Chapter 10
Intimate Partner Violence in Nigeria

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10.1 Overview of the Author

I am a Nigerian with more than 20 years' experience in my native country before relocating to the United States in 2012. I am a demographer and social statistician by training with a research focus on population dynamics and health, with a particular interest in sexual and reproductive health, women's position and roles in the society, and men's engagement in reproductive health. My previous research examined the processes through which women and men engage in different aspects of sexual and reproductive health in response to the demands of a changing social environment.

More recently, my work has focused on women's status within the family and society and emphasized the importance of the larger social context on issues of gender-based violence (GBV) and intimate partner violence (IPV), women's reproductive health autonomy, and male responsibility as partners in the development programs. My interest in research on a woman's status was strongly influenced by my experience growing up as a boy with four sisters and witnessing my uncles abusing their spouses, particularly when they disagreed over sexual relations within their marriage. My interest in understanding ways Nigeria can reduce levels of IPV was strongly influenced by the principles and philosophy of the 1994 International Conference on Population and Development held in Cairo, Egypt, and the 1995 Fourth World Conference on Women, held in Beijing, China, which endorsed changes in gender norms and gender equity.

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S. M. Stith, C. M. Spencer (eds.), *International Perspectives on Intimate Partner Violence*, AFTA SpringerBriefs in Family Therapy,
https://doi.org/10.1007/978-3-030-74808-1_10

10.2 Overview of Nigeria

Nigeria is multiethnic and culturally diverse, with more than 386 ethnic groups (Ugbem, 2019). It has 36 autonomous states and the Federal Capital Territory with 774 local governments. Family structures in the country are both nuclear and extended, with elites inclining more toward the nuclear structure with minimal linkages to the extended family and the family structure being extended in the general population. Christianity and Islam are the two predominant religions in Nigeria, though traditional beliefs also persist.

Largely because of its oil revenue, Nigeria is seen as a powerhouse of economic strength and development in sub-Saharan Africa. However, the erratic nature of global oil prices has led to unstable economic growth, despite recent diversification to non-oil sectors such as tourism and agriculture (Riti et al., 2016). Despite some progress in the socioeconomic spheres, Nigeria's human capital development remains poor. The country ranked 152 of 157 countries in the World Bank's 2018 Human Capital Index and 125 out of 145 countries on the Gender Equality Index. In addition, employment creation remains weak because of various developmental challenges facing the country with negative impacts on social and economic well-being.

The patriarchal nature of Nigerian society exposes Nigerian women and girls to disproportionate inequality in income and opportunities which, in turn, renders them more prone to poverty and more vulnerable to domestic violence (Oyediran et al., 2011; Feyisetan & Oyediran, 2019). After marriage, a woman surrenders to her husband's exclusive rights of household decision-making, including those related to employment and career progression. This traditional view gives male spouses permission to violate or batter their wives as a disciplinary measure to ensure their compliance to marital obligations (Oyediran & Feyisetan, 2017). Nigeria's rigid gender norms also result in acceptance of wife battering, increase the power of the extended family over married couples, and restrict women's ability to seek redress against violence within the marriage (Oyediran & Isiugo-Abanihe, 2005; Rettig et al., 2020).

This feminization of poverty often forces poor women to rely on their partners for personal needs and household maintenance; and men use this economic vulnerability to abuse and violate their wives. The experience of an IPV survivor, shared with the Coordinator of the Lagos State Domestic and Sexual Violence Response Team (DSVRT), captures the implication of feminization of poverty on IPV in Nigerian context: "At least I work and I earn a salary. What would have happened if I were a housewife without money, no family support? It would have been terrible. Not that it is not terrible … but it could have been worse" [Wana Udobang, quoted from *The Guardian*, January 5, 2018].

