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Community perceptions of gender-based violence: the role of strategic communication and digital health in prevention and recovery

Percepções da comunidade sobre a violência de gênero: o papel da comunicação estratégica e da saúde digital na prevenção e na recuperação

Percepciones de la comunidad sobre la violencia de género: el papel de la comunicación estratégica y la salud digital en la prevención y la recuperación

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Abstract
Gender-based violence (GBV) is a pervasive but under-documented problem in sub-Saharan Africa, with little community-level evidence from mid-sized Nigerian towns. This study examined community perceptions of the nature, causes, effects, and preferred solutions to GBV in Suleja Local Government Area, Niger State, Nigeria, and considered whether strategic communication, social media, and digital health tools could extend locally-preferred prevention and recovery strategies. A concurrent mixed-methods design combined a structured questionnaire administered to 120 community members with a focus group discussion involving five survivors and two service providers. Descriptive statistics and weighted mean scoring ranked perceived causes and effects, while transcripts were analysed thematically. Most respondents (85.8%) reported direct or witnessed GBV, and 62.5% rated it a very serious problem. Poverty was the most endorsed cause, followed by low education and childhood exposure to violence, while psychological trauma, fear, and suicidal ideation were the most endorsed effects. Awareness campaigns were the most preferred intervention (79.2%), ahead of legal or law-enforcement measures, consistent with the behaviour change literature. The study also considers digital health tools, including teletherapy, chatbot helplines, and mobile safety planning, as a low-cost complement to recovery services, and outlines steps needed to test these strategies causally in similar Nigerian settings.

Keywords
Gender-Based Violence, Social And Behaviour Change Communication, Social Media, Digital Health, Telehealth, Social Learning Theory, Community Perceptions.

Resumo

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A violência de gênero (VG) é um problema generalizado, mas pouco documentado, na África Subsaariana, com poucas evidências em nível comunitário provenientes de cidades nigerianas de médio porte. Este estudo examinou as percepções da comunidade sobre a natureza, as causas, os efeitos e as soluções preferidas para a VG na Área de Governo Local de Suleja, no Estado do Níger, na Nigéria, e avaliou se a comunicação estratégica, as redes sociais e as ferramentas digitais de saúde poderiam ampliar as estratégias de prevenção e recuperação preferidas localmente. Um desenho de métodos mistos simultâneos combinou um questionário estruturado aplicado a 120 membros da comunidade com uma discussão em grupo focal envolvendo cinco sobreviventes e dois prestadores de serviços. Estatísticas descritivas e pontuação média ponderada classificaram as causas e os efeitos percebidos, enquanto as transcrições foram analisadas tematicamente. A maioria dos entrevistados (85,8%) relatou ter sofrido ou testemunhado violência de gênero, e 62,5% classificaram o problema como muito grave. A pobreza foi a causa mais citada, seguida pelo baixo nível de escolaridade e pela exposição à violência na infância, enquanto trauma psicológico, medo e ideação suicida foram os efeitos mais citados. Campanhas de conscientização foram a intervenção mais preferida (79,2%), à frente de medidas legais ou de aplicação da lei, em consonância com a literatura sobre mudança de comportamento. O estudo também considera ferramentas de saúde digital, incluindo teleterapia, linhas de apoio com chatbots e planejamento de segurança por celular, como um complemento de baixo custo aos serviços de recuperação, e descreve as etapas necessárias para testar essas estratégias de forma causal em contextos nigerianos semelhantes.

Palavras-chave
Violência de Gênero, Comunicação para Mudança Social e de Comportamento, Mídias Sociais, Saúde Digital, Telessaúde, Teoria da Aprendizagem Social, Percepções da Comunidade.

