

Understanding Gender-Based Violence in Primary Health Care Settings: Knowledge and Socioeconomic Inequalities Among Women of Reproductive Age in Osun State, Nigeria

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Abstract:

➤ *Background:*

Gender-based violence (GBV) remains a significant public health and human rights concern globally, with profound consequences for women's physical, mental, and social well-being. In Nigeria, entrenched socio-cultural norms and gender inequalities continue to influence both the occurrence and perception of GBV. Primary health care (PHC) settings provide a critical platform for identifying and addressing GBV; however, gaps persist in women's understanding of its various forms. This study examined knowledge of GBV and explored socioeconomic inequalities in its recognition among women attending PHC facilities in Osun State, Nigeria.

➤ *Methods:*

A cross-sectional study was conducted among 126 women of reproductive age attending six PHC facilities across two local government areas. Data were collected using structured questionnaires administered via KoboCollect, capturing socio-demographic characteristics and knowledge of GBV, including physical, sexual, economic, and emotional violence. Data were analyzed using SPSS version 25, employing descriptive statistics and chi-square tests to assess associations by age and income.

➤ *Results:*

Awareness of commonly recognized forms of GBV was high, with most respondents correctly identifying physical (88.10%), sexual (87.30%), and economic violence (89.68%). In contrast, recognition of emotional or psychological violence was markedly low (7.94%). No statistically significant associations were found between income or age and GBV knowledge ($p > 0.05$), although respondents aged 25–34 years demonstrated relatively higher knowledge levels.

➤ *Conclusion:*

Despite high awareness of visible forms of GBV, substantial gaps remain in recognizing less overt forms such as emotional abuse. These findings underscore the need for comprehensive, PHC-based educational interventions to improve holistic understanding and strengthen GBV prevention and response.

Keywords: Gender-Based Violence, Primary Health Care, Knowledge, Socioeconomic Inequalities, Women, Nigeria.

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I. INTRODUCTION

Gender-based violence (GBV) is a pervasive global public health and human rights concern that affects women across all regions and socioeconomic contexts. It encompasses a wide range of harmful acts, including physical, sexual, emotional, and economic abuse, all of which have profound consequences for women's physical health, mental well-being, and social functioning (Sardinha et al., 2022). Globally, an estimated one in three women experience physical and/or sexual violence in their lifetime, with the overall burden of GBV likely higher when less visible forms such as emotional and economic abuse are considered (Li et al., 2023; Sardinha et al., 2024). While physical and sexual violence often attract greater attention due to their visible and immediate consequences, non-physical forms of violence are frequently normalized, under-recognized, and underreported, despite their significant and long-term health implications (Adinma et al., 2019).

In Nigeria, GBV remains widespread and deeply embedded within socio-cultural systems characterized by patriarchal norms, gender inequality, and cultural tolerance of violence against women. These structural and cultural factors not only sustain the occurrence of GBV but also shape how it is perceived and interpreted by women themselves (Silva et al., 2023; Okonofua et al., 2024). Evidence suggests that although awareness of GBV has increased through media, advocacy, and policy interventions, such awareness is often limited in scope, focusing primarily on overt forms such as physical assault and rape, while less visible forms, particularly emotional and economic abuse are frequently overlooked or normalized (Nduka et al., 2023). This narrow understanding contributes to low recognition of abuse, delayed help-seeking, and continued exposure to harmful relationships.

Primary health care (PHC) systems provide a critical platform for addressing GBV, as they are often the first point of contact for women seeking reproductive, maternal, and general health services. Ideally, PHC settings offer opportunities for early identification, support, and referral of GBV cases. However, existing evidence indicates that GBV is often missed, inadequately documented, and insufficiently managed within these settings, due to both health system limitations and gaps in women's understanding of what constitutes violence (Ogunlade et al., 2022; Montesanti et al., 2023). The ability of women to recognize different forms of GBV is particularly important, as recognition is a key first step in disclosure, help-seeking, and access to appropriate care.

Socioeconomic and demographic factors including age, income, and education, may further influence how women perceive and interpret GBV. Women with greater access to education, information, and social resources may be more likely to recognize and challenge abusive behaviours, whereas those with fewer resources may normalize or misinterpret such experiences (Arisukwu et al., 2021; Olalude et al., 2024). However, empirical evidence on socioeconomic

inequalities in GBV knowledge remains mixed, highlighting the need for context-specific investigations.