10.3 Intimate Partner Violence in Nigeria

IPV generally includes physical, sexual, and emotional abuse, which often do not occur in isolation of each other. The Nigeria Demographic and Health Survey (NDHS) showed that the combined prevalence of IPV (physical, sexual, or emotional) increased from 31% in 2008 to 36% in 2018 (NPC Nigeria & ICF, 2019). IPV prevalence (including physical, sexual, and/or emotional violence at spouse's hands) varies by geographical setting in Nigeria: from a high of 50% in the North Central region to a low of 20% in the South West region of the country, according to the Nigeria Demographic and Health Survey (2018). Results differ widely by state; the proportion of women experiencing IPV by a husband in the last 12 months is highest in Gombe (69%) and lowest in Jigawa (10%) (NPC Nigeria & ICF, 2019).

These geographic variations in IPV prevalence can be attributed to differences in human capital development and cultural conservatism, especially education and social norms that encourage women's roles and responsibilities in the family and society. Women in the South West are more educated than their counterparts in the North Central. When women have a higher level of education, men are more likely to feel threatened and to fear that women might break patriarchal norms and values that promote women's subjugation and subservience, which can increase male-to-female violence. Conversely, though, education may help in conflict resolution and communication among couples. The education configuration may also explain the difference in the prevalence and incidence of IPV at the state level.

Nigeria's patriarchal culture shapes the context of IPV prevalence. Husbands are seen as always right and usually win in any marital disputes against their wives. Family members who step in to mediate are likely to pronounce women guilty—despite obvious signs of violence—because they are mostly concerned about the family name. Mrs. Titilola Vivour-Adeniyi, the Coordinator of the DSVRT in Lagos State, described a situation in which Mrs. XYZW (masked) went to her parents for help after years of abuse. Her father urged her to drop all the charges filed against her husband, while her mother was worried about the family's reputation. "My mother said they want to return me back so I don't disgrace her. Even after the beating she said you have to save the face of the family. You have to go back. So I went back" [Wana Udobang, quoted from *The Guardian,* January 5, 2018].

Despite the high incidence of IPV, marriage is still regarded as a prized attainment in Nigeria. Nigerian women have adopted a sort of "don't ask, don't tell" rule when it comes to reporting violence or leaving the marriage, because wedding vows are regarded as sacred. Because of this view, women are quietly encouraged to remain in abusive relationships. Nevertheless, the negative impacts of IPV are clear and serious. Exposure to IPV may result in poor health outcomes, physical injuries, gynecological problems, unintended pregnancy, sexually transmitted infections, depression, and, in extreme cases, death (Gordon, 2016; Anzaku et al., 2017).

Given the growing rates of IPV and its consequences, scholars have identified key predictors of IPV in Nigeria. Many studies have drawn attention to the scope of violence against women in Nigeria and the factors that place women at risk of IPV

in general (Anzaku et al., 2017; Oladepo et al., 2011; Oyediran & Cunningham, 2014; Oyediran & Feyisetan, 2017; Fagbamigbe et al., 2020). This research has created platforms for open debate and opportunities for design of evidence-based interventions and policies to prevent this type of violence.

Research shows that IPV is more likely among women with primary education, those living in cities or in the south-south region, Christian women, women whose husbands consume alcohol, and women who witnessed domestic violence as a child (Oyediran & Feyisetan, 2017). As an example, having lower levels of education limits opportunities and increases economic vulnerability, so that less educated women are more vulnerable and more likely to be abused by their husbands, who are often more economically stable. Due to the norms of intergenerational marriage, in which wives often marry much older partners and defer them, women are likely to submit to male power and abuse (Oyediran et al., 2011). Infertility and lack of children are well entrenched as a major cause of IPV. Infertility also drives illegal recruitment of young girls to be surrogates in so-called baby factories, where they are forced into surrogate pregnancy, and the babies they bear are sold (Makinde et al., 2017a; Solanke et al., 2018).

10.4 IPV Interventions

The numerous negative health and social consequences on individuals, families, and the wider society have led policy makers, implementers, and civil society to seek ways to tackle the problem. These stakeholders recognize IPV as a serious concern, not just from a human rights perspective but also from social, economic, and health standpoints. This acknowledgment is evident in the number of programs implemented and the increasing level of resources earmarked for such program. For instance, the 2015 Violence Against Persons Prohibition (VAPP) Act is passed with the objective of eliminating all forms of violence in both the private and public spheres and includes the right of victims of violence to seek assistance (Federal Ministry of Women Affairs and Social Development [FMWASD], 2015).

