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ABSTRACT

Background: Gender-based violence (GBV) is any harmful act including physical, sexual, and emotional abuse based on gender norms, with significant health, social, and economic consequences. Despite its devastating impact, GBV among males and other under-recognized groups remains understudied. This study assessed the prevalence and pattern of GBV among undergraduates, and respondents' knowledge of its effects.

Methodology: A cross-sectional study of 413 University of Calabar undergraduates was conducted using multi-stage sampling. The questionnaire inquired about the experience of GBV and respondents' knowledge of its effects. Data was analyzed using Statistical Package for Social Science (SPSS), with logistic regression assessing the association between GBV and age, sex, marital status, and academic year, reporting odds ratios (ORs), 95% confidence intervals (CIs), and p-values to evaluate statistical significance and the precision of estimates.

Results: GBV prevalence among participants was 19.4%, with emotional violence (threats, intimidation and verbal abuse) being most common (18.6%). Prevalence was slightly higher in males, but not significantly so ($p>0.05$). The logistic regression analysis revealed no significant relationship between GBV and age, sex, marital status, academic year, though older individuals had slightly lower odds of experiencing GBV, while males had slightly higher odds compared to females. Most respondents agreed that GBV has psychological, social and health implications.

Conclusion: The study showed that GBV affects both male and female Nigerian students. Universities should implement strict policies, awareness programs, and student support systems including a formal GBV reporting system, survivor support services, and mandatory training for students and staff to address GBV effectively.

Key Words: Gender-based violence, Prevalence, Students, Male, Female

INTRODUCTION.

Gender-based violence (GBV) is not only a pervasive violation of human rights but also poses a public health menace affecting individuals and communities globally. GBV refers to any harmful act perpetrated against a person's will based on socially ascribed differences between males and females, and has no socioeconomic nor ethnic and cultural disparities.[1,2] The United Nations (UN), in the Convention on Elimination of all Forms of Discrimination against Women (CEDAW), describes it as an act likely to result in physical, sexual or psychological harm or suffering to women, including threats or acts of coercion, arbitrary deprivation of liberty, private or public, in the family or community.[3] This definition, although limited in scope because it only addresses GBV among women and neglects male GBV, provides insight into the dimensions of GVB. A subset known as School-Related GBV (SRGBV) refers to acts of violence in and around schools, usually as a result of gender norms and stereotypes.[4] It includes verbal abuse, bullying, sexual abuse, harassment, and other types of violence.

Globally, GBV affects one in three women during their lifetime. Millions of women globally live with the scars of violence, with 35% experiencing physical violence and about 7% of them previously sexually abused during their lifetime, with higher rates observed among intimate partners.[5] Across Central and West Africa, millions of young adults and children endure corporal punishment that leaves emotional scars and damages their right to learn. Over half of all school teachers in these regions also resort to physical disciplinary methods daily.[2] GBV also occurs in men, though it has received less attention in research, legislation and public health policy. "Men experience GBV at varying rates, with 3.4–20.3% facing physical violence, 7.3–37% experiencing psychological abuse, and 0.2–7% subjected to sexual violence.[6] Some African studies also showed that boys were disproportionately punished more than their female counterparts.[2] While figures vary due to factors like cultural norms and reporting mechanisms, studies have consistently highlighted the existence of GBV in all genders. This issue devastates survivors of violence and their families and entails significant social and economic costs and psychological burdens.[7]

GBV is enacted in diverse ways, ranging from physical acts to online aggressions manifesting as physical, sexual, or emotional violence.[8]The forms of GBV are not mutually exclusive, as multiple types can happen simultaneously and reinforce each other.[8] Physical violence is the intentional use of physical force against oneself, another person, or a group or community, resulting in or with a likelihood of resulting in psychological harm, injury, deprivation, or death.[9] The most typical variety noted is pushing or shoving, probably due to the ease of commission without necessarily causing considerable harm to the victim.[9] Sexual violence encompasses any sexual act, attempt, or unwanted sexual comments or advances directed at an individual by anyone, irrespective of their relationship or setting. It includes but is not limited to rape, psychological intimidation, blackmail, or other threats, usually in situations where the victim cannot consent due to intoxication, drug influence, sleep, or mental incapacity.[10] Emotional abuse entails mistreatment of a psychological nature rather than physical harm, and encompasses verbal abuse, recurring criticism, and subtler tactics such as intimidation, manipulation and refusal to be pleased. The verbal abuse alters the victim's self-worth and emotional well-being, resulting in an emotionally abused victim.[11]