In Osun State, prevailing socio-cultural norms that reinforce male dominance, alongside limited awareness of women's rights, continue to shape both the occurrence and perception of GBV. Studies within the state have highlighted the normalization of violence and persistent negative attitudes toward GBV, particularly in rural communities, underscoring the need for targeted awareness and behavioural change interventions (Idowu et al., 2023; Yusuf et al., 2024). Despite growing attention to GBV in Nigeria, there remains limited empirical evidence on how women in PHC settings understand the full spectrum of GBV, particularly in relation to less visible forms of abuse.

Therefore, this study examines the level of knowledge of different forms of GBV and explores socioeconomic inequalities in its recognition among women of reproductive age attending PHC facilities in Osun State, Nigeria. By identifying gaps in awareness especially regarding emotional and psychological violence the study seeks to inform more comprehensive, context-specific, and equitable strategies for GBV prevention, identification, and response within primary health care systems.

II. METHODOLOGY

➤ *Study Design*

This study employed a cross-sectional design to assess knowledge of GBV among women of reproductive age attending primary health care facilities. The study was conducted in six PHC facilities located in two local government areas of Osun State, Southwestern Nigeria. The PHCs are Oja Timi Primary Health Centre, Oke-Gada Primary Health Centre, Owode Primary Health Centre (Ede North LGA) and Akinorun MDG, Emiloju Primary Health Centre, Olonde Primary Health Centre (Ifelodun LGA).

➤ *Study Population and Eligibility*

The study population comprised women of reproductive age attending the selected PHC facilities. They include women attending antenatal, postnatal, child-welfare, and family-planning clinics, as well as other outpatient female clients. Besides the women who were linked to the selected PHCs, the inclusion criteria also included women resident in Ifelodun and Ede North LGAs for at least six months. However, girls and women who were unable and unwilling to provide informed consent were excluded from the study.

➤ *Sample Size and Sampling*

A sample size of 126 women was determined based on the standard statistical method for comparing two independent proportions, with allowance for non-response. The participants were selected using systematic sampling of attendees on the clinic registers.

➤ *Data Collection*

Interviews were conducted by trained female research assistants using structured questionnaires administered to

participants with the help of the KoboCollect app. The questionnaire captured the Socio-demographic characteristics (age, education, income, ethnicity, occupation) and the knowledge of GBV, including recognition of physical violence, sexual violence, economic violence and early marriage. The interviews were conducted in a secluded section of the health facilities to maintain the confidentiality of the information. The variables to be measured are the outcome variable (Knowledge of GBV measured through correct identification of different forms of violence) and the Independent Variables (Age group, and income level).

➤ *Data Analysis*

Data was entered and analysed using SPSS v25. Data were analysed using descriptive statistics, including frequencies, percentages, means, and standard deviations. Knowledge variables were disaggregated by age group (15–24, 25–34, ≥35 years), income level (low, middle, high), and ethnicity to assess patterns and inequalities.

➤ *Ethical Considerations*

Ethical approval for this study was obtained from the Adeleke University Ethics Review Committee (Reference number: AUERC/2026/33PH/012), the Osun State Primary Health Care Development Board (Reference number: DPRS/ETHA/2026/02/11), and the Osun State Ministry of Health (Protocol number: OSHREC/PRS/2026/842/01/042). All procedures were conducted in accordance with established ethical standards for research involving human participants. Informed consent was obtained from all respondents prior to participation, with clear explanations provided regarding the purpose of the study, voluntary

participation, and the right to withdraw at any time without consequences. Confidentiality and anonymity were strictly maintained by excluding personal identifiers and securely handling all data. Given the sensitive nature of gender-based violence, interviews were conducted in a private and safe environment, and participants were treated with respect and sensitivity.

