Intimate Partner Violence In Nigeria: A Review of Prevalence, Associated Factors And Policy Response

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ABSTRACT

Background: Intimate partner violence (IPV) is a major challenge to the health and well-being of women. Yet, the picture of IPV in Nigeria remains hazy because of fragmented data and reporting.

Objective: This paper presents a comprehensive review of IPV studies in Nigeria, with the aim of facilitating a holistic picture of the IPV situation in Nigeria which can inform advocacy, reforms and stimulate further research.

Methods: Key electronic databases were searched for articles published on IPV in Nigeria from year 2000 to 2015. A total of 53 studies met the inclusion criteria. Nationally representative studies and technical reports on IPV were also accessed.

Results: Prevalence of IPV ranged between 28% and 87%. Low education, young age, polygamous marriage setting, acceptance of IPV, experience of violence in home of origin and use of psychoactive substances by both the partner and the respondents were found to be consistently associated with IPV. Other associated factors were spouses with low level of education and unemployed spouses. Consequences of IPV included mental distress, commonly, depression, anxiety, sleep disturbances and suicidal ideations and physical injuries. IPV disclosure was often through informal sources. A fairly high proportion of health professionals were documented to have a low index of suspicion for IPV and not adequately skilled in the identification and management of IPV.

Conclusion: The implications of the current state of knowledge regarding IPV in Nigeria for policy and programming as well as future research are discussed.

INTRODUCTION

Domestic violence, which is also known as domestic abuse, spousal abuse, spousal battering, family violence and intimate partner violence (IPV), is a pattern of behaviour which involves the abuse by one partner against another in an intimate relationship such as marriage, cohabitation, dating or within the family (Shipway, 2004). Domestic violence can take many forms, including physical aggression or assault or threats of such, sexual or emotional abuse, controlling or domineering behaviour, intimidation, stalking, neglect and economic deprivation (Shipway, 2004). IPV is known to occur in every culture and geographical location. While IPV is known to affect both sexes, and the gender pattern may differ in terms of the pattern of violence, females are by far more affected all over the world. IPV has very far reaching health and social consequences and has come to the forefront as a priority global public health challenge to address if we are to succeed at the sustainable development goals.

Nigeria is the most populous country in sub-Saharan Africa, with an estimated population of 140 million in 2006 (NPC & ICF, 2014). It is a culturally diverse country, with about 374 identifiable ethnic groups, of which Hausa (in the north), Yoruba (in the South-west), and Igbo (in the South-east) are the dominant groups. In general, Nigerian cultural setting is strongly patriarchal in nature. Sporadic tales of gender-based violence (GBV) and spousal violence have trailed communities all over Nigeria for decades. However, the shroud of silence surrounding IPV and the belief that domestic violence is a family affair that outsiders need not meddle in, has made it a "silent and persistent challenge" that has not received the deserved attention over time. However, in recent times, there have been several "sensational" reports in the newspapers about deaths of women from IPV, bringing the issue into greater public consciousness (Project alert on violence against women, 2013).

Yet, till date, the level of perception regarding the fact that IPV is a major public health challenge appears still to be very low among the general public and authorities. Although the literature shows that several studies have been carried out on IPV in Nigeria, particularly in the recent years, the picture of IPV in Nigeria remains hazy because of fragmented data and reporting. This paper presents a comprehensive review of IPV studies in Nigeria, with the aim of facilitating a coherent and holistic picture of IPV situation in Nigeria, which can inform needed advocacy and programme interventions as well as stimulate further research, and draw relevant implications for this purpose.

METHODS

An extensive electronic search was

conducted through the databases of PubMed, Medline and African Journal online (AJOL) to include studies from year 2000-2015. The terms used in the search engine included "intimate partner violence", "spousal violence", "domestic violence" "Nigeria". The search was limited to published articles and technical reports. The information extracted from the journals were categorized and presented under the main foci of interest: frequency of occurrence, associated factors, consequences, disclosure and help-seeking behaviour.

RESULTS

We identified 53 studies fitting our search criteria. These studies were sifted through to identify common themes and the results are presented below. Though there was a good representation for most parts of the country in terms of geographical location of the studies, clusters were found in the South West, South-South, South East and North Western parts of the country (Figure 1).

