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Promoting post-Covid-19 inclusive and sustainable rural women's health in Nigeria

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PROJECT PROFILE

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PREFACE

This Policy Brief 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 Brief focuses on the need for policymakers in Nigeria to recognise the importance of unpaid care and domestic work in the country based on the findings of the on-going project on 'Gender Inequality and Rural Women's Health in post-Covid-19 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 and the University of Windsor to carry out the study and the publication of this policy brief. We appreciate and acknowledge the contributions of other Team Members to the execution of the project.

Introduction

The Covid-19 pandemic had major impacts on the health care of women in Nigeria particularly in the rural areas. Covid-19 disrupted antenatal, skilled birth, and postnatal family planning services which were normally inadequate in rural communities. Women and girls were vulnerable to the impact of Covid-19 on several fronts and represent a group whose needs including antenatal, skilled birth, and postnatal family planning services were disrupted, leading to unmet needs for contraception and an increase in unintended pregnancies. Restricted travel due to the fear and anxiety associated with contracting Covid-19 resulted in delays in accessing prompt skilled care and essential healthcare services such as pregnancy care, immunisation, and nutritional supplementation. Misconceptions relating to Covid-19 prompted concerns and created distrust in the safety of the healthcare system. Innovative measures are required to address these obstacles and ensure that rural women are not denied access to available, accessible, acceptable, and quality maternal healthcare services in the post-covid-19 period. Some key strategies worth instituting include encouraging healthcare providers to adopt innovative and technological approaches to administer all services that can be offered remotely, promote the standard of care improvements and contribute to the co-design of public health messaging to dispel fears in rural communities. It is against this background that this policy brief reviews the impact of Covid-19 on rural women in Delta and Edo States and the implications for policies on promoting post-Covid-19 inclusive and sustainable rural women's health in Nigeria.

Perspectives the impact of the Covid-19 pandemic on rural women's health in Delta and Edo States

Gender norms underpin many different aspects of health-seeking behaviours and health services delivery in the rural communities of Delta and Edo States. However, not only are they difficult to measure, but due to their pervasive nature, it is often difficult to establish direct causal relationships between norms and health systems factors and as a result, likely reflect indirect impact on health outcomes. Women's health care is not determined solely by the provision of health-care treatments, but also by whether women have free and safe access to such services. In contexts where men hold the majority or all decision-making power in the household, this can limit women's access to health and reproductive health care services, particularly if they have restricted freedom of movement or if they have no control over household finances. In the rural communities of Delta and Edo States, gender intersects with other social determinants of health and other grounds of discrimination, such as education, income, and place of residence, and it influences exposure to health risks, health-seeking behaviours and the ability to access health services. Unequal power relations in the household may affect a woman's access to health care and gender stereotypes and unequal power relations may hamper women negotiating contraceptive use. Maternal mortality has long been considered a human rights issue rooted in discriminatory practices that prevent women seeking, accessing and receiving appropriate care. Health policy and

practice addressing maternal mortality will need to build on, reinforce and include strategies for eliminating discrimination against women and enabling women's empowerment. Public health emergencies as reflected in covid-19 increase the burden on health systems, making barriers to accessing quality health services greater for people of all genders. These barriers are often acutely felt by those who are most marginalized and those who are already at increased risk, as well as those in caregiving roles who take on the additional care work that health systems cannot support.

Women's access and use of maternal health care facilities

Nigeria is the second largest contributor to maternal mortality worldwide and has a birth rate of five children per woman. The country's estimated 58,000 maternal deaths per year accounts for 19% of the global total pregnancy-related deaths. Furthermore, maternal deaths are twice as likely among women in rural areas, compared to women in urban areas. Men largely determine women's access to modern health facilities and the availability of resources for maternal health related expenditure. Universal access to sexual and reproductive health-care services is essential for women's and girls' health and well-being, and for gender equality. It increases their decision-making power about their own sexual and reproductive health. Sexual and reproductive health is equally important for men, and improving the access of boys and men to sexual and reproductive health services supports more gender equal sharing of responsibilities for healthy sexuality, which is important for healthy relationships. Gender norms and power dynamics can shape behaviours in ways that directly impact the sexual and reproductive health and rights of women, men, and families. Key behaviours shaped by gendered norms and attitudes include (but are not limited to) sexual debut, condom use, family planning, forced or unwanted sex, number of sexual partners, and transactional sex. Maternal healthcare services utilisation is therefore important for early detection of mothers who are at high risk of illness and mortality during pregnancy. Women have a basic right to be protected when they undertake the risky enterprises of pregnancy and childbirth. Contraception's demand side has also been affected by Covid-19. Due to lockdown requirements some women in rural communities were unable to visit health care providers to access contraceptives, including emergency contraception, or, importantly, because they wish to avoid exposure to infection in crowded clinics, whether this is a real concern or a perceived concern. Furthermore, the costs of these services became high for those who are facing economic insecurity as a result of changes to work because of lockdown. This is compounded by the risk of sexual and gender-based violence associated with quarantine, and the barriers to self-determination that some women face during isolation with abusers. Key challenges affecting reproductive health issues in the rural communities of Delta and Edo State include but not limited to lack of capacity of health facilities to provide comprehensive reproductive health care services,

inequalities in the distribution of essential drugs and equipment among the health facilities, communication and transport infrastructure is inadequately developed and the deployment of health personnel which often favour urban areas where the secondary and tertiary levels of care are concentrated.

