How has Nigeria responded to the gendered impacts of COVID-19?

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Overview

The COVID-19 pandemic has disproportionately impacted women and vulnerable groups, as well as compounded pre-existing gender inequalities. As a result, measures to mitigate the gendered impacts of COVID-19 must be part of pandemic response and recovery plans. This report analyzes the gender-responsiveness of Nigeria's COVID-19 plan by asking:

1. How has the COVID-19 pandemic impacted women and vulnerable groups in Nigeria?
2. What measures were included in Nigeria's National COVID-19 Pandemic Multi-Sectoral Response Plan (the Plan) to specifically address the gendered impacts of COVID-19?
3. What measures have been taken to address and respond to the gendered impacts of COVID-19 in Nigeria?
4. What else can be done to ensure a gender-responsive pandemic plan in Nigeria?

This report covers both the primary and secondary gendered impacts of COVID-19. Primary impacts refer to immediate, direct impacts, such as COVID-19 infections, vaccinations, deaths, and related illnesses; while secondary impacts refer to longer-term social, economic, and non-COVID-19 health impacts. In each section of the report, we outline the measures taken by the Nigerian government and recommend how to strengthen these interventions by introducing a gender lens.

Summary of findings

Nigeria's COVID-19 response has been governed by the National COVID-19 Pandemic Multi-Sectoral Response Plan and coordinated by the Presidential Task Force/Presidential Steering Committee on COVID-19 and related bodies at the State level. Our analysis of the pandemic response has uncovered many areas where gender analysis could strengthen decision-making and improve health and quality of lives.

In terms of clinical and pharmacological responses to the virus – such as testing, treatment, and vaccination – the government has failed to collect sex- and age-disaggregated data, which undermines critical analysis of trends and potential inequities. Health information and promotion schemes have been mainly generic and not tailored to groups that could be particularly vulnerable to infection, such as women with disabilities and women in conflict-prone areas. As a result, the government has in practice assumed that all people have the same choices or ability to conform with advice such as handwashing and isolating. Yet, history has taught us that women rarely operate on a level playing field with men.

Emerging research from around the world is demonstrating that the COVID-19 pandemic has gendered effects. Through our analysis, we found that Nigerian policies and interventions to address COVID-19 have mostly neglected to take gender into account. The National COVID-19 Pandemic Multi-Sectoral Response Plan does pay some attention to marginalization and poverty; however, it largely overlooks gender. Although in some States, remedial actions outside the scope of the Plan were later put in place to tackle issues such as gender-based violence.

Our analysis demonstrates that federal policy is out of step with the gendered impacts of the pandemic and on the ground realities. For example:

- Women reported difficulties obtaining government palliatives or aid. According to a July 2020 survey of 5,813 women from nine States and the Federal Capital Territory, 75.8% did not receive any assistance, while 15.9% received food items, 3.7% received facemasks and sanitizers, and 1.2% received cash[1].

- The same survey also showed that 60% of women were "fully engaged" in childcare[1]. Men have not stepped up to share the burden of care work and have instead focused on returning to paid work [2].

- In a survey of 105 health care workers (54.3% female) at three COVID-19 isolation and treatment centers in Lagos State from 20 April to 20 June 2020, 16.2% had depression and 15.2% had anxiety[3]. Levels of depression and anxiety were highest among nurses, compared to physicians and other health care workers[3].

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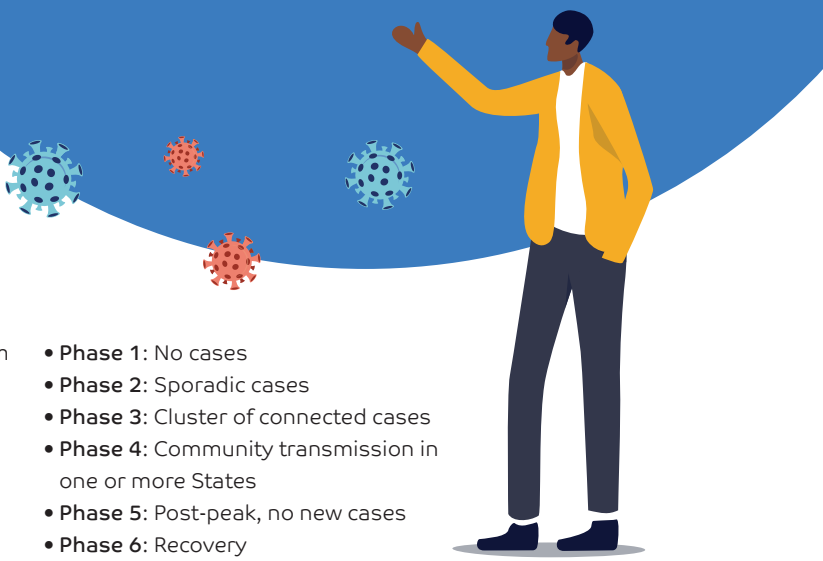

- A survey of 755 respondents in Lagos, Ogun, and Abuja from 25 April to 4 May 2020 found that the mental health toll of the pandemic may be exacerbated by domestic violence. Respondents who experienced emotional abuse (15% of respondents) were almost two times more likely to develop depression and 1.68 times more likely to develop post-traumatic stress disorder[4].