Prevalence

Several studies (36) reported the prevalence of IPV in Nigeria, however only 3 studies determined both the lifetime prevalence and 1 year prevalence of IPV (Owoaje et al 2005; Alo et al 2012; Balogun et al 2012), about 7 calculated the lifetime prevalence of IPV (Odujurin et al 1993; Efetie et al 2007; Adebayo et al 2010; Antai et al 2011; Arulogun et al 2011; Aderemi et al 2012; Owoaje et al 2012; Umana et al 2014) while about 7 studies evaluated the 1year prevalence of IPV (Ilika et al 2002; Ezegwui et al 2003; Okenwa et al 2009; Mapayi et al 2011; Mapayi et al 2012*; Iliyasu et al 2015; Tanimu et al 2016) The lowest prevalence was 7.3% obtained from a study carried out in Ile-Ife in 2006 among 224 married women (Fatusi et al 2006), while the highest was 87% from the study in Lagos in 2015 among 400 married women (Onibogi et al 2015) (Table 1).

Whereas 31 studies (59.6%) reported on the prevalence of physical violence, 22 (42.3%) reported on the prevalence sexual violence, while 23 (44.2%) reported on the prevalence of psychological violence. Based on the 31 studies that reported on physical violence, the prevalence ranged from between 7.3% and 78.8%, (Ilika et al 2002, Okemgbo et al 2002; Kaidal & Sanusi, 2004; Fawole et al 2005, 2008 & 2010; Fatusi et al, 2006; Efetie et al 2007; Umeorah et al 2008; Awusi et al, 2009; Esere et al 2009, Gyuse et al, 2009; Okenwa et al 2009 ; Arulogun et al, 2011 ; Antai et al, 2011; Yusuf et al, 2011; Aderemi et al,2012; Balogun et al, 2012 ; Owoaje at al, 2012 , Envuladu et al 2012; Iliyasu et al 2012 & 2016; Itimi et al. 2014; Umana et al. 2014; Chimah et al 2015, Aduloju et al 2015, Sigbeku et al 2015, Olowokere et al 2015, Onigbogi et al. 2015; Ogboghodo & Omuemu 2016, Tanimu et al 2016).

The 22 studies that reported sexual violence presented a range of 3% to 82.7% (Okemgbo et al 2002, Ameh et al 2004, Fatusi et al ,2006; Efetie et al 2007 ; Umeorah et al 2008; Fawole et al 2008&2010; Awusi et al, 2009 ; Gyuse et al, 2009; Okenwa et al 2009 ; Antai et al, 2011; Balogun et al, 2012; Envuladu et al 2012, Oladepo et al Owoaje et al 2012, Iliyasu et al 2012; Umana,. 2014;Chimah et al. 2015; Sigbeku et al. 2015; Olowookere et al. 2015 Onigbogi et al. 2015; ;Iliyasu et al. 2016; Ogboghodo & Omuemu 2016; Tanimu et al. 2016;). Twenty one studies reported psychological violence with a range from 18.8% to 94% (Ilika et al 2002, Fatusi et al, 2006; Efetie, 2007; Umeorah et al 2008, Fawole et al 2008 &2010, Gyuse et al 2009, Awusi et al 2009, Okenwa et al 2009, Arulogun et al, 2011, Aderemi et al 2012, Balogun et al 2012, Owoaje et al 2012, Enyaladu et al 2012, Umana et al 2014; ;Chimah et al. 2015; Sigbeku et al. 2015; Olowookere et al. 2015 Onigbogi et al. 2015; ;Iliyasu et al. 2016; Ogboghodo & Omuemu 2016; Tanimu et al. 2016). Ten of the studies reviewed reported IPV in pregnancy (Ameh et al 2004, Ezegwui et al 2003, Efetie et al 2007; Gyuse et al, 2009; Awusi et al, 2009; , Mapayi et al, 2011& 2012; Envuladu et al 2012 , Iliyasu et al 2012; Ogboghodo & Omuemu 2016) and the prevalence ranged from 7.4% to 37.4%.

