Baseline Study on the Discriminatory Laws, Attitudes and Societal Practices Hindering Diverse Sex Workers' Access to Sexual and Reproductive Health and Rights Services in Selected Senatorial Local Governments in Rivers State, Nigeria

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ABSTRACT

Achieving comprehensive access to Sexual and Reproductive Health and Rights (SRHR) services remains a pressing global health challenge, particularly for marginalized populations such as sex workers, who face the highest unmet needs. This study exposes the baseline issues related to discriminatory laws, attitudes, and societal practices that hinder diverse sex workers' access to comprehensive SRHR services in Rivers State, Nigeria. Specifically, the study identified key barriers affecting sex workers' access to SRHR services, evaluated their satisfaction with these service deliveries, examined the effects of societal inequalities and discriminatory legal practices on their health outcomes, and proposed sensitivity and rights-based approaches for improving service delivery. The study adopted stratified sampling methodology and collated both quantitative and qualitative data through desk reviews and analysis of existing state health policies, in-depth focus group discussions with 300 diverse sex workers, and analysis of 2000 feedbacks collected through questionnaires embedded in the Kobo Collect app. Key study findings revealed that significant majority (91.1%) of sex workers have experienced discrimination when accessing SRHR services in formal healthcare facilities, with primary sources of these discriminations perpetuated by healthcare workers (77.4%), brothel owners (47.1%), and family members (43.9%). Consequently, 89.9% of respondents have avoided formal healthcare facilities, opting instead for local pharmacies (66%), traditional medical specialists (56.8%), and self-medication (48.4%), despite its adverse effects such as recurrent Sexual Transmitted Infections (STIs) (57.5%), worsening STIs to Sexual Transmitted Diseases (STDs) (58.3%), unwanted pregnancies (18%), post-abortion complications (27.1%), adverse drug reactions (49.1%), and drug abuse/overdose (48.4%). In addition, there was notable dissatisfaction among respondents regarding SRHR services as 61.4% of engaged sex workers rated "Poor to Very Poor" for service affordability, a mixed opinions for availability and accessibility as respondents rated "Fair to Poor" (57.4% for availability and 68% for accessibility) and 75% of the respondents criticized the accountability system to be "Poor to Very Poor". Qualitative analyses of existing laws and policies in the State revealed an institutional neglect and exclusion of sex workers from health service protections as some state laws and policies, such as Rivers State Reproductive Law, Rivers State Contributory Health Protection Programme, Rivers State Strategic Health Development Plan, and the Rivers State HIV/AIDS Anti-Discrimination Law, were non-inclusive and perpetuate discriminatory practices against sex workers in SRHR service provision. To close-in the gaps, the study recommended implementing non-discrimination policies, reducing waiting times, ensuring strict privacy and confidentiality measures, reforming laws to ensure inclusive service delivery, providing non-clinical training on gender identity and sexual orientation for healthcare providers, appointing focal persons for key populations, and enforcing accountability systems across healthcare facilities as a right based model for enhancing SRHR outcomes for diverse sex workers in Rivers State.

Keywords: Discrimination, HealthCare, Intersectionality, Sex Workers, Service Providers, SRHR,

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INTRODUCTION

Sex work, recognized as one of humanity's oldest professions, presents distinct challenges amplified within traditional African communities, notably in Nigeria. Normative constraints historically limit sex workers' access to economic opportunities, societal integration, and basic privileges. In African contexts, sex work remains morally contentious, deeply embedded in cultural, legal, and social frameworks that withhold recognition of it as a legitimate job choice (Adebisi et al., 2020). Additionally, societal attitudes in Nigeria perpetuate the marginalization of sex workers, reinforcing their exclusion from mainstream health, economic and social spheres. This stigma intersects with broader issues of gender inequality, poverty, and socio-economic disparities, increasing the manifold challenges faced by this marginalized group (Okoro et al., 2021). Such exclusion do not only restrict their access to essential healthcare and legal protections but also heightens their vulnerability to exploitation and violence.

Despite Nigeria's commitments to international human rights treaties such as the Maputo Protocol, UN Declarations, Beijing Convention, and CEDAW Laws, the criminalization of sex work results in unmet SRHR services due to regional disparities within Nigeria where the northern regions explicitly criminalize sex work under penal codes, while southern regions indirectly prohibit it through criminal code. Also, the United Nations' Sustainable Development Goal 5 targets gender equality and the empowerment of all women and girls, aiming for universal SRHR access by 2030. However, sex workers are excluded in this movement building hence encountering significant barriers perpetuated by widespread human rights violations. These barriers include severe stigma and discrimination from healthcare providers, legal obstacles stemming from criminalization, lack of protective laws, insufficiently adapted health services, and economic vulnerabilities that impede their ability to afford and seek care. Consequently, sex workers experience compromised reproductive health increasing their risks of HIV and other STIs, and notable mental health challenges.

In the southern region of Nigeria, specifically in Rivers State, the 2022 ban on sex work by the state government (https://www.pulse.ng/news/local/wike-bans-prostitution-nightclubbing-in-rivers/nh2tdph) had profound implications for sex workers as it exacerbated their already precarious circumstances. This legislative announcement further entrenched sex workers in a web of discriminatory laws and practices that not only stigmatize their job choice but also silence their voices within the broader societal discourse. By criminalizing their livelihoods, the government imposed legal barriers that curtail their fundamental rights, including access to basic healthcare and Sexual and Reproductive Health (SRH) services. This prohibition not only reinforces societal prejudices but also pushed them further into the shadows; making it increasingly difficult for them to seek and receive essential health services.

To address these adversities and foster inclusivity, urgent actions are essential to ensure equitable SRH access for sex workers which necessitates combating stigma and discrimination within healthcare settings, reforming coercive SRH policies, and advocating for gender-responsive resource allocation to support sex workers-led initiatives within the broader health equity movement.

Problem Statement

In Nigeria, particularly in the southern region, sex workers face a complex interplay of cultural, religious, and social factors that perpetuate deep-seated inequalities, discriminatory policies, stigma, and legislation which systematically erodes them of their fundamental rights. These forces significantly influence gender norms, institutional practices, and the daily realities of sex workers, severely restricting their autonomy in decision-making regarding their bodies and limiting their access to comprehensive SRHR services. Despite international obligations to ensure human rights without discrimination, Nigerian laws frequently target sex workers and LGBTIQ individuals based on their occupation, sexual orientation, gender identity, and expression, exposing them to violence, extortion, blackmail, stigma, discrimination, and victim blaming. The enduring consequences of these systemic challenges are profound, exacting a heavy toll on the physical, psychological, sexual, and reproductive health of sex workers.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

Also, structural barriers within the healthcare system further exacerbate these issues, including limited availability of non-discriminatory healthcare services, cultural competence gaps among healthcare providers, and inadequate training on the specific needs of sex workers. These barriers obstruct sex workers' access to timely and appropriate healthcare services, perpetuating high levels of discrimination, dissatisfaction, and adverse health outcomes. Moreover, the scarcity of robust, data-driven research compounds these challenges, impeding meaningful progress towards addressing root causes and implementing effective policy reforms.

To comprehensively address these critical issues, urgent action is needed to generate comprehensive evidence through thorough quantitative and qualitative research methodologies; to amplify the voices and experiences of sex workers towards an informed evidence-based advocacy efforts aimed at challenging discriminatory practices, advocating for legal reforms, and enhancing access to comprehensive SRHR services. Hence, this study seeks to advance a research agenda that illuminates the baseline intersectional dynamics of societal and structural barriers within the healthcare system, particularly in Rivers State to catalyze a transformative change that uphold the rights of sex workers towards responsive healthcare system that respects their diverse needs within the broader framework of human rights and social justice.

