Determinants, Disclosure, and Help-Seeking Behaviour in Domestic Violence: A Comparative Study of Women in Rural and Urban Settings in Anambra State, Nigeria

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ABSTRACT

Background

Domestic violence (DV) against women remains a pervasive public health problem worldwide. Disclosure and help-seeking behaviours are critical pathways for accessing support and protection, yet they remain poorly understood in low- and middle-income countries, including Nigeria. This study examined the determinants, disclosure patterns, and help-seeking behaviours related to DV among women in rural and urban settings.

Methods

A comparative cross-sectional mixed-methods study was conducted in Nnewi North (urban) and Anaocha (rural) Local Government Areas. A total of 588 women aged 18 years and older were recruited. In addition, 20 survivors who disclosed DV during the survey were purposively selected for in-depth interviews. Quantitative data were analysed using descriptive statistics and multivariable logistic regression while qualitative data were thematically analysed.

Results

The mean age of respondents was 31.88 ± 10.1 years, with the majority aged 20–29 years (35.4%), married (67%), and self-employed (56.3%). Key determinants of DV included alcohol and substance abuse by partners

(adjusted odds ratio [aOR]: 1.45; 95% CI: 1.03–2.04), economic hardship (aOR: 0.66; 95% CI: 0.47–0.92), and educational disparity between partners (aOR: 1.75; 95% CI: 1.18–2.62). Economic hardship was more significant in rural areas, whereas alcohol and substance abuse were more prevalent in urban areas. Overall disclosure rates were below 50%, with survivors primarily confiding in parents or siblings (28.4%) and in-laws (17.9%), while disclosure to healthcare providers was rare, particularly among urban women. Help-seeking prevalence was 42.2% among rural women and 38.1% among urban women, with emotional support being the most commonly received form and legal support the least accessed.

Conclusion

Domestic violence against women in Anambra State is influenced by partner-related, socioeconomic, and educational factors, with low disclosure and limited help-seeking observed across rural and urban settings. Interventions should promote safe disclosure, strengthen formal support systems, and address contextual determinants to improve the protection and well-being of survivors.

Keywords: Domestic violence, Determinants, Disclosure, Help-seeking behaviour, Rural–urban differences, Nigeria, Women's health

INTRODUCTION

Domestic violence (DV) against women remains a pervasive public health and human rights problem globally, with profound consequences for women's physical, mental, sexual, and reproductive health, as well as for families and societies at large. The World Health Organization (WHO) estimates that nearly one in three women worldwide have experienced physical and/or sexual intimate partner violence in their lifetime, with the burden disproportionately borne by women in low- and middle-income countries (WHO, 2021). Beyond immediate injuries, DV is associated with depression, anxiety, post-traumatic stress disorder, substance use disorders, unintended pregnancies, sexually transmitted infections, and increased maternal morbidity and mortality (Devries et al., 2021; Sardinha et al., 2022). Despite increased global attention, DV remains underreported, poorly disclosed, and inadequately addressed, particularly in sub-Saharan Africa. Nigeria bears a substantial share of the DV burden in Africa. Recent national and subnational studies indicate that between 25% and 45% of ever-partnered women report lifetime experience of physical, sexual, or emotional violence, with wide contextual variations across geopolitical zones, socioeconomic strata, and cultural settings (National Population Commission [NPC] & ICF, 2019; Benebo et al., 2022). In south eastern Nigeria, entrenched patriarchal norms, strong kinship structures, bride-price practices, and social expectations surrounding marriage and endurance often normalize violence and discourage women from speaking out (Okemgbo et al., 2021; Umeh et al., 2023). These sociocultural dynamics interact with economic stressors and behavioural factors to shape both the occurrence of DV and women's responses to it. Studies have identified alcohol and substance abuse, economic hardship, low educational attainment, and educational or age disparities between partners as key determinants of DV (Ahinkorah et al., 2021; Peterman et al., 2021). The COVID-19 pandemic further exacerbated these risk factors through job losses, financial strain, and increased household stress, leading to reported surges in DV globally and in Nigeria (Sediri et al., 2020; Ojeahere et al., 2022). However, determinants do not operate uniformly across contexts. Rural and urban environments differ markedly in terms of livelihood opportunities, social networks, access to services, and exposure to substance use, which may differentially influence both the risk of violence and coping pathways (Aboagye et al., 2022; Alio et al., 2024). Yet, empirical evidence directly comparing rural and urban settings within the same sociocultural region in Nigeria remains limited.

Disclosure and help-seeking behaviour constitute critical but underexplored dimensions of DV. Globally, fewer than half of women who experience DV ever disclose their experiences, and even fewer seek formal support from healthcare providers, law enforcement, or legal institutions (Sardinha et al., 2022; WHO, 2021). In Nigeria, disclosure is often confined to informal networks such as parents, siblings, or in-laws, while engagement with formal services is rare due to fear of stigma, retaliation, financial dependence, lack of trust in institutions, and limited awareness of available services (Aihie, 2020; Owoaje et al., 2021). Health systems, despite being strategic entry points for identification and support of survivors, remain underutilized, particularly in urban settings where anonymity paradoxically coexists with weak social support (Onyemelukwe et al., 2023). Understanding who women disclose to, why they choose certain pathways, and what forms of support they

ultimately receive is essential for designing survivor-centred interventions. Importantly, rural–urban differences in disclosure and help-seeking are not well characterized in the Nigerian context. Rural women may face stronger traditional norms, geographical barriers, and limited service availability, while urban women may experience heightened substance use exposure, economic inequality, and fragmented social ties (Benebo et al., 2022; Umeh et al., 2023). Hence, this study examines the determinants, disclosure patterns, and help-seeking behaviours related to domestic violence among women of reproductive age in rural and urban settings of Anambra State, Southeast Nigeria.