Factors associated with IPV

Education

Findings on education as a predictor of IPV among women were reported by three studies. Alo et al (2012) in their study in south west Nigeria reported that women who had post-secondary education were found to be 2.91 times less likely to experience spousal violence than women who had no education. On the other hand, Antai et al (2012), in their study carried out among a nationally representative sample found out that women with primary education had a significantly lower likelihood of experiencing physical IPV (OR- 0.64, 95% CI: 0.49 - 0.83), emotional IPV (OR = 0.60, 95% CI: 0.46 - 0.78) and "any IPV" (OR = 0.65, 95% CI: 0.52 - 0.82) compared to those who had secondary or higher education. On the other hand, Mapayi et al, 2011 reported that those who had primary and secondary education experienced more violence than those who had tertiary education or no education (p= < 0.001). The odds of women experiencing physical intimate partner violence was 3 times higher among those with no formal education or primary education than among those with secondary or tertiary education (adjusted odds ratio aOR 3.22; 95%CI 1.54-6.77) (Onigbogi et al. 2015). A lack of formal education (adjusted odds ratio [OR] 2.21; 95%CI 1.21–7.43), employment in the informal sector (OR 2.01; 95%C: 1.02–4.52), and having an unemployed spouse (OR

1.56; 95%CI 1.02–3.15) or one with low level of education (OR 2.32; 95%CI 1.87–4.21) were independently associated with IPV (Iliyasu, Galadanci et al. 2016). Having a level of education above the mean for the community was associated with a higher likelihood of experiencing physical IPV (OR = 1.12, 95% CI: 1.06 - 1.20), emotional IPV (OR = 1.14, 95% CI: 1.07 - 1.21), and "any IPV" (OR = 1.16, 95% CI: 1.10 - 1.23).

Employment

Employment was found to be significantly associated with IPV in three studies, albeit in different directions. Unemployed women had a significantly lower likelihood of experiencing emotional IPV (OR = 0.47, 95% CI: 0.30 - 0.73) and "any IPV" (OR = 0.53, 95% CI: (0.36 - 0.78) compared to employed women in a study by Antai et al, 2012. On the other hand, unemployment was found to be a risk factor for spouse violence in a study by Adebayo et al 2010 (OR = 0.68, 95% CI: 0.47 - 0.99). Also, Alo et al. in 2012 reported employment to be protective against IPV: women in employment were 1.16 times less likely to experience spousal violence compared to unemployed women who. Furthermore, Onigbogi et al. (2015) found that the odds of experiencing sexual violence was 6 (2times for adjusted odd ratio) times higher among women whose partners were unemployed compared to those whose partners were employed as professionals or skilled workers (OR 2.37 95%CI – 0.42 -13.3)).

Socio-economic Status

Based on the secondary analysis of 2013 NDHS, Alo and colleagues (2012) reported that women in the high socio-economic status (based on wealth index) were almost three times (OR= 2.73) less likely to experience spousal violence than women who are in the low SES group. However, Mapayi et al (2011) found that women were three times more likely to report violence in their relationships if they had higher earning power (above 50 dollars per month) compared with those who had no earning power (OR = 3.21, 95% CI: 1.47 - 12.04).

The 2008 NDHS suggests a positive association between women's experience of IPV in Nigeria and their socio-economic status as measured by wealth index. Women in the highest wealth quintile were reported to have the highest prevalence of physical violence (33.7% vs. 18.8% in those in the lowest quintile) as well as sexual violence (7.2% vs. 5.8% in those in the lowest quintile and 5.3% in those in the second quintile).

Marital status and type of marriage

Six studies reported significant associations between IPV and marital status. Fawole et al (2005) found that women in non-marital relationships have higher risks of experiencing physical form of IPV compared to married women ($p < 0.05$) in three southwestern states. Alo et al (2012) reported a somewhat similar pattern as women who are married were 1.11 times less likely to experience spousal violence than women who are cohabiting with their partner. Envuladu et al (2012) similarly reported that being legally married was found to be protective against violence in pregnancy (OR 0.4, 95% CI 0.17 -0.79). On the contrary, in a study among adult women and men in three selected states of Nigeria, Oladepo et al (2011) found that married female respondents were more likely to experience physical violence than single respondents (OR= 1.71, 95%CI: 1.15-2.53) and Mapayi et al, 2011 found that women who reported violence were more likely to be single or separated compared to being married or cohabiting (χ^2=11.54, df =3, p=0.009) and being married or cohabiting with a partner reduced the chances of violence by six fold and fivefold respectively compared with being single (OR= 0.17, 95%CI: 0.06 – 0.47).

