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Assessment of Prevalence, Response and Prevention of Gender-Based Violence (GBV) in Enugu State, Nigeria

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Abstract

Gender based Violence is a dire socio-economic scourge, especially in developing societies. Due to the culture of silence and other factors, the recorded statistics within these nations are less than the actual prevalence. This study adopts the mixed research method to interrogate the effectiveness of subnational government initiatives in prevention and response to gender-based violence (GBV) in Enugu State, Nigeria. The findings are based on 133 certified copies of returned questionnaires, while the interviews were conducted until saturation. The study found, among others, that gender based violence is prevalent in Enugu state. In terms of sub-national government initiatives, the study revealed that underfunding and a shortage of staff undermined the efforts of the Legal Aid Council and the state ministry of justice towards addressing GBV cases. The data revealed that the state partners with NGO's such as Women's Rights Advancement and Protection Alternative (WRAPA), etc. However, it fails to cover the needs of physically challenged persons; similarly, most rural residents do not access state-based services against GBV. The state requires a dedicated budget line for GBV prevention that will enable it to establish more Sexual Assault Referral Centres (SARCs) and shelters across the state, especially within the rural areas. There is also a need to train law enforcement agencies and health workers, engage traditional and religious leaders and other stakeholders towards formulating a comprehensive policy and implementing collaborative efforts in combating the dire challenges of GBV.

Keywords: Gender, Violence, Sub-national, Governance, Non-Governmental organizations, Women

Introduction

In developed societies, some women are intentionally avoiding marriage, while in developing societies, women are increasingly getting divorced owing to one incident of violence or another. Violence can be broadly categorized into three types, depending on who has committed the violence: interpersonal, self-directed, and collective violence (Krug et al., 2002). Ordinarily, violence is an undesirable circumstance to society, a group or an individual; it is felt at any given time or space. Actions such as self-mutilation and suicidal thoughts or actions are forms of self-directed violence. The instrumental use of violence against a set of persons or a group by another group who identify themselves as different, to achieve political, economic or social objectives, is known as collective violence. For instance, acts of terrorism, gang warfare, genocide and the systematic abuse of human rights occurred between the Hutus and Tutsi in Rwanda (Accomazzo, 2012). The last typology of violence, interpersonal violence, relates closely to gender based violence. This form of violence occurs between individuals. This form of violence occurs between individuals who know one another, such as in cases of intimate partner violence, or abuse of elderly or child family members. Sexual assault, which might happen between individuals who are unknown to each other or strangers, is also a form of interpersonal violence (WHO, 2002).

Gender based violence, also known as GBV, is seen as violence committed against someone based on their gender identity, gender expression or perceived gender (Cotter & Savage, 2019). Similarly, it is argued that gender based violence implies violence directed against a person because of that person's gender (including gender identity/expression). Although the United Nations (1993) took a narrow feminine perspective, stating that such an act constitutes violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. The view is limited by suggesting that gender based violence is violence against women; it has to be noted that men could also be victims. Bouta et al (2005) acknowledged that GBV could be meted out on both men and women, and described it as a home and communal physical, sexual, and psychological abuse frequently committed. However, the frequencies with which GBV occur

affects women more than men. It is worth mentioning that in most developing societies, such as Nigeria, because of their position in society, the male gender is frequently associated with being the perpetrators of GBV *(Berlinda Majola et al, 2023).*