Statement of the Problem

Domestic violence (DV) against women remains a critical public health, social, and human rights challenge worldwide, yet it continues to be largely hidden due to low rates of disclosure and inadequate help-seeking. Although global evidence indicates that approximately one in three women experience physical or sexual intimate partner violence in their lifetime, fewer than half of survivors disclose their experiences to anyone, and only a small proportion seek formal support services such as healthcare, legal, or social welfare systems (Sardinha et al., 2022; World Health Organization [WHO], 2021). The invisibility created by non-disclosure undermines timely identification, limits access to care and protection, and perpetuates cycles of violence, particularly in low- and middle-income countries such as Nigeria. Sociocultural norms that emphasize marital endurance, family privacy, and female submissiveness often discourage women from speaking out, while fear of stigma, blame, retaliation, and family disintegration further suppress disclosure (Benebo et al., 2022; Umeh et al., 2023). Consequently, many women confide only in informal networks typically parents, siblings, or inlaws rather than in formal institutions that are better positioned to provide comprehensive protection and support (Owoaje et al., 2021). Disclosure to healthcare providers, law enforcement agencies, or legal services remains particularly rare, despite the well-documented role of these systems in mitigating health consequences and preventing recurrence of violence (Onyemelukwe et al., 2023). Help-seeking behaviours following disclosure is similarly limited and uneven. Even when women disclose abuse, the support they receive is often restricted to emotional reassurance or short-term financial assistance, while access to legal remedies and structured psychosocial services remains minimal (Sardinha et al., 2022). Structural barriers which include weak referral systems, limited availability of survivor-centred services, poor enforcement of protective laws, and lack of confidentiality further constrain women's ability to seek and obtain effective help (WHO, 2021). These challenges are compounded by economic dependence on abusive partners, which reduces women's agency and capacity to pursue formal support pathways. Rural–urban differences add an additional complexity to disclosure and help-seeking behaviours. Rural women may face stronger traditional norms, geographic isolation, and limited service availability, whereas urban women may experience greater exposure to alcohol and substance use, economic inequality, and fragmented social support networks (Ahinkorah et al., 2021; Aboagye et al., 2022). In Anambra State, Southeast Nigeria, where strong kinship ties coexist with rapid urbanization, there is a notable gap in context-specific evidence on how women navigate disclosure and help-seeking following domestic violence. The persistence of low disclosure and limited help-seeking, coupled with contextual rural–urban differences and key determinants such as alcohol and substance abuse, economic hardship, and educational disparities between partners, underscores a critical research and policy gap. Without robust comparative evidence that integrates women lived experiences, interventions risk being poorly targeted and ineffective. Therefore, this study seeks to address this gap by examining the determinants, disclosure pathways, and help seeking behaviours related to domestic violence among women in rural and urban settings of Anambra State, Nigeria.

Conceptual Framework

The conceptual framework for this study is grounded in the ecological and Behavioral models of domestic violence, which posit that women's experiences of domestic violence (DV), disclosure, and help-seeking behaviours are shaped by the interaction of individual, relational, household, and contextual factors. In this framework, domestic violence experience is influenced by key socio-demographic and partner-related determinants, while disclosure and help-seeking behaviours function as downstream responses that are moderated by individual agency and contextual access to support systems.

At the determinant level, the framework identifies alcohol and substance abuse by partners, economic hardship, and educational disparity between partners as primary risk factors for DV. These determinants operate within

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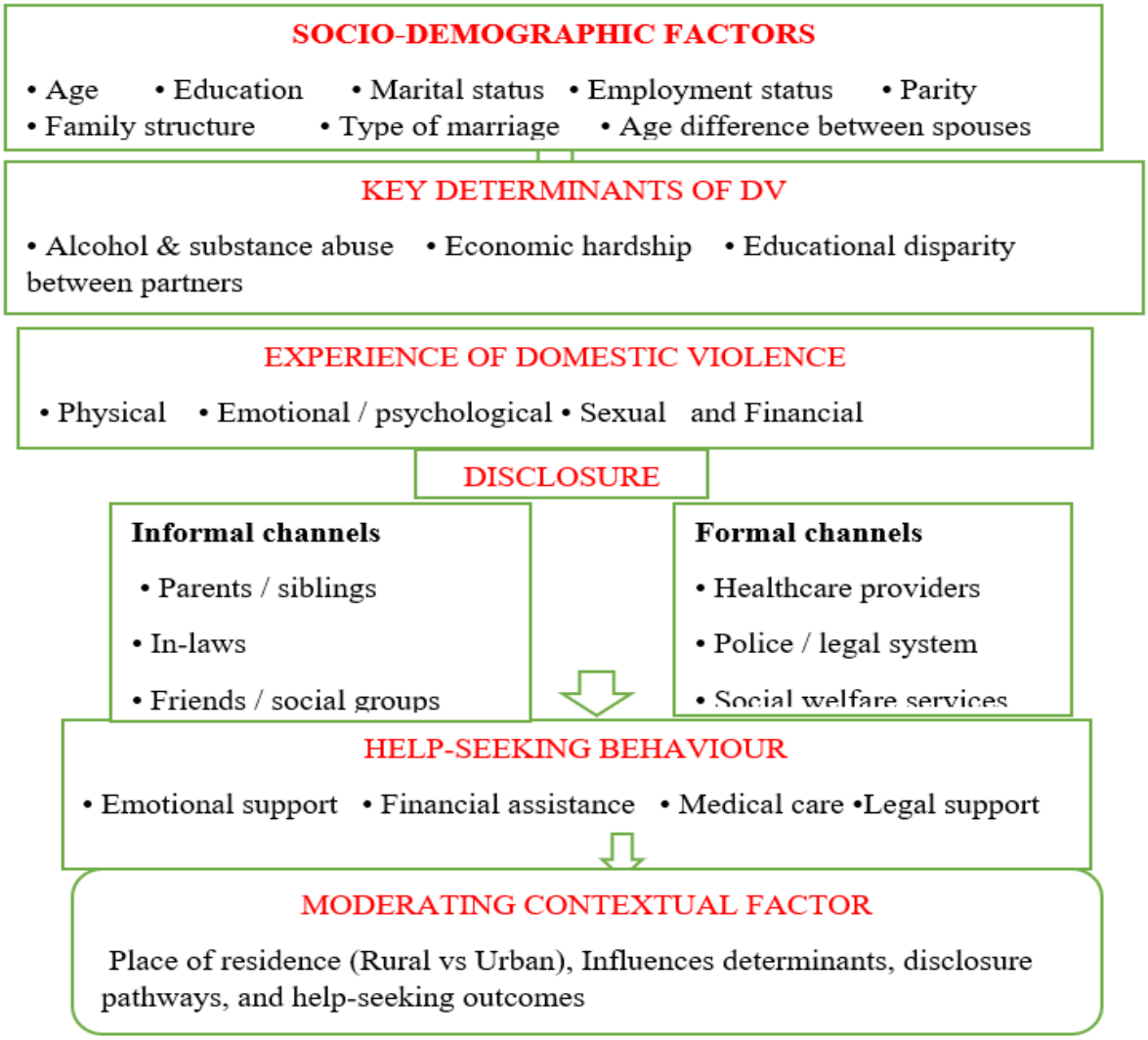
broader socio-demographic characteristics, including women's age, marital status, education, employment status, family structure, parity, type of marriage, and age difference between spouses. The influence of these determinants is further shaped by place of residence (rural versus urban), reflecting differences in social norms, economic opportunities, exposure to substance use, and access to services.

