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Disclosure of domestic violence and help-seeking behaviours among female survivors living with Human immunodeficiency virus (HIV) in Anambra State, Nigeria

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Domestic violence (DV) remains a pervasive public health challenge that affects women's physical, mental, and social well-being. Disclosure and help-seeking behaviours among survivors are critical for effective intervention and support. This study assessed the disclosure patterns and help-seeking behaviours of female survivors of DV in Nigeria. A descriptive cross-sectional study was conducted among 300 women living with Human immunodeficiency virus (HIV) in a tertiary teaching hospital. Data were collected using an interviewer-administered questionnaire. The mean age of respondents was 37.3 ± 11.0 years. The overall prevalence of physical, emotional, sexual, and combined forms of DV was 15.3, 13.3, 8.7, and 5.0%, respectively. Among the 46 (15.3%) survivors, 13% did not disclose their experience, while 28.4% reported to parents or siblings, 19.6% to in-laws, 21.7% to religious leaders, 13% to health workers, and 4.3% to friends or social groups. No reports were made to law enforcement agencies. Most respondents (80%) received counselling, prayer, or emotional support, while 10% received financial assistance, 7.5% shelter, and 2.5% medical support. Disclosure of DV among women living with HIV in Anambra State remains suboptimal. Strengthening community sensitization, integrating DV screening into HIV care, and empowering women through accessible support services are essential for improved outcomes.

Key words: Domestic violence (DV), disclosure, help-seeking behaviour, human immunodeficiency virus (HIV), Anambra State.

INTRODUCTION

Domestic violence (DV), also referred to as intimate partner violence (IPV), remains a major global public health concern and a violation of fundamental human rights. It encompasses physical, sexual, psychological,

and economic abuse inflicted by a current or former intimate partner or family member (World Health Organization [WHO], 2018). The WHO estimates that nearly one in three women worldwide (30%) have experienced physical or sexual violence by an intimate partner at least once in their lifetime (Devries et al., 2023). The consequences of such violence extend beyond immediate physical injuries to include mental health disorders, chronic illnesses, reproductive health complications, and increased vulnerability to Human immunodeficiency virus (HIV) infection (Sardinha et al., 2022; Chirwa et al.,2021). In sub-Saharan Africa, the prevalence of DV is particularly high, reflecting deep-rooted gender inequalities, sociocultural norms, and limited access to legal or social support systems (Ezeudu et al., 2021). Nigeria, being the most populous country in Africa, faces a significant burden of DV, with national studies reporting lifetime prevalence ranging between 20 and 50% among women of reproductive age (Adebayo et al., 2021; National Population Commission, 2022). Despite the enactment of the Violence Against Persons (Prohibition) Act (VAPP) in 2015, enforcement remains weak, and many survivors continue to experience stigma, economic dependence, and inadequate institutional support (Ojukwu and Anyikwa, 2015).

Disclosure of violence and subsequent help-seeking behaviour are crucial steps toward addressing DV and preventing its recurrence. However, these actions are often hindered by fear of retaliation, social shame, economic constraints, and lack of trust in formal institutions such as the police or health services (Ayodapo et al., 2022; Onah et al., 2020). Research shows that women who disclose their experiences typically seek support from informal sources such as family members, religious leaders, or friends, rather than formal agencies (Uzochukwu et al., 2021). This trend limits opportunities for effective intervention and protection. Among women living with HIV, the intersection between DV and health vulnerabilities is particularly challenging. IPV has been associated with poor adherence to antiretroviral therapy, increased viral load, and reduced quality of life (Hatcher and Smout, 2022). Furthermore, the disclosure of HIV status can sometimes trigger domestic conflict or violence, further discouraging women from seeking help (Osuagwu et al., 2023). Despite the evident link between HIV and DV, limited data exist in Nigeria, especially in southeastern states such as Anambra, on how female survivors disclose violence and seek help. Understanding the patterns of disclosure and help-seeking behaviours among women living with HIV who experience DV is critical for developing tailored interventions that integrate HIV care and gender-based violence (GBV) services. This study, therefore, aimed to assess the disclosure and help-seeking behaviours of female survivors of DV attending the HIV clinic at Nnamdi Azikiwe University Teaching Hospital, Nnewi, Anambra State, Nigeria.