Traditional attitudes towards women perpetuate GBV. Stereotypical roles where society sees women as subordinates to men create a power skew that enables violent acts in a background of inequity related to race,

disability, religion, age, social class, and sexuality. Previous studies have also shown a relationship between place of residence and GBV. Undergraduates who live far away from family and those staying on campus are at an increased risk.[12] Alcohol consumption has been linked to GBV, significantly increasing its likelihood. Family type and early life experiences, including divorce and witnessing parental violence, predispose to GBV later in adulthood.[13] Additionally, diverse social, psychological and mental health outcomes have been linked to GBV, such as insomnia, depression, low self-esteem, fear of future sexual relationships, guilt, undue rage, and in extreme cases, death.[4,14]Also, sexual assault can result in unwanted pregnancies in females, and sexually transmitted infections (STIs), including HIV in male and female genders.[15] Notable effects in males include shame, guilt, and social prejudice (questioning of masculinity), among others.[16] In humanitarian crises, reporting or seeking services for GBV can lead to further threats of violence, social stigma, and ostracization, thus hindering victims from accessing lifesaving services like food, shelter, and healthcare.[15] While existing research predominantly focuses on GBV among women, there is limited data on GBV experiences among males and other under-recognized groups. Some authors argue that women bear the greater burden of GBV and its consequences, with men wielding GBV as a tool of power and control over women.[17] However, others caution against the silence of male victimhood, suggesting that male experiences are sometimes viewed as diminishing the urgency of GBV against women.[18] This study aims to bridge this gap in knowledge by assessing the prevalence and patterns of GBV in both male and female counterparts in a university setting. The findings will serve as baseline data for future studies and provide evidence-based information for public health policymakers.

MATERIALS AND METHODS

Study Design

This study employed a cross-sectional descriptive design to assess the prevalence and patterns of GBV among undergraduate students. Self-administered questionnaires were used to collect data from the participants.

Study Setting

The study was conducted at the University of Calabar, located in Calabar Municipal, Cross River State, Nigeria. The University comprises 16 faculties and 3 institutes, with a total undergraduate population of 40,645 students.[19]

Sample Size Determination

The sample size for this study was determined using Cochran's formula, which is applicable when the prevalence is known. The formula used was $n = \frac{Z^2 \times P \times Q}{d^2}$, where n represents the minimum sample size, Z is the standard normal deviate, estimated at 1.96 for a 95% confidence interval, P is the proportion of the outcome of interest (58.8%), Q is 1 minus P (0.412), and d is the desired level of precision (0.05). Plugging in these values, the calculation yielded 372.3. To account for a 10% non-response rate, the minimum estimated sample size was adjusted to 413.33, which was then rounded to 413. This precautionary adjustment followed standard sampling practice to ensure adequate statistical power, in case some participants opted out or provided incomplete responses.

Eligibility Criteria

Participants in this study included all registered full-time undergraduate students at the University of Calabar who provided informed consent and were present in class during the data collection period. This study specifically excluded postgraduate students, students who did not consent to participate, and those who were absent during the time of data collection.

Sampling Method

A multi-stage sampling technique was employed in this study. In the first stage, selection was done in two phases to ensure representation from both science- and arts-based faculties. First, faculties were categorized into science and arts groups. Then, simple random sampling was done within each category using manual balloting, where faculty names were written on separate slips, shuffled, and randomly picked from a box to select seven out of the sixteen faculties in the University. In the next stage, the same balloting method was used to randomly determine the departments from selected faculties to administer the questionnaire. In the final stage, a stratified random sampling method was used to get the proportion per study level in the selected department.