Experiencing domestic violence triggers a decision-making process regarding disclosure, which represents a critical mediating pathway in the framework. Disclosure may occur through informal channels (parents, siblings, in-laws, friends) or formal channels (healthcare providers, law enforcement, legal and social welfare services). Disclosure, then influences help-seeking behaviour, conceptualized as the active pursuit and receipt of support following abuse. Help-seeking may take multiple forms, including emotional support, financial assistance, medical care, and legal support. The framework recognizes that disclosure does not automatically translate into effective help-seeking; rather, help-seeking is constrained or facilitated by structural factors such as service availability, affordability, confidentiality, and trust in institutions. Rural–urban residence moderates these pathways, contributing to observed differences in the type and extent of support accessed.

Figure 1. Conceptual Framework of Determinants, Disclosure, and Help-Seeking Behaviour in Domestic Violence among Women in Rural and Urban Anambra State



METHODOLOGY

Study Design and Setting

The study was a community-based comparative cross-sectional study conducted in Anambra State, Southeast Nigeria. Two Local governments arears (LGAs) were selected by probability sampling technique: Nnewi North (urban) and Anaocha (rural), to reflect diverse socio-economic and cultural contexts.

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Study area

The study was carried out in Anambra State, one of the 36 states in Nigeria. The state 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. 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, 2023). It has a total area of 4,710 km², 1,264/km² Population Density and 2.2% Annual Population growth rate (city population, 2023). Based on 2006 census projections, the estimated population of Anambra State for 2024 was approximately 6.95 million to over 7 million people (Anambra 2025, 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 0-14 years constitute 35.5% of the population, those aged 15-64 years make up 60.5%, and individuals above the age of 65 account for 4% of the total population (city population, 2023). The major occupation is trading and agriculture. According to the National Population Commission, Awka Anambra State, the Local Government Areas are categorised into Urban and Rural Local Government Areas. There are seven Urban Local Government Areas which include Awka South, Idemili North, Ihiala, Nnewi North, Nnewi South, Onitsha North, and Onitsha South. There are fourteen rural Local Government areas which are Aguata, Anambra East, Anambra West, Anaocha, Awka North, Ayamelum, Dunukofia, Ekwusigo, Idemili North, Idemili South, Njikoka Ogbaru, Orumba North, Orumba South, and Oyi local government area.

Quantitative study

The Study Population

This study population comprised all women 18 years and older living in households of the selected study areas.

Inclusion criteria

This included all women 18 years and older who have lived in the selected communities of study for at least one year prior to the study.

Exclusion criteria

This include women who were critically ill and not fit to participate during the study period *Sample Size Determination*

The formula for comparative studies for proportions was applied to calculate the sample size for this study. The formula is $n = 2(Z\alpha+Z\beta)^2 P (1-P)/(p_1 - p_2)^2$ (Charan et al., 2021)

Where n= Minimum sample size for each group.

The level of significance (α) and the power of the test (1-β) were set at 5% and 80% respectively

Zα= Standard normal deviate corresponding to the probability of type 1 error (α) at 5% =1.96

Zβ =Standard normal deviate corresponding to the probability of making type II error (β) of 20%. The power at 80% was used which is =0.84. p1 and p2 were the proportion in two groups of a similar study.

P is pooled prevalence calculated by adding prevalence is group 1 and prevalence in group 2 and then dividing the sum by 2.

In this study reference was made to research by Ajah *et. al.* in southeast Nigeria where the prevalence of physical domestic violence was 37.2% among the rural women and 23.5% in urban women (Ajah et al., 2014).

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Therefore, p1 and p2 were respectively 0.372 and 0.235

Substituting the values into the equation, $n = 2(Z\alpha+Z\beta)^2 P (1-P)/ (p1 –p2)^2$ n= 176.60

Approximately 177 participants in each group were calculated.

A 10% non-response rate was considered using the formula, n/(1-f) where n= sample size, f is the proportion of non-response rate. Therefore, total sample size = 176.6/ (1-0.1)

= 176.6/0.9 = 196.22. Sample size for the study was approximately 196.