Resumen
La violencia de género es un problema generalizado pero poco documentado en el África subsahariana, y se dispone de escasa evidencia a nivel comunitario procedente de localidades nigerianas de tamaño medio. Este estudio examinó las percepciones de la comunidad sobre la naturaleza, las causas, los efectos y las soluciones preferidas para la violencia de género en el área de gobierno local de Suleja, estado de Níger (Nigeria), y analizó si la comunicación estratégica, las redes sociales y las herramientas de salud digitales podrían ampliar las estrategias de prevención y recuperación preferidas a nivel local. Se utilizó un diseño concurrente de métodos mixtos que combinó un cuestionario estructurado administrado a 120 miembros de la comunidad con un grupo de discusión en el que participaron cinco supervivientes y dos prestadores de servicios. Las estadísticas descriptivas y la puntuación media ponderada clasificaron las causas y los efectos percibidos, mientras que las transcripciones se analizaron temáticamente. La mayoría de los encuestados (85,8 %) declaró haber sufrido o presenciado violencia de género, y el 62,5 % la calificó de problema muy grave. La pobreza fue la causa más señalada, seguida de el bajo nivel educativo y la exposición a la violencia durante la infancia, mientras que el trauma psicológico, el miedo y las ideas suicidas fueron los efectos más señalados. Las campañas de sensibilización fueron la intervención más preferida (79,2 %), por delante de las medidas legales o de aplicación de la ley, en consonancia con la literatura sobre el cambio de comportamiento. El estudio también considera las herramientas de salud digital —como la teleterapia, las líneas de ayuda con chatbots y la planificación de la seguridad a través del móvil— como un complemento de bajo coste para los servicios de recuperación, y esboza los pasos necesarios para evaluar estas estrategias de forma causal en contextos nigerianos similares.

Palabras clave
Violencia de Género, Comunicación para el Cambio Social y de Comportamiento, Redes Sociales, Salud Digital, Telesalud, Teoría del Aprendizaje Social, Percepciones de la Comunidad.

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1. Introduction

Gender-based violence (GBV) is a globally pervasive violation of human rights, affecting individuals across every age, class, and cultural setting, and disproportionately harming women and girls (World Health Organization [WHO], 2021). It encompasses physical, sexual, psychological, and economic harm carried out on the basis of gender, and it is sustained by patriarchal norms, unequal power relations, and structural inequality (García-Moreno *et al*., 2005; Russo & Pirlott, 2006). Globally, roughly one in three women experience physical or sexual violence in their lifetime (Leal Filho *et al*., 2023), and intimate partner violence alone accounts for a substantial share of violent deaths among women of reproductive age (Who, 2021).

In Nigeria, national surveys estimate that roughly one in three women aged 15–49 have experienced physical or sexual violence (Titilayo, Omisakin, & Ehindero, 2014; Oyediran, 2016), and the burden is compounded in settings marked by conflict, poverty, and weak service infrastructure. Niger State, and Suleja LGA specifically, occupies a distinctive position: it is a peri-urban transit corridor bordering the Federal Capital Territory, combining features of both rural and urban Nigeria, yet it remains comparatively understudied relative to Nigeria's larger metropolitan centres. Anecdotal and organisational reports point to a high burden of GBV in Suleja, but rigorous, community-grounded empirical evidence has been lacking.

This gap matters for two connected reasons. First, without locally grounded evidence on how community members themselves understand the nature, drivers, and consequences of GBV, prevention programming risks being generic and poorly targeted. Second, the modes through which such evidence could translate into behaviour change and survivor recovery are shifting: alongside conventional interventions (law enforcement, legal aid, shelters), social and behaviour change communication (SBCC) including radio drama, community dialogue, and increasingly social media and digital health tools has emerged as a documented, if unevenly evaluated, prevention and recovery pathway across sub-Saharan Africa (Sundani, Mangaka, & Mamokhere, 2022; UNICEF, accessed 6 August 2026). Nigeria-specific work suggests social media platforms such as Twitter and WhatsApp are already used to raise awareness of GBV and to mobilise advocacy (Ajayi-Ayodele & Oguntomisin, 2024), while a growing number of Nigerian digital services helplines, chatbots, and app-based safety and counselling tools now offer survivors confidential, remote pathways into care (Prime Progress NG, 2025). Yet the extent to which any of these tools reach or resonate with communities like Suleja, where educational attainment and connectivity are mixed, is unknown.

