

Prevalence and Pattern of Intimate Partner Violence During COVID-19 Pandemic Among Nigerian Adults

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Objectives: Our objectives were to determine the prevalence, pattern, and associated sociodemographic, psychosocial, and COVID-19-related factors associated with intimate partner violence (IPV) during the COVID-19 pandemic among Nigerian adults. **Method:** We conducted an online survey among Nigerian adults ($n = 994$, aged 18–72 years) who completed the HARK questionnaire, Hospital Anxiety and Depression Scale, Perceived Social Support Scale, and factors associated with the COVID-19 pandemic. Logistic regression was carried out with presence or absence of IPV as the outcome variable. **Results:** Prevalence of IPV among women was 57.5%, while it was 42.5% among men, during the COVID-19 pandemic. IPV was significantly associated with younger age; having no children; increased threat of income due to COVID-19; anxiety; depression; reduced frequency of accessing COVID-19 updates via TV, radio, and news outlet; self-isolation due to COVID-19 symptoms; and self-reported impact of COVID-19 on recreation. A high monthly income, presence of anxiety and depressive symptoms, threat of COVID-19 to income, and self-reported impact of COVID-19 on recreation increased the odds of experiencing IPV. **Conclusion:** Our findings indicate that the ongoing COVID-19 pandemic has had a significant impact on the experience of IPV among adult Nigerians. The implications of our findings are that both men and women were affected by IPV during the COVID-19 pandemic. Modalities for reducing IPV and its aftermath among this population should include online psychosocial support measures, which may offer anonymity and reduced stigma.

Clinical Impact Statement

Our findings indicate high levels of intimate partner violence among both male and female Nigerians during the COVID-19 pandemic. These findings highlight the need to recognize vulnerable groups and mitigate the increased risk for intimate partner violence due to COVID-19-related factors.

Keywords: intimate partner violence, COVID-19, Nigeria

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The ongoing pandemic caused by the coronavirus-SARS2 virus has placed unprecedented stress not only on the health and livelihood of individuals but also on the health care systems and economies of most countries (van Gelder et al., 2020). Measures to curtail its spread, which included lockdowns and social distancing, even though highly essential in limiting the spread of the virus, may have had unintended negative consequences (Bradbury-Jones & Isham, 2020). These measures may foster economic vulnerability, isolation, loneliness, and physical, social, and psychological health risks (Bradbury-Jones & Isham, 2020; van Gelder et al., 2020). An area of immense concern during pandemics is the potential increased risk of social adversities such as domestic violence, particularly intimate partner violence (IPV; Peterman et al., 2020). For the majority of victims of IPV, the home is not a safe place.

According to the World Health Organization, IPV refers to any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship (Krug et al., 2004). IPV has been described as one of the most common acts of violence against women (World Health Organization, 2012); it is a public health concern and has far-reaching consequences for the physical, reproductive, and mental health of women. IPV disproportionately affects women, with about 1 in 3 women experiencing IPV worldwide (Devries et al., 2013). However, men may also be victims of IPV (Carro et al., 2011); approximately 1 in 10 men are victims of IPV in the United States (Smith et al., 2018). In Nigeria, prior to the COVID-19 pandemic, the prevalence of IPV was high. Almost 1 in 4 women reported having ever experienced IPV in 2013 (Benebo et al., 2018), with lifetime exposure to IPV from their current husband or partner ranging from 5% for sexual violence, to 14% for physical violence, and to 19% for emotional violence. A higher prevalence rate for IPV of 30% was reported for girls and women aged 15–49 years old in 2018 (Nigeria Population Commission, 2019), suggesting a progressive increase over time. Despite scarce data, incidents of increased domestic violence during the COVID-19 (coronavirus disease 2019) pandemic have been reported from China, the United Kingdom, Italy, the United States, Brazil, and Australia (Devries et al., 2013; Taub, 2020). There have been mixed reports regarding the prevalence of IPV during the COVID-19 pandemic in Nigeria. A community study by Unim et al. (2020) in Calabar, Nigeria found an increase in the overall prevalence of IPV during this period, while an online survey by Ojehere et al. (2021) found an overall decrease in the overall prevalence of IPV as well as physical, emotional, sexual, and financial violence.

Some of the social measures imposed by governments to limit the spread of COVID-19 may overlap with strategies employed in an abusive relationship. For example, lockdown and social distancing measures may enhance isolation of IPV victims, inhibiting them from accessing help from friends, family, colleagues, or health services and creating constant proximity to the abuser and closer monitoring and control by the perpetrator (van Gelder et al., 2020).