Conceptual framework

The conceptual framework shows how individual, interpersonal, community, health-system, and legal/policy factors shape mediators such as perceived stigma, fear, and self-efficacy. These mediators, in turn, influence whether women living with HIV (WLHIV) disclose DV and whether and how they seek help. It also shows how help-seeking and outcomes feed back into the system. The individual factors include HIV status and its visibility (diagnosis, ART status), mental health, substance use, economic dependence, education, and knowledge. Interpersonal factors include partner behaviour (severity and frequency of violence, control, threat), family support, and household power dynamics. The community-level factors include social norms (gender norms, acceptability of violence), community stigma toward both HIV and DV, and religious or cultural expectations. The health system factors include availability, accessibility, and perceived confidentiality of health and psychosocial services; provider attitudes; and integration of HIV and GBV services. The legal and policy environment include existence and enforcement of protective laws, legal literacy, and access to legal aid. The mediators mediate the relationship between contextual determinants and the decision to disclose or seek help. The mediators include perceived stigma (HIV and DV), fear of retaliation (partner violence, social ostracism), self-efficacy to act, risk perception, anticipated loss (economic, child custody), and trust in services (Figure 1). Disclosure and help-seeking behaviours could be through the informal or formal pathways. The informal pathway includes the family, peers, religious leaders, and community leaders. While the formal pathway includes the health services (integrated HIV/GBV care), psychosocial support, police and legal services, and shelters. Choice of route of disclosure depends on perceived confidentiality, prior experience, cost, access, and anticipated effectiveness.

METHODOLOGY

Study design

The study was a hospital-based descriptive cross-sectional study

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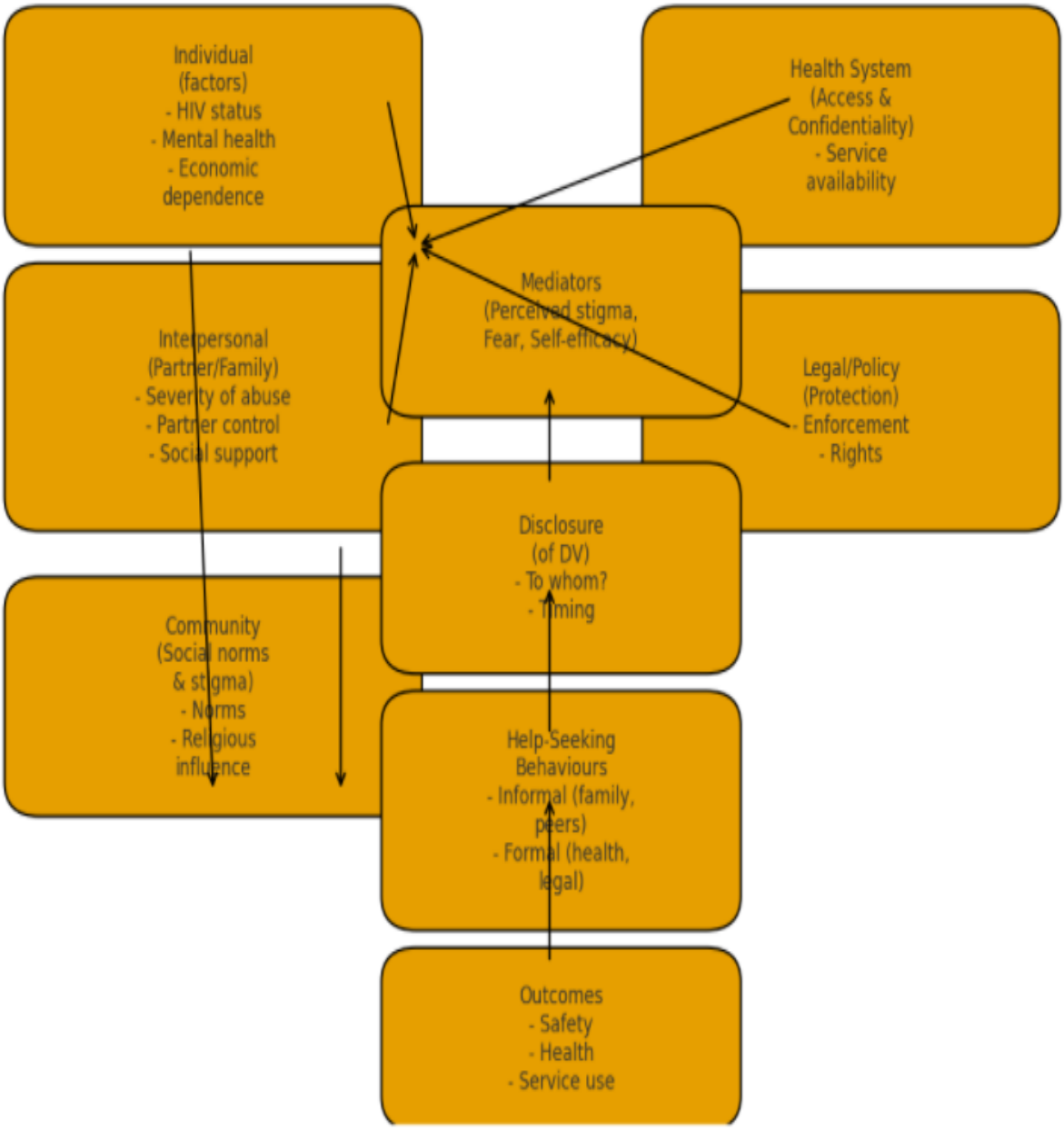

