accepted in any previous application for a higher degree. All sources of information have been acknowledged.

OGUNWALE, A.O.

Date

CERTIFICATION

This is to certify that this dissertation entitled “Knowledge, Perceptions and Help-Seeking Behaviours of Marital Rape among women in Oyo State, Nigeria” has been read and approved as meeting the requirements of the Department of Health Promotion and Environmental Health Education, University of Ilorin, Ilorin Nigeria for the award of Doctor of Philosophy Degree (PhD) in Health Education

Dr. O. L. Olaitan
(Supervisor)

Date

Dr. O. L. Olaitan
(Head of Department)

Date

Prof. N.B. Oyediji
(Dean of Education)

Date

(External Examiner)

Date

DEDICATION

This dissertation is dedicated to the great God of perpetual grace, Saviour of mankind, the Holy One of Heaven. Hallow and honour to His immortal name. His grace has saved met through the thick and thin. To Him alone be all the praise.

ACKNOWLEDGEMENTS

All praise to God Almighty for His unending love, grace, gift of wisdom and provisions which helped in completing this study. To Him be all the glory and honour.

The researcher is greatly indebted to the competent, brilliant and charismatic supervisor, Dr. O.L Olaitan who has really contributed immensely to this work. His exceptional, professional and sound guidance was instrumental to the successful conduct and completion of this study. He was always ready to listen, advise, make constructive criticisms and offer support. May God Almighty reward him abundantly.

The researcher wishes to express profound gratitude to Prof. R.A Sheu- the immediate past Head of Department and the Departmental Post Graduate (PG) programme Coordinator, whose invaluable and multifarious insights played critical role in the shape and content of this work. Also, sincere gratitude goes to Prof A.A Sanusi and Dr. O.S Oniyangi who provided good intellectual insights and helped in validating my study instruments. The researcher cannot forget Dr A.O Onifade for his fatherly advice, moral support and intellectual input into this work. Special thanks to Dr. I. Ologele, the Assistant PG Coordinator, for his support, words of encouragement and friendly gestures. The researcher sincerely appreciates the help and inputs of other highly esteemed lecturers in the department- Mr. D. A. Baba, Mrs K.A. Jiddah, Mrs. A. M. Elias, Mrs. J. F James, Mr. I. Kperogi, Mr. S. N. Akorede and Mr. Q. A. AbdulRasaq. The intellectual contributions of Prof E.A. Ogunsakin are specially acknowledged.

It is necessary to thank Dr. Bode Kayode and other sound scholars and examiners within and outside the University who made huge contributions to this work. The researcher acknowledges all the authors whose works were used as reference materials for this study. Also, the contributions of all the community leaders and contact persons who provided support during the data collection are acknowledged.

The researcher is indebted to Dr. O.F. Oshiname and Dr. O.E Oyewole for their sound mentoring, professional advice and fatherly love. Also recognized and appreciated is the warm support of Prof. J.G Adewale, the Provost, Oyo State College of Agriculture and Technology (OYSCATECH) Igboora, the entire staff of the Department of General Studies as well as other colleagues in OYSCATECH, Igboora, Oyo State. Special appreciation goes to Mrs O. Amao,

Damilola Oyewo, Engr. O.E. Akangbe and Engr. A.O Ilori for their strong support and encouragements.

The researcher appreciates Dr. I.O. Oguntunji, Mr L.O. Malomo, Mrs E. Fasikun, Mrs Oyewole and Mr O. Amao for encouragement and support in the course of the programme. Special tributes need to be paid to Bukky Ogunbela, Jamiu Abdulqudus, Emmanuel Alebiosu for their various assistance and support which contributed to the success of this research work. A million thanks to Janet Ogundairo, Adebisi Adebimpe, Funmilayo Shittu, Omotunde Ilesanmi and Ibukun Tubi for their assistance and support during the field work. The researcher is equally grateful to all the hardworking and competent research assistants who provided good help in the course of conducting the study. The researcher received plenty of inestimable friendly support and strong encouragements from Bukky Oyawuyi, Oladipupo Olaleye and Jubeelo Tella. Special appreciation goes to Reverend (Dr) & Dr (Mrs) Awopegba, Rev & Mrs Adeleke, Pastor & Mrs Olubodun, Architect & Evangelist (Mrs) Akintunde, Pastor Temitope Oyeyemi, Dr. Odunayo Familoni, Bro. Gbenga Adeoye and Bro. Kunle Amosu for their warm support, encouragement and fervent prayers. The unparalleled love and outstanding support received from Ajibola Popoola are sincerely acknowledged.

The researcher is eternally grateful to his wonderful parents, Mr. & Mrs. J.B. Ogunwale, whom God has been using as sources of blessing and Joy. Their ceaseless prayers, encouragement and love have always been yielding positive results. Much love to Akinniyi, Temmy, Jason and Mr Yinka Akindele. I cannot forget the soothing smile of my treasured brother- Kayode Akintude Ogunwale, who departed so soon.

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LIST OF ABBREVIATIONS

CDC- Center for Disease Control and Prevention

CEDAW- United Nation’s Convention on the Elimination of All Forms of Discrimination
Against Women

CLEEN- Center for Law Enforcement Education in Nigeria

FGN- Federal Government of Nigeria

HIV – Human Immunodeficiency Virus

ICCPR- International Covenant on Civil and Political Rights

ICPD- International Conference on Population and Development

NDHS – Nigeria Demographic and Health Survey

PSTD- Post Traumatic Stress Disorder

SPSS – Statistical Package for Social Science

STIs – Sexually Transmitted Infections

UNFPA- United Nations Population Fund

UNICEF – United Nations Children’s Fund

UNIFEM- United Nations Development Fund for Women

UNODOC- United Nations Office on Drugs and Crime

VAPPA- Violence Against Person’s Prohibition Act

WHO – World Health Organisation

ABSTRACT

Marital Rape is a public health problem which poses great threat to the health and wellbeing of many women. Despite the serious nature of the problem, it has received only minimal public health attention in Nigeria. Evidence-based data on knowledge, perceptions and issues on help-seeking behaviours which could be used to facilitate the design of appropriate interventions for addressing marital rape are scanty. The objectives of the study were to: (i) assess knowledge of health consequences of marital rape; (ii) determine perception of marital rape; and (iii) identify help-seeking behaviours relating to marital rape among married women in Oyo State, Nigeria.

The study adopted a descriptive cross-sectional design and employed mixed research methods. A total of 1,200 women who had ever been married and aged 18 – 60 years were sampled into the quantitative component of the study using a multi-stage sampling technique. A pretested researcher-designed semi-structured questionnaire with co-efficient alpha of 0.89 was used to collect quantitative data. Focus Group Discussions (FGD) guide was used to elicit qualitative data from 12 homogenous groups of women. Quantitative data were analyzed using descriptive statistics and Chi-square (χ^2) at $p = 0.05$, while the FGD were subjected to thematic analysis.

The findings of the study were that:

- i. knowledge of health consequences of marital rape was significantly determined by respondents' educational status ($\chi^2=30.3$, $df=6$, $p<0.001$); The FGD participants revealed that women often experience various health and social consequences such as body and vagina injuries, depression, divorce and strained relationships as a result of marital rape;
- ii. perception of marital rape was significantly determined by respondents' age ($\chi^2=22.59$, $df=2$, $p<0.001$); Majority of the FGD participants perceived marital rape as a less serious form of violence; and
- iii. help-seeking behaviour of marital rape was significantly determined by perception of marital rape ($\chi^2=10.43$, $df=2$, $p<0.001$); The thematic analysis revealed that shame and fear of being stigmatized contributed to the behaviour of not seeking for appropriate help including healthcare, counseling services and social support.

The study concluded that women's educational status was a factor that influenced knowledge of health consequences of marital rape and women's age was related to perception of marital rape. In addition, perception of marital rape influenced help-seeking behaviour among marital rape survivors. The implication of this study is that women's knowledge, perception and help-seeking behaviour which are essential for marital rape control are inadequate. Therefore, the researcher recommended that community-based educational initiatives should be employed for promoting knowledge of health burden of marital rape. Public health education programmes focusing on changing perceptions that can increase vulnerability to marital rape should be organized for women in the communities. Also, social support should be given to marital rape survivors to enable them seek for appropriate forms of help.

Word Count: 453

CHAPTER ONE

INTRODUCTION

Background to the study

Violence against women including sexual violence is a global public health and human rights problem and is ranked as one of the most severe forms of violations of human dignity (Garcia-Moreno & Stockl, 2009). It has been noted to cuts across ethnicity, race, class, religion, education level, and international borders (USAID, 2012). Although violence against women is a universal phenomenon, the scope of the problem differs from one society to another (WHO, 2010). Violence against women especially by their male partners is more serious in African societies including Nigeria (Oyediran & Isiugo-Abanihe, 2005; Tegbar, Yemane, Nigussie & Mirgissa, 2010; Ushie, Eneji, Ugal, Anyaoha, Ushie, & Bassey, 2011).

The UN Convention on Declaration on Violence against Women of 1993 (CEDAW) defines "violence against women" to mean any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, whether occurring in public or in private life (United Nations, 1993). Violence against women which may also be referred to as gender-based violence undermines not only the safety, dignity, overall health status, and human rights of the millions of individuals who experience it, but also affects economic stability, and security of nations (United Nations General Assembly, 1993; USAID. 2012). The African Charter on Human and Peoples' Rights (Banjul Charter) ensures provisions for the protection of the woman from violence and the State obligations to ensure that the woman's rights to equality and non-discrimination are achieved (Amnesty International, 2007).

All forms of violence against women or gender-based violence constitute universally acknowledged deviant criminal behaviours which are condemned and frowned upon by various international human rights treaties such the United Nations Convention on Elimination of all forms of Discrimination Against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR) and African Charter on Human and People's Rights (United Nations, 1993; United Nations General Assembly, 1991; United Nations Population Fund, 1999; United Nations Development Fund for Women, 1999). Nigeria is a signatory to these international human rights treaties (Amnesty, International, 2007).

Violence against women takes many forms including physical, sexual, psychological and economic (WHO, 2010; USAID. 2012). An estimated one in three women worldwide has been beaten, coerced into sex, or otherwise abused in her lifetime (Heise, Ellsberg & Gottemoeller, 1999). Rape and other forms of sexual violent behaviours are ranked among the most serious and extreme forms of gender-based violence affecting women in different parts of the world (Buddie and Miller, 2001; Onyejekwe, 2008; Amnesty International, 2009; WHO, 2010; USAID; 2013). Rape and other forms of sexual violence compromise women physical and emotional integrity, dignity, autonomy as well as privacy. According to World Health Organization report, one fifth of all women have experienced rape and other forms of related sexual assaults (Garcia-Moreno & Watts, 2011).

Rape is not peculiar to any particular ethnicity or socio-economic class and cuts across all ages in Nigeria (Akinlusi, Rabi, Olawepo, Adewunmi, Ottun & Akinola, 2014). All women or females of all age groups are at risk of rape but the most vulnerable include out-of- school adolescents (Ajuwon et al, 2001; Okoro & Obozokhai, 2005), students of tertiary institutions

(Geidan, Njoku & Bako, 2010; Olaleye & Ajuwon, 2011; Ogunwale et al, 2012), the physically challenged (Ekabua, Agan, Iklaki, Ekanem, Itam & Ogaji, 2006) and children (Akinlusi et al, 2014). Women in dating relationships (Izugbara, Duru, Dania, 2008; Ogunwale et al, 2012) and married women (Ashimolowo & 2012; Uwaoma, Osita-Njoku & Madukwe, 2011) have also be noted to be vulnerable to rape in Nigeria. Despite the reality of marital rape and some evidence-based data that corroborate it, many people in Nigeria are favorably disposed to doubting the existence of rape in intimate relationship. Marital rape thus represents a health problem that is often not given the much needed public health attention.

Rape can be defined as any form of sexual penetration which is often characterized by use of force, threat, deception, fear of harm, inducing substances or other measures that may interfere with consent or sexual rights of an individual (Tjaden & Thoennes, 2006; Ogunwale, Oshiname & Olaitan, 2014). Several studies such as Bergen, (2006), Olaleye & Ajuwon, (2011); Akinlusi et al (2014) and CLEEN (2014) have noted that most perpetrators of rape are people who are known to rape survivors including acquaintances, friends, neighbors, people in position of authority, relations, dating partners and spouses. Rape committed by a spouse or husband falls under the category of marital rape (Ogunwale et al, 2014).

Marital rape which is also known as spousal rape can be described as sexual intercourse or penetration carried out by a spouse with the use of force, threat of force, or any other coercive means (Bergen, 2006; Ambekar, 2009). It includes any form of unwanted sexual intercourse which could be in form of vaginal, anal or oral sex (Monisola & Ajayi, 2013).

Marital rape may also be referred as spousal rape or wife rape or rape in matrimony (Bergen, 2006; Monisola & Ajayi, 2013).

Marital rape is one of the serious forms of violence against women that has existed for centuries throughout the world (Russell, 1990; WHO, 2002; Salan, 2005). This condemnable social demeanour is prevalent in most parts of the world especially developing nations including Nigeria (Uwaoma et al, 2011; WHO, 2013). Studies such as Dratch (2006) and Mahoney and Williams (2007) have noted that marital rape accounts for about 25% of all rapes and is experienced by 10-14% of married women. Some studies such as Uwaoma et al (2011), Envuladu, Chia, Banwat, Lar, Agbo, Zoakah (2012) and Ezechi et al (2004) have documented that marital rape is a pervasive health burden which affects many women in Nigeria.

It has been noted that most women who are raped in marriage experience severe forms of physical abuse and emotional abuse (Eby, Campbell, Sullivan, & Davidson, 1995; Bergen, 2006). The extent of trauma and psychological injury faced by survivors of marital rape may be greater than that of other forms of rape such as stranger rape and acquaintance rape (Bennice & Resick, 2003). Marital rape affects women physically, emotionally and mentally, and has significant negative impact on families and society in general. Many survivors of marital rape are likely to experience repeated episodes of rape (Tjaden & Thoennes, 2006). Survivors of marital rape are less likely to get help or support from friends, family, crisis centers and the police than those who are survivors of other forms of rape (Leslie, 2003). Survivors of marital rape could have to resort to enduring their ordeal and finding ways of coping on their own with their ordeals despite the health consequences and distinct psychological trauma that could be associated with marital rape experience. Being

knowledgeable about the seriousness of marital rape and the myriads of health consequences of marital rape could make women to view marital rape as being serious and seeks for appropriate preventive and control measures.

Most survivors of marital rape on their own may not view forced sex from partners as a crime or problem that demand attention (Kung'u, 2011) and often considered the phenomenon as a private matter (Bennice & Resick, 2003). Such negative perception represents tacit tolerance for sexual violence in marriage in our societies and could be a disincentive for practicing appropriate behaviours including seeking for help from professionals that could facilitate the prevention and control of marital rape.

Evidence-based data on women's knowledge of health burden of marital rape, their perception of marital rape as well as behaviour relating to seeking for help when marital rape could serve as useful baseline data for designing and implementing appropriate interventions that are useful for the prevention and control of marital rape. This explains why this study was designed to determine marital rape related knowledge, perceptions and help-seeking behaviours among married women in Oyo State, Nigeria.

Statement of the Problem

Ideally it is normally expected that married partners will have consensual sexual intercourse as part of the privileges of marriage, but situations where women experience forced or coercive sexual intercourse in the hands of their spouses is abnormal and constitute act of abuse. Marital rape remains one of the serious forms of domestic violence that is yet to be fully recognized in Africa including Nigeria despite evidence suggesting the pervasive nature of the phenomenon.

In Nigeria, studies such as Ezechi et al (2004); Uwaoma et al (2011) and Ashimolowo and Otufale (2012) have earlier observed that marital rape is a health burden that is being experienced by women in Nigeria. For instance, a study conducted by Uwaoma et al (2011) in Imo State in Nigeria among 350 purposively selected women revealed that 27.8% women had ever experienced marital rape. Another study conducted by Ezechi et al (2004) among pregnant women attending ante-natal clinics in two private hospitals in Lagos observed that 14.2% pregnant women suffered forced sexually intercourse in the hands of their husbands. Ashimolowo and Otufale (2012) who conducted a study on domestic violence among 220 women that were purposively selected from two agricultural zones in Ogun State observed that 11.3% women had being subjected to marital rape. Although few afore-mentioned studies have shown that marital rape is prevalent in Nigeria, it was observed that the information on marital rape in Nigeria are mainly derived from sentinel studies and did not utilize rigorous methodological procedures and had some methodological flaws. The use of large sample size and adoption of robust methodological approach including the combination of both quantitative and qualitative data that are more generalizable for exploring the burden of marital rape phenomenon in Nigeria is more desirable.

Marital rape poses serious health consequences to the health of women (Bergen, 2006). Women who are survivors of marital rape experience various forms of physical and vagina injuries and reproductive health consequences such as sexually transmitted infections, HIV and unwanted pregnancies due to limit women's ability to practice safer sex (WHO, 2010). Experience of marital rape during pregnancy may increase the risk of low birth infant, preterm delivery and neonatal death (Covington, Hage, Hall & Mathis, 2001); Bergen, 2006; Ntaganira, Muula, Siziya, Stoskopf, & Rudatsikira, 2009). The social health consequences associated with marital rape often affect the social roles of

women and have overreaching effects on their families and jobs. The researcher observed during his practicum in Ibadan, Oyo State, observed that many women who have been raped by their husbands often experience intense psychological consequences which include anxiety, depression, negative feelings about sex, feelings of helplessness as well as post-traumatic stress disorder. Previous studies such as Bennice and Resick (2003) and Mahoney and Williams (2007) noted that a survivor of marital rape may experience multiple or repeated cases due to the husband's access to his wife. This situation often leads to constant psychological trauma and debilitating social consequences.

During practicum in Ibadan, the researcher observed that several women have the perceptions that support or encourage marital rape. It was noted that women's perception of marital rape is a serious problem which influence their attitudes and behaviours towards adoption of appropriate prevention and control measures. A previous study conducted among dating partners by Oshiname, Ogunwale and Ajuwon (2013) noted that having negative or supportive perception for rape could be associated with experience of rape. The pattern of perception of rape as well as women's characteristics traits that could be associated with it need to be fully explored.

In addition, it is assumed that adequate attention is yet to be directed to married women knowledge of health consequences of marital rape, perceptions of marital rape related issues as well as behavioural practices that may have implications for the prevention and control of marital rape in Nigeria. This study was therefore designed to determine knowledge, perception and help-seeking behaviour among women in Oyo State, Nigeria.

Research questions

The following research questions were raised to guide this study:

1. What is the level of knowledge of the health consequences of rape among women in Oyo State, Nigeria?

2. What are the perceptions relating to marital rape among women in Oyo State, Nigeria?
3. What are the help-seeking behaviours of women who were marital rape survivors in Oyo State, Nigeria?

Hypotheses

1. Respondents' knowledge of health consequences of marital rape will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.
2. Respondents' perception of marital rape will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.
3. Respondents' previous history of sexual violence will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.
4. Respondents' age will not significantly determine the knowledge of health consequences of marital rape among women in Oyo State
5. Respondents' education status will not significantly determine the knowledge of health consequences of marital rape among women in Oyo State.
6. Respondents' family type will not significantly determine the knowledge of health consequences of marital rape among women in Oyo State.
7. Respondents' age will not significantly determine the perception of marital rape among women in Oyo State.
8. Respondents' marital status will not significantly determine the perception of marital rape among women in Oyo State.

9. Respondents' family type will not significantly determine the perception of marital rape among women in Oyo State.
10. Respondents' age will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.
11. Respondents' marital status will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.
12. Respondents' family type will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.

Purpose of the study

The main objective of this study was to investigate knowledge, perception and help-seeking behaviour of marital rape among women in Oyo State, Nigeria. Specifically, this study was designed to;

1. assess the knowledge of the health consequences of rape among women in Oyo State, Nigeria.
2. determine the perceptions relating to marital rape among women in Oyo State, Nigeria.
3. Identify the help-seeking behaviours of marital rape among women in Oyo State, Nigeria.

Significance of the study

There are many issues that are yet to be fully understood and explored on the subject of marital rape in Nigeria. This research which was formative in nature has the potential to contribute to knowledge gaps relating to marital rape issues in Nigeria. Legal provisions

relating to rape in Nigeria do not adequately capture marital rape issues. The study findings may be helpful in raising awareness and contributing to the shaping of reforms, policies and laws relating to marital rape in Nigeria.

The study is potentially beneficial for designing interventions that will address issues relating to knowledge, socio-cultural norms and practices that favour the marital rape occurrence in Nigeria. It could also be particularly used in creating awareness on the reality, nature, magnitude and health consequences of marital rape. The findings of the study can help married women gain knowledge of potential situations, skills and measures that can be used to prevent marital rape as well as promote healthy marital relationships. Creating awareness on the need for survivors of marital rape to seek medical care and psycho-social assistance is also very crucial. The findings of this study could also be very useful in this direction. Evidence from the study can help health specialists including medical doctors, health educators, health counselors as well as law enforcement officers, legal practitioners and other professional that may have contact with abused women or survivors of marital rape gain insight into various marital rape related issues including nature of marital rape, how to resolve marital rape problem, types of support services relating to prevention and control of marital rape which can be offered.

Scope and Delimitation of the Study

The study was conducted in Oyo State. All categories of women with marital experience including those who are married, divorced or widowed constituted the population of this study. The study adopted a descriptive design of cross-sectional type. Elderly women who

are above the age of 60 years were excluded from the study. The sample size for the survey was 1,200 women. A multi-stage sampling was used to select participants appropriately from senatorial districts, Local Government Areas (LGAs), wards, communities and houses. A total of 6 LGAs out of the 33 LGAs were used for the study. Researcher's designed structured questionnaire was used for collection of quantitative data. Qualitative data were also collected by conducting twelve focus group discussions across different parts of Oyo State (2 FGDs were conducted in Oyo town, 2 FGDs were also conducted in Ogbomoso town while 8 FGDs were done in various parts of Ibadan metropolis).

The quantitative data was analyzed using descriptive statistics such as frequency counts and percentages for univariates data and inferential statistics in form of chi-square at 0.05 level of significance. Analysis of the quantitative data were facilitated by the use of the Statistical Package for Social Science (SPSS) version 20.0. The qualitative data analysis process involved transcription of the tape-recorded data, coding using a mixed method of deductive and inductive coding approach and thematic analysis was done with the use of ATLAS Ti version 7.5. Results from both quantitative data and qualitative data were triangulated and presented in the study. The main outcome variables of the results were knowledge of health consequences of marital rape, perception of marital rape as well as help-seeking behaviours of marital rape survivors. Experiences of marital rape among the women were first identified before determining the help-seeking behaviours associated with marital rape.

Operational Definition of Terms

The under listed operational terms are defined with respect to their peculiar meaning in the present study.

Help-seeking behaviour: A term used to describe a constructive or positive response/action relating to medical service, counseling, legal service or any other assistance or measure useful in addressing challenges associated with marital rape.

Marital rape: It describes the type of rape that a woman suffers in the hands of her husband or ex-husband.

Knowledge of health consequences of marital rape: This refers to facts, correct information and practical understanding about health consequences of marital rape that has been acquired through experience or education.

Perception of marital rape: It refers to the way in which individuals conceive or interpret the issue of marital rape. Within the context of the study, individuals' perceptions were labeled as either negative (inappropriate) or positive (appropriate) perception.

Previous history of sexual violence – refers to the different forms of sexual violence excluding marital rape that women had experience before being married to her spouse.

Survivor of marital rape: A woman who had suffered experience of unwanted or coercive sexual intercourse in the hands of her husband. This expression is preferred to the word “victim” so as to avoid stigmatizing against them.

Woman: A female person who is currently married or ever been married (include those who are divorcee and widows)

CHAPTER TWO

REVIEW OF RELATED LITERATURE

A literature review is an organized and systematic presentation of what has already been studied and published on a particular subject, with the purpose of informing the researcher on what is already known about that subject (Burns & Grove, 2005). The focus of this study is to investigate marital rape related knowledge, perceptions, and help-seeking behaviours among married women in Oyo State, Nigeria. This chapter deals with review of some related literatures and serves as links between the past works and the current study. Therefore, based on the above research problem, scholarly articles including international, national and local journals; periodicals and books related to the study were extensively reviewed in the following areas viz:

- Conceptual Framework of the Study
- Theoretical Framework of the Study
- Introduction and concept of marital rape
- Prevalence of marital rape
- Factors which can increase women's vulnerability to marital rape
- Factors that can increase men's risk of committing marital rape
- Perceptions relating to marital rape
- Help-seeking behaviours of sexually abused women
- Health consequences of marital rape
- Rape prevention and control approaches
- Appraisal of Literature review

THE CONCEPTUAL FRAMEWORK

Conceptual framework deals with the ways in which ideas are organized to achieve the purpose of a research (Shields & Rangarjan, 2013). The design of the conceptual framework

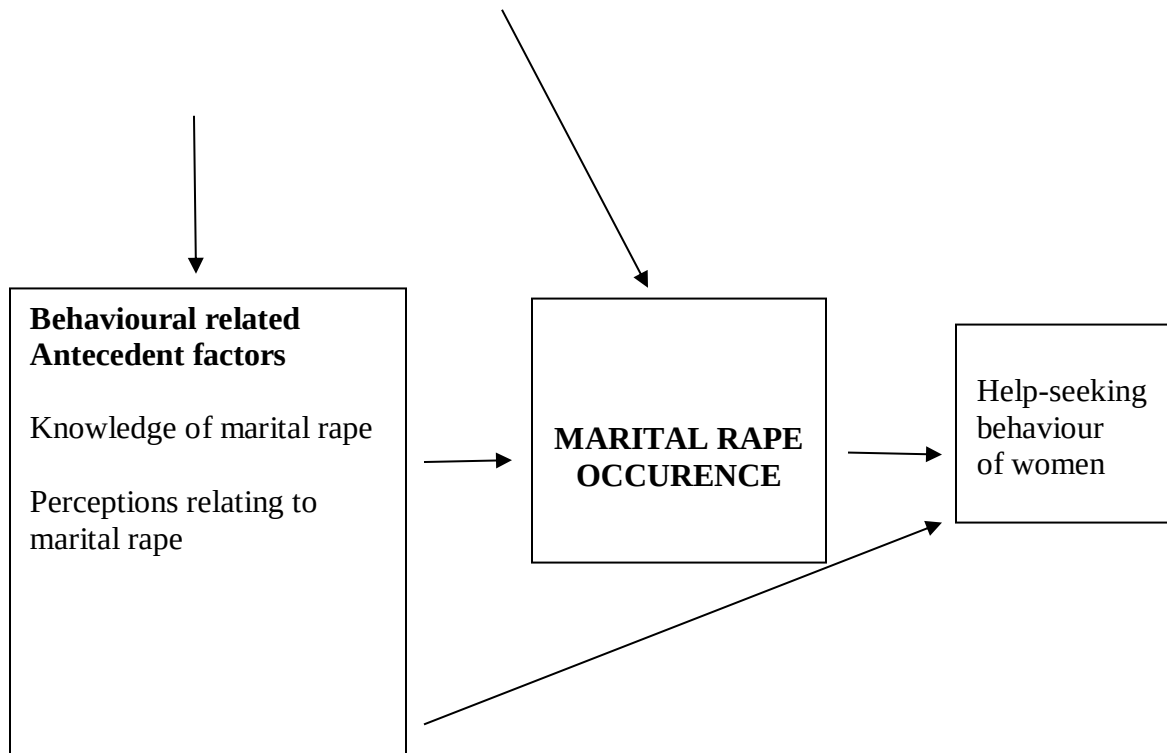
for this study is based on the objectives of the study and variables gleaned from the relevant theories. The conceptual framework presents marital rape occurrence as a major health problem confronting married women with the various related antecedent variables. In this study, the researcher hypothesizes that variables such as age (being young), educational level, religion and history of sexual victimization could influence marital rape occurrence or situation. Besides, these demographic characteristics of married women can also be linked behavioural related antecedent factors of marital rape such as knowledge of marital rape, perceptions relating to marital rape. A survivor's failure or inability to seek for help following experience of marital rape may promote re-victimization experience (i.e re-occurrence of marital rape). Experience of adverse physical, social and mental health consequences following marital rape occurrence may influence survivors to seek for appropriate help in form of medical care, psycho therapy, counseling, social support and/or legal advice and intervention.

**ANTECEDENT
VARIABLES**

Individual Characteristics
Age of a married woman,
Educational level or background
Type of family
Marital status
Previous history of sexual violence

**PROXIMATE
VARIABLE**

**OUTCOME
VARIABLE**



Source: Researcher Developed (2016)

Figure 2.1 - Conceptual framework of marital rape experience among married women

THEORETICAL FRAMEWORK

A theory is a set of well-defined concepts, definitions and propositions that explain or predict events or situations by illustrating the relationships between variables (Nutbeam & Harris,

1999; Glanz & Rimmer, 2005). Theories help to explain the dynamics of health behaviours, including processes for changing them, and the influences of the many forces that affect health behaviours, including social and physical environments. Theories provide researchers and practitioners in the field of health promotion and education a road map for studying problems, developing appropriate interventions, and evaluating their successes (Glanz & Rimmer, 2005). Researchers and practitioners use theory to investigate answers to the questions of “why,” “what,” and “how” health problems should be addressed. By seeking answers to these questions, researchers and practitioners clarify the nature of targeted health behaviours (Glanz & Rimmer, 2005). Health promotion theories and models can help to bind together research observations and ideas, and make sense of them (Nutbeam & Harris, 1999). The Health Promotion related theories which have been tested and found to be relevant to this study include Social Learning Theory, Ecological Model and PRECDE Model.

Social Learning Theory

Social Learning Theory which was postulated by Albert Bandura asserts that people learn not only from their own experiences, but by observing the actions of others and the benefits of those actions. The theory expands on traditional behavioural theories, in which behaviour is governed solely by reinforcement, by placing emphasis on the important roles of various internal processes in the learning individual. Social learning theory integrated behavioural and cognitive theories of learning in order to provide a comprehensive model that can account for the wide range of learning experiences that occur in real world. Social learning theory draws heavily on the concept of modeling, or learning by observing a behaviour (Bandura, 1973; Bandura, 1979).

