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Lethal intimate partner violence and gendered dimensions of the COVID-19 lockdown in Nigeria: evidence from a descriptive analysis of secondary data

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ABSTRACT

Introduction Concerns emerged over the escalation of intimate partner violence (IPV) as many governments imposed COVID-19 lockdown measures. This paper examined the lethality trends, gender contexts and sources of fatal IPV during the prelockdown, lockdown and postlockdown years (2019–2021) in Nigeria. This research aims to shed light on the impact of the pandemic lockdown on IPV-related mortalities.

Methods The study used secondary data from the Nigeria Watch database, an online resource on lethal violence and human security in Nigeria. It relied on IPV datasets extracted and analysed descriptively at the univariate level.

Results Results indicate a steady increase in IPV-related mortalities, with 205 fatalities—62 in 2019, 69 in 2020 and 74 in 2021—resulting from 180 IPV incidents. Males were the main protagonists, as the majority of IPV victims were women, including female spouses (51%) and female lovers (23%), compared with male spouses (18%) and male lovers (7%). A trend analysis of IPV-related fatalities showed that the worst affected states are in southern Nigeria, with Lagos recording the most cases. Apart from the undefined causes of IPV-related fatalities, more deaths emanated from arguments between intimate partners (50) and infidelity (37). Aside from other reasons, most victims died from dangerous weapons (46) and battering (27).

Conclusion This paper underscores the steady increase in IPV-related deaths year over year, not just during the COVID-19 lockdown period, and highlights the importance of policy and practise to prevent and respond to IPV incidents.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Intimate partner violence (IPV) is a global health problem that affects individuals of all genders, but women are more likely to experience IPV in nature and severity compared with their male counterparts.

WHAT THIS STUDY ADDS

⇒ It provides a detailed analysis of IPV fatalities in Nigeria during the prepandemic, pandemic and postpandemic years (2019–2021). It highlights the steady increase in IPV-related fatalities year over year, not just during the COVID-19 lockdown period.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study stresses the need for continuous efforts to effectively manage IPV in Nigeria and beyond, while also offering insights into building resilience against future pandemics and lockdowns.

INTRODUCTION

Nations across the world grappled with the outbreak of the coronavirus (COVID-19) in 2020. In response to the pandemic, many governments imposed restrictions on public gatherings, schools, businesses and places of worship, causing populations to face a physical and financial inability to access healthy and diverse food.[1 2] In Nigeria, the first lockdown was implemented on 27 April 2020 and was initially scheduled for 2 weeks,[3] but was extended for 2 weeks following the spike in COVID-19 cases. More drastic measures, including the use of face masks, handwashing and social distancing, were introduced to further strengthen the containment measures. However, such measures were poorly enforced and created confusion amidst partial compliance in some parts of the country.[3] The impact of the COVID-19 pandemic and the consequent lockdown measures was profound on health and well-being,[4] especially in low-income households that relied on daily wages to survive in developing countries, including Nigeria. In the wake of poor infrastructure and a lack of robust measures to cope with the pandemic and its fallouts, existing socioeconomic inequalities and access to healthcare, food and other essential services were exacerbated,[5] thereby increasing intimate partner violence (IPV).[6–10]

In conceptualising IPV, the WHO and Garcia-Moreno *et al* defined it as the behaviour within an intimate relationship that causes harm to a partner, including acts of physical

and sexual violence, emotional abuse, verbal threats, isolation and controlling behaviours.[11 12] These types of IPV are not mutually exclusive and often co-occur within abusive relationships and in all intimate relationships, including those between married, cohabiting and dating partners. Irrespective of the type, IPV is a global health problem whose occurrences and impacts are usually hidden from the public's glare. Evans *et al* best describe it as the 'hidden pandemic' that forces victims to stay away from reporting IPV.[13] The concealment stems from the fear of revenge, limited awareness of support services, low educational attainment, poverty and cultural beliefs that tend to subtly discourage women from challenging relational violence.[14] Bradbury-Jones *et al* and Piquero *et al* classified several factors that may contribute to and escalate IPV during lockdown measures as increased stress, financial strain, social isolation, reduced access to support services and increased barriers to leaving abusive relationships.[2 15]

As a complex social issue, IPV affects individuals of all genders, with gender playing a significant role in shaping the nature and consequences of such violence. The gendered dimensions of IPV explain the interplay of gender norms, roles and expectations and the incidents, patterns and dynamics of violence within intimate relationships.[16] There is global and regional evidence that women and girls experience IPV in nature and severity more than their male counterparts,[17–19] with one in five women experiencing physical and/or sexual violence by an intimate partner in her lifetime.[20]

Broadly speaking, violence has been endemic across Nigeria and has increased lately as a result of complex issues, including poverty, inequality, ethnoreligious conflicts, violent norms, terrorism, etc.[21] This generally high level of violence within Nigerian society has had increasing implications for intimate relationships among Nigerians. For instance, in Nigeria, the prevalence of emotional, physical and sexual IPV has been on the increase since 2018, following a decline in 2013.[22] Therefore, it is unsurprising that during the COVID-19 lockdown, Nigeria experienced an increase in the number of IPV incidents, with women and girls the main victims.[23] For instance, in May 2020, the Women at Risk International Foundation reported a 50% increase in cases of gender-based violence in Lagos State since the onset of the lockdown.[24] Over 3000 cases, the majority of which involved IPV, were reported to the Nigerian Ministry of Women Affairs and Social Development in June 2020.[25] The numerous cases suggest that the COVID-19 lockdown aggravated IPV in Nigeria. For instance, the Domestic and Sexual Violence Response Team of the Ministry of Justice, Lagos State, reported a 134% increase in rape cases, defilement and domestic violence and treated 2356 domestic violence cases in 2018, 1312 more than the 1044 cases treated in 2017.[26]

