

Original Research Article

DOI: <https://dx.doi.org/10.18203/2394-6040.ijcmph20211966>

Coping strategies available for women living with HIV/AIDS experiencing intimate partner violence in the Singida region, Tanzania

Agnes L. Kosia^{1*}, Gasto Frumence¹, Tumaini Nyamhang¹,
Ave Maria Semakafu¹, Deodatus Kakoko²

¹Department of Development Studies, ²Department of Behavioural Sciences, School of Public Health and Social Sciences, Muhimbili University of Health and Allied Sciences, Dar-es Salaam, Tanzania

Received: 25 February 2021

Revised: 15 April 2021

Accepted: 16 April 2021

***Correspondence:**

Dr. Agnes L. Kosia,

E-mail: agneskosia@yahoo.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Intimate partner violence is a major public health problem in Tanzania, yet little is known about the coping strategies among women living with HIV/AIDS who experiencing IPV. The objective of the study was to explore the coping strategies employed by women living with HIV/AIDS experiencing IPV who attended care and treatment services in the Singida region.

Methods: A qualitative phenomenology study design was performed in which data were collected through in-depth interviews with 35 women living with HIV/AIDS who also experienced IPV. Content analysis was used to analyse the data.

Results: We found that women living with HIV/AIDS experienced IPV used family members, such as their mothers, sisters, and brothers as a coping mechanism to express their pains. Spiritual leaders counselled them spiritually and psychologically and they were advised on how to live with their violent partners. Other coping mechanisms included reporting to the police and the legal system, and the use of support groups. Through support groups, they obtained relief from depression, loneliness, isolation, stigma and discrimination.

Conclusions: This study concludes that coping mechanisms helped women living with HIV/AIDS to reduce the stress associated with HIV/AIDS and intimate partner violence. The government of Tanzania should strengthen policies related to IPV and HIV/AIDS among all women in Tanzania. Moreover, local government authorities should build safe homes for all survivors of intimate partner violence throughout the country.

Keywords: IPV, HIV/AIDS, Women, Coping mechanism

INTRODUCTION

Coping strategies refer to the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimize stressful events.¹ The conscious efforts to solve the problems created by stressful events that are appraised as exceeding a person's capacity and resources.² Furthermore, coping strategies represent an individual's cognitive and behavioural efforts to manage stress by reducing, minimizing,

mastering, or tolerating internal and/or external environmental demands that are perceived as taxing or exceeding one's resources and that have the potential to endanger one's well-being.³ There are various theories and coping strategies, including the two main types of coping strategies: problem-focused coping and emotion-focused coping.¹

Intimate partner violence (IPV), also called domestic violence, is a behaviour that results in emotional,

physical, sexual, or psychological harm to a current or former partner or spouse. IPV occurs in all communities and in all types of relationships, and has extensive physical, mental health, social, and economic consequences.⁴⁻¹⁰ IPV continues to be frighteningly common and is unaccepted within many societies.¹¹ The World Health Organization estimates that 30% of women globally who have been in a relationship have experienced physical or sexual IPV. In Africa, this has been estimated to be as high as 36.6%.¹² Recent studies across the African continent have yielded prevalence estimates of either physical or sexual IPV ranging from 18% in the past year to 71% in a lifetime. However, the accuracy of these widely ranging estimates is uncertain, given the underreporting of IPV.¹³

According to the WHO 2005 multi-country study carried out in 10 countries, violence against women showed varied forms and patterns across the different countries and cultures¹⁴. Sub-Saharan African (SSA) countries standout, with the highest levels of violence against women in the world.¹⁵ It has been reported that 14 out of the 15 countries with the highest level of women who deem wife-beating as justifiable are found in SSA.¹⁶ In SSA countries, many women experience violence in diverse forms, including physical, emotional, psychological and sexual. Moreover, much of this violence is perpetrated by the women's husbands or close partners.¹⁷ This study explored the coping strategies available to women LWHA experiencing IPV attending care and treatment services in the Singida region in central Tanzania.

