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# Factors influencing help-seeking behaviour among young women with experience of intimate partner violence in Nigeria

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## Abstract

**Background** Help-seeking has been identified as one of the most potent ways of stopping gender-based violence. However, studies have shown that poor help-seeking behaviour persists among women with experience with intimate partner violence (IPV) in Nigeria. This study examines the factors influencing help-seeking behaviour among young women with IPV experience in Nigeria. Young women within the age bracket of 15–29 years were considered because they are disproportionately affected by IPV.

**Methodology** This study utilised the 2018 Nigerian Demographic and Health Survey (NDHS) data. Data were analysed with descriptive statistics, chi-square tests, and logistic regression.

**Results** The results revealed that religion [$\chi^2 = 11.700$, $p < 0.05$], place of residence [$\chi^2 = 8.710$, $p < 0.05$], level of education [$\chi^2 = 14.659$, $p < 0.05$], and ethnicity [$\chi^2 = 40.135$, $p < 0.05$] significantly influence the help-seeking behaviour of young women with experience with IPV. Participants from the South-South region of Nigeria were 49% less likely to seek help (OR 0.49, CI 0.28–0.84, $p < 0.05$) compared to those from the South-West region. Additionally, participants with formal education were 35% less likely to seek help (OR 0.35, CI 0.15–0.84, $p < 0.05$) than those without formal education.

**Conclusion** The study recommends implementing culturally sensitive and region-specific interventions to address barriers that hinder uneducated women from seeking help. These findings also suggest that policies and programs should consider sociocultural factors such as region, ethnicity, and educational level.

**Keywords** Demographic factors, Help-seeking behaviour, Intimate partner violence, NDHS, Young women

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## Introduction

Gender-based violence (GBV) remains a major problem across the globe and constitutes a serious public health concern. It is an obstacle to human rights violations, which continue to endanger the lives of many women around the world [1, 2]. Although males are also victims of violence, there is a disproportionate rate and impact on women and girls [3]. Scholars have noted that different forms of GBV exist, but the most common form is intimate partner violence (IPV) [4, 5]. Approximately 30% of IPV cases are reported worldwide [6]. Additionally, 25% of young women were implicated in the incidence of IPV observed [7]. Sub-Saharan Africa reportedly has one of the highest IPV prevalence worldwide, with 33% lifetime IPV [8]. Brown et al. [9] reported a prevalence of 36% in sub-Saharan Africa. In Nigeria, the incidence of intimate partner violence (IPV) among young women is 31% [10] while the prevalence of IPV among pregnant women is reported at 26.2% [11].

The transition from adolescence till adulthood especially for young women aged 18–24, is an important time in their development. They explore their identities, become more independent, and form close relationships. Researchers have consistently found that people in this age group are especially at risk for intimate partner violence (IPV) because of a number of factors that make them more vulnerable, such as being emotionally immature, having little experience with relationships, being financially dependent, and feeling social pressure [10, 12]. Also, studies have shown that young women in this age group are less likely to ask for help when they are in an abusive relationship. This is often because they are afraid of being judged, don't know about the services that are available, and think that abuse is normal in early relationships [13, 14]. It is important to focus on this group of people because they are more vulnerable and because early intervention may stop the long-term mental and physical effects of IPV.

IPV includes all forms of intimate relationships ranging from sexual, physical, and emotional abuse while the most common form of IPV is physical, which include punching and kicking [6]. Sexual IPV refers to unconscented sexual violence, whereas emotional IPV involves controlling and threatening the victim to intimidate or isolate them. This study considers the three forms of IPV to allow a comprehensive representation of IPV. IPV has serious consequences, causing significant harm to physical, mental, and social well-being. Victims may experience severe headaches, injuries, chronic pain, trauma, recurring violence, low self-esteem, social disengagement, psychological anguish, despair, anxiety, hopelessness, cognitive dysfunction, and suicidal ideation, among others [9, 15, 16]. IPV murder accounts for 38% of all female homicides worldwide [6]. Given the devastating consequences of IPV, it is important to study the help-seeking behaviour of victims for proper interventions.

