**International Journal of Medical Science and Health Research**

Vol.10, No.04; 2026

ISSN: 2581-3366

# Structural and Social Barriers to Accessing Survivor-Centered Post-violence Care Among Sex Workers in Abuja, Nigeria: A Mixed-methods Study

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doi: 10.51505/ijmshr.2026.10401 URL: http://dx.doi.org/10.51505/ijmshr.2026.10401

Received: May 21, 2026 Accepted: Jun 03, 2026 Online Published: July 06, 2026

**Abstract**

Gender-based violence (GBV) among sex workers represents a major public health and human rights crisis globally. Effective post-violence response systems are essential for reducing the physical, psychological, and social consequences of violence. However, marginalized populations such as sex workers frequently encounter substantial barriers when attempting to access healthcare, legal aid, psychosocial support, and shelter services. This study aimed to assess access to survivor-centered post-violence care and identify structural and social barriers affecting sex workers in Abuja, Nigeria. A comparative cross-sectional mixed-methods study was conducted among 455 sex workers operating in Gwagwalada, Bwari, and Abuja Municipal Area Council (AMAC). Participants were recruited using respondent-driven and venue-based sampling approaches. Qualitative data from focus group discussions revealed pervasive experiences of stigma, fear of arrest, institutional distrust, and concerns regarding confidentiality that discouraged help-seeking behaviors. Quantitative data were collected using structured questionnaires and analyzed using chi-square statistics and logistic regression, while qualitative data from focus group discussions were analyzed thematically. The findings revealed low utilization of post-violence response services. Approximately 67.3% of respondents reported receiving no support services following violence. Access to healthcare services was reported by only 12.1% of respondents, while psychological support (8.7%), legal aid (6.5%), and shelter services (5.4%) remained critically underutilized. Major barriers included healthcare provider stigma, fear of police harassment, criminalization of sex work, discriminatory shelter policies, and inadequate mental health services. Access to psychological support, legal aid, and shelter services significantly improved recovery outcomes ($p < 0.05$). The study demonstrates that institutional discrimination and structural violence significantly limit access to survivor-centered care among sex workers in Abuja. Strengthening trauma-informed healthcare, legal reforms,

peer-led interventions, and non-discriminatory shelter systems are essential to improve access to post-violence care for this vulnerable population.

**Keywords:** Gender-based violence, sex workers, post-violence care, healthcare access, Nigeria, structural barriers

## 1. Introduction

### *1.1 Global Perspectives on Gender-Based Violence*

Gender-based violence (GBV) remains one of the most pervasive violations of human rights and a major public health concern worldwide (World Health Organization [WHO], 2021). GBV encompasses physical, sexual, emotional, psychological, and economic violence directed against individuals based on gender norms, identities, and inequalities (United Nations Population Fund [UNFPA], 2020). Survivors of GBV frequently experience severe physical injuries, sexually transmitted infections (STIs), unwanted pregnancies, mental health disorders, social exclusion, and long-term socioeconomic instability (Deering et al., 2014).

Comprehensive survivor-centered post-violence care is critical for mitigating the immediate and long-term consequences of GBV. International guidelines recommend rapid access to emergency medical treatment, HIV post-exposure prophylaxis (PEP), emergency contraception, forensic examinations, psychological counseling, legal aid, and safe shelter services for survivors of violence (WHO, 2013).

### *1.2 Sex Workers and Disparities in Access to Post-Violence Care*

Despite global efforts to strengthen GBV response systems, access to post-violence care remains highly unequal, particularly among marginalized populations such as sex workers (Scorgie et al., 2013). Globally, sex workers face disproportionately high levels of physical and sexual violence due to criminalization, poverty, stigma, discrimination, and lack of legal protection (Shannon et al., 2015). Structural Violence Theory explains how institutionalized inequalities and discriminatory policies systematically expose marginalized groups to harm while limiting access to healthcare and justice systems (Farmer, 2004).