This study therefore had two aims. The first, primary aim was to document, through a mixed-methods community survey, the nature, causes, and effects of GBV as perceived by residents of

Suleja LGA, and the interventions they themselves prioritise. The second, integrative aim was to situate these community-generated priorities within the broader empirical literature on strategic communication, social media, and digital health as GBV prevention and recovery tools, in order to identify a testable, evidence-informed extension of the study's recommendations rather than a generic call for "more awareness." The study is guided by four research questions that examine the nature and perceived prevalence of gender-based violence (GBV) in Suleja Local Government Area (LGA), explore the principal causes of GBV as identified and ranked by community members, assess the effects of GBV most strongly recognised by respondents, and identify the interventions prioritised by community members, while examining how these align with the evidence base on communication-driven and digitally-enabled GBV prevention.

1.1 Contribution of the Study

This paper contributes to the literature in three ways. First, it provides community-level, empirically grounded evidence on GBV from a Nigerian LGA that has received little prior sociological attention. Second, it applies weighted mean scoring to the study's ordinal (Likert-type) data, allowing perceived causes and effects to be ranked rather than only reported as marginal percentages, a modest but real gain in analytical precision over the descriptive percentages typically reported in comparable community studies. Third, it extends the discussion beyond the conventional recommendations (law enforcement, shelters, legal aid) by connecting the community's own stated preference for awareness-based intervention to the empirical SBCC, social-media, and digital-health literature, and by specifying what a rigorous test of a communication- or technology-based intervention in Suleja would require. The study aligns with Sustainable Development Goals 1 (No Poverty), 3 (Good Health and Well-being), 4 (Quality Education), 5 (Gender Equality) and 16 (Peace, Justice and Strong Institutions).

2. Literature Review and Theoretical Framework

2.1 Conceptualising Gender-Based Violence

GBV is defined by the WHO as any act that causes physical, sexual, or psychological harm on the basis of gender, encompassing intimate partner violence, sexual violence, harmful traditional practices, and economic abuse (García-Moreno *et al*., 2005). The European Institute for Gender Equality similarly frames GBV as violence directed at a person because of their gender, or that affects persons of a particular gender disproportionately, situating the concept firmly within structural gender inequality rather than isolated interpersonal conflict (European Institute for Gender Equality [EIGE],

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2024). Feminist scholarship reinforces this structural framing, treating GBV as an outcome of systemic gender inequality and patriarchal power structures rather than a series of unrelated incidents (Dobash & Dobash, 1979; Crenshaw, 1991), a framing this study adopts.

2.2 Global, Regional and National Burden

Global estimates put lifetime prevalence of physical or sexual intimate partner violence among women at roughly 30% (WHO, 2021). Regional clinical and health-systems evidence from South Africa likewise documents a substantial and sustained burden of GBV presenting at health facilities, underscoring the health sector's centrality to both response and data on the problem (Abrahams, Jewkes, & Mathews, 2010). Nigerian Demographic and Health Survey data indicate that approximately 28% of women aged 15–49 have experienced physical or sexual violence (Oyediran, 2016), a figure broadly consistent with the elevated rates reported qualitatively and quantitatively in the present study's sample.

2.3 Theoretical Framework

Three theories jointly frame this study. Social Learning Theory (Bandura, 1977) holds that aggressive and violent behaviour is acquired through observation, modelling, and reinforcement within families, peer networks, and, notably, through media exposure. A substantial body of subsequent work extends this to mass and social media specifically: repeated media portrayals of violence can normalise it, while media models of respectful or prosocial behaviour can shift attitudes in the other direction (Bandura, 1986; Mares & Woodard, 2005). This dual-direction property of social learning is the theoretical hinge connecting this study's causal findings (childhood exposure to violence as a driver) to its communication- and technology-based recommendations (media and digital tools as potential levers for un-learning violence-supportive norms and for supporting survivor recovery).

Feminist Theory (Dobash & Dobash, 1979) explains GBV as an outcome of structural gender inequality and male-dominated power relations, consistent with respondents' strong endorsement of patriarchal norms and gender inequality as causes in this study. The Socio-Ecological Model (Heise, 1998) situates individual risk within nested layers of influence individual history, relationship, community, and societal structure providing a frame for integrating this study's individual-level (violent childhood), relational (intimate partner dynamics), community (cultural norms), and structural (poverty, weak institutions) findings into a single explanatory model.