Despite global reports on the increase in IPV incidents, studies that explore the COVID-19 lockdown effect on the lethality of IPV incidents are scarce. Several studies have focused on trending IPV incidents during the COVID-19 lockdown,[2 5–10] but have largely failed to highlight the lethality of such IPV incidents before, during and after the lockdown. For instance, Piquero *et al* examined the effect of COVID-19-related restrictions on reported incidents of domestic violence pre-COVID-19 and post-COVID-19 restrictions. They found an increase in domestic violence in response to COVID-19-induced stay-at-home/lockdown orders.[2] However, they failed to highlight the lethal outcomes brought about by the increased domestic violence resulting from the COVID-19 restrictions. This is particularly important as many IPV cases lead to the deaths of intimate partners, where a majority of deaths are gender related, with victims being mostly women and girls.[17 27] While women and girls are affected by gender-based killings globally, Africa as a region witnessed the highest absolute number of deaths (20 000) and also witnessed the highest number of violent acts relative to the size of its female population (2.8 per 100 000 female population) in 2022.[17] While the United Nations Office on Drugs and Crime (UNODC) and UN Women document is authoritative and quite insightful on the overall number of gender-based deaths resulting from IPV, the document did not highlight individual countries' contributions to this overall number of deaths. For instance, the UNODC data did not specifically highlight the data from Nigeria and hence points to the importance of measuring these deaths in the Nigerian context. Recognising that the COVID-19 lockdown influence on IPV lethality should not be assessed in isolation, the prelockdown and post-lockdown years (2019 and 2021) were investigated to highlight the comparative effects of the COVID-19 lockdown on IPV lethality in Nigeria. Nigeria operated a phased COVID-19 lockdown restrictions, amounting to three staggered phases of lockdown restrictions.[28] The first phase was declared on 27 April 2020 while the third phase ended on 19 October 2020.[28] The end of the third phase of lockdown restrictions culminated in the resumption of international flights, restriction of public gatherings to 50 persons and reopening of schools, restaurants, event centres, etc.[29] Hence, regardless of some minor guidelines to manage the pandemic, 2021 witnessed no sweeping lockdown restriction measures. The easing-up phases of the lockdown in Nigeria witnessed the highest cases of the virus, which was attributed to the emergence of new variants of the virus; however, the Nigerian government continued to ease the lockdown measures in 2021, citing economic, sociopolitical and health considerations. This paper, therefore, examined the lethality, trends, gender contexts, sources and modes of IPV fatalities pre-COVID-19, during and post-COVID-19 lockdown period in Nigeria. The findings in this study provide insights towards the lethality of IPV in Nigeria and other countries with similar characteristics and resilience building against future pandemics and lockdowns.

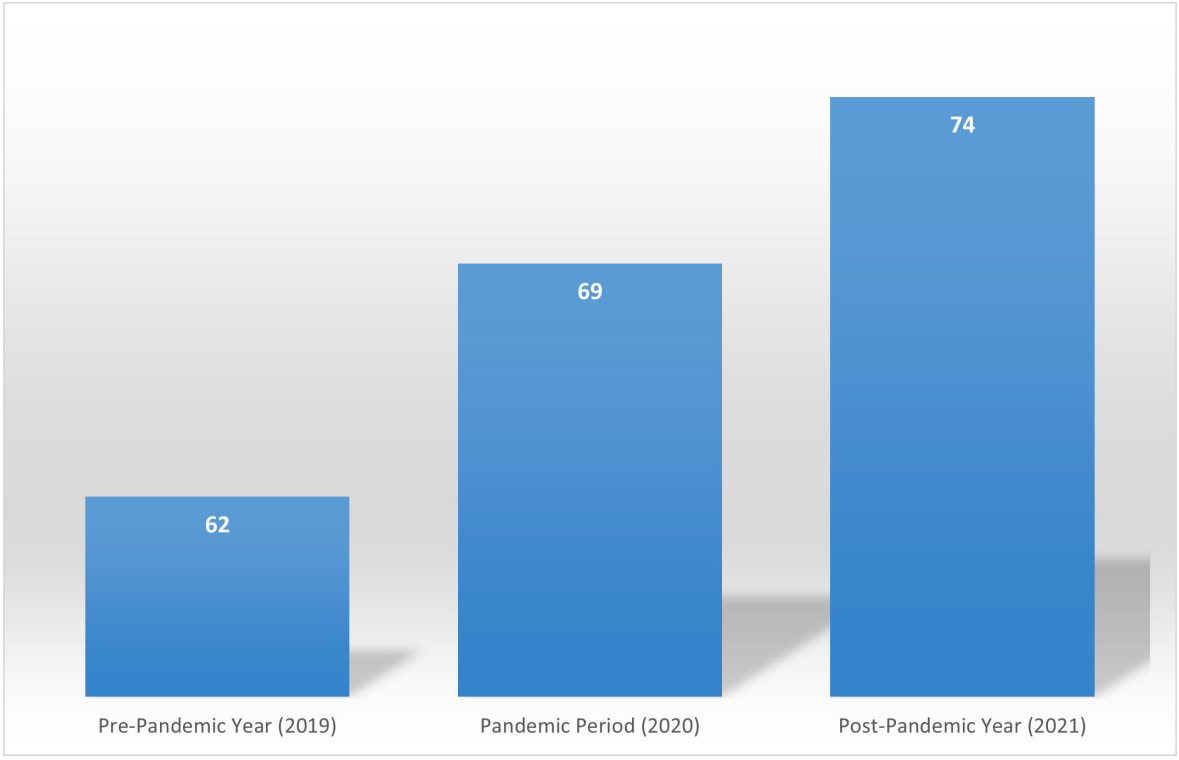

Figure 1 Distribution of overall intimate partner violence-related fatalities in Nigeria (2019–2021).

METHODOLOGY

Study design

This study employed the cross-sectional design to descriptively analyse secondary data on deadly IPV between 2019 and 2021. A total of 180 fatal IPV incidents that resulted in 205 fatalities were extracted from the lethal violence database of the Nigeria Watch (NW), an online database on human security in Nigeria since 2006. Having used and analysed already existing data, there was no exposure to participants.

Study area

This study took place in Nigeria, the most populous country in Africa. Nigeria operates the state system, with 36 administrative states, 1 Federal Capital Territory (FCT) and 774 local government areas (LGAs), including 6 in the FCT. This study collected and analysed data on IPV-related fatalities from all the states and the FCT.

Data source

In this study, we extracted secondary data on IPV-related fatalities from NW, an online database on human security in Nigeria since 2006. The meticulous approach that aims to maintain the reliability of data and the relevance for our research objectives guided our choice of the NW database. Given the unreliability of data from government agencies, we specifically preferred a source with a history of accurate and thorough data collection processes. The NW, as an ongoing project, took off on 1 June 2006[30] and has been consistent with its methodology. The project is hosted by the Institute for French Research in Africa at the University of Ibadan in Nigeria and belongs to the Casualty Recorders Network, an international organisation that is committed to improving standards and international humanitarian and human rights law. Formerly funded by the Japanese International Cooperation Agency and the Managing Conflict in Northeast Nigeria (a programme under the British Department for International Development, NW is currently supported by the Institut de Recherche pour le Développement, Paris.