Figure 1. Determinants and mediators of disclosure and help-seeking behaviour.
Source: Developed from literature review of similar studies.

conducted in a tertiary teaching hospital, the Nnamdi Azikiwe University Teaching Hospital, Anambra State, Southeast Nigeria.

Study area

The research was conducted in Anambra State, which is one of the 36 states in Nigeria. The capital of Anambra State is Awka. The name "Anambra" is a translation from the original name of the river Omambala. Anambra State shares borders with Delta State to the west, Imo and Rivers State to the south, Enugu State to the east, and Kogi State to the north. The original Anambra State was created in 1976 when East Central State was divided into Anambra and Imo States. There are three senatorial districts in the state, namely Anambra North senatorial district, Anambra Central senatorial district and Anambra South senatorial district. There are 21 local government areas in the state. The indigenous ethnic groups residing in Anambra State primarily consist of the Igbo community, which represents 99% of the total population. Anambra is ranked as the eighth most prominent state within Nigeria, and it is the second most densely populated state in Nigeria, following closely behind Lagos State (City Population Anambra State, 2025). It has a total area of 4,710 km², a population density of 1,264/km², and an annual population growth rate of 2.2% (City Population,

2023). As of 2022, Anambra State's projected population was 5,953,500 (City Population Anambra State, 2025). The male population accounts for 50.7% of the total, while the female population represents 49.3% (City Population, 2023). Furthermore, the age demographic breakdown shows that individuals aged 0 to 14 years constitute 35.5% of the population, those aged 15 to 64 years make up 60.5%, and individuals above the age of 65 account for 4% of the total population (City Population Anambra State, 2025). The major occupation is trading and agriculture. In 2022, the estimated HIV prevalence in Nigeria was 2.1%, while Anambra State, located in South-Eastern Nigeria, had a 2.4% prevalence, with about 96,392 people living with HIV (People Living with HIV [PLHIV]) (Ukueku et.al., 2025). However, a significant number of individuals living with HIV remain unidentified due to factors such as stigma, limited access to HIV testing services (HTS) across diverse settings, and the lack of focused and strategic approaches to HTS.

The Nnamdi Azikiwe University Teaching Hospital (NAHUTH), Nnewi, was selected as the study site for this research. This institution is a federal teaching institution renowned for its academic excellence. The hospital is equipped with a specialized HIV unit that operates a routine HIV clinic from Monday to Friday each week. Comprising six consulting rooms, this unit attends to approximately 80 clients on a daily basis. Notably, female clients constitute a significant majority of the individuals seeking care at the clinic. It is important to highlight that NAUTH was initially established by the Anambra State of Nigeria (ASN) as the Anambra State University of Technology Hospital, Nnewi, sharing premises with the then General Hospital, Nnewi. Subsequently, on the 16th of June, 1990, the General Hospital was officially handed over to the Teaching Hospital Management Board. A major milestone was achieved on Friday, July 19, 1991, when the then Anambra State Military Governor, Col. Robert Akonobi, formally commissioned the hospital, temporarily utilizing the General Hospital as a location. In a significant development, the Federal Government of Nigeria renamed the hospital as the Nnamdi Azikiwe University Teaching Hospital in honour of the late Dr. Nnamdi Azikiwe, GGFR PC, Owelle of Onitsha, as per Decree No. 68 of the 1992 constitution.