Goal and Objectives

This study aims to expose the underlying baseline of existing discriminatory laws, attitudes and societal practices hindering diverse sex workers' access to comprehensive sexual and reproductive health services in selected senatorial districts in Rivers State, Nigeria. Through this overarching goal, the study responds to the following key research strategic objectives which seeks to:

a. Identify key barriers affecting diverse sex workers' access to SRHR services
b. Assess and gain a deeper understanding of diverse sex workers' SRHR service satisfaction feedbacks
c. Establish the correlative effects of societal inequalities and discriminatory laws/practices on the sexual and reproductive health outcomes of diverse sex workers.
d. Draw-up sensitivity and right based approaches for improving access to services for diverse sex workers in Rivers State

MATERIAL AND METHOD

Study Duration and Location

The study was conducted in Rivers State (4.8396° N, 6.9112° E) in the southern region of Nigeria over a 12-months period, from April 2023 to March 2024, across fifteen (15) Local Government Areas (LGAs) in State. These LGAs represent the three (3) senatorial districts: Rivers East, Rivers South East, and Rivers West. To ensure accurate data collection and validation of locations, the Kobo Collect app installed on all tablets utilized a geo-coding mechanism to track the real-time locations of data collectors and participants during field activities.

Study Sample and Sampling Techniques

The sample size was determined using a stratified sampling methodology to ensure representative samples from sub-groups of sex workers across the three senatorial districts of Rivers State. The study leveraged sex workers population data from 2018 Key Population Size Estimation and Validation, funded by PEPFAR and supervised by the University of Maryland, School of Medicine, Baltimore (NACA, 2019) (https://naca.gov.ng/wp-content/uploads/2021/05/Key-Population-Capture-Recapture-Estimation-Nigeria-2019-1.pdf). According to this data, there were approximately 28,700 sex workers in Rivers State (1,435 hotspots with an average of 20 individuals per hotspot). To project the population to 2023, Kirkt's Theory of Population Projection (1996) was applied: $P_n=P_o\times(1+R)^n$

where P_n is the projected population at time, P_o is the base year population, R is the annual growth rate (0.032), and n is the number of years between the base and projected years.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

Applying this formula: $P_n=28,700\times(1+0.032)^5$

The projected population of sex workers in 2023 is approximately 33,595. Similarly, to determine the sample size, the study employed Taro Yamane's (1967) formula as follow: $S=N/1+N(e)^2$ Where, S is the sample size, N is the target population, e is the level of precision (±2%), and 1 is a constant. Mathematically, a sample size of 2,326 was deemed necessary to achieve a 95% confidence level, ensuring the true population value is within ±2% of the surveyed value. The stratified sampling technique was used to select 2,326 participants across the senatorial districts and Local Government Areas (LGAs). However, due to eligibility criteria based on years of experience in accessing health services and duration of stay within the studied location, only 2,000 respondents' views were valid for the research and these participants are distributed as follows:

- **Rivers East**: 858 Participants across Obio-Akpor, Port-Harcourt, Ikwerre, Etche, and Okrika LGAs.
- **Rivers South East**: 610 Participants across Eleme, Gokana, Khana, Tai, and Oyigbo LGAs.
- **Rivers West**: 532 Participants across Abua-Odual, Ahoada East, Akuku-Toru, Bonny, and Onelga LGAs.

Study Design Roadmap

1	In April 2023- Under the guidance of a Research Consultant, the study co-created its research questionnaires with knowledgeable diverse sex workers leaders and successfully integrated it into the Kobo Collect app.
2	In May and June 2023, the research data collection methodology was formulated and diverse sex workers also trained as data peer collectors based on these
3	In July, August and September 2023, the trained data collectors started and completed data collection across various hotspots based on selected sample size across 15 Local Government Areas (LGAs) in Rivers State.
4	In October and November 2023, the study alongside a research data analyst analyzed the data findings, summarized the key findings and
5	In December 2023- March 2024, the study drafted comprehensive report of the research and presented it to members of the community of stakeholders for

Data Collection Techniques/Tools

The study utilized the following data collection techniques:

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

a. **Policy Analysis Reviews:** The study systematically conducted policy mapping and assessed and identified likely discriminatory policies impacting diverse sex workers' access to Sexual and Reproductive Health and Rights (SRHR) services using the existing health and human rights laws, policies, and frameworks in Rivers State.
b. **Participatory Focus Group Discussion (PFGDs):** The study engaged diverse sex workers through PFGDs to gain deeper insights into their lived experiences of accessing Sexual and Reproductive Health and Rights (SRHR) services from health facilities across their respective locations. This method allowed for rich qualitative data by creating a participatory environment where participants could openly share their experiences and perspectives.
c. **Kobo Collect Feedback Mechanism:** The study employed Kobo Collect, an open-source Android app, to collect survey data. This powerful and reliable software is designed for collecting, analyzing, and managing data for surveys, monitoring, evaluation, and research. The study leveraged trained peer data collectors, who were sex workers themselves, to gather data from other sex workers. This peer-led approach helped create a comfortable atmosphere for the research participants, encouraging them to be more relaxed, open, and honest when responding to questions on the Kobo Collect platform.
d. **In-depth Interviews:** The study used one-on-one conversations with key representative of the sex workers community to gather detailed insights and a deep understanding of the kobo collect feedbacks. This approach provided valuable context and depth to study, offering a deeper understanding of complex issues, behaviors, and motivations seen at the backend of the Kobo Collect.

DATA ANALYSIS AND RESULTS PRESENTATION

Quantitative Data (Kobo Collect)

Table 1: Demographic Presentation of Respondents

Variables	Frequency	Percentage
LGAs of Respondents		
Obio/Akpor	237	11.9
Port-Harcourt	232	11.6
Ahoada East	181	9.1
Okirika	152	7.6
Ikwerre	140	7.0
Eleme	139	6.9
Oyigbo	139	6.9
Tai	123	6.2
Gokana	117	5.9
Bonny	113	5.7
Etche	97	4.9
Onelga	95	4.8
Khana	92	4.6
Akuku Toru	81	4.1
Abua	62	3.1

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

Age		
15-19	101	5.0
20-24	839	42.0
25 29	780	39.0
30-34	243	12.2
35-39	30	1.5
40-44	6	0.3
45-49	1	0.0
Sexual Orientation		
Bi-sexual	112	5.6
Gay	76	3.8
Heterosexual	1789	89.5
Lesbian	23	1.1
Genders of Sex Workers		
Female Sex workers (FSWs)	1884	94.2
Male Sex workers (MSWs)	107	5.4
Trans-gender Sex workers (TGSWs)	9	0.4

In Table 1 above, the majority of the sex workers engaged operates in Obio/Akpor (11.9%) and Port-Harcourt (11.6%) LGAs and falls mostly within the age category of 20-24years (42%) of age and are mostly heterosexual (89.5%) in nature with female sex workers (94.2%) being the most predominant diversity of sex workers engaged.