Help-seeking behaviour is the totality of actions taken by an individual to seek support when confronted with challenges. Help-seeking behaviour can play a crucial role in mitigating the impact of IPV and can serve as a protective factor for survivors, yet the practice of such behaviour remains alarmingly low in Nigeria. Tenkorang et al. [17] reported that 65% of women who had experienced IPV in Nigeria have not sought help, Alade et al. [18] confirmed that 67% of women did not seek help at all, either formally or informally, among women experiencing IPV. Formal sources include contacting the police, health care providers, professional counselling psychologists, and social workers, whereas informal sources include informing close relatives, parents, friends, and religious leaders. Several factors affect the help-seeking behaviour of IPV victims.

Spencer [19] identified associations between help-seeking behaviour and factors such as tertiary education, having an abusive father, controlling behaviours from husbands, intimate physical partner violence (IPV), and physical injury. Additional influencing factors include personal responsibility; victim-blaming attitudes; the severity of the situation; and various individual, interpersonal, and sociocultural factors [20, 21]. Help-seeking behaviour among young women experiencing IPV in Nigeria is a critical issue that intersects with several sustainable development goals (SDGs). It is relevant in attaining SDGs goals 3 and 5, which address good health and well-being. Addressing factors influencing help-seeking can improve access to help as well as health care and eliminate violence against young women, thereby promoting gender equality [22].

While significant research has been conducted on help-seeking behaviour among IPV survivors in various African countries, there remains a notable gap in the literature, specifically concerning Nigeria. Most existing studies focus on urban populations, leaving a substantial knowledge gap regarding the experiences of young women in rural areas, where cultural and infrastructural barriers to help-seeking may be more pronounced, this study addresses this gap by including both urban and rural participants. Additionally, few studies have explored the intersectionality of factors such as age, educational level, and socioeconomic status in shaping help-seeking behaviour, especially among young women in Nigeria. Also, while studies have shown important of informal and official help-seeking sources, there is limited understanding on how these patterns work in Nigeria, especially when using large, nationally representative samples. Furthermore, the role of digital platforms and social media as potential avenues for seeking help in Nigeria has not been sufficiently explored.

Hence, this study examines sociodemographic factors such as age, education, religion, ethnicity, location, marital status, income and media access influencing help-seeking behaviour among young women with experience with IPV in Nigeria. This study examines a population marked by vulnerability and undergoing substantive changes. It speaks to a gap in current literature and adds to the development of interventions specific to context, consistent with both national and global efforts to eliminate violence against women. The findings have critical implications for the development of effective, culture-sensitive, and geographically relevant programs that may augment integrated strategies in sub-Saharan Africa and other low- and middle-income settings.

### Theoretical framework

This study is anchored on Social Learning Theory by Albert Bandura [23], which emphasised that people learn behaviours by modelling others. The theory focuses on cognitive processes that shape and keep social behaviours, with observational learning, modelling, reinforcement, punishment, and self-efficacy as key component. Bandura's idea of triadic reciprocal determinism, which could be personal, behaviour, and the environment factors are all important in understanding what makes people who are experiencing IPV seek help or not.

Women can learn from watching what happens to other people in IPV situations. For instance, studies have found that women are more likely to seek help for IPV if they see other women doing so successfully [24]. People's attitudes about divorce and separation can also affect how IPV is seen and whether help is sought as women may be less likely to get help in communities where these things are frowned upon [25]. Age and exposure also matter. Younger women are more likely to be affected by their peers and social media, while older women may rely more on traditional beliefs and family structures [26]. Education can help people understand how IPV affects them and how important it is to get help.

Religious teachings can either make people more likely to ask for help or less likely to do so. For instance, teachings that stress getting through tough times may make women less likely to ask for help, while leaders who speak out against IPV may encourage women to take action. In the same way, women are more likely to come forward when they are in ethnic communities that are okay with people asking for help. On the other hand, stigma in some groups can keep people quiet. Support services are easier to find in cities, so urban women may also have more chances to access to help [27]. Also, women learn from the choices of others and use what they learn to act as young women who see other women not asking for help may start to think that it is normal, while unmarried women may feel freer to ask for help because society doesn't expect them to stay. Access to resources can also affect choices as women who are more financially stable are more likely to leave abusive relationships, while women who are financially dependent may feel stuck [10].