Study population

The study population consisted of all women living with HIV who were accessing care at the HIV unit of Nnamdi Azikiwe University Teaching Hospital, Nnewi (NAUTH).

Inclusion criteria

This included all women living with HIV who were accessing care at Nnamdi Azikiwe University Teaching Hospital, Nnewi (NAUTH).

Exclusion criteria

This includes:

1) Women living with HIV who were critically ill,
2) Women living with HIV who did not give consent for the interview,
3) Female adolescents living with HIV who are less than 18 years old.

Sample size determination

The sample size was determined using the Cochran's formula for descriptive studies, given as (Charan et.al., 2021):

$N= Z^2 pq/d^2$

where n = the minimum sample size, Z= standard normal deviate of the 95% confidence, which is 1.96, P = prevalence or proportion of outcome measure from previous studies, q =1-p, and d= precision or margin of error usually fixed at 5% (0.05). The prevalence of DV of 22.1% from a previous study in Aminu Kano Teaching Hospital, Nigeria by Iliyasu et al. (2011) was used. Computing the values into the formula: $N= Z^2 pq/d^2$ and considering a 10% non-response rate, the total sample size was approximated to 300.

Sampling technique

A systematic random sampling technique was adopted for this study. During each clinic day, serial numbers were assigned to all eligible women living with HIV attending the HIV clinic. The total number (N) of eligible female clients present at each clinic day was counted, and each person was given a serial number. After the routine daily health talk by the staff nurse, information about DV and the importance of the research was discussed with them by the principal investigator. Then the first participant was selected by a simple random method. The next respondent was selected at every constant interval (k). The k interval was determined by dividing N (the total number of eligible clients present for that day) by n (the number of clients to be interviewed for that day, which was 20). Therefore, at every k interval, the next participant was selected until the required 20 participants for that clinic day were reached. About 50 female clients visit the clinic on average every day, and the clinic runs from Monday to Friday every week. This procedure was repeated for 15 clinic days (at least three weeks) to capture the required sample size for the study.

Study instruments

A semi-structured interviewer-administered questionnaire adapted from the “WHO multi-Country Study on Women’s Health and Domestic Violence” was used as the study instrument to collect data for this study. The interviewer-administered questionnaire had four sections, which include Section A, which provided data on social-demographic characteristics of the respondents. Section B screened for physical, emotional (psychological), and sexual violence. There were 3 screening questions for physical violence, 4 screening questions for emotional or psychological violence, and 3 screening questions for sexual violence. The response to each screening question will either be “Yes” or “No”. Participants who answered “Yes” to one or more of the questions on violence were considered victims of intimate partner violence. Section C assessed the help-seeking behaviour and support received by the respondents experiencing IPV. The questionnaire was prepared and administered in English language.

Data collection method

Data was collected by five trained female data collectors. The study members were told about the study, its importance, and its benefits in the HIV clinic each day. Questions were entertained and clarifications made. They were informed that participation was voluntary and assured of confidentiality and privacy. Verbal and written consents were obtained before the collection of data started. Data collection was done in quiet, private consulting rooms by the data collectors. The women were asked questions using the questionnaires, and their responses were appropriately registered on the questionnaires. The study lasted for a duration of 22 weeks.

Pre-testing

The instruments for the research were pretested at the Nnewi North health centre, Nnewi, which conducts HIV clinic services from Mondays to Fridays. A pre-test of 10% (30) of the sample size was used. The pre-testing assessed the validity of the questionnaire, the capability of the research assistants, the interactions and cooperation between interviewer and interviewee, the time it takes to complete the interview, the need for necessary corrections in the study instrument, and the feasibility of the sampling procedures.