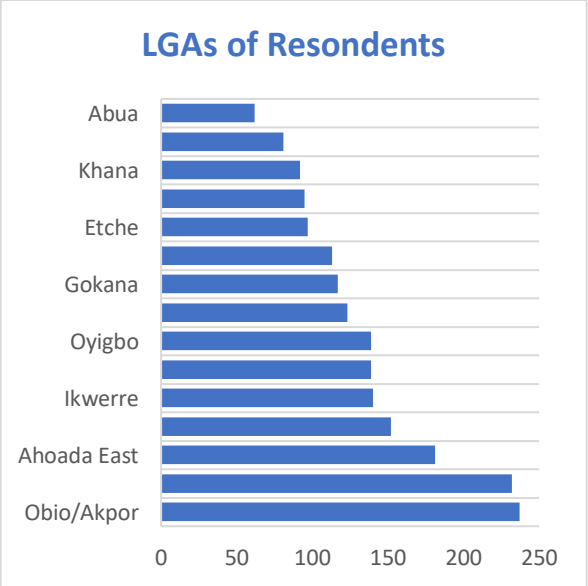

Fig 1: LGAs distribution of diverse of sex workers engaged.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

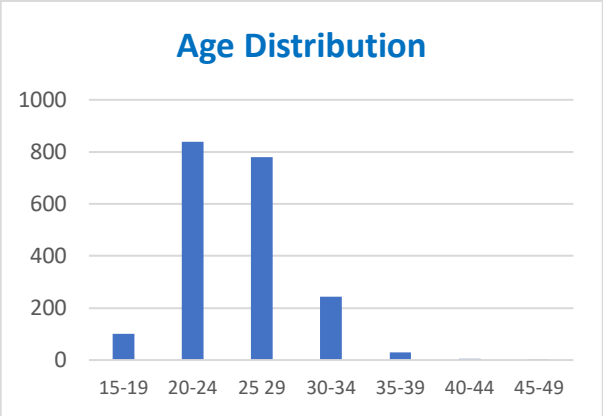

Fig 2: Age distribution of diverse of sex workers engaged.

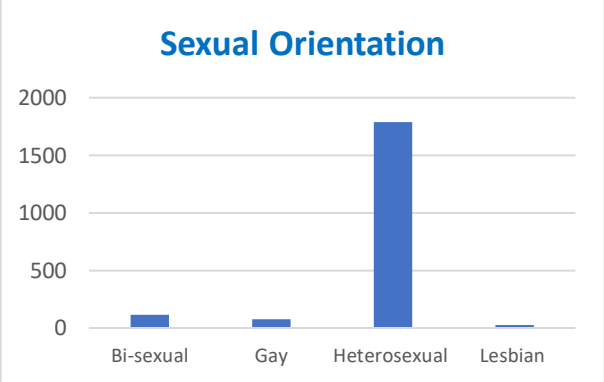

Fig 3: Sexual orientation of diverse of sex workers engaged.

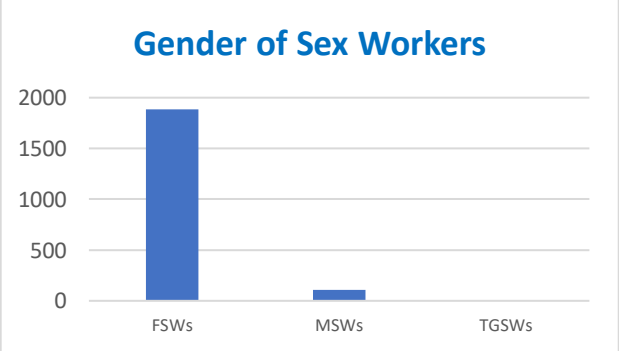

Fig 4: Diverse gender of sex workers engaged.

Table 2: Sex Workers Social Livelihood Versus Utilization of Health Care Services

Variable	Frequency	%
How many clients do you see on average in a week		
20-34 Clients	938	46.9
35-39 Clients	819	41.0
40-49 Clients	177	8.8
50+ Clients	66	3.3

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

How much do you charge on average for a Sex Work per Session		
₦500 - ₦999	24	1.2
₦1000 - ₦2999	300	15
₦3000 - ₦4999	1536	76.8
₦5000 and above	140	7.0
How much do you spend on Health care Services		
₦1000 - ₦4999	370	18.5
₦10000 -₦14999	719	36.0
₦15000 and above	339	17.0
₦5000 - ₦9999	572	28.6
Have you seek Healthcare services related to sex work?		
No	173	8.7
Yes	1827	91.4
How often do you seek health care services in Facilities		
Monthly	98	5.4
Once in 3 months	323	17.7
Once in 6 months	757	41.4
Once in a year	649	35.5
What kind of SRHR services have you sought in Last One Year?		
HIV Testing Services (PrEP, PEP and ART)	1871	93.6
STI testing and treatment	1734	86.7
Cervical cancer and breast examination	1772	82.8
Family planning	352	16.5
Post abortion care services	872	40.8

Table 2 shows the rate of use of health care facility and the services of the sex workers. Majority has 20-34 clients in a week, and earns ₦3000-₦4999≡$2-$3.3 and spends ₦10,000-₦14,999≡$6.7-$10. Majority of these sex workers have sought health services as related to their work and the mostly commonly sought services are HIV (93.6%) and STIs (86.7%)