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2.4 Communication, Social Media, and GBV Prevention

A growing evidence base treats social and behaviour change communication (SBCC) as a distinct, evaluable category of GBV intervention, rather than an informal adjunct to legal or clinical response. SBCC approaches combine mass media (radio drama, television), community dialogue, interpersonal communication, and increasingly digital and social media to shift the attitudes, norms, and behaviours that sustain violence (UNICEF, accessed 6 August 2026; Health Communication Capacity Collaborative, accessed 6 August 2026). In Nepal, a cluster-randomised trial of a multi-component SBCC strategy combining radio drama with community mobilisation was designed specifically to test its effect on intimate partner violence attitudes and behaviours, reflecting the field's move toward causal, not merely descriptive, evidence (Green *et al*., cited in the Change Starts at Home study protocol).

Within Africa specifically, social media has been documented as an active GBV-campaign channel: in South Africa, campaigns using Facebook, Instagram, and Twitter/X have mobilised advocacy communities around GBV (Sundani *et al*., 2022), and analysis of South Africa's violence-prevention work suggests that online dialogue, when paired with in-person interventions, can measurably shift how gender norms are discussed (Institute for Security Studies [ISS] Africa, accessed 6 August 2026). In Nigeria, a survey-based study in Akure South LGA, Ondo State, found that residents encounter GBV-related content mainly via Twitter and WhatsApp and that such exposure is associated with greater self-reported awareness of GBV and related gender-equality issues (Ajayi-Ayodele & Oguntomisin, 2024). These findings are directly relevant to Suleja: they suggest that even in settings with mixed literacy and connectivity, mobile-based platforms already used for other purposes could plausibly be repurposed for GBV messaging, though this has not, to our knowledge, been tested in Niger State.

At the same time, the literature is careful not to overstate the causal power of communication alone. UNICEF's SBCC guidance stresses that even well-designed campaigns cannot by themselves dislodge deeply entrenched practices such as child marriage or female genital mutilation without accompanying structural and service-level change (UNICEF, accessed 6 August 2026). This qualification is important for interpreting the present study's own finding that 79.2% of respondents favour awareness campaigns: community preference for a communication-based solution is not, by itself, evidence that such a solution would be effective, and the Discussion section returns to this distinction.

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3. Methods

3.1 Study Design and Setting

The study used a concurrent mixed-methods design, combining a cross-sectional structured survey with a qualitative focus group discussion (FGD), conducted in Suleja LGA, Niger State, Nigeria — a peri-urban transit town bordering the Federal Capital Territory, Abuja, with an estimated population of 368,900 (National Population Commission of Nigeria; National Bureau of Statistics).

3.2 Population, Sampling, and Sample Size

The target population comprised residents of Suleja LGA with lived experience of, or exposure to, GBV, spanning teenagers (15–17), young adults (18–24), adults (25–44), and seniors (45+). Sample size was determined using the Taro Yamane (1967) formula, $n = N / (1 + Ne^2)$, with N = 368,900 and a 10% margin of error, yielding a minimum sample of approximately 100; the study administered 120 questionnaires to allow for incomplete responses and to strengthen subgroup representation. Participants were selected using a combination of simple random sampling (community survey) and purposive sampling (FGD participants and service-provider key informants), the latter chosen for their direct knowledge of GBV cases in the community. The FGD comprised five GBV survivors and two service providers.

3.3 Instrumentation and Data Collection

A structured questionnaire captured socio-demographic characteristics, prevalence and nature of GBV, perceived causes and effects (rated on a five-point scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree), and preferred solutions (multi-response yes/no items). Items were read aloud and explained for respondents with limited literacy. The FGD used an open-ended guide and was audio-recorded with consent, then transcribed and analysed thematically alongside the survey data (data triangulation).