Validity and completeness

NW was established to fill the vacuum of a reliable database on lethal violence in Nigeria. Since 2006, the database has remained Nigeria's most comprehensive database on lethal violence because of its consistency in all stages of data management, from data sourcing to archiving. It collates and disaggregates data by date and location (State, LGA, town, village or 'offshore zone'), causes, protagonist and relations. NW sources data from Nigeria's major national dailies and reports by the police, hospitals and human rights organisations (primarily Human Rights Watch and Amnesty International). The major national dailies are selected based on geographical spread to ensure wider coverage. NW also sources data from private security firms, companies and embassies. All sources of information are scanned and archived in PDF formats, making it easier for users to keep track of previous records for reference. To control under-reporting, over-reporting and differences in reported figures, the NW team uploads as many reported sources and their figures as possible. Such an approach allows the

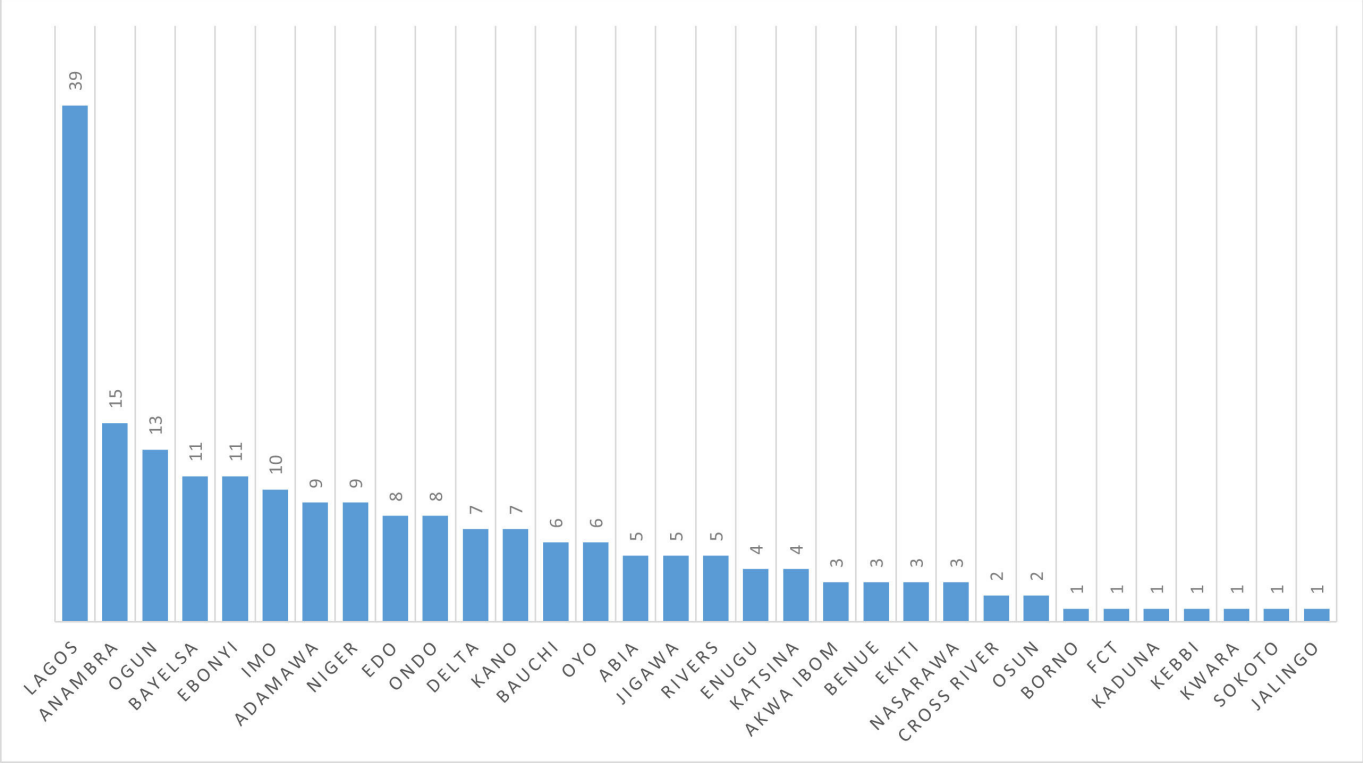

Figure 2 Distribution of intimate partner violence-related fatalities by states in Nigeria (2019–2021). FCT, Federal Capital Territory.

database to generate an average number of fatalities for each violent incident.

Variables and categories

The variables involved in this study are lethal IPV incidents, sex, gender, COVID-19 lockdown, period, geographic location, immediate circumstances and instruments used. From the NW perspective, a lethal IPV incident involves any relational act that culminates in the fatality of one or both spouses, dating partners or co-wives. Sex is categorised into male and female binary. Regarding gender identities and norms, available data captured on sex binary and therefore excludes same-sex relationships or trans women as there is an existing law against same-sex relationships in Nigeria. Hence, gender is subcategorised into wives and female lovers, males are subdivided into husbands and male lovers. COVID-19 lockdown refers to the timing and duration of lockdown measures imposed during the COVID-19 pandemic in Nigeria. The period was categorised into three: prepandemic (2019), pandemic (2020) and postpandemic (2021) periods for which data on lethal IPV was restricted. Geographic location involves the various states within Nigeria where lethal IPV incidents occurred. Immediate circumstances as defined by the NW involve the immediate events or triggers leading to lethal IPV incidents, such as misunderstandings over abortion or unplanned pregnancy, infidelity, jealousy, property or inheritance, rituals or spirituality, unwanted sexual advances, co-wives' quarrels, money or food matters, physical fights, arguments over issues and other undefined causes. Instruments used include weapons or methods used in fatal IPV incidents, such as knife, acid and gun attacks, poisoning, setting ablaze, strangulation and battering, among others. These classifications are similar to those by Campbell *et al*, in their multisite case–control study of risk factors for femicide in abusive relationships.[27]

Data analysis

A descriptive statistical analysis of lethal IPV data was conducted at the univariate level using the Excel spreadsheet after sorting IPV data from the other categories of deadly violent occurrences. To explore the lethality, the absolute number of fatalities resulting from IPV across 3 years (2019–2021) was mapped. IPV fatalities were broken down by states to gain more information about the dynamics and trends of IPV-induced mortalities during the coverage period. The total number of IPV deaths between 2019 and 2021 across the federation was broken down by states and years to chart the trends of IPV-related fatalities. To explore the gender dimensions of IPV-induced mortalities within the period under coverage, the absolute number of deaths by gender categories and relational status (males and females, male and female spouses/lovers) was examined. Furthermore, we explored the gendered contexts of IPV-related fatalities by state to map the geography of gendered fatalities from IPV. The sources of IPV-related fatalities were also analysed before, during and after the COVID-19 pandemic lockdown. We achieved this by examining the immediate circumstances that led to fatal IPV incidents. We categorised these incidents into: misunderstandings