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

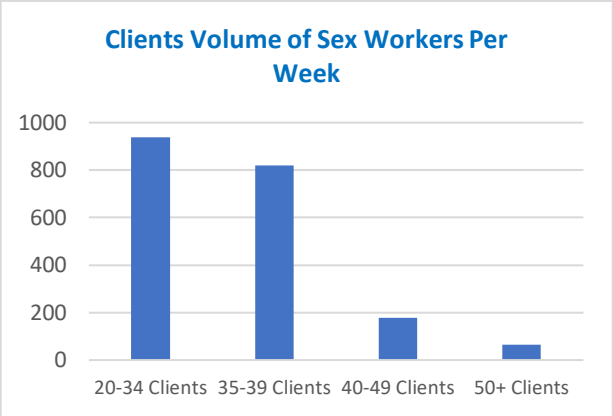

Fig 5: Sex workers' Clients Volume per Week

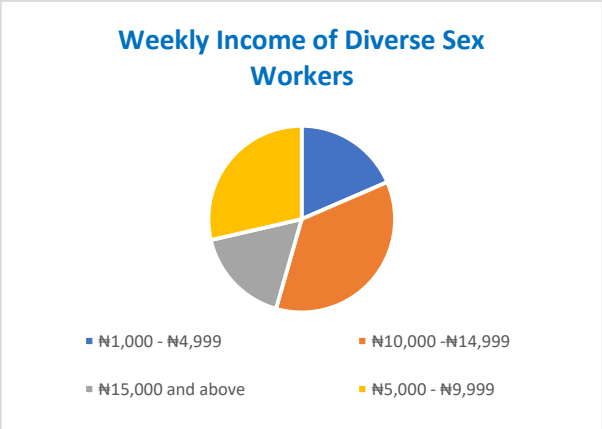

Fig 6: Diverse Sex workers' Weekly Income

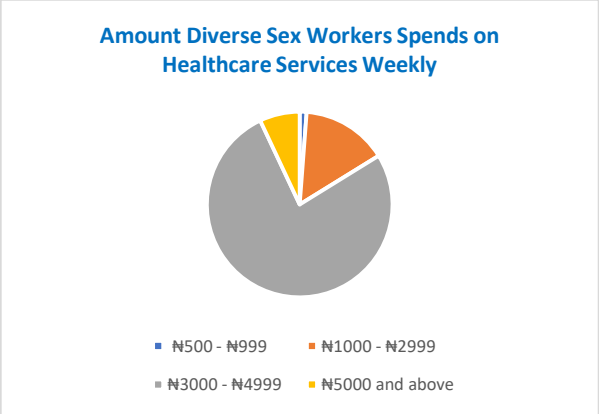

Fig 7: Diverse Sex workers' Weekly Expenses on Healthcare

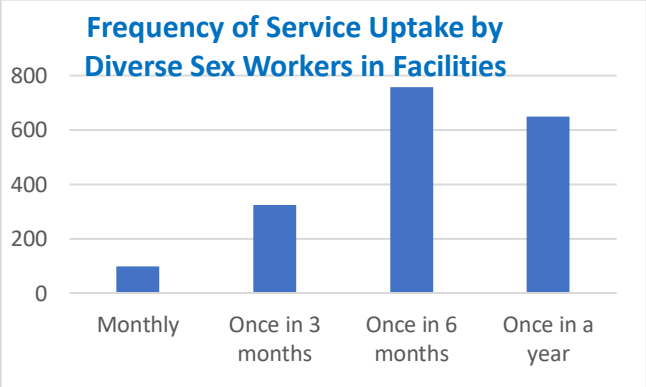

Fig 8: Frequency of Service Uptake by Sex Workers in Facilities.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

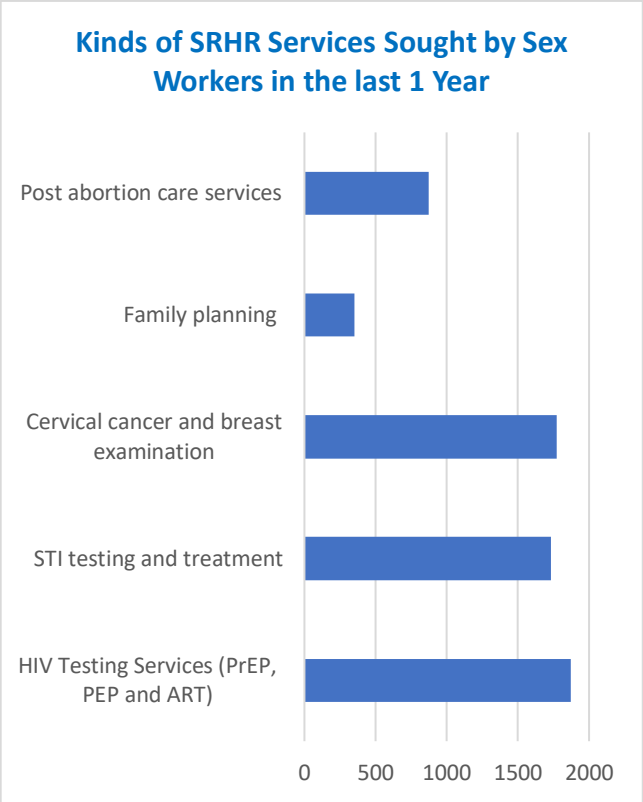

Fig 9: SRHR Services sought in Facilities by Sex Workers in the last 1 Year

Table 3: Effects of Societal Inequalities and Discriminatory Practices on Health Outcomes of Diverse Sex Workers in SRHR Services Uptake

Variables	**Frequency**	**(%)**
Have you ever been Discriminated in accessing the above mentioned SRHR services?		
Yes	1822	91.1
No	178	8.9
Who were Perpetrators of this discrimination?		
Clients	382	17.9
Family members	938	43.9
Brothel owners / chairladies	1008	47.1
Healthcare workers	1655	77.4
Law enforcements agents (Police)	0	0
Have you ever avoided seeking SRHR services in Facilities because of anticipated or previously experienced stigma and discrimination?		

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

Yes	1797	89.9
No	203	10.1
If yes, how do you NOW seek healthcare services?		
Self-medication	1036	48.4
Local pharmacy	1411	66
Trad-medical Specialist	1215	56.8
None of the above	3	0.1

Table 3 above shows that majority of the respondents have been a victim of discrimination in accessing SRHR services (91.1%) and most perceived perpetrators were the healthcare workers (77.4%) and the brothel owners/charladies (47.1%). As a consequence, most of the respondents are now skeptical to access health care services due to anticipated or experienced stigma (89.9%) and currently now rely mostly on local pharmacy (66%) and trad-medical specialist (56.8%) options for their SRHR care services.

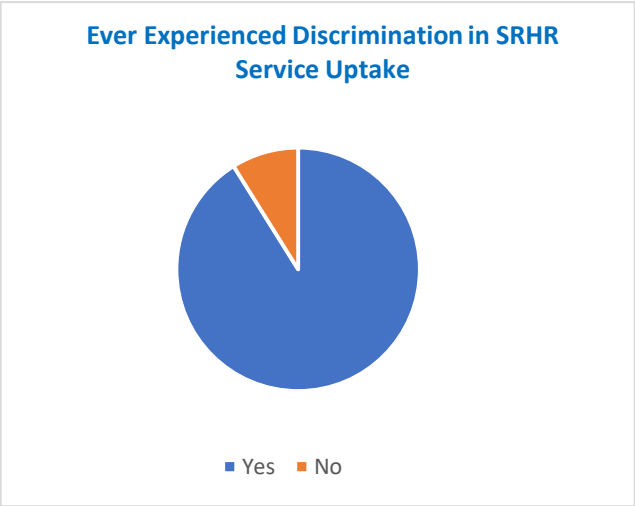

Fig 10: Discrimination Status in SRHR Service Uptake

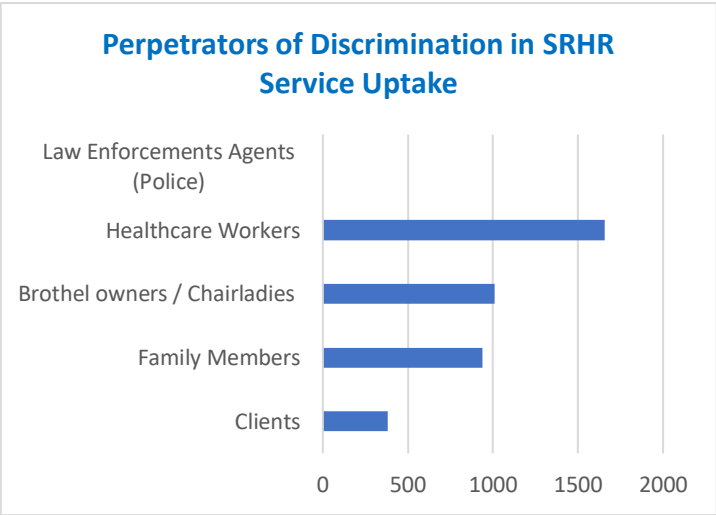

Fig 11: Perpetrators of Discrimination in Sex Workers Bid to Access SRHR Services

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

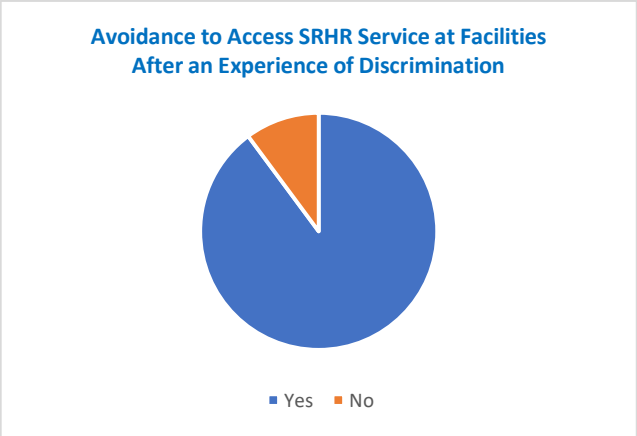

Fig 12: Avoidance Status of SRHR Service Uptake after an experience of Discrimination