Disasters have also been shown to exacerbate already existing gender inequalities and power hierarchies prevalent in the society, leading to an increase in IPV (Fraser, 2020; Peterman et al., 2020). The traditional gender roles, patriarchal system, and cultural expectation of men and women in the society may further increase the vulnerabilities of women and girls during a disaster situation (Robbers et al., 2016). Also notable is the ensuing economic vulnerability that may result due to job loss, unemployment, investment failures,

and reduced incomes, which may increase friction, tension, and frustration in homes, particularly among perpetrators of IPV (Madufo, 2020; Peterman et al., 2020). The Ebola outbreak in West Africa, during which similar social measures of curfews, quarantine, and closure of schools were enacted to limit the spread of the epidemic, was associated with an “epidemic” of rape, sexual assault, and violence against women, which has remained largely underresearched (Onyango et al., 2019).

In sub-Saharan Africa, especially Nigeria—the most populated country in the subregion (Abubakar & Dano, 2018)—a nationwide lockdown was instituted on March 30, 2020 (Ibrahim et al., 2020), in response to the COVID-19 pandemic, in which all public institutions were shut down and physical movement restricted; however, this lasted about a month as the federal government was unable to provide financial support (Ibrahim et al., 2020; Oginni et al., 2020; Oginni, Okanlawon, & Ogunbajo, 2021) to privately owned businesses and self-employed individuals. Some state governments extended the lockdown for 2 extra weeks as they saw fit (Ibrahim et al., 2020). A gradual easing of lockdown was instituted between May 5, 2020, and July 27, 2020, with enforcement of nationwide curfew from 8 p.m. to 6 a.m. daily, interstate movement restriction, a ban on domestic and international flights, and a ban on gatherings of more than 20 people outside of the workplace (Ibrahim et al., 2020). In addition to these, the government promoted and enforced public health measures including social distancing, wearing of face masks, hand washing/sanitation practices (Ibrahim et al., 2020; Oginni et al., 2020), and, more recently, vaccination. However, the pandemic measures have been associated with worsening economic indices including inflation and increased unemployment (Ozili, 2020). Financial constraints can increase the tendency to aggression (Benson & Fox, 2004), which is more likely to be enacted when partners stay at home and spend more time together because of the pandemic. There were inadequate socioeconomic measures in place to cushion the effects of restrictions on economic activities as part of the COVID-19 response (Renzaho, 2020). The additional lack of an aggregated and systemic response to violence against women and girls, weak health systems, and weak rules of the law may further exacerbate the potential adverse social and mental impacts of the COVID-19 pandemic. For example, although the Nigerian criminal code (Federal Republic of Nigeria, 1999) prescribes punishment for unlawful and indecent assaults on men, women, and girls, the penal code used in Northern Nigeria permits the husband to correct his wife with physical punishments. Also, cases of domestic violence are hardly ever brought to trial as law enforcement agents consider them family affairs that should be resolved as such (Benebo et al., 2018). It is also unknown to what extent men would be affected by IPV during the COVID-19 pandemic.

The main aim of this study was to determine the prevalence of IPV during the COVID-19 pandemic and to examine the contributory effect of the COVID-19 pandemic on IPV. Our specific objectives were to identify the pattern of IPV and sociodemographic, psychosocial, and COVID-19-related factors associated with IPV among Nigerians during the COVID-19 pandemic.

Method

Using a cross-sectional design and convenience sampling method, participants were recruited via social media platforms

(Facebook, Twitter, Whatsapp, etc.) and completed an online survey from June 21 to August 6, 2020. The participant information page contained the aim and objectives of the study, an informed consent page, and the survey questionnaires. The inclusion criteria were being at least 18 years old, residence in Nigeria for at least 6 months prior to the lockdown and through the period of the pandemic, fluency in English, being able to use the internet, and absence of severe cognitive or physical impairments.

A total of 1,013 individuals participated in the study; 43 were excluded due to missing data, while four participants who identified as gender nonbinary were excluded from analysis by sex as the number was too small for subanalysis (Oginni, Oloniniyi, et al., 2021). The study comprised 50.4% men and 49.6% women; 61.3% of participants were single, while 34.9% were married; and 77.9% were heterosexual, while 22.1% were not heterosexual (Oginni, Oloniniyi, et al., 2021). Ethical approval was obtained from the Ethics and Research Committee of the Institute of Public Health, Obafemi Awolowo University.