Because of the governance structure that authorizes the autonomous state to legislate on concurrent issues as prescribed by the constitution, Nigerian states, including the Federal Capital Territory, are expected to integrate the VAPP within their statutes, and states have begun this integration. A number of states have also passed similar laws to address IPV, including the Gender-Based Violence (prohibition) Law in Ekiti State (2011) and the Prohibition Against Domestic Violence Law of Lagos, State Law No 15 (2007).

A number of civil society organizations (CSOs) and nongovernmental organizations (NGOs) address IPV by providing legal clinics, psychosocial services, shelters, and mental health therapy to IPV survivors. An important CSO in this field is the International Federation of Women Lawyers (FIDA), with affiliates in all 36 states and the Federal Capital Territory. This non-state actor operates through the state umbrella to provide prompt, effective representation for IPV survivors. The

FIDA state chapters collaborate with the federal and state ministries of justice, serving as an important resource for IPV survivors who lack the financial capacity to pay for representation.

Research has also identified the need to provide IPV survivors with medical service. Providers have begun receiving training on how to screen and identify survivors or women who are at risk of IPV during medical visits and antenatal visits (Fawole et al., 2019). Some IPV survivors also use social media, such as WhatsApp groups, to obtain information and mobilize support. There is a need to expand such initiatives and to make support and surveillance widely available.

Research on IPV interventions in Nigeria is sparse. Only one study has examined the effectiveness of these interventions. This study evaluated the effectiveness of counselling sessions for pregnant women identified as being in a dysfunctional family. During 3 biweekly interventions that coincided with their routine antenatal care, providers used the SOS-DoC counselling framework: offer *s*upport and assess safety; discuss *o*ptions; validate patient's *s*trengths; *do*cument observations, assessment, and plans; and offer *c*ontinuity (Stratton et al., 2010). The counselling emphasized encouraging women to take actions to reduce their own vulnerability. The results showed an improved family function score among the experimental group from 2.92 ± 0.92 to 2.16 ± 0.63 ($p < 0.0001$), and the control group score changed from 2.48 ± 0.73 to 2.29 ± 0.82 ($p = 0.116$) (Akor et al., 2019). This result implies that improving women's skills in communicating and handling conflicts could contribute to reducing the incidence of IPV. However, there is clearly a need for more research to show other interventions that can reduce IPV in the Nigerian context.

Though many of the studies on IPV have focused on women as victims, men also experience IPV. The root cause for women's violence in Nigeria is unclear. However, in a patriarchal context, women are more likely to become aggressors or perpetrators of IPV when their male partners cannot fulfill their responsibility as the provider of household needs. A number of men have died, were brutalized, or were maimed for life by their violent female partners. However, evidence on this phenomenon is limited in Nigeria. The small number of studies on the topic has had mixed results; some studies say such cases are rare, while others describe an epidemic of IPV against men (Dienye & Gbeneol, 2009; Oladepo et al., 2011, Ayodele, 2017). Dienye and Gbeneol (2009) conducted a retrospective medical record review of all the patients who were seen at the General Outpatient Department of the University of Port Harcourt Teaching Hospital, Port Harcourt, Nigeria, over a period of 5 years (2000–2005). They found an incidence of 22 male IPV victims per 100,000 cases examined. Another study in Oyo, Kaduna, and Enugu states found that 12% of male patients were physically abused by their partners and 7% were sexually abused (Oladepo et al., 2011). The underreporting of IPV among male victims is likely due to patriarchal norms (making men unwilling to acknowledge their abuse), stigmatization, and women's use of traditional norms to control their male victims (Ayodele, 2017).

There are no existing studies or known interventions on IPV among lesbian, gay, bisexual, transgender, and queer (LGBTQ) in Nigeria or in the overall West Africa

subregion of sub-Saharan Africa. This is likely due to social attitudes toward LGBTQ throughout the region.