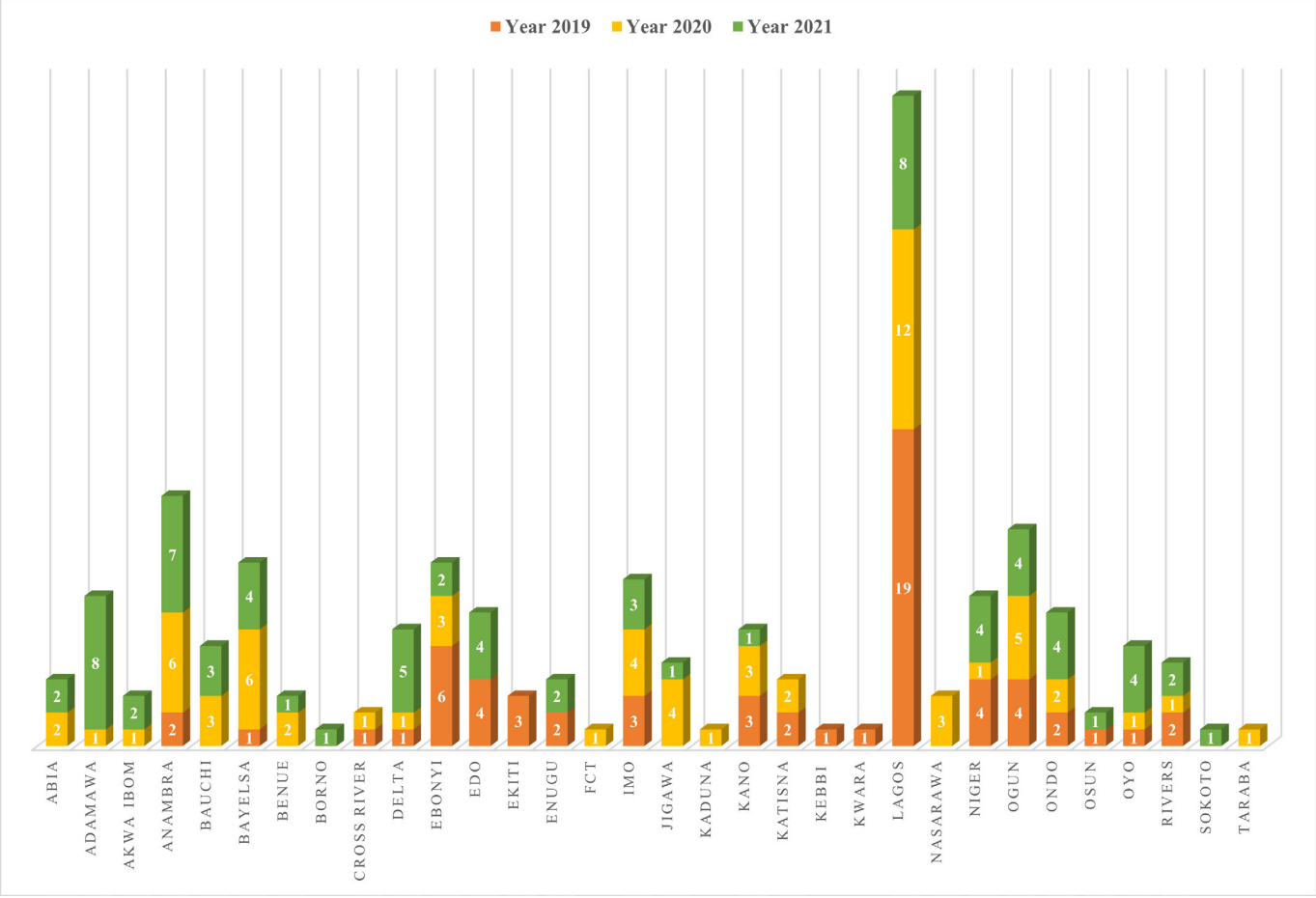

Figure 3 Distribution of disaggregated intimate partner violence fatalities by states and years (2019–2021). FCT, Federal Capital Territory.

over unplanned pregnancy and abortion, infidelity and jealousy, property inheritance, unwanted sexual advances, co-wives' quarrels, money and food matters, physical fights, arguments over sundry issues and other unidentified causes. To examine the mode of IPV-related fatalities, we explored the instruments that IPV perpetrators employed against their victims. These instruments were categorised into sharp objects, acid, guns, poisons, fire, strangulation, battering and others. The results of all these descriptive analyses were presented in charts.

Patient and public involvement

No patients or the public were directly involved in developing this study's research questions and outcomes. Also, no patients took part in the recruitment and design of this study; hence, they were not asked to assess the time required to participate in the research. As no patients were involved in the study, no patients will be involved in disseminating the research results.

RESULTS

Fatalities resulting from IPV in Nigeria

The data in figure 1 show that 205 deaths resulted from 180 IPV incidents across the country between 2019 and 2021. The fewest IPV-related fatalities (62) occurred in 2019, a prepandemic year. This number increased by 7 points to 69 in 2020, the pandemic year, and then rose by 5 points to 74 in the postpandemic year. The pattern of IPV-related deaths suggests a steady increase in IPV-related fatalities within the period under coverage.

Trends of IPV fatalities by states (2019–2021)

Figure 2 illustrates the deaths that occurred from IPV incidents in various states of Nigeria. Out of the 36 states and the FCT, IPV fatalities were reported in 32 states between 2019 and 2021 except in Gombe, Kogi, Plateau, Yobe and Zamfara. Data revealed that 6 states in southern Nigeria recorded the most incidents, with Lagos accounting for 39 deaths, Anambra (15), Ogun (13), Bayelsa and Ebonyi (11 each) and Imo (10), while the least affected states are from northern Nigeria, including Taraba, Sokoto, Kwara, Kebbi, Kaduna, Borno and the FCT, each with a fatality.

IPV fatality trends by states in Nigeria and years

To gain further nuanced insights into the dynamics of IPV fatalities among states over the years (2019–2021), IPV fatalities for each state were disaggregated according to the years they occurred to aid a comparative analysis of the effect of the COVID-19 pandemic lockdown. In figure 3, the data showed no specific pattern regarding

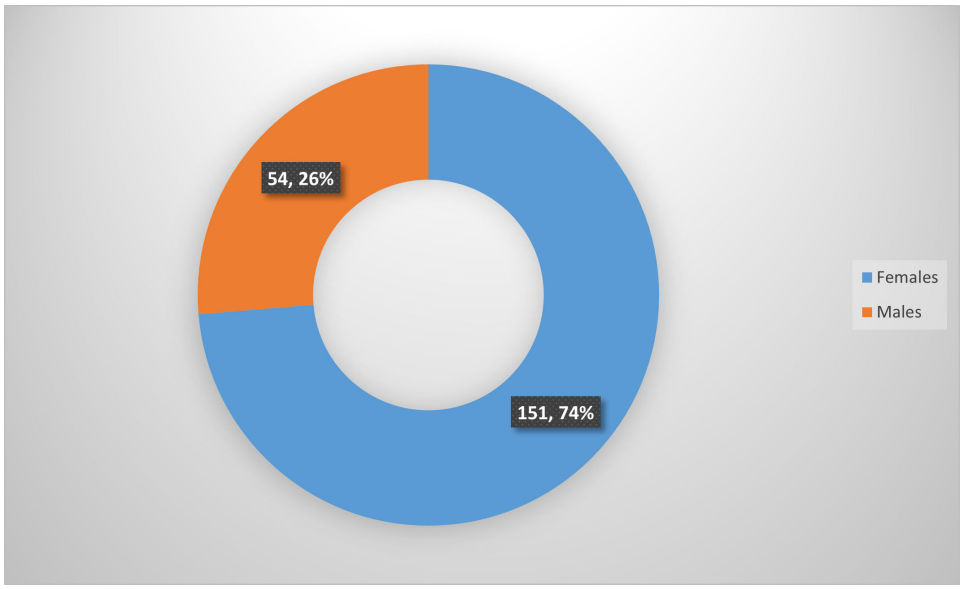

Figure 4 Distribution of fatal intimate partner violence victims by gender categories (males and females).