Instruments

The sociodemographic section contained single questions each to elicit the following information—age, sex, highest level of education (rated as no formal education, primary education, vocational, secondary education, first degree, postgraduate), marital status (rated as single; married; divorced, separated, or widowed), number of children (rated as none, one, two, three, four and above), employment status (rated as unemployed/retired, student, employed), and monthly income (categorized as \leq \$60, \$60.01 to \$120, \$120.01 to \$300, \$300.01 to \$600, \geq \$600.01).

The HARK questionnaire was used to assess IPV. It is a four-item, self-report instrument with questions about experience of “humiliation,” “afraid,” “rape,” and “kicking” in the past year. These capture emotional, psychological, sexual, and physical abuse (Sohal et al., 2007). Responses for humiliation and afraid questions were merged to give a single variable referred to as emotional abuse. Each item was answered with a “no” or “yes” scored 0 or 1, respectively. Individuals whose responses were “yes” to at least one of the four questions were categorized as having experienced IPV, while those who responded “no” to all the questions were categorized as not having experienced IPV. The HARK questionnaire was selected based on its short length and ease of administration to reduce respondent fatigue. It has been previously used in Nigeria (Oginni et al., 2019) and had a good Cronbach’s alpha of .73 in the present study. The sensitivity of the HARK at the cutoff score of ≥ 1 was 81%, and the specificity was 95% (Sohal et al., 2007).

Psychosocial factors included anxiety and depressive symptoms and perceived social support. Anxiety and depressive symptoms were assessed using the 14-item Hospital and Anxiety Scale, with seven items each for Anxiety and Depression subscales (Zigmond & Snaith, 1983). Each item was rated on a 4-point Likert scale ranging from 0 (*not at all*) to 3 (*yes, definitely*), and total scores derived as a sum of individual responses were used in analyses. Higher scores indicated higher levels of anxiety or depression. Cronbach’s alphas for both subscales in this study were .81 and .64, respectively. Perceived social support was assessed using the 12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988). Each item was rated on a 7-point Likert scale ranging from 1 (*very strongly disagree*) to 7 (*very strongly agree*),

and total scores derived as a sum of individual responses were used in analyses. Higher scores indicated higher perceived support, and Cronbach’s alpha in the present study was .97.

Factors associated with the COVID-19 pandemic were assessed using questions adapted from a previous survey (White & Van Der Boor, 2020). These included if participants had tested positive for COVID-19 categorized as “no” or “yes”; if they had self-isolated for COVID-19 symptoms categorized “yes” or “no”; their level of worry about getting infected categorized as “not worried” or “worried”; their level of worry about family members getting infected categorized as “not worried” or “worried”; difficulty switching off from media (TV, radio, newspaper) categorized as “no” or “yes”; difficulty switching off from media (Facebook, Twitter) categorized as “no” or “yes”; frequency of assessing COVID-19 updates via TV, radio, or news outlet categorized as “never/rarely/occasionally” or “frequently/very frequently”; frequency of assessing COVID-19 updates from government/World Health Organization website categorized as “never/rarely/occasionally” or “frequently/very frequently”; threat to livelihood/income from COVID-19 categorized as “no” or “yes”; and “Has the current situation made positive impact on your life?” categorized as “no,” “indifferent,” or “yes.” Self-reported impact of COVID-19 on marriage and relationships, physical health, recreation, parenting, spirituality, and community life were assessed using separate questions with responses categorized as “impact absent” or “impact present.” Isolation during the lockdown was assessed with a single question and categorized as “disagree/neutral” or “agree.”

Analysis

Analysis was carried out using SPSS Version 20. Data was summarized using proportions, means, and standard deviations; chi-square tests were further used to test the associations between sociodemographic factors, COVID-19-related factors, psychosocial factors, and presence or absence of IPV. Sex differences were tested using chi-square tests and independent-samples *t* tests as appropriate. Multiple logistic regression analyses were carried out with IPV as the outcome variable and including only variables with a statistically significant bivariate association ($p < .05$).

Results

Descriptive Statistics and Prevalence of IPV

The mean age of participants was 31.16 (± 9.80 ; see Table 1). The prevalence of IPV in the past year was 30.4%.