Therefore, sample size for the respondents in the rural and urban communities was 196 participants each. Applying a design effect of 1.5 as multistage sampling technique was used, the total sample size became 1.5 * 392 = 588. Therefore, total number of participants was 588. The number of participants for each group was approximated to 294.

Sampling Technique

The multistage sampling technique was used for the selection of the study participants. The stages involved stratification, simple random sampling technique and the World Health Organization modified cluster sampling technique -

Stage 1: Stratification

The Local Government Areas were stratified first into the urban and rural LGAs

Stage 2: Simple random sampling technique

One LGA was selected from each stratum using simple random sampling technique. Nnewi North Local Government was randomly selected from the seven urban LGAs. From the fourteen rural Local Government areas, Anaocha Local Government Area was randomly selected.

Stage 3: Simple random sampling technique- Selection of the wards.

One ward each were selected from the Nnewi North and Anaocha LGAs by simple random sampling method. Nnewi-Ichi ward 2 was selected from Nnewi North LGA and Neni ward 1 was selected from Anaocha LGA.

Stage 4: Selection of the Households and respondents

The World Health Organization modified cluster sampling technique was employed at this stage. Starting from a prominent central point (a school), a bottle was spinned on the ground. From the direction the bottle was facing, the first house on the right was selected, and then moving clockwise, all women in each household who met the inclusion criteria were studied until the required sample size was obtained. In each household, only one eligible woman was studied and in compounds with more than one household, all eligible women were studied.

Data Collection

Quantitative data were collected using structured interviewer-administered questionnaires adapted from validated instruments (WHO Multi-Country Study on Women's Health and Domestic Violence). Items assessed were determinants, disclosure of domestic violence and help-seeking behaviours. The questionnaire had four sections;

Section A: Socio-demographic characteristics of respondents

Section B: Determinants of domestic violence

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Section C: Disclosure of domestic violence experienced

Section D: Help-seeking behaviour of survivors of domestic violence

Validity and Reliability of Study Instrument

A semi-structured interviewer-administered questionnaire adapted from the WHO Multi-Country Study on Women's Health and Domestic Violence was used to collect data for this study. The study instrument was reviewed by experts and my supervisors for face and content validity. The questionnaires were translated to Igbo language then back translated to English to ensure that the original meanings of the research questions were retained.

Pre-Testing

The study instruments for the research were pretested in a different Local Government area in Anambra state different from the selected LGAs for the research. A pre-test of 10% (approximately 59) of the sample size (588) was used. The pre-testing assessed the validity of the questionnaire, the capability of the research assistants, time it takes to complete the interview, need for corrections in the study instrument and feasibility of the interview process.

Data Analysis

Quantitative data were analysed with the IBM SPSS version 25. Descriptive statistics summarized the sociodemographic characteristics, determinants, disclosure of DV and help-seeking behaviours among the urban and rural women. Chi-square tests compared the urban and rural groups.

Qualitative Study

Qualitative study type

In-depth interview (IDI) was employed in the qualitative study

Study population

It includes all the survivors of domestic violence.

Inclusion criteria

It includes all the women survivors who experienced domestic violence captured during the quantitative study.

Exclusion criteria

Women who were not be able to grant the in-depth interviews (IDIs)

Sampling technique

Twenty women who experienced domestic violence were purposively selected for the study. Ten of the survivors were selected from each of the wards under study. Each of the participants that meet the criteria for the in-depth interviews (IDI) was counselled and interviewed by the principal researcher and the research assistants simultaneously after identification from the quantitative study until the required number was reached.

Method of Qualitative data collection

Data was collected using the in-depth interview (IDI). All respondents in the quantitative study who experienced domestic violence qualified for the in-depth interview. Ten survivors were selected from Neni ward 1 under the rural LGA (Anaocha) and ten were selected from Nnewi-Ichi ward 2 in Nnewi North LGA. Each participant was told about the essence of the IDI and its benefit. The conversations were tape-recorded and documented to

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improve qualitative data analysis. Before initiating the interviews, measures were taken to make participants relax using different techniques such as, small talk for a few minutes, helped them remain comfortable during the interview. We also assured participants that their responses will be kept confidential. Each IDI lasted for about 25 to 30 minutes per participant.

Qualitative interview guide

The interview guide was designed to capture the participants' experience, disclosure pattern and help-seeking behaviours after the domestic violence. The interview guide was developed based on prior experience, expert opinions, and from reviewing relevant literature on the subject.

Interview guide pre-test

The interview guide was pretested in a different community at other sites with similar characteristics for clarity, time it takes to complete each interview and for validity. This was done simultaneously with the pre-test of the quantitative study.

Qualitative data analysis

In-depth interviews (IDIs) explored details of the experiences by the survivors, their disclosure patterns and help-seeking behaviours. Thematic qualitative analysis was employed to analyse the data collected.

Ethical Considerations

Ethical approval was obtained from the University of Port-Harcourt Ethics Committee. The ethical approval reference number was UPH/CEREMAD/REC/MM107/012 and dated 25th February 2025. Written informed consent was obtained, and confidentiality was assured and maintained. The survivors of domestic violence were counselled and given contacts of relevant agencies that assist survivors of DV.

RESULTS

Socio-demographic Characteristics

The most common age was the 20 to 29-years (208;35.4%). For the urban respondents, the most common age group was the 30 to 39-year age group (109(37.1%)). While for the rural respondents, the most common age group was the 20 to 29-year age group (113;38.4%). The mean age of the respondents was 31.88±10.1 years. The mean ages for the urban and rural respondents were 31.3± 9.4 years and 32.4± 10.8 years respectively. Most of the respondents were Igbos (534; 90.8%) and Christians (512;87.1%). This was similar for the urban and rural groups. Most of the respondents were married or cohabiting (394; 67.0%) and this reflects in the urban and rural groups (180;61.2% and 214;72.8% respectively). See table 1.