Globally, one in three women experiences GBV in her lifetime (World Health Organization, WHO 2021). In Nigeria, cultural norms, poverty, and systemic weaknesses exacerbate GBV prevalence (Amnesty International, 2022). Reports suggest that there has been an improvement in the availability of data on violence against women and girls considerably in recent years, and the data on the prevalence of intimate partner violence (an aspect of GBV) is now available for at least 161 countries (UN Women, 2021). It is estimated that about 736 million women worldwide have experienced physical and/or sexual violence, or both. Similarly, 1 in 3 women globally have experienced violence in their lifetime; 45,000 women and girls worldwide were killed by their intimate partners or their family members in 2021 (WHO, 2021). The prevalence of gender based violence within the African continent is simply alarming. For instance, in Sub-Saharan Africa, 1 in 4 women and girls have undergone female genital mutilation. Levels of female genital mutilation vary widely across countries. The data from Nigeria is rather very alarming, 27,698 cases of sexual and gender-based violence were recorded in five states and the FCT between 2020 and 2023 (Opara, 2023). In addition, 1,145 fatal GBV cases were reported, with 393 perpetrators convicted. 35% of women in Nigeria experience intimate partner violence at some point in their lives, and 31% of women in Nigeria have experienced physical violence from age 15, mostly by intimate partners. Approximately 20 million survivors of GBV exist in Nigeria, accounting for 10% of the global total (Human Rights Agency, 2025). While specific data on Southeast Nigeria is not readily available, Enugu State, which is part of the Southeast region, has reported that - 89.9% of GBV victims were women, 51.4% of cases were in the age group 20-39 years, and sexual abuse accounted for 56.8% of GBV cases (Opara, 2023).

As the negative impacts of gender-based violence on victims, families, and society become more widely acknowledged the world over, Nigeria and countries globally are taking several measures to address this growing problem (Kowalczyk et al., 2015). Nigeria's government enacted the Violence against Persons Prohibition Act (VAPP) in 2015 to combat gender-based violence, which is considered a crucial step in protecting women and

vulnerable populations (Ikuteyijo et al., 2024). Enugu State domesticated the VAPP Law in 2019, established a GBV Response Unit under the Ministry of Gender Affairs, launched a 24-hour GBV hotline, and conducted periodic awareness campaigns in schools, markets, and religious institutions. Partnerships with NGOs have supported psychosocial counselling, legal aid, and community sensitization programs. However, despite these interventions, GBV prevalence remains a concern, and gaps in service accessibility and effectiveness persist. Previous studies on GBV in Nigeria often focus on national trends, with limited empirical evidence assessing subnational program effectiveness. This gap limits evidence-based improvements in state-level interventions. Enugu State, despite progressive policies, continues to record significant GBV cases, raising questions about the actual impact of its initiatives.

Contextual Review: Sub-National Governments and GBV, Prevention and Response

This section reviews relevant issues relating to sub-national groups on GBV in the context of the extant literature. The role of Sub-national agencies cannot be overemphasized. For instance, sub-national (regional, state, provincial, municipal/local) governments are pivotal actors in preventing and responding to gender-based violence (GBV). Because they are closer to communities than national authorities, sub-national bodies often hold primary responsibilities for service delivery, community mobilization, and local regulatory implementation - making them crucial for translating national policy into accessible, culturally-appropriate action (UN Women, 2015). Such agencies include Non-Governmental Organizations (NGO's), Community-Based organizations (CBOs), Faith-based organizations and the local government, etc. Notably, local governments typically manage or coordinate front-line services: primary health clinics, referral networks, psychosocial counselling, emergency shelters, and local legal clinics. Because survivors first seek assistance locally, strengthening these services at the sub-national level directly affects access, quality, and timeliness of care. Manuals and program guidance for government ministries emphasize equipping sub-national units to deliver and monitor essential services (Institute for Research and Democratic Development, IREDD, 2022)

Moreover, effective GBV response requires coordination across health, justice, social protection, and civil society. Sub-national actors convene and sustain Local/State GBV coordination mechanisms (referral pathways, case management systems, crisis response teams), which are essential to avoid fragmented or duplicative services and to ensure survivor-centered care. Humanitarian guidance and UN/NGO frameworks stress that local coordination saves lives and improves case outcomes (UN Women, 2019). On specificity, to accomplish these goals effectively, the local government are expected to design, fund, and implement targeted prevention activities—focusing on school curricula, community dialogues, media campaigns, and men/boys engagement—tailored to local norms and languages. Sub-national authorities can leverage proximity to traditional and religious leaders to shift norms that condone GBV. Evidence shows that locally adapted prevention (e.g., school programs, community mobilization) reduces acceptance of violence and changes behaviours over time (Ezenwosu & Uzochukwu, 2025). Not only local government, but municipal and state units are often first to collect GBV incident data (clinic records, police reports, case management databases). Sub-national monitoring enables timely surveillance, identifies service gaps, and produces local indicators for performance management—critical for evidence-based program adjustments. International guidance calls for strengthening local data systems and routine reporting (UN/Human Rights, 2017).