Table 4: Service Satisfactory Feedbacks Across visited Government Operated Facilities

Variable	**Excellent (%)**	**Good (%)**	**Fair (%)**	**Poor (%)**	**Very poor (%)**
Attitude of SRH Service providers	30 (1.4)	99 (4.6)	436 (20.4)	865 (40.4)	570 (26.6)
Affordability of SRH services	20 (0.9)	75 (3.5)	592 (27.7)	889 (41.6)	424 (19.8)
Availability of SRH services	29 (1.4)	107 (5.0)	637 (29.8)	817 (38.2)	410 (19.2)
Accessibility of SRH service	23 (1.1)	115 (5.4)	407 (19.0)	895 (41.8)	560 (26.2)
Accountability of SRH services	18 (0.8)	59 (2.8)	318 (14.9)	834 (39.0)	771 (36.0)

Table 4 illustrates the satisfaction levels among various diverse sex workers regarding SRHR service provision. The feedback indicates that most respondents rated the services as relatively poor, very poor, and fair with only a small percentage of respondents reporting an excellent or good level of satisfaction.

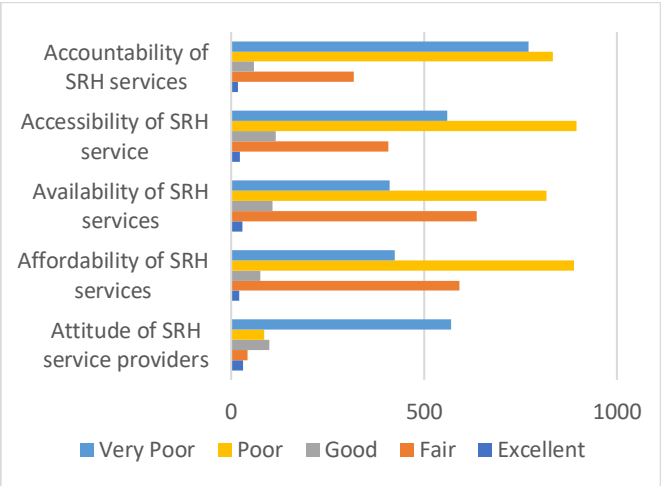

Fig 13: Diverse Service Satisfactory Feedbacks on SRHR Service Delivery

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

Table 5: Other Key Barriers to Quality SRHR Services for Sex Workers

Variables	Frequency	%
Long Waiting Time	1084	50.7
Confidentiality	1366	63.9
Very Whorephobic, Homophobic and Transphobic in nature	1279	59.8
No Focal KP Person for Friendly Interaction	998	46.7
Traditions, Religious bias Practices/ Judgment	504	23.6
Mis-Diagnosis/ Mis-Management	1033	48.3
Systemic and legal Discriminatory issues	1213	56.7
Purposeful Inflation of SRHR services cost	383	17.9
Complete Denial of Service	0	0

Table 5 represents the most perceived key barriers to quality SRHR service uptake among sex workers. From the result the four most perceived barriers were long waiting time (50.7%), confidentiality issues (63.9%), hate for sex work and queer persons (59.8%) and the system and legal discriminatory landscape (56.7%).

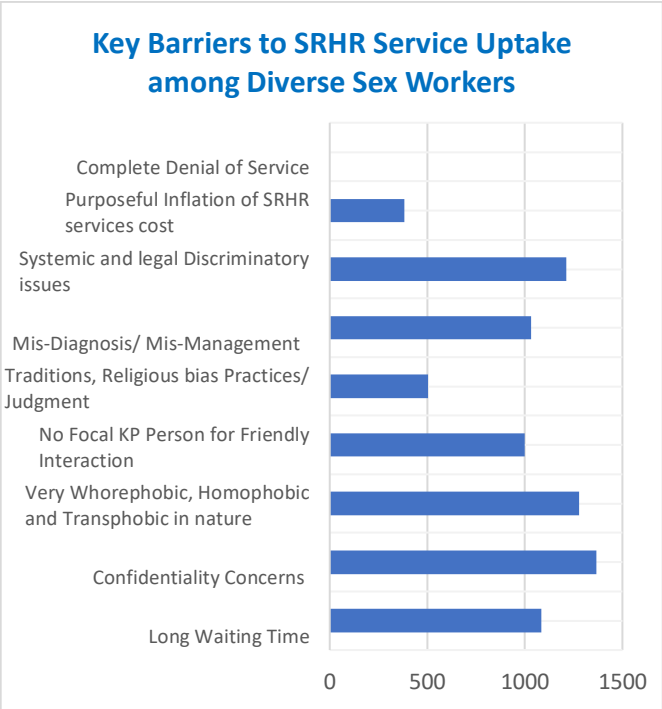

Fig 14: Key Barriers to Uptake of SRHR Services among diverse sex workers

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

Table 6: Long-term Impact Poor SRHR Service Uptake Option and Best Models for Improve Access to SRHR Service for Diverse Sex Workers

Variable	Frequency	(%)
Have you experienced any side effects from seeking SRHR services from informal Service Points.		
Yes	1700	79.5
No	97	4.5
If yes what are some of the side effects		
Re-occurring STIs	1230	57.5
Worsening cases of STIs to STDs	1248	58.3
Unwanted pregnancies	384	18.0
Damage of reproductive system.	162	7.6
Overdose/ drug abuse	1035	48.4
Adverse Drug Reactions	1051	49.1
Post Abortion Complications	579	27.1
Death	0	0.0
What are some of the major changes or improvements you would like to see in the Healthcare system with regards to SRHR service delivery.		
Implementation of non-Discrimination Policy	1765	82.5
Strict Privacy and Confidentiality Practice	1240	58.0
Appointment of Focal Person for Key Population	1012	47.3
Law reform/Change Laws for inclusive Service Delivery	1114	52.1
Non-Clinical Training for Healthcare providers on Gender Identity and Sexual Orientation.	1192	55.7
Reduced Waiting Time	1530	71.5
Reduced Service Cost	0	0.0

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

Table 6 outlines the long-term effects of inadequate SRHR service uptake among sex workers, as well as the most effective models for enhancing service uptake. The data indicate that a significant majority of respondents (79.5%) have experienced adverse side effects from utilizing informal service points. Among these side effects, the most commonly reported were exacerbated cases of STIs progressing to STDs (58.3%), recurrent STIs (57.5%), Post Abortion Complications (27.1%) etc. Furthermore, the table highlights key strategies for improving service delivery. A large proportion of respondents identified the effective implementation of non-discrimination and anti-stigmatization policies (82.5%), reduced waiting times (71.5%), and stringent privacy and confidentiality measures (58%) as crucial factors for enhancing SRHR service uptake among sex workers.

Fig 15: Respondents who have experienced any side effects from seeking SRHR services from informal Service Points.