Bandura (1979) contends that aggression is learned by observing models that exist in everyday society and outlines three sources of these models: one's family; one's subculture; and the mass media. Parents are often potent models of behaviour for children. Alexander, Moore, and Alexander (1991) suggests that children who witness sexual violence between their parents learn powerful messages about gender hierarchy and power that could influence their relationships later in life. Several studies have revealed that experiencing and/or witnessing sexual violence in childhood, is linked with future sexual violence and intimate partner violence (Riggs, Caulfield & Street, 2000; Humphrey and White, 2000; Stith, Rosen, Middleton, Busch, Lundeberg & Carlton, 2000; Kaura & Allen, 2004).

The subculture in which one lives or with which one has repeated contact can also be a source of aggressive models. Violent peers, gangs and certain all-male enclaves are examples of such subgroups. Subcultures that value traditional male roles and the "macho" image teach younger generations that aggressive behaviour is acceptable, functional, and rewarding. Previous studies such as Boeringer, Shehan, & Akers (1991) and Olley (2008) have noted that peers can also serve as models of sexual aggression. It is suggested that inclusive peer groups or male groups such as fraternities may provide a context for modeling and reinforcing rape-supportive behaviour (Boeringer et al, 1991). Positive consequences for sexual aggressive behaviour may include social approval, affirmation of one's masculinity and manhood, and increased social status. Negative consequences for refusing to engage in sexual aggression may include ostracization, rejection, and ridicule. Men who have friends who indulge in sexual abuse of women or have rape supportive behaviours have more opportunities to observe such behaviours modeled and reinforced.

A third source of aggressive models noted by Badura (1973) is the mass media. Television, for example, has been shown to be an excellent vehicle for the symbolic modeling of aggression. Previous studies such as Malamuth and Check (1981) and Donnerstein (1980) have noted that sexual violence against women is symbolically modeled through violent pornography and aggressive-erotic films. Donnerstein (1980) found in his experimental study that the men who watched an aggressive-erotic film (rape film) later displayed the most intense aggression, but only towards female confederates.

One of the tenets of social learning theory is that aggression is learnt behaviour acquired through observation and imitation of people. Explaining marital rape from social learning theory point of view, it can be said that marital rape which is an aggressive or violent behaviour may be perceived as normal behaviour by some women when they observe that close significant persons such as mothers or friends have suffered or endured such behaviours. Young women can gain knowledge of marital rape as well as cultivate their perception and help-seeking behaviours relating to marital rape from their observation of older women or their fellow women's behaviours or experiences of marital rape. Women can acquire their knowledge, perceptions as well as develop behaviours relating to marital rape from social contacts or structures such as mass media and religious organizations. Mass media wrong portrayal of marital rape related issues has the potential of influencing women's experience, perception and behaviour relating to marital rape. The theory also suggests that repeated or previous exposure to marital rape or similar sexual violence may cause individuals or survivors to accept or tolerate such aggressive behavior. This implies that previous experience of sexual violence can reinforce future behaviour or experience of

marital rape. Sternberg and Williams (2009) alluded to the fact that reinforcement can also contribute to motivated behavior.

Ecological Model

Ecological model explains how the physical and socio-cultural environments at various levels influence people's behaviour. These levels highlight the interaction and integration of biological, behavioural, environmental and social determinants, as well as the influence of organisations (such as workplace and clubs), other persons (like family, friends and peers), and public policies which together help individuals make healthy choices in their daily lives (Glanz & Rimmer, 1995). Several studies and reports such as Heise et al (1999); WHO (2002) and WHO (2010) have used the Ecological model to explain and addresses issues relating to sexual abuse of women. Within the spectrum of ecological model, issues relating to marital rape can be analysed at five levels, which include- intra-personal, inter-personal, organizational, Community and policy.

Intra-personal factors are personal factors which include biological and personal history that may increase the likelihood that an individual will become a survivor or perpetrator of sexual violence and inter-personal violence (WHO, 2002; WHO, 2010). Relevant intrapersonal factors that can put a woman of risk of being sexual violence and other forms of abusive behaviours in the hands of her husband may include low socio-economic status, being young and previous experience of sexual victimization as well as inadequate knowledge about issues relating to sexual violence and misperceptions about sexual violence. These intra-personal factors interface with the environment and society (Hanson, Hanson, Vardon, McFarlane, Lloyd, Muller & Durrheim, 2005).

Inter-personal factors include factors that increase risk as a result of relationships with peers, intimate partners and family members. These are a person's closest social circle and can shape their behaviour and range of experiences (WHO, 2010). According to WHO (2010), relationship characteristics such as having multiple sexual partners and peers acceptance of rape myths are some of the factors that could be related to perpetrating or experiencing of marital rape.

The organisational or institutional factors cover commercial organisations, institutions, associations and clubs which have structure, rules and regulations which enable people to pursue specific objectives and have direct influence over the physical and social environments maintained within their organisations (Hanson et al., 2005). Provision and accessibility to institutional social support, help and essential services from sources of help such as hospitals and Police are important factors that can influence sexual abuse of women as well as constitute essential strategies in the prevention and control of marital rape and other forms of abuses against women.

The community or societal factors have significant influence on the health behaviour or experience of individuals. The community refers to an assemblage or group of people interacting together and sharing social understanding or common interest. It provides means for socialization including adoption of certain norms, values, belief and habits. Societal norms, perceptions and response of the community towards abuse of women generally and marital rape in particular could influence occurrence of marital rape. Previous studies such as Izugbara et al (2004) and WHO (2010) observed that the society perceives men to be economically and religiously superior, and of higher status compared to women.

Policy refers to set of guidelines and provisions that guide human actions in social system. It includes regulations, rules or laws targeting the reduction of sexual violence including marital rape. The exemption of marital rape as an offence in the legal provisions addressing rape in Criminal and Penal Codes of Nigeria represents a serious policy gap that can serve as an incentive for marital rape occurrence as well as inhibits prevention and control of marital rape and other related offences.

The PRECEDE Model

The acronym PRECEDE stands for Predisposing, Reinforcing and Enabling Causes in Educational Diagnosis and Evaluation (Green & Kreuter, 1999). It has served as a conceptual framework in health education planning aimed at diagnosing the health problems of a community, understanding the factors that influence the people's behaviour and developing intervention to promote healthy behaviour (Green & Kreuter, 1999). The model consists of three groups of factors namely predisposing, enabling and reinforcing factors which can influence behaviour.

The predisposing factors are behavioural antecedent factors that make any given health-related behaviour more (or less) likely to occur. They are factors which must be present before a behavioural decision takes place (antecedent). Predisposing factors include knowledge, attitudes, values and inherent qualities which are useful for throwing light on the issue of marital rape. For example, little or lack of knowledge on issues relating to marital rape as well as rape myths related beliefs, perceptions and norms may increase a woman's vulnerability to marital rape or prevent her from labeling her victimization as rape. Abused

women may justify marital rape based on acceptance of traditional sex-role stereotypes and misconceptions relating to sexual consent in marriage.

Enabling Factors include resources, conditions of living, societal supports, policies and skills that facilitate behaviour occurrence. Several factors or circumstances including inability to satisfy husband sexually and inability to effectively communicate sexual refusal may facilitate the occurrence of marital rape. Lack or inaccessibility to proper social support and help services that can facilitate women prevent or control marital rape can make women have misperceptions about marital rape and/or prevent them from seeking for appropriate help.

Reinforcing factors relates to the influence of significant others such as peers, parents, other relations as well as significant bodies or organizations such as religious bodies, mass media. Friends and family members may discourage an abused woman from defining an incidence as rape as well as reporting and seeking help following experience of abuse (CLEEN, 2014). Close friends or family relations can be sources of emotional relieve, succor or rehabilitation for women who experience marital rape. Religion organizations through their various teachings, beliefs, programmes and practices can influence women's marital rape knowledge, perception and help seeking behaviours. Religious organizations should play positive roles in the eradication of misperceptions and inappropriate behaviours that can fuel marital rape.

Introduction and Concept of Marital Rape

Increasing evidence from researches and reports has done a great deal in putting the issues related to marital rape on the public agenda. Some of the researches that have yielded considerable evidence on marital rape issues include Hanson & Gidycz, 1993; Tjadan and Thoennes, 2000; Barnett, Miller-Perrin, and Perrin, 2005; Gage, 2015; Johnson & Das, 2009). Although there are limited available literature sources on that specifically focused on marital rape especially in developing nations including Nigeria (Bennice & Resick, 2003; Ambekar, 2009), the epidemiology and issues relating to marital rape cut across both developed and developing nations (WHO, 2002; WHO, 2010).

Serious challenges that have posed limitations to documentation of rape issues especially in Nigeria include the problem of under-reporting, fear of social stigmatization and shame (Ajuwon et al, 2001; Elegbeleye, 2006; WHO, 2010; Ogunwale et al, 2012). The reluctance in accepting that sexual consent can be denied within intimate relationships may be one of the reasons why marital rape is yet to be considered as serious problem in Nigeria. Nigeria is among the few nations in the world where marital rape constitutes an exception to the definition of rape (Uwaoma et al, 2011), despite the convincing epidemiological evidence that marital rape has severe consequences of rape on women's health and wellbeing (Heise et al, 1999).

There is no consensus of opinion on what constitutes rape (Lohmann, 2008). Definitions of rape have been based on various legal, socio-cultural, religious and philosophical perspectives. Many authors often use the terms "rape" and "sexual assault" interchangeably (Kullima, Kawuwa, Audu & Warkentin, 2008). It has been noted, however, that though the two concepts are related, some differences do exist between them (Warkentin, 2008).The

term “sexual assault” which is also referred to as “sexual violence” is broader than rape as it includes a range of other behaviours such as unwanted sexual touching or fondling and the use of arguments or pressure to coerce a woman into having sexual intercourse, as well as the legal definition of rape (Warkentin, 2008). Thus, rape can be said to be a form of sexual violence (Warkentin, 2008).

Rape can be succinctly described as an act of subjecting someone to unsolicited sexual contact or penetration against his or her wish or without obtaining his/her consent (Rana, 2008; Tjaden & Thoennes, 2006). Rape occurs when there is lack of choice or consent by an individual to engage in sexual encounters (Masho, Odor & Adera, 2005; Nadesan, 2001). Measures that may be used by rape perpetrators which may compromise an individual’s ability to give sexual consent include force or physical violence, threat, intimidation, pressure, blackmail, deception, fear of harm, abuse of position or authority, drug or inducing substances, taking undue advantage of age, immaturity, weakness, disability and health condition of an individual (Ogunwale et al, 2014). The various means used by rape perpetrators share a common characteristic; they all compromise an individual’s ability to give sexual consent devoid of coercion (Heise et al., 1999; Ogunwale et al, 2014; Olaleye & Ajuwon, 2011). Rape could be in form of genital, oral or anal penetration (Warkentin, 2008) and may involve the use of penis, finger, other body parts or objects such as stick and vibrator (Akinade, Adewuyi & Sulaiman, 2010).

Rape can exist in different forms or types (WHO, 2002; Akinlusi et al, 2014). Different forms or types of rape based on the nature of the rape or situation of occurrence may include “child rape” (rape committed against children; those that are less than 10 years are highly

vulnerable to this form of rape), Olley (2008) and Akinlusi et al (2014); ‘gang rape’ (rape committed by two or more persons); “male rape” (this is used to referred to rape committed by females against males; although this is less common than rape perpetrated against females, it does exist), WHO, 2002. Rape has also been reported among people of the same sex i.e those in homosexual sexual relationship (WHO, 2002).

There are various typologies or forms of rape based on the relationship between the rape survivor and offender (Akinlusi et al, 2014). These include “stranger rape” (rape perpetrated by unknown person(s) to the rape survivors), Tjaden and Thoennes (2010); “acquaintance rape” (rape perpetrated by a known person such as friends, neighbors and teachers, with whom an individual has not established a romantic relationship), Ogunwale et al (2013); “date rape” (rape which is perpetrated by someone with whom an individual (survivor) has willingly entered into a dating or romantic relationship), Ogunwale et al (2012) as well as marital rape which is yet to gain much public attention.

Marital rape may be described as an unwanted intercourse or penetration carried out by a spouse with the use of force, threat, or any other coercive means (Bergen, 2006; Ambekar, 2009). Some synonymous terms with marital rape are “spousal rape” and “wife rape”. Wife rape conceptualizes marital rape as sexual offences committed majortly women only. Some researchers adopt terms such as domestic violence, intimate partner violence, partner violence, or relationship violence to refer to marital rape situation (Forke, Myers, Catallozzi & Schwartz, 2008). The Domestic violence has been defined by WHO (2011) as the range of sexually, psychologically and physically coercive acts used against women by current or former male intimate partners. Hence, domestic violence extends beyond marital rape and

encompasses all other forms of violent acts against a partner including physical, emotional and sexual violence. The term Intimate Partner Violence (IPV) or partner violence is often reserved for describing aggression that occurs between cohabiting or married couples (Barnett, Miller-Perrin & Perrin. 2005; Coker, Davis, Arias, Desai, Sanderson, Brandt & Smith, 2002). Although marital rape may be considered within the broad spectrum of domestic violence, intimate partner violence and sexual violence, it however represents a serious form of public health problem affecting many women that should be considered as a different and unique phenomenon especially for the purpose of in-depth scholarly attention.

Prevalence of marital rape

Marital rape is a widespread social problem affecting a lot of women (Mahonney & Willimans, 2007), but due to cultural considerations especially as it manifest in a culture of silence and low reportage by survivors, it is extremely difficult to obtain a reliable data on the prevalence and incidence of marital rape as well as others forms of intimate partner violence (Adekeye et al, 2011).

There is limited research evidence on the magnitude of marital rape especially in developing nations (WHO, 2002). The few available information are often fragmented, derived from sentinel studies gleaned from studies focusing on sexual assault and most of these studies contain a number of methodological problems or limitations in the way the data were reported that make it difficult to arrive at estimates of the prevalence and incidence of marital rape.

A United Nations report on 65 countries compiled from government sources showed that more than 250,000 cases of rape or attempted rape were recorded by police annually (United

Nation, 2002). It has been reported that in some countries nearly one in four women experience rape by an intimate partner including dating partner (WHO, 2002).

In United States, one in four women is a survivor of a rape attack with majority of the cases involving intimate partners rape (Lohmann, 2008). The National Intimate Partner and Sexual Violence Survey of United States reported that nearly 1 out of 10 women in the United States has been raped by an intimate partner in her lifetime (Black et al, 2011). One of the earlier studies conducted on marital rape by Finkelhor and Yllo (1985) among 323 ever-married/cohabited women in Boston found that 10 percent were survivors of marital rape, while another study 930 San Francisco women found that 8 percent were survivors of marital rape (Russell, 1990).

According to USAIDS (2006) approximately 16% of married, divorced, or separated women experience sexual assault by their spouse. Kenya Demographic and Health Survey conducted in 2006 reported that 13% of married women being raped by their male partners. In Uganda, 40.4 percent of Uganda's women residing in the Lira & Masaka Districts reported that they experience forms of intimate partner violence including marital rape (WHO, 2002).

According to CLEEN (2014) national survey that was conducted among 11,518 women in various parts of Nigeria, it was noted that 2.3% of the women experienced rape in the hands of their husbands. The study carried out by Ashimolowo and Otufale (2012) reported a prevalence of 11.3% among 220 women in Ogun State. The study conducted by Uwaoma et al (2011) noted a prevalence of 27.8% among married couples in Imo State, Nigeria. Ezechi et al (2004) documented in their study which was carried out among pregnant women in the eastern part of Nigeria that 14.2% pregnant women were subjected into forced sexual

intercourse by their husbands. The prevalence of marital rape in Nigeria is likely to be seriously limited by underreporting and cultural factors that conspire to keep the marital rape survivors invisible (Oyediran & Isugo, 2005). In addition, inconsistencies in the prevalence of marital rape reported in the afore-mentioned studies may be due to methodological issues such as definition of the concept of marital rape, measurement errors as well as differences in sample size and sampling techniques adopted in various studies. This phenomenon, however, underscores the need for robust empirical data on prevalence and burden of marital rape across the various parts of Nigeria.

Factors which can increase women's vulnerability to marital rape

Marital rape is a phenomenon that mostly affects women especially young women who are sexually active (Russo, 2000). The risk of marital rape is likely to decline as women aged Humphrey and White (2000). Young persons are four times more likely than women older than 24 years to experience rape (Rickert, Vaughan & Wienmann, 2002). Humphrey and Kahn (2000) stated that women ages 16 to 24 years experience rape at rates four times higher than the assault rate of older women.

Several studies have associated with the use of alcohol and other drugs with increased risk of rape (Meyer, 2000; Fitzgerald & Riley, 2000; Hensley, 2003; Slaughter, 2000; Abbey, Zawacki, Buck, Clinton & McAuslan, 2001; WHO, 2010). It may be difficult for a woman to resist sexual coercion when under the influence of alcohol or psychoactive drugs (Abbey et al., 2001). Women who abuse alcohol and psychoactive drugs including sex-enhancing drugs may find it difficult to refuse unwanted sexual intercourse.

Studies from a wide range of settings show that, while rape cuts across all socioeconomic groups, women living in poverty are disproportionately affected (Heise & Garcia-Moreno, 2002; Jewkes, Sen & Garcia-Moreno, 2002). A study conducted by Ezechi et al (2004) among pregnant women in Nigeria also observed that low socio-economic status is a risk factor for sexual abuse and other forms of abusive behaviours experience by pregnant women in the hands of their partners. Poverty forces many women to depend solely on their partners and create gender inequality which render them vulnerable to sexual coercion (Heise & Garcia-Moreno, 2002; Jewkes et al., 2002). Such women are may be likely to endure forced sex in a bid not to forfeit her economic means. Low educational status have also been found to increase women risk of being abused by their partners (WHO, 2002).

Women may be at increased risk of sexual violence in the hands of their partners when they become more educated and thus more empowered (WHO, 2002). Women with no education were found in a national survey in South Africa to be much less likely to experience sexual violence than those with higher levels of education (Jewkes & Abrahams, 2002). In Zimbabwe, women who were working were much more likely to report forced sex by a spouse than those who were not (Watts, Koegh, Ndlovu, & Kwaramba, 1998). The likely explanation is that greater empowerment brings with it more resistance from women to patriarchal norms (Jewkes, Penn-Kekana & Levin, 2002).

Inadequate knowledge and skills relating to how to negotiate sexual consent or propose refusal to sexual intercourse could put women at risk of forced sex by their partners (Wood & Jewkes 2001). Several studies such as East and Adams (2002) and Jejeebhoy & Bott (2003) observed that many young women involved in intimate partner rape do openly and clearly communicate refusal of sexual advances. In a qualitative study carried out by Hof & Richters

(1999), among young mothers aged 14–24 years in Bulawayo, Zimbabwe, several of the mothers linked their pregnancy with their inability to refuse sex from their husbands. Rape may be perceived as a form of punishment for women and as a way of resolving conflicts in intimate relationships (Ajuwon et al., 2001).

A history of childhood sexual abuse has been shown to be predictive of subsequent marital rape (Gil-Gonzalez et al., 2007; Jespersen, Lalumiere & Seto, 2009; WHO, 2010). Bennice & Resick (2003) in their study gave possible explanation for this association between exposure to childhood sexual abuse and marital rape. According to the authors, it is possible that women with history of childhood sexual abuse learned at a young age that forced sex is an acceptable manner in which to express feelings of love. Therefore, they may be more likely to tolerate such experiences within their marriages as well, excusing their husbands' behaviour as acts of love. Women who were sexually abused as children may be more likely to dislike and refuse sex later in life. Wives who refuse sex with their husbands may be at greater risk for marital rape (Bennice & Resick, 2003).

Women who have previously being sexually abused by intimate or non-intimate partners during adulthood are more likely to experience marital rape compared to those without prior exposure to sexual violence (WHO, 2010). There are studies which point towards this direction. For example, one study from India showed that women who reported previous rape by strangers were 3.8 times more likely to be raped by intimate partners compared to those without previous exposure (Boyle, Georgiades, Cullen & Racine, 2009). Previous exposure to sexual abuse may contribute to future survivorization by changing a woman's attitude towards rape; decreasing her ability to recognize risk; lowering her self-esteem; increasing

her guilt, shame and embarrassment; and reducing her sexual assertiveness (Bennice & Resick, 2003; WHO, 2010).

Many cultural norms limit young women's ability to negotiate the terms of their sexual relationships because intimate partner violence including marital rape has its roots in socially constructed gender norms (Bergen, 2006). In a study carried out by Rickert et al. (2002) in USA, almost one out of five young women stated that they never had the courage to stop foreplay at any time or refuse sexual intercourse with an intimate partner with whom they had previously had sex. Acceptance of traditional gender roles and rape myths have been reported as risk factors for experiencing sexual violent crimes including marital rape (CDC, 2000; WHO, 2010). These attitudes may be transferred across generations through learning processes, the media, schools, and witnessing (WHO, 2010).

The likelihood of sexual violence especially intimate partner rape is related to the extent to which beliefs in male superiority and male entitlement to sex are entrenched in a community, the general tolerance in the community of sexual assault and the strength of sanctions, if any, against perpetrators (Jewkes et al., 2002). How a community responds to partner violence may affect the overall levels of intimate partner violence including marital rape in a community (Heise & Garcia- Moreno, 2002). In Nigeria, many Yoruba gender norms make women vulnerable to rape (Ajuwon, et al., 2004). Based on Yoruba norms, women are expected to play passive roles in sexual relationships including relying on men to make decisions regarding when to have sex and conditions under which to have sex (Ajuwon, et al., 2004).

Factors that can increase men's risk of committing marital rape

Although sexual violence perpetration is found to be pervasive among all category of men, among the factors increasing the risk of a man committing rape are those related to attitudes and beliefs, as well as behaviour arising from situations and social conditions that provide opportunities and support for abuse (WHO, 2002).

Sexually violent men have been shown to be more likely to consider rape survivors to be responsible for the rape and are less knowledgeable about the impact of rape on survivors (Drieschner & Lange, 1999). Men who perpetrate rape are likely to have an exaggerated sense of masculinity and believed to differ from other men in terms of impulsivity and antisocial tendencies (Crowell, 1996). Men who hold the traditional belief of men superiority over women and consider their wives as possessions are likely to sexually abuse their wives (Ushie et al., 2011).

Sexual violence is also associated with a preference for impersonal sexual relationships as opposed to emotional bonding (Malamuth, 1998). Men with such preference often have multiple sexual partners. Several studies have noted that men who have multiple sexual partners are more likely to perpetrate of marital rape (WHO, 2002; Jewkes et al., 2006; Tang & Lai, 2008; Dalal, Rahman & Jansson, 2009; Johnson & Das, 2009).

Some men use violence against their wives, especially when such men want their wives to leave or divorce the marriage (Glantz & Halperin, 1996). This is a frequent occurrence especially when such men are seeing another woman outside their matrimonial homes. Some men may also consider forced sex with their women as a form of punishment for women and as a way of resolving conflicts in relationship (Ajuwon et al, 2001).

There is evidence to suggest that sexual violent behaviour is a learnt behaviour in some men, particularly as regards child sexual abuse. Violence is perceived as a learned behaviour and children who witness sexual violence between their parents learn powerful messages about gender hierarchy and power that could influence their relationships later in life (Alexander et al., 1991). Childhood environments that are physically violent, emotionally unsupportive and characterized by competition for scarce resources have been associated with sexual violence (Crowell, 1996). Sexually aggressive behaviour in young men, for instance, has been linked to witnessing family violence, and having emotionally distant and uncaring fathers (Ouimette & Riggs, 1998). Men raised in families with strongly patriarchal structures are also more likely to become violent, to rape and use sexual coercion against women, as well as to abuse their intimate partners, than men raised in homes that are more egalitarian (Crowell, 1996).

Alcohol has been linked with the occurrence of rape and other violent crimes (Testa, 2004; Flake, 2005; Gage, 2006; Sampson, 2006; Martin, Taft & Resick, 2007; Tang & Lai, 2008; Johnson and Das, 2009; Dalal, Rahman & Janson, 2009; WHO, 2010). Alcohol affects men's perception of women's sexual intent (Meyer, 2000; Abbey et al., 2001). Cross-sectional studies from different low and middle-income countries report that men who misuse alcohol are 1.6 to 4.8 times more likely to perpetrate intimate partner violence (Abraham et al., 2004; Ramiro, Hassan & Peedicayil, 2004; Flake, 2005; Gage, 2006; Dalal et al., 2009; Johnson & Das, 2009). Experimental researches suggest that alcohol consumption may elevate men's sense of sexual entitlement and reduce their sensitivity to women's sexual resistance (Marx, Gross, & Adams, 1999; Abbey, Buck, et al. 2003). However, there has been limited research exploring placebo effects and findings from available studies are mixed (Abbey, 2011). The

exact role of alcohol plays in rape cases is still not clear yet as alcohol is not always a feature of all rape cases.

The use of rape facilitating drugs has been identified by researches as risk factors for intimate partner rape (Fitzgerald & Riley, 2000; Hensley, 2003; Slaughter, 2000). Issues relating to use of drugs and types of drugs used by rape perpetrators in marital rape settings have not been well documented. One reason for the use of rape facilitating drugs is that perpetrators do not have to use any force, since it will be difficult for a woman to resist as her state of being is more submissive or even unconscious (Abbey et al., 2001).

Weak community sanction against sexual abuse of women by intimate partner has been identified as a risk factor for perpetrating and experiencing intimate partner violence (WHO, 2010). Societies with strong community sanctions against all forms of intimate partner violence including marital rape are likely to record low levels of spousal rape and other forms intimate partner violence, such societies are also likely to provide necessary support for abused women in the areas of access to support services such as family support and provision of shelter. Community sanction or prohibition is a strategy that could be used to discourage sexual abuse of women (WHO, 2010).

The lack of recognition of marital rape as a form of rape under Nigerian justice system may serve as a tacit incentive for perpetration of marital rape or discourage survivors from recognizing the reality of marital rape (Akinade et al., 2010; Uwaoma et al, 2010). The legalization of marital rape as a crime and prosecution of perpetrators of marital rape may be helpful in addressing the burden of marital rape.

Perceptions relating to marital rape

There are various perceptions and misconceptions that may influence behaviour and attitudes of individuals towards marital rape (Ferro, Cermele, Saltzman, 2008; Tegbar, Yemane, Nigussie & Mirgissa, 2012). Some studies carried out in African countries including Zimbabwe (Rumbidzai, 2013) and Ethiopia (Tegbar et al., 2012) noted that many people do not believe that marital rape exists. Even some survivors of marital rape do not consider their experiences of forced sex by their husbands as rape (Mahonney & Williams, 2007). Nevertheless, women who had been abused by their partners are two times more likely to believe that marital rape occurs than those who have never had such experience (Basile, 2002).

These misconceptions may not be unconnected with the patriarchal view of marriage in which it is believed that a husband has full access to his wife's body with or without her consent (Russell, 1998). Many people erroneously felt once a man and a woman have entered into marital contract, which is a legitimate and voluntary institution, it would be difficult to talk about coerced sex (Tegbar et al, 2012). The study carried out by Tegbar et al (2012) in Ethiopia revealed that family arbitrators perception that married woman should not refuse sex as that might prompt her partner to involve in extramarital affairs.

In some situations where marital rape is considered as been inappropriate, it is not believed that the act was a violation of the wife's rights and usually not labeled as rape (Ferro et al, 2008; Tegbar et al, 2012). Tegbar et al (2012) noted in their study that many women opined that rape is not the right word in marital context.

Marital rape is not viewed as serious as other types of rape (Monson, Byrd & Langhinrichsen-Rohling, 1996; Ferro et al, 2008). Frese, Moya and Megías (2004) noted that people in general hold a husband less responsible for raping his wife than the stranger rapist, and they consider marital rape less traumatic. In Nigeria, it is rape perpetrated by strangers that are usually frowned upon and labeled as “real rape” (Oshiname, Ogunwale & Ajuwon, 2013). The belief that marital rape is less serious form of rape is false because several studies have demonstrated that survivors of rape perpetrated by known offenders are as prone to develop trauma symptoms as survivors of stranger rape (Koss, 1993; Shapiro & Schwarz, 1997). A study conducted by Kernsmith (2008) further confirmed that the extent of trauma and psychological injury faced by survivors of marital rape may be greater than that of survivors of other forms of rape.

In general, people do not blame married women for being raped by their husbands as they tend to do for survivors of rape in an acquaintance rape setting (Frese, Moya & Megías, 2004). But still, there is a common perception that perpetrators of marital rape are less responsible than the perpetrators of stranger rape. The RMA individuals are more likely to justify husbands for raping their wives than the perpetrators of stranger rape (Frese, Moya & Megías, 2004). Women who are raped by intimate partners including husbands may perceive their rape experiences as their fault and blame themselves for their ordeals (Ogunwale et al, 2012; Ogunwale & Oshiname, 2014). Self-blame by survivors of rape constitutes a major barriers against seeking for appropriate help (Ogunwale et al, 2012).

Help-seeking behaviours of sexually abused women

Women who are sexually abused often endure the ordeal in silence and do not usually report cases of rape or seek for appropriate health care services following their experiences of phenomenon (Olaleye & Ajuwon, 2011; Ogunwale et al, 2012). Reasons or factors which prevent women who suffered from marital rape and other forms of intimate partner violence from reporting their ordeal include relationship with rape perpetrators, age of survivors (Abdulkadir et al, 2011), self-blame and stigmatization (Ogunwale et al, 2012; Ajuwon, 2013), perception of the associated health challenges as not being serious (Ogunwale et al, 2012), cultural taboos (Odu, Falana & Olotu, 2014), fear of not being believed or being victimized (Abe, 2012). Inadequate and inappropriate sexuality socialization on sexual abuse prevention within the culture may affect the disclosure of rape cases by abused women (Awosusi & Ogundana, 2015). Friends, families and community members often put pressure on abused women not to report their ordeals to appropriate authorities (Ajuwon et al, 2004, Onyejekwe, 2008; CLEEN, 2014). Akinlusi et al (2014) documented that many families do frown at public confession of being sexually violated and can view reporting such situation as a ridicule or smear to family image. A study involving the review of police records on rape conducted in Nigeria by Shaahu et al (2004) shows that the police was requested to terminate its investigation and prosecution of 56.8% cases of reported rape based on the wishes of survivors. Several studies such as Alhassan (2013) and CLEEN (2014) noted that women who suffer from rape in Nigeria are often reluctant to report their experience to police because of fear of the leakage of the report to the general public, lack of sensitivity in handling rape cases by the police and the acceptance of bribes by the police to prevent the

course of justice. Study conducted by CLEEN (2014) noted that a higher proportion of raped women were not satisfied with the way the police treated them or handled their cases.