## Methodology

The population for this study consisted of young Nigerian women aged 15 to 29. Nigeria was chosen because of its notably low rates of help-seeking behaviour for intimate partner violence (IPV). Located on the western coast of Africa, Nigeria has a population of approximately 230 million people [28], a diverse geography, and hundreds of spoken languages, with English as the official language. It currently has 6 regions that comprise 36 states with FCT.

Nigeria is a place of interest for the study because several factors discouraging help-seeking are more pronounced in Nigeria. Some cultural and religious issues, such as patriarchal norms, gender inequality, social expectations, and religious beliefs, may shape how women, especially young women, perceive and respond to IPV. The disparity in access to resources between urban and rural areas is another factor. Finally, Nigeria is the most populous black nation in the world and a low and middle-income country with a very high population of youth [29, 30]. The findings from the current study could be used to guide interventions that could not apply to other LMICs in SSA to manage the burden and associated factors of IPV. The youth age range of 15–29 is considered for this study because it is a transition phase of moving from adolescence to adulthood and may be vulnerable to IPV. The Nigerian Demographic and Health Survey (NDHS) reported that young women had a higher prevalence of IPV (34.6%).

This study utilised secondary data from NDHS (2018), which is a household population-based survey carried out by the National Population Census (NPC) in 36 states and the Federal Capital Territory [31]. The sample for the 2018 NDHS was a stratified, two-stage selection. Stratification involved dividing each of the 36 states and the Federal Capital Territory into urban and rural areas. In total, 74 sampling strata were identified. The samples were selected independently in every stratum via two-stage selection. Data from young women between the ages of 15 and 29 who had experienced intimate partner violence of any form (physical, sexual, and emotional) were drawn from the 2018 Nigerian Demographic and Health Surveys dataset.

Young women who had experienced physical, emotional, or sexual IPV within the age range of 15–29 years were filtered out of the general population used for the study by the NDHS. A total of nine hundred and sixty-seven (967) samples were used for this study.

### Variable measurement

Intimate partner violence (IPV) was measured using 15 items drawn from the Domestic Violence Module of the 2018 Nigeria Demographic and Health Survey (NDHS). These items assessed three distinct forms of IPV. Physical IPV (9 items: d105a, d105b, d105c, d105d, d105e, d105f, d105j, d106, and d107), sexual IPV (3 items: d105h, d105i, and d108), and Emotional IPV (3 items: d103a, d103b, and d103c; d104 was also included as emotional abuse). Each item had a 5-point response scale: never, sometimes, often, yes but not in the last 12 months, and yes in the last 12 months. For analysis, responses were dichotomized: any indication of having ever experienced a particular act (regardless of timing or frequency) was coded as 1 ("ever experienced"), and "never" was coded as 0 ("never experienced").A woman was considered to have experienced a specific type of IPV if she responded "yes" to at least one item within that category. Furthermore, a composite binary variable was created to represent "any form of IPV", coded as 1 if the woman had experienced emotional, physical, or sexual IPV, and 0 if she had experienced none. Respondents who had not experienced any form of IPV were excluded from the IPV analysis sample.

Help-seeking behaviour serves as the outcome variable in this study and was measured in the NDHS data coded as d119y. The participants were asked if they had sought help from anyone for the IPV they had experienced. They were able to answer no-coded as 0 and yes-coded as 1. Source of help was measured by some items directed to the participants asking who they sought help from. The options given include neighbours, others, social service organizations, friends, police, religious leaders, lawyers, and doctors labelled d119u, d119x, d119xb, d119xd, d119xe, d119xf, d119xg and d119xh, respectively, with yes and no response formats. In this study, each source of help (e.g., neighbours, family, police, religious leaders, healthcare workers) was analyzed as a separate variable to capture the diversity of help-seeking behaviour. This approach allows for a more understanding of where women turn for support following IPV and helps identify patterns in preferences for formal versus informal support systems. Each source is treated as a binary variable indicating whether or not it was utilized.