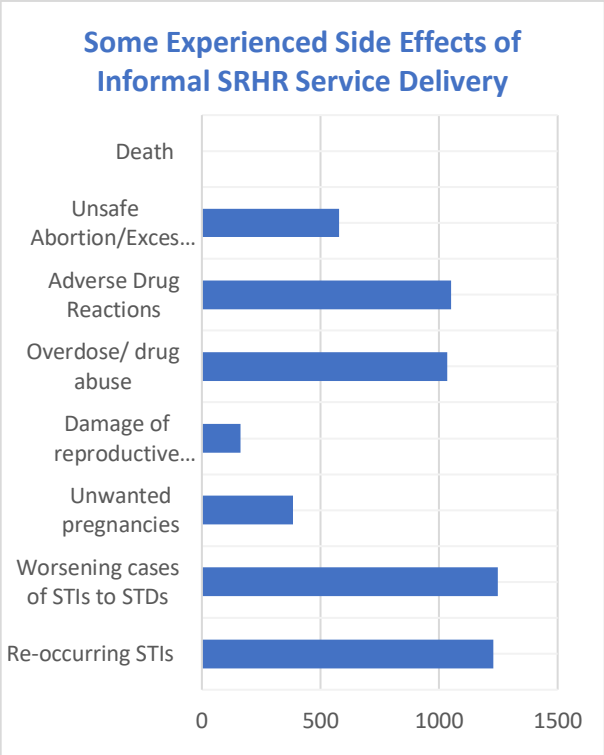

Fig 16: Some Experienced Side Effects of Informal SRHR Service Delivery

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

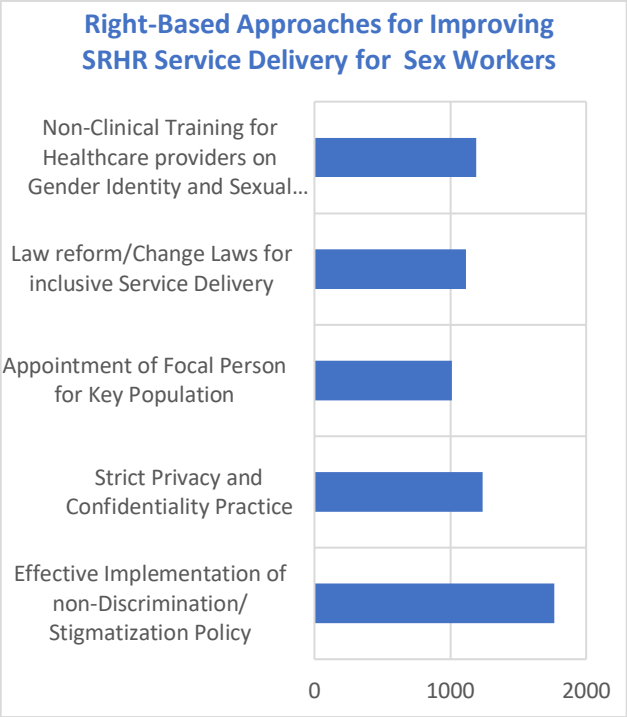

Fig 17: Some Proposed Major Improvements for Effective SRHR Service Delivery to Sex Workers

Qualitative Data

To validate and form correlations with the quantitative data collated from the use of Kobo Collect, the study engaged diverse sex workers through series of participatory focus group discussion and conducted desk reviews of existing laws to match feedbacks from respondents with realities.

Participatory Focus Group Discussions

The study conducted a series of Focus Group Discussions (FGDs) involving over 300 diverse sex workers, highlighting their experiences across several key themes:

a. Legal Barriers:

1. "They made me feel like a criminal just for seeking basic healthcare."
2. "The laws make it impossible to report violence without fearing retaliation."
3. "Laws criminalizing our work make us afraid to seek medical help, even when we need it."

b. Stigma and Discrimination:

1. "Society sees us as disposable; we face judgment everywhere."
2. "Even our families turn away from us because of what we do."

c. Access to Services:

1. "Clinics shut their doors on us, saying they can't help."
2. "We need more places where we can go without fear of being turned away."
3. "Sometimes, we can't afford the services even when we find a clinic that treats us well."

d. Healthcare Provider Attitudes:

1. "Doctors treat us like we're not worth their time, like we don't deserve care."
2. "Nurses whisper and laugh when they see us; it's humiliating."

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

3. "I worry about my privacy. Will the clinic keep my information confidential?"

e. Safety Concerns:

1. I avoid hospitals unless it's life or death; the risk of mistreatment is too high."
2. "I've been denied pain relief after surgery because they assumed I deserved the pain.

f. Self-Medication/ Informal Service Points:

1. "Informal clinics and pharmacies are more discreet, so I prefer them over hospitals where I might be judged. However, I worry about the quality of care and the qualifications of those providing the services."
2. "Self-medication feels like the only option sometimes because we face too much stigma in hospitals. However, it's a gamble with our health."
3. "I often buy medications directly from the pharmacy without a prescription because it's faster and cheaper. But sometimes, I don't get better, and I have to go to the hospital eventually, spending more money."

Policy Desk Review/Analysis

The study conducted a desk review of existing policies, laws, and plans, analyzing their provisions and identifying significant discriminatory gaps as follows:

Table 7: Analysis of some Existing Health Laws/Policies/Plans on its Discrimination Tendency to SRHR Service Uptake

S/N	Laws/Policies/ Framework	Discriminatory Key Gap
1.	Rivers State Reproductive Law (2003)	• **Section 2** of the Law requires all individuals seeking reproductive health services to provide evidence of tax payment, an identity card, and a Local Government identification letter. These requirements are discriminatory towards sex workers, as their occupation places them at odds with societal norms, making it difficult for them to meet these stipulated conditions. With this discriminatory inequality, their access SRHR services will be undermined as it violates their rights as rightsholders. • **Section 4** of the Law recognizes the need for specialized and cost-free reproductive health services for adolescents and adults in designated hospitals in the State. However, it failed to provide specific provisions for sex workers and key populations at large (despite their unique vulnerabilities and need similar to adolescents) especially the transgender sex workers, particularly in the area of gender-affirming care.
2.	Rivers State Contributory Health Protection Programme (RIVCHPP) (2020)	• **Section 52** (Interpretation) of the RIVCHIPP law defines "vulnerable groups" as pregnant women, children under five years, the aged, persons with disabilities, the poor, and others. However, this section notably omits explicit mention of sex workers nor any of the key population typologies. While the term "others" could

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

		theoretically encompass these groups but the absence of specific references may lead law enforcers and implementers to overlook or undervalue the inclusion of sex workers and other key populations to benefit and enjoy the protections provided under the RIVCHIPP law
3	Rivers State Strategic Health Development Plan (2010-2015) and (2018-2022)	• **Strategic Objective 2.1** of its WorkPlan is perceived to be discriminatory to sex workers due to its gender non-responsive approach to budgeting and planning. This omission fails to acknowledge and address the distinctive health needs and vulnerabilities encountered by diverse sex workers in the workplan, thereby potentially breaching principles of non-discrimination and equality
4.	Rivers State HIV/AIDS Anti-Discrimination Law	• Before the passage of the 2014 HIV/AIDS Anti-Discrimination Act, Rivers State had formulated its own HIV/AIDS Anti-Discrimination legislation to specifically address local issues affecting People Living with HIV (PLHIV). However, the current iteration of the Rivers State HIV Anti-Discrimination law is outdated and has not been revised in accordance with the 2014 Act. As a result, discrimination in service delivery persists against PLHIV, particularly impacting key populations such as sex workers.