Training of research assistants

Five female research assistants who have completed at least secondary school level education and can read and understand English were recruited and trained. They included 2 voluntary staff in the HIV unit and 3 staff nurses working in the HIV unit. They speak, understand, and verbally translate English into the Igbo dialect to enhance accurate data collection, especially among less educated participants. The research assistants received three days of training on interviewing techniques, as well as the purpose and importance of the study. They were also trained on the importance of privacy, the sensitivity of the research topic, appropriate conduct during interviews, and maintaining respondent confidentiality. Only female research assistants were employed in the study to improve participant comfort and cooperation.

Plan for data management

The collected data were supervised each day to ensure accuracy and completeness. A meticulous data cleaning process was employed, involving techniques such as frequency analysis, sorting, and listing to identify missing values and outliers. Any identified errors were rectified by referring back to the original questionnaires. The subsequent analysis of the data was conducted using SPSS version 25.

Measurement of variables

The experience of IPV, which is a qualitative variable, nominal, and dichotomous, was considered as the dependent or outcome variable, while the independent variable included sociodemographic factors of the victims and the perpetrators. The sociodemographic factors included age, religion, current marital status, duration of current relationship, ethnicity, level of education, occupation, duration of HIV infection, current viral load status, and other variables.

Statistical analysis

Data were organized and documented in tables, frequencies, percentages, and figures. The variables of respondents were described using simple frequencies, measures of central tendency, and measures of variability. Bivariate statistical analysis was conducted to examine the relationship between each independent variable and the outcome variable of domestic violence. All variables with p-value <0.2 at 95% confidence interval (CI) in the bivariate analysis were taken into the multivariable analysis to find the factors that are significantly associated with domestic violence and control for confounders using SPSS version 25. Odds ratios (OR) with 95% CI were reported to show the strength and direction of associations.

Ethical considerations

Ethical clearance was obtained from the ethics research committee of school of Postgraduate Studies, University of Port-Harcourt. The University of Port-Harcourt ethics reference number is UPH/ SPH/ ACAD/MPH/ ETHICS/ 2022/ 044, and it was issued on 27th February, 2023. Written informed consent and signed consent were obtained from each participant, clearly addressing and informing them about the purpose, risk, and benefit of the study. It was emphasized that all information obtained would be treated with confidentiality and that participants had absolute freedom to withdraw at any time.

RESULTS

A total of 300 interviewer-administered questionnaires were used to collect data for the research, and a response rate of 100% was achieved. The mean age of the respondents was 37.3(±11.0). Most of the respondents were 40-49 years (92; 30.7%) and 50 years and above (93; 31.0%). The age of the respondents was significant in the experience of domestic violence ($\chi 2$: 15.76; P: 0.001). Respondents who were older than 49 years experienced domestic violence more than other age groups in the study (28.0%). Most of the participants were Christians (294; 98.0%) and married (218; 72.7%). The association of the marital status of women living with HIV to domestic violence was significant ($\chi 2$: 9.12; P: 0.029). The divorced women experienced domestic violence the most (40.0%), while the married women experienced the least in the experience of domestic violence (12.8%). Most of the respondents were in a relationship for over 5 years (139; 46.3%), followed by those in a relationship between 1 and 5 years (106; 35.3%). Respondents who were not in a relationship and those in a relationship between 1 and 5 years experienced domestic violence the most (25.0% and 17.0% respectively). However, the duration of the relationship was not significant. The Igbos made up the majority in this study (254; 84.7%). The respondents who were Hausa experienced domestic violence the most (17.6%); however, ethnicity was not significant in this study. In the study, most of the respondents had a secondary school education (158; 52.7%). It was noted that respondents with no formal education and those with primary school education experienced domestic violence more often than their counterparts (24.0 and 19.7%, respectively). The level of education of the respondents was, however, not significant. The occupation of the majority of the respondents was business or trading (179; 59.7%). The respondents not working (students and housewives) were the next highest in number (59; 19.7%). The professionals experienced domestic violence the most (27.3%). The occupational status of the respondents was not significant. The monthly wages of most of the respondents were below ₦30,000 (164; 54.7%). Respondents having a monthly income of less