Findings show that the vast majority (over 91 percent) of the household members who had live births in Delta and Edo States received pre-natal care during pregnancy. The vast proportion (84 percent in Delta State and 67.5 percent in Edo State) of pre-natal health care visits relates to periodic checks during pregnancy. This is confirmed by the finding that over 80 percent of the household members that had live births in Delta and Edo States visited health centres for between 3 and four times. The findings show that pregnant women do not generally depend on other sources of care such as traditional care or self-care at home compared with the situation in the last two decades. Traditional gendered views about sex and reproduction in the study areas of Delta and Edo States contribute to poor sexual and reproductive health by impeding communication and creating unstated expectations and pressures.

Covid-19 and women's health care

School closures during the period of Covid-19 led to increased sexual activity amongst teenagers. With enhanced barriers for accessing contraception, this resulted in an increase in adolescent pregnancy and, eventually, school drop-out rates that disproportionately affected adolescent girls.

Almost all respondents in the two states agreed to the fact that women and girls were more negatively affected by Covid-19 Pandemic in terms of access to health care. This was attributed to increased workload for the women such as spending more hours in doing care and domestic work. For those with younger children, the care and supervision work increased during this period. This resulted to much stress for the women who may have to cook, clean the house, sweep the compound and other unpaid work which are normally done by women and girls in the study areas due to some cultural gender stereotypes. In many rural communities in Delta and Edo States, 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 were at risk of experiencing sexual harassment and other forms of gender-based violence when seeking health services, including vaccination. Women in the rural communities of Delta and Edo States 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. However, it was reported by the respondents that basic hygiene items to households in the survey areas during the period were available to many households

most of the time. The limited impact of the Covid-19 pandemic on the availability of key hygiene items in the rural communities of Delta and Edo States is largely as a result of the fact that the knockdown period was short, generally about four to six weeks.

The findings further show that most male and female respondents in Delta and Edo States reported that they have fallen ill during the period of the Covid-19 pandemic and after. In Delta State 68.9 percent of the males and 72 percent of the female respondents reported that they fell sick during the period of the pandemic and after. In Edo State 64.6 percent of the male and 54.3 percent of the female respondents reported that they fell sick during the period of the pandemic and after. As the Covid-19 pandemic reached the rural areas of Delta and Edo States, it caused concern, fear and stress, all of which are natural and normal reactions to the changing and uncertain situation that everyone found themselves in. The survey findings show that about half of the male and female respondents in Delta and Edo States reported that Covid-19 affected their emotional health because of the anxiety they went through as they were not sure of the future for them and their children.

Despite the prevalence of health challenges during the period of Covid-19 in the rural areas of Delta and Edo States, access to health care in terms of health insurance coverage is very poor. Contraception's demand side was also affected. Due to lockdown requirements some women were unable to visit health care providers to access contraceptives, including emergency contraception, or, importantly, because they wish to avoid exposure to infection in crowded clinics, whether this is a real concern or a perceived concern. Furthermore, the costs of these services became prohibitive for those who are facing economic insecurity during the period. The findings show that in Delta State 92.1 percent of the male respondents and 94.1 percent of the female respondents reported that they had no health insurance coverage. In Edo State, the proportions are largely similar with 93 percent of the male respondents and 97.2 percent of the female respondents reporting that they had no health insurance coverage of any type.

With respect to maternal and family planning services, about half of the respondents reported that they had problems accessing maternal health care and family planning in which the vast majority of them indicated that it was due to financial constraints. Some reported that some of the pregnant women could not access or go for ante- natal due to restrictions of movement and transportation problems. Some of them gave birth at home during the Covid-19 pandemic period. Other respondents reported that they could not access family planning services because most hospitals were not attending to patients. Also, some of the health staff were afraid to attend to patients during that time. Covid-19 decreased women's access to essential sexual and reproductive health services because some of the women who were to go to health centres for immunization were scared to visit them because they had the notion that they were going to be given Covid-19 vaccine. Finally, in

addition to the caregiving burden, social norms in some contexts dictate that women and girls are the last to receive medical attention when they become ill, which could hinder their ability to receive timely care for Covid-19.