On the other hand, humanitarian and development actors document that when local governments institutionalize multi-sectorial coordination and allocate budgets to shelters, hotlines, and health training, reporting and survivor access improve. UN/NGO handbooks and manuals show improved outcomes where sub-national GBV coordination is functional (IREDD, 2022). In addition, country-level and county/city-level case studies (e.g., county GBV service gap analyses in Kenya; local government initiatives described by UCLG networks) show that municipal-led school programs and community dialogues reduce acceptance of intimate-partner violence and increase help-seeking (Ezenwosu & Uzochukwu, 2025).

However, there are certain common constraints that are debilitating against sub-national level intervention. For instance, under-resourcing and weak financing pipelines. Many local governments lack dedicated budgets for GBV services; national transfers or donor funding

can be irregular and unsustainable. Decentralized financing without earmarked GBV funds often result in under-funded shelters, insufficient staff, and gaps in training (Banyan Global, 2024). Besides, most sub-national agencies lack institutional capacity and are often constrained by fatigue. Local units may lack trained personnel (clinical management of rape, case managers, prosecution support), and multi-sector committees can be poorly staffed or dependent on NGOs—limiting continuity when external partners exit. Guidance documents emphasize capacity strengthening at sub-national levels. (UN,Women, 2019). Undoubtedly, obnoxious cultural practices stand very significantly as a constraint. To illustrate, local norms—patriarchal attitudes, stigma, and reliance on informal dispute resolution, can inhibit reporting and uptake of formal services. In some contexts, political sensitivities at the sub-national level lead to reluctance in enforcing laws that are perceived as contradicting customary practices (UN/Women, 2017; Onota & Nkata, 2025). Additionally, inconsistent local reporting, non-standardized indicators, and the absence of interoperable case management systems make it hard to track outcomes and hold local authorities accountable. International agencies call for standardized local data collection and routine monitoring (UN,Human Rights, 2017).

Meanwhile, International studies (UN, Women, 2020) demonstrate that localized GBV strategies enhance responsiveness when backed by adequate resources. In Nigeria, subnational programs in Lagos and Ekiti States have improved survivor reporting rates and prosecution outcomes (Adeleke et al., 2021). However, in many states, service gaps, cultural stigma, and underfunding persist (Okoli & Nwankwo, 2022). No comprehensive peer-reviewed study has yet assessed Enugu State's GBV initiative effectiveness. State-level initiatives such as domesticating Violence-Against-Persons legislation, establishing GBV hotlines, and creating school-based anti-GBV clubs - have been documented in Nigerian states (including policy briefs and civil society reports from Enugu), and are associated with increased awareness and reporting where implementation is consistent. However, lack of knowledge regarding peer-reviewed evidence from Enugu and comparable states highlights persistent gaps in shelters, forensic services, and prosecution capacities, which hamper overall effectiveness. Consequently, this study is aimed at assessing the

effectiveness of subnational government initiatives in the prevention and response to gender-based violence (GBV) in Enugu State, Nigeria.

Methods

The study adopted the qualitative design. This design was adopted because it enabled the researchers to explore the depth and complexity of GBV-related issues from the context of victims, potential victims, and service providers in Enugu State, Southeast Nigeria. Enugu state is made up of 17 local governments, while the major Enugu city is within Enugu North and South local governments. The state serves as host to the Nigerian premier University, the University of Nigeria in Nsukka. Enugu is the capital of old eastern Nigeria, with most colonial and independent cultural relics. The study population is based on the estimated population of Enugu State, 4,690,100 (City population, 2016). The study engaged a strata of the population comparison of the Ministry of Women and gender affairs staff, Local government desk officers of the Ministry, executives of women-led NGO's, community-based women and their leaders, and women-led faith-based organizations.