In most cases, sexually abused women prefer to report their ordeals and seek for help from non-formal agencies like friends and families (Ajuwon et al, 2001; CLEEN, 2014; Ogunwale et al, 2012). Study conducted by CLEEN (2014) observed that non-formal agencies like friends and families followed by religious leaders and traditional leaders topped the list of sources from where rape survivors satisfactorily obtained help. Lack of appropriate social support, help and care needed for survivors of rape to overcome their ordeals constitutes serious threat to prevention and control of rape.

Although women who experience rape commonly prefer not to seek for health care (Ogunwale et al, 2012; CLEEN, 2014), the experience of serious or threatening adverse health consequences resulting from rape often compel some survivors to seek for medical attention (Ajuwon et al, 2004, Ogunwale et al, 2012). Studies have shown that most of these survivors who ought to seek for medical care often resort to self-medication or opt for the patronage of patent medicine vendors and pharmacies instead of visiting hospital where they could be given proper medical attention (Ajuwon et al, 2004, Ogunwale et al, 2012). This pattern of health seeking behaviour can lead to the complications of the physical health problems experienced by the survivors.

Health consequences of marital rape

The health consequences of marital rape are often far-reaching and have implications for the physical, reproductive, mental, and social health and wellbeing of survivors (Mahoney and Williams, 2005; WHO, 2010). Marital rape can also have significant impact on the families, communities and wider society (WHO, 2010).

Survivors of marital rape often suffer severe physical injuries (Mahoney & Williams, 2007; WHO, 2010). The common physical injuries that may be experienced by marital rape survivors include: vaginal bleeding or infection, decreased sexual desire, genital irritation, pain during intercourse, vagina stretching, anal or vaginal bleeding, chronic pelvic pain and urinary tract infections (Mulugeta, 1998; Bennice & Resick, 2003; WHO, 2010). The study of Campbell and Alford (1989) in their study reported that some women became infertile as a direct result of the rape. A study carried out by Coker, Sanderson, Fadden and Pirisi (2000) found a significant relationship between sexual partner violence and cervical cancer.

Women who experience marital rape may find it difficult to protect themselves against unintended or unwanted pregnancy (Hof & Richters, 1999; Martin, Kilgallen, Tsui, Maitra, Singh & Kupper, 1999; Silberschmid & Rausch, 2001; WHO, 2010) particularly in the absence of family planning options. Limited ability of abused women to negotiate condom use with their husbands may also put them at higher risk of unwanted pregnancy (Maman, Campbell, Sweat & Gielen, 2000). Increase in pregnancy complications may occur as a result of marital rape (Janssen et al., 2003). The study of Campbell and Alford (1989) observed that some women experienced miscarriages or stillbirths as a result of forced sex during pregnancies. Abused women may be more likely to terminate pregnancies as a strategy to eliminate this additional source of power and control within the relationship (Evins &

Chescheir, 1996). Forced sex is related to higher risk of transmitting HIV (Maman et al., 2000; Krug, Dahlberg, Mercy, Zwi & Lozano, 2002; WHO, 2010). Vaginal penetration, abrasions and cuts which commonly occur during rape may facilitate the entry of pathogens through the vaginal mucosa (Lohmann, 2008; Wingood, DiClemente & Raj, 2000).

Women who have been sexually abused by their partners could experience intense and debilitating psychological consequences that are even more traumatic than those experienced by survivors of rape involving strangers and acquaintances (Mahoney & Williams, 2005; Plichta & Falik, 2001). Serious psychological disorders which can result from marital rape include humiliation, reduced self-esteem, anxiety, depression, shame, negative feelings about sex as well as increased risk of Post Traumatic Stress Disorder (PTSD) (WHO, 2010; Plichta & Falik, 2001; Black et al, 2011). Symptoms which could be characteristic of PTSD include persistent re-experiencing of the event, persistent avoidance of stimuli associated with the event, and persistent symptoms of increased arousal (Lohmann, 2008). Some other serious emotional problems that survivors of marital rape may be confronted with are loss of confidence, fear, feelings of insecurity, feelings of helplessness, worthlessness, thoughts of suicide, attempted suicide and other forms of sex-harming behaviours (Bennice & Resick, 2003; WHO, 2010; Black et al, 2011).

Survivors of marital rape can also experience self-blame based on their character, actions, or circumstances surrounding their rape experience (Frazier, Mortensen & Steward, 2005). Survivors who experience self-blame may feel that they should have done something differently and therefore feel that their experience was as a result of their fault (Frazier et al, 2005). The consequences of self-blame may include lack of motivation to seek care, cutting oneself off from other people, anger and aggression (Frazier et al., 2005).

The degree to which survivors of marital rape experience emotional consequences varies based on factors such as the amount of emotional support available, prior experiences, and personal coping styles. Some survivors of rape may become very withdrawn and uncommunicative, others may act out sexually and become promiscuous, (Lohmann, 2008). Children in households where marital rape occurs often suffer from the psychological effects of witnessing violence, and such violence can undermine the ability of their mothers to care for them (Bergen, 2006).

The social consequences of marital rape may include separation of couple, stigma and discrimination (WHO, 2010). It may also lead to deterioration of the marriage (Russell, 1990) as well as divorce. Survivors of intimate partner rape are likely to engage in risky sexual behaviours (Lohmann, 2008). Marital rape may impact negatively on productivity, as affected women are often unable to engage fully in productive economic activity. In spite of the threatening health consequences that may be associated with marital rape, survivors are reluctant to report their ordeals to anyone or seek for medical or psychological assistance (Bergen, 2006; Forke, Myers, Catallozzi & Schwartz, 2008; Uwaoma et al, 2011).

Studies have found that the majority of marital rape survivors report being raped more than once, and multiple experiences of marital rape seem to lead to more serious consequences for the victims (Russell, 1990; Bennice & Resick, 2003; Mahoney & Williams, 2007). Marital rape victims often experience additional forms of trauma, such as physical partner violence (Bennice & Resick, 2004).

Rape prevention and control approaches

Prevention and control approaches to intimate partner violence and sexual violence include human rights, criminal justice, public health approach (Smithey & Straus 2002; WHO, 2010) and pro-social bystander model (Banyard, Plante & Moynihan, 2005; Cornell University, 2007). Although many of these approaches and strategies appear to have potential for prevention and control of rape on theoretical grounds, they however have never been systematically implemented (WHO, 2010). These approaches will be elaborated upon or reviewed.

The human rights approach

The human rights approach is based on the obligations of states to respect, protect and fulfill human rights which helps to prevent, eradicate and punish violence against women and girls (WHO, 2010). It recognizes violence against women and girls as a violation of many human rights to which women are entitled. These rights include rights to life, liberty, autonomy and security of the person; the rights to equality and non-discrimination; freedom from torture and cruelty, inhuman and degrading treatment or punishment; the right to privacy; and the right to the highest attainable standard of health (WHO, 2010).

The afore-mentioned human rights are enshrined in international and regional treaties, national constitutions and laws. These documents stipulate the obligations of states, and include mechanisms for holding states accountable (WHO, 2010). In 1985, the UN adopted the Domestic Violence Resolution as a human rights issue. According to United Nations, violence against women and girls constitutes the single most prevalent and universal violation of human rights (United Nations General Assembly, 1991). The UN continues to expand its role in the creation of human rights standards in the area of criminal justice and in

assisting and monitoring implementation of the standards. Member states are urged to consider laws proscribing all forms of intimate partner violence which includes marital rape. Nations that have not criminalized IPV are classified as violating internationally recognized norms relating to human rights, (Smithey & Straus, 2002).

At the UN sponsored World Conference on Women, in Beijing in 1995, representatives of 186 nations adopted the Beijing Platform of Action. Countries that adopted this platform became obligated under international law to eliminate discrimination and violence against women in all its forms (Jejeebhoy & Cook 1997). Although tremendous progress has been made towards gender equality in many countries, the process has hardly begun in some and in some it has been reversed (Smithey & Straus, 2002).

There are a number of international, continental and sub-regional protocols that frame the issue of Violence against women within the African Context (Stewart, Sommerfelt, Borwankar, Oluwole, Fogg & Going, 2010). The most important of these is the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa that was adopted in Maputo on 11 July 2003 (Stewart et al, 2010).

Nigeria is a signatory to many treaties, conventions or charter relating to human rights including rights of women. These include: 1948 United Nations Declaration for human rights; 1952 Convention on the Political rights of Women; 1966 International Covenant on Civil and Political Rights (ICCPR); 1979 Convention for the Elimination of All forms of Discrimination Against women (CEDAW); 1994 International Conference on Population and Development (ICPD); 1995 Beijing Declaration and Platform of Action; the United Nations Resolution and 2003 African Charter on Human and People Rights (Federal Ministry of

Women's Affair and Social Development, 2006). Though the country ratified CEDAW alongside other member states, it is yet to domesticate CEDAW at national and state levels. It also has a constitution that seeks to guarantee the rights of all citizens irrespective of gender (Federal Ministry of Women's Affair and Social Development, 2006). Although Nigeria has a National Gender Policy, issues relating to violence against women especially IPV were not adequately captured (Federal Ministry of Women's Affair and Social Development, 2006). Full implementation of the provisions of the afore-mentioned covenants, treaties, protocols and related laws in Nigeria have great potentials for preventing marital rape.

The criminal justice approach

The criminal justice approach sees IPV and sexual violence as a violation of law (Meyer, 2000). Its main task is centered on responding to rape after it has occurred by enforcing appropriate laws (WHO, 2010). This involves properly identifying perpetrators of rape, ascertaining their guilt and ensuring that they are appropriately sentenced (WHO, 2010). According to WHO (2010), preventing rape through criminal justice approach relies primarily on deterrence, incarceration and the punishment and rehabilitation of perpetrators.

Rape is a criminal offence in Nigeria and the Nigeria legal system has provision for redress (Ajuwon et al., 2004; Amnesty International, 2009). For instance, all forms of torture and other inhuman or degrading treatment which include rape are prohibited by the 1999 Nigerian constitution (FGN, 1999). Section 34(1) of the Nigerian 1999 constitution states that: "Every individual is entitled to respect for the dignity of his person, and accordingly (a) no person shall be subjected to torture or to inhuman or degrading treatment".

The Penal Code (Nigerian laws Cap 89), applicable in the northern part of Nigeria, criminalizes both rape and "defilement" (rape of a girl under the age of 13 years). According to section 282(1) of the Penal Code:

"A man is said to commit rape if he has sexual intercourse with a woman in any of the following circumstances -- (a) against her will; (b) without her consent; (c) with her consent, when her consent has been obtained by putting her in fear of death or hurt; (d) with her consent, when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married; (e) with or without her consent, when she is under fourteen years of age or of unsound mind".

Rape is explained by the Criminal Code act (Nigerian laws Cap 38), applicable in the south of Nigeria (Section 357), as:

"Any person who has unlawful carnal knowledge (carnal knowledge could be interpreted as penetration using body parts or foreign objects) of a woman or girl, without her consent, or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind, or by fear of harm, or by means of false and fraudulent representation as to the nature of the act, or in the case of a married woman, by personating her husband, is guilty of an offence which is called rape"(FGN, 1990). Under Section 358 of Criminal Code Act, rape is punishable by life imprisonment, with the possible addition of caning (FGN, 1990).

According to the Criminal Act of Oyo State (1978), Rape is defined as follows: *"an unlawful sex with a woman or girl without her consent, or with her consent if the consent is obtained or by means of false and fraudulent representation of the act"*. Under this Act, rape and the attempt to rape are punishable by life and 14 years imprisonment respectively. The essential requirements for convicting a perpetrator of rape are that sexual intercourse was forced, that there is evidence of marks of violence on the body of the survivors, that there is a sign of

struggle at scene of rape, that the immediate report of sexual coercion is extracted from the survivor without force and the survivor submits herself for medical examination (Criminal Act of Oyo State, 1978).

Apart from the fact that laws on rape are outdated and usually not operational, the laws have several inadequacies (Amnesty International, 2009). The laws do not specify what constitutes sexual consent and how sexual consent should be obtained. Based on the provisions of both the Criminal and penal codes, a woman is not physically capable of committing the offence of rape against a man (Ashiru & Orifowomo, 2015).

The definition of the offence as contained in both the Criminal and Penal Codes of Nigeria portray that a man cannot be guilty of rape perpetrated against his wife (Ola & Ajayi, 2013; Emeka & Emejuru, 2015). Researches have proven that women can be raped by their husbands. Researches have proven that women can be raped by their husbands. For instance, studies by Uwaoma et al (2011) and Ashimolowo and Otufale (2012) carried out in Nigeria, have noted that married women often experienced rape in the hands of their husbands. In a long line of judicial authorities, the courts in Nigeria have applied the law on rape as contained in the statutes referred to above and have held that rape is the act of sexual intercourse committed by a man with a woman who is not his wife and without the woman's consent (Obidimma & Obidimma, 2015). Hence, under no circumstance can a man be charged of raping his wife. Presenting evidence of struggle or physical resistance as required by the law for substantiating a case of rape may be extremely difficult in marital rape situation. Studies have shown that rape of intimate partners may not necessarily involve the use of physical force (Mediterranean Gender Institute 2008; Lohmann, 2008). Legal prerequisite for rape under the Nigerian Criminal and Penal Codes laws which demand

medical examination for proving a case of rape may not be appropriate in marital rape situations as many women raped by intimate partners are likely not to seek for health care from health care facilities due to stigmatization, self-blame and confidentiality issues (Ajuwon et al, 2004, WHO, 2010). These situations thus undermine the possibility of survivors of marital rape seeking legal redress as well as inhibit efforts to prevent and control marital rape.

Nigeria has a Violence Against Person Prohibition (VAPP) Act that came into being in 2015. The act constitutes a legal framework for preventing and controlling sexual violence and other forms of gender-based violence in the country. The provisions in this act supersede those of the Criminal and Penal Codes in terms of rape and other related sexual offences. The VAPP Act takes into cognizance a gender-neutral definition of rape and thus recognizes that both men and women can experience rape and can perpetuate it themselves. The Act takes into consideration the fact that a person can be raped through the vagina, anus or mouth. It also recognizes the fact that a person can be raped by anyone including spouse. The act thus identifies marital rape as a criminal behaviour (Ashiru & Orifowomo, 2015). Based on the legal provisions of the VAPPA, a person convicted of the crime of rape is liable to life imprisonment.

Public health approach

According to world report on violence and health (WHO, 2010), the public health approach is a science-driven, population-based, interdisciplinary, inter-sectoral approach based on the ecological model which emphasizes primary prevention. Rather than focusing on individuals, the public health approach aims to provide the maximum benefit for the largest number of

people, and to extend better care and safety to entire populations (Dahlberg & Krug, 2002). The public health approach draws knowledge from many disciplines including medicine, epidemiology, sociology, psychology, criminology, education and economics (WHO, 2010). The public health approach to intimate partner and sexual violence emphasizes a multi-sectoral response because these forms of violence are multi-faceted problems. According to the public health approach sexual violence, rather than being the result of any single factor, is the outcome of multiple risk factors and causes, interacting at four levels of a nested hierarchy (individual, close relationship/family, community and wider society), (WHO, 2010).

From a public health perspective, prevention strategies can be classified into three types, namely: primary, secondary, and tertiary prevention (Dahlberg & Krug, 2002; Smithey & Straus 2002; WHO, 2010). In order to effectively address the public health problem of IPV, health professionals, policy makers, educators, and women's advocates must intensify violence prevention efforts across the three levels of prevention (Lohaman, 2008). It is necessary to explain what the concepts of primary, secondary and tertiary prevention are within the context of sexual violence.

Primary prevention is aimed at preventing sexual violence before it occurs (WHO, 2010). It is a population level approach, which stresses that the issue of concern is of relevance to the whole population. Primary prevention strategies seek to remove the causes or 'determinants' of sexual violence, prevent the development of risk factors associated with violence, and/or enhance the factors which have protective effects against violence (Chamberlain, 2008). The objective of primary prevention campaigns might be general awareness, individual behaviour change, or a call to public action (Dejong & Atkin, 1995).

Primary prevention seeks to influence the formation of individual and community attitudes, on the assumption that this will impact on behaviours and ultimately result in a reduction of sexual violence (Young, 2004). The target of primary prevention is not only individual behaviour change, but a community level shift in the values and norms that support sexual assault (Young, 2004). Prevention efforts may address rape-supportive attitudes and norms through public information and awareness campaigns in mass media or in particular contexts such as sports and workplaces, education programs, or 'edutainment'. They may address gender inequalities and patriarchal power relations through policies promoting gender equality, skills training in respectful relationships, or community development and the mobilisation of women's and men's networks for change (Harvey, Garcia-Moreno & Butchart, 2007).

The application of primary prevention is seldom used to address intimate partner violence (Sherman, Schmidt & Rogan, 1992). It has been relatively neglected, with the majority of resources directed towards either secondary or tertiary prevention (Smithey & Straus, 2002; WHO, 2010). However, primary and secondary prevention are not mutually exclusive categories. Some policies and programmes serve both purposes. For example, shelters for battered women, in addition to aiding survivors, make an important contribution to primary prevention through community education programmes and through empowering women (Smithey & Straus, 2002).

Secondary prevention focuses on early identification and intervention, targeting individuals at high risk for either perpetration or survivorization and working to reduce the likelihood of their further or subsequent engagement in or subjection to violence. Succinctly put, it intends to break the pattern of violent behaviour before it becomes deeply ingrained (Smithey &

Straus, 2002). It is intended to reverse progress towards sexual violence and to reduce its impact. According to WHO (2010) secondary prevention focuses on the more immediate responses to violence, such as pre-hospital care, emergency services or treatment for STIs following a rape. Furthermore, secondary prevention includes efforts such as early identification and counseling of first-time offenders to challenge and change behaviour as soon as possible after its occurrence (Smithey & Straus, 2002).

Tertiary prevention centers on responding after rape has occurred (Carmody et al., 2009). The activities focus on responding to or treating the problem by minimising the impact of violence, restoring health and safety, and preventing further survivorisation and perpetration (Chamberlain, 2008; WHO, 2010). Tertiary prevention includes counseling or psychotherapy, referral for survivors, advocacy as well as community-wide interventions, criminal justice services and sex offender treatment programmes (Meyer, 2000; Smithey & Straus, 2002). The reform of rape related statutes, the enforcement of existing laws and the prosecution of accused rapists are more examples of this prevention strategy (Meyer, 2000).

The public health approach is an evidence-based and systematic process involving four inter-related steps, namely: defining the problem; investigating why the problem occurs; exploring ways to prevent the problem and disseminating information on the effectiveness of programmes and increasing the scale of proven effective programmes (WHO, 2010). According to WHO (2010), approaches to prevent rape (whether targeted at individuals or entire communities) must be properly evaluated for their effectiveness. Furthermore, the programmes should be adapted to local contexts and subjected to rigorous re-evaluation to ensure their effectiveness in the new setting.

Pragmatic Perspective

This pragmatic perspective to prevention is based on the belief that there are identifiable causes (risk factors) and identifiable conditions that help one avoid (protective factors) negative experiences, (Meyer, 2000). This model was originally designed to prevent drug abuse but was later extended to sexual violence prevention (Meyer, 2000). According to the model, prevention efforts should focus on reducing risk and increasing protective factors related to rape (Meyer, 2000). The model is yet to be fully applied to rape prevention (Meyer, 2000).

Social change model of prevention

Rape occurs in a specific social context that condones or promotes violent behaviour (Townsend and Campbell, 2010). Social change strategy is based on the belief that rape occurs because of a societal structure which treats people unequally, resulting in unequal power distribution among all citizens, (Meyer, 2000). This unequal power distribution is tied to age, gender, race and class (Meyer, 2000). The model views all children and women as potential survivors of rape and all men as potential perpetrators of rape (Meyer, 2000). The model believes that sexual violence is both a social and individual act and that the society has the power to influence occurrence of rape (Townsend & Campbell, 2010). According to Townsend and Campbell (2010), rape prevention must take into consideration both social norms and individual behaviours. Changing norms about rape and the quality of relationships within a community through strategies that promote gender equality are the focus of social change model of rape prevention (Meyer, 2000; Townsend & Campbell, 2010).

The pro-social bystander approach

The pro-social bystander model of sexual violence prevention was developed by Dr. Victoria Banyard of University of New Hampshire, USA (Cornell University, 2007). The model calls for prevention efforts that take a wider community approach in which an individual's behaviours as a bystander intervene in ways that can prevent the occurrence of rape. The model views men as potential bystanders or witnesses to behaviours related to rape (Cornell University, 2007). The model is based on the premise of changing broader community norms about sexual violence by increasing men's awareness of risky behaviours such as alcohol abuse and adherence to traditional gendered behaviour, helping them to identify the behaviours and encouraging them to take responsibility to intervene during high-risk situations (Banyard, Plante & Moynihan, 2005). For effective rape prevention programmes men should assume responsibility for the prevention of sexual violence against women and promote anti-violence values (Berkowitz, 2004)

Appraisal of Review of Related Literature

Rape has been considered as a serious public health problem and one of the most heinous violent crimes which one person can be committed women. It has been described as unwanted and unacceptable sexual intercourse (in form of oral, anal, vaginal sex, forced insertion of objects into a woman's vagina), often characterized by physical force, threat or/and use of drugs. Marital rape, which is the type of rape perpetrated by a spouse, is a major form of rape that affects many young women. However, this type of rape unlike other forms of rape has not gained much public attention.

In Nigeria, there is dearth of information from literature relating to marital rape especially in developing nations including Nigeria. Marital rape is yet to be given adequate scholarly

attention. Most of the available literatures on marital rape were conducted outside Nigerian settings. Only a few studies have focused on marital rape related issues in Nigeria. It was noted that most of the limited available studies on marital rape issues in Nigeria have several limitations which include: small sample size and limitation in scope, weak methodologies and inability to fully properly capture the experience of marital rape survivors.

The few Nigerian studies which have focused on prevalence of marital rape in reported varying prevalence rates. The exact prevalence and incidence of marital rape in various parts of Nigeria remain unraveled. The behaviour of many abused women of not seeking for help and reporting ordeals represent serious limitations. It was noted from the literatures reviewed that there is paucity of information on proximate determinants or antecedent factors that could be predispose women to marital rape in Nigeria. Studies that particularly focused on women's knowledge of marital rape were not available to the researcher despite thorough and consistent search for through the various literature sources. Some researches conducted outside Nigerian have noted the existence of perceptions which could increase women vulnerability to marital rape. However, there are limited literature which chronicled perceptions relating to marital rape based on various socio-cultural constructions in Nigeria.

Several factors such as poverty, alcohol abuse, previous experience of victimization and cultural norms and beliefs have been noted as factors which could increase women's experience of marital rape. Much is yet to be understood in terms of the specific contributions of some survivors' characteristics such as age, religion, educational status to the phenomenon of marital rape. Why it may be clear that many survivors of marital rape do not perceive the phenomenon of marital rape as being serious and have several misperceptions relating to marital rape, the patterns and predictors of these perceptions need

to be considered with a view to using the findings to design educational interventions that could help in addressing marital rape.

Despite the adverse health consequences associated with marital rape, survivors of marital rape rarely seek for help and necessary health care services that could help them overcome their ordeals. Some of the major reasons that often are associated with this behaviour include fear of being stigmatized and self-blame. The behaviour of not seeking for help following experience of marital rape is likely to be associated with several personal, social, cultural and religious factors. Help-seeking behaviours of marital rape survivors need to be considered in this light.

Despite the fact that survivors of marital rape rarely report their ordeals to anyone, some of them still disclose their experiences to significant others such as friends and relatives. The type of help received from this category of persons and its effectiveness towards the provision of good rehabilitation for survivors of marital rape is some of the issues that represent literature gaps. There is paucity of information on coping mechanisms or measures that are being adopted by survivors of marital rape as well as the effectiveness of various preventive efforts or strategies towards marital rape prevention and control.

Some of the perspectives on rape prevention include human right perspectives, criminal approach and public health approach. Public health approach which includes primary, secondary and tertiary prevention presents an opportunity for integrated and inter-sectoral prevention and control of rape. There is paucity of literatures relating to Behavioural Change Communication (BCC) strategies and interventions that are been directed to address the phenomenon of marital rape in Nigeria.

There are legal enactments in Nigeria which prohibits rape and serves as disincentives for perpetration of the deviant behaviour. However, most of these the legal enactments are evidence-based and are not comprehensive enough to address marital rape. For instance, the conditions which need to be fulfilled before a case of rape can be established are very difficult for survivors of marital rape to meet.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter was discussed under the following sub-headings: research design, population of the study, sample and sampling techniques, research instrument, validity of the instrument, reliability of the instrument, procedure for data collection and method of data analysis.

Research Design

A descriptive cross-sectional survey design was employed in this study. According to Lavraas (2008), a cross-sectional survey design helps to collect data in order to make inference about a population of interest at one point in time. Survey research also involves a clear definition of the problem, collection of relevant and adequate data, careful analysis and interpretation of the data and skillful or professional reporting of findings (Abiola, 2007). Oladunni (2005) further explained that it may involve the exploration of an observed phenomena or the description in a precise form of the characteristics of individuals, groups, people or phenomena in education. This design allowed the researcher explored marital rape related knowledge, perceptions and help-seeking behaviours among married women in Oyo State, Nigeria.

Population of the Study

Population is a larger group from which samples can be drawn. It is the defined group of interest to whom the researcher will be generalizing the result of the study. Population for this study comprised all women who were married or were previously married in Oyo State. Oyo State is the fifth most populated State in Nigeria and the second most populated in south-west geopolitical zone. According to National Population Commission (2006), Oyo

State population for 2017 was projected at 7,594, 147 with female population constituting 49.9% (3,789,479). The National Population Census (2006) projection for 2017 revealed that there were 1,623,440 that were ever married in Oyo State. A further break down of the marital status of these women showed that those that were married, separated, divorced and widowed were 1,485, 753, 31, 624, 15, 454, 90, 609 respectively (NPC, 2006).

Sample and Sampling Technique

Sample can be described as a finite subset of the population. Sample for this study was selected among women (who were currently and ever married) in Oyo State, Nigeria. The appropriate sample size was determined using the sample size formula for a single cross-sectional survey (Pourhoseingholi, Vahedi & Rahimzadeh, 2013). The formula is as follows:

$$n = \frac{(Z)^2 pq}{e^2}$$

Where,

n is sample size

Z is standard normal deviation at 5% (Standard value of 1.96)

P is the assumed prevalence of marital rape at 14.2% (the estimate of key proportion).

A prevalence of 14.2% was reported in a Nigeria study (Ezechi et al, 2004).

q is 1 – p (1- 0.142 = 0.858)

e is desired level of precision at 2% or 0.02.

$$n = \frac{(1.96)^2 \times 0.142 \times 0.858}{(0.02)^2}$$

$$= 1170$$

The calculated sample size was increased to **1,200** in consideration for attrition or cases of non response cases.

The sampling technique that was adopted for selection of the participants who represented the study sample was multi-stage sampling technique. It can be described as a sampling technique that is carried out in various stages. The description of the multi-stage sampling procedure (involving five stages) that was used in selecting participants for the study is as follow:

Stage 1

The study area was organized into three clusters based on the available three senatorial districts in Oyo State. Two LGAs were selected from each of the 3 senatorial districts using simple random sampling of balloting procedure. In total, 6 LGAs were randomly selected from the 33 LGAs in Oyo State. The total sample size of 1200 was distributed proportionately across the 6 LGAs. Details of the selected LGAs and the proportionate selection of participants are contained in table 3.1.

Stage 2

Five wards were randomly selected from each of the 6 LGAs that were involved in the study. Altogether a total of 30 wards were used in the study. The selecting of wards was achieved using sampling random sampling method with the aid of balloting paper.

Stage 3

Four communities or areas in each of the 30 wards were randomly selected. For each ward involved in the study, the four communities were selected from the list of communities using simple random sampling of balloting procedure. Records of the communities or areas were obtained from the data of Independent National Electoral Commission (2015). In total, 120 communities or areas were selected in the study.

Stage 4

Within each of the 120 communities or areas, 10 houses on the average where married women reside were randomly selected across the various sub-areas or streets. Altogether, a total of 1,200 houses were selected from all 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 an area, sub-area or street. The list of houses or numbers allocated to houses 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.

Stage 5

From each of the 1200 houses, an eligible woman (ever married) aged 18 - 60 years was selected to participate in the study. However, where there were two or more eligible women in a house, balloting was used to pick the woman that was interviewed. A selected participant was interviewed in her house or place under a private condition without any other person being present.

Table 1: Proportionate selection of women across the selected LGAs

S/N	LGA	Number of wards	Population of people	Population of females	Population of women who were ever married	Proportion of respondents selected from LGA
1	Akinyele (Oyo Central)	12	287, 668	144, 867	62, 063	$\frac{62, 063 \times 1,200}{351, 380}$ = 212
2	Oyo West (Oyo Central)	10	185, 327	91, 143	39, 438	$\frac{39, 438 \times 1,200}{351, 380}$ = 135
3	Ogbomoso South (Oyo North)	10	136, 328	61, 535	28, 904	$\frac{28, 904 \times 1,200}{351, 380}$ = 99
4	Ogbomoso North (Oyo North)	10	270, 078	130, 170	55, 713	$\frac{55, 713 \times 1,200}{351, 380}$ = 190
5	Ibadan North (Oyo South)	12	418, 468	157, 543	67, 428	$\frac{67, 428 \times 1,200}{351, 380}$ = 230
6	Ibadan North East (Oyo South)	12	450, 147	228, 586	97, 834	$\frac{97, 834 \times 1,200}{351, 380}$ = 334
	TOTAL		1, 748, 803	802, 844	351, 380	1,200

Source- 2017 projection figure of data of National Bureau of Statistics (2012)

Research Instruments

A pretested semi- structured questionnaire which included a 8-point knowledge and 20-point perception scales as well as a Focus Group Discussions (FGD) guide were used to collect data. The triangulation of the quantitative and qualitative data collection methods was adopted to ensure that the weaknesses of one are counter-balanced by the strengths of the others.