Intimate partner violence and HIV in Tanzania

IPV is a major public health and human rights concern in Tanzania. According to the WHO multi-country study on women's health and domestic violence (2000-2003), the prevalence of IPV was 41% and 56%, respectively, among a representative sample of ever-partnered women in Dar es Salaam and the southern district of Mbeya.^{18,19} Particular concern is the evidence of links between IPV, sexual risk behaviours, and HIV infection among women living with HIV/AIDS (LWHA). According to a study conducted in the HIV voluntary counselling and testing centre in Dar es Salaam, the prevalence of IPV was ten times higher among young HIV-positive women (<30 years of age) than among similarly aged HIV-negative women.^{20,21}

Coping strategy model

Coping strategy is not considered as personality trait or style that remains stable across situations. Rather, coping is considered to be a set of strategies that are available to be implemented to match specific situations. According to Lazarus and Folkman (1984) there are two types of coping strategies: emotional and problem focused coping.² Emotional focused coping strategy focuses on the internal emotional states, rather than on the external

situations that trigger emotional responses. However, problem focused coping strategies function to alter the stress by direct action. This form of coping is more probable when conditions are appraised as amenable to change. Problem-focused strategies include learning new skills, finding alternatives, channels of gratification, or developing new standards of behaviour. Some of the coping strategies include seeking social support, which may serve both emotional and problem-focused functions at the same time. Both emotional and problem-focused forms of coping strategies are used by most individuals in response to stressful events.^{22,23}

Coping strategies for IPV among women LWHA

Coping strategies among women LWHA experiencing violence reveal that women exercise agency and varying degrees of control of their lives, even within the constraints of multiple forms of subordination.²⁴ It is therefore vital to acknowledge that women who experience violence are not merely victims but survivors.²³ Although there are limited formal support services available to women LWHA experiencing IPV, they have developed their own coping strategies and mechanisms that draw on informal networks such as family members, including parents, brothers and sisters, aunts, and local and religious leaders.²³ However, women LWHA rarely report violence to the police or formal legal services, since they need to maintain their relationships and fear the negative consequences of their male partners.²⁵

Current study used the problem and emotional focused strategies developed by Lazarus and Folkman to examine the coping strategies developed by women LWHA attending care and treatment clinics in Singida, Tanzania. Little is known about the coping strategies of women LWHA experiencing IPV who attend care and treatment clinics in this area.

METHODS

Study area

Current study was conducted at the care and treatment clinic (CTC) and the prevention of mother to child transmission (PMTCT) of HIV/AIDS, which form part of the reproductive and child health (RCH) unit at the Singida regional hospital. The Singida regional hospital serves as a referral hospital in the region. We chose the Singida regional hospital CTC to explore the coping strategies of women LWHA attending the CTC and IPV is high among women living with HIV/AIDS.

Study design

This was a qualitative phenomenology design used to identify phenomena and focused on subjective experiences and understanding the structure of IPV among women LWHA in which data were

collected through in-depth interviews (IDIs). The use of IDIs enabled the researchers to gain in-depth experience information at the CTC. The inclusion criteria/eligibility for participation included being a woman and HIV positive, experiencing IPV, and attending the CTC and PMTCT unit.

Socio-demographic characteristics of the study participants

The participants in this study were women LWHA attending the CTC in the Singida region aged between 20 to 79 years. The majority of the women were widows whose husbands had died of HIV/AIDS, while a few women were separated from their male partners due to violence. Few of the interviewed women were cohabiting. The majority of participants had received a formal education. Few had received primary or secondary school education. Economically, the majority of the study participants were engaged in small businesses, such as selling local brew and fruits. A few were engaged in tailoring, while others were peasants.

Selection of study participants

The study used purposive sampling to obtain representative samples by including groups of women LWHA who experienced IPV regardless of their marital status. CTC and PMTCT clinics were used as an entry point where women LWHA could be identified. The counsellors introduced the researchers to the first few participants, who were known to have experienced IPV through their disclosure to health care workers. Among the widowed and separated women, some were living with new partners, while others had decided to live alone with their children. The majority of HIV-positive women knew each other through the use of the CTC services and attendance at support groups, which met once a month to provide psychosocial support. The inclusion criteria were all the HIV positive women who experienced IPV who are attended CTC and PMTCT. The exclusion criteria were all HIV negative women who were not attended CTC and PMTCT and were not experienced IPV. Written informed consent forms were provided to all interviewees who participated in the study.