In sub-Saharan Africa, sex workers experience severe barriers to accessing healthcare and social support services. Studies conducted in several African countries have shown that healthcare providers frequently stigmatize sex workers, resulting in delayed healthcare-seeking behaviors and avoidance of formal institutions (Scorgie et al., 2013). Fear of arrest, police harassment, social discrimination, and breaches of confidentiality further discourage sex workers from reporting violence or accessing post-violence support services (Ochonye et al., 2023).

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*1.3 Institutional Responses to Gender-Based Violence in Nigeria*

Nigeria has established Sexual Assault Referral Centres (SARCs) and gender desks within police stations to improve survivor-centered responses to GBV (Nigeria Rights, 2023). However, the accessibility and effectiveness of these services remain inconsistent due to inadequate funding, shortages of trained personnel, weak referral systems, and reliance on donor support (Nigeria Rights, 2023). For sex workers, the criminalization of sex work further complicates access to institutional support systems, as survivors risk arrest or discrimination when seeking help from police or healthcare providers (Banyan Global, 2021).

Recent Nigerian studies have reported persistent challenges in the implementation of survivor-centered GBV services, including inadequate referral systems, provider stigma, weak coordination among service providers, and insufficient funding for support programs (Ochonye et al., 2023; Adebayo et al., 2024). Despite the establishment of Sexual Assault Referral Centres, access remains particularly limited among criminalized populations such as sex workers.

Healthcare provider bias represents a significant barrier to accessing post-violence care. Studies have documented instances where sex workers are denied medical treatment, verbally abused, blamed for violence, or treated disrespectfully within healthcare facilities (Scorgie et al., 2013). Such discrimination contributes to delayed treatment of injuries, untreated STIs, and increased psychological trauma.

Mental health services are also critically limited for survivors of violence in many low-resource settings. Survivors of GBV frequently experience depression, anxiety, post-traumatic stress disorder (PTSD), suicidal ideation, and substance abuse disorders (WHO, 2023). However, specialized trauma-informed mental health support remains scarce and inaccessible for highly marginalized populations such as sex workers (Scorgie et al., 2013).

*1.4 Emerging Trends in Technology-Facilitated Violence*

The emergence of technology-facilitated gender-based violence (TFGBV) has further increased the vulnerability of sex workers, particularly those operating through digital platforms. Cyberstalking, online harassment, blackmail, and non-consensual image sharing have become increasingly common forms of violence against women and sex workers globally (Brain Builders, 2023). These experiences contribute to severe psychological distress and social isolation.

Although technology-facilitated violence was not quantitatively assessed in the present study, several participants described experiences of online harassment, threats, and unauthorized sharing of personal information during focus group discussions, suggesting the need for future studies to investigate this emerging form of violence.

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### *1.5 Theoretical Underpinning: Structural Violence Theory*

Guided by Structural Violence Theory (Farmer, 2004), this study conceptualized structural barriers as institutional, legal, economic, and policy-related factors that limit access to survivor-centered services, while social barriers included stigma, discrimination, fear of disclosure, and negative community attitudes. These constructs informed the assessment of healthcare utilization, legal support seeking, psychological support utilization, and shelter access among sex workers in Abuja.

Structural Violence Theory provides a useful framework for understanding how social structures, laws, and institutional practices may systematically disadvantage marginalized populations and limit their access to healthcare, justice, and social protection services.

### *1.6 Study Rationale and Knowledge Gap*

Although previous studies have examined the prevalence of gender-based violence among sex workers in Nigeria, limited research has specifically explored barriers to accessing survivor-centered post-violence care among this population in Abuja. Understanding these barriers is essential for developing inclusive public health interventions, improving service utilization, and strengthening institutional responses to violence.

Therefore, this study aimed to assess access to post-violence response services and identify structural and social barriers affecting sex workers in Abuja, Nigeria.

## 2. Methods

### *2.1 Study Design*

A comparative cross-sectional mixed-methods study was conducted among sex workers operating in Abuja, Nigeria.