The collection of the quantitative data was done by means of a researcher designed semi-structured questionnaire. The design of the questionnaire was done after a review of literature. The questionnaire was organized into two broad sections labeled A and B. Section A was used to elicit information on socio-demographic characteristics of respondents. Section B which was further broken down in four (4) sub-section or division (B1, B2, B3, B4). The respondents' knowledge of health consequences of marital rape was assessed using the questions in Sub-section B1. Perceptions of issues that can increase women's vulnerability to marital rape was assessed using questions in section B2. Sub-section B3 contained questions that were used to determine respondents' experience of marital rape. Help-seeking behaviours of marital rape survivors were identified using questions contained in sub-section B4. Detail information about the questionnaire can be seen on Appendix II.

The FGD guide used in the study was framed to probe into the following issues: concept of marriage, concept of marital rape/forced sex in marriage, perception issues relating to marital rape occurrence, perceived causes of marital rape and factors that may increase women vulnerability to marital rape. The FGD guide also included questions relating to women's knowledge of adverse health consequences of marital rape, help-seeking behaviours related issues as well as pattern of reporting of marital rape among women. Details of the FGD guide

can be seen on Appendix I. Results of the FDG was used in the modification of the questionnaire. In selecting participants for the FGD, homogeneity of participants was considered and only participants with similar characteristics such as age, educational status and socio-economic status were considered in the same FGD. The conduct of the FGD was conducted up to till the level of saturation was reached. In total, twelve FGD sessions was conducted across the various parts of the study area.

Validity of the instruments

Validity is the extent to which an instrument or test measure what it purports to measure (Abiola, 2007). In order to ensure the validity of the instrument items, in terms of comprehensiveness, clarity, correctness, construction, appropriateness of the language expression, precision and accuracy of words, draft of the instruments were given to the researcher's Supervisor, three lecturers in the Department of Health Promotion and Environmental Health Education, University of Ilorin as well as two experts in the public health with bias for gender based violence. All relevant comments and suggestions from the jurors were carefully considered as approved by the researcher's Supervisor and used to improve the quality of the instrument.

Reliability of the Instruments

Reliability is the degree of accuracy with which an instrument measures whatever it is measuring (Abiola, 2007). In order to determine the reliability of the questionnaire it was pretested among forty women in Osun State who shared similar characteristics with the study participants. The internal consistency of the questionnaire was determined using Cronbach's Alpha model technique of SPSS (version 20.0). The reliability co-efficient

obtained was 0.89 implying that the instrument was reliable. The FGD guide was also pretested among 2 groups of participants (with 7 participants in each group). Few revisions were made on the instruments before they were finally used.

Procedure for Data Collection

Data collection is defined as a systematic process of gathering information relevant to the study in order to answer the research questions (Burns & Grove, 2005). The researcher viewed data collection as a method of obtaining information needed for the testing of hypotheses or answering research questions. In order to gain recognition and have smooth access to the communities, the researcher embarked on community entry process to gain the support of community leaders in the various communities where the study was conducted.

Participation in the study was made voluntary and informed consent was obtained from each participant before being enrolled into the study. Each participant was provided with information about the focus of the study, objectives of the study, study methodology, inconveniences that might arise and the potential benefits of the study to society. No identifier such as name of participants was required and all information that was provided was kept confidential. Each of the study participants were provided little incentive after participating in the study. The ethical principles guiding the use of human participants in research were taken into consideration in the conduct of the study. Ethical approval for the study was sought from the Ministry of Health, Oyo State Research Ethical Committee.

Data collection was carried out with the help of twelve trained female research assistants. The research assistants included graduates of public health, health education, medical

sociology and guidance and counseling. The research assistants that were recruited were all married women. The research assistants were exposed to a 4-hour intensive training that was facilitated by the researcher. The training focused on the objectives and importance of the study, the sampling processes, how to administer the study instruments, how to secure respondents' informed consent and general interviewing skills. They were exposed to the contents and items of study instruments –questionnaire and FGD guide using both in English and Yoruba versions.

Twelve FGDs were conducted across the various areas of the state. Two FGDs were conducted in Oyo town, two FGDs were also conducted in Ogbomoso town while eight FGDs were done in various parts of Ibadan metropolis. Participants' characteristics such as educational status and language proficiency or proffered language of respondents were put into consideration in selection of participants for FGD. The participants of each FGD session were homogenous and this created the opportunity for them to participate freely in the FGDs. Comfortable places such as community halls and other large rooms which guaranteed the safety of the participants and confidentiality of the information supplied were used as venues for the FGDs. The venues had comfortable seats, good ventilation and there were no disturbances and distractions from people.

The duration of the FGDs varied between 55 minutes and 1 hour 30 minutes. Each of the FGDs was tape recorded and facilitated by a moderator, note-taker and observer. A moderator asked the questions and made use of the FGD guide to facilitate the harvesting of the different ideas and opinions from the discussants. The moderator sought for clarifications where necessary and guided the discussions appropriately. A note-taker was in-charge of note taking and made use of good tape recorder to record the discussions to prevent loss of

important information. There was an observer for each of the FGD who noted the reactions and subtle attitudes of the discussants and useful non-verbal communication. The participants were assured that the opinions expressed by them would be kept secret and so were encouraged to share their views freely on the issues raised for discussion. Discussions were carried out in participants' preferred choice of language (either English, Yoruba or a mixture of both). In three FGDs, discussions were done in English language as participants spoke English fluently. These discussion sessions had educated participants. There were three FGDs groups where English was mixed with Yoruba during their discussions as participants could speak both languages very well. Yoruba was the major language of discussion in six FGD sessions. The research assistants who facilitated the FGDs were vast in both languages and had being exposed to the both English and Yoruba versions of FGD guide.

The administration of the questionnaires was achieved through the help of the trained research assistants. The informed consent of the respondents was obtained prior to their involvement in the study. They were informed of their right to withdraw from the study at anytime if they wish to do so. Both English and Yoruba versions of the questionnaire were made available so as to allow the respondents to use any of their preferred language. The respondents were informed that their confidentiality would be guaranteed during and after the study. The questionnaires were administered in private places within respondents' house, compound or neighborhood.

Methods of Data Analysis

The questionnaires were collated and edited by the researcher with the help of research assistants. The questionnaires were checked for completeness and a serial number was given to each questionnaire for easy identification and recall. A coding guide was developed by the researcher after a careful review of the responses in all the questionnaires. After the entire questionnaire has been hand-coded, a template was then designed on the SPSS (version 20.0) for entering of the coded data. Each questionnaire response was entered into the computer using the SPSS software- version 20.

Scoring of the items on knowledge of health of consequences of marital rape as well as the perception related items or questions were based on the scales designed along with the questionnaire. For knowledge of consequences of marital rape which was assessed using a set of questions based on a 8-point knowledge scale (respondents were expected to supply 8 correct options or answers) each correct option or answer was given a score of 1. The total scores on knowledge for each respondent was computed and then transformed on SPSS software as either poor, fair or good knowledge of health of consequences of marital rape. Knowledge scores of ≤ 2 , 3- 5 and ≥ 6 were rated as poor, fair and good knowledge of health consequences of marital rape respectively.

There were 20 perception items or statements contained on a 20-point scale in the questionnaire. Each respondent had an option of indicating whether she agrees, disagrees or she was undecided with each of the perception statement. The option picked by a respondent for each perception related statement was given a score of either 1 or 0 depending on appropriateness of the option. Option that was correct or appropriate for each perception

statement was scored 1 (the correct or appropriate options for the perception statements were indicated in table 4.3). The total scores on perceptions of marital rape for each respondent was computed and then transformed on SPSS software as either negative or positive perception of marital rape. Perceptions scores of ≤ 10 and > 10 were classified as negative and positive perceptions of marital rape.

The quantitative data were analyzed using descriptive statistics including frequency counts, percentages and mean. The hypotheses tested using Chi-square at 0.05 level of significance. The results were presented using tables and charts. In addition, summary of the results were written in text and presented in chapter 4.

Data from the FGDs were subjected to thematic analysis. Thematic analysis is a method of analyzing qualitative data which involves identifying and analyzing patterns in qualitative data (Clarke & Brain, 2013). Several procedures were involved in the data management and analysis of the FGDs data. It started with the transcription of tape recordings of the FGDs which was done as soon as the data were collected to avoid loss or omission of important details. The transcriptions were done by researcher and three research assistants were involved in the data collection. The transcriptions were rechecked and thoroughly vetted by the researcher to ensure quality assurance. The transcriptions (which were in rich text formats) were entered into the ATLAS Ti software (version 7.5).

Coding of the data was done using an integrated approach i.e a combination of deductive and inductive coding procedures. The codes were linked appropriately to the corresponding quotations. Over 400 primary codes were generated and were further grouped into secondary or family codes for ease of data interpretation and management. Memos were created where

necessary and were linked with appropriate codes and quotations. Themes emerged based on patterns of results as reflected in similar codes and quotations. Themes were further explored along the pattern of results based on major points of agreements, contrasting views or points, striking and salient points that were made by the participants. Themes are patterns across data that are important to the description of a phenomenon and become the categories for analysis (Jennifer & Muir-Cochrane, 2006). The participants' languages, ideas and opinions were carefully examined; systematically categorized and recurrent themes were noted. The last procedure involved in the thematic analysis of the data was writing of summaries and provisions of appropriate verbatim quotes. Data were technically subsumed and incorporated into the study. The qualitative data were triangulated with the quantitative data obtained from the questionnaires.

CHAPTER FOUR

RESULTS AND DISCUSSION OF FINDINGS

This chapter presents the results and discussion of findings on the knowledge, perception and help-seeking behaviour of marital rape among women in Oyo State, Nigeria. Results and discussion of findings covered personal data of respondents as well as issues relating to the objectives, research questions and hypotheses. Inferential statistics of chi-square was used to test the hypotheses set for this study at 0.05 alpha level of significance and presented in tables. The reports of the results and discussion covered both qualitative and quantitative findings which were triangulated appropriately in this section.

Table 2: Descriptive statistics showing socio- demographic information of respondents

N= 1200		
Characteristics	Number	%
*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	41.3
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	16.3
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.

^βMean 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.

Respondents' Socio-demographic characteristics

Table 2 shows the basic socio-demographic characteristics of the respondents. All the 1200 respondents were adult women residing in Oyo State. This was so because they were purposively selected for the study. The ages of respondents ranged from 18 – 60 years with a mean age of 36.6 ± 9.6 years. Sixty five percent of the respondents were Christians and 32.8% were believers of Islamic faith. Yorubas constituted majority of the participants with 76.8% and 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 with no formal education constituted 7.4%. Respondents who had ever married a single husband constituted 91.2% of the study population. Respondents who were employed or working were 84.2%.

N = 1200

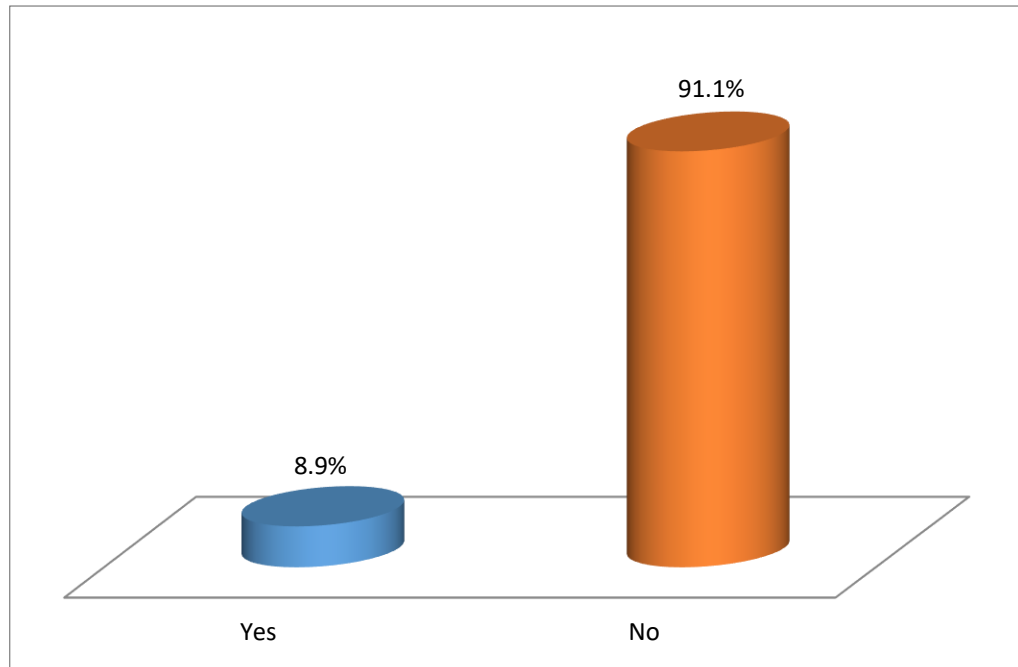
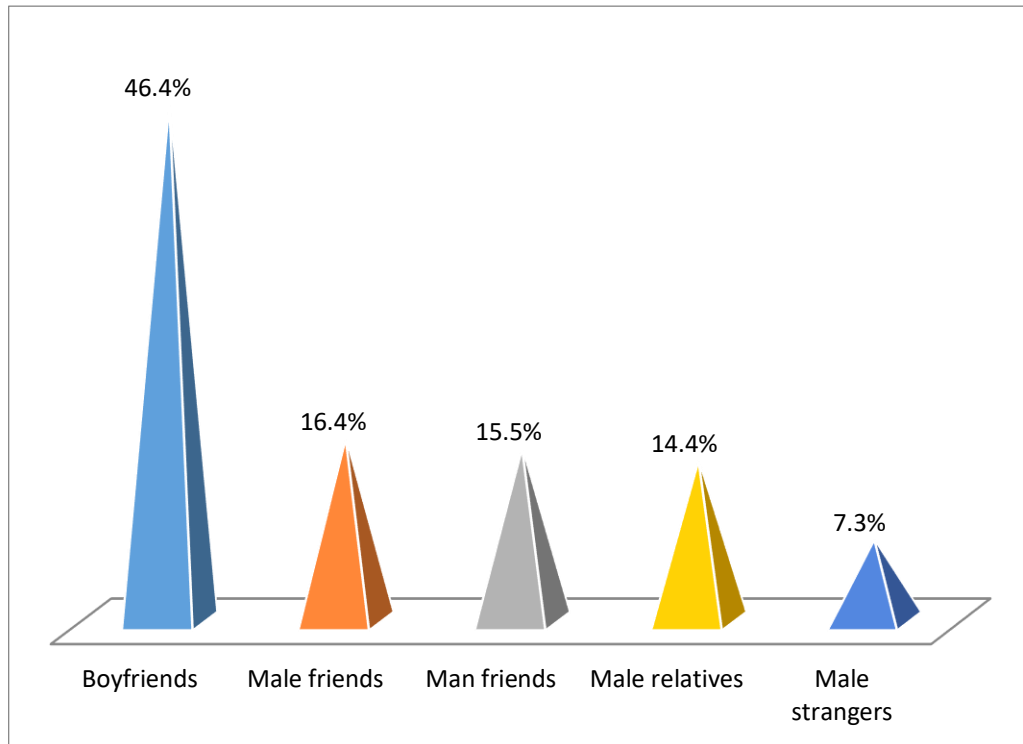


Figure 1- Respondents' previous history of sexual violence

Figure 1 shows information relating to respondents' previous sexual violence experience suffered in the hands of other people apart from marital partners. One-hundred and seven respondents (8.9%) indicated that they had history of sexual violence which they suffered in the hands of other people who were not their husbands.

N= 107*



Note: Multiple responses were present

Figure 2: Categories of persons who had previously sexually violated respondents

Information relating to categories of persons in whose hands respondents had previously being sexually violated is presented in figure 4.4. Boyfriends (46.4%) topped the list of the persons who had sexually violated respondents, followed by male friends (16.4%) (see figure 2 for detailed information).

Knowledge of health consequences of marital rape

Answer to Research Question 1

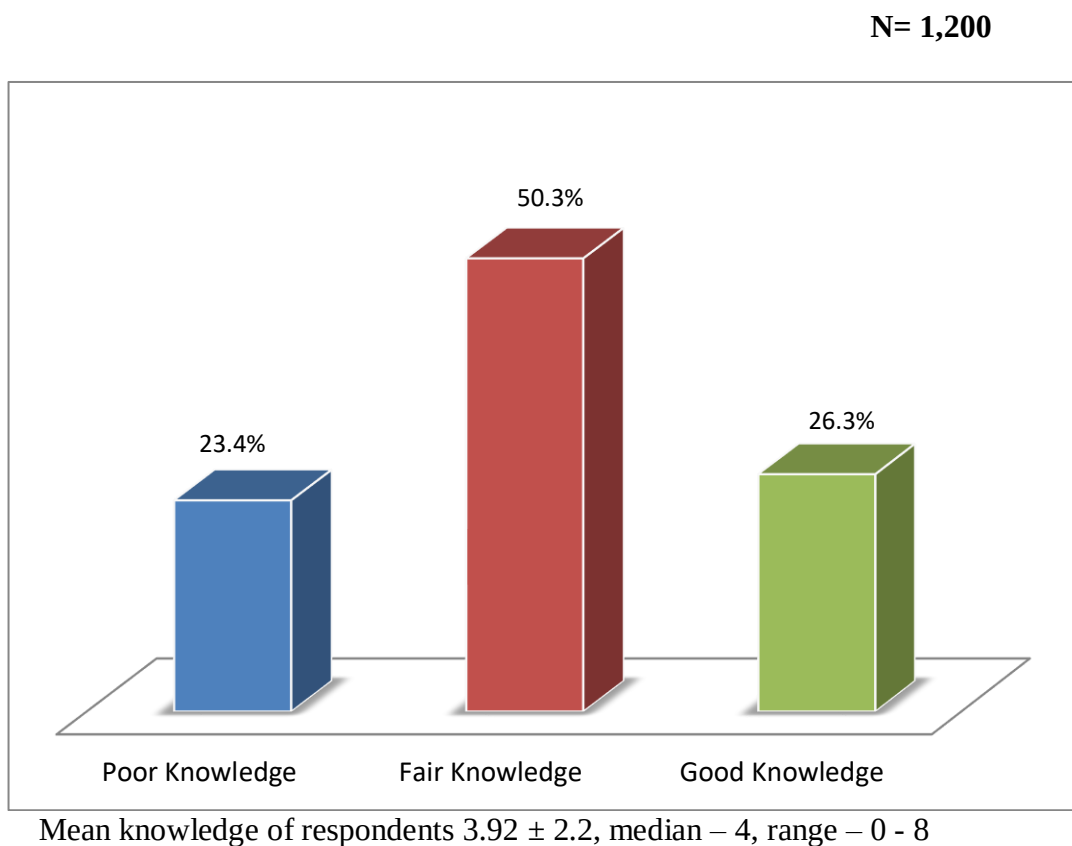


Figure 3: Respondents' level of knowledge of health consequences of marital rape

The proportion of respondents with good, fair and poor knowledge scores relating to marital rape are shown on figure 4.5. About half of the respondents (50.3%) had fair knowledge of the health consequences of marital rape. Those who had good knowledge of health consequences of marital rape constituted 26.3%, while 23.4% had poor knowledge of the phenomenon. Respondents had a mean knowledge score of 3.9 ± 2.2 (see figure 3 for details)

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

Physical health consequences of marital rape	Number*	%
Body injury	403	36.8
Body pain	387	37.0
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 (PTSD)	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 effect 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	8.6
Stigmatization	68	7.1
Lack of trust	18	1.9
Others++	16	1.7
Sexual health effect 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 (0.2%), change of mood (0.1%)

++Others – Feel neglected (1.2%), bad influence on children (0.5%)

As shown on Table 4.2, body injury and body pain had the highest proportions among the physical health consequences of marital rape mentioned by the respondents with 36.8% and 37.0% proportions respectively. Table 4.2 also shows 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 4.2, divorce/separation with 47.9% topped the list of the major 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.

Discussants across the groups affirmed that experience of marital rape can be associated with various adverse health consequences. They identified various physical, psychological, social and sexual health related adverse consequences that women can suffer. The discussants mentioned that women can experience physical health consequences in form of bodily harms or injuries like fracture, dislocation, pain, bruises as well as disability and sickness as a result of being subjected to forced sexual intercourse by their husbands. Some discussants also mentioned that frequent experience of forced sexual intercourse in the hands of husbands can make women look older than their ages. Typical responses of discussants include the following:

The adverse effects of marital rape on women include scars and some of physical injuries (Participant 5, FGD UCH Ibadan).

If a man uses force to handle the woman, the woman's leg may be dislocated or broken and such damage may lead to permanent disability for a woman. In the course of pushing a woman, she may injury and head and it could lead to death. So, there are several adverse health consequences that could result from it (Participant 1, FGD Durbar Oyo).

A woman who suffers rape in the hands of the husband can be faced with various adverse health challenges. One of such, adverse health challenges that can be associated with such act is bleeding (Participant 5, FGD Akobo, Ibadan).

A woman may experience swollen face or severe physical injury as a result of being forced into sexual intercourse by the husband especially when the husband has to beat up the woman (Participant 1, FGDMokola, Ibadan).

The woman will look older than her age and not even happy most times, she will be sick all the time (Participant 3, FGD Yemetu, Ibadan)

Focus group discussants across the various groups mentioned that forced sexual intercourse perpetrated by husbands can be associated with various psychological health consequences such as depression, thinking and recalling memory of the incidence. Other psychological health consequences that were mentioned included unhappiness, loss of self-esteem and mental health challenges. Some of the discussants' verbatim responses were as follow:

Experience of forced or unwanted sexual intercourse in the hands of husband can make a woman to have psychological effects especially experience fear at home (Participant 2, FGD Town-hall Ogbomoso).

There is a lady who down the street, she will just be roaming about. There was at day I notice her, I asked from people around that I have seen her wandered around about 3 – 4 times in a short period. I was told it was the

husband that made her that way, that the husband is always subjecting her to forced sexual intercourse. The forced sexual intercourse has made her brain not to settle down (Participant 5, FGD Akobo, Ibadan).

The greatest of the adverse effects of being subjected to forced sex by one's husband is that one will always be recalling the memory of the incidence (Participant 3, FGD Ashi, Ibadan).

The woman might even be thinking over and over the incident and no one can say the effect of deep thought the woman might end up with. It might lead to hypertension, partial stroke or full stroke (Participant 4, FGD Ashi, Ibadan).

The adverse effect of marital rape on women can be psychological, it could lead to loss of self-esteem and sense of being, making the woman feel to be nothing and making them to lose their sense of worthiness (Participant 7, FGD UCH, Ibadan).

It can lead to depression and affects a woman's self-esteem (Participant 2, FGD UCH, Ibadan).

Participants of the focus group discussion across the various groups stressed that experience of forced sexual intercourse in the hands of their husbands can result to various adverse social consequences. Majority of the participants mentioned that frequent experience of marital rape could lead to divorce or separation of couple. It was also noted that such experience could lead to strained relationship between married partners as well as disharmony at home. Some of the discussants' verbal expressions were as follow:

Experience of marital rape can lead to separation from the man if the case is not well treated or handed (Participant 4, FGD Town-hall, Ogbomosho).

Subsequent forced or unwanted sexual intercourse in the hands of husband can make a woman to abandon her marital home and elope with the children when the problem is getting too much (Participant 3, FGD Akobo, Ibadan).

Such experience often results into separation at the end of the day. Because one person can kill the other if care is not taken (Participant 2, FGD, Orita-mefa, Ibadan).

It can also widen the relationship between themselves and also between the children (Participant, FGD Olorunda, Ibadan).

Marital rape can affect the social relationship of married partners. The way they will be relating will not be normal any more (Participant 7, FGD UCH, Ibadan).

Several discussants mentioned that forced sexual intercourse by husbands can lead to vagina pain and injures including vagina bleeding and damages of the vital parts or organs of the female reproductive systems. It was also mentioned by some participants that forced sexual intercourse could increase women's risk of contracting sexually transmitted infections including HIV.

Some of the discussants' verbal expressions were as follow:

If a man has a forced sexual intercourse with a woman it can lead to stomach pain or vagina pain (Participant 1, FGD Mokola, Ibadan).

There are some women who experience vagina pain when they are being subjected to force or violent sexual intercourse (Participant 7, FGD Mokola, Ibadan).

It can damage the internal organ of the woman especially the womb because of force that was used during the activity (Participant 4, FGD Ashi, Ibadan)

She might eventually have diseases like STDs, HIV e.t.c (Participant 7, FGD Yemetu, Ibadan).

Two focus group discussants mentioned that experience of forced sexual intercourse in the hands of husband at a time that women have just given birth and have not started using family planning methods can lead to unwanted pregnancy. One of the discussants made her point this way:

It can lead to unwanted pregnancy may be they already give birth to four children already and the woman is on drugs and that day she did not use her drug and the husband forced her to have sex (Participant 1, FGD Ijokodo, Ibadan).

Some participants of the focus group discussion across the various groups mentioned that women's experience of forced sexual intercourse in the hands of husband does not make them as well as the husbands to enjoy sexual intercourse. They further commented that sexual intercourse among married partners only are enjoyed when both married partners are willing and mutually decided to have sexual intercourse. Typical verbatim expressions which reflect this viewpoint are as follow:

In such situation where a man decides to force his wife to have sexual intercourse, they will not enjoy the sex. The man that is forcing the woman will not enjoy the sex and likewise the woman that is being forced into the sexual act (Participant 7, FGD Mokola, Ibadan).

If a man subject his wife to forced sexual intercourse, both partners will not be able to enjoy it. It is better they both agree to it and do it in a good mood, so that they can both enjoy it (Participant 5, FGD Mokola, Ibadan).

If a woman is not in the right mood or forces the wife to have sex, even the man will not enjoy it (Participant 1, FGD Ogbongbodu, Oyo).

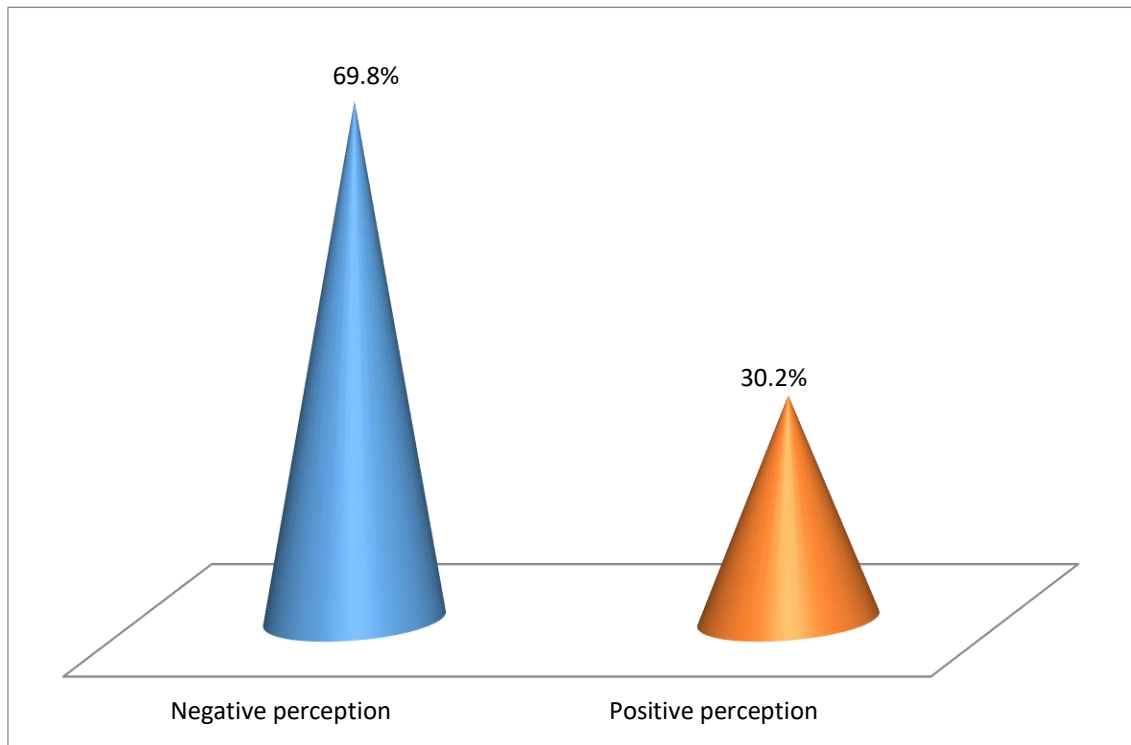
Sex should be something to be enjoyed between you and your husband (Participant 3, FGD Ijokodo, Ibadan).

If a man forces his wife to have forced sexual intercourse, they both would not enjoy it. The husband only needs to beg her if she is not willing to have sex (Participant 4, FGD Olorunda, Ibadan).

Perception of marital rape

Answer to Research Question 2

N=1200



Mean Perception of respondents 8.9 ± 3.6 , median – 9.0, range – 0 - 19

Figure 4: Respondents' perception of marital rape

Information on the perception scores of respondents and the proportion of respondents with negative and positive perceptions relating to marital rape are shown on figure 4.6. Respondents' perceptions scores ranged from 0 -19 with 8.9 ± 3.6 . Respondents who had negative perception relating to marital rape were 69.8% (see figure 4.4 for details).

Table 4a: Perceptions relating to Marital Rape

*Marital rape related perceptions	Pattern of response		
	Agree (%)	Undecided (%)	Disagree (%)
Being subjected to forced or unwanted sexual intercourse by one's husband is not a pleasant experience	1004(83.7) ^β	50(4.2)	146(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(34.3)	205(17.1)	584(48.7) ^β
A man who subjects his wife to forced sexual intercourse should be blamed for such 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 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 reason why some men have forced or unwanted sexual intercourse with their wives.	435(36.3)	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 experience rape (forced or unwanted sex) in the hands of her husband should inform the social welfare office	465(38.8) ^β	206(17.2)	529 (44.1)

^β- correct/appropriate perception

Table 4b: Perceptions relating to Marital Rape

*Marital rape related perceptions	Pattern of response		
	Agree (%)	Undecided (%)	Disagree (%)
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 (39.8) ^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(45.3)	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(14.8)	372(31.0) ^β
A married women should not leave her husband because of experience of marital rape	607(50.6)	213(17.8)	380(31.7) ^β
A woman who experience 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 experience rape (forced or unwanted sex) in the hands of her husband should just endure it	489(40.8)	228(19.0)	483(40.3) ^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 4 (4a & b) 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. As much as 71.2% of them opined that a man who subjects his wife to forced sexual intercourse should be blamed for such 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.