Data collection

In-depth interviews were conducted to collect data. The interviews explored information and coping strategies available at the CTC and in the community for women LWHA but at the same time experiencing IPV. Interviews were conducted in a relaxed atmosphere so that the HIV positive women could feel comfortable and had the opportunity to talk to the researcher and express their feelings freely. Interviews were conducted between February and March 2014. Prior to the interviews, the interviewer introduced herself to each participant, explained the purpose and importance of the study and assured them that all the information they provided would

be handled carefully and that confidentiality would be maintained throughout. A total of 35 interviews were conducted. The interviews were conducted in the Kiswahili language. Transcripts were then translated into English. Each interview lasted between 45 and 60 minutes. Participants granted researchers permission to take notes and to make tape recordings.

Data management and analysis

The audio-recorded interviews were translated from Kiswahili into English. The transcripts and field notes were analysed manually by the first author by reading and re-reading to become familiarized with the data. We started with the condensed meaning and extracted the unit codes. The codes were determined from the categories. Similarities and differences were analysed to determine the relationship between the codes and the meaning unit, with jargon words being avoided. NiVO version 8 statistical package was used to analyze the data. We read the interview texts in order to identify relevant patterns related to the topic of coping mechanisms available to women LWHA experiencing IPV attending CTCs in the Singida Region, Tanzania. Content analysis was used to analyse the data.

Trustworthiness of the data

The trustworthiness in this study was assured by the researcher who was engaged in data collection through in-depth interviews. The study involved the research team attending peer-debriefing sessions to reflect on and discuss procedures and interpretations of the data. Using this process, we sought to ensure confirmation and consistency. It can be confirmed that the study findings were shaped by the respondents' information and not by researcher bias, motivation or interest.

RESULTS

The analysis of coping strategies for women LWHA experiencing IPV attending CTCs in Singida generated the following themes: coping strategies through family members; support groups through authoritative organs such as religious leaders, the police and legal systems, or local leaders. In addition, women LWHA found homes provided by the village chairperson to be safe places to use during periods of IPV.

Explaining experiences of violence to family members

Women LWHA who experienced IPV reported that when their male partners beat them severely, the first people they turned to for possible help were family members such as their parents, especially their mothers, sisters, brothers and aunts. When they express their pain to family members, they feel considerably better, since their family members listen to and sympathize with them. Above all, they provide psychological and financial support.

One participant (woman aged 38 years) reported; "I have told my parents this is the first time that I have shared my problems with them. I feel very comfortable because my family members listen to me, they sympathize my problem with me. They always help me psychologically and financially. I feel very good because I have people around me to share my problems."

Similarly, according to cultural issues related to family matters, IPV has to be addressed first within the family before other members of the community became aware of the information. At this level, couples were called together to discuss IPV problems. The violent male partners were advised to request reconciliation from their female partners. "both families members must intervene. At the end they will set for reconciliation in both sides and the violent male partner admit guilt in front of his parent if the female partner agree then the case end there then they we go back home to live together. By using family member's reconciliation (woman aged 40 years)."

Table 1: Basic characteristics of study participants.

Category (n=35)	HIV+ women	Frequency
Age	20-39	17
	40-60	19
Marital status	Married	10
	Widowed	16
	Separated	7
	Cohabiting	2
Level of education	No formal education	13
	Primary school	16
	Secondary school	6
Source of income	Small business	20
	Peasants	15

Seeking spiritual support from religious leaders

Respondents in this study reported that they found coping mechanisms through religious leaders. When they discussed their violence with them, they were counselled spiritually, with the religious leaders reminding them about living in good relationship, about forgiveness and about taking care of their children.

The comfort they received from this counselling resulted in them forgiving their husbands and feeling affection towards their male partners once again. They reported that they preferred to report their IPV cases more to religious leaders. As one participant (woman aged 44 years) reported, "Church leaders are the people I have sought help from and they usually give good advice. I am satisfied with the good advice that they have given me because after their advice we stayed together and I am thankful for that."