Figure 1: Map of Enugu State, Source: Researchers.

The study adopted the multi-stage sampling technique. First, Enugu was purposively selected. The selection of Enugu state is based on the fact that the state serves as a gateway to Southeast Nigeria. If most if the GBV sub-national interventions are mainstreamed in Enugu, there is a likelihood that other states would follow suit, and vice versa. The researchers then stratified the population into an occupational framework comprising Government agencies, civil societies and faith-based organizations. The lead author initiated recruitment using word-of-mouth to reach the respondents (O'Brien. Harris, Beckman, Reed, & Cook, 2014). He first visited the locations to survey the environments and introduce the study to potential participants through a convenience sampling technique (Atkinson, R. and Flint, 2001). After formal introductions, he introduced the study to them and asked if they would be willing to participate. The process facilitated the recruitment of initial participants through the snowball method (Ghaljaie, Naderifar and Goli, 2017). The first group of participants then encouraged others to participate. Inclusion criteria include working within the selected professional category and being a woman. All currently residing within the Enugu State, Nigeria, and 18 years and above. The researchers conducted a total of thirty-four in-depth interviews with the assistance of seven research assistants.

For the purpose of data collection, the structured questionnaire was used for quantitative data collection, while the interviews were conducted using a semi-structured key informant guide. The instrument was pre-tested, and necessary adjustments were made before it was used for final data collection. The interviews were conducted between February and July 2024, lasting between 20 and 50 minutes for each interview (aged 18 and above). We conducted the interviews using the English language, though some questions were explained in Igbo and Pidgin English for effective comprehension of the issue. The researchers moderated the interview while the assistants took notes and digitally recorded the procedure using a voice recorder with permission from the participants. The researchers preserved the anonymity of the respondents by using pseudonyms instead of their real names. And the data was collected until saturation. The data was analyzed manually through thematic analysis. The audio recordings were

transcribed verbatim, read many times, and cross-checked for accuracy. The relevant themes were generated and presented together with the qualitative findings.

Findings

The findings are presented in two sections: the socio-demographic characteristics of respondents and the substantive issue.

Section A: Socio-demographics

Table 1: Socio-Demographic Characteristics of Respondents

Category	**Response**	**Frequency**	**Percentage**
Gender	Male	58	43.6%
	Female	75	56.4%
	Total	**133**	**100**
Area	Urban	86	64.7%
	Rural	47	35.3%
	Total	**133**	**100**
Age group	18-30	47	35.3%
	31 -45	53	39.8%
	46 - 60	27	20.3%
	60÷	6	4.5%
	Total	**133**	**100**
Disability Status	Yes	8	6.0%
	No	125	94.0%
	Total	**133**	**100**
Religiosity	Christianity	89	66.9%
	Islam	13	9.8%
	Traditional worship	9	6.8%
	Others	23	17.3%
	Total	**133**	**100**

Source: Field Survey 2025

Table one shows that a majority of the respondents 75(56.4%), were male. In terms of residential area, majority of the respondents 86(64.7%) reside in urban area. With regards to age category the table shows that a majority of the respondents 53(39.8%) were between the age of 31 – 45 and lastly in terms of disability status most of the respondents 125(94.0%). In terms of religiosity the table revealed that a majority of the respondents are Christians (66.0%). It could be inferred that perhaps due to women are more mostly at the receiving end of GBV they participated more in the study.