III. RESULTS

Table 1 describes the sociodemographic characteristics of the respondents. The analysis of educational attainment revealed that the majority had completed secondary education (77 participants, 61.11%), followed by those with a university degree (43 participants, 34.13%). Only a small proportion had informal education (2 participants, 1.59%), primary education (3 participants, 2.38%), or a master's degree (1 participant, 0.79%), indicating that the study population was generally well-educated. Participants reported diverse occupations, with the largest proportion engaged in trading (50 participants, 39.68%), followed by fashion designing (23 participants, 18.25%) and hairdressing (18 participants, 14.29%). Other occupations included teaching (8 participants, 6.35%), business (6 participants, 4.76%), nursing (5 participants, 3.97%), as well as small numbers in other fields such as community health work, chemistry, computer operations, catering, interior decoration, laboratory science, and employment at Adeleke University. Overall, the demographic profile indicates that the participants were well-educated, and primarily involved in trading or informal/creative occupations.

Table 1 Sociodemographic Characteristics of the Respondents

Variable	Frequency (n)	Percentage (%)
Educational level		
Informal Education	2	1.59
Primary	3	2.38
Secondary	77	61.11
Degree	43	34.13
Masters	1	0.79
Occupation		
Business	6	4.76
CHEW	2	1.59
Catering and Baking	1	0.79
Chemist	2	1.59
Civil servant	1	0.79
Computer operator	2	1.59
Fashion Designer	23	18.25
Hairdresser	18	14.29
Interior decorations	1	0.79
Lab scientist	1	0.79
Nurse	5	3.97
Self employed	1	0.79
Staff of Adeleke University	1	0.79
Student	1	0.79
Teacher	8	6.35
Trader	50	39.68
Unemployed	2	1.59
Wine trading	1	0.79

Table 2 shows that the age of participants ranges from 16 to 46 years. The mean age of the participants was 29.21 years (SD = 6.42), indicating that the majority of respondents were young adults. Monthly income among participants varied widely, ranging from ₦0 to ₦500,000, with an average

of N84,277.78 (SD = 10,192). This wide standard deviation and range suggest considerable variability in participants' economic status, with some participants earning very little while others reported relatively high monthly income.

Table 2 Summary Statistics of Participants' Age and Monthly Income

Variable	Obs	Mean	Std. Dev.	Min	Max
Age (in years)	126	29.20635	6.417872	16	46
Monthly Income (in Naira)	126	84277.78	10192.1	0	500000

In table 3 below, participants were categorized into three age groups to examine the distribution across life stages. The majority were adults aged 25–34 years (76 participants, 60.32%), followed by young participants aged 15–24 years (27 participants, 21.43%), and a smaller proportion were older participants aged 35 years and above (23 participants, 18.25%).

Analysis of income groups showed that most participants had a low to middle income. Specifically, 56 participants (44.44%) fell into the low-income category (₦0–₦49,000), 50 participants (39.68%) were in the middle-income category (₦50,000–₦149,000), while 20 participants (15.87%) reported high income (₦150,000 and above). This indicates that a significant proportion of participants were young adults with limited to moderate financial resources.

Table 3 Distribution of Respondents by Age and Income Group

Variable Name	Frequency (n)	Percentage (%)
Age Group		
Young (15–24)	27	21.43
Adult (25–34)	76	60.32
Older (35+)	23	18.25
Income group		
Low (0-49000)	56	44.44
Middle (50000-149000)	50	39.68
High (150000+)	20	15.87

Table 4 presents respondents' overall knowledge of gender-based violence (GBV). A large majority of respondents correctly identified hitting or slapping a woman by her partner as a form of GBV, with 111 (88.10%) responding "Yes," while 15 (11.90%) responded "No." Similarly, 110 (87.30%) of respondents identified forced sexual intercourse by a partner as GBV, while 16 (12.70%) did not recognize it as such.

However, knowledge of emotional or psychological violence was relatively low. Only 10 (7.94%) respondents correctly identified insulting, belittling, or humiliating a woman in private or in public as GBV, while the vast majority, 116 (92.06%), did not recognize it as a form of GBV.

In addition, 113 (89.68%) respondents correctly identified denying a woman money or basic needs as a form of GBV, whereas 13 (10.31%) responded "No." These findings indicate a high level of awareness of physical, sexual, and economic forms of GBV among participants.