- According to CARE International program data of 201 family planning visits, contraception use among adolescent girls dropped by 66% from January to May 2020, compared to 46% for adult women[5].

- From March to April 2020, reports of gender-based violence nearly quadrupled in Lagos State, Ogun State, and the Federal Capital Territory, which were under full lockdown[6]. Several female students were also raped and murdered during the pandemic, which ignited protests across the country[7].

- In a 2020 CARE International survey of 308 adolescent girls in Nigeria, 31% of girls reported that they did not attend school in the last year. Their reasons for not attending school included lack of funds to pay for school fees and supplies (34%), school closures (33%), and needing to work to support their families (8%)[5].

- Women comprised only two out of twelve members (17%) of the Presidential Task Force on COVID-19[8]. In addition, women's participation in decision-making at the community level has also dropped during the pandemic. According to a July 2020 survey of 5,813 women from nine States and the Federal Capital Territory, only 21.3% of women participated in community decision-making during the pandemic, compared to 77.6% before the pandemic[1].

There is an urgent need to put in place new policies and interventions to address these impacts and avert future harms. To this end, our report makes recommendations that are clustered around the following thematic areas: livelihoods and social protection, care work, the health workforce, mental health, sexual and reproductive health, gender-based violence, education, and participation in decision-making.

Overview of Nigeria's COVID-19 response plan and programming

On 18 May 2020, the Nigerian Federal Government released the National COVID-19 Pandemic Multi-Sectoral Response Plan (the Plan), which outlines the roles of all government sectors during six phases of the pandemic[9]:

- **Phase 1**: No cases
- **Phase 2**: Sporadic cases
- **Phase 3**: Cluster of connected cases
- **Phase 4**: Community transmission in one or more States
- **Phase 5**: Post-peak, no new cases
- **Phase 6**: Recovery

The Plan largely focuses on preventing, containing, and mitigating COVID-19 infections, as well addressing the socioeconomic impacts of the pandemic through the provision of palliatives or aid. It does not specifically mention women or gender, but includes measures aimed at poor and vulnerable groups.

Nigeria's federal-level COVID-19 response has been coordinated by the Presidential Task Force on COVID-19, which was established on 9 March 2020[10]. Within the Presidential Task Force is the National COVID-19 Response Centre, led by the National Coordinator of the Presidential Task Force[9]. There are corresponding State-level COVID-19 Task Forces, led by State Governors, or in the case of the Federal Capital Territory, the Minister of the Federal Capital Territory[9].

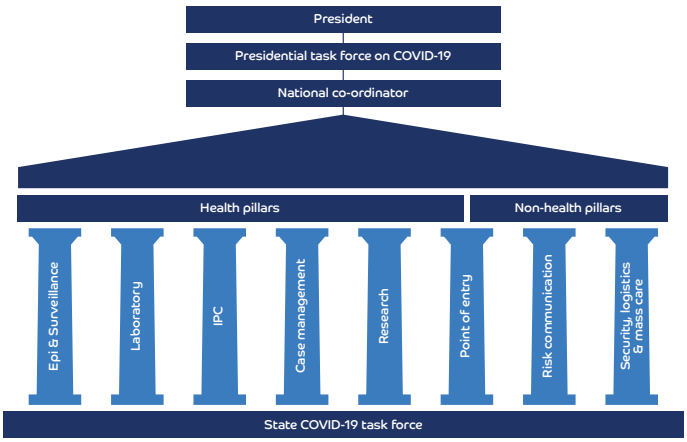

Figure 1: Nigeria's COVID-19 Response Mechanism
(Source: National COVID-19 Pandemic Multi-Sectoral Response Plan)

On 1 April 2021, following the expiration of its tenure, the Presidential Task Force transitioned to a Presidential Steering Committee, with a modified mandate to reflect the longer-term nature of COVID-19[11]. The structure of the new Presidential Steering Committee will correspond to the country's current focus on vaccine oversight, risk communication, international travel quarantine, and sub-national engagement[11].

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Primary impacts

Infections and deaths

In Nigeria, more men have contracted and died from COVID-19, compared to women. As of 6 June 2021, there have been 156,845 confirmed COVID-19 cases, of which 60% were men and 40% were women[12]. Men with confirmed COVID-19 diagnoses were 62% more likely to die compared to women with confirmed COVID-19 diagnoses[12]. Of the 1,566 COVID-19 deaths in Nigeria, 71% were men and 29% were women[12]. (Real-time data available here.)