the fatalities recorded by states in the prepandemic, pandemic, and postpandemic years. Hence, the data suggest no specific influence of the COVID-19 pandemic lockdown on IPV fatalities. While some states recorded more fatalities in the prepandemic year and fewer in the pandemic and postpandemic years, others recorded more in the pandemic and less in the prepandemic and postpandemic years. For instance, Lagos and Ebonyi states recorded more deaths in the prepandemic year (2019) than in the pandemic (2020) and postpandemic years (2021), while Bayelsa, Ogun, Imo, Jigawa, Benue and Taraba states recorded more IPV fatalities in the pandemic year (2020) than others. Six states, Adamawa, Anambra, Delta, Ondo, Oyo and Sokoto, recorded more IPV fatalities in the postpandemic year than they did in each of the other years under coverage.

Sex and gender dimensions of IPV-related deaths (2019–2021)

In figure 4, the relationship between IPV-related deaths and sex categories (males and females) is illustrated. From the data illustration, females appear to be dying more from IPV incidents and account for about 74% of overall fatalities between 2019 and 2021 while males made up for the remaining 26%. By implication of the data in figure 4, males are the main protagonists of IPV incidents in Nigeria, while females bear its brunt.

Further disaggregation of IPV victims by gender relational categories in figure 5 revealed that of the 205 IPV-related fatalities recorded between 2019 and 2021 across the country, 104 were wives, 47 were female lovers, 31 were husbands and 23 were male lovers.

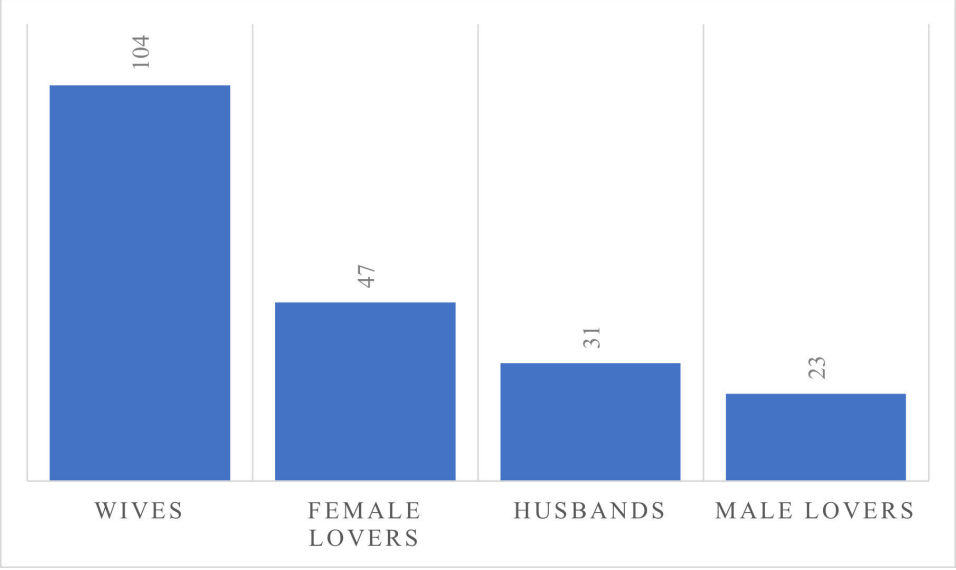

Figure 5 Distribution of intimate partner violence fatalities by gender-relational categories.

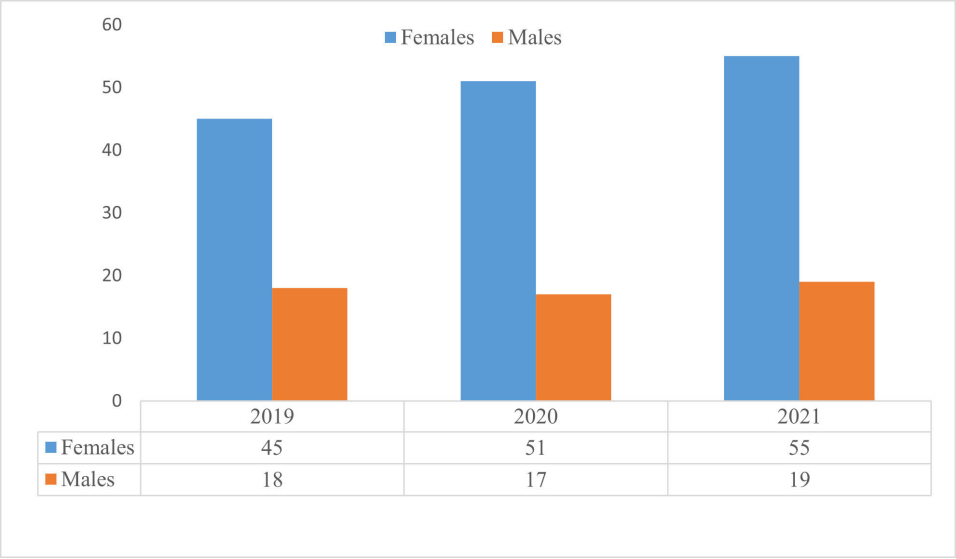

Figure 6 Trending intimate partner violence-related fatalities by sex and year.

For further insights into the sex dimensions of IPV fatalities, trend analysis by sex categories was conducted. As illustrated in figure 6, there was a steady increase in female IPV fatalities across Nigeria. The same did not apply to males, whose fatality figures dipped in 2020 but slightly increased in 2021. Female fatalities resulting from IPV were higher in all the years (2019–2021) than males. Specifically, 45 females lost their lives in 2019, 51 in 2020 and 55 in 2021, compared with 18 male fatalities in 2019, 17 in 2020 and 19 in 2021.