Sociodemographic and Psychosocial Characteristics Associated With IPV

Participants who experienced IPV were younger (30.89 ± 8.84) than those who had not experienced IPV (31.28 ± 10.21 , *t* test = .58, $p = .011$; see Table 1). More women (57.5%) reported experiencing IPV, compared to 42.5% of men ($\chi^2 = 9.84$, $p = .002$). The majority (80.1%) of those who had experienced IPV had a university education ($\chi^2 = 19.66$, $p = .001$). Of those who experienced IPV, 58.7% were single, compared to 62.4% of those who had not experienced IPV ($\chi^2 = 9.70$, $p = .008$). About half (51.3%) of those

Table 1
Sociodemographic and Psychosocial Characteristics Associated With IPV

Variables	Total (n = 994) (%)	IPV present (n = 302) (%)	IPV absent (n = 692) (%)	t test/ χ^2 ^a	df	p value
Age (<i>M</i> ± <i>SD</i>)	31.16 (9.80)	30.89 (8.84)	31.28 (10.21)	0.58	992	.011
Sex				9.84	1	.002
Female	494 (49.9)	172 (57.5)	322 (46.7)			
Male	495 (50.1)	127 (42.5)	368 (53.3)			
State of residence				3.09	2	.213
North	182 (18.3)	59 (19.5)	123 (17.8)			
South/southeast	184 (18.5)	64 (21.2)	120 (17.3)			
Southwest	628 (63.2)	179 (59.3)	449 (64.9)			
Highest educational level				19.66	5	.001
No formal education	21 (2.1)	6 (2)	15 (2.2)			
Primary education	21 (2.1)	8 (2.6)	13 (1.9)			
Vocational/apprentice	55 (5.5)	18 (6)	37 (5.3)			
Secondary education	113 (11.4)	28 (9.3)	85 (12.3)			
First degree	513 (51.6)	133 (44)	380 (54.9)			
Postgraduate	271 (27.3)	109 (36.1)	162 (23.4)			
Marital status				9.70	2	.008
Single	610 (61.4)	178 (58.9)	432 (62.4)			
Married	344 (34.6)	103 (34.1)	241 (34.8)			
Divorced/separated/widowed	40 (4.0)	21 (7)	19 (2.7)			
Number of children				15.30	4	.004
None	591 (59.5)	155 (51.3)	436 (63)			
1	104 (10.5)	45 (14.9)	59 (8.5)			
2	121 (12.2)	43 (14.2)	78 (11.3)			
3	100 (10.1)	32 (10.6)	68 (9.8)			
4 and above	78 (7.8)	27 (8.9)	51 (7.4)			
Employment status				0.20	2	.905
Unemployed	128 (12.9)	39 (12.9)	89 (12.9)			
Student	287 (28.9)	90 (29.8)	197 (28.5)			
Employed	579 (58.2)	173 (57.3)	406 (58.7)			
Payment mode				2.90	2	.234
No payment	75 (13.4)	28 (16.8)	47 (12)			
Partial payment	212 (37.9)	57 (34.1)	155 (39.4)			
Full payment	273 (48.8)	82 (49.1)	191 (48.6)			
Monthly income				15.60	4	.004
≤\$60	340 (34.2)	95 (31.5)	245 (35.4)			
\$60.01 to \$120	181 (18.5)	58 (19.2)	126 (18.2)			
\$120.01 to \$300	241 (24.2)	78 (25.8)	163 (23.6)			
\$300.01 to \$600	116 (11.7)	49 (16.2)	67 (9.7)			
≥\$600.01	113 (11.4)	22 (7.3)	91 (13.2)			
Anxiety (<i>M</i> ± <i>SD</i>)	15.73 (4.52)	17.14 (3.77)	15.11 (4.68)	-6.69	992	<.001
Depression (<i>M</i> ± <i>SD</i>)	14.74 (3.57)	15.72 (2.99)	14.31 (3.72)	-5.82	992	<.001
Perceived social support (<i>M</i> ± <i>SD</i>)	36.81 (17.25)	32.54 (17.17)	38.68 (16.97)	5.23	992	<.001

Note. IPV = intimate partner violence.