Of the six studies that reported on the relationship between IPV and types of marriage (polygamous versus monogamous marriages), four (Envuladu et al, 2011; Onigbogi et al 2015; Iliaka et al, 2002; Mapayi et al, 2011) reported that polygamous marriages recorded significantly higher prevalence of IPV, two studies (Esere et al 2009 and Adebayo et al 2010) did not report any significant difference.

Compared to women who married at younger ages, peers who married at older ages had less likelihood of experiencing emotional IPV (OR = 0.90, 95% CI: 0.83 - 0.87) or "any IPV" (OR = 0.91, 95% CI: 0.85 - 0.97).

Attitude towards IPV and decision-making autonomy

Women's attitude reflecting the acceptance of wife beating and gender-based violence has been reported to be significantly associated with IPV. Alo et al (2012) reported that women whose attitude is favorable to wife beating are 3.01 times more likely to experience spousal violence than women who are not favorably disposed to such attitude. Owoaje et al 2012 reported a similar pattern although lower odds ratio (OR: 1.75; 1.2-2.4). Antai et al (2011) in their analysis of the 2008 NDHS dataset also reported that women who justified wife beating had a higher likelihood of experiencing physical abuse (RR = 1.66; 95% CI: 1.40 - 1.96) than women who did not justify wife beating. Antai et al (2011) reported that women with decision-making autonomy had lower likelihood of experiencing physical abuse (RR = 0.71; 95% CI: 0.59 - 0.86) than women without decision-making autonomy.

Exposure to Violence in Childhood

Violence in the family of origin has emerged as a powerful risk factor for

being a victim of IPV in women. Alo et al (2012) reported that women who are exposed to parental violence as children are 2.98 times more likely to experience violence from their husbands/partners than women without such exposure. Past history of exposure of IPV during childhood years was also positively associated with IPV experience (OR=8.13; 95% C.I. 3.69-17.86) in a study by Fatusi et al (2006) in Ile-Ife. Also, Fawole et al (2005) found out that a parental background of fighting was significantly associated with women being beaten ($p < 0.05$) in a study among civil servants in Ibadan, Nigeria. Previous childhood experience of psychological abuse (OR: 4.71; 95% CI: 3.23 - 6.85) and sexual abuse (OR: 5.18; 3.21-8.36) have also been significantly and positively associated with experiencing IPV (Fawole et al, 2009). Onigbogi et al (2015) reported that witnessing parental violence increased the likelihood of experiencing physical (2 times) and psychological (3 times) violence among respondents. Also, respondents whose partners had witnessed parental violence had a higher likelihood of experiencing physical (2 times) and psychological (6 times) violence compared to those whose partners had no such experience.

Parity

Parity has been reported to be significantly associated with IPV among women of age 15-49 years (Alo et al, 2012): the odds of experiencing IPV increased by 1.51 for every increase in parity. Similar to this, Mapayi et al, 2011 reported that having children was associated with a statistically significant increase ($\chi^2 = 30.02$, $df = 2$, $p = < 0.001$) in violence and having two or more children increased the chances of reporting violence by six-fold compared with those who had none (OR = 6.3, 95% CI: 3.01 – 13.20).

Partner factors

Partners' alcohol consumption was found to be positively associated with IPV in eight studies across Nigeria – Owoaje et al 2012 (OR: 2.85; 1.50-5.41); Fawole et al 2005 ($p < 0.05$); Fawole et al 2009 (OR 1.67; 95% CI: 1.10-2.53); Balogun et al 2012 (rural: OR = 2.3; 95% CI 1.2-4.4; urban: OR = 3.2; 95% CI 1.4-7.2); Oladepo et al 2011 (OR =1.52, 95%CI: 1.11-2.08, p=0.009); Lar et al 2012 ($p<0.001$), Odor & Unwaha, 2012 ($p<0.05$) and Mapayi et al, 2011($p= < 0.001$).

Onigbogi et al (2015) found that the odd of physical violence was almost 2 times higher and the odd for psychological violence 3 times higher among those whose partners took alcohol daily compared to those whose partners never took alcohol. Those whose partners had abused psychoactive substance previously were 12 times more likely to have experienced physical violence than those whose partners had never used psychoactive substances. Owoaje reported an association between IPV and partner's previous abuse of psychoactive substances (58.3%, $p<0.050$) and previous involvement in a physical fight (55.9%, $p<0.0001$).