3.4 Data Analysis

Quantitative data were analysed descriptively (frequencies and percentages) using SPSS. To move beyond simple percentage reporting, five-point response items on causes and effects were additionally converted to weighted mean scores (WMS), using integer weights from 5 (Strongly Agree) to 1 (Strongly Disagree), to permit ranking of items by average endorsement strength rather than by the "Strongly Agree" category alone; items are reported with both their WMS and their combined Agree/Strongly Agree percentage. Because the underlying design used non-probability

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elements (purposive selection of key informants) and a single-LGA convenience frame, no inferential statistics (e.g., chi-square tests of association, regression) are reported; the analysis is descriptive and hypothesis-generating rather than confirmatory, and this constraint is revisited in the Limitations. Qualitative FGD data were analysed using descriptive thematic coding, with themes cross-checked against the quantitative findings.

3.5 Ethical Considerations

Ethical approval was obtained from the relevant federal health ministry, and informed consent was obtained from all participants prior to data collection, with participants informed of the study's purpose, their right to withdraw at any time, and the measures taken to protect confidentiality. Data were collected and stored anonymously; identifying details were removed from FGD transcripts prior to analysis, with particular attention to the elevated re-identification risk in a close-knit community.

4. Results

4.1 Socio-Demographic Characteristics

Table 1 summarises the demographic profile of the 120 respondents. Most were young adults: 31.7% were aged 18–22 and a further 24.2% were 23–27. Women made up 60.0% of the sample. Respondents were roughly evenly split between Islam (50.0%) and Christianity (48.3%), with 1.7% reporting traditional religious practice. Just under half (48.3%) were employed and 45.8% unemployed; 48.3% were single and 38.3% married.

Table 1

Socio-demographic characteristics of respondents (N = 120).

Variable	Category	Frequency	%
Age	18–22 years	38	31.7
	23–27 years	29	24.2
	28–32 years	26	21.7
	33+ years	27	22.5
Gender	Male	48	40.0
	Female	72	60.0
Religion	Islam	60	50.0
	Christianity	58	48.3
	Traditional	2	1.7
Occupation	Employed	58	48.3

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Variable	Category	Frequency	%
	Unemployed	55	45.8
	Other	7	5.8
Marital status	Single	58	48.3
	Married	46	38.3
	Divorced	14	11.7
	Other	2	1.7

Source: field survey

4.2 Nature and Perceived Prevalence of GBV

A large majority of respondents, 85.8% (n = 103), reported having personally experienced or directly witnessed GBV, against 14.2% who had not. When asked to rate the seriousness of GBV as a community problem, 62.5% rated it "a very serious problem" and a further 22.5% "a significant problem" — that is, 85.0% of respondents rated GBV as at least a significant community concern. Among the specific types of violence encountered or witnessed, physical violence was most frequently reported (38.3%), followed by sexual violence (29.2%), emotional/psychological violence (20.8%), economic violence (10.0%), and other forms including digital abuse (1.7%). FGD participants corroborated this pattern with first-person accounts of physical assault, coerced/early marriage, and economic control, one survivor recounting repeated beating tied to unmet informal-trade sales targets, and another describing a partner's control over household resources alongside physical violence.

4.3 Perceived Causes of GBV

Table 2 ranks the seven candidate causes by weighted mean score (WMS), computed from the same Strongly Agree–Strongly Disagree distributions reported in the original survey. Poverty was the most strongly endorsed cause (WMS = 4.45; 91.7% Agree/Strongly Agree), followed by lack of education (WMS = 4.15; 82.5%), violent childhood (WMS = 4.06; 78.3%), and cultural norms and traditions (WMS = 4.04; 79.2%). Gender inequality, patriarchal male dominance, and conflict/war were also strongly endorsed (WMS 3.7–3.9) but ranked comparatively lower. This ordering — economic precarity and low education outweighing, though not displacing, normative/structural explanations — is broadly consistent with prior Nigerian and regional evidence linking economic stress to elevated GBV risk (Abramsky *et al*., 2019).