Water, Sanitation, Hygiene and women's health

The quality and extent of water, sanitation, and hygiene (WASH) services—such as providing clean drinking water or hygiene supplies or conducting solid waste management varies greatly in the rural communities of Delta and Edo States. WASH infrastructure, which are limited in these rural settings was insufficient to meet increased demand during the Covid-19 pandemic period. WASH staff were reallocated to respond to the health emergency, reducing populations' access to safe water for cleaning or drinking at a time when good hygiene and sanitation practices were most critical. In such situations, women and girls found that their access to hygiene and sanitary materials was reduced due to decreased household income or increased household competition for scarce hygiene resources, impeding their ability to conduct household-level disease prevention efforts or to attend to their own hygienic needs. Finally, as the prevalence of GBV increased during the Covid-19 period and resources become scarcer, women and girls became more vulnerable when travelling to collect water for household use. Consequently, Women and girls have to satisfy additional requirements for privacy when using WASH facilities, because of patriarchal norms of female modesty and cultural or religious taboos around menstruation. Furthermore, the gendered division of labour determines women's role as primary water purveyors and their responsibility for all water-related tasks, limiting their access to education, income-generation or leisure time. Where water is paid for, pricing can disproportionately affect women and girls by increasing their domestic workload because it becomes increasingly hard to find water from different and cheaper sources. Finally, decision making within families and communities is usually seen as the role of males, leaving others unable to advocate their WASH needs and priorities. Yet, even when marginalised rural women are formally involved in decision making, their agency can be limited by informal structures of norms and traditions, such as the idea that being talkative in public meetings could ruin a married woman's reputation.

Promoting post-Covid-19 inclusive and sustainable rural women's health

It is important for Nigeria's health systems particularly with respect to women in rural communities to consider the challenges faced with Covid-19 as lessons to be learned in the case of future health crisis, and to develop adequate response strategies and preparedness, both for human and material resources tailored toward rural women's health needs. From the Covid-19 pandemic experiences, it is almost important for Nigeria to establish a resilient health system that is adaptive enough to address

pandemic-related issues by investing in pandemic preparedness. Health professionals should be recruited, trained and more prioritized than ever, establish effective surveillance and response system, particularly at the community level, and provision of adequate medical equipment. Women's health should be prioritized against all odds, especially pregnant women and newborns during the post-pandemic era. In the case of a future lockdown, the women's reproductive health, maternal health, and newborn sectors should focus on planning means of transportation and the availability of maternal and child health services. Against the background of the health challenges facing rural women during and after Covid-19, a number of policy issues derived from the sustainable development goals must be addressed to enhance the health status of women in the rural communities of Delta and Edo States and indeed other parts of Nigeria.

- Maternal mortality has long been considered a human rights issue rooted in discriminatory practices that prevent women seeking, accessing and receiving appropriate care. Health policy and practice addressing maternal mortality in Nigeria in general and Delta and Edo States in particular will need to build on, reinforce and include strategies for eliminating discrimination against women and enabling women's empowerment.
- The elimination of violence in all its forms against women and girls has important implications for women's mental health and well-being (SDG target 3.4), addressing alcohol use disorders (SDG target 3.5) and, in certain contexts, reducing HIV incidence (SDG target 3.3). Policies must be put in place and implemented to contain the prevalence of violence against women in the rural communities of Nigeria where gender norms appear to support such practice.
- Policies and actions on harmful practices, such as child, early and forced marriage and female genital mutilation, is crucial for reducing maternal mortality (SDG target 3.1), reducing neonatal and child mortality (SDG target 3.2) and ensuring girls' and women's access to sexual and reproductive health-care services (SDG target 3.7) are urgently required in post-Covid-19 rural communities of Nigeria.
- Recognizing and valuing women's unpaid care work (SDG target 5.4), in particular chronic care and other long-term care work, is directly linked with achieving universal health coverage (SDG target 3.8). Policies and actions to officially recognise women's unpaid care work are urgently needed in post-covid Nigeria.
- Provision of universal health coverage in Nigeria is crucial for addressing women's and men's biological and gender-based needs and ensuring their access to health care. Women who have been abused (SDG target 5.2) need to have access to comprehensive woman-centred medical care to enable them to regain health and well-being and maintain an adequate standard of

living. Ensuring provision of publicly funded care services (SDG target 3.8) also has an impact on the volume and distribution of unpaid care work (SDG target 5.4).

- Non-communicable diseases (NCDs) have been a leading cause of death among women in Nigeria for decades. This burden is expected to increase substantially in the coming decades, especially in the rural communities of Nigeria. Policies and programmes that prevent and respond to NCDs need to consider the specific needs of women and girls. For instance, physical activity is a pivotal risk factor for NCD deaths, but women and girls are generally less active than men and boys as a result of harmful gender norms that limit both their mobility and equal participation in physical activities like sports. Obesity in women, especially during pregnancy, contributes to the health risks of their children and amplifies health inequities across generations. To overcome the challenge of NCDs in Nigeria, there is need for greater attention and investment in the health issues that generally, though not exclusively, affect women.

- Civil societies should be involved in monitoring the implementation of existing policies and programme on enhancing women's health in post-Covid Nigeria, a good way to keep the government accountable. Since Covid-19 is a disease of Public Health Emergency, there is a need for multiple efforts to mitigate and reduce the adverse impact of the disease on MNCH and reproduction health as a whole. In order to better address public health emergencies both at the national and local levels and to further reach the most vulnerable population, particularly at the grassroots level, the maternal and reproductive health sector should collaborate with civil society organizations in response to outbreaks or future pandemics as it offers diverse new ideas.

Project

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