POLICY PAPER

CPED Policy Paper Series No.2, 2023

The Impact of Covid-19 on Women's Unpaid Care and Health in Nigeria: A Synthesis of the Literature

This work was carried out with the aid of a grant from the Women RISE initiative, jointly supported by the Canadian Institutes of Health Research (CIHR), the Social Sciences and Humanities Research Council (SSHRC) and the International Development Research Centre, Ottawa,

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The Impact of Covid-19 on Women's Unpaid Care and Health in Nigeria: A Synthesis of the Literature

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Published by

Centre for Population and Environmental Development (CPED)
54 Akenzua Street, Off Airport Road
P.O. Box 10085, Ugbowo Post Office
Benin City, Nigeria.

First Published in 2023

PREFACE

This Policy Paper which is peer-reviewed is part of the outputs of the on-going research of the Centre for Population and Environmental Development (CPED) on the research project titled "Gender Inequality and Rural Women's Health in Post-covid-19 Nigeria: Working with Policymakers and actors to promote inclusive and sustainable rural women's health in Nigeria" funded by the International Development and Research Centre (IDRC) under its Women Rise Initiative Programme.

This Policy Paper synthesizes the literature on the gendered effects of the Covid-19 pandemic on Nigerian women's rights and wellbeing by focusing on studies of the impact of the mandatory lockdowns and movement restrictions women's unpaid care burdens and their access and use of health care for the benefit of policymakers in Nigeria.

The project team, CPED and the University of Windsor are particularly grateful to IDRC and its partners for the funding of the Women Rise Initiative Programme to which CPED and the University of Windsor are beneficiaries. This has enabled CPED to carry out the study and the publication of this policy paper. We appreciate and acknowledge the contributions of other Team Members to the execution of the project.

INTRODUCTION

While both women and men in Nigeria have had their livelihoods disrupted by Covid-19, longstanding gender inequalities indicates that women were more negatively affected in terms of their quality of life and long-term economic prospects. Women were also forced to balance the bulk of unpaid care work with the daily demands of earning money for the household. Women in different parts of Nigeria had to pick up most of the added domestic and childcare responsibilities that the pandemic has generated. This added workload limited women's ability to pursue economic goals outside of the home. Similarly, the accessibility and use of health care services by women were significantly affected by Covid-19. This paper synthesizes the literature on the gendered effects of the Covid-19 pandemic on Nigerian women's rights and wellbeing by focusing on studies of the impact of the mandatory lockdowns and movement restrictions women's unpaid care burdens and their access and use of health care. The literature shows Covid-19 intensified pre-existing gender inequalities between women and men in different parts of the country. The synthesis of the various studies conducted in the country shows that intensification of gender inequities, gender-based violence, sexual abuse, scanty access to reproductive health services and social justice, and barriers to participation in education, and employment were major outcomes of the impact of Covid-19 in Nigeria. This issue-based synthesis of the literature is largely for the benefit of policymakers in Nigeria.

Nigeria's Response to Covid-19

The Covid-19 pandemic had devastating effects in many countries across the globe, affecting every aspect of humanity. Most countries in sub-Saharan Africa including Nigeria met the crises in a weak position. Aside from the heath/mortality effects of the pandemic in Nigeria, the seemingly clearer effect is the impact of the social distancing and lockdown measures on the economy. How people make a living and access markets was impacted by covid-19 across Nigeria. These disruptions were driven primarily by restrictions put in place to curb the spread of the virus.

The Nigerian Centre for Disease Control (NCDC) is the government agency in charge of Covid-19 preparedness and response activities (Nigeria Centre for Disease Control, 2020). A Corona virus Preparedness Group was established at the end of January 2020 by the Nigerian government following the development of the epidemic in China. National NGOs, civil society organisations, international NGOs and UN agencies are also engaged in responding to the

pandemic and the effects of Covid-19 containment measures. Since mid-March 2020, Federal and State Governments in Nigeria have put in place several measures to prevent, mitigate, and respond to the spread of Covid-19 across the country. These include lockdowns, movement restrictions, social and physical distancing measures, as well as public health measures. The distribution of cases is uneven and has resulted in a diversified response from the Federal Government. The degree of implementation and level of compliance from the population varies from state to state; this is related to their perception of the government and trust in government directives, and different levels of education and sensitisation to the measures (Nigeria Centre for Disease Control, 2020) (Fig.1.1).