than ₦30,000 and ₦30,000 to ₦50,000 experienced more domestic violence (15.9 and 14.8% respectively). The monthly income of the respondent was not significant. The study revealed that the mean and median duration of HIV infection were 2.6 and 3.0 years, respectively. Most of the respondents had the HIV infection for over five years (175; 58.3%). Respondents who were positive for less than 1-year experienced domestic violence most (33.3%), while the other groups had a similar frequency of domestic violence (14.9 and 14.7% for respondents having HIV infection >5 years and 1 to 5 years, respectively). The duration of HIV infection was not significant in this study. Most of the respondents had viral load of <20 copies/ml (191; 63.7%), 15% (45) of the respondents had viral load of 20 to 1000 copies/ml, 14.7% (44) of the respondents were not sure of their viral load status and 6.6% (20) had viral load higher than 1000 copies/ml. The respondents with viral load of <20 copies/ml and 20 to 1000 copies/ml experienced domestic violence more than the other groups (17.5 and 15.6% respectively). Respondents who were unsure of their viral load status and those with a viral load greater than 1000 copies/ml experienced domestic violence at rates of 10.0 and 9.1%, respectively. Viral load status was not significantly associated with domestic violence in this study. Most respondents had between one and five children (59.3%; n = 178). Those with more than five children experienced the highest rate of domestic violence (24.2%). The association between the number of children and domestic violence was statistically significant ($\chi^2 = 9.71$; $p = 0.027$).

Most of the women disclosed their HIV status to relatives or partners (210; 70.0%), whereas 30.0% did not disclose their status to anyone. Women who did not disclose their HIV status experienced slightly higher levels of domestic violence compared to those who disclosed (15.6% vs. 15.2%). However, the association between HIV status disclosure and domestic violence was not statistically significant (Table 1).

A total of 46 survivors of domestic violence seek help. It was noted that 13% (6) of the victims did not report to anybody, 28.4% (13) reported to their parents or siblings, 19.6%((9) reported to partner' parents or in-laws, 21.7% (10) reported to religious leaders, 13.0% (6) reported to health workers in the hospital, and 4.3% (2) reported to friends or their social organizations. There was no report to the law enforcement agency (Table 2). In the study, out of the 40 victims who reported their experience, most of the victims (32; 80%) were counselled, prayed for, or given emotional support. 10% of the victims had financial support, 7.5% (3) were given shelter, and 2.5% (10) had medical support (Table 3).

DISCUSSION

This study examined the disclosure and help-seeking behaviours of female survivors of DV living with HIV in Anambra State, Nigeria. The findings revealed that 15.3% of the respondents experienced physical violence, 13.3% emotional violence, 8.7% sexual violence, and 5.0% combined forms of abuse. The prevalence of DV observed in this study is consistent with findings from other Nigerian and sub-Saharan African studies, although slight variations exist due to differences in study populations and methodologies. For instance, Adebayo et al. (2021) reported a national prevalence of 21% for physical violence and 9% for sexual violence among women of reproductive age in Nigeria, while Ayodapo et al. (2022) found a prevalence of 18.6% among women attending antenatal clinics in Southwestern Nigeria. Similarly, a study conducted in Enugu State reported that 22.4% of women living with HIV experienced at least one form of DV (Uzochukwu et al., 2021). These findings underscore that intimate partner violence remains a pervasive issue across different socio-demographic contexts in Nigeria. The current study found that only 87% of victims disclosed their experience, while 13% did not report to anyone. This aligns with the results of Onah et al. (2020) and Uzochukwu et al. (2021), who observed that fear of stigma, economic dependence, and lack of confidence in formal institutions often discourage survivors from seeking help. Comparable patterns have been reported in Kenya and Uganda, where informal disclosure to family members or religious leaders was more common than reporting to police or healthcare providers (Okoth et al., 2022; Nanfuka et al.,2021). The preference for informal networks in the present study, such as parents, siblings, and religious leaders, reflects the socio-cultural environment in which family and faith-based systems play crucial support roles but may lack the capacity to provide legal or psychosocial protection. The absence of reports to law enforcement agencies in this study is particularly concerning. Similar findings were reported in studies from Lagos and Northern Nigeria, where only 3 to 5% of survivors sought police intervention despite the existence of protective legislation (Adesina and Adeyemi, 2023; Yakubu et al., 2022). This gap underscores the weak enforcement of the VAPP Act and low public confidence in justice systems (Ojukwu and Anyikwa, 2015). Strengthening awareness of the VAPP Act and sensitizing police and judicial officers to respond to GBV cases could bridge this gap.