### *2.2 Study Area*

The study was conducted in Gwagwalada, Bwari, and Abuja Municipal Area Council (AMAC) within the Federal Capital Territory (FCT), Nigeria.

### *2.3 Study Population, Inclusion and Exclusion Criteria*

#### 2.3.1 Study Population

The study population consisted of sex workers who reported experiencing physical, sexual, or emotional violence within the preceding 12 months.

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2.3.2 Inclusion Criteria

- Female sex workers aged 18 years and above.
- Reported experiencing physical, sexual, or emotional violence within the previous 12 months.
- Resided or worked within AMAC, Bwari, or Gwagwalada.
- Provided informed consent.

2.3.3 Exclusion Criteria

- Individuals younger than 18 years.
- Those unable to provide informed consent.
- Participants who declined participation or provided incomplete responses.

*2.4 Sample Size and Sampling Technique*

The minimum sample size was determined using Cochran's formula for estimating a single population proportion:

$n = Z^2 p(1-p)/d^2$

Where:

• n = required sample size

• Z = standard normal deviate corresponding to 95% confidence level (1.96)

• p = estimated prevalence of GBV among sex workers. Since no recent prevalence estimate specific to Abuja was available, p = 0.50 was used to maximize sample size.

• d = margin of error (0.05)

Substituting the values:

$n = (1.96)^2 \times 0.50 \times (1-0.50)/(0.05)^2$

$n = 384.16$

Therefore, the minimum sample size was 384 participants. After adjusting for a 15% non-response rate, the final minimum sample size became 442 participants. A total of 455 participants were eventually recruited and included in the analysis.

A combination of venue-based sampling and respondent-driven sampling (RDS) was used. Initial participants ("seeds") were identified through community-based organizations working with sex workers. Participants subsequently referred eligible peers within their networks until the required sample size was achieved. This approach was considered appropriate due to the hidden and stigmatized nature of the study population.

*2.5 Data Collection and Measurement of Variables*

2.5.1 Data Collection

Quantitative data were collected using structured interviewer-administered questionnaires assessing:

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- Utilization of healthcare services;
- Access to psychological support;
- Legal aid utilization;
- Shelter services utilization;
- Perceived barriers to accessing care.

Qualitative data were collected through six focus group discussions (FGDs), each comprising 8–10 participants. Discussions were facilitated by trained researchers using a semi-structured guide exploring experiences of violence, healthcare access, legal support, shelter utilization, stigma, and institutional barriers. Interviews were audio-recorded, transcribed verbatim, and analyzed using Braun and Clarke's thematic analysis framework.

2.5.2 Measurement of Variables

Access to survivor-centered care was measured using self-reported utilization of healthcare services, legal aid, psychological support, and shelter services following experiences of violence. Structural and social barriers were assessed using a series of Likert-scale and binary-response questions examining experiences of stigma, fear of arrest, confidentiality concerns, financial constraints, discrimination, and institutional trust.

*2.6 Data Analysis*

Data were analyzed using SPSS version 23.0. Descriptive statistics, chi-square tests, and logistic regression analyses were performed. Statistical significance was set at $p < 0.05$. Multivariable logistic regression models were adjusted for age, education level, duration of sex work, and geographical location to minimize confounding effects and identify independent predictors of access to survivor-centered services.

*2.7 Ethical Approval*

Ethical approval for this study was obtained from the Research Ethics Committee of the Federal Medical Centre, Abuja, Nigeria prior to the commencement of data collection. Permission to conduct the study was also obtained from relevant local authorities and community gatekeepers within the selected study areas. Written informed consent was obtained from all participants after providing detailed information regarding the study objectives, procedures, potential risks, benefits, and their rights as research participants. Participation was entirely voluntary, and respondents were informed that they could decline participation or withdraw from the study at any time without any consequences. To protect confidentiality and anonymity, no personal identifiers were collected, and all responses were coded using unique identification numbers. Interviews and focus group discussions were conducted in private and secure locations to minimize the risk of disclosure and social harm. Audio recordings and study records were stored securely and accessed only by authorized members of the research team.