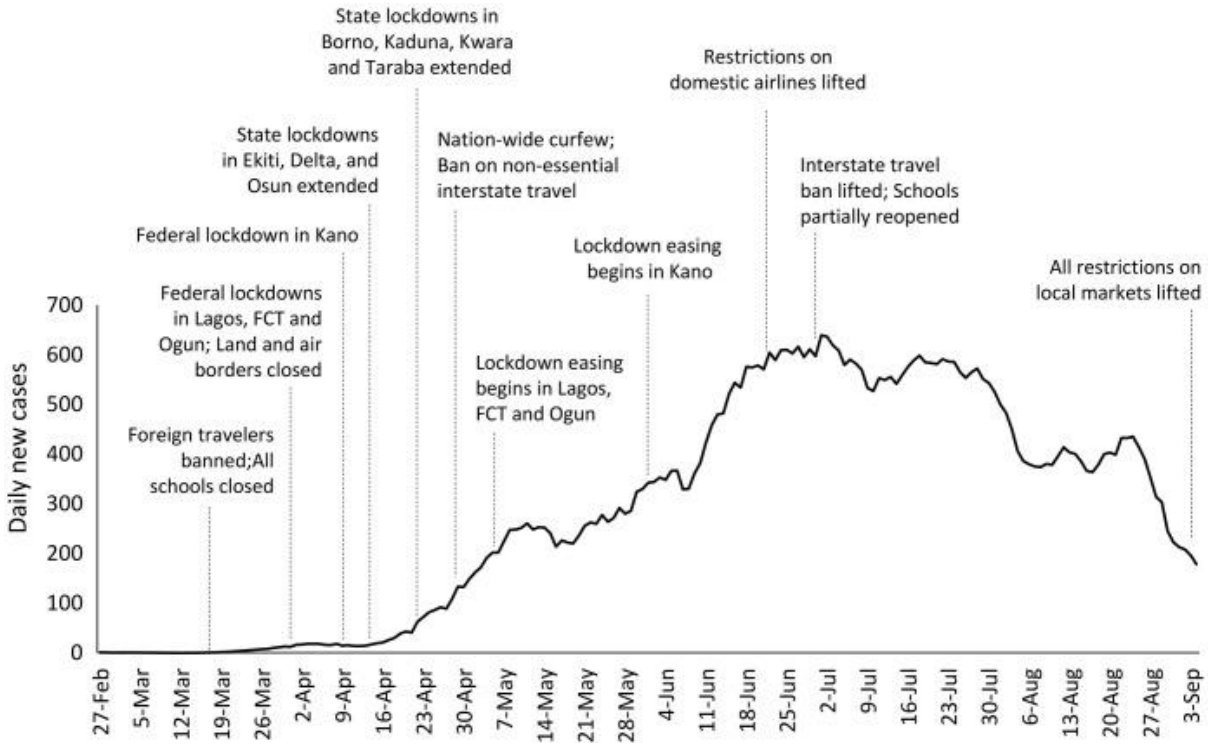

Fig. 1.1: Patterns of Government Response to covid-19 in Nigeria February to September 2020

Fig. 1.1 shows average daily increases in confirmed Covid-19 infections in Nigeria, and provides a timeline of major policy responses, especially at the federal level of government. The first confirmed case of Covid-19 in Nigeria was detected in a traveller who arrived in Lagos from Europe on February 27, 2020. In response, the government invested in preparedness measures, including a US$27 million increase in funding for the *Nigeria Centre for Disease Control (NCDC)* to strengthen laboratory testing and isolation capacity. The government also

launched public education campaigns emphasizing hand washing, maintaining physical distance from people, and avoiding large gatherings.