Tools for Data Collection

A structured, self-administered questionnaire was adapted from a previous study[20] for data collection. The sections of the questionnaire comprised the socio-demographic characteristics of the respondents (age, gender, marital status, faculty, academic year and religion), prevalence, patterns, and effects of GBV, along with recommendations to be provided. Age was categorized into two groups; less than 21 years and 21 and above. Marital status was classified as single or married, with married respondents being those who were

ever legally married. The academic year was categorized as 100, 200, 300 and ≥400 level represented the first, second, third and fourth and above year of study respectively. To explore students' experiences with GBV, the questionnaire began with a general screening question ("Have you ever experienced gender-based violence?"), followed by a structured items addressing specific forms of violence, including physical, sexual, and emotional/psychological abuse, as well as the frequency of incidents, the relationship to the perpetrator, and the resulting health effects. The questionnaire also consisted of close-ended questions that enabled the collection of relevant data to answer the research questions on the respondents' knowledge of the effects of GBV.

Method of Data Collection

The questionnaire was pretested at the University of Cross River State (UNICROSS), and amendments were made afterward. It was then administered to each class after prior approval from class representatives and verbal consent from students. To mitigate recall and social desirability bias, questions were framed neutrally, responses were anonymized, participants were assured of confidentiality, and issues were clarified on request. Four hundred and thirteen (413) questionnaires were shared, returned, completed, and found valid.

Data Analysis

The questionnaire data was verified to minimize entry errors, outliers, and missing values. Data was analyzed using the Statistical Package for Social Sciences (SPSS) version 21.0 for Windows. The data was analyzed using the measures of central tendency and dispersion. Tables were used to present frequencies. The level of significance was set at a p-value less than or equal to 0.05. Relationships were tested with inferential statistical techniques (chi-square- Pearson, unadjusted) test as this is appropriate for categorical variables. We also conducted a logistic regression analyses to explore the association between the demographic and academic factors and the outcome of interest. The variables we included in the models were age, sex, marital status, and academic year. These variables were selected based on their relevance in existing literature and their potential influence on gender-based violence (GBV) experiences. Age was included as GBV vulnerability and reporting tendencies may vary across different age groups. Sex was considered because GBV disproportionately affects certain genders, with variations in both prevalence and patterns. Marital status was analyzed as it can influence exposure to GBV, particularly in contexts where intimate partner violence is a major component. Academic year was examined to assess whether exposure to GBV changes over time as student's progress through university, potentially due to increased independence or changing social dynamics. We ran separate logistic regression models for each variable to estimate their individual effects on the outcome and calculated the odds ratio (OR) for each variable along with its 95% confidence interval (CI), without adjusting for the effects of other variables. After examining the unadjusted models, a multivariable logistic regression analysis was conducted, which included all four variables (age, sex, marital status and academic year) at once. This allowed us to see how each factor influenced the outcome while accounting for the other variables. We assessed the statistical significance of each variable by looking at the p-values, with values less than 0.05 indicating a significant relationship with the outcome. We also calculated the 95% confidence intervals for each odds ratio to understand the precision of the estimates. If the confidence interval for an odds ratio did not include 1, we considered the relationship statistically significant.

The goodness-of-fit of the logistic regression model was assessed using the Hosmer and Lemeshow Test that assessed the calibration of the model by comparing observed and expected outcomes, with a non-significant result indicating good fit.[21]

Ethical Consideration

Ethical approval was obtained from the Ethics Committee of the University of Calabar Teaching Hospital with the with the assigned protocol number **UCTH/HREC/33/514**. Informed consent was obtained from the participating students who were fully briefed about the study's purpose and procedures. Given the sensitive nature of GBV, particular care was taken to ensure participants were aware of their right to voluntary participation and the option to withdraw at any time without consequence. Confidentiality was strictly maintained throughout the study, and participants were assured that their responses would be anonymized. The questionnaires were filled individually to ensure privacy and encourage honest responses, with no group discussions held to protect participants' privacy.

RESULTS

Four hundred and thirteen (413) University of Calabar undergraduate students were surveyed using a self-administered questionnaire. The response rate for this study was 100%.