Section B: Substantive Issues

This section is categorized into five thematic relevant which includes, GBV context, laws and policies, access to legal justice, support services and information and awareness.

a) GBV prevelence

Table 2: GDV Experience

Category	Response	Frequency	Percentage
Experienced GBV in last 5 years	Yes	78	58.6%
	No	55	41.4%
Forms of GBV Experienced	Domestic/IPV	31	39.7%
	Sexual violence	15	19.2%
	Mental/emotional	43	53.8%
	Physical/violence	29	37.2%
	Economic violence	18	23.1%
	Harmful traditional practices	12	15.4%
Location of GBV Experience	Home	46	59.0%
	School	10	12.8%
	Workplace	17	21.8%
	Religious institution	3	3.8%
	Public place	21	26.9%

	Others	5	6.44%

Source: Field Survey 2025

The composite table shows that in terms of GBV experience a majority of the respondents (58.6%) have experienced GBV. Mental and emotional GBV were recorded most (53.8%). In terms of location, GBV occurred the table shows that a majority of the respondents (59.0%) said it occurred at home. The qualitative data aligned with the quantitative data as the interviewee acknowledged that the prevalence of GBV were recorded at different Sexual Assault Referral Centers within the state, warning that the figures does not represent the actual situation as most incidents are not reported. A study participant stated thus: the rate at which the incidence of GBV occurs in most families is very alarming, the previous year we recorded about (327) incidences and these data does not represent the actual figure as culture of silence hinders some victims from coming up to report.

The study further interrogated the help seeking options mostly available within the study area. The findings are presented in table 3.

Table 3: Help seeking on GBV

Category	Response	Frequency	Percentage
First Place to Seek Help	Police/law enforcement	14	17.9%
	Family/relatives	46	59.0%
	Friends/neighbors	31	39.7%
	Employer/work colleague	5	6.4%
	Lawyer	2	2.6%
	Religious leader	19	24.4%
	Traditional leader	9	11.5%
	Did not seek help	17	21.8%
Reason for Seeking Help	Proximity/accessibility	38	48.7%
	Trust	57	73.1%

	Services	9	11.5%
	Perception they could help	42	53.8%
	Financial constraint	19	24.4%

Source: Field Survey 2025

The table shows that in terms of first place they seek GBV help, (59.0%) seek help from their families and the reason for seeking help from family is because of trusted (73.1%). However, the qualitative data found that the available referral centers are grossly inadequate and mostly situated in the urban areas making it inaccessible for victims of GBV within the rural area. This implies that inaccessibility of the centers to most of the survivors disposes them towards seeking support from their family.

Furthermore, the study examined the extent laws and policies and this is presented in table 4.

b) Laws and policies

Table 4: Law and Policies

Category	**Response**	**Frequency**	**Percentage**
Aware of GBV laws/policies	Yes	41	30.8%
	No	92	69.2%
Formal laws effective	Yes	18	13.5%
	No	83	62.4%
	Not Sure	32	24.1%
Know someone convicted of GBV	Yes	12	9.0%
	No	121	91.0%
Aware of customary/religious laws	Yes	69	51.9%
	No	64	48.1%
Customary laws help prevent GBV	Yes	37	27.8%
	No	96	72.2%

Source: Field Survey 2025

The table shows that a majority of the respondents (69.2%) were not aware of GBV laws/policies. On the contrary the qualitative data revealed that the State had domesticated Violence against Persons Prohibition (VAPP) Act in 20202. The qualitative data also revealed that a majority of the respondents (91.0%) do not know someone ever convicted of GBV. This finding was corroborated by the qualitative which suggested "despite having these laws, implementation remains a major challenge" This implies that though there are GBV laws most of the respondents are not aware of such laws and their implementation.

One of the crucial aspect of GBV is the level of access to legal justice system, this is important especially due to mass poverty among many Nigerian women the study interrogated this factor in table 5.

c) Access to Legal Justice

Table 5 Legal Justice

Category	Response	Frequency	Percentage
Where would seek justice	Formal justice	42	31.6%
	Informal justice	79	59.4%
	Would not seek justice	12	9.0%
Aware of legal assistance	Yes	26	19.5%
	No	107	80.5%
Feel safe as witness	Yes	31	23.1%
	No	64	48.1%
	Not sure	28	21.1%
	Depends on protection	10	7.5%
Informal justice helps victims	Yes	52	39.1%
	No	41	30.8%
	Not sure	40	30.1%

Source: Field Survey 2025

The table shows that a majority of respondents (59.4%) said they would seek justice from informal justice. Majority (80.5%) were not aware of legal assistance. The quantitative finding is not in tandem with the qualitative data. From the interview, it was found that legal services from Legal Aid council and the Ministry of justice exist to assist such persons on pro bono basis. Although such services were found not to be accessible to all due to 'understaffing'. Perhaps the inaccessibility of such services disposes victims into seeking informal justice's services as was recorded by a majority of the respondents (39.1%).