Demographic factors were utilized in the study. Ages above 29 years were excluded from the dataset. Age was categorized into three categories (15–19, 20–24, and 24–29), labelled v013 in the dataset. Religion was labelled v130 in the dataset and categorized into Catholic, other Christians, Islamic, traditionalist, and others with a code of v130 in the dataset. Location was measured by the type of place of residence, labelled in the dataset as v025, and categorized into two categories (rural and urban). Ethnicity was measured by region, which was labelled v024 and categorized into six categories (northcentral, northeast, northwest, southeast, south−south, and southwest) in the dataset. Marital status was measured by IPV relationship status, with the item "Ever been married or in a union" labelled v535. The response format was formerly married, lived with a man, and no. This was relabelled as others, formerly married, and lived with a man. Income was measured by a wealth index labelled v190, with the poorest, poorer, middle, richer, and richest categories. Educational status was measured by level of education. Digital access was measured by summing two relevant variables together (phone use and internet use labelled as v169a and v171a, respectively) and recoding them.

Cases with missing data on any of the key study variables were excluded using listwise deletion. This complete case approach was used due to the low percentage of missing responses in the variables of interest. No imputation techniques were applied.

### Statistical analysis

SPSS version 25 was used as a statistical package for data analysis. At the univariate level, descriptive statistics (frequency distribution and percentage) were used to check the level of help-seeking behaviour and the sources of help-seeking behaviour subscribed to by young women experiencing IPV in Nigeria. At the bivariate level, the chi-square test was used to test the associations between independent variables (age, religion, marital status, income, ethnicity, location, occupation, level of education and digital access) and the dependent variable (help-seeking behaviour). On a multivariate level, binary logistic regression was used to analyse the influence of the independent variables found to be significant at the bivariate level on the dependent dichotomous variable.

Binary logistic regression was used for the multivariate analysis because the main outcome variable which is help-seeking behaviour is dichotomous in nature which is limited to "yes" or "no," This statistical method is useful for binary dependent variables because it enables the calculation of the probability of help-seeking behaviour occurring based on predictor variables and it allow to know the variables that might affect the outcome and find the most important ones.

### Ethical considerations

The Nigerian Demographic and Health Survey (NDHS) dataset from 2018 was used for this study. The survey protocols were examined and cleared by the National Health Research Ethics Committee of Nigeria (NHREC) and the Institutional Review Board (IRB) of ICF International. The DHS data collection complied with international ethical standards, such as the U.S. Code of Federal Regulations for the Protection of Human Subjects (45 CFR 46) and the principles of the Declaration of Helsinki. Informed consent was received from all

**Table 1** Socio-demographic characteristics of the participants

| Characteristics | Frequency (N = 976) | Percentage (100%) |
|---|---|---|
| *Age (years)* | | |
| 15–19 | 101 | 10.3 |
| 20–24 | 325 | 33.3 |
| 25–29 | 550 | 56.4 |
| *Religion* | | |
| Catholic | 124 | 12.7 |
| Christian | 449 | 46.0 |
| Islam | 398 | 40.8 |
| Traditionalist | 5 | 0.5 |
| *Relationship/Marital status* | | |
| Formerly married | 54 | 5.5 |
| Lived with a man | 16 | 1.6 |
| Others (spousal/boyfriend, cohabiting) | 906 | 94.0 |
| *Region* | | |
| North Central | 236 | 24.2 |
| North East | 267 | 27.4 |
| North West | 97 | 9.9 |
| South East | 123 | 12.6 |
| South South | 153 | 15.7 |
| South West | 100 | 10.2 |
| *Place of residence (Location)* | | |
| Urban | 322 | 33.0 |
| Rural | 654 | 67.0 |
| *Educational status* | | |
| No education | 318 | 32.6 |
| Primary | 163 | 16.7 |
| Secondary | 454 | 48.5 |
| Tertiary | 41 | 4.2 |
| *Wealth index* | | |
| Poorest | 220 | 22.5 |
| Poorer | 214 | 21.9 |
| Middle | 233 | 23.9 |
| Richer | 209 | 21.4 |
| Richest | 100 | 10.2 |
| *Tribe* | | |
| Igbo | 140 | 14.3 |
| Hausa | 143 | 14.7 |
| Fulani | 106 | 10.9 |
| Ekoi | 3 | 0.3 |
| Ibibio | 29 | 3.0 |
| Igala | 14 | 1.4 |
| Ijaw/Izon | 38 | 3.9 |
| Kanuri/Beriberi | 21 | 2.2 |
| Tiv | 57 | 5.8 |
| Others | 325 | 33.3 |
| Total | 976 | 100.0 |