In terms of support received, most victims in this study were offered emotional or spiritual assistance, while only a few received financial, medical, or shelter support. This pattern has been similarly documented in Tanzania and Ghana, where emotional support predominated due to limited institutional resources (Kilonzo et al., 2020; Mensah and Ofori et.al.,2021). Conversely, in South Africa, where integrated GBV-HIV services exist, survivors were more likely to access medical and legal support (Khumalo and Mabaso, 2023). This comparison

Table 1. Socio-demographic characteristics of respondents.

Variable	Yes (109; 36.3%)	No (291; 63.7%)	Total (300)	Chi-Square	P-Value
Age (years)					
<30	5 (13.9)	31 (86.1)	36		
30-39	10 (12.7)	69 (87.3)	79	15.76	0.001*
40-49	5 (5.4)	87 (94.6)	92		
>49	26 (28.0)	67 (72.0)	93		
Religion					
Christianity	45 (15.3)	249 (84.7)	294	0.69	0.722
Islam	1 (25.0)	3 (75.0)	4		
Others	0 (0.0)	2 (100.0)	2		
Marital status					
Single	11 (17.2)	53 (82.8)	64		
Married	28 (12.8)	190 (87.2)	218	9.12	0.029*
Cohabiting	1 (33.3)	2 (66.7)	3		
Divorced/separated	6 (40.0)	9 (60.0)	15		
Duration of the relationship					
<1	1(6.7)	14(93.3)	15		
1-5	18(17.0)	88(83.0)	106	3.10	0.172
>5	17(12.2)	122(87.8)	139		
No relationship	10(25.0)	30(75.0)	40		
Ethnicity					
Igbo	40 (15.7)	214 (84.3)	254		
Yoruba	3 (13.6)	19 (86.4)	22	1.97	0.701
Hausa	3 (17.6)	14 (82.4)	17		
Others	0 (0.0)	7 (100.0)	7		
Level of education					
No Formal education	6 (24.0)	19 (86.0)	25		
Primary	12 (19.7)	49 (80.3)	61	4.17	0.322
Secondary	22 (13.9)	136 (86.1)	158		
Tertiary and above	6 (10.7)	50 (89.3)	56		
Occupation					
Not working/Housewife	7 (11.9)	52 (88.1)	59		
Professional	3 (27.3)	8 (72.7)	11	1.54	0.724
Civil servant	7 (14.9)	40 (85.1)	47		
Business/Trading	28 (15.6)	151 (84.4)	179		
Others*	1 (25.0)	3 (75.0)	4		
Monthly income (₦)					
<30,000	26 (15.9)	138 (84.1)	164	0.25	0.885
30,000-50,000	20 (14.8)	115 (85.2)	135		
>50,000	0 (0.0)	1 (100.0)	1		
Duration of HIV infection(years)					
<1	3 (33.3)	6 (66.7)	9	0.43	0.314

Table 1. Contd.

1-5	17 (14.7)	99 (85.3)	116		
>5	26 (14.9)	149 (85.1)	175		
Viral load status					
<20	33 (17.3)	158 (82.7)	191		
20-1000	7 (15.6)	38 (84.4)	45	1.84	0.509
>1000	2 (10.0)	18 (90.0)	20		
Not sure	4 (9.1)	40 (90.9)	44		
Number of children					
0	4 (6.7)	56 (93.3)	60	9.71	0.027*
1-5	27 (15.2)	151 (84.8)	178		
>5	15 (24.2)	47 (75.8)	62		
Disclosure of HIV status					
Yes	32 (15.7)	178 (84.8)	210	0.35	0.944
No	14 (15.6)	76 (84.4)	90		

Table 2. Reporting of domestic violence by respondents who experienced domestic violence.

Variable	N=46	Frequency (%)
Did not report	6	13.0
Parents/ Siblings	13	28.4
Partner parents/In-laws	9	19.6
Religious leader	10	21.7
Friends/ Social Organization	2	4.3
Health Worker/Hospital	6	13.0
Law Enforcement Agency	0	0.0
Total	46	100

N: The number of respondents who experienced domestic violence.