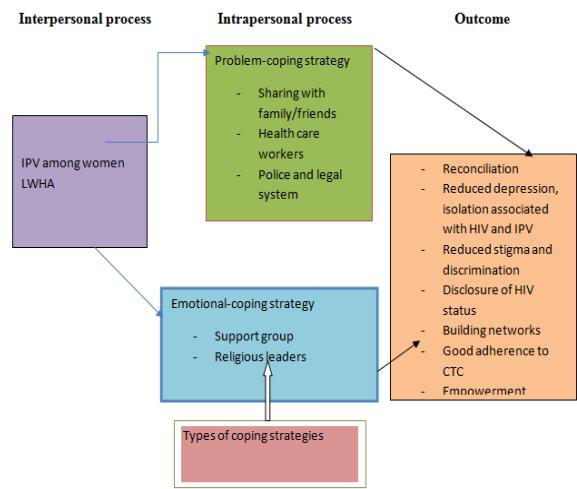


Figure 1: Summary of the findings according to the Lazarus and Folkman framework model.

Reporting of serious injury to the police and legal systems

Women LWHA reported that they tried to find support from formal systems such as the police, health services, and legal advice services. They stated that they only reported to the police when they experience severe physical violence from their male partners due to fear of stigma and discrimination from the police and the legal systems. Police stations have established gender-based desks to address all IPV cases. As one participant (woman aged 33 years) reported, "I reported my husband to the police several times. So the police officer knows me very well. So sometimes when they see me they know that I am reporting the same problem. I found that people like me who are HIV positive we experiencing IPV we face stigma and discrimination from the police and the community as well."

Seeking relief from loneliness by taking part in support group meetings

Women interviewed in this study reported that they had various unique needs and concerns which they thought could be addressed through support groups. They had their group of women living with HIV/AIDs in the Singida region and usually they meet on a monthly basis to discuss their needs and concerns. Their support group reduced their apprehension, depression, loneliness and isolation including building networks of friends to socialize with and provided emotional support, including empowering them to value themselves, and to improve their life. As was reported by one participant (woman aged 56 years), "this group helped us to reduce our pains. Since I joined this group, I found that I got support which relieved my pains because we share our sorrow and happiness among ourselves."

Taking refuge in homes of village leaders

In current study, women LWHA reported that they had left their homes several times as a result of the violence they had experienced at the hands of their male partners. They had to turn to the village chairperson, as this was the only safe place for them to run to, especially when the violence occurred during the night; there were no safe shelters available to them in their community. At the home of the village chairperson, they were received and supported with accommodation for one night. As one participant (woman aged 32 years) reported, "so for me to be safe I usually run to village chairperson for safety overnight. He provided me with basic needs such as food and shelter for one night. Then in the morning I report about my issue to him."

DISCUSSION

Current study reports the coping strategies and support available for women living with HIV/AIDS experiencing IPV. It adopted the coping strategy model of Lazarus and Folkman by examining the interpersonal processes of being a woman LWHA, the intrapersonal processes of problem and emotional-coping strategies, and the outcomes. In terms of the intrapersonal problem-coping strategies, we found that women LWHA experiencing IPV used family members such as their own parents, especially their mothers, and sisters, brothers and aunts to express their IPV pains. Through this coping mechanism they felt that they had people who valued them. Our study is in line with others that showed that women experiencing IPV use various available support systems, problem-coping strategies and help-seeking behaviours²⁶. They had different personal coping strategies, including avoidance, defence, escape, and social and family members; these types of coping mechanisms have been reported to have positive effects among married women experiencing IPV in Nigeria.²⁷ Spiritual support was also among the intra-personal processes of emotional coping strategies we found in current study. The women reported that religious leaders counselled them on how to cope with their violent male partners and with their HIV status. In addition, they were comforted both psychologically and spiritually. They preferred to report their IPV issues to religious leaders and health care workers working at the CTC and PMTCT, as they were satisfied with the advice they received and their counselling sessions. Our finding corroborate with other studies which showed that social support from religious institutions (e.g. churches, synagogues, mosques) was found to be a key factor in many women's abilities to rebuild their lives and family relationships²⁸. The desire for a loving religious family is an expressed need for many women. Those women with a welcoming, caring religious experience reported feelings of hope for healing after such a distressing life event.²⁸ Furthermore, women are logical and assertive in their response to IPV, which they respond to by making active help-seeking efforts that are largely unmet; if the women stay in the abusive relationship, it is due to lack of