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Given the sensitive nature of gender-based violence and sex work, trained research assistants conducted interviews using trauma-informed approaches to minimize participant distress. Participants who disclosed severe psychological distress or experiences requiring support were provided with information and referrals to appropriate health, counseling, and psychosocial support services available within the study area.

## 3. Results

### *3.1 Utilization of Post-Violence Response Services*

A total of 455 subjects took part in this study. Table 1 presents the utilization of post-violence response services among respondents. Most respondents (67.3%) reported receiving no support services following violent assaults. Table 1 presents the utilization of post-violence response services among respondents. Most participants (67.3%) reported receiving no support services following violent incidents. Access to healthcare services was reported by 12.1% of respondents, while psychological support (8.7%), legal aid (6.5%), and shelter services (5.4%) were less frequently utilized. Logistic regression analysis showed that utilization of psychological support (OR = 2.50; 95% CI: 1.24–5.01; p = 0.010), legal aid services (OR = 2.90; 95% CI: 1.33–6.32; p = 0.008), and shelter services (OR = 2.70; 95% CI: 1.20–6.08; p = 0.015) was significantly associated with improved recovery outcomes. Healthcare service utilization showed a positive but non-significant association (OR = 1.80; 95% CI: 0.94–3.46; p = 0.078).

Table 1. Utilization of post-violence response services among respondents (n = 455)

| Service Accessed | Frequency (n) | Percentage (%) | OR | 95% CI | p-value |
|---|---|---|---|---|---|
| Healthcare services | 55 | 12.1 | 1.80 | 0.94–3.46 | 0.078 |
| Psychological support | 40 | 8.7 | 2.50 | 1.24–5.01 | 0.010* |
| Legal aid services | 30 | 6.5 | 2.90 | 1.33–6.32 | 0.008* |
| Shelter services | 25 | 5.4 | 2.70 | 1.20–6.08 | 0.015* |
| No support services | 305 | 67.3 | — | — | — |

Key: OR = Odds Ratio; CI = Confidence Interval.
Odds ratios compare participants who accessed each service with those who did not access that specific service.

*Statistically significant at $p < 0.05$.

### *3.2 Structural and Institutional Barriers to Care*

The qualitative findings revealed multiple barriers limiting access to survivor-centered care among respondents. Figure 1 presents the major barriers reported by respondents, including fear of police harassment and arrest (76%), stigma from healthcare providers (68%), discrimination

within shelters (61%), fear of public exposure (58%), lack of mental health services (53%), financial constraints (49%), and distrust of institutions (44%).