Socio-Demographic Characteristics

The mean age of respondents was 22.37±3.07 years, with the majority between the ages of 21 – 30 years (73.7%). Higher proportions were males (50.4%). Unmarried respondents were predominant (74.1%), while individuals who ever legally married comprised 25.9%. Most respondents were Christians (97.8%) (Table 1).

Prevalence of GBV

The overall prevalence of GBV among the respondents was 19.4%. The most prevalent form was emotional violence, with 18.6% (n=77), while sexual violence had the least occurrence, with 13.3% (n=55) (Table 2).

Older students (>21 years) experienced slightly higher GBV prevalence compared to younger students (<21 years), but this difference lacked statistically significance (p>0.05). Among genders, males experienced a slightly higher prevalence of GBV than females, with prevalences of 19.7% and 19%, respectively. Those who were ever legally married experienced GBV more than their single counterparts. We also found a higher prevalence of GBV among students in higher academic years, with students in 400level and above experiencing it more than those in lower levels of study. However, none of these patterns reached statistical relevance (p>0.05) (Table 3).

The logistic regression analysis showed no significant relationship between the demographic and academic factors studied and the likelihood of experiencing GBV. Older individuals appeared to have slightly lower odds of experiencing GBV (adjusted OR = 0.95, 95% CI: 0.88–1.03), but this effect showed no significant association (p = 0.19). Similarly, while males seemed to have slightly higher odds of experiencing GBV compared to females (adjusted OR = 1.054, 95% CI: 0.64–1.70), this difference was not significant (p= 0.86). Married individuals were somewhat less likely to experience GBV compared to their single counterparts (adjusted OR = 0.72, 95% CI: 0.42–1.23). However, this association was not statistically significant (p = 0.23). Students in higher academic years showed a small, non-significant decrease in the odds of experiencing GBV (adjusted OR = 0.88, 95% CI: 0.69–1.13, p = 0.32). In summary, while the variables of age, sex, marital status, and academic year showed some trends in their relationships with GBV, none of these associations were demonstrable statistically (Table 4).

The model demonstrated a good fit, as indicated by the non-significant result of the Hosmer and Lemeshow Test (p = 0.232), suggesting that the observed and expected frequencies were closely aligned.

Effects Of GBV

Respondents were also asked about their awareness of the effects of GBV. Their responses highlighted a range of consequences including loss of self-esteem (96.5%), loss of concentration in school (95.4%), sexually transmitted infections (89.5%), suicidal thoughts (89.2%), sleep disturbance (89%), strained relationship (86.8%), unwanted pregnancy (83.6%), hospital admission (80.9%), urge to abuse alcohol (80.4%) and drugs (77.4%). Other psychological effects include suicidal thoughts (89.2%) and running away from home (84.9%).

DISCUSSION

We discovered that the overall prevalence of GBV was 19.4% among the population studied, with the male prevalence (19.7%) slightly above that of females (19%). The commonest GBV was emotional violence, and its major effects identified by respondents were psychological, with loss of self-esteem being the most notable.

We had a similar overall prevalence with results obtained in a study among female undergraduates in Port-Harcourt (19.8%).[22] However, our findings sharply contrast earlier studies conducted in Calabar and Northern Nigeria in 2012 and 2011, respectively, with individual prevalences of 51.7%,[14] and 58.8%.[20] This difference could result from the disparity in the study population as both studies were done on female undergraduates, with a focus on sexual violence only, not GBV in its entirety. A study on GBV among female healthcare professionals in Northern Nigeria reported a high prevalence of 93.5%.[23] Findings from a similar study in Sierra Leone also had an estimated 62% prevalence.[24] This disparity could be due to the predominant age group among respondents in the studies above, as majority of participants in the studies were of an older age bracket (mean age of 28.69) compared to our study that had a mean age of 22.37±3.07. Older females would be more likely to have more experiences with GBV than the younger age group of females in our study.[25]Healthcare professionals also tend to be more enlightened about GBV and as such, share their experiences more.