Figure 7 illustrates the result of the analysis of IPV-related deaths by sex. Lagos state recorded the highest number of female victims (30), followed by Anambra (13), Ogun (12), Imo (10), Ebonyi (9), Bayelsa (7) and Niger (7), while Sokoto, Taraba, Osun, Kwara, FCT and Borno states reported the lowest number of female victims, with each accounting for one female death. Except for Niger state, most of the affected states are in southern Nigeria. Conversely, the fewest number of female fatalities occurred in states in the north. Only Kebbi and Nasarawa states failed to record female fatalities within the period under coverage. While Borno, Kaduna, Kwara, Osun, Sokoto, Taraba, Cross River, Akwa Ibom, Ekiti, Enugu and Imo states did not record male

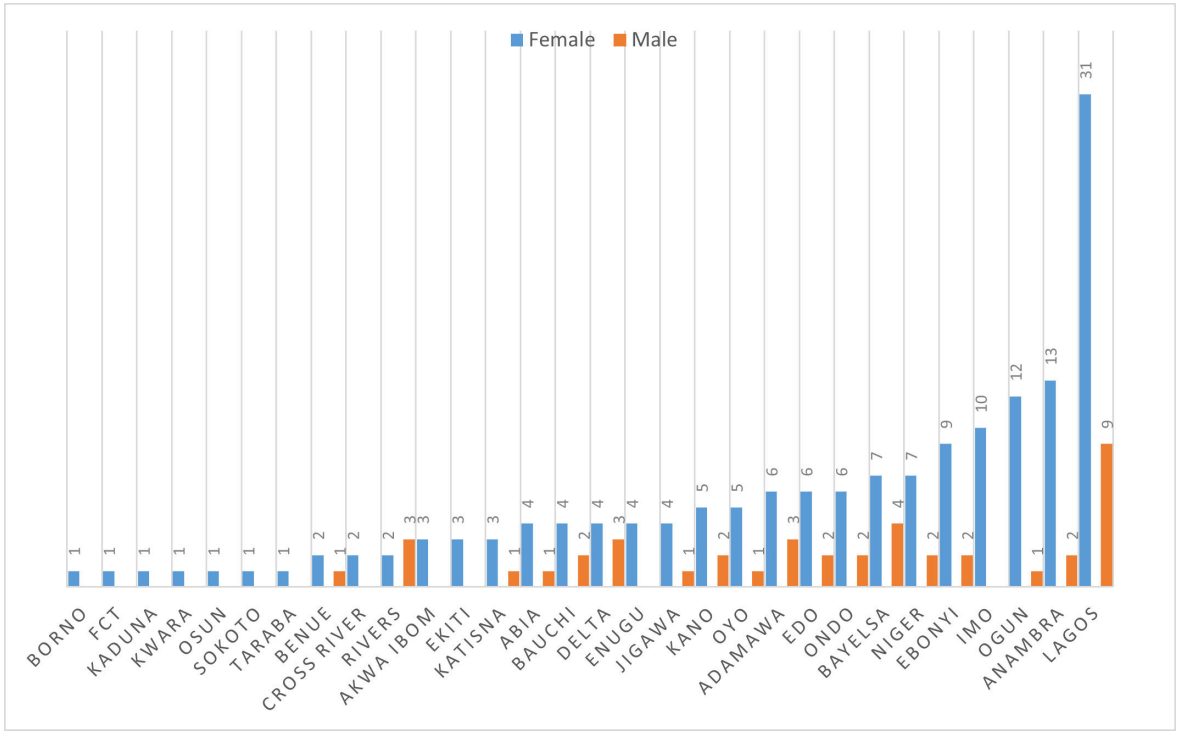

Figure 7 Distribution of male and female intimate partner violence fatalities by states. FCT, Federal Capital Territory.

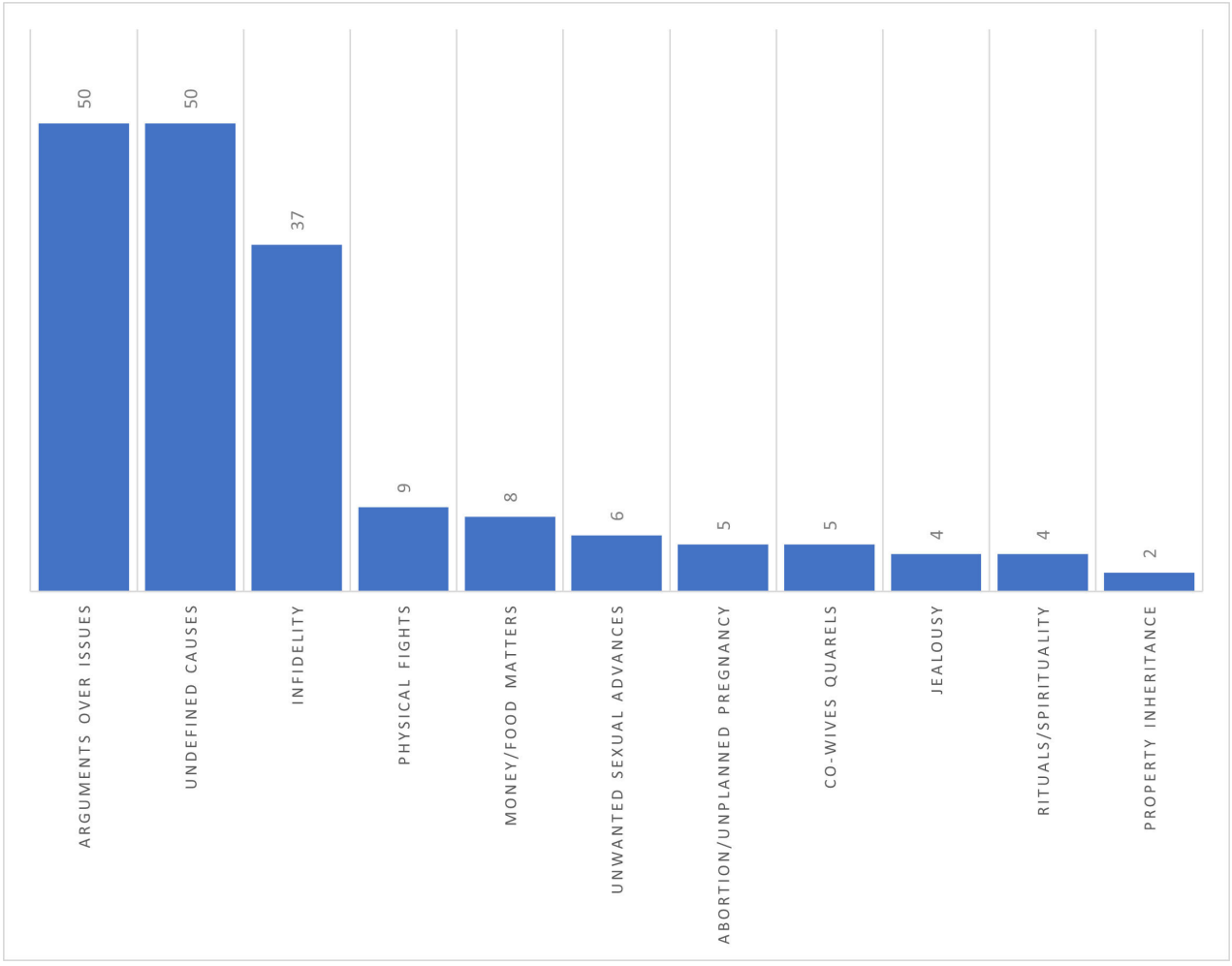

Figure 8 Distribution of the sources for intimate partner violence-related fatalities (2019–2021).

fatalities, Lagos, Bayelsa, Delta, Adamawa, Nasarawa and Rivers states experienced more male fatalities than Ogun, Oyo, Kebbi and Katsina. Jigawa, Benue and Abia were the least affected states.