Table 1: Socio-demographic characteristics of respondents

Variable	Urban (294)	Rural (294)	Total (588)	Test statistics	P-value
	Frequency (%)	Frequency (%)	Frequency (%)		
Age (years)				8.80	0.066
<19	28(9.5)	22(7.5)	50(8.5)		
20-29	95(32.3)	113(38.4)	208(35.4)		
30-39	109(37.1)	95(32.3)	204(34.7)		
40-49	52(17.7)	42(14.3)	94(16.0)		

>50	10(3.4)	22(7.5)	32(5.4)		
Mean ±SD	31.3±9.4	32.4±10.8	31.9±10.1		
Ethnicity				1.10	0.578
Igbo	270(91.8)	264(89.8)	534(90.8)		
Yoruba	20(6.8)	23(7.8)	43(7.3)		
Hausa/Fulani	4(1.4)	7(2.4)	11(1.9)		
Religion				1.39	0.499
Christianity	260(88.4)	252(85.7)	512(87.1)		
Traditional	28(9.5)	32(10.9)	60(10.2)		
Islam	6(2.0)	10(3.4)	16(2.7)		
Marital status				10.27	**0.016***
Single	71(24.1)	43(14.6)	114(19.4)		
Married/Cohabit	180(61.2)	214(72.8)	394(67.0)		
Divorced	19(6.5)	16(5.4)	35(6.0)		
Widow	24(8.2)	21(7.1)	45(7.7)		

The predictors of domestic violence for the urban and rural respondents were alcohol and substance abuse (P: 0.034, aOR:1.45; 95%CR:1.028-2.035) with a higher likelihood in the urban setting, economic hardship (P: 0.014, aOR:0.66; 95%CR:0.473-0.921) with a higher likelihood among the rural respondents than the rural respondents, and educational disparity (P: 0.006, aOR:1.75; 95%CR:1.177-2.615) with a higher likelihood among the urban respondents than the rural respondents (See table 2).

Table 2: Predictors of domestic violence

Variable	**Urban (n, %)**	**Rural (n, %)**	**Test statistics**	**P-value**	**aOR**	**95%CI**
Alcohol and substance abuse	191(65.0)	163(55.4)	4.50	0.034	1.45	**1.028-2.035***
Religion	129(43.9)	95(32.3)	0.53	0.469	0.68	0.238-1.938
Economic hardship	124(42.2)	155(52.7)	5.98	0.014	0.66	**0.473-0.921***
Educational disparity	79(26.9)	54(18.6)	7.62	0.006	1.75	**1.177-2.615***

n: number, %: Percentage, aOR: adjusted Odds Ratio, CI: Confidence Interval, *: significant CI

Disclosure of domestic violence was below 50%. The pattern of disclosure was similar in both urban and rural survivors. The majority of the reporting was to their parents or siblings in all the groups (216;28.4%, 84;28.6%, and 83;28.2% for the total, urban and rural groups respectively). The next highest of the disclosure was to the

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in-laws in all the groups (105;17.9%, 48;16.3% and 57;19.4% for the total, urban and rural groups respectively). The lowest percentage of disclosure was to friends and social groups. There was significant difference in the reporting to healthcare workers between urban and rural(P:0.001), the rural survivors report more to healthcare worker than the urban survivors of DV (See table 3).

Table 3: Disclosure and pattern of disclosure of domestic violence

Variable	Urban	Rural	Total	Test statistics	P-value
	(n, %)	(n, %)	(n, %)		
Disclosure of DV	106(36.1)	110(37.4)	216(36.7)	0.12	0.732
Parents and siblings	84(28.6)	83(28.2)	167(28.4)	0.56	0.756
In-laws	48(16.3)	57(19.4)	105(17.9)	1.04	0.595
Friends/social group	14(4.8)	17(5.8)	31(5.3)	0.34	0.844
Healthcare worker	7(2.4)	29(9.9)	36(6.1)	15.29	**0.001***
Religious leader	18(6.1)	23(7.8)	41(7.0)	0.66	0.719
Law enforcement agent	44(15.0)	37(12.6)	81(13.8)	1.54	0.462

DV: Domestic violence, *: Significant P-value: number

Most of the rural survivors of domestic violence seek for help more than the urban counterpart (124;42.2% and 112; 38.1% respectively). This difference was however not significant. Emotional support was the most common form of support received across the groups with more rural women receiving emotional support than the urban women (82;27.9% and to 64;21.8% respectively). While more urban respondents received financial support more the rural women (54;18.4% and 51; 17.3% respectively). There is no significant difference in help-seeking patterns between the urban and rural survivors of domestic violence (see table 4).

Table 4: Help-seeking behaviour and support received following domestic violence

Variable	Urban	Rural	Total	Test statistics	P-value
	(n, %)	(n, %)	(n, %)		
Seek for help	112(38.1)	124(42.2)	236(40.1)	1.02	0.313
Emotional counselling	64(21.8)	82(27.9)	146(24.8)	3.03	0.220
Shelter	34(11.6)	35(11.9)	69(11.7)	1.15	0.563
Legal support	7(2.4)	9(3.1)	16(2.7)	1.11	0.573
Financial support	54(18.4)	51(17.3)	105(17.9)	2.21	0.331

Qualitative results

Disclosure of intimate partner violence

In the in-depth interviews (IDIs) most of the participants reported informally, that is to their immediate families, in-laws and religious leaders A rural participant who was slapped by her husband called her parents who encouraged her to come back to the family house. Her partner was a 27 years old carpenter. She was a 22-yearold

house wife, married for 2 years, lost her trading business a year ago, she has completed secondary school education. During the interview, she felt helpless though hopeful that the situation will improve when she gets money to start her trade She pathetically said *"my husband is a carpenter and came home angry and frustrated one day…… he asked for food, immediately I said food is not ready, I received very painful slap on my face and he walked out immediately".*

An urban respondents said *" my oga and I go to the same church, I have reported to our pastor who has always advice my husband to trust me and concentrate on other important things in life…"*

" I have complained to my siblings and they do not like his attitude though the cannot talk to him..". This is a response from a rural survivor.