Our study also found that male respondents experienced GBV slightly more than their female counterparts. Although this difference did not reach statistical significance, it suggests that men also experience high levels of GBV. A similar finding was reported in a 2023 study done in Abuja, Nigeria, which showed that various forms of physical, sexual and psychological abuse were experienced more by male undergraduates than females.[26]However, a study done among men and women in three Nigerian states showed that females respondents (15.1%) experienced GBV more than males (11.8%).[27]Such findings also discovered in a Somali study showed that 35.6% of women reported a greater adult lifetime experience of physical or sexual violence, when compared to 31.2% of male respondents who had been victimized as adults.[28] This results could stem from cultures in these regions that rationalize men's physical aggression towards women. As a result, most studies focus on violence perpetuated against girls and women, which is understandable as females are more vulnerable to gender inequalities and their effects.[18] The higher GBV prevalence among males in our study may be due to the structure and content of the survey instrument, which could influence participant responses. The deviation may also be due to underreporting in previous research due to factors such as societal expectations of male dominance, masculinity and cultural norms discouraging male emotional expression and patriarchy in the university setting. These factors may have discouraged male students from reporting their experiences and underplays the reality and extent of GBV that boys and men experience. While GBV is more commonly studied in women, emerging research highlights its impact on men and other under-recognized groups. Societal expectations of masculinity and cultural barriers may contribute to the invisibility of male and gender-diverse survivors.[29] Applying a gender-inclusive, intersectional lens is essential to understand these issues and ensure that support systems address the needs of all survivors.

We also found that psychological/emotional violence (18.6) was the most prevalent form of GBV encompassing threats, verbal abuse, and intimidation, among others. This was consistent with previous studies that also identified emotional violence was the commonest form of GBV.[22,23,30]A study in Northern Nigeria reported even higher rates of verbal and psychological abuse, which is often easier to commit through words gestures and psychological tactics.[20] Additionally, the Northern Nigerian penal code does not forbid domestic violence, but suggests that a man's assault on his wife is not a crime.[31]There is also reluctance by some Northern Nigerian states to adopt the Violence Against Person's Prohibition (VAPP) Act, which proscribes all forms of violence in both private and public settings.[32]

Married respondents had a higher prevalence of GBV compared to the unmarried at some point in their lives, though with less likelihood of experiencing GBV. Although these findings did not reach statistical significance, the observed trend was in keeping with a study in Northern Nigeria, where married women were more likely to experience violence than single women.[20]Another study done among males and females in 3 Nigerian states, showed that married females were more likely to experience physical violence than their single counterparts.[27]Global estimates also show that about 33% of African women have experienced Intimate Partner Violence, and about 38% of female murders were committed by their intimate partners.[33] According to the "Marital Power Theory", power imbalance in a marriage contributes to the perpetuation of such violence, and this might play a role.[34] In situations where one partner excessively controls the other partner, many aspects of the relationship, like communication, decision-making and overall relationship satisfaction, are affected. These problems lead to further abuse of power, resulting in emotional, physical and physical violence.[34]

Most respondents agreed that GBV has psychological, social and health implications such as stigma, depression, loss of esteem, contracting sexually transmitted diseases or infections, unwanted pregnancy, and abortion, among others. This finding underscores the reports in previous studies that GBV has a deleterious effect on student's academic performance.[35] It also negatively affects the victims' health, leading to fear, trauma, anxiety, and an increased risk of sexually transmitted infections including HIV/AIDS.[36]

We also found that the likelihood of experiencing GBV decreases slightly with increasing academic year, though this was not significant. The finding suggests that the relationship between academic factors and GBV is more complex than we might expect. While more school experiences accompanies increasing years and shape student's lives, it does not primarily influence GBV risk. A constellation of factors including like cultural attitudes, personal circumstances, and access to support services, might have a stronger influence. For example, in some environments, social norms, the presence of community resources, or support systems might be more important in preventing or addressing GBV. This study's finding that males experienced GBV more than females among has critical implications. It challenges entrenched gender stereotypes and suggests the need to develop inclusive policies and programs that support male victims. The data call for heightened awareness and education regarding male GBV, as well as providing tailored support services, including mental health care and legal assistance in the university community. Addressing cultural and social norms that hinder male undergraduate victims from reporting GBV is paramount. Ensuring the legal framework provides equal protection for all victims, regardless of gender, and fostering a culture of peer support and

bystander intervention can contribute significantly to a safer campus environment. These findings emphasize the importance of a holistic and inclusive approach to GBV, ensuring that all victims receive the necessary support and protection. The lack of statistical significance in our findings also underscores the need for further research with larger sample sizes to understand male GBV better and ensure robust, evidence-based interventions. These efforts could lead to more comprehensive and effective approaches to combat GBV across all demographics.