^a T test/chi-square showing the differences between IPV present and IPV absent population.

who experienced IPV had no children, compared to 63% of those who had not experienced IPV ($\chi^2 = 15.30, p = .004$). Only 7% of those who experienced IPV earned more than \$600.01 (~N234,984) per month, compared to 13.2% of those who did not experience IPV ($\chi^2 = 15.60, p = .004$). The mean score for anxiety was higher among those who experienced IPV (17.14 ± 3.77) compared to those who did not experience IPV ($15.11 \pm 4.68, t \text{ test} = -6.69, p = .001$). Similarly, the mean score for depressive symptoms was higher in those who experienced IPV (15.72 ± 2.99) compared to those who did not experience IPV ($14.31 \pm 3.72, t \text{ test} = -5.82, p = .001$).

Gender Differences in Pattern of IPV

For all forms of IPV, women indicated a higher prevalence, with more women (30%) experiencing emotional abuse when

compared to men (21.2%; $\chi^2 = 9.94, p = .002$; Table 2). More women (17.2%) experienced sexual abuse when compared to men (8.1%; $\chi^2 = 18.65, p = .000$), and more women (15.6%) experienced physical abuse compared to 1.1% of men ($\chi^2 = 4.28, p = .024$).

COVID-19-Related Factors Associated With IPV

Twenty percent of those who experienced IPV had self-isolated due to COVID-19 symptoms, compared to 9.7% of those who had not experienced IPV ($\chi^2 = 23.11, p < .001$; see Table 3). About 84% of those who experienced IPV had some level of worry about getting infected with COVID-19, compared to 79% of those who had not experienced IPV ($\chi^2 = 16.61, p = .000$). About 86% of those who had experienced IPV were worried about their family members getting infected with COVID-19, compared to 79% of

Table 2
Gender Differences in Pattern of IPV in the Past 1 Year

Variable	Total (<i>n</i> = 989) (%)	Female (<i>n</i> = 494) (%)	Male (<i>n</i> = 495) (%)	χ^2 ^a	<i>df</i>	<i>p</i> value
Emotional abuse				9.94	1	.002
No	736 (74.4)	346 (70.0)	390 (78.8)			
Yes	253 (25.6)	148 (30.0)	105 (21.2)			
Sexual abuse				18.65	1	<.001
No	864 (87.4)	409 (82.8)	455 (91.9)			
Yes	125 (12.6)	85 (17.2)	40 (8.1)			
Physical abuse				4.28	1	.024
No	857 (86.7)	417 (84.4)	440 (88.9)			
Yes	132 (13.3)	77 (15.6)	55 (11.1)			

^a Chi-square showing the differences between female and male populations.

those who had not experienced IPV ($\chi^2 = 6.60, p = .010$). More people who had experienced IPV accessed COVID-19 updates frequently via print newspapers (40.4%); TV, radio, or news outlets (54%); government or World Health Organization websites (43.4%); and social media (62.3%; $\chi^2 = 46.31, p = .000$; $\chi^2 = 47.44, p = .000$; $\chi^2 = 26.35, p = .000$; $\chi^2 = 23.14, p = .000$, respectively). About 56% of those who did not experience IPV agreed that COVID-19 threatened their livelihood and income, compared to 43.4% of those who experienced COVID-19 ($\chi^2 = 13.26, p = .000$). Also, 57.3% of those who experienced IPV did not think that the COVID-19 pandemic had a positive impact on their life, compared to 42.6% of those who did not experience IPV ($\chi^2 = 18.25, p = .000$). About a third (35.8%) of those who experienced IPV felt more isolated than usual, compared to 44.4% of those who did not experience IPV ($\chi^2 = 5.98, p = .000$).

Multivariate Associations

Table 4 shows that the odds of experiencing IPV were significantly lower with increasing age ($OR = .98, 95\%$ confidence interval [.95, 1.00]) compared to those of younger age. IPV was lower in those with one or more children ($OR = .37, [.22, .64]$) compared to those with no children. It was significantly higher in those with a high monthly income ($OR = 2.84, [1.35, 3.51]$) compared to those with a low income. It was also higher in those who scored high on the Anxiety and Depression scales ($OR = 1.07, [1.03, 1.11]$; $OR = 1.05, [1.00, 1.10]$). It was also lower in those who accessed COVID-19 updates on TV, radio, or news outlets frequently or very frequently ($OR = .52, [.31, .86]$) compared to those who never, rarely, or occasionally accessed it. The odds of experiencing IPV were higher in those who agreed that COVID-19 was threatening their livelihood or income ($OR = 1.79, [1.32, 2.44]$) compared to those who disagreed. The odds of experiencing IPV were lower in those who self-isolated for COVID-19 symptoms ($OR = .44, [.28, .68]$). The odds of experiencing IPV were higher in those who agreed that COVID-19 had an impact on their recreation ($OR = 2.71, [1.68, 4.37]$) compared to those who disagreed or were neutral. The odds of experiencing IPV were lower in those who agreed that COVID-19 had an impact on their marriage and relationship ($OR = .79, [1.26, 6.61]$) compared to those who disagreed or were neutral. The odds of experiencing IPV were lower in those who admitted to having a history of mental health problems ($OR = .37, [.21, .67]$).