As much as 54.3% of the respondents shared the perception that married women do not have the right to refuse sex from their husbands. Forty five percent of the respondents opined that a woman who experience rape (forced or unwanted sex) in the hands of her husband should not inform anyone. The view of 44.2% the respondents was that being subjected to forced or unwanted sexual intercourse by one's husband should not be regarded as rape. Fourty two percent of the study respondents perceived that a woman should tolerate marital rape for the sake of the marriage. The perception that a woman who experience rape (forced or unwanted sex) in the hands of her husband should just endure it was affirmed by 40.8% of the respondents. 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 (See the table 4b for further details).

The FGD participants across the twelve groups shared their perceptions of marital rape. Although there were varied perceptions relating to marital rape, all participants frowned at marital rape and opined that it is not right for husbands to subject their wives into forced sexual intercourse. The frequently occurring opinion was that sexual intercourse in marriage should be mutually agreed upon and women should not be made to suffer unduly because of sexual intercourse. Some of typical responses of the discussants reflecting the awful nature of marital rape were as follows:

An act like forcing one's partner into sexual intercourse is not good and is even forbidden by God (Participant 6, FGD Ogbongbodu, Oyo).

It is not a pleasant or good behaviour for a man to be subjecting his wife to forced or unwanted sexual intercourse. That is the way I perceive it to be (Participant 2, FGD Town-hall, Ogbomoso).

It is not good for a man to be subjecting his wife to forced or unwanted sexual intercourse. The right thing is for a man to seek for the sexual consent of his wife and the woman should willingly accept the sexual request (Participant 6, FGD Akobo, Ibadan).

A practice subjecting one's wife to forced or unwanted sexual intercourse is not good. Couples are supposed to show love to one another. If a man force a woman into sexual intercourse, the woman will not do it in a way that will make the man enjoy it, she will just do it with the mindset that just do what you want to do and allow me to be (Participant 2, FGD Mokola, Ibadan).

It was revealed from the focus group discussions that situations where women are subjected into forced sexual intercourse make sexual intercourse repulsive and not enjoyable as it ought to be among married partners.

In such situation where a man decides to force his wife to have sexual intercourse, they will not enjoy the sex. The man that is forcing the woman will not enjoy the sex and likewise the woman that is being forced into the sexual act (Participant 7, FGD Mokola, Ibadan).

It is not right for a man to subject a woman to sexual intercourse except both parties agree to it. If a man subject his wife to forced sexual intercourse, both partners will not be able to enjoy it. It is better they both agree to it and do it in a good mood, so that they can both enjoy it (Participant 5, FGD Durbar Oyo).

It is not good at all for a man to force his wife into sexual act. When both married partners are happy is the period when sexual act is enjoyed the most. A woman is being punished when she is been forced to have sexual intercourse and that is terrible and a bad attitude that God hates (Participant 5, FGD Yemetu, Ibadan

Some discussants further perceived marital rape as a kind of behaviour that is frowned upon by the society and should not be tolerated or handled with levity. Some of their typical responses reflecting this viewpoint are as follow:

It is a bad thing that should not be tolerated or accepted in our society (Participant 5, FGD Ashi, Ibadan).

It is very bad and it should not be handled with levity (Participant 7, FGD Ashi, Ibadan).

Yoruba people frowns at it. Our community does not value such behaviour. There are some men that when they want to have sexual intercourse with their wives all the people in the house will hear about it. I once lived in a place, in a compound in Layaju in Ibadan, a woman and his husband will be chasing themselves around the house. The wife will be

shouting that his husband has started again o, that the husband wants to have sex with her but she did not agree to his sexual advances. They will be chasing one another and the neighbors usually get tired of such behaviour (Participant 4, FGD Mokola, Ibadan).

Several participants vividly opined that forced sexual intercourse experienced by women in the hands of their husbands is a serious phenomenon that be considered as rape. They portrayed such behaviour as an illicit act that should not be tolerated especially when such behaviour is recurrent. The following are some of the interviewees' verbatim expressions which vividly illustrate these viewpoints:

The idea of a man subjecting his wife to forced sexual intercourse is not good, it is like raping one's wife. I consider such as rape. It is rape when a woman is being subjected to sexual intercourse against her will of the woman and it involved the use of force (Participants 4, FGD Durbar Oyo).

The situation of forced sexual intercourse in marriage can be called rape, nothing but rape because the agreement a man signed with the wife is to make the woman happy, feel important and respect her kfeelings which is against forcing a woman against her wish (Participant 4, FGD Town-hall, Ogbomoso).

If a man is forcing a woman to have sexual intercourse there is no longer love in such relationship. Such act can be considered as rape because it does not come willingly from a woman's mind and she is being forced into it (Participant 2, FGD Ogba-jagun, Ogbomoso).

It can be considered as rape if a man uses force to have sexual intercourse with his wife. If it comes from the mind of a woman, she will do it

wholeheartedly and both the man and the woman will be happy about it (Participant 5, FGD 4, FGD Ogba-jagun, Ogbomoso)

...A man who does such thing is a wicked man. Such man can kill the woman, he is not a husband. Such wife should hurriedly pack her things out of the house (Participant 1, FGD Mokola, Ibadan).

One discussant further pointed out that marital rape is a criminal behaviour that should be given legal sanctions or punishment. She expressed her opinion this way:

A man has no reason to rape the wife, as a responsible husband. I think rape is worse than any other thing that I know. In fact if a husband rape his wife, such man is a criminal, he need to be hanged (Participant 3, FGD Ijokodo, Ibadan).

There were several participants across some groups who had several perceptions that are supportive of marital rape. Some discussants perceived marital rape as a typical occurrence in marriage and did not see anything serious in experiencing such act. In addition, several discussants opined that forced sex in marriage should be called rape. Across the various groups, there were a number of discussants that held on to the view that women should be blamed for acts of being subjected to forced sexual intercourse by their husbands. Some of the discussant verbatim responses were as follow:

A situation where a man subjects his wife to forced or unwanted sexual intercourse when the wife turns down his sexual request is not rape. It is the woman that wants to deny the man his sexual rights (Participant 3, FGD, Orita-mefa, Ibadan).

If the man has the urge and the woman is not interested and the man decides to force the woman it is not rape. I don't think so. The man is

your husband and you are not sleeping with a stranger are you getting me. The woman that said she is not interested, when the thing enters you will find out that she will enjoy it. Is that rape? That is not rape (Participant 1, FGD, Orita-mefa, Ibadan).

Sex is the number one thing in marriage. It is the pillar of marriage. When a woman keeps complaining that she is tired every day, the man will have no choice than to force the woman (Participant 3, FGD Orita-mefa, Ibadan).

It is normal thing a man can use force or threat to subject his wife into having sex intercourse when a woman is not interested. Such sexual intercourse cannot be referred to as rape. It is what has happened to me before (Participant 2, FGD, Orita-mefa, Ibadan).

There is nothing like rape between husband and wife once a man and a woman get married in church or in court, the man has access to his wife anytime and any day (Participant 3, FGD Ashi, Ibadan).

As for me, there is nothing like rape in marriage in as much the woman is married to the man, the man has the right to have sex with her anytime any day. Maybe the behaviour or ways the man used to have sex with his wife is wrong but it should not be called rape, instead they should find another name to call such act (Participant 6, FGD Yemetu, Ibadan).

The FGD participants across the various groups gave a long list of reasons that can lead to marital rape occurrence. Across the various groups, several discussants mentioned that the practice of indulging in extra-marital affairs by women is the major reason why men subject their wives into sexual intercourse when they discovered their behaviours. The discussants explained that the husband of women who indulge in extra-marital affairs often decide to

subject them to forced sexual intercourse in order to prevent or deter them from having sexual affairs with their extra-marital partners.

It is women who practice extra-marital affairs that majorly suffer force sexual intercourse in the hands of their husbands (Participant 7, FGD Mokola, Ibadan).

A man can subject his wife into forced sexual intercourse when he realizes that the wife is indulging in having sexual intercourse with someone outside and she is also declining the man's sexual request or advance (Participant 6, FGD Ogbongbodu, Oyo).).

Some women's urge for sex is high outside with concubine but low inside with her husband. When the husband gets to know that his wife has extra marital affairs, he would want to be forcing her to sexual act in order to render her useless with the other man outside (Participant 3, FGD Town-hall Ogbomoso).

If a woman indulges in extra-marital affairs can be a reason why a man can subject his wife to forced or unwanted sexual intercourse. For such a woman, the husband can accuse her of having extra-marital sexual partners outside and denying him of sex and consequently insists on having sex with the woman with force (Participant 2, FGD Ogba-jagun Ogbomoso).

If a woman is harlot that she is having extra-marital affairs, it can make the husband be subjecting her to forced sexual intercourse so that prevent her from doing so (Participant 3, FGD Ogba-jagun Ogbomoso).

If a man suspects that a woman indulges in extra-marital affairs, he can subject her into forced or unwanted sexual intercourse in order to make her overawed. It is a situation that occurs commonly (Participant 2, FGD Akobo, Ibadan).

A man can say since a woman has been practicing extra-marital affairs he will always subject her to sexual intercourse whether she wants it or not at any time of the day, be it in the morning, afternoon or night, so that the woman will be restrained from further indulging in extra-marital affairs. This situation is a common occurrence (Participant 5, FGD Akobo, Ibadan).

It was also revealed that some men subject their wives into forced sexual intercourse to confirm their suspicion of the women indulgence in extra-marital affairs. Some discussants comments reflecting this viewpoint include the following:

If a man knows or suspects the woman to have been involved in sexual intercourse with an extra-marital partner, he may want to test it if the woman has been involved in such act. Such situation often results in a man subjecting his wife to forced sexual intercourse (Participant 5, FGD Ogbongbodu, Oyo).

If a man notices that his wife is indulging in extra-marital affairs, he may insist on having sexual intercourse with the wife to know if the woman has had sex outside or not (Participant 5, FGD Ogba-jagun Ogbomoso).

A man may decide that he will force his wife to have sexual intercourse, especially when there is suspecting. I have since a case of man that demanded that the wife should show him her pant after she returned from her outing. Due to lack of trust and suspicion, a man could subject his wife to forced sexual intercourse (Participant 6, FGD Ogbongbodu, Oyo).

Some participants across the focus group discussion groups perceived the use of psychoactive drugs and alcohol intoxication as reasons why men subject their wives into forced sexual intercourse. The discussant mentioned that men who are fond of taking psychoactive drugs as well as those who are perpetual drunkards can beat up their wives and

subject them to forced sexual intercourse if their sexual request is being declined. The following are some of the interviewees' verbatim expressions which illustrate these viewpoints:

Use of hard drugs and alcohol can make a man to subject his wife to sexual intercourse. A man who is fond of using hard drugs or abusing alcohol can have sexual intercourse with a woman to the point of death (Participant 6, FGD Durbar Oyo).

It is those that take alcohol and hot drinks that does not really have sense that often subjecting his wife to forced sexual intercourse (Participant 5, FGD Ogba-jagun Ogbomoso)

If a man that subject his wife to force sexual intercourse is examined thoroughly, it will be certain that he is not normal upstairs or not responsible at all. He might be alcohol drunkard or Indian hemp smoker whose behaviours are different from that of normal human beings (Participant 4, FGD Ashi, Ibadan).

If a man comes to the house drunk and request for sexual intercourse which is not been accepted, he could be beat up such a woman and have her subjected into forced sexual intercourse (Participant 3, FGD Mokola, Ibadan).

Alcohol is like the way of life of some people and people who are drunkards if they get home and have sexual urge and the wives say "No" they could force them (Participant 7, FGD UCH, Ibadan).

Several discussants across all the focus discussion groups acknowledged that men could subject their wives into forced sexual intercourse when wives are fond of turning down their sexual request.

Use of physical force is mostly used to subject a woman into sexual intercourse when the woman is resisting her husband's sexual advances (Participant 2, FGD Ashi, Ibadan).

When a woman rejects her husband's sexual advances often and often and the man counts it as cheating, he would find other way to fight for himself and in the process may have to force the woman into sexual intercourse (Participant 3, FGD Ashi, Ibadan).

Sexual denial at home due to one reason or the other might lead to marital rape (Participant 6, FGD Town-hall, Ogbomoso).

The discussants unanimously agreed across the various groups that is it not a good behaviour for women to be turning down their husbands sexual request. However, many discussants affirmed “*there can be a lot of reasons at times why a woman can turn down the husband's sexual request*”. The most frequently mentioned reason why women could turn down their husbands' sexual request is if the husband is not providing for the home when he has the capacity to do so. Most of the discussants opined that if men fail to provide for their wives and home they are supposed to be denied their sexual right so that they could realize the importance of doing so.

When a man is not doing what he ought to be doing as the head of the home it makes a woman to deny the husband the right of having sexual intercourse (Participant 2, FGD Ogba-jagun Ogbomoso)

If a man is not responsible and not taking care of his family, surely the wife will be turning him down whenever he proposes to have sex with her because the woman is not happy with him and this will not allow her to be in mood to have sex (Participant 4, FGD Ashi, Ibadan).

If the man is not ready to take the responsibility over the children, the woman can use sex to punish the husband (Participant 8, FGD Ijokodo, Ibadan).

As for me, if I ask for something and my husband did not provide it and expect to have sexual intercourse with me, I will decline. Such request will be turned down at that moment (Participant 7, FGDMokola, Ibadan).

Another major reason given for declining husbands' sexual demand is if husband is indulging in extra-marital affairs. Similarly many discussants opined that women often turn down their husbands sexual advances due to fear of contracting sexually transmitted infections including HIV when they know or discover that their husbands are indulging in marital infidelity. Few discussants, however, disagreed that women should not because of husbands' practice of indulging in extra-marital activities decide to decline their husbands' sexual request. The following are some of the discussants' verbatim responses which illustrate women's decision to turn down husbands' sexual advances due to marital infidelity:

I can turn down my husband's sexual request or advances as punishment especially if it is sin of adultery. I will close up my border in order not to be affected by deadly diseases (Participant 4, FGD Yemetu, Ibadan)

A woman can turn down her husband's sexual request or advances due to a man's practice of infidelity. A woman may know the various women that her woman is having extra-marital affairs with and due to the fact that she does not want to contract sexually transmitted diseases, she could decline her husband's sexual request or advances (Participant 5, FGD Ogbongbodu, Oyo).

A woman may turn down the husband's sexual request or advances if the husband has concubines (Participant 4, FGD UCH, Ibadan).

If the husband is having extra-marital affairs, and the woman is afraid of some terrible diseases outside now like HIV. She might withdraw herself from her husband by rejecting his sexual advances (Participant 6, FGD Town-hall, Ogbomoso).

When you suspect or know that your husband is having extra marital affairs because of what is going on outside like HIV, so at times you refuse to have sex with him, for him not to infect you (Participant 1, FGD Ijokodo, Ibadan).

The fear of contracting HIV can make a woman to turn down her husband's sexual request or advances. When a woman knows that her husband practices extra-marital affairs she will be looking for every means of avoiding sexual intercourse with the man, though she may not make it obvious but she will not relate intimately with the husband (Participant 2, FGD Akobo, Ibadan).

Some participants mentioned that some women often decline to have sexual intercourse with their husbands because of fear of being pregnant especially when such women have just given birth to children and have not been using family planning methods. One discussant has this to say:

We become pregnant even while nursing children of 2 months...I gave birth to a child 2014 and another child in 2015. I know the type of stress that I passed through. So how can a child be born with Copper T, how can injection fail? This is why women are avoiding having sexual intercourse with their husbands and men will not want to use condom with is a bit safe. Men will say it is skin-to-skin that they enjoy. If they can make the different types of family planning methods that are available not to be fake again to reduce the stress being faced by women, we will not be willing to avoid sexual intercourse.

Few (four) discussants viewed that denying husbands right to sexual intercourse because of husbands practice of indulging in extra-marital affairs is not appropriate. One of the discussants vividly expressed that women's behaviour of turning down husbands sexual request because of marital infidelity or fear of contracting sexual transmitted infections can further motivates such men to practice of marital infidelity. The discussant expressed her verbatim response this way:

Fear of husband not being faithful does not give rooms for saying "No" to one's husband advances for sexual intercourse, it will worsen the situation because the man will capitalize on the woman's rejection of him for sex. All we need to do is to put condom inside his wallet or bag when going out and if he should ask he should ask for the reason for putting the condom inside his wallet or bag when going out, a woman should not hesitate to tell the husband extra affair in a cool manner. She should explain that the condom is for his protection and her protection too as wife at home (Participant 3, FGD Ashi, Ibadan).

There were several discussants across the various groups who unanimously stated that economic dependence on husbands could create opportunity for men to subject their wives to forced sexual intercourse. Few discussants, however, insisted that economic dependence could not be used as reason for subjecting a woman into forced sexual intercourse. The discussants opined that it is not appropriate for a woman to depend on the husband totally for finance without her making some financial contributions to the upkeep of the home. They perceived that women that are not economically dependent are less likely to be abused sexually by their husbands. The quotes which vividly illustrate the discussants perspective on this issue are as follow:

Economic dependence or reliance on husband by a woman can be a reason why a man can subject his wife to forced or unwanted sexual intercourse (Participant 2, FGD Akobo, Ibadan).

Some men also believe in having forced sexual intercourse with their wives because they are the one feeding them (Participant 3, FGD Ashi, Ibadan).

Economic dependence on a man by a woman can provide opportunity for a man to subject his wife to forced or unwanted sexual intercourse. The world where we are today is different, the appropriate thing is for both a man and a woman to work and contribute financially to the upkeep of the home if one does not want the children to suffer. If a man uses 24 hours to feed a woman, he may think that the woman is not doing anything and think that the woman ought to be useful for something (Participant 7, FGD, Ogbongbodu, Oyo).

If a woman depends economically on a man totally, such a woman is enslaving herself under the spouse. The best thing is for a man to give fifty naira and the wife to add her 30 naira for the survival of the family. If it is the man that provides for the house, he can be compensating himself with sexual act at any time (Participant 3, FGD Town-hall, Ogbomoso).

Depriving husbands of sexual intercourse as well as not satisfying husbands sexually were perceived as reasons for marital rape. Some discussants acknowledged that women who starve their husbands of sex or those who fail to satisfy their husband sexually could suffer forced sexual intercourse in the hands of their husbands when their husbands could no longer condone such habits. Some of the verbatim expressions which typify their viewpoints are as follow:

A man can subject his wife to forced or unwanted sexual intercourse if a woman deprives or starves her husband of sex (Participant 5, FGD Akobo, Ibadan).

May be a woman is not allowing her husband to have sexual intercourse with her and it could even be that she is even practicing extra-marital affair and she prefers the sexual relation with her outside partner. And whenever the husband wants to have sexual intercourse with her she does not allow it and the husband has to resolve to the use of force to have sexual intercourse with the woman (Participant 2, FGD Mokola, Ibadan).

A man may subject his wife to forced sexual intercourse because the woman has not been satisfying him (Participant 1, FGDMokola, Ibadan).

If the woman is not satisfying her husband sexually, she is vulnerable to rape when the man cannot cope again instead of having extra marital affairs (Participant 6, FGD Town-hall, Ogbomoso).

Two discussants from different groups affirmed that behaviour such as subjecting a woman to forced sexual intercourse exists when there is no longer love between married partners. They presumed that when love exists between husband and wife, behaviour like subjecting a woman to forced sexual intercourse cannot exist. One of the discussants made her verbal expression this way:

When a man subjects his wife to forced sexual intercourse it could be that there is no longer love between the man and his wife. If there is no longer love between married partners, a man can do all sort of bad things (Participant 4, FGD, Ogbongbodu, Oyo).

A number of the focus group discussants opined that marital rape occurrence can be attributed to cultural and religious reasons that supports male dominance and give men rights over women. Some of the discussants' verbatim quotes that portray this viewpoint are as follow:

A man can say I have paid for your dowry, I own you and I have all the right to do whatever I want. Cultural belief that a woman is the property

of a man can be responsible for occurrence of marital rape in some few instances (Participant 6, FGD Durbar Oyo).

There are cultural beliefs that support the use of force to subjects one's wife into sexual intercourse (Participant 5, FGD, Orita-mefa, Ibadan).

As a Muslim, there is a religious belief that a woman must not say No to their husband's sexual request if she does not want to be beaten throughout that day. Such belief might give Muslim men effrontery to be raping their wives whenever it is against women wishes (Participant 3, FGD Town-hall, Ogbomoso).

That might be true that cultural and religious beliefs can make a man to subject his wife to forced or unwanted sexual intercourse but civilization has come, it should not be so again. I personally kick against such act under the belief of religion (Participant 6, FGD Town-hall, Ogbomoso).

Some discussants disagreed with the perception that cultural and religious reasons are responsible for why men subject their wives into sexual intercourse. One of the discussants who commented that that cultural and religious reasons cannot be used for subject one's wife into forced sexual intercourse has this to say:

A reasonable man will not because of the cultural belief that a woman is the property of a man and subject his wife into forced or unwanted sexual intercourse (Participant 1, FGD, Orita-mefa, Ibadan).

Some participants bemoaned that the society has tolerance for marital rape. They stated that the society often believe that women do not have any right to turn down their husbands sexual advances. The discussants alluded to the fact that the societal attitudes about sexual intercourse in marriage is not in favour of women. Typical verbatim quotes of discussant are as follow:

The society does not belief in marital rape especially in Yoruba land; people believed that a woman cannot say “No” to husband’s sexual request (Participant 5, FGD UCH, Ibadan).

The society believes that the man has the right to have sex with his wife at any time. When you even you report him to your family, they will that it is the right of the man (Participant 7, FGD UCH, Ibadan).

The society does not belief in marital rape. People who experience such things will even make a female child to believe that it is a normal thing that she has to endure in marriage (Participant 8: FGD, UCH Ibadan).

The participants of the focus group discussions across the groups had divergent views relating to women’s experience of rape in marriage. Majority of the discussants across 10 groups out of the 12 groups affirmed that women could suffer forced sexual intercourse in marriage. Some discussants opined that forced sexual intercourse cannot exist in marriage. Several discussants further vividly expressed that occurrence of marital rape is commonly experienced among women. Many discussants knew close people who had experienced marital rape and few of the discussants disclosed in their narrations that they have also experienced it. It was noted that women often experience marital rape after being subjected to beating and physical torture by their husbands. From the narrations of the discussants it was obvious that women experience marital rape often suffer various forms of adverse health consequences including physical injuries such as swollen face, body pain, shame and feelings of distrust. It was also noted that some women who suffered marital rape left their houses temporarily while some sought for permanent separation. Some of the discussants’ verbatim expressions about women’s experience of marital rape are as follow:

It is not uncommon in marriage for a man to subject his wife into forced sexual intercourse. For instance, my husband used to do it, if he asks me for sex, if I did not accept by the time am sleeping, he will just subject me to forced sexual intercourse. That is how he used to do. Even though I say sorry am tired, he will say I can go to my house if I know am tired (Participant 4, FGD Ijokodo, Ibadan).

There is a case of these our neighbours, the man does not have the confidence to have concubine, anytime the wife says she does not want sex, the man use to force her (Participant 6, FGD UCH, Ibadan).

One of our neighbours, he can call the wife from her shop at anything, he will lock her up in the house and will often use physical force by beating her or using belt on her to subject her to forced sexual intercourse. The woman is always crying after such incidence. There was a time that the woman packed her things out of the man house and went to her parents' place. But her parents brought her back to the house that it was the woman's choice that she married the man. Despite this, the man has refused to change. Anytime this man has another woman that he is having after extra-marital affair with he will relapse on this habit, but whenever he does not have any woman outside, he will continue with his practice (Participant 4, FGD Akobo, Ibadan).

Some men can slam their wives to the wall because they want to have sexual intercourse with them, some will find their wives in the bathroom and start forcing their wives into sexual intercourse right from there. This kind of behaviour is not good. There are some men that they do not know the appropriate private place for sexual intercourse, they want to have sexual intercourse anytime they want, they will just forcefully remove or tear the clothes of the wife and subject the wife to forced sexual intercourse (Participant 5, FGD Ogbongbodu, Oyo).

Rape in marriage is a major problem. I personally have been looking for way out of this problem. I have a friend who has given birth to eight children against her wish, she is being raped always when her husband is under the influence of alcohol at night and the man does not take care of the eight children. As am talking I will love her to be here to narrate her ordeal, but she said she is far from this place when I called her now. Such a man should be jailed by government if report is made at the necessary place (Participant 4, FGD Town-hall, Ogbomoso).

There is a case that happened that I have witnessed before, the woman we were living together. I just saw that her eyes were swollen in the morning and I asked her for what happened to her, she did not want to say it in the presence of everybody. When it remained only me and her, she told me that it was the husband that wanted to have sex with her when he has just given birth and the child was just after 40 days and the husband beat her that her mouth was swollen (Participant 3, FGD Ogba-jagun Ogbomoso)

One case that I know of which is so strange to me is the case of a young woman, although when she wanted to marry the man he people told her not to marry the man but she was so much in love with the man and had to marry the man. After she married the man, the situation of the man's excessive sex demand became too serious that the woman said it out. This woman noticed that whenever they enter into the house the man will have sex with her till the following day break and anytime the woman shouts, the man will block her mouth with something so that she cannot shout. She said after the husband has satisfied him himself by having sex with her through the vagina, she will force her to have anal sex to the extent that it affected the way the woman was walking. Anytime the woman objects, the man will beat her up. On one particular day, the woman told the husband's mother who discussed with the husband but the husband did not change. It came to a point that one day the woman had to pack her things

and left the man's house for some time and after she gave birth that the family intervened in the issue the woman came back to the house and the man promised not to do such thing again. After the woman return to the house, the same thing was happening. Another day that the man repeated the same thing something dropped from the body of the man, whenever the man wants to have sex with the woman he usually put something in her pocket. The woman picked up the thing that dropped and was showing it around and saying that the husband has been using charm to have sexual intercourse with her (Participant 7, FGD Ogba-jagun, Ogbomoso).

Marital rape experience

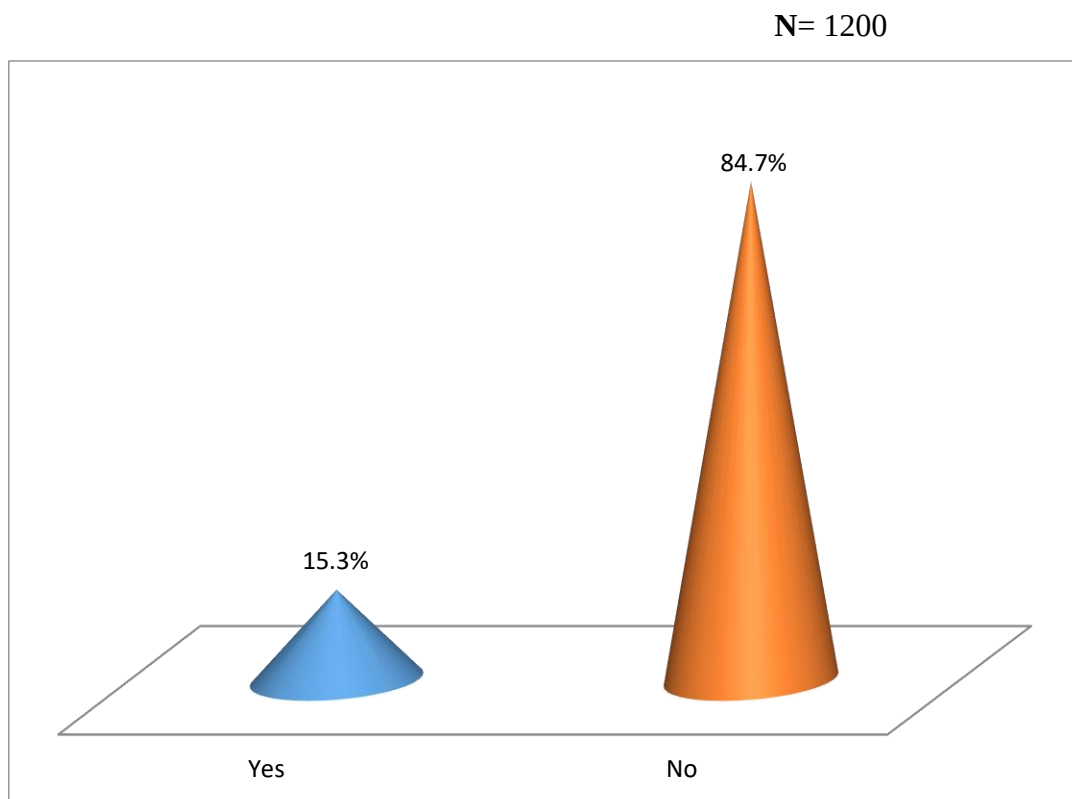
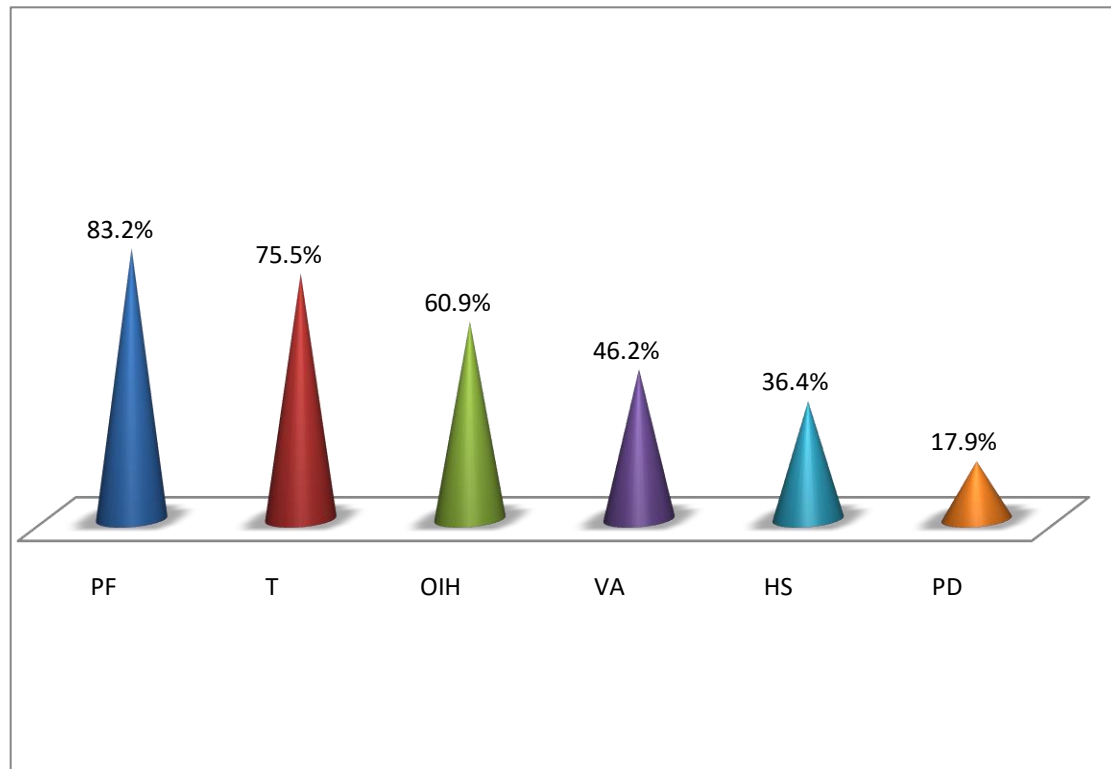


Figure 5: Respondents who had ever experienced marital rape

Information about respondents who had ever experience marital rape is shown on figure 5. A total of 184 women which accouts for 15.3% of the respondents had experienced marital rape.