Source: GWIHR Policy Desk Review Analysis (2022-2023)

DISCUSSION OF FINDINGS

This study explored a baseline of discriminatory attitudes, laws, and societal perceptions that impede sex workers' access to SRHR services in Rivers State, Nigeria. It examines sex workers' health-seeking behaviors, utilization of services, satisfaction levels, prevalent barriers, and their proposed strategies for improvement. The findings highlight how existing discriminatory laws and policies shape healthcare dynamics, affecting the overall well-being and comprehensive SRHR access for sex workers as follows:

Demographic of Sex Workers

Table 1 showed that the study engaged 2,000 sex workers across various Local Government Areas (LGAs) in Rivers State. Key findings revealed a distribution across LGAs such as Obio/Akpor (11.9%), Port-Harcourt (11.6%), Ahoada East (9.1%), Okirika (7.6%), etc. The majority of participants were female (94.2%), with the largest age group being 20-24 years (42%), and most identifying as heterosexual (89.5%). These demographics reflect the concentration of sex work in urban areas like Obio/Akpor and Port-Harcourt, which offer higher population density and economic opportunities conducive to diverse sex work activities. The predominance of young females in this study highlights the specific environments where sex work is more visible and accessible, contrasting with male and LGBT sex workers who often operate discreetly online or from home due to societal stigmatization and associated risks. To contextualize these findings, existing literature emphasizes how urbanization and economic dynamics influence sex work patterns, particularly in African settings where urban centers attract diverse sex work populations seeking better economic opportunities and anonymity (Okonofua, 2018). Studies also underscore the gendered dimensions of sex work, where women are more visible in brothel-based and non-brothel-based settings compared to men and LGBT individuals who face greater social and legal barriers to visibility (Scorgie et al., 2013).

Sex Workers Social Livelihood Versus Utilization of Health Care Services

The study as showed in Table 2 provided significant insights into health-seeking behaviors and service utilization among sex workers in Rivers State. Nearly half (46.9%) reported managing a high client load of 20-

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

34 clients per week, with a majority (76.8%) charging between ₦3000 - ₦4999≡$2-$3.3 per session. Financially, 36.0% allocate ₦10000- ₦14999≡$6.7-$10 monthly for healthcare expenses, indicating substantial investment despite economic challenges. However, a significant proportion (41.4%) of sex workers accessed healthcare facilities biannually, citing hesitancy and fear of the unknown within the healthcare system as primary barriers. From the respondent, the predominantly sought sexual and reproductive health services included HIV Testing Services (PreExposure Prophylaxis (PrEP), Post Exposure Prophylaxis (PEP) and Antiretroviral Therapy (ART) (93.6%), STI testing and treatment (86.7%), cervical cancer and breast examinations (82.8%), and post-abortion care services (40.8%). This shows the need for targeted behavioral change communication to enhance preventive practices and address occupational health risks increasing HIV and STIs prevalence. Additionally, the demand for cancer screening highlights the necessity for expanded screening initiatives to facilitate early detection and intervention. These findings are consistent with existing literature highlighting similar healthcare-seeking behaviors among marginalized populations, attributed to barriers like stigma, economic constraints, and healthcare provider attitudes (Smith et al., 2020; Johnson & Brown, 2018). Addressing these challenges through strategies aimed at building trust, improving affordability, and expanding healthcare outreach is critical to improving health outcomes among sex workers.

Effects of Societal Inequalities and Discriminatory Practices on SRHR Outcomes

Based on Table 3, a significant proportion of sex workers (91.1%) reported experiencing discrimination when accessing SRHR services. This discrimination are primarily perpetuated by healthcare workers (77.4%), who often used derogatory language, made judgmental comments, and provided substandard care to sex workers. Also, Brothel owners (47.1%) contribute to this discrimination through extortion, restrictions, and coerced referrals for health services. Additionally, family members (43.9%) played a pivotal role in determining access to SRHR services by expressing disapproval, manipulating finances, and exerting control over sex workers hence, reflecting societal biases and structural barriers within healthcare settings in the studied locations.

As a result of this widespread discrimination, a substantial majority (89.9%) of respondents actively avoided formal healthcare facilities. Instead, they turned to alternative sources such as local pharmacies (66%), traditional medical specialists (56.8%), and self-medication (48.4%). This shift highlights the perceived benefits of anonymity and reduced judgment at these informal points, despite the potential risks of inadequate or inappropriate care.

These findings underscore systemic issues within healthcare systems that perpetuate discrimination against sex workers, thereby increasing health disparities and vulnerabilities to long-term SRH issues. Existing literature, including studies by Shannon et al. (2015) and Deering et al. (2014), also documents the pervasive discrimination faced by sex workers globally, asserting that such discrimination not only impedes access to essential healthcare services but also deepens health inequities and risks among marginalized populations.

Service Satisfactory Level and Existing SRHR Uptake Key Barriers

The research findings in Table 5 showed that there was a notable dissatisfaction among respondents regarding SRHR services. A significant majority (67%) expressed dissatisfaction with the attitudes of service providers, rating them as "Poor or Very poor." This dissatisfaction likely arises from perceived indifference or judgmental behavior of the service providers, highlighting a critical need for improved training and sensitivity among healthcare personnel which correlates to an existing literature on healthcare provider attitudes and their impact on service utilization among marginalized populations (Smith et al., 2020). Similarly, affordability of services was considered inadequate by 61.4% of respondents, emphasizing the necessity for subsidized or low-cost options to ensure equitable healthcare access for sex workers which aligns with study that discussed financial barriers to healthcare in vulnerable communities (Jones & Brown, 2019). More so, Opinions on service availability and accessibility were mixed as significant proportion perceived these aspects as Fair to Poor (57.4% for availability and 68% for accessibility) which indicates gaps in distribution and operational efficiency of the facilities. These finding also echo concerns raised in previous research about uneven healthcare resource distribution and its impact on service accessibility (Gupta & Ooms, 2017). Moreover, accountability of services was criticized by 75% of participants, underscoring the need for stronger oversight

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

mechanisms and clearer feedback channels. This finding reinforces insights from global health governance literature emphasizing transparent and responsive healthcare systems (WHO, 2021). Further exploration into other key barriers to optimal SRHR service in Table 5 sheds light on numerous pervasive issues hindering sex workers' access to SRHR services. One significant barrier is long waiting times (50.7%), which discourage sex workers from seeking care due to their irregular and demanding schedules. These delays lead to lost income and increased exposure to unsafe working conditions. Also, Confidentiality concerns (63.9%) play a critical role, as many sex workers fear that their health status might be exposed or that they might face legal issues, deterring them from accessing essential services. Additionally, systemic discrimination (56.7%) manifests in judgmental attitudes, denial of services, or substandard treatment, making sex workers hesitant to seek care in the future. Moreso, the absence of a focal Key Population (KP) person for friendly interaction (46.7%) results in a lack of understanding and support, creating an unwelcoming and intimidating healthcare environment for diverse sex workers. Similarly, traditions and religious biases (23.6%) lead to moral judgment by healthcare providers, who often uphold certain religious and cultural norms, thus undermining sex workers' right to bodily autonomy. Furthermore, misdiagnosis or mismanagement (48.3%) is another critical issue, as it erodes sex workers' confidence in medical advice, making them reluctant to seek help even for serious health issues. Finally, the deliberate inflation of SRHR service costs (17.9%) reduces sex workers' financial ability to afford these services, leading to delayed care, untreated conditions, and increased health risks. These findings align with existing research, highlighting the structural and ethical challenges in healthcare delivery to marginalized groups (Brown & Smith, 2018). They underscore the systemic inadequacies in addressing the healthcare needs of sex workers, calling for comprehensive reforms to ensure inclusive and responsive service delivery that is sensitive to their needs.