Additionally, the study examined the available support services within the state. The findings are presented in table 6.

d) Support services

Table 6 Support Services

Category	Response	Frequency	Percentage
Know of SARCs/Shelters	Yes	19	14.3%
	No	114	85.7%
Aware of support services	Yes	37	27.8%
	No	96	72.2%
Aware of referral pathways (hospitals)	Yes	43	32.3%
Aware of referral pathways (Police)	Yes	51	38.3%
Aware of referral pathways (Support group)	Yes	17	12.8%
Aware of referral pathways (Legal representative)	Yes	9	6.8%
Aware of referral pathways (None)	Yes	61	45.9%
Informal better than formal	Yes	86	64.7%
	No	21	15.8%
	Not Sure	26	19.5%
SARCs functional and equipped	Strongly agree	5	3.8%
	Agree	11	8.3%

	Indifferent	21	15.8%
	Disagree	14	10.5%
	Strongly disagree	9	6.8%
	No response	73	54.9%

Source: Field Survey 2025

The table shows that a majority of the respondents (85.7%) do not know of SARCs. While the qualitative data shows that support centers are actually three within the state. The data further revealed that the centers are grossly inadequate for the state. The qualitative data equally also revealed that none of the centers has provision for physically challenged persons.

The researchers probed the information and awareness on GBV available within the study area. The findings are presented in table 7.

e) Information and Awareness

Table 7 Awareness

Category	**Response**	**Frequency**	**Percentage**
Know of GBV awareness programs	Yes	43	32.3%
	No	69	51.9%
	Not sure	21	15.8%
Usefulness of programs	Not useful	7	5.3%
	A little bit useful	19	14.3%
	Mostly useful	12	9.0%
	Completely useful	5	3.8%
	No response	90	67.7%
GBV Education in schools	Yes	117	88.0%
	No	16	**12.0%**

Source: Field Survey 2025

The table shows a majority of the respondents (51%) said they did not know of GBV awareness; also (67.7%) of the respondents did respondent on usefulness of awareness of

programs while a majority of the respondents (88.0%) said they were aware of GBV educational programs in schools. The quantitative data corroborated with the qualitative data as the interviewee stated that agencies do visits schools creating awareness on the issue although issues relating to GBV is not mainstreamed in school curriculum coupled with the fact that most schools might not be willing to implement the GBV protocols.

Lastly, the study examined the category of accessible services to GBV victims within the study area. The findings are presented in table 8.

Table 8. Accessible Materials

Category	Response	Frequency	Percentage
Accessible Materials	Audio/spoken	14	10.5%
	Braille printed	4	3.0%
	Visual content	18	13.5%
	Screen subtitling	5	3.8%
	Sign interpretation	9	6.8%
	Picture-based	15	11.3%
	Simplified messages	17	12.8%
	None	89	66.9%

Source: Field Survey 2025

The table shows that a majority of the respondents (66.9%) said they do not have access to any material. From the qualitative data revealed that agencies deploy radio jingles in English and native language, posters and pamphlets to create awareness information and education.