The outbreak of Covid-19 early in 2020 has forced government to employ restrictive measures and lockdown to slow the transmission of the virus. The restrictive measures and lockdown, along with the accompanying disruption in social networks' financial and job insecurity, may contribute to relationship distress and the potential for IPV. The spike in domestic violence due to the spread of Covid-19 remains a concern to Nigerian policy makers and development partners. Emergency calls by women subjected to violence by their intimate partners tripled in a single month, according to the Lagos State Domestic and Sexual Violence Response Team (UN Women, 2020). United Nations data from 24 Nigerian states showed a spike in GBV incidents, from 346 in March to 794 in the first part of April 2020, an increase of over 100% in just 2 weeks of lockdown (UN Women, 2020). The situation in Nigeria reflects a trend faced by women in stable relationships across sub-Saharan Africa.

10.5 Challenges to Controlling IPV in Nigeria

The patriarchal norms and values that shape thinking and behavior in Nigeria remain an obstacle. However, global changes in norms and attitudes have implications for reducing the trends of IPV in most countries, including Nigeria—as seen as the national laws and policies prohibiting GBV at both national and state levels, which support the concept that IPV and other domestic iniquities are unacceptable. However, a recent setback to these achievements was the rejection of the Gender and Equal Opportunities Bill by the Nigerian Senate. The bill was rejected because cultural and religious arguments were used to oppose the content and context (Makinde et al., 2017b).

A major barrier to eliminating IPV is the fact that survivors of domestic violence often choose to maintain their marriages, rather than seek help. Such actions are driven by societal and cultural views of divorce, especially the negative views toward divorced women, as even justified divorces are seen as failures. As a result, Nigerian women are often willing to trade their physical, emotional, and mental well-being for the title and status associated with being a married woman.

10.6 Current Opportunities to Curtail IPV in Nigeria

Despite the continuing incidence of IPV in Nigeria, and of the culture that enables IPV, current legal and cultural trends—including the enactment of laws at the national and state levels and the increasing number of IPV activists and resources—represent growing opportunities to implement broad-based, culturally specific interventions to reduce IPV. Reporting of IPV has increased relative to past years, due to

increased awareness of the issue and the availability of champions working toward elimination of the epidemic. The evolution of enhanced legal frameworks suggests further possibilities, for example, the VAPP Act of 2015, which specifies essential financial, legal, medical, and psychosocial support services for IPV survivors. In addition, the Lagos State-funded Domestic and Sexual Violence Response Team provides legal, medical, emergency, and psychological assistance to victims of domestic violence. The Federal Ministry of Women Affairs and Social Development and a number of states provide hotlines for women experiencing IPV; and the Lagos State emergency unit indicates that they have "an immediate response team (ready to be) deployed to the scene."

International Federation of Women Lawyers' (FIDA) legal clinics and mediation centers offer psychological treatment and counselling support for both IPV survivors and perpetrators. The counselling procedure is designed to strengthen spousal communication to reduce tension and de-escalate stress. Since the culture of male dominance still exists, the counselling focuses on arbitration, mediation, and helping couples learn how to walk away from a disagreement, rather than resorting to violence.

Furthermore, the current integration of gender-based activities into training programs for physicians, nurses, and other health-care cadres by some NGOs in Nigeria offers opportunity to provide and/or expand the needed physical, emotional, psychological, and health-care services to victims (Fawole et al., 2019). This expanded focus on IPV also improves providers' readiness to screen clients for risk or experience of IPV. There is a consensus among policy makers and programmers that training for health-care providers on counselling and screening is an opportunity that should be expanded. Government actors at both national and state levels should explore options for expanding IPV service provision at all level of health-care delivery in Nigeria building on the progress made by the professional bodies and civil society organizations in improving the legal environment and policy framework.