An association was also found between lower level of education of the partner and experience of IPV by the women. Ilika et al 2002 reported that women whose partners had secondary education experienced more violence than those whose partners had tertiary education ($p < 0.05$), so did Lar et al 2012 ($p=0.05$).

Community factors

Antai et al 2011 was the only study reviewed that examined and reported significant associations between community level factor and IPV. women who live in communities where wife-beating is more justified are likely to experience physical form of IPV (OR = 0.70, 95% CI: 0.52 - 0.94) or any form of (OR = 0.75, 95% CI: 0.57 - 0.97) compared with those in community where wife-beating is less justified (Antai et al, 2011). Also, living in communities with lower modern contraceptive use was associated with a higher likelihood of women experiencing physical IPV (OR = 1.64, 95% CI: 1.12 - 1.92) and sexual IPV (OR = 1.39, 95% CI: 1.14 - 2.06) compared to residence in a community with higher use of modern contraceptive (Antai et al, 2011).

Consequences of IPV

In a study by Mapayi et al (2012), anxiety and depression among the respondents were significantly associated with the experience of IPV. Women were ten times more likely to report being depressed (OR = 9.8, 95% CI: 4.57 - 20.97) and 17 times more likely to report anxiety (OR = 16.7, 95% CI: 3.96 - 69.99) if they were in violent relationships. Fatusi et al (2006) had noted that the self-reported effects mentioned by women victims of IPV were mainly psychological in nature: depression (48%), constant headache (33.3%), fear and anxiety (31%), loss of self-confidence (23%), suicidal ideation (11.3%), and menstrual irregularity (7.0%). IPV victims also reported negative effect on their work such as projection of anger to colleagues and/or clients (15.5%) and loss of concentration at work (31%).

Ilika et al (2002) also reported that 87% of abused women admitted that violence affected their health and on a likert scale of not distressed to extremely distressed, 80.6% felt extremely distressed after an abuse. Odor & Unwaha (2012) reported that 46.2% of the women with IPV experienced depression while 30.6% of them lived under fear and anxiety. The self-reported consequences of intimate partner rape by the women in a study by Esere et al (2009) in Lagos were physical injury (31.8%) and constant headache (27.3%). Psychological effects reported included sleep disturbances 18.18%); excessive fear and anxiety (9.09%); suicidal ideation (9.09%) and hatred for men (4.55%). Odor & Unwaha (2012) found the following consequences: cuts, punctures, bites (55.0%); scratches, abrasions, bruises (48.3%); and sprains, dislocations

(18.3%). Respondents who experienced violence also reported loss of concentration (71.1%) and loss of self-confidence (68.9%).
Anita et al (2011) documented a higher likelihood of terminated pregnancy among women exposed to physical IPV (OR = 1.52, 95% CI: 1.21 - 1.91), sexual IPV (OR = 1.62, 95% CI: 1.07 - 2.44), and "any" IPV (OR = 1.44, 95% CI: 1.19 - 1.76) compared to non-exposed women. Ameh et al (2009) reported that pregnant women exposed to IPV are less likely to book for antenatal care compared with non-exposed women ($p < 0.05$). Similarly, women with IPV were poor attendees at antenatal clinic (0 - 2 visits) compared to those who did not have IPV($p<0.05$).

Disclosure & Help Seeking Behaviour

Studies in Nigeria generally showed that a high proportion of women who experienced IPV do not disclose to anyone, and in cases where they do, it is hardly ever to the police or other legal authorities but rather to family members. Okenwa et al (2009) in their study of women in Lagos State reported that 54% of the participating women said that they would not disclose IPV. Among those willing to disclose abuse, 68% would opt to disclose to close relatives in contrast to 32% who would disclose to some form of institutional figures (such as religious leaders, law enforcement officers). Among women who were studied by Illika et al (2012) in South-east Nigeria, only 1% reported to the police whereas 47% reported to their husband's family, 9.4% to their own family, 37.8% to both families, and 7.9% to their pastor or husband's friends.
The study by Mapayi et al (2012) in agreement with other studies showed that most (67.9%) of the abused women disclosed their experience through the use of their informal support system. Among the women who disclosed, most (70%) did so to other females but only 8.8% of abused women reported to the police. Majority of the abused women who did not report the experience to anyone felt it was not serious enough.
On their reaction if they experienced domestic violence, 35.9% of pregnant women reported that they would keep it secret, 27.5% would report to their family, 15.7% would report to the doctor, while others would report to the in-laws, police, clergy or tell a close friend (Ameh et al, 2004).