**Table 2** Sources of help subscribed to by young women with IPV in Nigeria

| Help source | IPV help source | N (%) | Help source total % |
|---|---|---|---|
| Informal Help source | Neighbour | 2.2 | 7.1% |
| | Friends | 3.1 | |
| | Religious leader | 1.5 | |
| | Others | 0.3 | |
| Formal help source | Doctor | 0.1 | 0.4% |
| | Police | 0.3 | |
| | Lawyer | 0 | |
| | Social service | 0 | |

survey respondents before participation. The researchers applied for this dataset through the DHS programme, and approval was granted after 2 working days. NDHS data were collected with participants' informed consent, the use of coded responses, and the removal of personal identifiers. The participants' answers were also ensured to be confidential and anonymous. As secondary data users, researchers are responsible for maintaining and protecting privacy and ensuring that participants' responses remain anonymous. This study adheres to all applicable rules and regulations related to data protection in research.

## Results

Table 1 presents the socio-demographic characteristics of the participants in the study. The majority of participants were aged 25–29, majority resided in rural areas, and had attained secondary education. A notable proportion (32.6%) had no formal education, and only a small fraction (4.2%) had tertiary education. In terms of wealth distribution, most participants were concentrated in the lower and middle-income categories, with only 10.2% in the richest quintile. Religious affiliation was predominantly Christian (46%) and Muslim (40.8%), with smaller percentages identifying as Catholic or Traditionalist. Most respondents (94%) were in spousal, cohabiting, or dating relationships, while 5.5% were formerly married. Geographically, the Northeast and North Central regions had the highest representation, followed by the South-South and Southeast, while the Southwest and Northwest had the lowest. Ethnic diversity was evident, with "other tribes" accounting for the largest group (33.3%). Among the major ethnic groups, Hausa (14.7%), Igbo (14.3%), and Fulani (10.9%) were most represented, while Yoruba (10.2%) and other minority tribes such as Ijaw/Izon, Tiv, Ibibio, and Kanuri made up the remainder.

Table 2 reveals the source of help subscribed to by young women experiencing IPV in Nigeria. A significant portion of young women in Nigeria experiencing intimate partner violence (IPV) from the few participants that responded to this aspect in the data prefer informal support networks rather than formal support networks.

An average of 1.8% of the help was sought from neighbours, friends, religious leaders, or others. However, 3.1% of young women sought help from friends, 2.2% from neighbours, 1.5% from religious leaders and 0.3% from other informal structures. On the other hand, the use of professional and formal support was very low. This is reflected in the average, as 0.1% of women seek help from formal sources. Among the formal structure of seeking help, 0.3% of the young women sought police involvement, and 0.1% sought help from doctors. Notably, none of the women sought support from lawyers or social service personnel. In, summary, Table 2 reveals that People preferred to get help from friends, neighbours, and religious leaders instead of professionals. Participants rarely used formal sources like the police or healthcare providers, and none of them said they had asked for help from social workers or lawyers.

Table 3 shows the Chi-square analysis which was performed to determine the associations between sociodemographic variables and help-seeking behaviour in young women who experienced intimate partner violence (IPV) in Nigeria. The results in Table 3 shows that the association between religion and help-seeking behaviour among young women who experienced intimate partner violence (IPV) was statistically significant ($\chi^2 = 11.700$, $p < 0.05$). In the same vein, ethnicity was strongly associated with help-seeking behaviour in young women who experienced intimate partner violence (IPV) ($\chi^2 = 40.135$, $p < 0.05$). Additionally, residential type was significantly associated with help-seeking behaviour in young women who experienced intimate partner violence (IPV) ($\chi^2 = 8.710$, $p < 0.05$). There was a significant association between educational status and help-seeking behaviour in young women who experienced intimate partner violence ($\chi^2 = 14.659$, $p < 0.05$). Conversely, the association between marital status and help-seeking behaviours among young women who experienced intimate partner violence was not statistically significant ($\chi 2 = 4.320$, $p = 0.115$). Similarly, age ($\chi^2 = 4.087$, $p = 0.30$), wealth index ($\chi^2 = 8.027$, $p = 0.091$), occupation ($\chi^2 = 8.987$, $p = 0.439$), and digital access ($\chi^2 = 0.482$, $p = 0.497$) were not significantly associated with the help-seeking behaviour of young women who experienced intimate partner violence.