Religious leaders could also serve as champions in eliminating IPV. Traditionally, conservative religious norms and values have fueled IPV among Nigerian couples. However, since nearly the whole population (98.6%) identifies with some form of organized religion (NPC Nigeria & ICF International, 2019), there is a large potential for religious groups to play a positive role in combatting IPV. Religion and religious leaders have substantial influence on the behavior and attitudes of adherents (Oyediran et al., 2020). Also religious leaders are commonly the first responders in cases where married couples disagree (Wahab & Odetokun, 2014). Creating a counselling unit within religious institutions like mosques and churches, with a trained cleric as a mediator, could support positive changes in communities' views about IPV.

10.7 Conclusion and Way Forward

In Nigeria, IPV is prevalent but grossly underreported and under-documented due to a culture of silence. IPV cases are often resolved locally through indigenous mediation processes at home, at the community level, through religious institutions, or by a third party, mostly clan heads or religious clerics, who are considered to be neutral. IPV is a major contributor to morbidity and mortality among women and girls due to injury, chronic pain, gastrointestinal and gynecological problems, depression, and post-traumatic stress disorder.

At present, the prevailing laxness about addressing IPV, both in government and society in general, represents a major barrier to the reduction of IPV. There is no doubt that IPV survivors, and interventions to reduce the IPV epidemic, face enormous challenges in Nigeria and will continue to do so. First, the culture of silence will continue to influence the perception of women affected by IPV, impeding the collection of data on the extent of the problem. Second, pervasive cultural norms of male dominance hinder implementation of existing policy and programmatic action plans including legal frameworks. For example, though laws and policies have been enacted at the national and subnational levels, they require an implementation framework. Further, ensuring enforcement of laws against domestic violence will require changes in perceptions of women among government officials, law enforcement officers, and the population at large. Law enforcement officers and responders should regard IPV cases as health and human rights issues, rather than as "family affairs" that should be settled out of court. Third, responders and service providers, especially medical providers, need better training on IPV to be able to provide necessary clinical and therapeutic treatment. Lastly, there is a need for action research using a participatory approach, with high community involvement, to address IPV in Nigeria.

Despite these enormous challenges, there are opportunities to address the menace of IPV and its associated gynecological, physical, and psychological consequences in Nigeria. Policies and laws at the national and state levels should serve as enabling environments for survivors and advocates to report cases of domestic violence to the appropriate constituted authorities. In addition, the VAPP and other state-level policies and legal frameworks have increased activities by CSOs and champions to create awareness and raise resources to prosecute cases of IPV.

As importantly, the commitment of policy makers through activities of state institutions and agencies can help ensure that existing policies and legal frameworks are enforced and that resources are available to support those who have experienced IPV. As an example, the wives of political officeholders, including the spouses of the president and state governors, have launched projects to address GBV and support gender equality in Nigeria. These interventions seek to create and advocate for female empowerment at several levels—by helping women to play more significant roles in management and the professions; gain political influence within elected and appointed positions; and participate equally in household decision-making. Leaders' wives themselves can be powerful champions, for instance, Mrs. Bisi

Adeleye-Fayemi, the wife of the Ekiti state governor is a national advocate and champion of women's empowerment.

10.7.1 Recommendations

Overall, reducing the menace of all forms of IPV in Nigeria will be a massive undertaking. A society such as Nigeria, characterized by patriarchal norms and values, will need enforcement of national and state laws as well as community-based interventions that address the intergenerational transfer of cultural norms that support the traditions of male dominance and gender inequality. Liberating communities from shackles of entrenched cultural norms and values (and reducing the incidence of IPV) will require a multi-pronged, couple-centered approach. The five actions listed below would help to address and reduce the IPV epidemic in Nigeria:

1. Improving the skills and capacity of health-care providers to identify women at risk and providing clinical services to survivors.
2. Improving the organization and coordination of civil society groups to strengthen linkages and referral of IPV survivors to services, including clinical and psychosocial treatment.
3. Capacity strengthening to increase awareness of and "legal literacy" on IPV for community groups including women, men, boys, and girls.
4. Using mainstream and social media to raise awareness about IPV and build the capacity of individuals and groups to act as advocates against violence.
5. Mainstreaming IPV into all social development interventions and using opportunities such as the GBV/HIV intersections Plan of Action by the National Agency for the Control of AIDS to advance awareness and prevention of IPV.

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