An urban survivor who sells plastics in their living compound said *" I reported my husband to his elder sister who has appealed to him to take it easy on me…"*

DISCUSSION

This study examined the determinants, disclosure patterns, and help-seeking behaviours related to domestic violence (DV) among women in rural and urban settings of Anambra State, Nigeria, using a comparative mixed methods approach.

The study identified alcohol and substance abuse, economic hardship, and educational disparity between partners as significant determinants of domestic violence. These findings are consistent with global evidence demonstrating that substance use by intimate partners increases the likelihood of violent behaviour through impaired judgment, aggression, and conflict escalation (Sardinha et al., 2022; Devries et al., 2021). Similar associations have been reported in studies from South Asia, Latin America, and sub-Saharan Africa, underscoring the robustness of this relationship across diverse sociocultural contexts (Ahinkorah et al., 2021; Peterman et al., 2021). The observed rural–urban variation, with alcohol and substance abuse more prominent among urban respondents and economic hardship more significant among rural women, aligns with findings from other African settings. Urban environments often have higher availability and consumption of alcohol and drugs, while rural settings are more vulnerable to chronic poverty, livelihood insecurity, and financial dependence on male partners (Aboagye et al., 2022; Alio et al., 2024). Studies from Ethiopia, Ghana, and Kenya similarly report that economic stress is a stronger predictor of DV in rural households, whereas behavioural risk factors dominate in urban contexts (Seidu et al., 2021; Muluneh et al., 2022).

Educational disparity between partners emerged as a strong determinant of DV in this study, reflecting power imbalances within intimate relationships. This finding mirrors evidence from Nigeria and other sub-Saharan African countries showing that women who are less educated than their partners—or, conversely, more educated in highly patriarchal settings may face increased risk of violence due to threatened male authority (Benebo et al., 2022; Umeh et al., 2023). Such dynamics highlight the complex role of education as both a protective and risk factor, depending on relational and cultural contexts.

Disclosure rates in this study were below 50%, reinforcing the fact that domestic violence remains largely hidden. This pattern is consistent with global estimates indicating that fewer than half of survivors disclose their experiences to anyone, and far fewer disclose to formal institutions (WHO, 2021; Sardinha et al., 2022). Studies from Asia and Latin America similarly report low disclosure, driven by fear of stigma, normalization of violence, and lack of confidence in support systems (García-Moreno et al., 2020). In line with findings from other African and West African studies, survivors in this study most commonly disclosed abuse to parents, siblings, or in-laws, while disclosure to friends, social groups, and especially healthcare providers was rare (Owoaje et al., 2021; Aihie & Ojo, 2022). Research from Ghana, Sierra Leone, and Burkina Faso has documented similar reliance on family-based disclosure pathways, reflecting strong kinship systems and the perception of DV as a private family matter (Dickson et al., 2021; Ahinkorah et al., 2022). Notably, disclosure to healthcare providers was particularly low among urban women in this study. This contrasts with some high-income country settings, where urban residence is associated with greater service utilization (Alio et al., 2024), but aligns with Nigerian and subSaharan African evidence suggesting that health systems often fail to provide safe, confidential, and survivorcentred environments that encourage disclosure (Onyemelukwe et al., 2023). Fear of judgment, lack of

routine screening, and limited provider training have been consistently identified as barriers to disclosure within healthcare settings in Nigeria and beyond (Olowookere et al., 2020; Muluneh et al., 2022).

Help-seeking behaviour following disclosure was generally low in both rural and urban settings, with no statistically significant difference between the two groups. The overall help-seeking prevalence observed in this study is comparable to reports from other parts of Nigeria and West Africa, where less than half of women experiencing DV seek any form of assistance (Benebo et al., 2022; Owoaje et al., 2021). Globally, similar patterns have been observed in low-resource settings, where structural and sociocultural barriers limit access to formal support (Sardinha et al., 2022).

Emotional support emerged as the most commonly received form of help, followed by financial assistance, while legal support was the least accessed. This hierarchy mirrors findings from studies across sub-Saharan Africa and South Asia, where informal support dominates and engagement with legal systems is minimal (Ahinkorah et al., 2021; Seidu et al., 2021). In Nigeria, weak enforcement of domestic violence laws, fear of retaliation, lengthy legal processes, and mistrust of law enforcement agencies have been widely documented as deterrents to seeking legal redress (Onyemelukwe et al., 2023; Umeh et al., 2023). The low utilization of legal and formal support services observed in this study underscores missed opportunities for protection and long-term recovery. Evidence from countries that have invested in integrated referral systems and survivor-friendly legal frameworks demonstrates improved help-seeking and outcomes (García-Moreno et al., 2020). The contrast highlights the need for systemic reforms in Nigeria to strengthen institutional responses and build trust among survivors.