**Table 3** Chi-square tests showing the associations between the independent variables and help-seeking behaviour of young women with IPV experience

| Independent variables | $\chi^2$ | *P* value | df | Sig (@0.05 |
|---|---|---|---|---|
| Age | 4.087 | .130 | 2 | Non-significant |
| Religion | 11.700 | .008 | 3 | Significant |
| Region (ethnicity) | 40.135 | .000 | 5 | Significant |
| Type of place of residence | 8.710 | .003 | 1 | Significant |
| Educational status | 14.659 | .002 | 3 | Significant |
| Wealth index | 8.027 | .091 | 4 | Non-significant |
| Occupation | 8.987 | .439 | 9 | Non-significant |
| Marital/Relationship status | 4.320 | .115 | 2 | Non-significant |
| Digital access | .482 | .497 | 1 | Non-significant |

Table 4 below reveals the logistic regression analysis measuring the factors influencing help-seeking behaviour among young women who have experienced intimate partner violence (IPV) in Nigeria. Southwest Nigeria was used as a reference category. The southern region has a significant negative effect on help-seeking behaviour among young women who have experienced intimate partner violence (IPV) (OR = 0.49, CI 0.28–0.84,

**Table 4** Binary logistic regression results for help-seeking behaviour of young women with IPV experience

| Variables | B | S.E | Wald | df | Sig | Exp(B) | 95% CI for Exp(B) |
|---|---|---|---|---|---|---|---|
| Constant | 2.26 | 1.24 | 3.30 | 1 | 0.069 | 9.58 | |
| *Region* | | | 24.98 | 5 | 0.000 | | |
| North central | 0.45 | 0.28 | 2.61 | 1 | 0.11 | 1.57 | 0.91–2.73 |
| Northeast | 0.18 | 0.29 | 0.37 | 1 | 0.54 | 1.19 | 0.67–2.13 |
| Northwest | 0.43 | 0.35 | 1.46 | 1 | 0.23 | 1.53 | 0.77–3.07 |
| Southeast | −0.26 | 0.29 | 0.82 | 1 | 0.36 | 0.77 | 0.44–1.35 |
| South South | −0.72 | 0.28 | 6.59 | 1 | 0.01 | 0.49 | 0.28–0.84 |
| *Place of Residence* | | | | | | | |
| Urban | −0.33 | 0.17 | 3.61 | 1 | 0.06 | 0.72 | 0.52–1.01 |
| *Highest educational level* | 6.58 | 3 | 0.09 | | | | |
| Primary | −1.08 | 0.456 | 5.61 | 1 | 0.02 | 0.34 | 0.14–0.83 |
| Secondary | −1.05 | 0.445 | 5.54 | 1 | 0.02 | 0.35 | 0.15–0.84 |
| Tertiary | −1.07 | 0.419 | 6.49 | 1 | 0.01 | 0.34 | 0.15–0.78 |
| *Religion* | | | 2.03 | 3 | 0.57 | | |
| Catholic | −0.72 | 1.158 | 0.39 | 1 | 0.53 | 0.49 | 0.05–4.71 |
| Christian | −0.42 | 1.15 | 0.13 | 1 | 0.72 | 0.66 | 0.07–6.27 |
| Islam | −0.43 | 1.151 | 0.14 | 1 | 0.71 | 0.65 | 0.07–6.24 |