The government's response was coordinated by a Presidential Task Force, established in early March that worked closely with the NCDC (Ameh, 2020). The NCDC was made responsible for public health campaigns and for overall management of the testing, isolation, and treatment of patients. Nigeria's government was quick to recognize the potential scale of Covid-19's economic costs and was among the first developing countries to announce fiscal and stimulus measures to cushion economic impacts (Onyekwena, 2020). These measures included reducing government spending in anticipation of lower revenues and providing US$130 million to support households and small and medium-scale enterprises. More importantly, Nigeria's government was among the first on the subcontinent to enforce social distancing. All schools in the country were closed in mid-March, and several states and local authorities instituted bans on public and social gatherings. After a second case was confirmed in Lagos, Nigeria instituted bans on foreign travellers from 13 “highly infected” countries and stopped issuing visas on arrival (Ogundele, 2020). By late-March, with 44 confirmed cases, the government closed its land and air borders to all travellers for an initial period of 4 weeks and suspended all passenger rail services.

On 29 March, President Buhari announced specific restrictions for Lagos, FCT, and Ogun States, which together contain 14% of Nigeria's population. These “lockdown” measures restricted the movement of residents outside of their homes. They also closed many business operations, as well as the borders linking the lockdown states to the rest of the country. Passenger air travel was also suspended nationwide. Shortly afterwards the Presidential Taskforce issued exemptions for medical services, agricultural activities, food manufacturers and retailers, telecommunications, and certain financial services. The President also announced some palliative measures, mainly food distribution and a 2-month advance payment of the conditional cash transfers made by the government to vulnerable citizens. On 13 April, President Buhari announced a 2-week extension of the federal lockdown policies, which were also expanded to include Kano state (Federal Ministry of Budget and National Planning, 2020). Although it was the federal government that directed lockdown measures in four states, numerous other states implemented their own lockdown policies, sometimes predating the federal policies. States with significant social distancing measures included Akwa Ibom, Borno, Edo, Ekiti, Kwara, Taraba, Niger, Ogun, Ondo, Oyo, and Rivers. These lockdowns generally started with school closings, limited trading hours in informal markets, and restrictions on large social gatherings, including religious and sporting events. Restrictions were gradually

expanded until they largely resembled the federal lockdowns (e.g., stay-at-home orders and the closing of businesses and state borders).

By the end of April, the group of states under lockdown measures accounted for almost two-thirds of the national economy. Under growing pressure to relax restrictions, the President announced that lockdowns would be eased in Lagos, FCT and Ogun states starting from around mid-May, but that the lockdown in Kano was be extended until early June. As part of the movement restrictions, on 18 March, Nigerian authorities issued a travel ban and suspended visa on arrival for all travellers coming from countries that registered over 1,000 cases domestically. On 6 May the travel ban was extended to 7 June. All commercial flights to/from Nigeria were suspended, and only essential and emergency flights were allowed to fly to and from Lagos and Abuja international airports. These include humanitarian aid, medical, and relief flights. The federal government had also ordered compulsory health screenings at airports and border crossings, 14 days' self-quarantine upon arrival for people travelling but showing no symptoms, and isolation measures for travellers showing covid-19 symptoms. However, health screenings were not implemented due to lack of capacity and resources. On 30 March, Lagos and Abuja were placed under lockdown as the cities recording the highest number of cases. Ogun state was also placed under lockdown for being very close to Lagos: many people in Ogun commute to Lagos for work. Lockdown measures were soon extended and implemented at state-level in Lagos, Delta, Yobe, Jigawa, Bauchi and Kano states, and in the FCT. The lockdowns included closure of all offices and businesses, except for shops selling food and medicines, and hospitals. On 23 April, as the number of cases started to increase, the Government of Nigeria also banned inter-state travel, except for trade of essential goods. International trade has been significantly limited due to land, sea, and airport closures; however, food and medicines are still permitted to enter the country and travel across states.