Limitations of the Study

This study has several limitations that should be considered when interpreting the findings. Firstly, the cross-sectional design limits our ability to infer causal relationships between demographic characteristics and experiences of gender-based violence (GBV). While associations were explored, temporal directionality cannot be established. In addition, although the questionnaire was adapted from prior tools and structured to capture various GBV forms, it was not formally validated in the Nigerian university context. This may affect the reliability and cultural sensitivity of the measures.

Self-reported responses may also have introduced recall bias, social desirability bias, and potential misclassification of GBV types. Some participants may have underreported or misclassified incidents due to stigma or uncertainty. Moreover, the absence of qualitative or open-ended questions limited our ability to explore the deeper context of these experiences, while the severity and duration of GBV incidents were not assessed, constraining the richness of the data.

Although stratified multi-stage sampling was employed, the analysis did not apply design-based adjustments, such as weighting or clustering corrections. This may have introduced bias in prevalence estimates and underestimated standard errors, which could compromise the accuracy of p-values and confidence intervals. Additionally, the chi-square tests and logistic regression models used were unadjusted and did not control for confounding variables such as alcohol use, prior trauma, place of residence, or socioeconomic background, which may have influenced both exposure and outcome.

Lastly, although informed consent was obtained and participation was voluntary, no structured psychological support or referral system was in place. This represents a limitation in participant protection, especially considering the sensitive and potentially distressing nature of the questions. Despite these limitations, the study contributes valuable insights into GBV patterns among university students and highlights areas for future research.

Conclusion

This study highlights the significant burden of GBV among university students in Nigeria. Addressing GBV requires targeted policies, increased awareness, and student support programs to foster a safer academic environment. Further research is necessary for generalization, considering the reported limitations. Future research should also include multiple universities to enhance generalizability and capture regional variations in GBV experiences.

The similar GBV prevalence among genders necessitates a comprehensive approach. To improve awareness and identification of GBV victims, the university should provide formal confidential GBV reporting mechanisms physically and online via the institution's existing website, including online reporting forms, email addresses, and phone numbers. Additionally, advertisements on the website, campus notice boards, and other physical

platforms can help raise awareness and encourage reporting of GBV incidents. This mass sensitization about GBV's prevalence, forms, patterns, and effects is essential for both the university community and the public. The university should enforce clear sanctions and penalties against GBV, such as suspension or expulsion for perpetrators, mandatory counseling and public apology in cases of proven abuse. These sanctions should be enforce by university administration, with clear guidelines for reporting and handling cases. Additionally, students and staff must be educated mandatorily to recognize GBV and report it to appropriate authorities, such as campus security, student affairs or designated faculty members.

Victims should be promptly identified, screened, and integrated into support programs within the school and community. Sexual violence victims should receive immediate screening for STIs and emergency contraception. Social support groups such as university counseling services, GBV support centers, peer support groups, women and men's advocacy groups, and help lines can provide safe spaces for sharing experiences and emotional support, advocate for policy changes, and work with authorities to address GBV's root causes. The study underscores the need to address social norms, power imbalances, and gender inequalities across all genders to prevent and respond to GBV effectively. A coordinated approach involving school authorities, governments, civil society organizations, and individuals is essential to eradicate GBV.