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Table 2

Perceived causes of GBV

Perceived cause	WMS (rank)	% Agree/ Strongly Agree	n
Poverty	4.45 (1)	91.7	120
Lack of education	4.15 (2)	82.5	120
Violent childhood	4.06 (3)	78.3	120
Cultural norms and traditions	4.04 (4)	79.2	120
Gender inequality	3.90 (5)	77.5	120
Male dominance / patriarchal norms	3.81 (6)	75.0	120
Conflict and war	3.73 (7)	73.3	120

Note Source: field survey compilation

FGD accounts gave texture to the poverty finding: several participants linked violence directly to household financial strain ("if money no remain… he will just join and insult my life"), and to a normalised acceptance of male authority within marriage ("if he beat me and I talk he will say he is the man and I am his property").

4.4 Perceived Effects of GBV

Table 3 ranks the nine effect items. Psychological trauma was the most strongly endorsed consequence (WMS = 4.42; 95.0% Agree/Strongly Agree), followed by fear and suicidal tendencies (both WMS = 4.27), depression (4.26), and emotional trauma (4.19). Physical injury, while still highly endorsed (77.5% Agree/Strongly Agree), ranked lowest of the nine items (WMS = 3.94), suggesting that respondents perceive the psychological and mental-health burden of GBV as somewhat more pervasive than its directly physical burden a pattern consistent with trauma-focused literature on GBV's mental health sequelae (Jewkes, 2010).

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Table 3

Perceived effects of GBV

Perceived effect	WMS (rank)	% Agree/ Strongly Agree	n
Psychological trauma	4.42 (1)	95.0	120
Fear	4.27 (2)	87.5	120
Suicidal tendencies	4.27 (2)	90.0	120
Depression	4.26 (4)	89.2	120
Emotional trauma	4.19 (5)	87.5	120
Health crisis / complications	4.18 (6)	86.0	121
Economic distress	4.17 (7)	88.3	120
Lack of trust	3.99 (8)	81.7	120
Physical injuries	3.94 (9)	77.5	120

Note Source: field survey compilation and the health-crisis item's response counts sum to 121 rather than 120 in the original field data; this discrepancy is retained and flagged here rather than adjusted. Source: field survey; WMS computed from reported response distributions.

4.5 Preferred Interventions

Respondents were asked, in a multi-select format, whether each of several proposed strategies would help address GBV in Suleja. Increasing awareness through educational campaigns was the most widely endorsed strategy (79.2%), ahead of providing survivor support services such as counselling, shelter, and empowerment (71.7%); strengthening law enforcement and penalties (70.0%); offering free legal assistance (70.0%); providing free healthcare (68.3%); and promoting gender equality/challenging harmful norms (66.7%). A further 76.2% of respondents rated the involvement of local NGOs and civil-society organisations as "very" or "extremely" important. FGD participants specifically proposed community-level awareness channels: engaging schools, markets, and traditional leaders ("we can go to school's and market places even emir palace"), and using local radio to reach victims and raise reporting ("even fm radio invite people to speak on them so that people that have lost their love once… can reach their people").

This spontaneous FGD reference to radio as an awareness vehicle volunteered by participants without prompting about communication channels is a modest but genuine qualitative signal that community members already conceive of mass communication as a plausible GBV-response mechanism, independent of the survey's own awareness-campaign item.

5. Discussion

5.1 Principal Findings in Context

The 85.8% rate of direct or witnessed GBV exposure recorded here is markedly higher than the roughly 28–33% lifetime-prevalence estimates reported in national Nigerian surveys (Oyediran, 2016; Titilayo *et al*., 2014). This gap most plausibly reflects methodological differences rather than a true underlying prevalence gap: the present item measured any direct or witnessed exposure (a broader construct than the personal-victimisation measures used in DHS-type surveys), the sample was drawn through non-probability methods rather than a nationally representative frame, and 60% of respondents were women, a group with disproportionately higher GBV exposure. The finding should therefore be read as evidence of a strikingly high level of community exposure and salience, not as a directly comparable national prevalence estimate.