knowledge about their options, financial constraints or due to the inadequacy of the intervention efforts.²⁹ In current study we found that women LWHA experiencing IPV also used problem-coping strategies from formal systems such as the police and the legal system. However, due to the frequent reporting of IPV and being HIV positive, they also experienced stigma and discrimination from the police and legal staff. The government of Tanzania has introduced gender desks to support women experiencing gender-based violence. In collaboration with other stakeholders, the government has facilitated the establishment of gender desks in various ministry departments (e.g. police departments). Civil society organizations (CSOs) provide advocacy, legal aid, and health care services and organize media campaigns. Moreover, there are national policies, laws, strategies, and action plans in place to address gender equality.³⁰ Furthermore, the government, in collaboration with CSOs, is working to create an enabling environment for survivors to access services such as legal aid. The MOHCDGEC has been delivering services to gender-based violence (GBV) survivors despite the lack of GBV policy guidelines that would guide providers' actions when a survivor visits a health facility.³¹ Current study is in line with other studies carried out in the USA where literature shows that police officers who seemed more closely aligned with traditional policing ideals often expressed frustration with IPV calls, that officers believed that the genders of victims and perpetrators affected the seriousness of the IPV situation, that the persistence of traditional gender roles in relationships continue to influence societal views of IPV in order to take any instance of IPV seriously. However, the levels of seriousness vary as historically, the police view IPV as a private family matter.^{32,33} Among the intrapersonal processes of emotional-coping strategies, women LWHA experiencing IPV used support groups. Through these, they discuss their needs in relation to HIV and IPV and learn how to cope with stigma and discrimination in the community. Through support groups they reduce depression, loneliness, express their feelings among themselves, build networks, and feel valued and empowered.³⁴ Above all they adhere to their care and treatment clinics and antiretroviral treatment. Our study is in line with other studies conducted in Nepal on women LWHA battling stigma and discrimination that showed that HIV positive women have inimitable needs and concerns which can be best addressed with support groups. Involvement in a support group has been correlated with reducing apprehension, depression, being alone and isolation. Support groups offer a supportive environment for women with HIV to express their suppressed feelings in the company of women in the same situation. They also facilitate the sharing of strategies for securely disclosing HIV status, building a network of friends to socialize with and provide emotional support.³⁵

In current study we found that women LWHA experiencing IPV turned to the village chairperson, who provided a safe place during episodes of violence. In

current study there were no safe homes built by the government for IPV survivors. This implies that government has a role to build safe homes for IPV survivors. The village chairperson provided them with basic needs such as one day's accommodation and food. They were not able to run to other places, such as friends and relatives, as their male partner would suspect that they were having an extra marital relationship. For the survivors of IPV, housing takes on an additional meaning; it is the key to establishing a new life, free from abuse. Current study is in agreement with other studies which showed that IPV has been cited as a leading cause of homelessness among women. Women in abusive relationships often try to leave their partners to protect themselves and their children, which puts them at greater risk of a multitude of negative outcomes.³⁶ Furthermore, literature shows that women LWHA experiencing IPV prefer someone who listens to them with respect and assists them with finding housing resources, while also supporting them through setbacks. This lack of safe homes placed women and their children at risk of further exposure to IPV.³⁷ Studies have documented the need for social service professionals to build supportive, respectful, non-controlling relationships with clients affected by IPV and to work together to identify individualized needs instead of prescribing a set service regimen.³⁷

Limitations

This is a qualitative study in which we interviewed only women LWHA experiencing IPV who attended CTC and PMTCT units. We looked at the coping strategies of women LWHA experiencing IPV. A bias may have been introduced into our study, since only one type of respondent was interviewed, i.e. women LWHA who experienced IPV. We recommend further studies should be carried out to compare the two groups in order to generalize the findings in Tanzania.