N= 184



*Multiple response

Key: *PF- Physical Force
 *OIH- Opportunity of ill-health
 *HS- Harmful substance
 *T- Threat
 *VA- Verbal abuse/attack
 *PD- Psychoactive drug

Figure 6: Forms of coercive strategies or situations used by spouses to facilitate marital rape experience

Various forms of coercive strategies or situations that were used to by their spouses to facilitate their marital rape experience are shown in figure 4.6. Physical force with 83.2% was the most common form of coercive strategies or situations that were used to by their spouses to facilitate their marital rape experience, followed by threat which accounted for 75.5%. Use of psychoactive drugs to subject the respondents into forced sex was the least used coercive strategies for marital rape with a proportion of 17.9%.

Some discussants across the groups shared experiences of cases of marital rape which they had observed before or had experienced themselves. It was noted from the FGDs that marital rape cases were often accompanied with the use of physical violence in form of beating and physical torture by their husbands. It was clearly revealed that women who experience marital rape often suffer various forms of adverse health consequences including physical injuries such as swollen face, body pain as well as psychological problems such as shame and feelings of distrust. It was noted that some women who suffered marital rape left their houses temporarily while some sought for permanent separation. Some of the discussants' verbatim expressions about women's experience of marital rape are as follow:

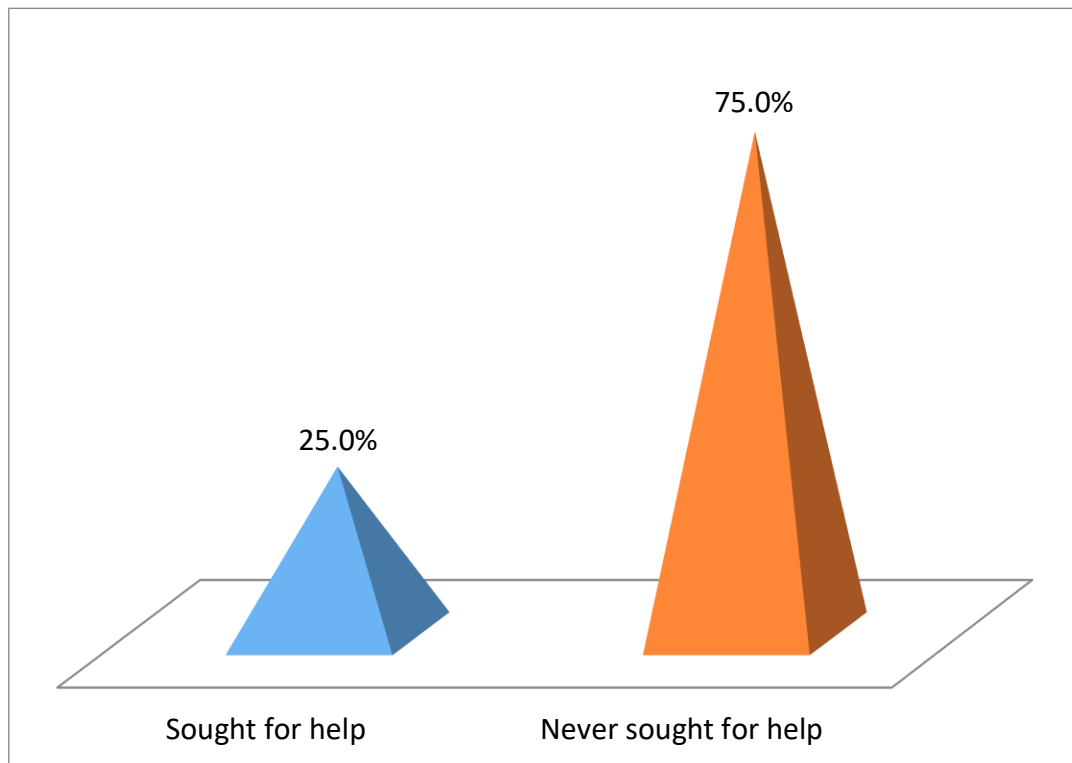
I have know a man that will be beating his wife and blood was coming out of the woman's womb and the man still had sex with her after that the man had the sex, he realised what he did (Participant 2, FGD Ijokodo, Ibadan).

There is a case that happened that I have witnessed before, the woman we were living together. I just saw that her eyes were swollen in the morning and I asked her for what happened to her, she did not want to say it in the presence of everybody. When it remained only me and her, she told me that it was the husband that wanted to have sex with her when he has just given birth and the child was just after 40 days and the husband beat her that her mouth was swollen (Participant 3,FGD Ogba-jagun Ogbomoso).

Help seeking behaviour of marital rape survivors

Answer to Research Question 3

N= 180⁺



NB: ⁺ Non responses were excluded

Figure 7: Help-seeking behaviour of marital rape survivors

Information relating to help-seeking behaviour of women who had ever experienced marital rape is shown on figure 4.7. Only one-quarter (25.0%) of the women who had ever experienced marital rape had sought for any form of help after experiencing marital rape (see figure 7 for details).

Table 5: Pattern of help seeking behaviours of survivors of marital rape

	N= 180 ⁺	
Pattern of help seeking behaviour following the experience of marital rape	Number	%
Sought medical assistance following marital rape		
Yes	27	15.0
No	153	85.0
Reasons for not seeking medical assistance		
Because I could endure it	72	48.3
Did not sustain any injury	33	22.1
Afraid of being stigmatized	22	14.8
No reason	13	8.7
Treated myself at home	6	4.0
Because of the stress of going for treatment	2	1.3
Did not know what to say	1	0.7
Sought legal assistance following marital rape		
Yes	25	13.9
No	155	86.1
Reasons for not seeking legal assistance*		
Because of the children	62	21.4
Afraid of making the experience public	33	11.4
He apologized to me	30	10.3
Afraid of being stigmatized	28	9.7
Afraid it could affect our relationship	27	9.3
Because I love him	25	8.6
Didn't know whether he was right or wrong	21	7.2
Did not want him to be punished	12	4.1
Was able to resolve it	12	4.1
Depend on him for financial support	8	2.8
Sought counseling services following marital rape		
Yes	31	17.5
No	146	82.5
Reasons for not seeking counseling services* (n =)		
Afraid of being stigmatized	54	25.4
Afraid of making the experience public	38	17.8
Because I love him	31	14.1
Did not know whether he was right or wrong	24	11.3
Thought he will change	18	8.5
Because of the children	17	8.0
Was able to resolve it	1	0.5

⁺ Non responses were excluded

*Multiple responses were present

⁺Ever sought for at least one form of help

Pattern of help-seeking behaviours of marital rape survivors and reasons adduced for not seeking for any form of help and other details are contained in table 5. As much as 85.0% of the women who had ever experienced marital rape did not seek for medical assistance. Major reasons adduced not seeking for medical help included because they felt they could endure it (48.3%), because they did not sustain any physical injury (22.1%) and fear of being stigmatized (14.8%). Only 13.9% of the survivors of marital rape sought for legal assistance. Several reasons were adduced for not seeking for legal assistance. Their major reasons for not seeking for legal assistance following their experience of marital rape included because of the children (21.4%), afraid of making the experience public (11.4%) and because their husbands apologized to them (10.3%). Some of the least mentioned reasons that were tendered for not seeking for legal assistance following their experience of marital rape included because they did not want their husbands to be punished (4.1%), because they were able to resolve it (4.1%), because they depend on their husbands for financial support (2.8%). Less than one-fifth (17.5%) survivors of marital rape sought counseling services following the marital rape experience. The reasons given for not seeking for counseling services after their experience of marital rape included fear of being stigmatized (25.4%), afraid of making the experience public (17.8%) and because of the love they have for their husbands (14.1%).

Almost all the discussants across the various groups considered it appropriate practice for survivors of marital rape to seek for help following their experience of marital rape. Discussants were of the view that survivors of marital rape could seek for help in the hospital for treatment of injuries sustained during the act, medical screening and relevant medical services. Discussants were well disposed towards seeking for help in form of advice and counseling from clergymen. They perceived that prayers and spiritual interventions could be sought as form of help from clergymen. Some discussants supported the view to seek for counseling services from counselors who could provide necessary guidance and useful assistance to marital rape survivors. Majority of discussants were not in support of seeking for help from legal services based on experience of marital rape. It was popularly believed that legal services or interventions cannot resolve the issue of marital rape. Few participants who acknowledged the importance of legal services stated that most women will not want their husbands to be jailed because of the experience of marital rape. Discussants views relating to the significance and sources of help-seeking behaviour for survivors of marital rape include the following:

It is a normal thing to seek for help especially medical help because there is no way such woman would not have been wounded during the act (Participant 5 FGD Town-hall, Ogbomoso).

It is good for a woman to seek for help from other people when the problem of marital rape is becoming serious. If one seeks for help in the hospital they will give her drugs or assist her on what to do. If she tells her clergymen about her ordeal, they offer prayers for her that will assist her. If a woman who suffers from marital rape does not keep her issue to herself (silent), she will be able to secure overcome it favorably (Participant 3, FGD Ogba-jagun, Ogbomoso)

There is nothing bad in seeking for medical check-up after being raped because the woman would have been wounded probably internally or externally (Participant 3, FGD Ashi, Ibadan).

It is very good idea to seek for appropriate help because most women would have been wounded physically and emotionally (Participant 6, FGD Yemetu, Ibadan).

Women who were raped by their husbands can go to hospital for treatment (Participant 7, FGD Yemetu, Ibadan).

Going to a counsellor is another good way to seek help after all such counsellor is a neutral person he or she will be in good position to direct her aright (Participant 6, FGD Ashi, Ibadan).

Legal practitioners too can be of help to women but who among the wives will allow their spouses to be jailed because of being subjected to forced sexual intercourse (Participant 4, FGD Yemetu, Ibadan).

Only few discussants considered family members as suitable sources of obtaining help after experiencing marital rape. Two discussants mentioned that family could provide useful help through their support and intervention. One of the discussants has this to say:

A woman who experience marital rape can go to family members for support (Participant 7, FGD Town-hall, Ogbomoso).

Discussants across the groups unanimously agreed that majority of the survivors of marital rape do not seek for help after experiencing marital rape due to shame and fear of being stigmatized. One of the discussant expressed her viewpoint this way:

It is shame that makes women who often experience marital rape not to seek for help (Participant 4, FGD Ogba-jagun Ogbomoso)

Discussants generally across the groups opined that women rarely inform people about their experience of marital rape and prefer to keep it to themselves alone rather than informing anyone about this. Several discussants vehemently held on to the belief that keeping silent about issue of marital rape is more appropriate due to the perceived inherent consequences of reporting such experience. Some discussants affirmed that more women these days are reporting their experiences of marital rape compared to what used to be obtainable years back. Typical verbatim quotes on reflecting the beliefs, practices and behaviours of women relating to reporting of marital rape are as follow:

Women do not report cases of rape they experience in the hands of their husband. It is difficult to report such (Participant 1, FGD, Orita-mefa, Ibadan).

Sex is one of the pillars of marriage, it will be difficult for a woman to report an experience of marital rape (Participant 1, FGD, Orita-mefa, Ibadan).

It is always handled within their family. Most women that are involved in marital rape keep it as secret (Participant 1, FGD Yemetu, Ibadan).

If at all one hears about it, it is by chance not that the woman that is involved comes out to openly disclose her ordeal (Participant 3, FGD Yemetu, Ibadan).

Reporting of rape in marriage in the olden days is not common at all in order to keep their homes and to take care of their children. But nowadays, it is very common, women don't harbour suffering like that of our parents in the olden days, they cry out which leads to separations these days (Participant 4, FGD Town-hall, Ogbomoso).

Majority of the discussants across the groups unanimously agreed that if women want to report their experience of marital rape it is preferable for them to report their ordeals to close persons

that they can trust. It was popularly believed that informing close persons or relatives like mothers, mother-in-laws, clergymen can help to guide against stigmatization often associated with reporting of marital rape. It was also believed that that these categories of persons can provide useful help and support for marital rape survivors. It was generally perceived that reporting experience of marital rape to someone who is not very close can bring about public ridicule and such experiences when shared can be used to castigate women who are marital rape survivors. Discussants across the groups frowned at women reporting marital rape experience to lawyers and Police. It was popularly believed that reporting to lawyers will bring about the end of the married. Discussants shared the common view that Police have no role to play in marital rape crisis that such issues are strictly private matters that should be settled within the family. Some of the discussants' verbal expressions reflecting the preferred choice of reporting marital rape experience to close and trusted persons are as follow:

If at all a woman wants to report her experience of forced sexual intercourse that she suffers in her husband hands, she is likely to inform her friends, she can't just go and report to her parents that her understand want to kill her using sexual intercourse (Participant 5, FGD Akobo, Ibadan).

Women who suffer forced sexual intercourse in the hands of the husband may report such ordeals but it is not just anybody they can inform because it is a serious problem. For instance, a woman may inform trusted people about her ordeals (Participant 1, FGDMokola, Ibadan).

Women who experience marital rape can only report their ordeals to elderly or matured people not just anyone. Because revealing such situation to anyone is like ridiculing oneself or the husband. If one report her husband to just anybody, a woman could be berated for such action. It could lead to stigmatization (Participant 3 FGD Mokola, Ibadan).

Women who experience marital rape report their ordeals majorly to close people like their mothers or husbands' mothers. They may also choose to report to other close people like Pastors. They do not report to anyone or friends because some people may use that to castigate them or their partners and term them as promiscuous persons (Participant 7: FGD Mokola, Ibadan).

It is only close person that a woman is supposed to inform about her ordeals like the husband's mother or one's mother who can caution the man (Participant 8, FGD Mokola, Ibadan).

Several discussants across the groups held on to the belief that it is a shameful act reporting or informing people about experience of marital rape. They stated that reporting such act often attracts stigmatization and blame. It was also mentioned that many women rather than report their experience or informing anyone about it, they often choose to endure it so that their relationships with their spouses will not be affected. Some discussants' verbatim comments reflecting these viewpoints are as follow:

Some women cannot say it that sexual intercourse caused problem between them and their husbands. But some women who are not often don't feel ashamed can say it out. Such habits are often attract blame and are considered shameful and disgraceful. So that is the reason why women don't want to report their experience (Participant 4, FGD, Ogbongbodu, Oyo).

Not common among women to report their ordeal, any woman who reports such incident is ready to scatter her matrimonial home (Participant 2, FGD Ashi, Ibadan)

Rape perpetrated by one's husband is not easy to report. Every woman who experiences it keeps it to herself in order to avoid being put to shame or losing her marriage (Participant 5, FGD Yemetu, Ibadan).

One cannot say it out, one of our Yoruba proverbs says “Nkan to ti ni loju ju ole lo wa, parts of what is worse than stealing is marital rape, one should endure it and keep it to herself for the sake of her marital status ((Participant 7, FGD Yemetu, Ibadan).

Reporting of rape in marriage in the olden days is not common at all in order to keep their homes and to take care of their children. But nowadays, it is very common, women don’t harbour suffering like that of our parents in the olden days, they cry out which leads to separations these days. But some reasonable mothers of our present days copy our parent’s style and stay with their children in order not to make those children suffer (Participant 4, FGD Yemetu, Ibadan).

The participants across the various groups opined that women can inform people or report their experience of marital rape to individuals that can provide them with help if experience of such ordeal has been persistent or frequent. The discussant perceived that informing people when experience of marital rape is becoming frequent is appropriate as it could help to secure help that could be necessary to change the behaviour of husbands who indulge in such practice. Typical verbatim responses which portray this viewpoint are as follow:

If the act of forced sexual intercourse is becoming too persistent, a woman may be forced to report her ordeals to people like relatives (Participant 1, FGD Mokola, Ibadan).

Some people report their experience of forced sexual intercourse in the hands of husband when it is becoming too frequent, she can tell her parents or inform friends that are close to her husband and tell them about what the husband is doing. It can be reported to one’s parents, husband’s parents or husband friends. One can report such issue to people and they will call the husband and talk to him (Participant 2, FGD Ogba-jagun Ogbomoso

A woman who has been raped by the husband has the right to report her ordeal. If the act is becoming continuous and the woman does not like it, she has the right to report to anyone who is a friend of her husband. She can tell the person these are the things that your friend is doing that she does not like. A woman can talk to the husband's friend if she knows that her husband trust his friend and can talk to her husband and he will surely change (Participant 5, FGD Durbar Oyo).

TEST OF HYPOTHESES

H₀ 1: Respondents' level of knowledge of health consequences of marital rape will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.

Table 6: Chi-square analysis showing knowledge of health consequences of marital rape and help-seeking behaviour of marital rape survivors

				N= 180		
Variables	Help-seeking behaviour			Chi-square value	Df	P-value
	Sought for Help N (%)	Did not seek for help N (%)	Total N (%)			
Knowledge of marital rape						
Poor Knowledge	14(26.9)	38(73.1)	52(100.0)	$\chi^2= 1.60$	2	0.45
Fair Knowledge	15(20.3)	59(79.7)	74(100.0)			
Good Knowledge	16(29.6)	38(70.4)	54(100.0)			

^Decision - the null hypothesis was accepted (i.e not significant) since the p-value obtained was >0.05

The hypothesis states that respondents' knowledge of health effects of marital rape will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.

The proportions of women who sought for help after their marital rape experience among those who had poor, fair and good knowledge of marital rape were 26.9%, 20.3%, 29.6 respectively.

From the result of this test of association, the p-value is higher than the pre-specified significance level (0.05), therefore the hypothesis is accepted. It can be concluded that respondents' knowledge of health consequences of marital rape did not significantly determine the help-seeking behaviour following experience of marital rape (see table 6 for further details).

H₀ 2: Respondents' perceptions of marital rape will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.

Table 7: Chi-square analysis showing perception of marital rape and help-seeking behaviour of marital rape survivors

				N= 180		
Variables	Help-seeking behaviour			Chi-square Value	df	p value
	Sought for	Did not seek	Total			
	Help	for help				
	N (%)	N (%)	N (%)			
Marital rape perception						
Supportive	17(16.2)	88(83.8)	105(100.0)	$\chi^2= 10.43$	1	0.001*
Non-supportive	28(37.3)	47(62.7)	75(100.0)			

***Decision - the null hypothesis was rejected since the p-value obtained was <0.05**

The hypothesis states that respondents' perceptions of marital rape will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State. A higher proportion (37.3%) of respondents who had positive perception relating to marital rape sought for help following their experience of marital rape compared with only 16.2% of those who had marital rape negative perception that sought for help after their experience of marital rape. From the result of this test of association, the p-value is less than the pre-specified significance level (0.05), therefore the hypothesis is rejected. It can be concluded that respondents' perception of marital rape significantly determined their help-seeking behaviour following their experience of marital rape (see table 7 for further details).

H₀ 3: Respondents' previous history of sexual violence will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.

Table 8: Chi-square analysis showing previously experience of sexual violence and help-seeking behaviour of marital rape survivors

N= 180						
Variables	Help-seeking behaviour			Chi-square Value	Df	P value
	Sought for Help	Did not seek for help	Total			
	N (%)	N (%)	N (%)			
History of sexual violence+						
Yes	26 (36.1)	46(63.9)	72(100.0)	7.90	2	0.004*
No	19(17.6)	89 (82.4)	108(100.0)			

+Previous history of sexual violence (different forms of sexual violence excluding marital rape)

***Decision - the null hypothesis was rejected since the p-value obtained was <0.05**

The hypothesis states that there is no significant association between respondents' previous history of sexual violence and help-seeking behaviours of marital rape among women in Oyo State. The proportions of women who sought for help after their marital rape experience among those who had poor, fair and good knowledge of marital rape were 26.9%, 20.3%, 29.6% respectively. From the result of this test of association, the p-value is higher than the pre-specified significance level (0.05), therefore the hypothesis is accepted. It can be concluded that help-seeking behaviour was not significantly associated with level of knowledge of health consequences of marital rape (see table 8 for further details).

H₀ 4: Respondents' age will not significantly determine the level of knowledge of marital rape among women in Oyo State.

Table 9: Chi-square analysis showing knowledge of health consequences of marital rape and respondents' age

					N = 1200		
Variables	Level of knowledge				Chi-	df	p value
	Poor	Fair	Good	Total	square		
	N (%)	N (%)	N(%)	N (%)	Value		
Age (in years)							
≤24 years	18 (31.6)	29 (50.9)	10(17.5)	57 (100.0)	$\chi^2=23.0$	4	<0.001*
25 – 49 years	247(25.3)	474(48.5)	256(26.2)	977(100.0)			
≥ 50 years	16 (9.6)	100(60.2)	50(30.1)	166(100.0)			

***Decision - the null hypothesis was rejected since the p-value obtained was <0.05**

The hypothesis states that respondents' age will not significantly determine the level of knowledge of marital rape among women in Oyo State. The proportions of respondents aged ≤24 years, 25 – 49 years and ≥ 50 years who had good knowledge of health consequences of marital rape were 17.5%, 26.2% and 30.1% respectively. From the result of Chi-square test, the p-value is less than the pre-specified significance level (0.05), therefore the hypothesis is rejected. It can be concluded that knowledge of health consequences of marital rape was significantly determined by the age of respondents (see table 9 for further details).

H₀ 5: Respondents' educational status will not significantly determine the level of knowledge of marital rape among women in Oyo State.

Table 10: Chi-square analysis showing knowledge of health consequences of marital rape and respondents' educational status

N = 1200

Variables	Level of knowledge				Chi-	df	p value
	Good	Fair	Poor	Total	square		
	N (%)	N (%)	N(%)	N (%)	Value		
Educational							
Status							
Non formal Edu.	22 (24.7)	41 (46.1)	26 (29.2)	89(100.0)	$\chi^2=30.3$	6	<0.001*
Primary	13(11.9)	53 (48.6)	43 (39.4)	109(100.0)			
Secondary	136(27.5)	240(48.5)	119(24.0)	495(100.0)			
Tertiary	145(28.6)	269(53.1)	93(18.3)	507(100.0)			

***Decision - the null hypothesis was rejected since the p-value obtained was <0.05**

The hypothesis states that respondents' educational status will not significantly determine the level of knowledge of marital rape among women in Oyo State. The proportions of respondents who had good knowledge of health consequences of marital rape among those who had no formal education, primary education, secondary education and tertiary education as their educational status were 24.7%, 11.9%, 27.5% and 28.9%. From the result of Chi-square test, the p-value is less than the pre-specified significance level (0.05), therefore the hypothesis is rejected. It can be concluded that knowledge of health consequences of marital rape was significantly determined by the respondents' educational status (see table 10 for further details).

H₀ 6: Respondents' family type will not significantly determine the level of knowledge of marital rape among women in Oyo State.

Table 11: Chi-square analysis showing knowledge of health consequences 'of marital rape and respondents' family type

N = 1200

Variables	Level of knowledge				Chi-	df	p value
	Good	Fair	Poor	Total	square		
	N (%)	N (%)	N(%)	N (%)	Value		
Family type							
Monogamy	232(23.2)	492(49.5)	272(27.3)	998(100.0)	$\chi^2=2.7$	2	P=0.27^
Polygamy	49(24.3)	109(54.0)	44(21.8)	202(100.0)			

[^]**Decision** - the null hypothesis was accepted since p value obtained is >**0.05** (i.e Hypothesis not significant)

The hypothesis states that respondents' family type will not significantly determine the level of knowledge of marital rape among women in Oyo State. The proportions of those who had poor, fair and good knowledge of health consequences of marital rape among respondents who had monogamous family were 23.2%, 49.5% and 27.3% respectively. Similarly, the distributions of poor, fair and good knowledge of health consequences of marital rape among those who were into polygamous family were 24.3%, 54.0%, 21.8% respectively. From the result of Chi-square test, the p-value is higher than the pre-specified significance level (0.05), therefore the hypothesis is rejected. It can be concluded that knowledge of health consequences of marital rape was not significantly determined by the respondents' family type (see table 11 for further details).

H₀ 7: Respondents' age will not significantly determine the perceptions of marital rape among women in Oyo State.

Table 12: Chi-square analysis showing perception of marital rape and respondents's age

N = 1200

Variables	Level of Perception			Chi-	df	pvalue
	Negative	Positive	Total	square Value		
	Perception	Perception	N (%)			
	N (%)	N (%)				
Age (in years)						
≤24 years	34 (59.6)	23(40.4)	57 (100.0)	$\chi^2= 22.59$	2	<0.001*
25 – 49 years	663 (67.9)	314 (32.1)	977(100.0)			
≥ 50 years	141(84.9)	25(15.1)	166(100.0)			

***Decision - the null hypothesis was rejected since the p-value obtained was <0.05**

The hypothesis states that respondents' age will not significantly determine the perceptions of marital rape among women in Oyo State. The proportions of respondents aged ≤24 years, 25 – 49 years, ≥ 50 years with negative perception of marital rape were 59.6%, 67.9% and 84.9% respectively. It was observed that negative perception of marital rape increased with increasing ages of respondents. From the result of this test of association, the p-value is less than the pre-specified significance level (0.05), therefore the hypothesis is rejected. It can be concluded that perception of marital rape was significantly determined by age of respondents (see table 12 for further details).

H₀ 8: Respondents' marital status will not significantly determine the perceptions of marital rape among women in Oyo State.

Table 13: Chi-square analysis showing perception of marital rape and respondents' marital status
N = 1200

Variables	Level of Perception			Chi-square Value	df	pvalue
	Negative Perception	Positive Perception	Total			
			N (%)			
	N (%)	N (%)				
Marital Status						
Married	683(68.8)	310(31.2)	993(100.0)	$\chi^2= 10.80$	2	0.005*
Widowed	75(85.2)	13(14.8)	88(100.0)			
Divorced	80(67.2)	39(32.8)	119(100.0)			

***Decision - the null hypothesis was rejected since the p-value obtained was <0.05**

The hypothesis states that respondents' marital status will not significantly determine the perceptions of marital rape among women in Oyo State. The proportions of respondents who had negative perception of marital rape among those who were married persons, widows and those who had divorced their spouses were 68.8%, 85.2% and 67.2% respectively. The result showed that more of those who had divorced their spouses had positive perception of marital rape. From the result of this test of association, the p-value is less than the pre-specified significance level (0.05), therefore the hypothesis is rejected. It can be concluded perception of marital rape was significantly determined by the respondents' marital status (see table 13 for further details).

H₀ 9: Respondents' family type will not significantly determine the perceptions of marital rape among women in Oyo State.

Table 14: Chi-square analysis showing perception of marital rape and respondents' family type

N = 1200						
Variables	Level of Perception			Chi-square	df	pvalue
	Negative Perception	Positive Perception	Total N (%)	Value		
	N (%)	N (%)				
Family type						
Monogamy	683(69.4)	305(30.6)	998(100.0)	$\chi^2= 0.44$	1	0.28^
Polygamy	145(71.8)	57(28.2)	202(100.0)			

^Decision - the null hypothesis was accepted since the p-value obtained was >0.05

The hypothesis states that respondents' family type will not significantly determine the perceptions of marital rape among women in Oyo State. It was observed that the proportion of those who had negative perception of marital rape was higher among those who had polygamous family (71.8%) than those who were into monogamous family (69.4%) who had negative perception of marital rape. From the result of this test of association, the p-value is higher than the pre-specified significance level (0.05), therefore the hypothesis is accepted. It can be concluded that perception of marital rape was not significantly determined by respondents' family type (see table 14 for further details).

H₀ 10: Respondents' age will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.

Table 15: Chi-square analysis showing help-seeking behaviour of marital rape and respondents' age

N= 180						
Variables	Help-seeking behaviour			Chi-square	Df	P value
	Sought for Help	Did not seek help	Total	Value		
	N (%)	N (%)	N (%)			
Age (in years)						
≤24 years	3 (21.4)	11(78.6)	14 (100.0)	$\chi^2= 0.10$	2	P=0.95^
25 – 49 years	39 (25.3)	115(74.7)	154(100.0)			
≥ 50 years	3(25.0)	9(75.0)	12(100.0)			

[^]**Decision - the null hypothesis was accepted since the p-value obtained was >0.05**

The hypothesis states respondents' age will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State. The proportions of respondents who sought for help following their experience marital rape among those aged ≤24 years, 25 – 49 years and ≥ 50 years were 21.4%, 25.3% and 25.0% respectively. From the result of this test of association, the p-value is higher than the pre-specified significance level (0.05), therefore the hypothesis is accepted. It can be concluded that the help-seeking behaviour was not significantly determined by respondents' age (see table 15 for further details).