Summary

Gender-based violence (GBV) refers to harmful actions directed at individuals because of their gender. It encompasses a range of behaviors including physical assault, emotional abuse, and unwanted sexual attention or contact. Globally, GBV remains a serious concern, especially among young people, and is known to impact survivors' mental health, social relationships, academic performance, and long-term wellbeing. While many studies have focused primarily on violence against women and girls, GBV is a broader issue that can affect people of all genders. Unfortunately, limited research exists on how GBV affects university students in Nigeria, particularly studies that include both male and female perspectives. This knowledge gap can hinder efforts to design inclusive interventions and responsive support systems on campuses.

To help address this gap, we conducted a study at the University of Calabar in southern Nigeria to assess the prevalence of gender-based violence among undergraduate students and to explore their understanding of its consequences. The study involved 413 students across seven faculties, who were selected using a multi-stage sampling technique. Each participant completed a structured questionnaire asking about their experiences with different forms of GBV—physical, emotional, and sexual—as well as their knowledge of the possible outcomes of such experiences.

Our findings reveal that GBV is a significant concern among university students. About 19.4% of respondents reported having experienced at least one form of gender-based violence in their lifetime. The most common form was emotional violence, which includes behaviors such as insults, intimidation, or threats. This form of abuse was reported by nearly all students who experienced GBV, and it appeared more frequently than physical or sexual violence.

One notable aspect of our findings is that male students reported slightly higher rates of GBV than female students, although the difference was not statistically significant. This challenges the commonly held perception that gender-based violence is primarily a women's issue and underscores the importance of recognizing that GBV can affect people of all genders.

We also examined whether certain factors such as age, marital status, or academic year were associated with the likelihood of experiencing GBV. None of these factors showed a statistically significant association, suggesting that GBV cuts across demographic categories and may affect any student, regardless of background.

When asked about the consequences of gender-based violence, most students demonstrated a clear understanding of its impact. Respondents recognized that GBV can lead to psychological trauma, physical injuries, social isolation, and long-term emotional distress. This indicates that awareness of the issue is relatively high among students, even though formal mechanisms for addressing it may still be lacking within university settings.

The results of our study carry important implications for both policy and practice. First, they highlight the urgent need for university authorities to establish clear and accessible reporting structures for victims of GBV, including confidential support services and trained counselors. Second, there is a need for campus-wide education campaigns that do not focus solely on female students but include male students and other marginalized groups as well. Third, stronger institutional policies should be implemented to prevent and respond to all forms of GBV, especially those that are less visible, such as emotional and psychological abuse.

In conclusion, this study reinforces the reality that GBV is not limited to any single gender or demographic. It affects a significant number of university students and requires a comprehensive, inclusive response. By expanding our understanding and recognition of all forms of GBV, and by acknowledging that male students can also be affected, institutions can take meaningful steps toward creating safer, more supportive educational environments for everyone.

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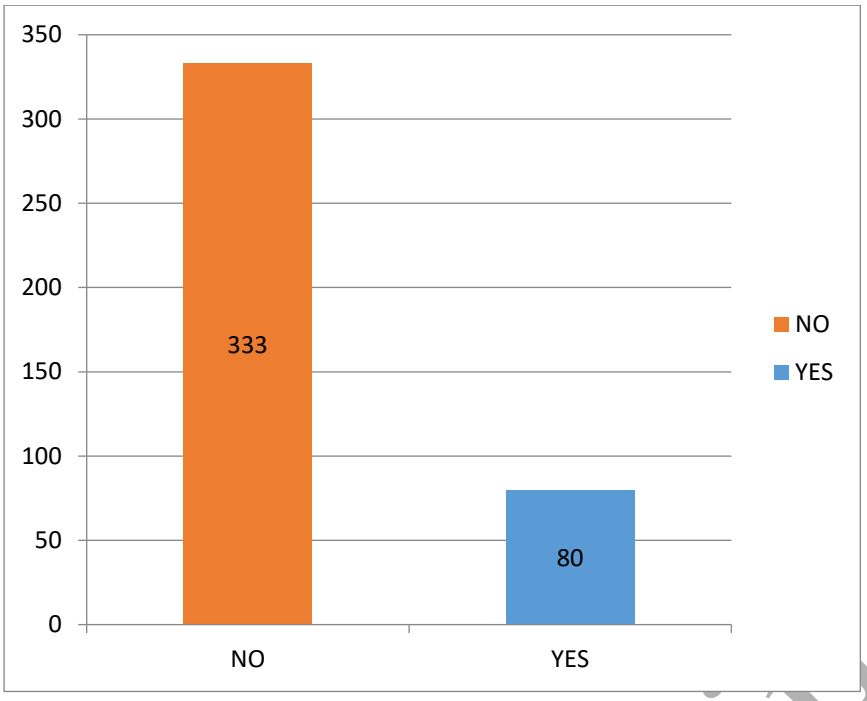
FIGURES AND TABLES.