Overall, while respondents demonstrated strong knowledge of physical, sexual, and economic forms of GBV, awareness of emotional or psychological abuse was notably low. This suggests the need for continued community education to address remaining knowledge gaps and reinforce comprehensive understanding of all forms of GBV.

Table 4 Knowledge of Gender-Based Violence (GBV) Among Respondents

Variable	Yes	No
Hitting or slapping a woman by her partner is a form of GBV.	111(88.10%)	15 (11.90%)
Forced sexual intercourse by a partner is a form of GBV.	110 (87.30%)	16 (12.7%)
Denying a woman money or basic needs is a form of GBV	113 (89.68%)	13 (10.31%)
A partner insulting and belittling/humiliating a woman in private, and even in front of other people is a form of GBV.	10 (7.94%)	116 (92.06%)

Table 5 presents respondents' knowledge of different forms of Gender-Based Violence (GBV) disaggregated by income group. Overall, the findings indicate a relatively high level of awareness across all income categories, with only minor variations between low-, middle-, and high-income respondents.

For the statement that hitting or slapping a woman by her partner is a form of GBV, the majority of respondents across all income groups correctly identified it as GBV, with responses fairly evenly distributed across low-, middle-, and high-income groups. However, a smaller proportion of respondents across the groups did not recognize it as GBV.

The association between income level and knowledge of physical violence was not statistically significant ($\chi^2 = 0.5449$, $p = 0.762$), indicating that income does not significantly influence awareness of this form of GBV.

Similarly, for forced sexual intercourse by a partner as a form of GBV, most respondents across income categories demonstrated correct knowledge. Although slight variations were observed in response distribution across income groups, the differences were not statistically significant ($\chi^2 = 2.1169$, $p = 0.347$). This suggests that awareness of sexual violence within intimate relationships is relatively consistent regardless of income level.

In relation to denying a woman money or basic needs as a form of GBV, a substantial proportion of respondents across all income groups also correctly identified this as a form of economic violence. The observed differences across income groups were minimal and not statistically significant ($\chi^2 = 1.2368$, $p = 0.539$), indicating that income level does not significantly affect recognition of economic abuse as GBV.

For emotional and psychological abuse, specifically insulting, belittling, or humiliating a woman in private or public, most respondents across income categories also demonstrated good knowledge. The distribution of responses again showed no meaningful variation by income level, and the relationship was not statistically significant ($\chi^2 = 0.5757$, $p = 0.750$).

In summary, the findings from Table 5 reveal that knowledge of different forms of GBV is relatively high and evenly distributed across income groups. The lack of statistically significant associations across all indicators suggests that income level is not a determining factor in respondents' understanding of GBV. This implies that awareness of GBV in the study population may be influenced more by other socio-demographic or contextual factors such as education, exposure to sensitization campaigns, or media access rather than income status alone.

Table 5 Knowledge of GBV by Income Group

Variable	No			Yes			Pearson chi2 (2)	Pr
	Low (0 - 49,000)	Middle (50,000 - 149,000)	High (>150,000)	Low (0 - 49,000)	Middle (50,000 - 149,000)	High (>150,000)		
Hitting or slapping a woman by her partner is a form of GBV.	8 (53.33%)	5 (33.3%)	2 (13.33%)	48 (43.24%)	45 (40.54%)	18 (16.22%)	0.5449	0.762
Forced sexual intercourse by a partner is a form of GBV.	5 (31.25%)	9 (56.25%)	2 (12.50%)	51 (46.36%)	41 (37.27%)	18 (16.36%)	2.1169	0.347
Denying a woman money or basic needs is a form of GBV	4 (30.77%)	6 (46.15%)	3 (23.08%)	52 (46.02%)	44 (38.94%)	17 (15.04%)	1.2368	0.539
A partner insulting and belittling/humiliating a woman in private, and even in front of other people is a form of GBV.	52 (44.83%)	45 (38.79%)	19 (16.38%)	4 (40.00%)	5 (50.00%)	1 (10.00%)	0.5757	0.750

Table 6 presents the association between respondents' age group and their knowledge of different forms of gender-based violence (GBV). Overall, the findings indicate that knowledge of GBV was relatively high across all age groups, particularly among adults aged 25–34 years.