The ranking of poverty as the leading perceived cause (WMS = 4.45) aligns with international evidence that economic precarity elevates GBV risk by constraining access to education, legal recourse, and exit options from abusive relationships (Abramsky *et al*., 2019). Its co-occurrence with low education and violent childhood as top-ranked causes is consistent with the socio-ecological model's emphasis on overlapping individual and structural risk layers (Heise, 1998), and with social learning theory's proposition that childhood exposure to violence is a distinct behavioural risk pathway, correlated with but separate from poverty (Bandura, 1977). This evidence gap also appears within the health system itself: Nigerian research on adolescent survivors' access to care documents non-existent counselling services, poor referral pathways, and limited provider training as structural barriers to recovery in low-income urban communities (Ikuteyijo, Kaiser-Grolimund, Fetters, Akinyemi, & Merten, 2023), a barrier profile that plausibly extends to Suleja and motivates the digital-health discussion below.

5.2 Communication and Social Media as a Complementary Intervention Pathway

The community's own stated priority awareness through educational campaigns (79.2%) sits within a documented, if still-maturing, evidence tradition. SBCC programmes elsewhere in the region have combined mass media (notably radio drama) with community mobilisation specifically to shift IPV-supportive norms, using designs, such as the Nepal cluster-randomised Change Starts at Home trial, capable of generating causal evidence rather than descriptive association alone. Closer to the present setting, Nigerian survey evidence indicates that residents already encounter GBV-related content through Twitter and WhatsApp, and that such exposure correlates with greater self-reported awareness of gender-equality issues (Ajayi-Ayodele & Oguntomisin, 2024), while South African

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evidence points to social media's capacity to mobilise GBV advocacy networks when paired with offline dialogue (ISS Africa, accessed 6 August 2026; Sundani *et al*., 2022).

Read through Social Learning Theory, this literature and the present findings suggest a coherent — though still untested in Suleja hypothesis: if childhood and community exposure to violence teaches violence-supportive norms through modelling, then sustained, community-embedded counter-modelling through trusted channels (local radio, community dialogue, and, for younger residents, social media and mobile messaging) could plausibly interrupt that same learning pathway. The FGD's unprompted reference to radio as a mechanism for reaching victims lends modest qualitative support to this being locally intuitive rather than externally imposed. However, the UNICEF SBCC guidance caution is important: communication interventions have not been shown to substitute for structural change, and given that poverty and low education outranked normative/attitudinal causes here, a communication-only response would likely under-address the community's own top-ranked driver of GBV. Practically, communication should therefore be framed as one deliberately sequenced component within a multi-level response alongside the economic and legal measures respondents also prioritised (legal aid, 70.0%; healthcare, 68.3%) and any social-media component should be paired with offline channels (radio, market and school outreach, religious and traditional leader engagement) given the mixed literacy and connectivity evident in this sample.

5.3 Digital Health and Digital Communication Tools for Survivor Recovery and Prevention

Beyond awareness-raising, a distinct strand of evidence concerns digital health: telehealth, mobile applications, and digitally-mediated communication used to support survivors' recovery and reduce repeat victimisation, rather than only shift community attitudes. WHO has flagged the mental-health toll of technology-facilitated GBV as an emerging priority, noting that most survivors of digital abuse still do not seek help despite a documented year-on-year rise in reported cases (World Health Organization, 2026), while UNFPA's Making All Spaces Safe programme extends survivor-centred response through digital channels while managing the risk that digital spaces themselves enable new abuse (United Nations Population Fund, accessed 6 August 2026) a dual character central to how these findings should be read. Telehealth counselling extends confidential, trauma-informed support to survivors facing transportation, childcare, or exposure-related barriers, provided clinicians follow safety-first protocols around private space and abuse-aware termination (Jack *et al*., 2021); an umbrella review of digital health strategies for adolescent sexual and reproductive health and GBV prevention in low- and middle-income countries likewise finds such tools highly feasible and acceptable even where effectiveness evidence remains limited (Huang, Kumar, Cheng, Urcuyo, &

Macharia, 2022), and qualitative work with GBV service providers in low-resource and displacement settings confirms that rapid digitalisation extends reach only where providers actively manage the gender digital divide and the risk that a survivor's device may be monitored by an abuser (Vahedi *et al*., 2024).