Recommendations

- Run health promotion campaigns targeted at men to encourage personal hygiene and preventive behaviors, such as handwashing, mask-wearing, and physical distancing, as well as early testing and treatment.

Policy measures

Nigeria initiated movement restrictions in March 2020, which included a ban on international flights, restrictions on gatherings, and the closure of schools and universities[13]. On 30 March 2020, the Federal Capital Territory, Lagos State, and Ogun State went into lockdown, and many other States later followed suit[13].

From 4 May 2020 onwards, the government began to ease the lockdown, gradually lifting stay-at-home orders and reopening businesses[14]. On 2 June 2020, the government shortened the nationwide curfew from 8pm-6am to 10pm-4am[15]. On 30 June 2020, the government lifted the ban on interstate travel[16]. And on 12 October 2020, federal government schools started to reopen[17].

COVID-19 cases began to rise again in December 2020, and on 26 January 2021, at the peak of the second wave, President Muhammadu Buhari signed the Coronavirus Disease (COVID-19) Health Protection Regulations 2021[18]. The regulations included restrictions on gatherings, mandatory face masks in public, as well as penalties for non-compliance to these regulations[18]. Subsequently, on 10 May 2021, the Presidential Steering Committee reintroduced additional restrictions, such as the closure of bars, clubs, and event centers[19].

Further analysis of the socioeconomic impacts of these policies as well as corresponding recommendations are outlined in the secondary impacts section.

Timeline[13–23]

- **27 February 2020** — First COVID-19 case confirmed
- **9 March 2020** — Presidential Task Force on COVID-19 formed
- **18 March 2020** — Travel ban on 13 countries; ban on gatherings of above 50 people in Lagos and Ogun States
- **19 March 2020** — Schools and universities closed
- **23 March 2020** — International flights banned; passenger railway services suspended
- **30 March 2020** — Federal Capital Territory, Lagos State, and Ogun State go into lockdown; many other States later follow suit
- **20 April 2020** — Domestic flights banned
- **27 April 2020** — Kano State goes into lockdown
- **2 May 2020** — Nationwide overnight curfew (8pm-6am)
- **4 May 2020** — First phase of the easing of the lockdown: stay-at-home order gradually lifted; businesses begin to reopen; mandatory face masks in public
- **2 June 2020** — Second phase of the easing of the lockdown: nationwide curfew shortened to 10pm-4am; banks resume normal operations
- **30 June 2020** — Third phase of the easing of the lockdown: interstate travel ban lifted
- **12 October 2020** — Federal government schools reopen
- **25 January 2021** — Alpha variant, which was first discovered in the United Kingdom, detected in Nigeria
- **26 January 2021** — President Buhari signs the Coronavirus Disease (COVID-19) Health Protection Regulations 2021
- **10 May 2021** — The Presidential Steering Committee reintroduces additional COVID-19 restrictions, including the closure of bars, clubs, and event centers

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Testing, treatment, and vaccination

As of 5 July 2021, 1.2% of the COVID-19 tests conducted in Nigeria over the previous week were positive (real-time data available here)[24]. This is also known as the positivity rate. A positivity rate of below 5% indicates adequate testing[25].

Nigeria began its COVID-19 vaccination rollout in March 2021. As of 6 July 2021, 2,514,902 people (1.2% of the population) had received at least one vaccine dose, while 1,386,365 people (0.7% of the population) had received two doses (real-time data available here)[26].

There is no sex- and age-disaggregated data on COVID-19 testing, vaccinations, hospitalizations, and intensive care unit admissions.

Recommendation

- Collect sex- and age-disaggregated data on COVID-19 testing, vaccinations, hospitalizations, and intensive care unit admissions.

Health information and preventive behaviors

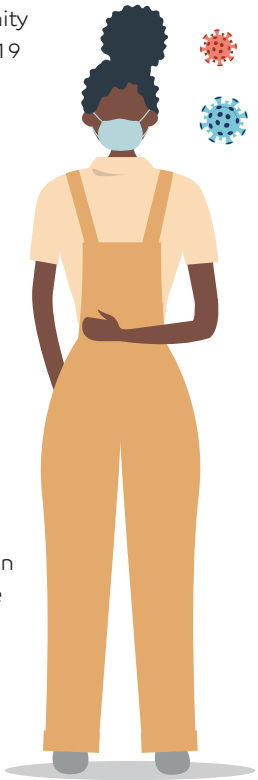
Men and women may obtain COVID-19 information through different means[2]. In the Northeast, men may have greater access to official channels such as radio, while women and girls tend to obtain information through their social networks and male relatives[2]. Women may face barriers to accessing COVID-19 information due to lower literacy, more time spent on caregiving and domestic work, and less access to the internet and technological devices[2]. Some women who do not own technological devices have had to use their husbands' devices to access information[27]. Nationwide, mobile internet usage is lower among women, with only 38% of women using mobile internet, compared to 54% of men[28]. Besides women, the elderly and persons with disabilities also face difficulties in accessing COVID-19 information[2].