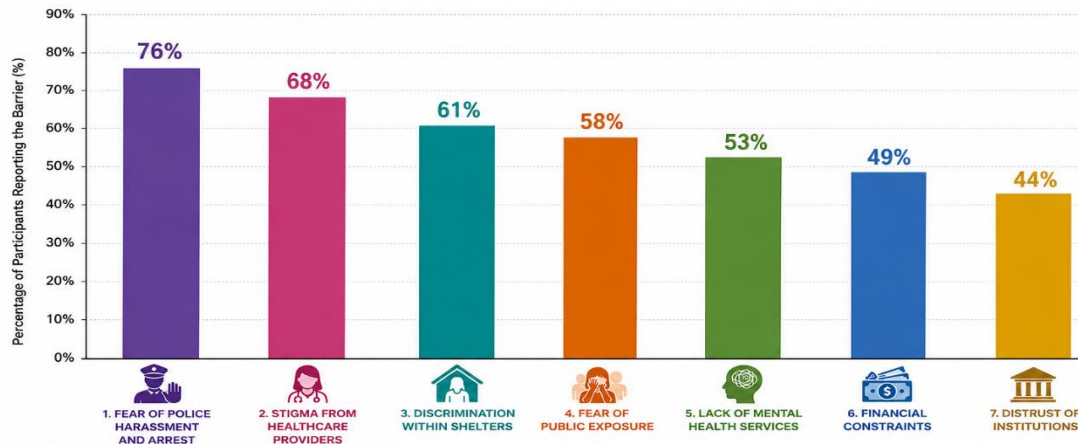


Figure 1: Major barriers limiting access to survivor-centered post-violence care

Representative participant statements included:
*"If I go to the police after violence, they may arrest me instead of helping me."* (FGD Participant, AMAC)
*"Healthcare workers often judge us before listening to our problems."* (FGD Participant, Bwari)
*"Many shelters do not accept sex workers, so most of us have nowhere safe to go."* (FGD Participant, Gwagwalada)

*3.3 Healthcare Provider Discrimination*

Table 2 shows that many respondents experienced significant challenges while seeking healthcare services. Fear of discrimination (68.6%) and delayed healthcare-seeking behavior (65.5%) were the most commonly reported experiences, followed closely by negative attitudes from healthcare workers (63.1%). More than half of the respondents (55.2%) also expressed fear of breaches of confidentiality, suggesting that stigma, poor provider attitudes, and concerns about privacy may substantially hinder access to timely and appropriate healthcare services.

Table 2. Respondents' experiences within healthcare facilities

| Experience Reported | Frequency | Percentage (%) |
|---|---|---|
| Fear of discrimination | 312 | 68.6 |
| Negative attitudes from healthcare workers | 287 | 63.1 |
| Fear of confidentiality breaches | 251 | 55.2 |
| Delayed healthcare-seeking behavior | 298 | 65.5 |

### *3.4 Legal and Law Enforcement Barriers*

Table 3 shows that legal and law enforcement-related barriers were highly prevalent among respondents. Distrust of police protection was the most frequently reported barrier (74.9%), followed by fear of arrest (70.3%) and fear of police extortion (65.1%). In addition, 61.1% of respondents reported fear of retaliation, indicating that insecurity, mistrust of legal institutions, and fear of abuse may significantly discourage affected individuals from seeking justice, protection, and support services.

Table 3. Legal and law enforcement barriers

| Barrier | Frequency | Percentage (%) |
|---|---|---|
| Fear of arrest | 320 | 70.3 |
| Fear of police extortion | 296 | 65.1 |
| Distrust of police protection | 341 | 74.9 |
| Fear of retaliation | 278 | 61.1 |

### *3.5 Mental Health and Shelter Service Challenges*

Figure 2 depicts the utilization of mental health and shelter services among the respondents. There was a very low utilization of psychological and shelter support services. Only 8.7% of participants reported receiving psychological support, while 5.4% accessed shelter services, whereas the overwhelming majority (91.3%) reported having no mental health support at all. These findings suggest major gaps in access to psychosocial and protective services.

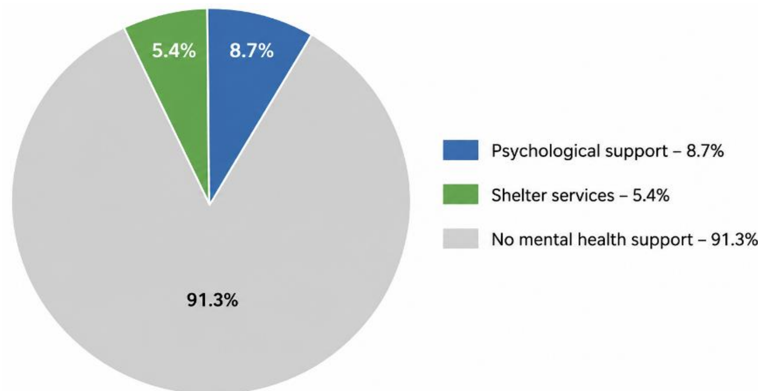


Figure 2. Utilization of mental health and shelter services by respondents

## 4. Discussion

The present study revealed critically low utilization of survivor-centered post-violence care services among sex workers in Abuja, Nigeria. Despite the extremely high burden of violence documented among this population, the majority of respondents did not access healthcare, legal aid, psychological support, or shelter services following violent incidents. These findings

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highlight profound structural and institutional barriers limiting access to care among highly marginalized populations.