Discussion of Findings

The study's findings reveal a multi-dimensional set of challenges undermining the effectiveness of Enugu State's subnational initiatives for preventing and responding to Gender-Based Violence (GBV). Despite the domestication of the Violence against Persons Prohibition (VAPP) Act in 2019, the establishment of a GBV Response Unit, and

partnerships with non-governmental organizations (NGOs), the high prevalence rate—58.6% of respondents reporting GBV experiences in the past five years—indicates persistent systemic weaknesses. This outcome is consistent with earlier research noting that while progressive GBV legislation exists in Nigerian states, weak enforcement and resource limitations hinder its impact (Okoli & Nwankwo, 2022). Mental and emotional abuse (53.8%) emerged as the most prevalent form of GBV, with most incidents occurring within the home (59.0%). This reflects findings from Berlinda Majola et al. (2023) that domestic settings often serve as primary sites for intimate partner violence, reinforced by patriarchal norms and a culture of silence. Underreporting, as highlighted in this study, mirrors Opara's (2023) observation that GBV statistics in Nigeria significantly underestimate true prevalence due to stigma and fear of reprisal.

Respondents showed a marked preference for informal support networks—especially family (59.0%)—over formal justice mechanisms. While legal aid services exist through the Legal Aid Council and the Ministry of Justice, underfunding and staff shortages limit their accessibility. This aligns with Banyan Global's (2024) findings that subnational GBV interventions in Nigeria are frequently under-resourced, leading to service gaps and reduced survivor confidence in formal systems. The urban-centric location of Sexual Assault Referral Centres (SARCs) further exacerbates rural exclusion. Only 30.8% of respondents were aware of GBV laws, and a mere 9% knew of any perpetrator convictions. These low awareness and enforcement levels suggest inadequate sensitization campaigns and poor legal follow-through. Ikuteyijo et al. (2024) emphasize that stakeholder engagement is crucial for effective legal implementation; however, the Enugu context demonstrates insufficient operationalization of such engagement, resulting in a gap between policy existence and practical impact. Awareness of SARCs and shelters was low (14.3%), despite the state hosting three such facilities. Furthermore, none of these centers provided disability-inclusive services, which contradicts UN Women's (2017) "leave no one behind" principle in GBV response. Awareness of referral pathways—particularly legal and psychosocial services—was similarly low, reducing survivors' ability to seek timely and appropriate assistance.

Although 88% of respondents acknowledged GBV education in schools, qualitative findings indicate these programs are not standardized in the curriculum. As Ezenwosu & Uzochukwu (2025) note, structured, school-based GBV education is vital for shifting harmful gender norms. The absence of accessible educational materials for 66.9% of respondents further points to significant outreach and communication gaps. Overall, the evidence suggests that Enugu State's GBV response is constrained by institutional fragility (underfunding, staff shortages), socio-cultural barriers (patriarchal attitudes, victim-blaming), geographical inequities (urban bias in services), and low public awareness. These constraints are consistent with findings from other Nigerian states and Sub-Saharan Africa, where legislative progress has not translated into substantial reductions in GBV (Adeleke et al., 2021). Without targeted, evidence-based reforms, state-level initiatives risk remaining symbolic rather than transformative.

Conclusion:

While Enugu State has taken notable steps - domesticating the VAPP Act, establishing GBV hotlines, and fostering NGO partnerships—these have not significantly reduced GBV prevalence. Survivors face persistent barriers, including limited access to justice, insufficient service coverage in rural areas, and cultural stigmatization. The heavy reliance on informal justice reflects systemic gaps in institutional capacity and community trust. Without robust institutional strengthening, proactive public sensitization, and community-driven norm change, GBV prevention and response will remain fragmented and reactive. The study recommends as follows; the allocation of ring-fenced funding for GBV prevention and response to ensure service sustainability and reduction in the reliance on external funding sources. Establishment of additional SARCs and shelters in rural local government areas in Enugu state, with **disability-inclusive infrastructure** to ensure equal access. Recruitment and training of specialized GBV prosecutors and law enforcement officers. Provision of continuous judicial training on survivor-centered approaches to reduce bias and improve conviction rates. Deployment of multi-channel communication strategies—including radio, television, and social media—in multiple local languages to promote GBV laws, referral pathways, and survivor rights. Integration of GBV education into the formal

school curriculum. Development of standardized local GBV data collection tools and interoperable case management systems to enhance surveillance, tracking of outcomes, and to inform evidence-based policy.

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