Adherence to public health guidance may also differ by gender and age. In an April 2020 survey of 1,554 respondents across Nigeria, men and younger people were less likely to engage in preventive behaviors such as handwashing, mask-wearing, and physical distancing, compared to women and older people, respectively[29]. This, alongside other biological and social factors, may help explain the higher infection rates among men. In addition, the survey also showed that younger people were less likely than older people to perceive that they were at risk of contracting or being affected by COVID-19[29].

The ability to practice preventive behaviors is also impacted by sanitation and living conditions. In the Northeast, where conflict has displaced over 1.8 million people, lack of access to water and sanitation as well as overcrowding in internal displacement camps have hindered handwashing and physical distancing[2]. In addition, COVID-19 curfews have further restricted access to water collection points[2]. The increased need for water during the pandemic has placed a greater burden on women and girls, who are often tasked to collect water[2]. Some women and girls have also faced harassment and violence at mixed-gender water collection points[2].

Recommendations

- Increase women's access to accurate COVID-19 information by translating COVID-19 messages to local languages and sign languages and disseminating these messages through various channels. In addition, use media platforms, such as radio call-in shows, to engage questions on COVID-19.
- Work with women's groups and community leaders to disseminate accurate COVID-19 information to women, the elderly, and persons with disabilities.
- Provide personal protective equipment (PPE) to women frontline workers, especially those who work in markets and have no access to PPE.
- Run health promotion campaigns targeted at men and young people to encourage personal hygiene and preventive behaviors such as handwashing, mask-wearing, and social distancing.
- Increase access to water and sanitation in internal displacement camps and ensure safety at water collection points.



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Secondary impacts

Livelihoods and social protection

About 90% of Nigerian women in the workforce are engaged in informal work, with little to no social protection and buffers[30]. Lockdowns and the closure of markets have eroded their income and threatened the survival of their small businesses, many of which lack cash reserves and insurance[1,31].

Lockdowns have also affected male-dominated occupations such as carpentry, motor repairs, and day labor, some of which were not classified as essential services[2]. When men lose their income, their wives have had to become the sole breadwinners in the household[31]. To put food on the table, some women started small-scale farming, some dipped into their business capital, while others resorted to selling off assets such as gold[1,2,31]. Household food insecurity disproportionately affects women, as they often skip meals or eat last, prioritizing men and children in the household[2].

Women also reported difficulties obtaining government palliatives or aid. In a July 2020 survey of 5,813 women from nine States and the Federal Capital Territory, 75.8% did not receive any assistance, while 15.9% received food items, 3.7% received facemasks and sanitizers, and 1.2% received cash[1]. Some respondents described these palliatives as mere "tokens"[1]. In the Northeast, women head of households living in internal displacement camps also reported difficulties obtaining aid due to their marital status[2].

Measures in the Plan

In each phase of the Plan there are measures related to the provision of palliatives or aid[9]. In terms of target groups, Phase 1 mentions "vulnerable populations," while Phase 4 mentions "poor and vulnerable groups (i.e., urban areas and remote areas)"[9].

Measures taken

The government has introduced several social protection measures which include[32–37]:

- Food aid for vulnerable households (announced on 1 April 2020)
- Cash transfers ₦20,000 (US$50) to poor and vulnerable households registered in the National Social Register (announced on 1 April 2020)
- Monthly cash transfers of ₦5,000 (US$12) for 6 months to a million poor and vulnerable households in urban areas (announced in January 2021)

- 50% income tax rebate for employers and business owners
- Loans of ₦50 billion (US$128.5 million) to households and micro, small, and medium enterprises affected by COVID-19. Applicants would need to prove that their income had been affected by COVID-19
- Loans of ₦3 million (US$7330) to poor families, which require collateral
- A 180-day mortgage moratorium for homeowners under the national housing fund, starting 1 March 2020
- A three-month repayment moratorium for TraderMoni, MarketMoni and FarmerMoni loans, which are federal loans for petty traders and artisans, women, and farmers, respectively

Recommendations

- Register more eligible people on the National Social Register to enable them to access cash transfers and food aid. Only about 36% of the 83 million people living below the national poverty line of ₦137,430 (US$381.75) per year were registered in the National Social Register, as of March 2021[38,39].
- Review the registration and exit parameters of the social protection scheme and adopt a revolving beneficiary model to expand its reach.
- Include community members, especially women, in the management of palliatives or aid, as there have been reports of irregularities in the distribution of palliatives[32].
- Provide loans and financial assistance to the informal sector through microfinance institutions. The current

pandemic assistance for businesses, such as tax rebates and loans, are mostly targeted at the formal sector, from which women are largely absent. Supporting the informal sector is crucial, as it contributes 65% of the country's total gross domestic product[32].