Healthcare services represented the most commonly utilized support system; however, access remained extremely low at only 12.1%. This finding is particularly concerning given the severe physical and sexual violence experienced by respondents. Immediate access to emergency healthcare following sexual violence is essential for HIV prevention, STI management, emergency contraception, and treatment of physical injuries (WHO, 2013). Delayed or absent healthcare access substantially increases long-term morbidity among survivors of violence.

Healthcare provider stigma emerged as one of the major barriers to accessing care in this study. Respondents reported fear of judgment, discrimination, and disrespectful treatment within healthcare facilities. Similar findings have been documented in studies conducted among sex workers in South Africa, Kenya, and Nigeria, where healthcare providers frequently displayed stigmatizing attitudes toward sex workers (Scorgie et al., 2013). Such experiences discourage healthcare-seeking behaviors and contribute to untreated health conditions among survivors.

Fear of police harassment and arrest also significantly discouraged respondents from seeking legal support or reporting violence. Criminalization of sex work creates an environment in which survivors fear becoming targets of arrest rather than recipients of protection (Ochonye et al., 2023). This finding supports structural violence theory, which explains how institutionalized inequalities systematically exclude marginalized populations from justice and protection systems (Farmer, 2004).

The low utilization of legal aid services observed in this study further demonstrates the limited accessibility of formal justice systems among sex workers. Respondents frequently expressed distrust toward police and legal institutions due to previous experiences of extortion, intimidation, and victim-blaming. Similar studies conducted in sub-Saharan Africa have shown that criminalized populations often avoid formal legal systems because of fear of secondary victimization (Deering et al., 2014).

Psychological support services were also severely underutilized despite high levels of emotional trauma among respondents. Survivors of GBV commonly experience depression, anxiety, PTSD, and suicidal ideation, requiring trauma-informed mental healthcare interventions (WHO, 2023). However, mental health services remain highly inaccessible in many low-resource settings, particularly for marginalized groups such as sex workers. The significant association between psychological support and improved recovery outcomes observed in this study underscores the importance of expanding accessible mental health services.

Shelter services were similarly inaccessible to most respondents. Many participants reported that available shelters maintained discriminatory policies against sex workers or required conditions

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incompatible with their realities. Lack of safe accommodation forces survivors to return to unsafe environments where they remain vulnerable to repeated violence and exploitation.

Technology-facilitated gender-based violence has also become an emerging concern among sex workers operating online. Cyberstalking, blackmail, online harassment, and non-consensual dissemination of intimate images contribute substantially to psychological distress and social vulnerability (Brain Builders, 2023). Digital safety interventions should therefore be integrated into broader GBV response frameworks.

Overall, the findings demonstrate that post-violence care systems in Abuja remain structurally inaccessible to sex workers due to criminalization, institutional stigma, and inadequate survivor-centered services. Policy makers should therefore expand trauma-informed healthcare training for healthcare workers serving key populations. Law enforcement agencies should establish confidential reporting mechanisms and strengthen accountability systems to reduce harassment of sex workers. Government and civil society organizations should increase funding for community-based mental health services and establish non-discriminatory shelters accessible to all survivors regardless of occupation. Peer navigator programs should be integrated into GBV response systems to facilitate referral, follow-up, and service utilization among sex workers.

## 5. Conflict of Interest

The authors declare no conflict of interest.

## 6. Study Limitations

Several limitations should be considered when interpreting the findings. First, the cross-sectional design limits causal inference between identified barriers and service utilization. Second, self-reported information may be affected by recall bias and social desirability bias. Third, because participants were recruited through venue-based and respondent-driven approaches, findings may not be fully generalizable to all sex workers in Nigeria. Finally, some experiences discussed during focus group discussions may have been influenced by group dynamics. Despite these limitations, the mixed-methods design provided valuable quantitative and qualitative insights into barriers affecting access to survivor-centered post-violence care.