On 28 April, President Muhammadu Buhari announced the gradual ease of lockdown measures following the negative impact of these on the country's economy and people's living conditions (Federal Government of Nigeria, 2020). A nationwide curfew between 8 pm and 6 am was announced as the lockdown was eased. Businesses are gradually re-opening, mostly in Lagos. Schools and places of worship remain closed across the country to prevent social gathering and allow physical distancing. Bars, restaurants, and cinemas remain closed. Wearing face masks was compulsory when in public places, shops, and on transportation. International and national passenger flights and inter-state travel remained banned. The government also announced socioeconomic programmes to ease the impact of Covid-19 containment measures

(Nnabuife, 2020). These included a moratorium for loans received by businesses within the framework of the Government Enterprise and Empowerment Programme and cash transfers of NGN 20,000 to some 2.6 million poor households for a period of four months. Food distribution has also been scaled up by the government in response to Covid-19 containment measures. During June, and despite continued increases in daily cases, the government lifted restrictions on domestic airlines and interstate travel and allowed schools to reopen for graduating students. The number of new cases peaked at the end of June and fell during July and August. On 3 September, the government lifted all remaining restrictions on local markets. Nigeria, like most other developing countries, found herself in perilous times faced with a twin-threat; the health crisis emanating from the Covid-19, and an economic crisis with an already rapidly contracting fiscal space amidst a global recession.

The effects of Covid-19 on unpaid care and domestic duties

The importance of unpaid care work has been recognised by researchers and development experts over the years. It is well known that unpaid care work not only contributes to maintaining the household but also as a critical component of social development. It is emphasised that unpaid care work offers stability at home which provides a base of security that enables other forms of economic advancement. It is not only crucial for children's development, but it also enables male family members to engage in productive labour in the mainstream economy. Unpaid labour is an essential but often unrecognized dimension of human well-being that provides essential domestic services within the household, for other households and community members. Unpaid care work also offers a social security net as women and girls perform the work (whether willing or not) to care for elderly family members in the absence of a strong healthcare or pension system.

The burden of unpaid care work falls disproportionately on women and girls while boys and men have more time to explore economic opportunities, self-development, recreation and leisure. The disproportionate burden of unpaid care on women and girls usually means that they have to give up opportunities such as starting a business or going to school to meet household obligations. This restricts the equal participation of women within the economy which means a reduction within the labour force and a loss of potential revenues and productivity which negatively impacts economic growth. Often unpaid care work and domestic duties are unaccounted for in the Gross Domestic Product estimates because it falls outside the production boundary (both formal and informal sector) of an economy.

An analysis report by ActionAid Nigeria (2011) defined unpaid care work as home-based tasks like “cooking, cleaning, collecting water and firewood, and caring for the ill, elderly and children. Some of the factors responsible for the high level of unpaid labour amongst women in Nigeria include; high level of illiteracy amongst women compared to men, high unemployment rate amongst females compared to men, the low status of women is embellished by cultural norms, poor health of the people especially women and deteriorating environmental conditions especially as it affects women, and high degree of poverty, accompanied by high levels of fertility, morbidity and mortality rate. Further extant literature on unpaid care work in Nigeria has shown that women and girls perform the majority of unpaid care work. A study conducted by the Core Welfare Indicators Questionnaire (CWIQ) shows that women spend most of their time doing unpaid care work: one in every two men spends time doing pursuits that earn them an income, one in every two women spends time doing unpaid work (Angel-Urdinola and Wodon, 2010). The report of the British Council Nigeria (2012) relates this phenomenon to persisting patriarchal ideologies in which men are seen as breadwinners, and women as homemakers. The implication is that women become primarily responsible for childcare, maintaining homes, washing, cooking, fetching firewood and water for drinking, as well as unpaid work such as helping with planting and harvesting firewood, food crops and cash crops.

The report further explains that due to unpaid care work responsibilities, women are also more likely to occupy low-level posts that offer them the flexibility they need to manage their households while working. The Nigeria National Bureau of Statistics (NBS: 2005) revealed that women devoted more of their time to unpaid activity in this order: childcare (17.2 %), cooking (10.1%), care of the elderly (9.8%) and recreation (8.3%) in the country. Notwithstanding this heavy responsibility bestow on women, the modern capitalist market system looks down on these types of work because they do not produce a market income. Therefore, it may be argued that this pejorative stance makes women very poor despite their longer hours on domestic work. These unpaid works is also often undercounted and undervalued because it is carried out simultaneously with paid and productive work, or when the career is also studying, eating, resting or socialising.