Preparedness and Screening for IPV among Health Professionals

Very few studies in Nigeria have assessed the preparedness of health professionals to manage IPV and routine screening of IPV in Nigeria in a tertiary healthcare institution in southwest Nigeria. Divorce/separation during pregnancy, alcohol and drug abuse in women, attempted suicide were the indices (with scores of 87.1%, 86.4% and 81.1% respectively) reported by health professionals in Ile-Ife as most likely to induce their suspicion of IPV experience among their female clients (Adeyemi et al, 2005). However, the study reported that 31.1% of the respondents may not appropriately detect VAW. No specific personal or professional factor was reported as being a significant predictor of ability of health professionals to detect IPV. In another study by Adeyemi and colleagues (2008), about 42% of IPV cases were adjudged as not likely to be properly managed by health professionals who participated in the study. The study also generally documented high level of poor attitude of health workers to IPV.
As John et al (2010) reported from a study that assessed the barriers and challenges to IPV screening by healthcare professionals in Kano, most health care professionals (74%) had not screened for IPV during the preceding 3 months. Yet, the majority of the women (76%) interviewed in the study had a preference for being screened routinely for IPV, and contrary to the perception of health workers, women who were screened expressed a higher satisfaction than women who had not been screened. Male gender, being elderly and of Yoruba ethnicity (the dominant ethnic group in southwest Nigeria) increased the likelihood of health workers undertaking screening.

DISCUSSION

The study attempted to paint a holistic picture about the challenge of IPV in Nigeria based on the review of published literature over fifteen years (2000-2015). Overall, available studies show that the prevalence of IPV is high in Nigeria and no geographical area is exempted. The picture is also one of significant variation across communities and geographical area, although direct comparison was not undertaken due to differences in the methodologies that various researchers had used across the country, including variation in data collection approaches, study population, and measures of prevalence.
In terms of factors associated with IPV, several discrepancies were found in the various studies reviewed. Education was found to be associated with IPV in some studies though the direction of the association varied. Some may argue that education makes violence less likely as the autonomy and assertiveness of the woman increase. On the other hand, these resultant effects may lead to greater degree of violence from a domineering man who may consider the woman's stance and attitude as rebellion that needs to be dealt with through violence given the patriarchal nature of the Nigerian society. It is also possible in the cultural context that the woman with lower level of education may be more likely to be subservient,

tolerate and accept violence and not report it while the converse is true for their educated counterparts. Economic and employment status was also found to have varying associations with IPV. Due to the patriarchal nature of the Nigerian society, the husband is supreme in decision making, when women work, the husband may want to take decisions about how her remuneration is spent which the wife/partner may object to. Also, the husband reserves the right to tell his wife to remain at home and not work and if the wife disagrees, it may be considered as rebellion and result consequently in violence (Mapayi et al, 2011).

Our review also shows that most of the women who had experienced IPV did not disclose their experience to anyone, and when they choose to disclose they relied more on people that they have close personal interaction with such as friends and family members. Very few women who had experienced IPV had reported the case to law enforcement agencies or disclosed to formal health workers. A major factor associated with this is the erroneous notion, based partly on culture and upbringing, that IPV is a "family affair" – another form of family and intra-marital conflict. As such, the otherwise positive and supportive traditional close-knit family system in Nigeria, where family members are arbiters in time of family conflicts and where divorce is practically a taboo, may inadvertently serve to reinforce this dimension of IPV. The idea of reporting family issues to outsiders, and particularly law enforcement agencies, is very strange to the Nigerian traditional system. Indeed, as some studies have shown, police officers have often been reluctant to intervene in IPV issues even when reported to them: rather, policemen often advice couples to go back home to settle IPV-related issues as family affairs (Ozo-Eson, 2008). Thus, the patriarchal cultural system, low status of women in the society, and dependence of many women on their spouse for provision of financial support – particularly among low income families and in communities where women are not encouraged to engage in formal work – support the propagation and sustenance of IPV in the Nigerian society.