CONCLUSION

In current study, we found that our participants used family members, religious leaders, the police and the legal system and support groups as coping mechanisms towards their HIV/AIDS and IPV. We used problem-focused and emotion-focused coping strategies to analyse the coping mechanisms developed by women LWHA experiencing IPV. We found that through these coping mechanisms they achieved reconciliation with their male partners, reduced emotional and psychological stress, reduced stigma and discrimination among themselves, felt empowered, built networks and felt valued, since they had people with whom they could share, and who listened to, their HIV/AIDS and IPV concerns, including family members and religious leaders. We strongly recommend that the government of Tanzania strengthen IPV policies and build homes for IPV and HIV survivors throughout the country, especially in underserved areas such as the Singida region.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Shelley Taylor in collaboration with the psychosocial working group. Available at: <https://macses.ucsf.edu/research/psychosocial/optimism.php>. Accessed on 20 January 2021.
2. Lazarus R, Folkman S. Psychological stress and the coping process. Germany: Springer Publishing Company; 1984.
3. Bauman HD. Coping with intimate partner violence: Battered women's use and perceived helpfulness of emotion-focused coping strategies. *J Aggr Maltreat Trauma.* 2008;17(1):23-4.
4. Rebecca FR, Jacky MJ, Jacquelyn CC, Megan HB. Intimate partner violence screening tools: a systematic review. *Am J Prev Med.* 2009;36(5):439-45.e4.
5. Arkins B, Begley C, Higgins A. Measures for screening for intimate partner violence: a systematic review. *J Psychiatr Ment Health Nurs.* 2016;23(3-4):217-35.
6. Abeya SG, Afework MF, Yalew AW. Intimate partner violence against women in west Ethiopia: a qualitative study on attitudes, woman's response, and suggested measures as perceived by community members. *Reprod Health.* 2012;9:14.
7. Vivilaki VG, Dafermos V, Daglas M, Antoniou E, Tsopelas ND, Theodorakis PN, et al. Identifying intimate partner violence (IPV) during the postpartum period in a Greek sample. *Arch Womens Ment Health.* 2010;13(6):467-76.
8. Msuya SE, Juma A, Neema M. Intimate partner violence and empowerment among women in Tanzania: prevalence and effects on utilization of reproductive health services. Available at: <https://dhsprogram.com/publications/pdf/WP106/WP106.pdf>. Accessed on 20 January 2021.
9. Saltzman FM, Shelley A. Intimate partner violence surveillance uniform definitions and recommended data elements. Available at: <https://www.cdc.gov/violenceprevention/pdf/ipv/intimatepartnerviolence.pdf>. Accessed on 20 January 2021.
10. Wingood GM, DiClemente RJ, Seth P. Improving health outcomes for IPV-exposed women living with HIV. *J Acquir Immune Defic Syndr.* 2013;64(1):1-2.
11. Laisser RM, Lugina HI, Lindmark G, Nystrom L, Emmelin M. Striving to make a difference: health care worker experiences with intimate partner violence clients in Tanzania. *Health Care Women Int.* 2009;30(1-2):64-78.
12. Rees K, Zweigenthal V, Joyner K. Implementing intimate partner violence care in a rural sub-district of South Africa: a qualitative evaluation. *Glob Health Action.* 2014;7:24588.