Table 3. Support received by victims of domestic violence who reported their experience of domestic violence.

Variable	N=40	Frequency (%)
Counselling/Prayers/Emotional Support	32	80.0
Financial support	4	10.0
Shelter	3	7.5
Medical support	1	2.5

N: The number of victims who reported domestic violence.

highlights the importance of integrating DV response mechanisms into HIV care settings in Nigeria to improve service uptake and survivor outcomes. The intersection between HIV and DV, as demonstrated in this study, also aligns with global evidence linking violence exposure to poor adherence to antiretroviral therapy and reduced engagement in care (Chirwa et al.,2021). Hatcher et al. (2022) and Osuagwu et al. (2023) reported that fear of violence following HIV disclosure remains a significant barrier to consistent treatment. Therefore, routine

screening for DV in HIV clinics, coupled with confidential counselling and referral systems, is critical for mitigating its adverse effects on health outcomes. Overall, the findings of this study emphasize that while disclosure of DV is relatively common among women living with HIV, help-seeking remains primarily informal and underutilized. A multi-sectoral approach involving health, legal, and community systems is essential to provide comprehensive and survivor-centred support. Additionally, empowering women through economic and educational opportunities could enhance their autonomy and capacity to report violence.

Conclusion

This study investigated the disclosure and help-seeking behaviours of female survivors of domestic violence living with HIV in Anambra State, Nigeria. The findings demonstrate that while a notable proportion of women disclosed their experiences of violence, the majority sought help through informal channels such as family members, religious leaders, and friends rather than formal institutions. No reports were made to law enforcement agencies, reflecting persistent barriers to justice and institutional response. The prevalence of physical, emotional, and sexual violence observed in this study underscores that domestic violence remains a significant public health and human rights issue among women living with HIV. The limited engagement with formal support systems highlights deep-rooted sociocultural norms, stigma, and lack of trust in available legal and healthcare mechanisms. These findings align with previous studies indicating that survivors often prioritize emotional and spiritual coping mechanisms over legal recourse due to fear of retaliation, economic dependence, and low institutional responsiveness. The intersection of HIV and domestic violence further exacerbates women's vulnerability. Intimate partner violence has been shown to impede HIV status disclosure, reduce adherence to antiretroviral therapy, and worsen psychological well-being. The absence of integrated screening and referral mechanisms within HIV treatment settings perpetuates underreporting and inadequate survivor support. Disclosure and help-seeking behaviours among survivors of domestic violence living with HIV in Anambra State remain suboptimal. Strengthening community awareness, promoting survivor-centred interventions, and integrating gender-based violence services within HIV care are essential to enhance protection, improve health outcomes, and uphold women's rights.

RECOMMENDATIONS

1) Integration of domestic violence screening into HIV care: The government and policymakers should incorporate routine screening for domestic violence into HIV treatment services. Healthcare workers should be trained to identify signs of abuse, provide confidential counselling, and refer survivors to appropriate support systems.
2) Strengthening formal support systems: Government collaboration between healthcare providers, law enforcement, and social welfare agencies should be enhanced to provide accessible, survivor-friendly services. Enforcement of the VAPP Act should be intensified to ensure protection and justice for survivors.
3) Community sensitization and advocacy: Agencies of government and non-governmental organization through public awareness campaigns, should target communities to challenge harmful gender norms, reduce stigma, and encourage help-seeking through appropriate channels. Engaging traditional and religious leaders can improve community acceptance of anti-violence interventions.
4) Economic empowerment of women: Poverty and economic dependence remain major barriers to disclosure and help-seeking. Empowerment initiatives, including microcredit schemes, vocational training, and education, should be prioritized to promote women's autonomy and resilience.
5) Multisectoral and policy-level interventions: Government and non-governmental organizations should adopt a coordinated approach integrating legal, health, and psychosocial services. Policy frameworks must emphasize gender-sensitive HIV care and provide sustainable funding for domestic violence prevention and response programs.

FURTHER RESEARCH

Longitudinal and mixed-method studies are needed to explore the causal relationships between HIV status disclosure, domestic violence, and mental health outcomes. Such research would inform evidence-based strategies for program design and implementation in similar contexts. The study can be expanded to include more facilities in different states of Nigeria to obtain a broader view on the subject matter.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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