Nigeria already has a small but active ecosystem of such tools: confidential helplines, app-based SOS and counselling features, and chatbot-mediated mental health and legal-aid services offered by organisations such as the Mirabel Centre, WARIF, the Domestic and Sexual Violence Agency, and Stand to End Rape (Prime Progress NG, 2025). None were named spontaneously by the present study's FGD participants, who referenced only radio; alongside the sample's mixed education and connectivity profile, this suggests local awareness of existing digital-health services may itself be low, consistent with the broader finding that health-system barriers to survivor support in low-income Nigerian communities concern referral pathways and provider training as much as service existence (Ikuteyijo *et al*., 2023). Set against Social Learning Theory, digital tools occupy a distinct niche relative to the mass-media strategies in Section 5.2: where SBCC targets community-level norms, telehealth and app-based safety planning operate at the individual level, offering a private route to help and a documented, if still-evolving, means of reducing repeat victimisation (WHO Regional Office for the Eastern Mediterranean, 2025). For Suleja, digital health should therefore be treated as a complementary second layer to the community's preferred awareness campaigns, useful for private, individual-level recovery work, provided it is deployed with the safeguards device-privacy checks, coded disclosure, provider training — that the literature treats as prerequisites rather than optional extras.

5.4 Limitations

This study has some limitations. First, because it was conducted within a single local government area using a combination of random and purposive sampling, the findings may not be generalisable to other settings. Second, the study relied primarily on descriptive analyses; therefore, the results should be interpreted as reflecting community perceptions rather than statistically confirmed associations. Third, the use of self-reported data may have introduced recall and social-desirability bias. Finally, the qualitative findings were based on a small purposively selected focus group, and the study did not directly evaluate the impact of social media, SBCC campaigns, or digital health interventions on GBV outcomes. These aspects warrant further investigation in future studies.

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6. Conclusion and Recommendations

This study provides community-grounded evidence that GBV is widely experienced and perceived as a serious problem in Suleja LGA, that poverty and low education are its most strongly endorsed drivers, that psychological and mental-health consequences are perceived as at least as pervasive as physical harm, and that community members themselves rank awareness-raising above law enforcement as their preferred first-line response. Read alongside the regional SBCC, social-media, and digital-health literature, this suggests a specific, testable next step for the study area rather than a generic call for more education. Taken together, the findings point toward a layered response: a community-facing communication strategy to shift the norms and awareness gaps the survey identified, combined with a private, individual-facing recovery channel for survivors who cannot or will not disclose within their immediate community, and underpinned by the economic and legal measures respondents also prioritised.

Accordingly, it is recommended that a multi-channel SBCC intervention be piloted in Suleja, combining local-language radio content, community dialogue involving traditional and religious leaders, and mobile or social-media messaging targeted at younger, more connected residents, evaluated with a pre–post or, resources permitting, cluster-randomised design against attitudinal and service-uptake outcomes, rather than assumed effective on stated preference alone. Alongside this, service providers and local health authorities should pilot and actively publicise a digital-health complement a confidential SMS or app-based helpline linked to existing Nigerian survivor-support services, telehealth counselling for survivors facing transportation or exposure-related barriers, and app-based safety planning implemented with explicit safeguards such as device-privacy checks, coded disclosure, and trained providers, since digital tools can extend reach to survivors unable to disclose within their community but can equally become a vector of harm without such safeguards. Any communication component should further be paired with the economic and legal measures respondents also prioritised, including livelihood support tied to poverty's top-ranked causal role, free legal aid, and strengthened survivor health and psychosocial services. Formal partnerships between local NGOs, civil-society organisations, and government agencies, which 76.2% of respondents already regard as important, should be strengthened to coordinate messaging and service delivery, including awareness of digital-health services that already exist nationally but appear under-recognised locally. Finally, follow-up research using a probability sampling frame and inferential statistical methods, such as logistic regression or chi-square tests of association, is needed to move the evidence base in Suleja from descriptive to confirmatory, and to permit a genuine test of the hypotheses advanced here.

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