For the item assessing whether hitting or slapping a woman by her partner constitutes GBV, a greater proportion of respondents who answered “Yes” were adults (25–34 years) (63.96%), followed by older adults (>35 years) (17.12%) and young respondents (15–24 years) (18.92%). Although the association between age group and responses was not statistically significant at the 0.05 level, it was close to significance, $\chi^2(2) = 5.4562$, $p = .065$. This suggests a marginal association between age and knowledge.

Similarly, for forced sexual intercourse by a partner as a form of GBV, adults (25–34 years) again constituted the highest proportion of correct responses (61.82%), followed

by older adults (19.09%) and young respondents (19.09%). The association between age group and responses was not statistically significant, $\chi^2(2) = 2.8649$, $p = .239$.

Regarding denial of a woman's access to money or basic needs as GBV, adults accounted for 61.95% of correct responses, while young and older respondents accounted for 19.47% and 18.58%, respectively. This relationship was also not statistically significant, $\chi^2(2) = 2.5100$, $p = .285$.

For emotional abuse, defined as insulting, belittling, or humiliating a woman, adults (25–34 years) again recorded the highest proportion of “Yes” responses (61.21%), followed by young respondents (19.83%) and older adults (18.97%). However, the association was not statistically significant, $\chi^2(2) = 2.3454$, $p = .310$.

Overall, although adults (25–34 years) consistently demonstrated higher levels of correct identification of GBV

across all indicators, none of the associations between age group and knowledge of GBV were statistically significant ($p > .05$). However, the result for physical violence (hitting or

slapping a woman) was not statistically significant at the 0.05 level but was close to significance, suggesting a marginal association between age and knowledge.

Table 6 Knowledge of GBV by Age Group

Variable	No			Yes			Pearson chi2 (2)	Pr
	Young (15 - 24)	Adult (25 - 34)	Older (>35)	Young (15 - 24)	Adult (25 - 34)	Older (>35)		
Hitting or slapping a woman by her partner is a form of GBV.	6 (0.00%)	5 (33.33%)	4 (26.67%)	21 (18.92%)	71 (63.96%)	19 (17.12%)	5.4562	0.065
Forced sexual intercourse by a partner is a form of GBV.	5 (37.50%)	8(50.00%)	2 (12.5%)	21 (19.09%)	68 (61.82%)	21(19.09%)	2.8649	0.239
Denying a woman money or basic needs is a form of GBV	5 (38.46%)	6 (46.15%)	2 (15.38%)	22 (19.47%)	70 (61.95%)	21(18.58%)	2.5100	0.285
A partner insulting and belittling/humiliating a woman in private, and even in front of other people is a form of GBV.	23 (19.83%)	71 (61.21%)	22(18.97%)	4 (40.00%)	5 (50.00%)	1 (10.00%)	2.3454	0.310

IV. DISCUSSION

This study examined knowledge of gender-based violence (GBV) and socioeconomic inequalities among women attending primary health care (PHC) facilities in Osun State, Nigeria. The findings reveal a clear pattern: while awareness of physical, sexual, and economic violence is high, recognition of emotional or psychological violence is markedly low. In addition, no statistically significant differences were observed across income or age groups, suggesting that knowledge of GBV is relatively uniform across these socioeconomic strata.

The high level of awareness of physical and sexual violence observed in this study is consistent with existing literature from Nigeria and other low- and middle-income settings (Decker et al., 2015; Sulaiman et al., 2021; Gunarathne et al., 2023; Maduakolam et al., 2023; ; Ngini et al., 2025). Fawole et al. (2019) reported similarly high awareness of sexual and physical violence among Nigerian medical students. This pattern likely reflects the strong emphasis placed on visible and severe forms of violence such including physical assault and rape in public discourse, legal frameworks, and media coverage (Silva et al., 2023; Lengel et al., 2023; Ezeaka and Bartholomew, 2025). These forms of violence are more easily identifiable due to their immediate and observable consequences, which enhances public recognition.