## Acknowledgements

The authors sincerely appreciate all study participants, field assistants, and institutions that supported the conduct of this study.

**References**

Adebayo, O., Bello, M., & Yusuf, H. (2024). Barriers to accessing gender-based violence services among vulnerable women in Nigeria. *BMC Women's Health*, 24(1), 118.

Amnesty International. (2023). *Human Rights Violations Against Sex Workers in Africa*.

Banyan Global. (2021). *USAID Nigeria gender analysis report*. USAID. https://banyanglobal.com

Brain Builders. (2023). *Technology-facilitated gender-based violence in Nigeria: Mapping harms, gaps, and pathways to justice*. Brain Builders Youth Development Initiative.

Connell, R. (2012). Gender, health and theory: Conceptualizing the issue, in local and world perspective. *Social Science & Medicine, 74*(11), 1675–1683. https://doi.org/10.1016/j.socscimed.2011.06.006

Deering, K. N., Amin, A., Shoveller, J., Nesbitt, A., Garcia-Moreno, C., Duff, P., & Shannon, K. (2014). A systematic review of the correlates of violence against sex workers. *American Journal of Public Health, 104*(5), e42–e54. https://doi.org/10.2105/AJPH.2014.301909

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology, 45*(3), 305–325. https://doi.org/10.1086/382250

Henry, N., & Powell, A. (2018). Technology-facilitated sexual violence. *Violence Against Women, 24*(11), 1280–1300. https://doi.org/10.1177/1077801217725726

Nigeria Rights. (2023). *Sexual and gender-based violence report*. Nigeria Rights Organization.

Ochonye, B. B., Abiodun, P. O., Sanni, F. O., Olufunke, T., Alamu, T. A., & Ogbonna, N. (2023). Gender-based violence against female sex workers in Nigeria: How helpful are grassroots interventions? *International Journal of Occupational Safety and Health, 13*(3), 313–320. https://doi.org/10.3126/ijosh.v13i3.52291

Scorgie, F., Nakato, D., Harper, E., Richter, M., Maseko, S., Nare, P., & Chersich, M. (2013). Sex workers' experiences of accessing healthcare in Africa. *Culture, Health & Sexuality, 15*(4), 450–465. https://doi.org/10.1080/13691058.2012.763187

Shannon, K., Strathdee, S. A., Goldenberg, S. M., Duff, P., Mwangi, P., Rusakova, M., & Boily, M. C. (2015). Global epidemiology of HIV among female sex workers. *The Lancet, 385*(9962), 55–71. https://doi.org/10.1016/S0140-6736(14)60931-4

UN Women. (2023). *Empowering rural women and communities to end gender-based violence in Nigeria*. UN Trust Fund to End Violence against Women.

UN Women. (2024). *Gender-Based Violence Services and Access in West Africa*.

UNAIDS. (2021). *Global AIDS update 2021*. UNAIDS. https://www.unaids.org

UNAIDS. (2024). *Addressing Violence Against Key Populations*. Geneva: UNAIDS.

UNFPA. (2020). *Gender-based violence in emergencies*. United Nations Population Fund. https://www.unfpa.org

United Nations Development Programme (UNDP). (2021). *Human development report*. UNDP. https://hdr.undp.org

WHO. (2024). *Violence Against Women: Global Progress Report*. Geneva: World Health Organization.

World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women*. WHO. https://www.who.int

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World Health Organization. (2021). *Violence against women prevalence estimates*. WHO. https://www.who.int/publications/i/item/9789240022256

World Health Organization. (2022). *Understanding and addressing violence against women*. WHO. https://www.who.int

World Health Organization. (2023). *Mental health and gender-based violence*. WHO. https://www.who.int

World Health Organization. (2023). *Violence against women*. WHO. https://www.who.int/news-room/fact-sheets/detail/violence-against-women