In a recent study in the rural areas of Bauchi and Gombe States of Nigeria, the overall workload of women and men was examined. It was found that in Bauchi State while just about 13 percent of the male respondents reported that they had sleep for less than 5 hours the previous night a higher proportion about 24 percent of the female respondents indicated that they were able

to sleep for less than 5 hours. Furthermore, about 10 percent of the male respondents in Gombe reported that they slept for over 15 hours the previous night the proportion of female respondents who had over 15 hours of sleep been just about 1 percent (Onokerhoraye, et al, 2023). There is no doubt that males in both Bauchi and Gombe States had more hours of sleep in the previous night than females. This basically reflects the pattern of the time for sleeping available to women and men in the study areas to the disadvantage of the females. The survey tried to confirm whether the reported sleeping hours by the male and female respondents was normal or was it that the previous night was an exception. The vast majority of both male and female respondents in Bauchi and Gombe States confirm that the sleeping hours which they reported over the previous night is the average or what can be described as the normal situation. In effect, females being under considerable stress working in unpaid household care combined with their normal economic activities are having less time to sleep or rest, an indicator of gender inequality in the study areas.

With specific reference to role of women and men in unpaid care and household work, it was found, as expected, that women in the rural areas of Bauchi and Gombe play dominant roles in unpaid care and household work compared with men. It was found that in Bauchi State 58.5 percent of the male respondents reported that they spent less than 3 hours in unpaid care and household works compared to 22.3% of women. This shows that some men in the rural communities of Bauchi are participating in household work even though at a low scale since they devote less hours to these activities compared with the female respondents that devote a higher number of hours to household work. Even though the findings show that male respondents do participate in unpaid household work on a limited scale most of the female respondents are involved in unpaid household work for longer hours which negatively affect their participation in other productive economic activities. These findings suggest that even in the primary production sector where most women in the rural areas work, they devote less time to their work in the sector because they are engaged in other activities largely unpaid household and care activities which tend to reduce the amount of time, they can devote to primary production activities. Rural women of all ages spend much of their day engaged in domestic chores, including collecting water and firewood, processing and preparing food, travelling and transporting, and caregiving. These tasks are unpaid and restrict a woman’s time and mobility. These domestic chores are a major constraint to the ability of smallholder farmers to increase agricultural productivity and achieve food and nutrition security (Onokerhoraye, et al, 2023).

There is no doubt that unpaid care and household work reinforces gender inequality through its impacts on girls' education, women's economic empowerment and women's political participation in Nigeria. In many cultures in Nigeria, children are socialized to believe that the man is the breadwinner, while caring is for women and girls. Women are seen as the nurturers, mothers and homemakers. These socially ascribed roles for providing care undermine women's rights and limit their opportunities, capabilities and choices. There are opportunity costs for girls' education that arise from the heavy burden of household chores too. Many girls drop out of school to assist with domestic activities, income generation activities and/ or care for siblings or the sick. Even where girls attend school, care workloads reduce time available for studying as well as time for play. The burden of providing care is usually greater in families with many dependents, such as young children, elderly members and the sick. Exhaustion and stress can result from the burden of providing everyday care because huge amounts of time and energy are involved in care activities. Impacts can be physical such as headaches, backaches, physical and exhaustion. The economic growth and development of any society is impossible without the support and contribution that comes from domestic labour. Reaching conclusions about a country's economic status without including the productivity of these women who do not get paid for their work is misleading and doesn't truly reflect the economic well-being of a society.