Figure 1:Overall Prevalence of Gender-Based Violence



1 ***Table 1***:Socio-demographic characteristics of the respondents (n=413)

	Frequency	Percentage
Age group/years		
<21	103	24.9
21 and above	310	75.1
Mean age: 22.37±3.07		
Gender		
Male	208	50.4
Female	205	49.6
Marital status		
Single	306	74.1
Ever Married	107	25.9
Faculty		
Agriculture	58	14.0
Arts and Humanities	67	16.2
Basic Medical Science	52	12.6
Biological Sciences	63	15.3
Management Sciences	64	15.5
Clinical Sciences	42	10.2
Law	67	14.2
Academic Year		
100level	82	19.9
200level	84	20.3
300level	85	20.6
≥400level	162	39.2
Religion		
Christianity	405	97.8
Islam	2	0.5
Others	7	1.7

2

***Table 2**:* Frequency and Patterns of Gender-Based Violence

Variable	Frequency	Percentage (%)
Frequency of Occurrence		
Daily	11	13.8
Weekly	16	20
Two times weekly	13	16.3
Four times monthly	4	5
Monthly	36	45
Prevalent Patterns		
Physical	75	18.2
Emotional	77	18.6
Sexual	55	13.3

1 ***Table 3:*** Association between socio-demographic variables and prevalence of GBV

VARIABLE	GBV Yes	GBV No	CHI-SQUARE	P-VALUE
Age group (years)				
<21	18 (17.5%)	85 (82.5%)	0.32	0.57
21 – 30	62 (20%)	248 (80%)		
Gender				
Male	41 (19.7%)	167 (80.3%)	0.03	0.86
Female	39 (19%)	166 (81%)		
Marital Status				
Single	53 (17.3%)	253 (82.7%)	7.33	0.06
Ever Married	27 (25%)	80 (75%)		
Academic Year				
100 level	15 (18.3%)	67 (81.7%)	7.33	0.20
200 level	10 (11.9%)	74 (88.1%)		
300 level	16 (18.8%)	69 (81.2%)		
≥400 level	39 (24.1%)	123 (75.9%)		

- **GBV Yes**: Participants who reported experiencing gender-based violence.
- **GBV No**: Participants who did not report experiencing gender-based violence.
- **Pearson Chi-Square (unadjusted)**: Statistical test used to assess the association between the variables and the experience of GBV.

P-Value: Significance level of the Chi-Square test; values below 0.05 indicate a statistically significant association.

2

1 *Table 4:* Multivariate Regression for Factors Associated with GBV

2

Variable	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	p-value (Adjusted)
Age	0.98 (0.89 - 1.07)	0.95 (0.87 - 1.02)	0.19
Sex **(ref: Female)**	1.09 (0.66 - 1.81)	1.04 (0.64 - 1.70)	0.86
Marital Status **(ref: Unmarried)**	0.75 (0.43 - 1.30)	0.71 (0.42 - 1.23)	0.23
Academic Year	0.84 (0.68 - 1.04)	0.88 (0.68 - 1.13)	0.32

- **Unadjusted OR: Odds ratio for each variable without adjusting for other factors.**
- **Adjusted OR: Odds ratio for each variable after adjusting for age, sex, marital status, and academic year.**
- **95% CI: 95% Confidence interval for the odds ratio, indicating the range within which the true value of the odds ratio is likely to fall.**
- **P-value (Adjusted): Significance level of the adjusted odds ratio; values below 0.05 indicate a statistically significant relationship with the outcome.**

3