Sources of IPV-related fatalities before, during and after the COVID-19 pandemic

Figure 8 illustrates that the highest number of IPV deaths (50) between 2019 and 2021 stemmed from arguments and misunderstandings between intimate partners, while infidelity resulted in 37 deaths and physical fights (9 victims). However, misunderstandings arising from property inheritance, rituals/spirituality, co-wives' quarrels and abortions/unplanned pregnancies were other sources of IPV fatalities.

Modes of IPV killings

Figure 9 shows that IPV victims die differently. Hence, it was necessary to investigate the modes of killing. The figure revealed that the use of sharp objects such as knives, axes and scissors was prominent and accounted for 46 deaths. This finding is logical as those weapons are easily accessible in households and are commonly used against the victims. Battering resulted in 27 deaths while setting ablaze caused 13 deaths, gun attacks (7) and poisoning (6). Most incidents that involved gun shootings were perpetrated by mostly serving and retired male security operatives. Setting ablaze was common in incidents that involved lovers, while acid attacks and poisoning were common among jealous lovers and co-wives who battled for attention. Other methods by which victims of IPV died included strangulation and pulling of the penis.

DISCUSSION OF THE FINDINGS

Using secondary data from the NW database, the lethal contexts of IPV incidents before, during and after the COVID-19 lockdown restrictions across Nigeria were explained. In addition, trends by year, state, sex, gender contexts, sources and modes of killing in IPV were all examined in this study. Overall, for the years under coverage (2019–2021), data revealed a steady increase in fatalities attributed to IPV incidents. The number of post-COVID-19 lockdown fatalities outnumbered those recorded before and during the pandemic lockdown periods. Hence, the lockdown appeared to have had no overwhelming effect on IPV lethality but on IPV incidents generally. Although previous studies had reported an increase in the frequency, severity and duration of physical violence and the use of weapons by partners during

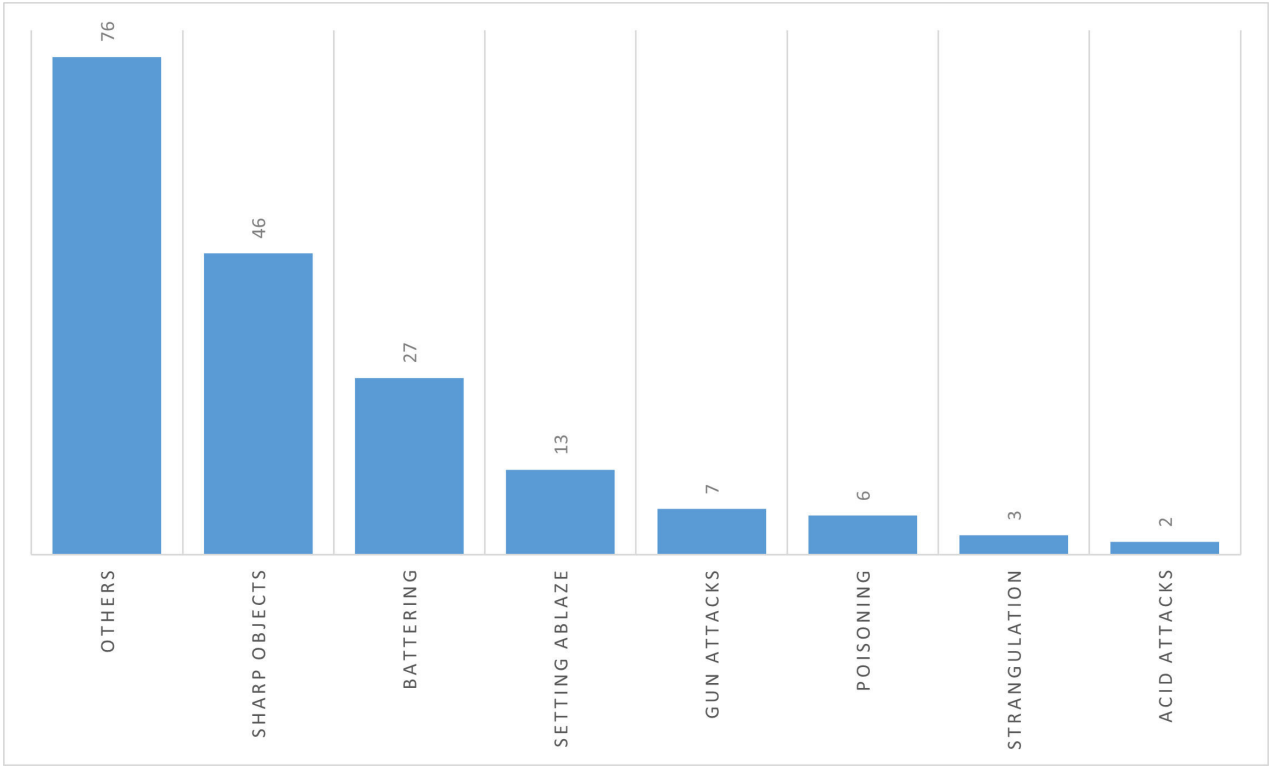

Figure 9 Distribution of intimate partner violence killings by modes of killing.

the lockdown period,[5–10 15 31] they failed to suggest how the culture of IPV is evolving and becoming more lethal and is progressively claiming more lives before, during the post-COVID-19 lockdown restrictions era. It means that not all IPV incidents are lethal but can lead to fatalities if unchecked.