Source: 2018 NDHS data

$p < 0.05$). The results also revealed that women in the southern region of Nigeria are 49% less likely to seek help than women in the southwestern region when all factors are held constant. Conversely, North Central, Northeast, Northwest, and South East Nigeria do not show statistically significant differences from the South−West region. The effect of place of residence shows that women in urban areas are less likely to seek help when faced with IPV than women in rural areas are (OR = 0.72, CI 0.52–1.01, $p < 0.05$). These results suggest that women with any level of formal education are significantly less likely to seek help than are those with no education. In terms of education, the results showed that women with primary education are 34% less likely to seek help when facing IVP than their counterparts without formal education are (OR = 0.34, CI 0.14–0.83, $p < 0.05$). Additionally, women with secondary education are 35% less likely to seek help when faced with IVP than their counterparts without formal education are (OR = 0.35, CI 0.15–0.84, $p < 0.05$). Similarly, women with a tertiary education are 34% less likely to seek help when facing IVP than their counterparts without a formal education are (OR = 0.34, CI 0.15–0.78, $p < 0.05$). These results suggest that women with any level of formal education are significantly less likely to seek help than are those with no education. The effect of religion on help-seeking behaviour among young women who have experienced Intimate Partner Violence (IPV)is not statistically significant (Wald = 2.03, df = 3, $p = 0.570$). In addition, categories of religion such as Catholic, Christian, and Islam show no significant differences from the reference category in terms of help-seeking behaviour among young women who have experienced Intimate Partner Violence (IPV).

## Discussion

This study examined the influence of sociodemographic factors such as age, education, religion, ethnicity, location, marital status, income and media access on help-seeking behaviour among young women with experience with IPV in Nigeria. The study revealed that religion, location of place of residence, level of education and ethnicity significantly influence the help-seeking behaviour of young women with IPV, whereas age, marital status, income, occupation, and digital access do not.

The significance of religion is unsurprising, as previous research has linked mental health help-seeking and spirituality [32]. Based on deductions from [33], this could be because religion plays a role in understanding and coping with stressful situations. This finding conflicts with the findings of Akther et al. [34] and [35], who reported a low rate of help-seeking among religious people. There is a need to facilitate non-rivalry collaboration among various religious institutions with health providers, social workers, and other related professionals and help service providers ensure reorientation that promotes positive perspectives and practices towards seeking help from various religious members.

The South-South region's much lower chances of seeking help (OR = 0.49) need to be looked into more. This result shows that women in the South-South are less than half as likely to get help for IPV as women in the reference region. There are a number of things in the environment that could have led to this result. The South-South zone has a lot of people living in cities and a lot of resources because it has an oil-based economy. It can also be traced to social and political problems, such as high levels of violence in communities, distrust in state institutions and social services which could make IPV seem normal in that setting [36]. In addition, many ethnic groups in the South-South have cultural norms that stress resolving conflicts within the family and discourage outside help with marriage problems [37].

With respect to the influence of location of place of residence on help-seeking behaviour, the findings of this study are in accordance with those of [38] who reported that rural–urban differences in accessing health help-seeking services. It is expected that people in urban areas have more access to social services and help than do those in rural areas.

The results of this study show that educated women were less likely to ask for help with IPV than uneducated women (OR = 0.34–0.35). However, this is contradictory to the case in many LMICs, where women with secondary or tertiary education are more likely to ask for help [21, 39]. This study disagree with that of Stiller [40], who revealed that women with secondary or tertiary education degrees had four times greater formal help-seeking probabilities than women with no schooling even after accounting for age, wealth, and relationship traits. Kurvinen et al. [41] reported that women with at least secondary education were 1.58 times more likely to receive assistance for IPV-related mental problems than their uneducated peers were. One of the possible reasons could be that educated Nigerian women may feel more social pressure to look good, which could make them less likely to report abuse or ask for help from outside sources because they are afraid of being shamed, blamed, or having their reputation damaged [42].This means that education alone doesn't guarantee that people will seek help. Instead, social norms, trust in institutions, and how people think about privacy may affect how Nigerian women seek help.

The influence of ethnicity on the help-seeking behaviour of young women with IPV aligns with the findings of Ahn et al. [43], who deduced that strict adherence to cultural mistrust is predictive of openness to help. This result also corroborates Cogan et al. [44] who established a relationship between negative cultural beliefs,

stigmatization, fear of judgment, and help-seeking. This is because the practices and lifestyles in a cultural setting are affiliated with shaping one's behaviour as it relates to seeking help.

Although religion was not statistically significant in the final model ($p = 0.57$), but it was retained because of its theoretical and contextual significance to Nigeria. Studies have shown the positioning of religion norms within cultural contexts that condition if and when women seek for help [17, 45]. Akangbe [45] illustrates how religious teachings and leaders influence help-seeking behaviour of IPV victims.