13. Abrahams N, Jewkes R, Laubscher R, Hoffman M, Health DC. Intimate partner violence: prevalence and risk factors for men in Cape Town, South Africa. *Violence Vict.* 2006;21:247-64.
14. Garcia-Moreno C, Jansen HAFM, Ellsberg M, Heise L, Watts CH. WHO multi-country study on women's health and domestic initial results on prevalence. *Genetics.* 2005;151(1):277-83.
15. Izugbara CO, Obiyan MO, Degfie TT, Bhatti A. Correlates of intimate partner violence among urban women in sub-Saharan Africa. *PLoS One.* 2020; 15(3):e0230508.
16. Bamiwuye SO, Odimegwu C. Spousal violence in sub-Saharan Africa: does household poverty-wealth matter? *Reprod Health.* 2014;11:45.
17. Itimi K, Dienye PO, Gbeneol PK. Intimate partner violence and associated coping strategies among women in a primary care clinic in Port Harcourt, Nigeria. *J Family Med Prim Care.* 2014;3(3):193-8.
18. Abramsky T, Watts CH, Garcia-Moreno C, Devries K, Kiss L, Ellsberg M, Jansen HA, Heise L. What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health.* 2011;11:109.
19. Krishnan S, Vohra D, de Walque D, Medlin C, Nathan R, Dow WH. Tanzanian Couples' Perspectives on Gender Equity, Relationship Power, and Intimate Partner Violence: Findings from the RESPECT Study. *AIDS Res Treat.* 2012;2012: 187890.
20. Maman S, van Rooyen H, Groves AK. HIV status disclosure to families for social support in South Africa (NIMH Project Accept/HPTN 043). *AIDS Care.* 2014;26(2):226-32.
21. Sharma V, Leight J, Verani F, Tewolde S, Deyessa N. Effectiveness of a culturally appropriate intervention to prevent intimate partner violence and HIV transmission among men, women, and couples in rural Ethiopia: Findings from a cluster-randomized controlled trial. *PLoS Med.* 2020;17(8):e1003274.
22. Durevall D, Lindskog A. Intimate partner violence and HIV in ten sub-Saharan African countries: what do the Demographic and Health Surveys tell us? *Lancet Glob Health.* 2015;3(1):e34-43.
23. Mitchell D. Stress, coping, and appraisal in an HIV-Seropositive rural sample: a test of the goodness-of-fit hypothesis. Available at: https://etd.ohiolink.edu/apexprod/rws_olink/r/1501/10?clear=10&p10_accession_num=ohiou1103225821. Accessed on 20 January 2021.
24. Addressing the links between gender-based violence and HIV in the Great Lakes region: Background Information on GBV and HIV. Available at: <http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/BSP/GENDER/PDF/HIVGBVbackgroundrep ort.pdf>. Accessed on 20 January 2021.
25. Paudel V, Baral KP. Women living with HIV/AIDS, battling stigma, discrimination and denial and the role of support groups as a coping strategy: a review of literature. *Reprod Health.* 2015;12:53.
26. Lokhmatkina NV, Agnew-Davies R, Costelloe C, Kuznetsova OY, Nikolskaya IM, Feder GS. Intimate partner violence and ways of coping with stress: cross-sectional survey of female patients in Russian general practice. *Family Prac.* 2015;86:412-9.
27. Pathak N, Dhairyawan R, Tariq S. The experience of intimate partner violence among older women: A narrative review. *Maturitas.* 2019;121:63-75.
28. Gillum TL, Sullivan CM, Bybee DI. The importance of spirituality in the lives of domestic violence survivors. *violence against women.* 2006;12(3):240-50.
29. Ethan B, Bunch J, Canner N, Michael Y. Beyond the Holacracy hype: the overwrought claims and actual promise of the next generation of self-managed teams. *Leadersh Health Serv.* 2019;32(1):113-28.
30. Tanzania ministry of health, community development, gender, elderly and children. Available at: <http://ghdx.healthdata.org/organizations/ministry-health-community-development-gender-elderly-and-children-mohcdec-tanzania>. Accessed on 20 January 2021.
31. Results from the 2011-12 Tanzania HIV/AIDS and malaria indicator survey. Available at: <https://dhsprogram.com/pubs/pdf/ais11/ais11.pdf>. Accessed on 20 January 2021.
32. Lockwood D, Prohaska A. Police officer gender and attitudes toward intimate partner violence: How policy can eliminate stereotypes. *Int J Criminal Justice Sci.* 2015;10(1):77.
33. Cho H, Seon J, Han JB, Shamrova D, Kwon I. Gender Differences in the Relationship Between the Nature of Intimate Partner Violence and the Survivor's Help-Seeking. *2020;26(6-7):712-29.*
34. Coker AL, Davis KE, Arias I, Desai S, Sanderson M, Brandt HM, Smith PH. Physical and mental health effects of intimate partner violence for men and women. *Am J Prev Med.* 2002;23(4):260-8.
35. Paudel V, Baral KP. Women living with HIV/AIDS (WLHA), battling stigma, discrimination and denial and the role of support groups as a coping strategy: a review of literature. *Reprod Health.* 2015;12:53.
36. Ogbe E, Harmon S, Van den Bergh R, Degomme O. A systematic review of intimate partner violence interventions focused on improving social support and/ mental health outcomes of survivors. *PLoS One.* 2020;15(6):e0235177.
37. Glass NE, Clough A, Messing JT, Bloom T, Brown ML, Eden KB, et al. Longitudinal impact of the myplan app on health and safety among college women experiencing partner violence. *J Interpers Violence.* 2021.

Cite this article as: Kosia AL, Frumence G, Nyamhangwa T, Semakafu AM, Kakoko D. Coping strategies available for women living with HIV/AIDS experiencing intimate partner violence in the Singida region, Tanzania. *Int J Community Med Public Health* 2021;8:2658-64.