Further findings also revealed that most IPV-related fatalities occurred more in Nigeria's southern states than in the north. Lagos headlined the states with the worst cases of lethal IPV. The state is outstanding when its population and cosmopolitan nature are brought into context and could explain the differential IPV fatality rate when compared with other states in Nigeria. This result is inconsistent with the WHO's multicountry study on violence against women.[32] The WHO multicountry study and others revealed that traditional gender norms and social norms supportive of violence were significant factors contributing to IPV and were more entrenched in rural compared with urban areas.[32–34] While Lagos state is highly urbanised, these traditional and social norms may still influence the prevalence of IPV. This suggests that the urbanisation of Lagos may not fully protect women from fatal IPV, as the influence of traditional norms and social support for violence can persist in urban areas. Lagos also has structures that identify and manage IPV incidents as well as encourage victims to seek support and remedy. Such structures encourage quick reportage of IPV incidents in the national dailies, where NW draws its data, hence the high rate of reported IPV fatalities in Lagos compared with other states. Although previous studies in Lagos state failed to report the number of fatalities from IPV during the pandemic, they confirmed an increase in its frequency.[24 26]

Overall, the study revealed some gender dimensions of lethal IPV between 2019 and 2021, with a majority of victims being women. An analysis of the relational status of the victims showed that wives and female lovers/partners suffered more fatalities than their husbands and male lovers. The implication is that males appear to be the main perpetrators and women the main victims, confirming previous findings that women constitute a disproportionate majority of the victims of fatal IPV.[17 20 35 36] Also, southern states recorded more female victims than Northern states. Multiple marriages exist in Nigeria and this may contribute to deadly IPV in Nigeria. Furthermore, plural marriages are more common in northern Nigeria where it is more accepted because Islam is the dominant religion. However, in the south, multiple marriages are not well accepted due to the influence of Christianity which frowns at it. Due to the wider acceptance in the north and the lack of it in the south, multiple marriages could account for the geographical variability in femicide risk. Additionally, southern states appear to be more liberal when compared with their more conservative counterparts in the north, where the Islamic religion and male-centric culture dominate. Therefore, people in the South could enjoy more freedom to report cases of IPV fatalities than in the North. Overall, the African patriarchal society, the economic dependence of most women on men, and the sociocultural norms that encourage women to put up with abusive partners because of their children could

explain the higher IPV fatality figures among females than males.

Sundry arguments over issues between partners, infidelity and jealousy were implicated as the significant sources of most fatal IPV incidents. Previous research corroborates this finding, as Campbell *et al* lists jealousy and separation as major risk factors for femicide.[27 37] Again, the prevalent use of sharp objects such as knives, axes and scissors on IPV victims is quite understandable as they are mostly available and commonly used in homes. Capaldi *et al*, in a systematic review of risk factors for IPV, acknowledged sharp objects as sources of IPV that could lead to death.[38] IPV fatalities also emanate from battering, burning, gun and acid attacks and poisoning. The findings are consistent with the report of Black *et al*, which identified hitting, burning, choking and assaulting with firearms as means through which victims of IPV died.[39] The Violence Policy Center also reported that most women are murdered by their intimate partners who use firearms.[40]

IMPLICATIONS OF THE FINDINGS FOR POLICY AND PRACTICE

From the findings of this study, it is evident that IPV-related fatalities have increased over the years. It is also evident that women constitute a disproportionate bulk of these IPV-related fatalities. To arrest this increasing number of IPV-related fatalities, there is a need to ensure unhindered reporting of IPV incidents through adequate policies. Reporting IPV incidents easily will ensure a better understanding of the problem and adequate policies to contain IPV incidents. Additionally, specialised agencies with adequately trained staff should be set up across states to manage IPV incidents and support victims, particularly women and also tackle the various norms and practices that encourage violence against women.

Strengths and limitations of the study

This study has several strengths that merit highlighting. First, the focus on lethal IPV provides a unique perspective on IPV in Nigeria, as many studies have focused on non-lethal IPV incidents. Second, the paper provides a detailed analysis of the data on IPV-related fatalities from the NW database. The study examines the lethality trends, gender contexts and sources of IPV during the prepandemic, pandemic and postpandemic years (2019–2021) in Nigeria. The paper also provides a trend analysis of IPV-related fatalities, showing the worst-affected states in Nigeria. Finally, the paper underscores the steady increase in IPV-related deaths year over year, not just during the COVID-19 lockdown period and highlights the importance of policy and practice to prevent and respond to IPV incidents.

Regardless of these strengths, the findings in this study should be interpreted taking into consideration certain limitations. First, one of the potential limitations of the NW database includes under-reporting, over-reporting and differences in reported figures of lethal IPV incidents among news media. These sources may have their biases, leading to biases in the data collection process. To address this issue, the NW team uploads all reported figures to the database, which generates an average number of deaths for each violent incident. Regardless of their best efforts, there could be some limits to which we can generalise on the findings of this study. Again, a notable limitation is that NW data do not account for same-sex relationships or non-heteronormative relationships and as such we could not determine if there were same-sex victims and perpetrators. For instance, since most victims of fatal IPV were females, we assumed that males were responsible since the data did not account for same-sex relationships. Second, the study relied on a single database from the NW, which may limit the generalisability of the findings, as other databases or sources of information may provide different insights into the trends and dynamics of deadly IPV incidents. Hence, due to this limitation, the Nigerian state needs to step into the gap by directly collecting data on lethal IPV incidents to aid comparability. Finally, this study did not provide detailed information on the socioeconomic and cultural factors that may have influenced the trends and dynamics of deadly IPV incidents in Nigeria. Therefore, future studies could be designed to collect socioeconomic data to aid robust statistical analysis to establish associations between various variables. However, the potential limitations of this study notwithstanding, this study provides an understanding of lethal IPV across the country and provides authorities with the insight and impetus to enact and execute effective policies and interventions that could prevent and respond to IPV-related fatalities in the future.

CONCLUSION

In conclusion, this paper has provided an overview of IPV in Nigeria by examining its lethality and trends, exploring its gender contexts, and identifying its sources before, during and after the pandemic lockdown. It also investigated the impacts of COVID-19 lockdown measures on deadly IPV. Drawing on secondary data from the NW database, the paper highlighted the increase in IPV-related fatalities, particularly among women, not just during the COVID-19 lockdown but before and after it. Hence, the lockdown measures may have significantly impacted non-lethal IPV incidents in Nigeria, but had little or no influence on IPV fatalities especially as such were already increasing before the pandemic and grew worse a year after the lockdown. However, the COVID-19 pandemic highlights the need for sustained action towards the effective management of both non-lethal and lethal IPV in Nigeria and beyond, particularly in the context of crises and emergencies. It is necessary to acknowledge that IPV is complex and multifaceted and requires a coordinated and multisectoral response from the government, civil society, healthcare providers, law enforcement and the broader community. Therefore, enhancing access to support services for IPV victims is

crucial. This could be accomplished by teaching medical staff, law enforcement personnel and social workers how to recognise and address IPV. Additionally, raising awareness about the signs of IPV, its impact on individuals and communities and available resources for support through community-based education programmes and social media campaigns can help prevent and address IPV before it turns fatal. Overall, this paper underscores the importance of research, policy and practice to prevent and respond to deadly IPV during future pandemics, with a particular focus on protecting the rights and well-being of survivors and promoting gender equality and social justice.

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