However, the study revealed the Non-significance of age, marital status, income, occupation, and digital access to help-seeking behaviour among IPV young women in Nigeria. It was expected that the relationship with digital access would be significant because people who engage more in social media have access to all kinds of counselling, help, or ideas that can help salvage the situation. This result contradicts the findings of Jayee and Amat [46] who reported a relationship between social media usage and help-seeking counselling. The non-significance of media access could be due to people's lack of awareness of the help resources and platforms available. The majority of individuals within the age range considered in this study are also in the habit of using their phone unproductively [45].

The results show that most people who asked for help did so through informal means, like friends, neighbours, and religious leaders. Very few people, on the other hand, used formal sources like the police, healthcare providers, or legal services. This low use of formal help is in line with other research that shows that people are afraid of being judged, don't trust formal institutions, or think they won't work in IPV response. This aligns with other studies that affirm low subscriptions to formal sources of help against IPV across different populations [32, 45]. Drawing inference from Evans and Feder [47] women prefer informal help because they feel that it is more effective and for fear of disclosure repercussions. Women may choose informal aid due to prior events such as recommendations to settle internally when formal settings are overstaffed by patriarchal men [42].

Patriarchal norm is valid in Nigeria as society often teaches to prioritize family reputation, obey their husbands, and keep marriages intact, even at the cost of ones own safety. Because of this, asking for help from official sources like the police, social workers, or the courts is often seen as a threat to the stability of the marriage and the family. A lot of women are afraid that reporting IPV will lead to the end of their marriage, losing custody of their children, or financial problems, especially when they depend on their partners for money. People often think that asking for formal help is "airing dirty laundry," which can make them feel ashamed or alone. Hence, people turn to family or religious leaders, which are seen as more socially acceptable and private [17, 45, 47].

### Limitations

This study is not without limitations. The study was conducted on young women. Hence, the results cannot be generalized to the larger population of women whose age would have impacted their behaviour. The researchers used the most recent available NDHS dataset from 2018 at the time of study. It was believed that access to a more updated dataset version would have provided current trends and improvements in the insights. Furthermore, NDHS data is a cross-sectional in design which makes it more difficult to determine the causal relationship between variables. Therefore, causality cannot be inferred, the associations found in this study should be interpreted with caution.

### Suggestions for further studies

Future research should consider the use of primary data to understand why IPV survivors prefer informal sources of help. Additionally, more qualitative research should be conducted to allow young women with IPV experience to freely share their opinions concerning other factors influencing their help-seeking behaviour. This will enable us to put in place effective interventions and adequate support services that address the real concerns and unique needs of survivors.

## Conclusion

This study provides evidence of the influence of religion, ethnicity, level of education, and location on help-seeking behaviour. It is therefore recommended that those measures be tailored to religious institutions where religious leaders are sensitized to the implications of failure to access help in IPV situations, thereby creating strong collaboration in providing a supportive environment that facilitates positive behaviour change towards seeking help. Greater focus should be placed on raising awareness in rural areas. Interventions and educational programs are needed to increase awareness of available resources for IPV survivors. Additionally, community-based, culturally sensitive counselling is essential to further educate and reorient individuals about support networks and the benefits of seeking help.

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**Author contributions**
Adaramoye conceptualized the study, wrote the first draft of the manuscript and analysed the data. Adedini critically reviewed the work for intellectual input. Sunmola designed the methodology, and reviewed the work. All authors read and approved the final manuscript.

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**Data availability**
This study used Nigeria Demographic and Health Surevy (NDHS) 2018 data set. https://dhsprogram.com/data/dataset/Nigeria_Standard-DHS_2018.cfm.

## Declarations

**Ethics approval and consent to participate**
Both are not applicable to this study. *Norm/standard for ethical research*: DHS Program's ethical standards and Helsinki's principles guided the investigation. *Approval committee*: Under the DHS protocol, the National Health Research Ethics Committee (NHREC), Nigeria, and the ICF Institutional Review Board, USA, granted ethical permission to use the NDHS data.

**Consent for publication**
This study utilised secondary data drawn from the Nigeria Demographic and Health Survey (NDHS, 2018). DHS program authorized the downloading of the survey data for the purpose of statistical reporting and analysis for this registered research.

**Competing interests**
The authors declare no competing interests.

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## Publisher's Note