- Provide collateral-free, low-interest loans to poor households. The current pandemic loans for poor households require collateral, which many women may not have.

- Set up bank accounts for women to facilitate their access to loans and digital cash transfers. In Nigeria, only 64% of women have or use any financial products or services, whether formal or informal, compared to 76% of men, as of 2019[40]. These levels have been increasing more quickly among men than women since 2012[40].

- Increase women's digital literacy as well as access to the internet and technological devices to enable them to take advantage of burgeoning e-commerce opportunities during the pandemic.

Care work

Prior to the pandemic, women in Nigeria were already spending 50% more time on childcare, compared to men[41]. The pandemic has further intensified this burden, as women have had to homeschool children as well as care for sick family members, especially when health services were inaccessible[2,31]. In a July 2020 survey of 5,813 women from nine States and the Federal Capital Territory, 60% of women were "fully engaged" in childcare[1]. Men have not stepped up to share the burden of care work and have instead focused on returning to paid work[2].

The burden of care work is further compounded by inadequate infrastructure. For example, a majority of households in Nigeria lack access to clean cooking fuel, which makes cooking more time-consuming as well as hazardous to their respiratory health[42]. Moreover, in internal displacement camps in the Northeast, women and girls have to walk a distance and wait in line to collect water[2].

Measures in the Plan

In the task list of the Plan, the Federal Ministry of Women Affairs, the National Emergency Management Agency, and/or the State Emergency Management Agency are to "provide care for children and orphans"[9].

Measures taken

The reopening of federal government schools in October 2020 may have helped ease the burden of care work.

Recommendations

- Allocate and utilize more public funds for early childcare centers to increase their accessibility, affordability, and quality.

- Provide tax credit and other incentives for childcare and domestic work.

- Engage men and boys to encourage them to share domestic and caregiving responsibilities.

- Invest in infrastructure such as water, sanitation, electricity, and clean cooking fuel to reduce time spent on domestic work.

Health workforce

In Nigeria, 3,175 health care workers have contracted COVID-19, 1.9% of the 167,859 COVID-19 cases in the country, as of 4 July 2021 (real-time data available here) (43). Sex-disaggregated data on COVID-19 infections and deaths among health care workers is not publicly available. Nonetheless, women are likely to be disproportionately affected, as they comprise about 60% of Nigeria's health workforce[44] and predominate in occupations with high patient-contact. For example, 87% of nurses in Nigeria are women[45].

The pandemic has also impacted the mental health of health care workers. In a survey of 105 health care workers at three COVID-19 isolation and treatment centers in Lagos State from 20 April to 20 June 2020, 16.2% had depression and 15.2% had anxiety[3]. Levels of depression and anxiety were highest among nurses, compared to physicians and other health care workers[3].

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Despite risking their lives to battle the pandemic, health care workers have not received adequate support and compensation. Since June 2020, resident doctors have gone on strike three times over unpaid salaries and hazard allowances, lack of life insurance, and inadequate personal protective equipment[46–48]. In addition, in September 2020, the union representing non-physician health workers, such as nurses, midwives, and radiologists, launched a strike to demand life insurance, changes to pay structures, and adequate personal protective equipment[49].

Working conditions of health care workers could be further impacted by proposed budget cuts. In June 2020, the Nigerian government also announced a plan to cut its primary health care budget by 43% in light of shrinking oil revenue and the economic fallout of the pandemic[50,51].

Measures in the Plan

The Plan includes measures to maintain adequate supply of PPE, to distribute PPE to frontline workers, and to train frontline workers on infection prevention and control[9].
In addition, there are also measures to provide counselling services and to activate rest and recuperation sites and confidential phone support lines for health care workers[9].

Measures taken

The Nigerian government agreed in June 2020 to pay frontline workers two months of hazard pay in response to strikes[52]. The government also reported spending ₦20 billion (US$52.56 million) on hazard allowances for health care workers from April to June 2020[48].

Recommendations

- Activate rest and recuperation sites and confidential phone support lines for health care workers, as stated in the Plan.
- Implement shift rotations and rest-periods to avoid burnout among health care workers.
- Provide adequate PPE to health care workers.
- Ensure timely payment of salaries and hazard allowances to health care workers.
- Provide life insurance to health care workers as well as paid sick leave to those who contract COVID-19 or experience mental health issues.

- Collect sex-disaggregated data on the number of health care workers who contracted and died from COVID-19.
- Review the pay structures of women-dominated health care occupations, such as nursing, midwifery, community health work, and hospital support and cleaning, to ensure equal pay for work of equal value.
- Include more women, including midwives, nurses, and community health workers, in health care leadership.
- Increase the number of women training as doctors.
- Analyze the factors that hinder women's progression in the health workforce and act on them.