H₀ 11: Respondents' marital status will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.

Table 16: Chi-square analysis showing help-seeking behaviour of marital rape and respondents' marital status

N= 180						
Variables	Help-seeking behaviour			Chi-square	Df	P value
	Sought for Help	Did not seek help	Total			
	N (%)	N (%)	N (%)	Value		
Marital Status						
Married	23(17.2)	111(82.8)	134(100.0)	$\chi^2= 20.43$	2	< 0.001*
Widowed	3(27.3)	8(72.7)	11(100.0)			
Divorced	19(54.3)	16(45.7)	35(100.0)			

***Decision - the null hypothesis was rejected since the p-value obtained was <0.05**

The hypothesis states that respondents' marital status will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State. The proportions of women who experienced ever sought for help following their experience of marital rape among those who were married, widows and those who had divorced their spouses were 17.2%, 27.3% and 54.3% respectively. From the result of this test of association, the p-value is less than the pre-specified significance level (0.05), therefore the hypothesis is rejected. It can be concluded that respondents' marital status significantly determine their help-seeking behaviour (see table 16 for further details).

H₀ 12: Respondents' family type will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State.

Table 17: Chi-square analysis showing help-seeking behaviour of marital rape survivors and respondents' family type

N= 180						
Variables	Help-seeking behaviour			Chi-square	Df	P value
	Sought for	Did not	Total	Value		
	Help	seek help	N (%)			
	N (%)	N (%)				
Family type						
Monogamy	35(25.2)	104(74.8)	139(100.0)	$\chi^2= 0.01$	1	0.55^
Polygamy	10(24.4)	31(75.6)	41(100.0)			

^Decision - the null hypothesis was accepted since the p-value obtained was >0.05

The hypothesis states that respondents' family type will not significantly determine the help-seeking behaviours of marital rape among women in Oyo State. The proportions of respondents that sought for help following their experience of marital rape among those who had monogamous and polygamous family were 25.2% and 24.4 respectively. From the result of this test of association, the p-value is higher than the pre-specified significance level (0.05), therefore the hypothesis is rejected. It can be concluded help-seeking behaviour related to marital rape was not significantly determined by respondents' family type (see table 17 for further details).

Summary of Findings

The following are the major findings of this study:

- i. Knowledge of health consequences of marital rape was generally poor among younger women
- ii. Higher educational attainment was related with good knowledge of health consequences of marital rape
- iii. Women's family status did not significantly determine their knowledge of health consequences of marital rape
- iv. Negative perception of marital rape was more common among older women
- v. Positive perception of marital rape was more common among women who were divorced
- vi. Women's family status did not significantly influence their perception of marital rape
- vii. The behaviour of seeking for help after experiencing marital rape was not significantly determined by women's age.
- viii. The behaviour of seeking for help after experiencing marital rape was more common practiced among women who were divorced
- ix. The marital status of respondents did not significantly determine their help-seeking behaviour relating to marital rape
- x. The behaviour of seeking for help after experiencing marital rape was more common among women who had positive perception of marital rape.
- xi. Women's knowledge of health consequences of marital rape did not significantly determine their help-seeking behaviour after experiencing marital rape
- xii. Previous history of sexual violence enhanced the behaviour of seeking for help after experiencing marital rape.

DISCUSSION

Although most respondents were currently married as at the time of the study, about one-tenth of the respondents had divorced their spouses. Reports from the National Bureau of Statistics (2012) and National Population Commission (2013) showed that many women in Nigeria have divorced their spouses. It has been noted that marital rape as well as other forms of domestic violence contribute to divorce (WHO, 2010). There is a need to tackle divorce which is becoming a serious social problem in Nigeria.

Many respondents admitted declining husbands' sexual request based on several reasons including mensuration ill-health/sickness and fatigue as a result of busy work or day. It is advisable that couple understand each other better and mutually agree on sexual matters in order to address problems that could be associated with sexual denial. This finding underscores the needs for sexuality education for married partners using various educational fora and enlightenment in community settings.

About 8.9% of the respondents had previous experience of sexual violence and mostly in the hands of previous boyfriends. This finding corroborates the previous findings such as Ogunwale et al (2012), Ogunwale & Oshiname (2015) which identified rape among dating partners as serious challenge facing many young women. Several studies such as Bennice & Resick (2003), Jespersen et al (2009) and WHO (2010) have found association between previous experience of sexual violence and marital rape.

The study has revealed that body injuries, body pain and body weakness were the major physical health consequences of marital mentioned by the respondents. The health consequences mentioned by the study participants are in tandem with some of the major health consequences

that were noted in previous studies and reports (Bennice & Resick, 2003; Mahoney & Williams, 2007; WHO, 2010). According to WHO (2010), survivors of marital rape often suffers severe physical injuries. The chance of physical injuries is often increased if marital rape experience is accompanied with physical violence. It has been noted that most women who are raped in marriage also experience severe forms of physical abuse (Eby, et al., 1995; Bergen, 2006; Mahoney & Williams, 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 and Falik (2001), Mahoney and Williams (2007) and WHO (2010) have discloses as being the 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 PTSD as major possible adverse psychological complications of marital rape. Marital rape can result into debilitating psychological trauma that are even more than other forms of rape involving non-partners (Russell, 1990, Burgen, 2006). Divorce, disagreement and strained relationship were among the major social health consequences of marital rape mentioned by respondents. These same adverse social health consequences have been reported by WHO (2010). According to WHO (2010), marital rape could lead to couple separation and strained relationship. Beyond the effect of marital rape on women, it could affect family relationship and have negative influence on the children. 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) have noted that women who are subjected to rape by their partners often experience vagina injuries and have increased risk of contracting sexually transmitted infections including HIV.

Level of knowledge of marital rape significantly increased with age of respondents. It is possible that older people had been exposed to more relevant educational opportunity that gave them better insights about rape related issues. Another possible explanation is that more of older people might have experienced marital rape or may know individuals who experienced it. It was observed from the study that 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 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 who have acquired several experience and learnt various sexual related issues compared with women who have been married for short duration.

The findings relating to the negative or wrong perceptions about marital rape reported in this study were similar to the pattern of findings reported in previous studies such as Fero et al (2008) and Tegbar et al (2010). Some participants considered marital rape as a normal phenomenon and opined that it should not be considered as a serious offence. Previous studies have earlier documented that marital rape is less likely than rape perpetrated by strangers or acquaintances to be accurately labeled as rape (Kirkwood & Cecil, 2001) or to be perceived as a serious offense (Monson, Byrd, & Langhinrichsen-Rohling, 1996; Monson et al., 2000). A previous study conducted by Walby and Allen (2004) similarly noted that women who experience sexual abuse in the hands of intimate partner are likely to classify their experience as rape if they suffer

serious physical injuries. There is need to design behavioural change communication interventions that can change women's negative perceptions about marital rape.

Findings which revealed that women do not perceive marital rape as being serious form of abuse as well as the perception that rape involving strangers that should be termed as "real rape" are in tandem with what other researches such as Ferro et al (2008), Kung'u (2011), Tegbar et al (2012) and Oshiname et al (2013) have documented in their studies. Research has shown that marital rape survivors are twice as likely to suffer physical injury compared to rape by strangers (Myhill & Allen, 2002). Apart from the risk of physical injuries and gynecological complications, experience of marital rape often results into serious psychological trauma (Bergen, 2006; WHO, 2010). Most survivors of marital rape often experience repeated episodes of rape (Bergen, 2006; Tjaden & Thoennes, 2006). Given the nature of marital rape and the myriads of health consequences faced by survivors as observed in the FGDs, it is not appropriate to consider marital rape as a less serious form of abuse.

It was noted from the FGDs that several socio-cultural factors such as economic dependence on husbands, cultural and religious reasons and societal tolerance for marital rape were perceived as major factors that are fueling marital rape. In Nigeria there is male dominance in sexual matters that finds its expression in different cultural norms, perceptions and attitudes which promote women's difference to men (Egbeleye, 2006). Men are socialized to believe that they are superior to women and so should dominate their partners (Izugbara et al, 2008; Taft, 2009). Within the Yoruba culture and most other Nigerian culture women are seen as properties of men and decisions about sexual matters are solely in the hands of men. A cultural re-orientation is necessary in order to effect changes in these gender-based socio-cultural perceptions which compromise the health, dignity and integrity of women. The re-orientation programme could be

implemented with the use of health promotion strategies such as public enlightenment, and advocacy, policy intervention.

Several respondents also opined that there is nothing a woman can do to prevent being raped. Previous studies conducted outside Nigeria such as Monson et al. (1996), Monson et al., 2000), Kirkwood and Cecil (2001) , Bergen (2006) and Tegbar et al (2010) have earlier documented that women often have perceptions that can fuel marital rape. Similar to the findings of these studies, Tegbar et al (2012) noted in their study that many people erroneously felt that once a man and a woman have entered into marriage, which is a legitimate and voluntary institution, it will be not possible to talk about coerced sex.

Many respondents had the misperception that women who are survivors of marital rape should not inform anyone about their ordeal. The focus group discussion revealed that women prefer that such issue should be kept as secret. This perception has the potential for making rape survivors not to acknowledge their experience as rape; it might also prevent them from seeking appropriate health care services which could help them prevent experiencing serious health consequences. Interestingly, majority of the respondents, however, opined that experience of forced or unwanted sexual intercourse by one's husband is not a pleasant experience and it can seriously affect the sexual desire of a woman. These viewpoints reflect the reality and challenge of marital rape. Only 30.2% of the survey respondents had postive perception of marital rape while majority had negative perception relating to marital rape. Negative percetions about marital rape have the potentials of putting women at risk of rape and are likely to prevent them from indulging in appropriate preventive health behaviours including seeking for help after being raped. This result pattern underscores the need for community-based health education

programmes that can discourage misperceptions about marital rape and other forms of domestic violence.

Negative perception for marital rape increased significantly with age of respondents as older persons had supportive perception. Similar to the findings of this current study, previous studies such as Kalra, Wood, Demarais, Verberg, & Senn (1998), Nagel et al (2005) and Ferro, Cermele, and Saltzman (2008) have found age of the respondent to be a predictor of people's perceptions of rape. Research has explained that younger participants are more sympathetic toward and less likely to blame rape victims than are older participants (Kalra, Wood, Demarais, Verberg, & Senn, 1998; Nagel et al., 2005). The results which show that more of older people have more of negative 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. The finding which revealed that more divorced women had positive perception of marital rape is not surprising as marital rape was more prevalent among divorced women (30.3%) compared with women who were married (13.7%) and those who were widows (13.6%). Moreover, positive perception of marital rape might have played a role in divorce situations that were stated as aftermath of marital rape in this study. More research works will be needed to fully explore the specific role of perception of marital rape in marital rape outcomes.

The study finding showed that 15.3% of the respondents had ever experienced marital rape. This underscores the fact that the phenomenon is of public health concern. Similar results have been noted in previous studies. According to USAIDS (2006) approximately 16% of women had experienced sexual assault in the hands of their husbands. A study conducted by Ezechi et al

(2004) in South Eastern Nigeria noted that 14.2% women had experienced marital rape. A study conducted by Uwaoma et al (2011) observed a prevalence of 27.8% among married couples in Imo State. Another study conducted by Ashimolowo and Otufale (2012) in Ogun State documented that 11.3% of married women had ever experienced marital rape. The result of the studies which corroborates previous findings implies that marital rape constitute serious health burden and thus deserves a serious public health attention.

The experiences of women who had marital rape that were shared during the FGD sessions revealed that many survivors experienced physical injuries, psychological complications, social health consequences including divorce and strained relationship. Previous studies such as Bennice and Resick (2003), Mahoney and Williams (2007) and WHO (2010) have earlier noted that women who experience marital rape are faced with such health consequences.

Only one-quarter of those who had experienced marital rape sought for at least one form of help. Previous studies by Abdulkadir et al (2001), Uwaoma et al (2011) and CLEEN (2014) also revealed that survivors of marital rape and other forms of intimate partner rape rarely seek for help. Respondents' belief that they can endure it, belief of not sustaining any feasible physical injury and fear of not being stigmatized were the major reasons for not seeking for medical help. These findings underscore the need to furnish women who are at risk of marital rape with educative information and supportive services that can promote their behaviour of seeking for appropriate help. Practicing appropriate help-seeking behaviour by marital rape survivors can contribute to the prevention and control of marital rape.

Fear of being stigmatized, self-blame and perceived non-susceptibility to any health effects were the major factors which served as barriers against the search for medical help and other forms of

care. These same barriers against the search for medical help and other forms of care were similarly noted in previous studies such as those of Ogunwale et al (2012), Akinlusi et al (2014), Ogunwale and Oshiname (2015). Women may need to be provided information through public enlightenment programmes on the need to obtain proper medical services and where to obtain such help following an experience of rape. Healthcare providers need to be user-friendly and ensure confidentiality of information divulged by survivors. Health workers should reassure rape survivors that necessary efforts would be made to protect their identity. In order to ensure this, health workers may need to be trained on the importance of confidentiality and empathy while providing care for rape survivors.

Only few of the survivors of marital rape sought for legal help or assistance following their experience of marital rape due to sake of their children, fear of making their experience public and because of the apology tendered to them by their husbands. Most participants of the focus group discussions raised objection against seeking for legal services as a result of marital rape and it was popularly believed that women should endure such ordeals or settle it within the family circle. Previous studies such as CLEEN (2014) and Mbadugha (2016) have also earlier noted that due to similar reasons observed in this study most women often endure marital rape, believing they have nowhere to go and in any case, believing, for good reason, that the law will not protect them. Mbadugha (2016) revealed that women who are being subjected to rape by their spouses choose to stay in the relationship, suffer in silence and carry their crosses with forced smiles on their faces. Marital rape survivors have the right to seek for legal services if they wish. Legal practitioners can help survivors of marital rape with advice, support services and legal professional services that could contribute to the prevention and control of marital rape.

Efforts should be directed at the design of legal interventions that have the potentials of addressing the burden of marital rape and fostering healthy marital relationship.

The result of this study which showed that only majority of the survivors of marital rape did not seek for counseling services is similar to the trend observed in previous studies such as Ogunwale et al (2012) and Ogunwale and Oshiname (2015) which observed that survivors of intimate partner violence rarely seek for counseling services. Fear of being stigmatized, fear of making their experience public and love for partners which cited as reasons for not seeking for counseling services were similar to reasons stated by survivors of rape in previous studies (Ogunwale et al, 2012; CLEEN, 2014). Counselling services have the potentials of equipping survivors with useful information and empowering them to take appropriate voluntary actions that can help them overcome the ordeals of marital rape. Counselling services which employ destigmatization strategies and involve appropriate support services should be made available at the community level for the benefits of women who are faced with the burden of marital rape.

The FGD discussants disclosed that it is usually shameful to report experience of marital rape. This pattern of behaviour is in tandem with the findings reported in previous studies (Tegbar et al, 2010; Ogunwale et al, 2012; CLEEN, 2014; Ogunwale & Oshiname, 2015). Fear of being stigmatized and embarrassed often discourage women in intimate relationships from informing people about their rape ordeals and prevent them from seeking for appropriate help needed to overcome their ordeals (CLEEN, 2014; Ogunwale & Oshiname, 2015). The findings of this underscore the need to provide women with social support that can help them overcome the ordeals of rape as well as design behavioural change communication interventions that can address the issue of stigmatization which prevent women from seeking for appropriate help.

It was observed in this study that there was significant association between help-seeking behaviour and marital status as majority of those who had divorced their partners sought for help following their experience of marital rape compared with few proportions of survivors who were married and widows who reported that they sought for help. One possible explanation could be that many respondents who were divorced could not cope with the ordeal and had to seek for help which possibly accounted for why they ended up being separated from their partners. Help seeking practice was significantly more pronounced among the respondents who had positive perception of marital rape. It is very reasonable that less of people who had perceptions that support marital rape will not want to seek for help as they are unlikely to see any benefit in seeking for help. The study showed that previous history of sexual violence significantly influenced help-seeking behaviour after experiencing marital rape. It is possible that women who had previous experienced sexual violence in the hands of other people had learnt from their experience or had previously benefited from seeking for help in the past.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary

This study was conducted mainly to examine knowledge, perceptions and help-seeking behaviours relating to marital rape among women in Oyo State. The specific areas examined included knowledge of health consequences of marital rape, perceptions relating to occurrence and experience of marital rape as well as help-seeking behaviours among marital rape survivors. The review of the related literature was done based on conceptual framework for the study, theoretical framework for the study and contents captured in the objectives of the study. The review of the literature also included rape prevention and control approaches as well as appraisal of review of related literature. The descriptive research of cross-sectional type was used in the conduct of the study. The population of the study was made up of women who had ever being married in Oyo State. A multi-stage sampling technique was used to select a total of 1,200 women who were interviewed using a validated semi-structured questionnaire. The questionnaire used yielded a reliability coefficient of 0.89 using Cronbach Alpha analysis. In order to complement the quantitative data, FGDs were conducted with twelve homogenous groups of women using a validated FGD guide. The quantitative data were analyzed with descriptive statistic including frequency and percentages for univariate data, while tests of associations based on the test the hypotheses postulated were subjected to inferential statistics of chi-square at 0.05 level of significance. Qualitative data were entered into Atlas Ti software, coded using an integrated approach of deductive and inductive coding and the data were subsequently subjected to thematic analysis. Appropriate conclusions and recommendations were made for the study.

Conclusion

Based on the findings of the study the following conclusions were made:

- i. Younger women significantly had poor knowledge of health consequences of marital rape
- ii. Higher educational status was significantly associated with good knowledge of health consequences of marital rape
- iii. Women's family type did not significantly determine knowledge of health consequences of marital rape
- iv. Women who were of older age groups significantly had negative perception of marital rape
- v. Marital status of women was significantly associated with perception of marital rape
- vi. Women's family type did not significantly determine their perception of marital rape
- vii. The behaviour of seeking for help after experiencing marital rape was not significantly determined by women's age.
- viii. The behaviour of seeking for help after experiencing marital rape was more common practiced among women who were divorced
- ix. The family type of women who had experienced marital rape did not significantly determine their help-seeking behaviour.
- x. Having positive perception of marital rape was significantly associated with the behaviour of seeking for help after experiencing marital rape.
- xi. Women's knowledge of health consequences of marital rape did not significantly determine their help-seeking behaviour after experiencing marital rape
- xii. The behaviour of seeking for help after experiencing marital rape was more commonly practiced by women who had previous history of sexual violence.

Recommendations

Based on the findings of this study, it is recommended that:

- i. Health educators should employ the use of educational initiatives that can upgrade women's knowledge of health consequences of marital rape especially among women with low educational status within the community.
- ii. Findings of this should be used as baseline data for designing appropriate public health education interventions aimed at discouraging or changing negative perceptions relating to marital rape among married women.
- iii. Health providers and professionals should provide encouragement and social support to married women who experience rape in the hands of the husbands to enable them seeks for appropriate help.
- iv. Researchers and programme implementers working on prevention and control of marital rape and other related domestic violence among women should design and implement educational interventions aimed at encouraging women to seek for appropriate help especially among those with previous history of sexual violence.

Suggestions for further study

It is suggested that further studies be carried out, to throw more light on some aspects of marital rape which were not covered in this study.

1. There is a need to carry out a similar study among women across communities in Nigeria and in various cultural settings in order to compare data and proffer effective solutions that would be more generalized.
2. Research is needed to determine the determinants of marital rape as well as the various effective measures that can be taken to address the burden of marital rape among women.
3. An interventional study is needed to determine effective strategies that could be used in preventing and controlling marital rape among women.
4. There is need to also carry out a similar study which focused on mens' knowledge, perceptions and behaviours relating to marital rape in order to be able to design comprehensive interventional package for addressing the problem of marital rape.

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APPENDIX I

UNIVERSITY OF ILORIN
FACULTY OF EDUCATION
DEPARTMENT OF HEALTH PROMOTION AND ENVIRONMENTAL HEALTH
EDUCATION

QUESTIONNAIRE ON KNOWLEDGE, PERCEPTIONS AND HELP-SEEKING
BEHAVIOUR OF MARITAL RAPE AMONG WOMEN IN OYO STATE, NIGERIA

Dear respondent,

I am, a student of the Department of Health Promotion and Environmental Health Education, Faculty of Education, University of Ilorin. I am carrying out a study relating to “knowledge, perceptions and help-seeking behaviour of marital rape among women in Oyo State, Nigeria. The information obtained will be used in the future for the design of programmes and interventions for prevention and control of marital rape among women. Your decision to participate in the study is voluntary. I assure you that whatever you tell me will be kept secret. Please note that your names are not needed on this questionnaire. If you have any question, please feel free to let me know. Thanks you for choosing to participate in the study.

Kindly show by ticking (✓) any of the 2 boxes, that your participation in this study was voluntary.

☐

I will participate

☐

I will not participate

For any information or comment, please contact the Researcher:

Akintayo O. Ogunwale

Department of Health Promotion and Environmental Health Education, Faculty of Education,
University of Ilorin.

Email: tayoogunwale@yahoo.com

Tel: 0706224198

Office use only

Serial no.....

LGA.....

Section A: Socio- Demographic Characteristics

Instruction: In this section tick (✓) the boxes that correspond to your answers or complete the spaces provided

1. Marital Status: (1) Married ☐ (2) Widow ☐ (3) Divorce ☐
2. Religion: (1) Christianity ☐ (2) Islam ☐
(3) Traditional Religion ☐ (4) Other (Specify) -----
3. Ethnicity (1) Yoruba ☐ (2) Igbo ☐ (3) Hausa ☐
(4) Others (Specify) -----
- 4 (a). Respondent's Educational Status
(1) No formal education ☐ (2) Primary education ☐
(3) Secondary education ☐ (4) Tertiary education ☐
(5) Others (Specify) -----
- 4 (b). Husband's Educational Status
(1) No formal education ☐ (2) Primary education ☐
(3) Secondary education ☐ (4) Tertiary education ☐
(5) Others (Specify) -----
- 5 (a). Respondent's age in years (at last birthday)
- 5 (b). Husband's age in years (at last birthday)
- 6 (a) Employment Status: (1) Working/Employed ☐ (2) Not working ☐
- 6 (b). Main occupation of respondent
- 7 (a) Family type (1) Monogamy ☐ (2) Polygamy ☐
- 7 (b). How many husband(s) have you ever had?
- 7 (c) How long have you been married to your present (or last) husband?
- 8 (a) Have you ever suffered forced or unwanted sexual intercourse in the hands of someone who was not husband? (1) Yes ☐ (2) No ☐
- 8 (b) If "Yes" to Q8a, which category of persons (listed below) has previously subjected you to forced or unwanted sexual intercourse sex against your wish?
 1. Boyfriend ☐ 2. Man-friend ☐ 3. Male friend ☐
 4. Male stranger ☐ 5. Male relative ☐
 6. Others, please specify.....

Section B

Sub-section B1: Knowledge relating to marital rape

Instruction: Complete the open spaces or tick (✓) the boxes that correspond to your answers in this section.

9. State **two (2)** examples each of the physical, psychological and social effects or complications of “marital rape”.

Table 1

Types of effects/ complications	Adverse Effects/ complications	Point/Mark obtained
(1) Physical health	(a)	
	(b)	
(2) Psychological health	(a)	
	(b)	
(3) Social health (Interpersonal relationship)	(a)	
	(b)	
(4) Sexual and reproductive health	(a)	
	(b)	
Total/Maximum point obtained=		

Sub-section B2: Perceptions relating to marital rape

Q10 - Instruction: Please indicate your response by ticking (√) in the appropriate box. Thank you for your time and honesty.

Table 2

	Marital rape related perceptions	Tick (√)			Point obtained
		Agree	Undecided	Disagree	
10.1	Being subjected to forced or unwanted sexual intercourse by one's husband is not a pleasant experience				
10.2	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				
10.3	Being subjected to forced or unwanted sexual intercourse by one's husband should not be regarded as rape				
10.4	A woman should tolerate marital rape for the sake of the marriage				
10.5	Being subjected to forced or unwanted sexual intercourse by one's husband is not as serious as being raped by a stranger				
10.6	A woman who is being subjected to forced or unwanted sexual intercourse by her husband is likely to have caused it				
10.7	A man who subjects his wife to forced sexual intercourse should be blamed for such act				
10.8	It is better for a woman who experience marital rape not to inform anyone				
10.9	Experience of forced or unwanted sexual intercourse by one's husband can seriously affect the sexual desire of a woman				
10.10	One factor that promotes 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				
10.11	The belief that women are properties of men may be reason why some men have forced or unwanted sexual intercourse with their wives.				
10.12	It is not appropriate to report one's husband because of experience of marital rape				
10.13	A woman who often suffered rape(situation of forced or unwanted				

	sexual intercourse) in the hands of her husband should file for divorce				
10.14	The stigma that follows the reporting of a case of “maritalrape” may be worse than the rape itself				
10.15	Married women do not have the right to refuse sex from their husbands				
10.16	A married women should not leave her husband because of experience of marital rape				
10.17	A woman who experience rape (forced or unwanted sex) in the hands of her husband should inform the social welfare office				
10.18	A woman who experience rape (forced or unwanted sex) in the hands of her husband should not inform anyone				
10.19	A woman who experience rape (forced or unwanted sex) in the hands of her husband should just endure it				
10.20	There is nothing a woman can do to prevent being raped (subjected to forced or unwanted sex) by the her husband				
	Total/Maximum point obtained =				

Sub-section B3: Marital rape experience

Instruction: Complete the open spaces or tick (✓) the boxes that correspond to your answers in this section.

11. Has your husband (or ex-husband) ever had sexual intercourse with you after beating or physically assaulting you contrary to your decision not to have sexual intercourse?

(1) Yes ☐ (2) No ☐

12. Has your husband (or previous husband) ever used any harmful substance or weapon to subject you to forced or unwanted sexual intercourse against your decision or wish?

(1) Yes ☐ (2) No ☐

13. Has there ever been a situation where your husband (or previous husband) used the opportunity of your ill-health or sickness to subject you to forced or unwanted sexual intercourse?

(1) Yes ☐ (2) No ☐

14. Has your husband (or previous husband) ever employed verbally assault or attack to subject you to forced or unwanted sexual intercourse by one's husband when you were not willing to do so?

(1) Yes ☐ (2) No ☐

15. Has your husband (or previous husband) used any form of threat or threatening situation to subject you forced or unwanted sexual intercourse against your wish?

(1) Yes ☐ (2) No ☐

16. Has your husband (or previous husband) ever used any drug or sleeping-inducing substance or any substance to subject you to forced or unwanted sexual intercourse against your wish?

(1) Yes ☐ (2) No ☐

17. If you have experienced any of the situations of forced or unwanted sexual intercourse described in questions 11 – 16, did you regard it as rape?

(1) Yes ☐ (2) No ☐

18. If you have experienced any of the situations of forced or unwanted sexual intercourse described in questions 11 – 16, but do not consider your experience as rape, what are your reasons for this?

NOTE: Please kindly discontinue with the questionnaire if you have never had experience of forced or unwanted sexual intercourse as described in **questions 11 -16**.

B4: Help-seeking behaviour and coping mechanisms of marital rape survivors.

Instruction: Kindly indicate your honest response by ticking (✓) the appropriate boxes or providing responses in the spaces provided.

19 (a). Did you ever seek for any medical assistance after the experience of forced or unwanted sexual intercourse you suffered in the hands of husband (or ex-husband)?

(1) Yes ☐ (2) No ☐

19(b). If ‘No’ to **Q19 (a)**, why did you not seek medical assistance?

(a) Did not sustain any injury ☐ (b) Because I could endure it ☐

(b) Treated myself at home ☐ (d) Afraid of being stigmatized ☐

(e) No reason ☐ (f) Other reason, please specify _____

19 (c) If ‘Yes’ to **Q19 (a)**, why did you seek for medical assistance?

20 (a). Have you ever sought legal assistance or advice following an experience of forced or unwanted sexual intercourse (rape) you suffered in the hands of your husband (or ex-husband)?

(a) Yes ☐ (b) No ☐

20 (b). If ‘No’ to **20 (a)**, why did you not seek legal assistance? You may tick (✓) one or more options that apply to you.

- | | | | |
|--|--------------------------|-----------------------------|--------------------------|
| (a) Did not know whether he was right or wrong | ☐ | (b) Because I love him | ☐ |
| (c) Afraid it could affect our relationship | ☐ | (d) Because of the children | ☐ |
| (e) Afraid of being stigmatized | ☐ | (f) Forgave him | ☐ |
| (g) Afraid of making public the experience | ☐ | (h) Thought he will change | ☐ |
| (i) Did not want him to be punished | ☐ | (j) Was able to resolve it | ☐ |
| (k) Dependent on his financial support | ☐ | (l) He apologized to me | ☐ |
| (m) Other reason, please specify_____ | | | |

21 (a). Have you ever sought counselling services after the experience of forced or unwanted sexual intercourse you suffered in the hands of your husband (or ex-husband)?

- (1) Yes ☐ (2) No ☐

21 (b). If “No” to **Q21 (a)**, why did you not seek counselling services? You may tick (✓) one or more options that apply to you.

- | | | | |
|--|--------------------------|----------------------------|--------------------------|
| (a) Did not know whether he was right or wrong | ☐ | (b) Because i love him | ☐ |
| (c)Thought he will change | ☐ | (d) It was not necessary | ☐ |
| (e) Afraid of being stigmatized | ☐ | (f) Was able to resolve it | ☐ |
| (g) He apologized to me | ☐ | | |
| (h) Did not know where to seek counseling services | ☐ | | |
| (i) Other reason, please specify_____ | | | |

APPENDIX I I
UNIVERSITY OF ILORIN

**FACULTY OF EDUCATION
DEPARTMENT OF HEALTH PROMOTION AND ENVIRONMENTAL HEALTH
EDUCATION**

FOCUS GROUP DISCUSSION GUIDE

Introduction

My name isand my colleagues are..... We have invited you to this discussion to come and share your views on some problems that women face at homes. This discussion is part of the research work for the award of PhD degree in Health Promotion and Environmental Health Education at the University of Ilorin. The discussion which will last for 30 – 45 minutes will focus on issues relating to sexual violence at homes. In the course of this discussion, your views will be respected and will not be used against you in any way. This discussion will be taped, so please speak up and speak clearly. Please do share your views without mentioning people's names. We want the discussion to be anonymous and to be confidential as possible. There is no right or wrong view, so feel free to express yourself. Remember your participation in this discussion is voluntary. Your decision not to be involved or drop at any point will not attract any penalty. However, should you decide to participate in this discussion, you will be doing the society a great service because the findings of this study will be useful in the design of interventions for the control and prevention of marital rape and related problems that are confronting women. Thank you for choosing to participate in the study.