Implications for Policy and Programmes

Though Nigeria is a signatory to a lot of documents from the international community (including the United Nations charters, African Charter on Human and Peoples Rights Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)), Nigeria had no comprehensive legislation on violence against women at the national level until 2015 when the 'Violence Against Persons (Prohibitions) Act' was passed (VAPP, 2015). The bill was originally submitted as the Violence Against Women Bill (2003), however, it was changed by the legislators who argued that acts of violence could be perpetrated against all individuals and it is suspected that the male-dominance of the legislative body may have had a role to play.

Prior to this, there were pockets of legislations in a few states (Lagos State, Enugu State) on domestic violence, harmful traditional practices or gender-based violence (Anyogu & Okpalaobi, 2017).

The result of this review indicates that significant efforts are needed to address the pervading attitude regarding disclosure and health-seeking behaviour for IPV. Among others, there is need for large-scale communication approaches that target communities, families and individuals to educate them about the health-related and other challenges relating to IPV.

Women particularly need to be educated about the need to report cases of IPV to health and legal professionals and receive appropriate management and support. IPV-related counselling services offered by appropriate practitioners need to be established across the country. To make this workable and cost-effective, such services should be integrated into existing services relating to women health and development, including primary health care facilities, well-women clinics, vocational training centres and women development centres. There is the need to also establish crisis centres that can provide shelter in the short-run for IPV victims who need such as part of a comprehensive approach to addressing IPV. Health workers need to be trained to have high index of suspicion and give appropriate management and support to IPV victims as well as link them with other relevant social and legal services. Law enforcement agencies and officers also need to be properly educated on the status of IPV as a legal issue that needs to be handled with all the sensitivity and seriousness that it deserves. Legal provisions regarding IPV-related issues need to be strengthened: in this regard, some existing laws need to be modified to reflect current thoughts about IPV as a criminal and health issue. An example of the law needing reform is the penal code that applies in Northern Nigeria (Penal Code, Cap 89, LFN, 1963) that indicates that a husband who corrects his wife (including use of physical force) without inflicting grievous hurt is not committing an offence, if the couple is subject to any natural law or custom in which such correction is recognized as lawful (Ladipo et al, 2005). New legal provisions that specifies appropriate punishment for IPV perpetrators and protect women from such gender-based abuses as has been witnessed in Lagos State recently are needed in other parts of the country.

Religious leaders constitute a trusted source of help for many IPV victims and potential victims as the review showed. Building the capacity of lay men and leaders of religious bodies to provide appropriate counselling, support

and referrals for both victims and perpetrators is an appropriate intervention. Working with faith communities as partners in addressing IPV is a particularly important strategy in Nigeria's highly religious environment. Ensuring that every woman using health facilities (either for themselves or other family members) is screened for IPV on a routine basis will help many women overcome the problem of reluctance to disclose IPV experience and facilitates greater access to relevant health and social support services. As Fatusi and Oyeledun (2002) had noted, "a successful fight against GBV must involve broad-based partnerships between public health professionals and those in other fields, including law and media professionals, teachers, community activists, and religious leaders".

Implications for Future Research

This review of existing literature indicates that while significant amount of information is available regarding IPV in Nigeria, we have a lot to learn still. On the one hand, Future research effort must address some of the weaknesses in the available literature. These include adaptation of more standard definitions and measures, adoption of standard data collection instruments, and more rigorous analysis with regards to identify determinants of IPV among different population groups. On the other hand, future research must also address the areas of gap in current literature. Among others, studies are needed to identify factors at community and social levels that are significantly associated with IPV. Studies also need to focus more on specific groups that have not received adequate attention in current literature: these include adolescents and young people in dating relationships; women with chronic health-related conditions (such as HIV) or those that are physically challenged; women in specific physiological states, such as pregnancy and menopause; and males. Cohort or longitudinal studies are particularly desirable. Beyond the strict confines of health and health effects, studies in Nigeria regarding IPV need to be broadened to areas such as policy analysis and economic impact of IPV. A large gap exists in literature regarding interventions that are efficient and cost-effective in various settings in Nigeria.

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