Mental health

Depression and post-traumatic stress disorder have increased during the pandemic. In a survey of 755 respondents in Lagos, Ogun, and Abuja from 25 April to 4 May 2020, two in five respondents had post-traumatic stress disorder, while one in three had depression, which is ten times higher than the pre-pandemic level of depression recorded in the Nigeria Mental Health Survey[4].

This mental health toll may be exacerbated by domestic violence. In the same survey, respondents who experienced emotional abuse (15% of respondents) were almost two times more likely to develop depression and 1.68 times more likely to develop post-traumatic stress disorder[4].

The increased mental health toll is especially concerning given the lack of mental health services in Nigeria. There are only

eight federal neuropsychiatric hospitals and fewer than 150 psychiatrists in Nigeria, a country of 211 million people[53]. The mental health sector is also severely underfunded, receiving less than 5% of the country's public health expenditure[54].

Measures in the Plan

The Plan includes measures to monitor the mental health of patients and frontline health workers and to provide counselling and psychological support services to health workers and the public[9].

In the task list of the plan, the National Emergency Management Agency, the Federal Ministry of Women Affairs, the Federal Ministry of Health, and/or the Ministry of Education are to "provide counselling and psycho-social support (200 therapists for population of 50 million for 14 days)"[9].

Measures taken

According to its Chairman, the Presidential Task Force has been concerned about the mental health of COVID-19 patients and has "intensified plans for in-country response under the treatment and post-treatment regimes"[55]. It is, however, unclear what specific steps have been taken.

Recommendations

- Provide counselling and psychosocial support through phone lines, as stated in the Plan.
- Develop digital mental health resources and services, such as websites, mobile apps, and virtual consultations. This could help fill critical gaps caused by the shortage of mental health professionals.
- Train mental health professionals to provide provide trauma-informed care, which is an approach that recognizes the impact of trauma and avoids retraumatization[56]. Trauma-informed mental health care is crucial given the increased risk of mental illness among those who have experienced violence.
- Assign patients to mental health professionals of the same gender, where possible, to increase patients' comfort in discussing deeply personal matters.
- Integrate mental health services into primary health care to increase their accessibility and to enable early intervention.
- Allocate and utilize more funds for mental health care during crises.

Sexual and reproductive health

During the pandemic, sexual and reproductive health services in Nigeria were disrupted due to the closure of clinics, lack of PPE, shortage of health care workers, and interruptions in contraceptive supply chains[1,31,57,58]. In addition, sexual and reproductive health services were not designated as essential services. The pandemic also limited the range of contraception available to women. Some women reported difficulties obtaining their preferred contraception and therefore stopped using contraception[31]. In the Northeastern state of Borno, long-acting reversible contraception such as intrauterine devices and implants, as well as emergency contraception, were less available compared to short-term methods such as pills and condoms[58].

On the demand side, women faced difficulties accessing services due to movement restrictions, fear of the virus, and lack of income to pay for out-of-pocket charges[1,31,57,59]. Additionally, women's lack of decision-making power in the household also hindered their access to services. Some women had to obtain their husbands' permission to leave the house for non-urgent health care, with some even being punished for failing to seek permission[59].

Lockdowns have had an even greater impact on adolescent girls' contraception use, which dropped more sharply during lockdowns and rebounded more slowly after, compared to that of adult women. According to CARE International program data of 201 family planning visits, contraception use among adolescent girls dropped by 66% from January to May 2020, compared to 46% for adult women[5]. In June 2020, following the easing of lockdowns, adolescent girls' contraception use increased by only 39%, compared to 52% for that of adult women[5].

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Sexual and reproductive health services will likely be further impacted by budget cuts to primary health care. In June 2020, the Nigerian government announced a plan to cut its primary health care budget by 43% in light of shrinking oil revenues and the economic fallout of the pandemic[50,51].

Measures in the Plan

The Plan does not explicitly mention sexual and reproductive health services.

Measures Taken

During the pandemic, the non-governmental organization Population Services International launched a marketing campaign to promote self-care contraceptive options, which are options that may or may not require women to see a health care provider[60]. This includes self-injectable contraceptives, online contraceptive purchases, and call-in family planning counselling[60].

In 2020, the Federal Ministry of Health, in collaboration with Population Services International and other stakeholders, released national guidelines for self-care for sexual and reproductive health[61].

Recommendations

- Ensure adequate supply of a range of contraception, including long-acting reversible contraception such as implants and intrauterine devices.
- Expand remote consultations and self-care contraceptive options, such as self-injectable contraceptives and online contraceptive purchases.
- Provide a longer supply of contraception to reduce the frequency of clinic visits.
- Provide adequate personal protective equipment to sexual and reproductive health service providers.
- Address misconceptions and stigma around contraception use.
- Ensure adequate budget for primary health care, including sexual and reproductive health services.