Discussion

This study assessed the prevalence, pattern, and sociodemographic, psychosocial, and COVID-19-related factors associated with IPV in Nigeria. The overall prevalence of IPV in the year preceding data collection (which included the lockdown period of April to May 2020 of the COVID-19 pandemic) was 30.4%. In contrast to previous findings from studies carried out in Nigeria (Benebo et al., 2018; Mapayi et al., 2013), during periods without a disaster or pandemic, the prevalence of IPV in our study was lower than what we would normally expect for Nigeria. The prevalence of IPV among women in this study was 57.5%, which is lower than a prevalence of 87% in a migrant community in Southwestern Nigeria (Owoaje & Olaolorun, 2006). While the migrant community may be particularly vulnerable to IPV, it is also possible that overrepresentation of single and educated participants may underestimate the true burden of IPV. Our study also found the prevalence among men to be 43.5%, which is higher than the 23.6% reported in another Nigerian study (Yusuf et al., 2011). Although this prevalence was lower compared to that among female participants, it is possible that the online nature of our study facilitated the disclosure of IPV by men in our study as Nigerian men may be unwilling to disclose their experience of IPV due to perceived stigma, which may stem from “the inability to keep their wives under control” (Dienye & Gbeneol, 2009), cultural expectations of masculinity that consider a male victim of IPV a weakling (Ayodele, 2017), fear of not being taken seriously in the society (Taylor et al., 2021), and denial of their victim status (Deborah et al., 2019).

For all patterns of IPV in the year preceding data collection (which included the lockdown period of April to May 2020), more women significantly experienced all patterns of IPV compared to men. In this study, 30% of women experienced emotional abuse, which is higher than the about 15% found by Benebo et al. (2018) in the same country. Among men, emotional abuse in this study was about 21%, which was lower than a study conducted among married men in Southwestern Nigeria, where it was almost 30% (Deborah et al., 2019). In contrast to a previous study (Benebo et al., 2018) that showed only 3% of women experienced sexual abuse, our study found that 17% of women experienced sexual abuse. Regarding physical abuse, over 15% of women in this study experienced it, which is higher than the 9% reported by Benebo et al. (2018) during a period without pandemic. Among men, about 11% reported experiencing physical abuse, which is lower than the 14% reported by Deborah et al. (2019). Overall, the rates of IPV