Finally, it needs to be emphasised that despite the recognition of care and household work as essential for human survival and personal well-being, excessive caring duties have been identified as a barrier to various human rights of girls and women, including the rights to freedom of speech, association and leisure, and the rights to formal productive work. Heavy care workloads can decrease health and well-being, while certain activities – for example, fetching fuel or water – can expose girls and women to the risk of assault. It has been argued that heavy and unequal care responsibilities are a major barrier to gender equality and to women's equal enjoyment of human rights, and, in many cases, condemn women to poverty. Therefore, the failure of countries such as Nigeria to adequately provide, fund, support and regulate care contradicts their human rights obligations, by creating and exacerbating inequalities and threatening women's rights enjoyment. The provision of care services can reduce the time constraints faced by women who perform the bulk of unpaid care and domestic work on a day-to-day basis. As such, they play a pivotal role in promoting substantive equality for women. The availability of care services can help redress women's socio-economic disadvantage by enhancing their ability to engage in paid work. Care services also contribute

to the transformation of gender stereotypes by allowing women to move out of the home and into the public domain. In doing so, they can enable women's enjoyment of a range of rights, including the rights to work, education, health and participation.

Covid 19 and Women's Health

Health care in Nigeria is characterised by a variety of poor indicators. The average life expectancy is 55 for women and 52 for men, which is low even amongst sub-Saharan countries. Other indicators include the HIV prevalence rate which is 1.5% of persons between 15-64, a maternal mortality rate of 512 per 100,000 live births, and infant mortality rate of 69 per 1,000 live births while for under-fives it rises to 128 per 1,000 live births. This indicates that for every 1,000 births in Nigeria, approximately five women die during pregnancy or within 2 months after childbirth. Nigeria also has the highest burden of childhood pneumococcal disease in Africa and the second highest in the world. Studies also show a high rate of non-communicable diseases, including mental health challenges. There is limited access support for mental health, and for persons with disability.

To address access to health care, Nigeria is committed to universal health coverage through various policy and legislative measures including the National Health Policy, the National Health Act, the National Health Insurance Scheme Act and states health insurance schemes. However, these policies are yet to be fully implemented to improve the health status of Nigerians. Since the signing of the Abuja declaration in 2001 where all African countries committed to allocating not less than 15% of the national budget to healthcare, Nigeria has consistently fallen below the benchmark. Allocation and expenditure to health and healthcare has averaged about 4% over the last decade. There is no doubt that Nigeria's commitment to ensuring universal health coverage is still far from being achieved. The major landmark achievements over the last two decades including the passage of the National Health Act in 2014 and the invigorated Primary Health Care system have been threatened by poor budgetary allocation and releases. As a result, the Nigerian healthcare system is to a significant degree dependent on donor funding for implementation of priority services such as malaria control, family planning, maternal and new-born child health. Access to health care remains a problem to achieving universal health coverage in Nigeria. Common barriers to accessing health are cultural, financial, physical, geographical and gendered.

Access to healthcare is gendered in several respects. As noted earlier, Nigeria records one of the highest maternal deaths globally with 20% of the total global maternal mortality rate.[1] An estimated 512 maternal deaths take place per 100,000 live births. Contraception uptake in Nigeria is one of the lowest in Africa, with only about 13.4% coverage. Factors related to both supply and demand have been identified as responsible including inadequate availability of contraceptives, limited human resources, limited financial and physical access to high quality services, poor infrastructure, low levels of awareness, cultural and religious restrictions. In addition to the high rate in maternal deaths, another health challenge which women are most vulnerable to compared to men is the HIV/AIDS. It has been reported that women are twice as likely to be living with HIV/AIDS compared to men. Shortage of human resources such as doctors and nurses put the country at risk of being unable to provide much needed Maternal, Neonatal and Child Health (MNCH) services on a sustainable basis. Furthermore, despite evidence that more and more people suffer from mental illnesses with prevalence higher among women than men, there are about 200 psychiatrists available to address mental health care concerns in the Nigerian population which is over 200 million.