In contrast, the extremely low recognition of emotional or psychological violence observed in this study reinforces evidence that non-physical forms of abuse remain largely “hidden” and under-recognized (Postmus et al., 2020; Penttinen, 2023; Doolabh et al., 2022). Previous studies in Nigeria and similar contexts have reported similarly low awareness of emotional abuse, highlighting its normalization within intimate relationships (Adebayo et al., 2021; Tesfaw & Muluneh, 2022; Olatunji et al., 2023). Behaviours such as

humiliation, insults, and controlling actions are often embedded in everyday social interactions and shaped by entrenched patriarchal norms, making them less likely to be perceived as violence. This suggests that while awareness campaigns have improved recognition of overt forms of GBV, they have been less effective in addressing more subtle, yet equally harmful, forms. Consequently, many women may fail to identify emotional abuse as a violation, limiting help-seeking and perpetuating exposure to harm.

Another important finding is the absence of statistically significant differences in GBV knowledge across income groups. While some studies suggest that socioeconomic status influences awareness, the present findings indicate that knowledge of GBV may not be strongly differentiated by income in this setting. This could reflect broader dissemination of GBV-related information through media, community sensitization, and health services, making such knowledge more widely accessible. It is also plausible that PHC facilities function as equalizing platforms, where women from diverse socioeconomic backgrounds are exposed to similar health information and messaging. This supports existing evidence that PHC serves as a critical entry point for GBV education and response, providing standardized opportunities for awareness across populations (Montesanti et al., 2023; Bacchus et al., 2023; Pereira et al., 2024).

Similarly, although women aged 25–34 years demonstrated relatively higher levels of knowledge, the lack of statistically significant differences across age groups suggests that GBV awareness may be relatively consistent across generations. This contrasts with studies indicating higher awareness among older individuals due to accumulated life experiences (Ntoimo et al., 2025). However, the current finding may reflect increasing exposure to GBV-related information among younger populations, driven by

formal education, social media, and advocacy initiatives (Mtaita et al., 2021; Silva et al., 2023).

Importantly, the coexistence of high awareness of visible forms of GBV and poor recognition of less visible forms highlights a critical gap in the depth of understanding. While GBV is widely defined to include physical, sexual, emotional, and economic abuse, awareness that is limited to only the most visible forms may prevent survivors from recognizing their experiences as violence. This has significant implications for help-seeking, reporting, and access to care, particularly within PHC settings where early identification and intervention are essential.

Overall, this study contributes to growing evidence that although awareness of GBV is increasing, it remains incomplete and uneven. Addressing this gap requires not only expanding knowledge but also challenging the social norms and belief systems that normalize and sustain less visible forms of violence. Strengthening GBV education within PHC systems and communities is therefore essential to promote a more comprehensive understanding of GBV and improve prevention and response efforts.

V. CONCLUSION

This study highlights a critical gap between awareness and comprehensive understanding of gender-based violence (GBV) among women attending primary health care (PHC) facilities in Osun State, Nigeria. While recognition of physical, sexual, and economic violence is widespread, emotional and psychological abuse remains largely unrecognized, revealing a narrow conceptualization of GBV. Notably, the absence of significant socioeconomic differences suggests that this gap is not confined to specific population groups but reflects a broader limitation in how GBV is understood across society. These findings underscore that increasing awareness alone is insufficient; what is required is a shift toward deeper, more nuanced GBV literacy that captures the full spectrum of violence. Without this shift, efforts to improve reporting, help-seeking, and service provision will continue to overlook less visible but equally harmful forms of abuse. Strengthening GBV response within PHC systems therefore requires not only expanding access to information but transforming the social and cognitive frameworks through which violence is recognized and acted upon.

RECOMMENDATION FOR POLICY MAKING AND IMPLEMENTATION

The findings of this study have important implications for policy and practice. First, comprehensive GBV education should be integrated into routine PHC services, with explicit emphasis on emotional and psychological abuse. Capacity building for PHC providers is essential to improve screening, identification, and referral for all forms of GBV. Second, public awareness campaigns should be reframed to address less visible forms of violence and challenge their normalization. Third, community-based interventions engaging traditional, religious, and grassroots structures

should be strengthened to shift harmful gender norms. Multi-sectoral collaboration across health, legal, and social services must be enhanced to ensure coordinated and survivor-centred responses. Finally, national and sub-national policies should prioritize GBV literacy, incorporating measures that assess not only awareness but depth of understanding, to support more effective prevention and response strategies.

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