CONCLUSION

This study provides compelling evidence that domestic violence against women remains a pervasive and largely hidden problem in both rural and urban settings of Anambra State, Nigeria, with persistently low levels of disclosure and limited help-seeking despite substantial exposure to violence. The findings demonstrate that key determinants namely alcohol and substance abuse, economic hardship, and educational disparity between partners continue to drive the occurrence of domestic violence, while contextual differences between rural and urban environments shape the prominence of these risk factors. Critically, the study highlights disclosure as a major bottleneck in the pathway to safety and support. Fewer than half of survivors disclosed their experiences, and when disclosure occurred, it was predominantly to informal family networks rather than to formal institutions. Engagement with healthcare providers, legal services, and law enforcement was minimal, underscoring missed opportunities for early identification, protection, and intervention. Even among women who disclosed abuse, help-seeking was modest, with support largely confined to emotional reassurance and limited financial assistance, while legal and structured psychosocial support were rarely accessed.

RECOMMENDATIONS

The recommendations made emphasize strengthening disclosure pathways, improving access to formal support services, and addressing key structural and contextual determinants of domestic violence. The recommendations include state and local governments full domestication, implementation, and enforcement of the Violence Against Persons (Prohibition) Act (VAPP Act) in Anambra State. Clear operational guidelines, survivor-friendly reporting procedures, and accountability mechanisms for law enforcement agencies are essential to increase trust and utilization of legal support services. Specialized domestic violence desks within police stations and family courts should be strengthened, with trained personnel, confidentiality safeguards, and referral linkages to health and social services. Legal aid services should be expanded and made accessible, particularly for economically dependent women.

The primary, secondary, and tertiary healthcare facilities should incorporate standardized screening for domestic violence into maternal, reproductive, and general health services. This will facilitate early identification and safe disclosure, especially for women who may not seek help elsewhere. Continuous training of healthcare workers on trauma-informed care, confidentiality, non-judgmental communication, and referral pathways is critical to creating safe environments that encourage disclosure and sustained help-seeking. Targeted community sensitization campaigns involving traditional leaders, religious institutions, women's groups, and men's associations should challenge norms that normalize violence and discourage disclosure. Economic hardship and

dependence were key drivers of domestic violence and barriers to help-seeking. Skills acquisition programs, access to microcredit, and employment opportunities should be expanded, particularly in rural areas, to strengthen women's financial autonomy and bargaining power. Public health interventions targeting harmful alcohol and substance use especially in urban settings should be strengthened. These may include regulation of alcohol sales, community-based rehabilitation services, and behavioural change programs for men.

Strengths And Limitations

This study has several notable strengths that enhance the robustness, relevance, and contribution of its findings. The comparative rural–urban design allowed for a nuanced examination of contextual differences and similarities in the determinants, disclosure patterns, and help-seeking behaviours related to domestic violence within the same sociocultural setting.

The use of a mixed-methods approach is a major strength. The quantitative component enabled the identification of statistically significant determinants of domestic violence and patterns of disclosure and help-seeking, while the qualitative in-depth interviews enriched these findings by capturing survivors' lived experiences, motivations, and barriers surrounding disclosure and support-seeking. This methodological triangulation strengthens the validity and interpretability of the results. This study employed a large sample size (n = 588) and a multi-stage sampling technique, enhancing the representativeness and generalizability of the quantitative findings within the study areas. The study places a specific and explicit focus on disclosure and help-seeking behaviours, which are often underexplored in domestic violence research in Nigeria and sub-Saharan Africa. By disaggregating disclosure pathways and types of support accessed, the study addresses a critical evidence gap and provides actionable insights for policy and programmatic interventions.

The study has some limitations that should be considered when interpreting the findings. The cross-sectional design limits the ability to establish causal relationships between identified determinants and domestic violence outcomes, as well as between disclosure and help-seeking behaviours. The study relied on self-reported data, which are subject to recall bias and social desirability bias. Given the sensitive nature of domestic violence, disclosure, and help-seeking, some participants may have underreported their experiences or provided socially acceptable responses, potentially leading to underestimation of prevalence and service utilization. The qualitative sample was relatively small and limited to women who disclosed violence during the survey. This may have excluded the perspectives of women who experienced violence but chose not to disclose at all, potentially underrepresenting the most marginalized or constrained survivors. The study did not include men or perpetrators, nor did it directly assess community, institutional, or service-provider perspectives. As a result, insights into perpetrator behaviours, institutional readiness, and systemic barriers are inferred from survivors' accounts rather than directly examined. Finally, while the findings are highly relevant to Anambra State and similar sociocultural contexts, generalizability beyond Southeast Nigeria should be made with caution, given regional variations in norms, service availability, and legal frameworks across Nigeria and sub-Saharan Africa.

Future Research

There are aspects for future research which include longitudinal designs to examine causal pathways between key determinants and experiences of domestic violence over time. There is a need for studies that evaluate the effectiveness of survivor-centred interventions aimed at improving disclosure, facilitating help-seeking, and enhancing access to formal support systems. Randomized controlled trials or quasi-experimental designs could test interventions such as community-based awareness programs, health facility-based screening and referral systems, and economic empowerment initiatives for women. The inclusion of male perspectives and perpetrators is critical for understanding the motivations, attitudes, and behaviours of male partners to comprehensive violence prevention. Future studies should incorporate male partners and perpetrators to identify risk factors for violence, social norms, and potential entry points for behavioural interventions. Further research should assess the readiness, capacity, and responsiveness of health, legal, and social welfare systems in addressing domestic violence. Mixed-methods studies that include service providers and institutional audits can identify gaps in policy implementation, confidentiality, accessibility, and effectiveness of support services. Future research should investigate DV, disclosure, and help-seeking among particularly vulnerable subgroups, such as adolescent girls, women with disabilities, migrant women, and those living in informal settlements. Understanding unique barriers and facilitators for these populations will inform inclusive and equitable interventions. Comparative

studies across different Nigerian regions and West African countries could explore how sociocultural norms, traditions, and community structures shape domestic violence, disclosure, and help-seeking patterns. This will help tailor interventions to local realities and inform culturally sensitive policy frameworks.