In many developing countries including Nigeria, huge gains were already being made towards realising universal health coverage and improving maternal and new-born health outcomes. However, Covid-19 disrupted this progress necessitating new thinking to protect these gains. The Covid-19 pandemic further highlighted gaps within the health sector and the attendant impact on gender in Nigeria. For instance, while sexual and reproductive health has been identified as a priority area for action by the Nigerian government, the Covid-19 pandemic necessitated a prioritization of emergency health care services putting sexual and reproductive services in jeopardy. Maternal healthcare service delivery only worsened with the outbreak of the Covid-19 pandemic as many harboured scepticisms in visiting healthcare centres for fear of contracting the virus. Many people in rural communities in Nigeria did not have access to running water and soap to wash hands as required by Covid-19 protocol. This is due to the inadequate water infrastructure in rural communities and further, the fact that during the first few weeks of the pandemic available hygiene supplies were bought making it difficult for some households to have access to these basic hygiene materials. In a survey carried out during the period in Nigeria’s Niger Delta region it was found that while 53.50 percent of the respondents indicated that their households always got hygiene materials to buy some 42 percent reported

that these materials were partially or only sometimes available for them to buy (Onokerhoraye, et al, 2021). Essential medicines are those drugs that satisfy the priority healthcare needs of the population. As a result of the surge in the pandemic, which led to the inevitable lockdown of the Nigerian economy, there was a noticeable decrease in production and exportation of raw materials as well as finished products (drugs) across different countries. These greatly affected the ease of access to these medicines for the consumers who need them either for treating acute ailments or for the management of chronic diseases. Nigeria is in its early stages of pharmaceutical development; thus, they rely on importation of drugs, raw materials, and equipment from other countries, notably India and China. Nigeria is highly dependent on other countries for its medicinal needs. The Covid-19 pandemic also caused an increase in the prices of medicines, hand sanitizers, face masks, personal protective equipment, and other medical equipment used for providing health care. Some 47.75 percent of the respondents reported that essential medicine/drugs are not available in clinics and pharmacies within their reach all the time since the Covid-19 pandemic while 34.75 percent indicated that these essential medicines/drugs were partially or sometimes available but usually expensive (Onokerhoraye, et al, 2021).

In another study which focused on the challenges in access and satisfaction with reproductive, maternal, new-born and child health services in Nigeria during the Covid-19 pandemic, it was found that about 43.51% of respondents had at least one challenge in accessing child and maternal health services since the Covid-19 outbreak (Balogun, *et al*, 2021). Close to a third (31.91%) could not access service because they could not leave their houses during the lockdown and 18.13 percent could not access service because there was no transportation. Balogun, et al (2021), reported that between 76 and 97 percent of the primary health centres offered essential reproductive, maternal, child, and adolescent health services before the lockdown. Except in antenatal, delivery and adolescent care, there was a decline of between 2 and 6 percent in all the services during the lockdown and up to 10 percent decline after the lockdown with variation across and within States. During the lockdown. Full-service delivery was reported by 75.2 percent whereas 24.8 percent delivered partial services. There was a significant reduction in clients' utilization of the services during the lockdown, and the difference between States before the pandemic, during, and after the lockdown. Reported difficulties during the lockdown included stock-out of drugs (25.7%), stock-out of contraceptives (25.1%), harassment by the law enforcement agents (76.9%), and transportation difficulties (55.8%). Only 2 percent of the primary health centres reported the availability of gowns, 18 percent had

gloves, 90.1 percent had hand sanitizers, and a temperature checker was available in 94.1 percent. Slightly above 10 percent identified clients with symptoms of Covid-19.

Yet another study by Allen (2021) pointed out that the response to the pandemic by authorities in Nigeria had direct and indirect impact and varied between urban and rural dwellers in the context of pre-existing patriarchal norms and severe health care deficiencies, especially for women and girls. He noted that the impact varied across states and regions and addressing needs such as family planning, safe delivery, antenatal care, prenatal care and treatment of victims of rape was difficult. It was observed that lockdowns were very significant for women and girls. Cases of rape and unwanted pregnancies were reported and suggested to have increased. While access to sexual health services and decisions about the use of contraceptives became more difficult for women and girls in the southern part of the country, it was much worse for those in northern rural communities who, in addition, faced debilitating violent conflict from the activities of bandits and terrorists (Allen, 2021). Furthermore, Olamide *et al* (2021) in their study in Southwest Nigeria, reported that a significant difference between the uptake of health care prior and during the Covid-19 pandemic as 65.7 of the respondents reported that the hospital recorded a low turn-out of patients during the pandemic and 47.8 percent indicated that some of the facility units/departments were temporarily closed due to Covid-19 pandemic. Factors influencing uptake of health services during the Covid-19 pandemic are fear of nosocomial infection, fear of stigmatization, and misconception on Covid-19 diseases and care. With respect to accessibility and utilization of family planning services in Nigeria during the Covid-19 pandemic in Nigeria, Esievoadje, *et al*, (2022) reported that there were both supply- and demand-side service disruptions. There was a disruption in the supply chain management system, affecting the production and distribution of family planning commodities. The demand-side issues were because of the lockdown measures on health seeking behaviour, absence, and increased cost of transportation.