Long-term Effects of Informal SRHR Service Uptake and Best Models for Improving SRHR Services

Table 6 revealed significant adverse effects among 79.5% of respondents who have accessed SRHR services through informal points. Key issues experienced includes but not limited to high prevalence of recurrent STIs (57.5%), worsen case of STI to more serious STDs (58.3%), unwanted pregnancies (18%), excessive bleeding and post-abortion issues (27.1%) which indicates deficiencies in service quality and professionalism by informal service points. The study also highlighted widespread instances of adverse drug reactions (49.1%) and drug abuse or overdose (48.4%) indicating systemic failures in medication management due to lack of laboratory sensitivity for prescriptions and diagnoses by informal service providers. These findings align with existing literature emphasizing the risks associated with relying on informal healthcare providers among marginalized group as the research consistently showed how such reliance can lead to delayed diagnoses, inadequate treatment, and increased health complications, particularly concerning STIs and general reproductive health (WHO, 2020; The Lancet, 2018). To address the issues, the respondents emphasized several recommendations to enhance healthcare access and improve outcomes at formal service points, including implementing non-discrimination policies (82.5%), reducing waiting times (71.5%), ensuring strict privacy and confidentiality measures (58%), reforming laws to ensure inclusive service delivery (52.1%), providing non-clinical training on gender identity and sexual orientation for healthcare providers (55.7%), and appointing focal persons for key populations (47.3%). These recommendations comply with literature advocating for comprehensive healthcare reforms aimed at improving accessibility, quality, and inclusivity in healthcare services for marginalized populations (UNAIDS, 2021; BMJ Global Health, 2019).

Qualitative Insights of Policy Landscape and Context

The study's policy desk review in Table 7 identified significant discriminatory gaps in existing health laws and policies in Rivers State as the Rivers State Reproductive Health Law requires evidence of tax payment and local government identification letter, which sex workers cannot provide, thereby limiting their access to SRHR services. This is consistent with findings by Bruckert and Hannem (2013), who discuss how bureaucratic requirements frequently marginalize sex workers by imposing barriers they cannot surmount. Additionally, the Rivers State Contributory Health Protection Programme does not explicitly mention sex workers as a vulnerable group, potentially excluding them from the health insurance benefits. This omission is highlighted in studies by organizations such as Amnesty International, which note the frequent exclusion of sex

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XI Issue XV September 2024 | Special Issue on Public Health

workers from healthcare policies that are designed to protect vulnerable populations (Amnesty International, 2016). Furthermore, the Rivers State Strategic Health Development Plan lacks gender-responsive budgeting and planning, failing to address the unique health needs of sex workers. This aligns with critiques from the Global Fund's Technical Brief on HIV and Key Populations, which emphasizes the need for gender-sensitive approaches in health planning to ensure equitable access to services (The Global Fund, 2019). The Rivers State HIV/AIDS Anti-Discrimination Law is outdated and not aligned with national anti-discrimination standards, perpetuating service delivery discrimination against sex workers. This finding echoes the United Nations' call for updating and aligning local laws with international human rights standards to ensure inclusive and non-discriminatory access to healthcare (UNAIDS, 2020). The policy analysis underscores the institutional neglect and active exclusion of sex workers from critical health services and protections. This is further supported by studies from the Lancet HIV, which document how legal and institutional barriers contribute to the health disparities faced by sex workers (The Lancet HIV, 2018).

The Focus Group Discussion with 300 respondents qualitatively highlighted the impacts of these discriminatory laws, revealing pervasive societal judgment and familial rejection significantly affecting their mental and physical health. Negative attitudes and confidentiality breaches by healthcare providers deterred sex workers from seeking necessary care. Safety concerns were also paramount, as many sex workers avoided healthcare facilities due to the risk of mistreatment and discrimination. These insights are corroborated by research on how stigma and discrimination in healthcare settings deter sex workers from accessing needed services hence further marginalizing them (Scambler & Paoli, 2008). These qualitative findings further revealed the deep-seated societal and legal challenges sex workers face, extending beyond healthcare access. Legal barriers and societal judgment create a climate of fear and marginalization, exacerbating difficulties in accessing services and maintaining overall well-being. This aligns with the broader literature on the social determinants of health, which emphasizes the need for comprehensive policy reforms to address the systemic inequities faced by marginalized populations (WHO, 2021).

RECOMMENDATIONS

Based on the findings, the study recommends that Government, Policy Makers, Civil society Organization and healthcare systems:

Reform Policies:

1. Implement and enforce policies that prohibit discrimination against sex workers in healthcare settings to ensure equitable access to SRHR services.
2. Reform existing health laws to explicitly include sex workers as a vulnerable group deserving of healthcare benefits and protections.
3. Incorporate gender-responsive budgeting and planning in health development plans to address the unique health needs of sex workers.

Improves Service Delivery:

1. Conduct regular non-clinical training on sexual orientation, gender identity and expression for healthcare providers to reduce stigma.
2. Appoint dedicated healthcare personnel for key populations, including sex workers, to ensure friendly and informed interactions in healthcare facilities.
3. Provide subsidized or low-cost SRHR services to alleviate financial barriers and ensure sex workers can afford necessary healthcare.
4. Strengthen privacy and confidentiality protocols in healthcare settings to build trust, reduce waiting time and encourage sex workers to seek formal healthcare services.

Monitoring, Accountability and Partnership:

1. Establish stronger oversight mechanisms and clear feedback channels to ensure accountability in healthcare service delivery.

2. Create transparent and responsive systems for sex workers to report discrimination and other issues encountered in healthcare settings.
3. Foster partnerships between formal healthcare facilities and informal service points to bridge gaps in healthcare access and quality.

Research and Data Collection:

1. Conduct ongoing research to monitor and evaluate the impact of implemented reforms and policies on sex workers' health outcomes and service utilization.
2. Use collected data to inform and refine strategies for improving healthcare access and reducing disparities among sex workers.

CONCLUSION

This study provided a valuable baseline of the discriminatory attitudes, laws, and societal perceptions that hinder sex workers' access to SRHR services in Rivers State, Nigeria. The findings underscore the intersection of healthcare dynamics, societal inequality and the SRHR outcomes of sex workers, highlighting the adverse impact of discriminatory policies and societal stigmas through the engagement of 2,000 diverse sex workers. The study comprehensively highlighted the myriad barriers sex workers face in seeking healthcare, ranging from financial constraints to pervasive discrimination by healthcare providers. Additionally, it exposes the detrimental effects of relying on informal healthcare service points for SRHR needs, underscoring the necessity of reinforcing inclusive service delivery across formal healthcare settings to improve health outcomes for sex workers. Furthermore, through qualitative insights, the study revealed deep-seated societal and legal challenges, emphasizing the urgent need for comprehensive policy and systemic reforms both in laws and in practice. These reforms are essential to addressing these issues and improving SRHR service access and delivery for sex workers. Given this identified baseline discriminatory gaps, the study also acknowledged that with persistent advocacy for legal reforms, positive shift in healthcare practices and institutional support of sex workers' rights that it is possible to create a society where the healthcare system recognizes and meets the tailored SRHR needs of sex workers in service delivery.

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