Table 3
COVID-19 Factors Associated With IPV

Variables	Total (n = 994) (%)	IPV present (n = 302) (%)	IPV absent (n = 692) (%)	χ^2 ^a	df	p value
Tested positive for COVID-19				0.008	1	.928
No	947 (95.3)	288 (95.4)	659 (95.2)			
Yes	47 (4.7)	14 (4.6)	33 (4.8)			
Self-isolation for COVID-19 symptoms				23.11	1	<.001
No	864 (86.9)	239 (79.1)	625 (90.3)			
Yes	130 (13.1)	63 (20.9)	67 (9.7)			
Level of self-worry about getting infected				16.61	1	<.001
Not worried	237 (24.3)	47 (15.8)	190 (28)			
Worried	739 (75.7)	250 (84.2)	489 (72)			
Level of worry about family member getting positive				6.60	1	.010
Not worried	179 (18.1)	40 (13.3)	139 (20.2)			
Worried	810 (81.9)	260 (86.7)	550 (79.8)			
Difficulty in switching off the media (TV, radio, newspaper)				5.74	1	.017
No	709 (80.0)	230 (84.9)	479 (77.9)			
Yes	177 (20.0)	41 (15.1)	136 (22.1)			
Difficulty in switching off from social media (Facebook, Twitter, etc.)				1.377	1	.271
No	675 (75)	211 (73.9)	464 (73.9)			
Yes	225 (25)	61 (22.4)	164 (26.1)			
Frequency of accessing COVID-19 updates via print newspapers				46.31	1	<.001
Never/rarely/occasionally	735 (73.9)	180 (59.6)	555 (80.2)			
Frequently/very frequently	259 (26.1)	122 (40.4)	137 (19.8)			
Frequency of accessing COVID-19 updates via TV, radio, news outlet				47.44	1	<.001
Never/rarely/occasionally	617 (62.1)	139 (46)	478 (69.1)			
Frequently/very frequently	377 (37.9)	163 (54)	214 (30.9)			
Frequency of assessing COVID-19 updates from government/WHO websites				26.35	1	<.001
Never/rarely/occasionally	677 (68.1)	171 (56.6)	506 (73.1)			
Frequently/very frequently	317 (31.9)	131 (43.4)	186 (26.9)			
Frequency of assessing COVID-19 updates from social media				23.14	1	<.001
Never/rarely/occasionally	490 (49.3)	114 (37.7)	376 (54.3)			
Frequently/very frequently	504 (50.7)	188 (62.3)	316 (45.7)			
COVID-19 threatening my livelihood/ income				13.26	1	<.001
Disagree/neutral	476 (47.9)	171 (56.6)	305 (44.1)			
Agree	518 (52.1)	131 (43.4)	387 (55.9)			
Has the current situation made positive impact on your life?				18.25	2	<.001
No	468 (47.1)	173 (57.3)	295 (42.6)			
Indifferent	156 (15.7)	40 (13.2)	116 (16.8)			
Yes	370 (37.2)	89 (29.5)	281 (40.6)			
Self-reported impact of COVID-19 on marriage and relationships				11.22	1	.001
Impact absent	297 (29.9)	68 (22.5)	229 (33.1)			
Impact present	697 (70.1)	234 (77.5)	463 (66.9)			
Self-reported impact of COVID-19 on physical health				1.75	1	.185
Impact absent	186 (18.7)	64 (21.2)	122 (17.6)			
Impact present	808 (81.3)	238 (78.8)	570 (82.4)			
Self-reported impact of COVID-19 on recreation				10.82	1	.001
Impact absent	120 (12.1)	52 (17.2)	68 (9.8)			
Impact present	874 (87.9)	250 (82.8)	624 (90.2)			
Self-reported impact of COVID-19 on parenting				5.41	1	.020
Impact absent	373 (37.5)	97 (32.1)	276 (39.9)			
Impact present	621 (62.5)	205 (67.9)	416 (60.1)			

(table continues)

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Table 3 (continued)

Variables	Total (<i>n</i> = 994) (%)	IPV present (<i>n</i> = 302) (%)	IPV absent (<i>n</i> = 692) (%)	χ^2 ^a	<i>df</i>	<i>p</i> value
Self-reported impact of COVID-19 on spirituality				0.05	1	.810
Impact absent	222 (22.3)	66 (21.9)	156 (22.5)			
Impact present	772 (77.7)	236 (78.1)	536 (77.5)			
Self-reported impact of COVID-19 on community life				2.16	1	.141
Impact absent	199 (20)	69 (22.8)	130 (18.8)			
Impact present	795 (80)	233 (77.2)	562 (81.2)			
Feeling more isolated than usual since lockdown				5.98	1	.014
Disagree/neutral	581 (58.5)	194 (64.2)	387 (55.9)			
Agree	413 (41.5)	108 (35.8)	305 (44.1)			

Note. IPV = intimate partner violence; WHO = World Health Organization.

^a Chi-square showing the differences between IPV present and IPV absent populations.

in the present sample were higher or comparable to those from previous studies and may further reflect direct and indirect impacts of the COVID-19 pandemic.

Associations With Sociodemographic, COVID-19, and Psychosocial Factors

Of the sociodemographic variables, younger age, having no children, and a higher monthly income increased the odds of experiencing IPV. The association of IPV with higher income in our study suggests that a higher socioeconomic status may not provide a buffer against experiencing IPV as previously reported (Bhona et al., 2019; Khalifeh et al., 2013). However, this needs to be interpreted with caution, especially since the majority of participants in this study had a high educational level, were employed, and had a high income. Similar to another study carried out during the COVID-19 lockdown in Northern Ethiopia (Gebrewahd et al., 2020), IPV was higher among those of a younger age. This may be due to inexperience in intimate relationships, inability to assert

themselves sufficiently with their partners, and financial dependence in their relationships (Bradley et al., 2020).

Participants who experienced IPV had lower levels of perceived social support, and this may reflect the diminished physical access to support networks. For example, activities outside the home (including work and leisure) may provide respite for individuals in relationships characterized by IPV, which may be limited by responses instituted to check the spread of the pandemic including social distancing and self-isolation (Oginni et al., 2020).