Furthermore, Ipas Nigeria (2021) pointed out that Covid-19 lockdowns exacerbated the pandemic's impact on women's access to safe abortion services. It was reported by Ipas Nigeria that an estimated 20,625 women were denied safe abortion services in the study sites with lockdowns, and an estimated 16,804 women were denied services in the comparison sites without lockdowns; a higher proportion of women anticipated to have abortions were denied safe services in sites with lockdowns (64%) than in comparison sites without lockdowns (49%); very few health-care facilities, pharmacies and drug stores were allowed to operate

during the lockdown. This meant fewer available health-care professionals who had to prioritize care for Covid-19 patients, thus reducing access to care for everyone else. of the thousands of women denied access to safe abortions during lockdown, many women may have resorted to clandestine, unsafe abortions that caused injury and at times death. The number of unsafe abortions caused by this denial of services is unknown, but it perceived that unsafe abortion has increased in Nigeria during the Covid-19 pandemic.

Finally, in a study on gender differences in work attendance among health care workers in Northern Nigeria during the Covid-19 pandemic, Taiwo *et al* (2022) reported that the Covid-19 pandemic resulted in the overwork of health care workers and greater household burdens for women. They pointed out that the Covid-19 pandemic in Northern Nigeria made female health care workers contend with the dual burdens of formal and informal care work. This contributed to lower attendance among female health workers and overwork for their male counterparts. It was concluded that given the heavy reliance on women health workers to sustain frontline health care generally and in situations of crisis like the Covid-19 pandemic, the health system in Nigeria was negatively affected by the low attendance of women during the pandemic period.

Conclusion

This synthesis of the literature on the impact of Covid-19 on women in Nigeria indicates that the pandemic had its effects on the delivery of unpaid care and domestic work in the various households in the country due to the fact that the knockdown policy of governments during the peak of the pandemic led to a considerable increase in unpaid care and domestic work. Most household members, both old and the young that needed care were forced to be at home all the time. Informal care support that is often provided by grandparents and grandmothers in particular has become more limited, as older persons are more susceptible to Covid-19 and have to keep physical distance from their family members. Furthermore, the Covid-19 crisis posed a shock to social norms around the distribution of unpaid care and household work. During the period of the Covid-19 pandemic there was a dramatic change in the time which women devoted to unpaid care and domestic work which again was due to the knockdown policy which restricted the movement of people.

Similarly, women face limited mobility to reach health facilities or vaccination sites, restricted decision-making power in their health seeking as well as limited access to and control over resources needed for advancing their health, including information about vaccines and vaccine

safety. Women and gender-diverse groups were also at risk of experiencing sexual harassment and other forms of gender-based violence when seeking health services, including vaccination. Women did not benefit from health care during the pandemic compared to men, and women with health and economic challenges prior to the pandemic experienced worsening health conditions as a result of skipping health care services during the pandemic. These gaps in care translated into higher numbers of women experiencing severe health issues after the health emergency from the pandemic resolves.

Despite the clear gendered implications of the pandemic crises as reflected in the literature synthesis, response and recovery efforts tend to ignore the needs of women and girls especially in the rural communities. Policymakers in Nigeria need to make sure that recovery efforts must focus on women. However, systematic data collection by national and state statistical bodies relating to how the pandemic impacted various groups is non-existent in Nigeria which raises the concern that Covid-19 policy response will ignore the priorities of the most vulnerable women and girls.

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