Kindly show by using any of the following 2 boxes, that your participation in this study was voluntary.

☐

I will participate

☐

I will not participate

For any information or comment, please contact:

Akintayo O. Ogunwale

Department of Health Promotion and Environmental Health Education, Faculty of Education,
University of Ilorin.

Email: tayoogunwale@yahoo.com Tel: 08053524780; 07062241984

S/N	Main questions	Follow up questions or hints
-----	----------------	------------------------------

1	(a) What makes marriage interesting?	• What are the values placed on marriage in this community? • What are some of the benefits of marriage?
2	(a) What are some of the challenges faced by married women?	• Probe for what they feel or perceive it to be.
	(b) What are the various forms of violence that occur at homes?	• Probe for the following -Physical violence including wife battery i.e beating of wife -Psychological violence including verbal abuse - Economic violence including depriving woman of finance even when the man has the economic means, withdrawal of economic incentive as a form of punishment. -Sexual violence including forced sexual intercourse if not mentioned
3	Now let us discuss issues relating to sexual matters. What do you think about sexual relations between husband and wife? What do you think about a woman turning down the sexual request or advances of her husband? What do you think are some of the reasons or situations that can make a woman to turn down her husband's sexual request or advances?	What are some of the advantages of sexual intercourse in marriage? Probe for How they perceive it to be? Probe for the following (if not mentioned) • If the husband is found of using drugs (sex-enhancing drugs) • The woman's previous sexual experience • Fear of being pregnant • Fear of losing pregnancy • Fear of husband not being faithful • Fear of HIV infection when husband is not faithful • As a form of punishment for a husband's wrong doing • If the husband does not provide for the family
4	What can you say about a	Probe for what they feel or perceive it to be.

	man subjecting his wife to forced or unwanted sexual intercourse when the wife does not want it?	How should such behaviour be considered? What about considering such behaviour as rape?
5	Now let us discuss issues relating to rape. How will you define or describe rape?	(a) The key characteristics of rape i.e what makes it different from consensual sexual intercourse (i.e mutually agreed sexual intercourse). (b) Probe for the following if not mentioned • Use of force or violence • Use of threat • Use of drug • Use of other coercive strategies to obtain sexual intercourse
6	How common is marital rape in the community?	
7	(a) What do you think are some of the reasons or situations that can make a man to subject his wife to forced or unwanted sexual intercourse (marital rape)? (b) What are the cultural and religious beliefs that make man to subject his wife to forced or unwanted sexual intercourse?	(a) Probe for the following • Influence of alcohol and drug use by man • Previous sexual experience • If a woman deprives or starves her husband of sex • As a form of punishment for a woman wrong doing • If a woman is not faithful (practicing infidelity or having extra-marital affair) Probe for the following • The cultural belief that a woman is the property of a man and as such a man can do anything that he wants to her • Religious belief that women should submit to their husbands as head of the family
8	How often do women who are raped by their husbands report their ordeal? How do survivors of marital rape cope with their ordeals	• If survivors do not usually report, why is it so? Probe for reasons Probe for what they do to help them overcome their situations

9	Who are the categories of women that usually experience marital rape (forced or unwanted sexual intercourse in the hands of husband)? What are the factors that can make women vulnerable to rape?	Probe for Probe for • Inability to sexually satisfy a man • Depriving or starving one's husband of sex • Practice of extra-marital affairs by a woman • Economic dependence on a man • Abuse of alcohol or use of psycho-active drugs including sex-enhancing drugs • Lack of laws and community sanctions against rape which constitute discrimination against women
10	What are the adverse health consequences that may be associated with marital rape (experience of forced or unwanted sexual intercourse in the hands of husband)?	Probe for the following • Physical health consequences i.e consequences or effects on survivors body or disease occurrence • Psychological health consequences i.e consequences or effects on mind, feeling, emotions e.t.c • Social health consequences i.e consequences or effects on relationship with perpetrator-husband, effects on the family and family life.
11	What can you say about seeking for help following experience of marital rape (forced or unwanted sexual intercourse suffered by a woman in the hands of her husband)? What are the reasons why women may not report cases of marital rape?	Probe for what each of the following • Seeking for medical help • Seeking for counseling and other forms of psychotherapy • Seeking for spiritual help or assistance • Seeking for support from family and others
12	What are the measures or things that can be put in place to prevent and control the problem of marital rape in Nigeria	Probe for what each of the following can do to address the problem of marital rape • Women, • Men/husbands • Relations and neighbours • Community leaders

		• Mass media • Governments • Social welfare • Non-governmental organizations working on women's right and violence related issues • Religious bodies- churches and mosques • Counsellors • Law enforcement agencies including Police • Legal practitioners • Lawmakers or Parliamentarians
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APPENDIX III
UNIVERSITY OF ILORIN
FACULTY OF EDUCATION
DEPARTMENT OF HEALTH PROMOTION AND ENVIRONMENTAL HEALTH
EDUCATION

**IWE IWADI LORI OHUN TI OJOMO IMO ATI ERO AWON OBINRIN ABILEKO,
ITANKALE, IRIRI ATI IPENIJA TI OROMON IFIPA BANILOPO ABI IBANILOPO
ALAINIFESI TI OHUN DOJUKO AWON OBINRIN TOTIGBEYAWO ABI LOKO NI
IPINLE OYO, NAIJIRIA.**

Oludahun tooto,

Oruko mi ni....., _____, mo je akeko imo
ijinle agba ni eka ti oun risi igbelaruge ilera ati eko ilera agbegbe, agbon ti ikeko, fasiti ti Ilorin.
Mo nse iwadi lori ohun ti ojomo imo ati ero awon obinrin abileko, itankale, iriri ati ipenija ti
oromon ifipa banilopo abi ibanilopo alainifesi ti ohun dojuko awon obinrin totigbeyawo abi loko
ni Ipinle Oyo, Naijiria. Awon oro abi ero ti abagba latodo yin ni yio je lilo fun siseto igbekale
awon eto ati awon idasi latise idena ifipa banilopo ati awon isoro ti oromo ti ohun dojuko awon
obinrin totigbeyawo. Ipinu yin lati kopa ninu iwadi yi je alaifiipa se. E jowo afe ki e mo pe beere
fun oruko yin abi oruko enikan kan. Mofi dayinloju pe gbogbo ohun ti ebaso funwa ni yio wa ni
ipamo. Ti e bani ibeere kankan, ejowo efokanbale lati fitomi leti. Modupe fun kikopa yin ninu
iwadi yi.

Ejowo, e fihan nipa lilo eyikeyi ninu awon apoti wonyi wipe kikopa yin ninu iwadi eko yi je
alaifipase.

Ma kopa, ati wipe maa towo bowe

Ma kopa, sugbon mi o ni kowo bowe

Fun alaye ati afikun Kankan, ejowo ekan si:

Akintayo O. Ogunwale

Department of Health Promotion and Environmental Health Education,

Faculty of Education,

University of Ilorin.

Email: tayoogunwale@yahoo.com; Tel: 08053524780; 07062241980

Abala A: Awon nkan idamo Oludahun-

Instruction: In this section tick (✓) the boxes that correspond to your answers or complete the spaces provided

1. Ipo ini oko (1) Mo ni loko ☐ (2) Opo ☐ (3) Tiko oko ☐
2. Esin yin (1) Onigbagbo ☐ (2) Musulumi ☐
(3) Abalaye ☐ (4) Other (Specify) -----
3. Eya ti e nse (1) Yoruba ☐ (2) Igbo ☐ (3) Hausa ☐
(4) eya miran (e daruko) -----
- 4 (a). Iwe ti ogaju ti eka
(1) Nkolo ile iwe ☐ (2) Iwe-alakobere ☐
(3) Eko grama ☐ (4) Eko Unifasiti ☐
(5) Iwe miran (e daruko) -----
- 4 (b). Iwe ti ogaju ti oko yin ka
(1) Nkolo ile iwe ☐ (2) Iwe-alakobere ☐
(3) Eko grama ☐ (4) Eko Unifasiti ☐
(5) Iwe miran (e daruko) -----
- 5 (a). Ojo ori ni odun?
- 5 (b). Ojo ori oko yin ni odun
- 6 (i) Ipo ise sise: (1) Mo nse ise ☐ (2) Mi o sise/ mi o ni ise ☐
- 6 (ii). Ojulowo ise ti e nse
- 7 (a). Apejuwe idile (1) idile oko kan iyawo ka ☐ (2) Idile olopo iyawo
- 7 (b). Otito igbawo ti eti fe oko yin?.....
- 7 (c) Otito oko melo ti etini ri?.....
- 8 (a) Se e ti ni iriri ifipabanilopo ri lowo enikankan ti o yato si oko yi?
(a) Beeni (b) Beeko
- 8 (a) Nije ti idahun yin si ibere 10a ba je “beeni” (ti e ba ti ni iriri ifipabanilopo ri lowo enikankan ti o yato si oko yi), irife awon wo ni o ti fi ipabanilopo ri
- (1) Okunrin ti e n’fe ti o ti gbe iyawo ☐ (2) Okunrin ti e n’fe o ti ni iyawo ☐
(3) Ore okun ☐ (4) Ajoji okunrin ☐ (5) Manlebi okunrin ☐
(6) Eniyan miran ti e le so fun wa ?

Abala B1: Imo lori ibalopo nititipa/ibalopo alainife si larin loko-lawe

9. So apere meji ni okokan lori awon ipenja ifipa banilopo ti ojemo ilera ara, okan, ibagbepo/ibare.

Tabili kini

Eka awon ilera/ ipenja ilera	Alaye ipenja/ abajade tabi ijamba ti ko daara
(1) Ipenja ilera ti o jemo ara abi ise le arun	(a)
	(b)
(2) Ipenja ilera ti o jemo ilera/ailera okan ati ironu	(a)
	(b)
(3) Ipenja ti jemo ibare (abi ibagbepo)	(a)
	(b)
4) Ipenja tabi ijamba ti jemo ibalopo ati awon ikan ti o sopo pelu oyin ati omo bibi	(a)
	(b)

Abala B2: Awon ero ti ojemo ifipa banilopo/ibalopo alainifesi larin loko-lawe

Q10. Ilana: Jowo fi ero re han nipa mi maaki (✓) awon iho toba awon idahun yin mun. Modupe lowoyin funasiko yin ati otito.

Q10 - Instruction: Please indicate your response by ticking (✓) in the appropriate box. Thank you for your time and honesty.

Tabili keji

	Ero ti ojemo ifipa banilopo/ibalopo alainifesi larin loko-lawe	Maki (✓)		
		Ojomo ero mi	Mi o lesa	Ko jomo ero mi
10.1	Didojuko ifipa banilopo/ibalopo alainifesi nigbati akofe latowo oko eni kise iriri todara			
10.2	Didojuko ifipa banilopo/ibalopo alainifesi nigbati akofe latowo oko eni kise iriri todara			
10.3	Didojuko ifipa banilopo/ibalopo alainifesi lati owo oko eni je oun to wopo ti koye ki obinrin kankan koyora re lenu lelori			
10.4	Didojuko ibanilopo afiipase/ibalopo alainifesi lati owo oko eni koye kari bi ifipa banilopo			
10.5	Obinrin ye kolegba ibanilopo afiipase/ibalopo alainifesi lati owo oko re monra nitori igbeyawo			

10.6	Obinrin ti oko re balo nitipa leje pe iru iyawo be ni se okunfa re			
10.7	Oye ki aba iru okunrin ti ofi ipa ba iyawo re ni ajosepo/ibalopo yi			
10.8	Odara fun obinrin toni idojuko ibanilopo afiipase/ibalopo alainifesi lati owo oko re latimasofun enikankan			
10.9	Iriri idojuko ibalopo tipa lati odo oko eni le sejamba fun ife si ibalopo lati odo obinrin			
10.10	Okan ninu oun ti oun se okunfa ibanilopo afiipase/ibalopo alainifesi lati owo oko ni igbagbo wipe oye ki iyawo le ma gba fun oko nigbakigba ti o ba nifesi ibalopo pelu iyawo re			
10.11	Igbagbo pe iyawo je nkan ini oko je idi ti awon okunrin kan ma nfi ipa ba iyawo won lopo			
10.12	Kotona ki a fi ejo oko eni sun nitori idojuko ibanilopo afiipase/ibalopo alainifesi lati owo oko			
10.13	Obinrin ti o n'bama dajuko ifibapanilopo/ibalopo alainifesi lati owo oko ni gbogbo igba ye ko jawe ikosile fun iru oko be			
10.14	Itiju towa leyin ifisun iru ifibapanilopo/ibalopo alainifesi lati owo oko le burujai ju iriri ibalopo irure lo			
10.15	Awon obinrin ti o bati loko koni eto lati ko ibalopo pelu awon oko won			
10.16	Obinrin koye koko oko re sile nitori idojuko ifibapanilopo/ibalopo alainifesi lati owo oko			
10.17	Obinrin ti oun dojuko iriri ifibapanilopo/ibalopo alainifesi lati owo oko ni gbogbo igba ye ki o mu oro ire losi si odo awon eletu ilu ti oun dasi iru oro be (social welfare office)			
10.18	Obinrin ti oun dojuko iriri ifibapanilopo/ibalopo alainifesi lati owo oko re koye ki o so fun enikankan			
10.19	Obinrin ti oun dojuko iriri ifibapanilopo/ibalopo alainifesi lati owo oko re ye ki ofi arada			
10.20	Kosi nkankan ti obinrin le se toleje koma dojuko ifibapanilopo/ibalopo alainifesi lati owo oko			

Abala B3: Itankale/Piposi ifibapanilopo/ibalopo alainifesi larin loko-laya

Atona: Fi idahun ti oye si awon iho towa nisale wonyi nipa mimaki (√) awon iho tobaba awon idahun yin mun ju ninu eka yi. Jowo turaka latiso otito, gbogbo ounti ebafunwa ni yio wa ni idakonko?

11. Nje oko yin bayi (abi oko titele) tile tini ibalopo ti e oniifesi pelu yin leyin nina abi sisoro sini nitori ati ni iablopo pelu yin?

(1) Beeni

(2) Beeko

12. Nje oko yin bayi (oko yin atijo) tilo nkan toni ijamba abi ti ole derubani lati bayin ni ibalopo tipatipa abi alainifesi ti olodi si ipinu yin ni asiko igbakan?

(1) Beeni

(2) Beeko

13. Nje igbakankan wa ti oko yin (abi ti oko yin atijo) lo anfani ipo ilera yin latifi tipa bayin ni ibalopo tipatipa abi alainifesi ?

(1) Beeni

(2) Beeko

14. Nje oko yin (abi ti oko yin atijo) tilo oro kobakungbe tabi oro ibanije ni ibalopo tipatipa tabi ibalopo ni igba ti e o nife si iru nkan be?

(1) Beeni

(2) Beeko

15. Nje oko yin (abi ti oko yin atijo) tilo ohunkohun ti ole bani leri abi mu ijaye wa lati dojuko yin ko ibalopo tipatipa tabi ibalopo ni igba ti e o nife si iru nkan be?

(1) Beeni

(2) Beeko

16. Nje oko yin bayi (abi ti atijo) tile tilo oogun abi nkan tio muni nsun lati doju yin ko ibalopo tipatipa tabi ibalopo ni igba ti e o nife si iru nkan be?

(1) Beeni

(2) Beeko

17. Nje e ti ri iri kankan lati owo oko yin ti nfe (abi oko yin ti e ti fe ri) ti o fi arape tabi jomo awon irufe ifipabanipolo ti ati so tele ni awon ibere ti owa ni 13- 18. Se e yin ri iriri yin jeje bi ifipabanipolo?

(1) Beeni

(2) Beeko

18. Nje e ti ri iri kankan lati owo oko yin ti nfe (abi oko yin ti e ti fe ri) ti o fi arape tabi jomo irufe ifipabanipolo ti ati so tele ni awon ibere ti owa ni 11- 16- sugbon ti eyin o ka si ifipabanipolo ni oju yin. To ba je bi e, ki ni idi ti e ko fi ri irufe ikan be bi ifipabanipolo?

ITONA: E jowo ema tesiwaju pelu iwe ibeere yi ti ekobatini iriri ifipabalilopo tabi ibalopo alainifesi ri bi ibeere 13–18 se toka re.

Abala B4: Iwa ti o jomo wiwa iranlowo leyin idojuko ifipa banilopo tabi ibanilopo alainifesi lati owo oko

Atona: E jowo e so iriri otito nipa mimaaki ($\sqrt{}$) iru awon iho tabi ki e pese awon irufe idahun toba iriri yin mu. Awon idahun yin ni yio wa ni ipamo.

19 (a). Nje ebere fun iranlowo nipa itoju ilera leyin nini idojuko ibalopo tipatipa latowo oko (abi oko atijo)? (1) Beenì (2) Beeko

19 (b). Tobaje "beeko" si **ibeere 19 (a)**, kilode ti ekofiwa iranlowo nipa isegun oyinbo?

(a) Mi oni ipalara Kankan (b) Nitori mole fara daa

(c) Mo ntoju ara mi ni ile (d) Iberu ideyesi tabi fifiseleya

(e) Kosi idi kankan

(f) fun awon idi kan, so pato _____

19 (c) Tobaje "beenì" si **ibeere 19 (a)**, kilode ti ekofiwa iranlowo nipa isegun oyinbo?

20 (a). Nje ewa iranranlowo ofin abi igbaniyanju lati owo amofin (abi agbejoro) leyin nini idojuko ibalopo tipatipa latowo oko (abi oko atij)? (1) Beenì (2) Beeko

20 (b) Tobaje "beeko" si **ibeere 20 (a)**, kilode ti e kofiwa iranlowo ofin abi igbaniyanju lati owo

amofin (abi agbejoro)? E le maaki ($\sqrt{}$) ikan abi jubeelo ninu awon idahun toba firarape iriri yin?

(a) Nkomo boya ojebi abi ojare (b) Toripe moferan re

(c) Mo беру komojasi tituka igbeyawo wa (d) Nitori awon omo

(e) Mo беру fifiseleya (f) Mo darijin

(g) Mo беру titu asiri wa sita (h) Mo rowipe yio yipada

(i) O titoro aforijin lowomi (j) Atiyanju re

(k) Mo gbokanle iranlowo owo re (l) Nkofemodagbe

(m) Idi miran, se alaye _____

21 (a). Nje egba imoran latodo akosemose leyin idojuko ifipa banilopo latowo oko yin (abi oko atijo)? (1) Beenì (2) Beeko

21 (b). Tobaje "beeko" si **ibeere 21 (b)**, kilode ti e kofigba imoran latodo akosemose? E le maaki (✓) ikan abi awon idahun tobabayin mun

(b) Nkomo boya ojebi abi ojare ☐ (b) Toripe moferan ☐

(c) Momope yio yipada ☐ (d) Kojamo nkankan ☐

(e) Monberu fifiseleya ☐ (f) Atiyanju re ☐

(g) Otitoro aforijin lowomi ☐ (h) Komo ibi toyee kin ti gba imoran ☐

(i) Other reason, please specify _____

APPENDIX I V

IWE ITONISONA IWADI (IFOROWERO/IJIRORO) AJUMOSE (AKOJO ENIYAN) TOGBORO - FOCUS GROUP DISCUSSION GUIDE

Ibere

Oruko mi ni.....ati oruko awon akegbe mi..... Apeyin si Iforowero yi lati wa pin ninu ero yin lori awon isoro ti awon obinrin nkoju ninu ile. Adupe lowo gbogbo yin pe e se ayesi awon ipe wa. Iforowero yi je ara ise iwadi imoijinle fun gbigba oye eko agba dokita (PhD) ni eka ti oun ri si Igbelaruje ilera at eko ilera agbegbe ni Ile eko agba fasiti ilu Ilorin (University of Ilorin). Iforowero yi yio gbawa to iseju ogbon si iseju marun dinlaadota ni eyi ti o da lelori ise ti o jemo ibanilopo onija tabi oni wahala ti oun yo awo obinrin abileko lenu. Ninu Iforowero yi, a o pon iwoye yin le to bee ge akosi ni loo lodi sinyin ni ona kan tabi omiran. A o gba Iforowero yi sile ninu ero ilewo agbohun sile, fun idi eyi, ejowo e soro geere ati si'oke dada. E jowo e se alabapin iwoye yin laidaruko eniken nitori a fe ki Iforowero yiye eyi ti a ko le fi da eniken mo ati alasiri bo ti wule komo ko si iwoye ti o tona tabi ti ko tona fun idi eyi e turaka lati salaye ara yin daradara. E ranti wipe ilowo ninu iforowero yi kii se afipase rara.

Ipinu yin lati ma kopa mo tabi kuro ninu iwadi yi ko ni ijiya kankan rara pelu. Nipa bayi, ti e ba pinnu lati kopa ninu Iforowero yi, e nse awujo wan i oore bantibanti nitori wipe aabo iwadi eko yi yio wulo lati se agbelewon awon eeto lati dasi ikapa ati idena ifipa bani lopo ninu igbeyawo ati awon isoro ti o jemo ti oun koju awon obinrin.

Ejowo, e fihan nipa lilo eyikeyi ninu awon apoti wonyi wipe kikopa yin ninu iwadi eko yi je alaifipase.

Ma kopa, ati wipe maa towo bowe

Ma kopa, sugbon mi o ni kowo bowe

Fun alaye ati afikun Kankan, ejowo ekan si:

Akintayo O. Ogunwale

Department of Health Promotion and Environmental Health Education,

Faculty of Education,

University of Ilorin.

Email: tayoogunwale@yahoo.com; Tel: 08053524780; 07062241980

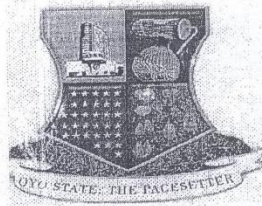
S/N	Ibeere gboogi	Ibeere ti o se iranwo (tabi Ibeere ti o tele)
1	(b) Kini ohun ti o mu igbeyawo dun tabi lamarinrin?	- Kini awon ohun iyebiye ti a gbele ori igbeyawo ni agbegbe yi? - Kini awon ohun ti oje anafaani igbeyawo?
2	(c) Kini awon ohun ti oje ienija ti awon abileko nko ju?	Beere fun awon ohun ti won leero tabi funra si wipe oje.
	(d) Kini awon orisirisi isoro/wahala ti o n'koju awon obinrin abileko ti o jomo ijamba inu ile tabi eto awon obinrin?	Beere fun awon nkan wonyi: Lilu iyawo Iwa ipa ti oun derubokan eni ti fi mon si soro eebu tabi oro alufansa/oro kobankugbe ati Fi iwa owo je obinrin nigba ti okunrin ni owo lowo, didaduro owo iranwo gegebi ona ijiya fun iyawo Ibalopo afi ipa se (iyen ti won ko ba mu enu ba tele)
3	Baayi, e je ki a jiroro lori awon ise ti o jomo ibalopo . Kini e lero nipa ibara enise onibalopo laarin oko ati iyawo Kini e ro nipa ki obinrin ko ibalopo nigba ti oko re ba nawa tabi beere fun? Kini elero wipe o le je awo idi tabi ise ti o le mu ki ibinrin koo inawosi tabi ibeere ibalopo fun oko re.	Kini awon anfani ibara eni lopo ninu igbeyawo Beere fun Bawo ni e se leero wipe oje/ Bawo ni e se risi? Beere fun awon nkan wonyi: - Ti okunrin ba kundun ati maa lo ogun amara le (fun ibalopo) - Awon iriri ibalopo ateyinwa obinrin (awon iriri ti obinrin ti la koja si eyin) - Iberu oyun nini - Iberu oyun bibaje - Iberu aisoto oko - Iberu kiko arun HIV nigba ti oko je alailooto - Gegebi ona ifiya jeni fun asise oko - Ti oko ko ba pese fun idile re
4	Kini e le so nipa ki okunrin fi ipa abi dandan ba iyawo re ni agoseopo (ibalopo) nigba ti iyawo ko nife si ibalopo.	Beere fun awon ohun ti won leero tabi funra si wipe oje. Bawo ni ki won se gba iru iwa yi. Nje a le ka iru iwa yi si ifipa banilopo

5	Bayi, e je ka jiroro nipa awon isele to jomo ifipa banilopo Bawo ni e sele tumo tabi juwe ibalopo afiipase (abi ibalopo alainifesi)	(b) Kini apeere ibalopo afiipase, Kini o mu ibalopo afiipase yato si ibalopo ti oko ati iyawo fi owo si (b) Beere fun awon nkan wonyin ti won ko ba mu enu ba: • Lilo ipa tabi ija • Lilo iderubani • Lilo oogun • Lilo awon ona alumokoroyi miran lati ni ibalopo
6	(a) Bawo ni ifipa banilopo ninu igbeyawo se wopo si ninu agbegbe?	
7	(c) Kini elero pe ole je awon idi tabi isele ti o le mu ki okunrin fi ipa ba iyawo re lopo (awon nkan ti o je ki obinrin se koju ifipa banilopo tabi ibalopo alainifesi ninu igbeyawo). (d) Kini awon igbagbo (abi ise) ti o jomo asa ati esin ti o man mu ki okunrin fi ipa ba iyawo re lopo?	(a) Beere fun awon nkan wonyin • Oti lile ati ogun ti okunrin lo • Iriri ibalopo ateyinwa • Fifidun tabi ebi ibalopo pa oko lati owo iyawo • Gegebi ona ifiya jeni fun asise obinrin • Ti obinrin ko ba je olotitio (rinrin irinkurin abi yiyan ale) (b)Beere fun awon nkan wonyin • Igbagbo asa wipe obinrin je dukia okunrin (oko re), nipa be okunrin le se ohunkohun fun obinrin re • Igbagbo esin wipe ki obinrin terbia fun awon oko won gegebi olori ile
8	Bawo ni awon obinrin ti oko won man fi ipa bawonlopo se man fi ejo oko won sun si (tabi salaye iriri won si)? Bawo ni awon obinrin ti ori koyo ninu ifipa banilopo ninu igbewayo se n’kopa (abi koju) ipeneja won?	• Ti won ti won ti ri iru iriri be ko nba fi ejo awon oko won fun/abi salaye iriri won, kini idi ti o fi ribe? Beere fun ohun ti won se lati ran ara won lowo lati bori awon isele (ipenija) won
9	Iru awon sawawu obinrin ti won ma n saba ni iriri ifipa banilopo ninu igbewayo (ibalopo ipa tabi alainifesi lati owo awon oko won)? Kini awon oun ti o ni ewu fun obinrin ti ole se okunfa ifipa	Beere fun • Aikun oju osunwon lati le te okunrin lorun nipa ibalopo

	banilopo?	• Fifi ibalopo dun oko eni • Iwa ki obinrin ma yan ale • Gbigbe ara le okunrin fun eto isunna (nina owo) • Asilo oti lile tabi lilo ogun amaraya gaga/amarale to fi mon ogun amuibalopo le yagiyagi • Aisi ofin ati ibawi (idajo) lati owo ilu abi awujo ti o lodi si ifipabanilop eyi ti o jebi iwa ideyesi awon obinrin (iwa aika awon obinrin kun).
10	Kini awon ipenja ti o jemo ilera ti oun koju awon obinrin ti won ri iriri ifipa banilopo?	Beere fun awon nkan wonyin • Ipenaja ilera ti o jemo ara abi ise le arun • Ipenaja ilera tio jemo ailera okan ati ironu • Ipenaja ilera ti o jemo ibare (abi ibagbepo), pelu oko ti o n'fipa banilopo, larin ebi, ipa lori igbeaye idile (abi molebi)
11	Kini ele so nipa wiwa iranlowo ti o ye ki obinrin wa (tabi rigba) leyin iriri ifipa banilopo (ninu igbewayo) lati owo awon oko? Kini awon idi ti obinrin le maa fe fi ejo ise le ifipa banilopo (ninu igbewayo) lati owo awon oko sun?	Beere funkini ohun kan ti awon wonyi • Wiwa iranlowo fun itoju ara • Wiwa iranlowo ti latodo awon agbani nimoran • Wiwa iranlowo lati odo awon ojise olorun • Wiwa iranlowo abi atileyin lati odo awon ebi abi awon miran
12	Kini awon nkan tabi igbese ti a le lakale lati k'apa ati dena isoro ifipa banilopo (ninu igbewayo) lati owo awon oko?	Beere funkini ohun kan ti awon wonyi lese lati samojuto (abi bori) isoro ifipa banilopo ninu igbewayo • Awon obinrin • Awon okunrin/oko • Molebi ati alabagbe • Olori agbegbe abi ilu • Awon oniroyin • Ijoba • Alamojuto ise idagbasoke ilu/ Alamojuto ise ibagbepo ara ilu • Awon elegbejebge ti kii se ti ijoba ti won sise lori eto omoniyani ati ise le to jomo eto obinrin abi ijamba ti oun koju awon obinrin • Elesin elekajeka – soosi ati mosalasi • Kaunsilo – agbananimoran • Awon agbofinro to fi mon awon olopa • Awon amofin • Awon asofin, abi omo ile igbimo asofin

TELEGRAMS.....

TELEPHONE.....



MINISTRY OF HEALTH
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No.

All communications should be addressed to
the Honorable Commissioner quoting

Our Ref. No. AD 13/ 479/ 065

May, 2016

The Principal Investigator,
Department of Health Promotion and
Environment Health Education,
Faculty of Education,
University of Ilorin,
Ilorin.

Attention: Ogunwale Akintayo

**ETHICAL APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE**

This is to acknowledge that your Research Proposal titled: "Marital Rape Related Knowledge, Perceptions and Experiences among Women in Oyo State, Nigeria." has been reviewed by the Oyo state Review Ethical Committees.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

A circular official stamp of the Ministry of Health, Oyo State, with a signature across it.

(Dr) Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee