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REFERENCE

1. Aboagye, R. G., Okyere, J., Seidu, A.-A., Ahinkorah, B. O., & Yaya, S. (2022). Experience of intimate partner violence among women in rural and urban areas of sub-Saharan Africa: A multilevel analysis. BMC Women's Health, 22(1), 1–12. https://doi.org/10.1186/s12905-022-01643-9
2. Ahinkorah, B. O., Dickson, K. S., Seidu, A.-A., & Schack, T. (2021). Women's exposure to intimate partner violence and its association with socio-economic factors in sub-Saharan Africa. Journal of Interpersonal Violence, 36(15–16), NP8480–NP8503. https://doi.org/10.1177/0886260519842850
3. Ahinkorah, B. O., Seidu, A.-A., Budu, E., & Yaya, S. (2022). Help-seeking behaviour among women experiencing intimate partner violence in West Africa. Journal of Interpersonal Violence, 37(21–22), NP20355–NP20375. https://doi.org/10.1177/08862605211031306
4. Aihie, O. N. (2020). Prevalence of domestic violence in Nigeria: Implications for counselling. Edo Journal of Counselling, 13(1), 1–11.
5. Alio, A. P., Salihu, H. M., Clayton, H. B., Mbah, A. K., & Marty, P. J. (2024). Intimate partner violence and help-seeking behaviors among women: Urban–rural differentials. Journal of Women's Health, 33(2), 145–154. https://doi.org/10.1089/jwh.2023.0198
6. Anambra 2025. (2025). Available at: https://www.premiumtimesng.com/news/top-news/833507anambra-2025-19-things-you-need-to-know-about-anambra-state.html#:~:text=2.,Nigeria's%20smallest%20states%20by%20landmass
7. Benebo, F. O., Schumann, B., & Vaezghasemi, M. (2022). Intimate partner violence against women in Nigeria: A multilevel study investigating individual and contextual factors. BMC Women's Health, 22(1), 1–14. https://doi.org/10.1186/s12905-022-01601-5
8. Charan, J., Kaur, R., Bhardwaj, P., Singh, K., Ambwani, S. R., & Misra, S. (2021). Sample size calculation in medical research: a primer. Annals of the National Academy of Medical Sciences (India), 57(02), 074080.
9. City population (2025). Anambra State, Nigeria. Available at: https://www.citypopulation.de/en/nigeria/admin/NGA004__anambra/. Accessed July 20th, 2025
10. Devries, K. M., Mak, J. Y. T., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., Lim, S., Bacchus, L. J., Engell, R. E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N., & Watts, C. H. (2021). The global prevalence of intimate partner violence against women. The Lancet, 397(10289), 1982–1999. https://doi.org/10.1016/S0140-6736(21)00364-6
11. Dickson, K. S., Ahinkorah, B. O., & Seidu, A.-A. (2021). Disclosure and help-seeking behaviour of women experiencing intimate partner violence in sub-Saharan Africa. Journal of Biosocial Science, 53(4), 593–609. https://doi.org/10.1017/S002193202000050X
12. García-Moreno, C., Zimmerman, C., Morris-Gehring, A., et al. (2020). Addressing violence against women: A call to action. The Lancet, 395(10234), 1153–1154. https://doi.org/10.1016/S01406736(20)30265-6
13. National Population Commission (NPC) [Nigeria] & ICF. (2019). Nigeria Demographic and Health Survey 2018. NPC and ICF. https://dhsprogram.com
14. Ojeahere, M. I., Kumswa, S. K., Adiukwu, F., Plang, J. P., & Taiwo, Y. F. (2022). Intimate partner violence and its mental health implications amid COVID-19 lockdown: Findings from Nigeria. Journal of Interpersonal Violence, 37(17–18), NP16599–NP16621. https://doi.org/10.1177/08862605211015213
15. Okemgbo, C. N., Omideyi, A. K., & Odimegwu, C. O. (2021). Prevalence, patterns, and correlates of domestic violence in selected Igbo communities of southeastern Nigeria. African Journal of Reproductive Health, 25(3), 69–81. https://doi.org/10.29063/ajrh2021/v25i3.6

16. Onyemelukwe, C., Owoaje, E. T., & Ajuwon, A. J. (2023). Health-seeking behavior and barriers to care among women experiencing intimate partner violence in Nigeria. BMC Health Services Research, 23(1), 1–10. https://doi.org/10.1186/s12913-023-09145-
17. Owoaje, E. T., Uchendu, O. C., Ajayi, T. O., & Cadmus, E. O. (2021). A review of intimate partner violence in Nigeria: Implications for public health interventions. Pan African Medical Journal, 39, 1–9. https://doi.org/10.11604/pamj.2021.39.1.27333
18. Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., Oertelt-Prigione, S., & van Gelder, N. (2021). Pandemics and violence against women and children. Center for Global Development Working Paper, 528.
19. Sardinha, L., Maheu-Giroux, M., Stöckl, H., Meyer, S. R., & García-Moreno, C. (2022). Global, regional, and national prevalence estimates of physical or sexual intimate partner violence against women in 2018. The Lancet, 399(10327), 803–813. https://doi.org/10.1016/S0140-6736(21)02664-1
20. Sediri, S., Zgueb, Y., Ouanes, S., Ouali, U., Bourgou, S., Jomli, R., & Nacef, F. (2020). Women's mental health: Acute impact of COVID-19 pandemic on domestic violence. Archives of Women's Mental Health, 23(6), 749–756. https://doi.org/10.1007/s00737-020-01082-4
21. Umeh, C. A., Adegboye, O. A., & Nwosu, C. O. (2023). Socio-cultural determinants of intimate partner violence against women in Nigeria. Journal of Biosocial Science, 55(1), 109–125. https://doi.org/10.1017/S002193202200010X
22. World Health Organization. (2021). Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. WHO. https://www.who.int