Gender-based violence

From March to April 2020, reports of gender-based violence nearly quadrupled in Lagos State, Ogun State, and the Federal Capital Territory, which were under full lockdown[6]. Several female students were also raped and murdered during the pandemic, which ignited protests across the country[7,62].

Amid the spike in gender-based violence, many shelters and one-stop centers in Nigeria were forced to close or scale back their services due to COVID-19 restrictions and inadequate PPE[6]. Their services were initially not recognized as essential services, but this later changed following public pressure. Additionally, during the lockdown, police from the Family and Support Unit were deployed to enforce the lockdown, while court proceedings were halted, limiting survivor's access to justice[6].

Gender-based violence may be even more rampant in the Northeast, where conflict has displaced over 1.8 million people. Internally displaced women living in camps face additional vulnerabilities to sexual harassment and exploitation when they seek necessities and collect water[2]. Reports also suggest that survival sex among internally displaced women has increased during the pandemic[2].

Measures in the Plan

The Plan does not explicitly mention gender-based violence.

Measures taken

In June 2020, the Nigerian Governors' Forum, which comprises the Governors of all 36 States, declared a state of emergency on sexual and gender-based violence in response to several high-profile murders of women[62,63]. As part of the emergency response, the Governors called on States to set up sex offender registries and to domesticate federal laws such as the Violence Against Persons (Prohibition) Act[62,63]. In addition, the Governors also pledged additional funding to relevant ministries, departments, and agencies to combat sexual and gender-based violence[63].

Recommendations

- Increase funding to shelters and one-stop centers to enable them to cope with the rise in gender-based violence. Funds could be obtained from the additional funding for gender-based violence allocated as part of the emergency declaration.
- Expand remote services for survivors, such as through phone lines, text messaging apps, online chats, etc.
- Designate services for gender-based violence survivors as essential services.

- Provide PPE and COVID-19 tests to shelters and one-stop centers to protect staff and survivors.

- Disseminate information on where survivors can seek help through mainstream and social media, and at frequently visited places such as pharmacies, clinics, markets, community centers, etc.

- Prioritize the issuing of protection orders and prosecution of gender-based violence cases.

- Domesticate and strengthen the Violence Against Persons (Prohibition) Act in all States to better deter perpetrators. Currently, 26 out of 36 States have yet to domesticate the act[6].

- Conduct community engagement programs to change social norms around gender-based violence. Such programs can be done in collaboration with existing community-based organizations and networks.

Education

In Nigeria, school closures have affected over 18 million female learners[6], which will exacerbate pre-existing education inequalities. Even prior to the pandemic, Nigeria had the highest number of out-of-school children in the world[64]: over 10 million children in Nigeria were out of school, of which 6 million were girls[65].

Girls' education has not only been affected by school closures, but also by decreased household income and increased domestic work during the pandemic. In a 2020 CARE International survey of 308 adolescent girls in Nigeria, 31% of girls reported that they did not attend school in the last year. Their reasons for not attending school included lack of funds to pay for school fees and supplies (34%), school closures (33%), and needing to work to support their families (8%)[5]. In addition, over half of the girls surveyed engaged in unpaid work, which included household chores, childcare, and selling items in the market[5].

Disruptions in education have been more severe in poorer, conflict-prone areas, as well as among poorer households. Many schools, particularly those in poorer, conflict-prone areas, did not have access to digital learning platforms, and neither did many students from poorer households. In most States, the government provided support for learning through radio and television, which may still be inaccessible to very poor families. In addition, men often control the use of radios and televisions at home, hindering children's access to learning.

Girls who are out of school are at an increased risk of sexual coercion and teenage pregnancies. While there is no available data in Nigeria, neighboring countries such as Kenya, Malawi, and Uganda have reported spikes in teenage pregnancies during the pandemic[66], which could be partly due to disruptions in education.

Disruptions in girls' education also increase their risk of child marriage. Child marriage is already prevalent in Nigeria, where 44% of girls are married before 18 years of age[6]. During the pandemic, there have been reports of parents marrying off their daughters, as they were unable to feed them[67].

Amid the disruptions in education, the government has, worryingly, cut the education budget. The education sector only received 5.8% of the total federal budget in 2021, a decrease from the previous 5-year average of 7%[68]. This would further hinder access to education, resulting in a domino-effect on girls.

Measures in the Plan

Phase 6 (recovery) of the plan includes the reopening of schools[9].

Measures taken

The Federal Ministry of Education developed several COVID-19 response plans for the education sector, including a response strategy, a contingency plan, and guidelines for school reopening[69]. Additionally, the Nigeria Education in Emergencies Working Group also developed a COVID-19 response strategy for the education sector in Northeast Nigeria[70].

Federal government schools started to reopen on 12 October 2020[17]. In Lagos State, schools need to be registered and certified for safety before reopening, while teachers are expected to take an online course on COVID-19 protocols[71].