Those who had current symptoms of anxiety and depression had increased odds of experiencing IPV, and this is consistent with previous findings (Capaldi et al., 2012; Rioli et al., 2017) and may be explained by the stress associated with IPV victimization. Alternatively, mental health problems may increase the likelihood of being targets of IPV in intimate relationships (Kendler et al., 1999).

Those who agreed that COVID-19 was a threat to their income or livelihood had higher odds of experiencing IPV, and this may be linked to worry and inability to meet financial obligations or increased financial dependence on the spouse/partner with a higher income. Those who had to self-isolate due to COVID-19 symptoms

Table 4

Multivariate Logistic Regression Model Depicting the Associations Between IPV and Sociodemographic, Psychosocial, and COVID-19-Related Factors

Variables	OR	<i>p</i> value	95% CI	
			LL	UL
Age	0.98	.045	0.95	1.00
Sex (ref = female)	0.76	.086	0.55	1.04
Highest educational level (ref = tertiary education)	0.71	.186	0.43	1.18
Marital status (ref = married)	0.74	.321	0.409	1.34
Number of children (ref = one or more children)	0.37	<.001	0.22	0.64
Monthly income (ref = \geq \$600.01)	2.84	<.001	1.35	3.51
Anxiety	1.07	.001	1.03	1.11
Depression	1.05	.05	1.00	1.10
Perceived social support	0.99	.011	0.98	1.00
Level of self-worry about getting infected (ref = worried)	0.69	.17	0.41	1.17
Frequency of accessing COVID-19 updates via TV, radio, news outlet (ref = frequently/very frequently)	0.52	.011	0.31	0.86
COVID-19 threatening my livelihood/income (ref = agree)	1.79	<.001	1.32	2.44
Self-isolation for COVID-19 symptoms (ref = yes)	0.44	<.001	0.28	0.68
Self-reported impact of COVID-19 on recreation (ref = impact present)	2.71	<.001	1.68	4.37

Note. CI = confidence interval; LL = lower limit; UL = upper limit; ref = reference.

were more likely to report experiencing IPV, and this may be linked to increased stress from worry about the adverse outcomes of infection. Alternatively, increased proximity during self-isolation may increase the likelihood of IPV through individuals taking out their frustrations on their partners.

Regarding the impact of COVID-19 on recreation, those who agreed that COVID-19 had an impact on their recreation had increased odds of experiencing IPV, which may be linked to complaints or grumbling about this to their partners. It is also possible that the limited opportunities for recreation due to the restrictions placed on travel, large gatherings, etc. may increase irritability and tension in intimate relationships, which can easily degenerate into interpersonal conflict and violence (Berlin; <https://www.hhs.se/contentassets/619aa7167ff54b4ba0df1f74bbfd6/a11.pdf>).

Limitations

Recruitment for this survey was online via social media platforms (Facebook, Twitter, Whatsapp, etc.). This convenience sampling may limit the generalizability of our findings; for instance, our data had more single individuals, those with a university education and postgraduate degrees, those without children, and more employed participants. This may mean that our findings may not be generalizable to those from lower socioeconomic backgrounds and with lower levels of education. While we assessed for psychosocial factors among our participants, no questions ascertained if these factors were a direct result of IPV they had experienced. Also, the cross-sectional nature of the data makes it difficult to ascertain causality; a longitudinal design would have been better suited.

Conclusion

To our knowledge, this is one of the few Nigerian studies to investigate prevalence, pattern, and sociodemographic, psychosocial, and COVID-19-related factors associated with IPV. Our findings indicate that a high monthly income, presence of anxiety, presence of depression, threat of COVID-19 to income, and impact of COVID-19 on recreation increased the odds of experiencing IPV. Older age, having more than one child, increased perceived social support, increased frequency of checking COVID-19 updates on TV or radio/news outlets, and having self-isolated due to COVID-19 symptoms reduced the odds of experiencing IPV. Thus, improving social support can be used as an intervention to help victims of IPV. Provision of safe homes that victims of IPV can use as temporary shelters especially during disaster/pandemic periods will be of immense benefit to survivors of IPV. Provision of toll-free helplines as well as online psychological interventions will also be useful. Further studies, including qualitative interviews to help understand measures that survivors of IPV perceive as necessary during such periods, are important.

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