In March 2020, the Federal Government released the Nigerian National Broadband Plan 2020-2025, which aims to deliver broadband to at least 90% of the population at a minimum speed of 25MBps in urban areas and 10MBps in rural areas for not more than ₦390 per 1GB of data by 2025[72]. The plan also aims to provide fiber optic access to 100% of tertiary institutions, 50% of secondary schools, and 25% of primary schools by 2025[72]. If implemented, the plan would facilitate students' access to online learning.

Recommendations

- Increase students' access to electricity, the internet, and technological devices to enable remote learning. These measures could be targeted at students from poorer households.

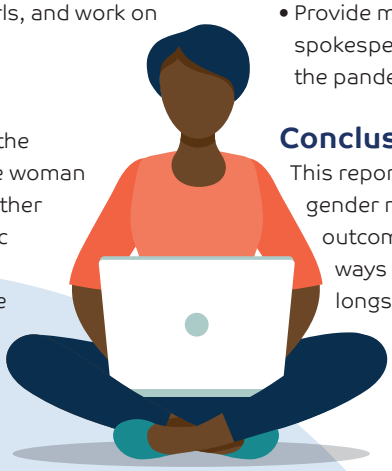
- Provide schools, especially those in poorer and conflict-prone States, with access to electricity, the internet, and technological devices to enable remote learning. While schools are currently open, they must also be prepared and equipped to return to remote learning should COVID-19 cases increase.

- Allow and encourage married, pregnant, or post-partum girls to continue their schooling, and provide them with childcare services.

- Track school retention and completion rates among married, pregnant, or post-partum girls, and work on increasing these rates.

Participation in decision-making

There was initially only one woman on the Presidential There was initially only one woman on the Presidential Task Force, and another woman was only added following public outcry. Despite the addition, women are still greatly underrepresented in the Presidential Task Force, compromising only 17% of its members (two out of twelve)[8]. Meanwhile, in the Northeast, women are part of various sub-committees, but they do not have the authority to make decisions and instead serve as representatives of the men who appointed them[2].



Women's participation in decision making at the community level has also dropped during the pandemic. According to a July 2020 survey of 5,813 women from nine States and the Federal Capital Territory, only 21.3% of women participated in community decision making during the pandemic, compared to 77.6% before the pandemic[1]. This could be due to increased domestic work, movement restrictions, and the need to obtain their husbands' permission to leave the house during the pandemic.

Women are also underrepresented in media coverage on COVID-19[73], despite comprising 60% of health care workers and being on the frontline of the pandemic response[44]. An analysis of COVID-19 news articles in Nigeria found that men were quoted nearly five times more frequently than women[73]. The coverage of women in COVID-19 news was even lower than in non-COVID-19 news[73].

Measures in the Plan

There is no specific mention of women's participation in the pandemic response. However, the Plan mentions engaging and working with stakeholders such as national and international organizations, as well as welfare, faith-based, and community agencies and groups[9].

Recommendations

- Implement quotas to ensure that women of diverse backgrounds are included in decision-making bodies.

- Include more women in the Presidential Steering Committee to ensure at least 35% women's representation.

- Ensure that women in leadership bodies have the authority to make decisions.

- Provide more opportunities for women to be media spokespersons and recognize their contributions to the pandemic response in the media.

Conclusion

This report brings to the fore the many ways in which gender norms, relations and roles have led to differential outcomes during the COVID-19 pandemic. In some ways the weaknesses in the pandemic response mirror longstanding failures to ensure gender equity within Nigerian society. The pandemic has exacerbated and further highlighted the devastating impact that this inequity has on women and girls.

Yet change is possible and the will to build back better provides impetus and opportunity for doing things differently. As a priority we call on the Nigerian government to:

- Bring **livelihood** relief to the informal sector and formalize the position of poor households and informal women workers by improving access to bank accounts and levels of digital literacy.
- Pay attention to the unpaid burden of **child and family care** that disproportionately falls on women in Nigerian society through society-wide interventions to shift harmful gender norms and practical measures to lessen this burden such as early child development centers and tax credit for childcare.
- Protect the mental and physical health of **health workers** by addressing workplace health and safety and changing salary and governance structures to promote gender equity.
- Safeguard **sexual and reproductive commodities and services** and expand remote self-care options.
- Adopt trauma informed care within health services at the primary level to alleviate the **mental health** burden being experienced across the country.
- Address **violence prevention** through community programs and law enforcement and increase the number of shelters, helplines, and other novel services for those experiencing gender-based violence.
- Increase access to **education**, particularly in poorer and conflict-prone settings and among married, pregnant, and post-partum girls and trial innovations for remote learning through better internet access.
- Ensure gender-parity in **participation in COVID-19 decision-making** bodies and address power relations within these institutions which prevent women's suggestions from being taken up.

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