About Us:
The Civil Resource Development and Documentation Centre (CIRDDOC) Nigeria is an Independent, non-governmental and not for profit organization established in 1996 for the protection and promotion of human rights and women's human rights and the strengthening of civil society. CIRDDOC is also committed to the institutionalization of good governance, gender equality and the rule of law. CIRDDOC is registered under Part C of Company and Allied Matters Act laws of the Federation of Nigeria 1990. (RC 10,928).

Our Vision: A world, in which human rights are guaranteed, protected and enforced on the basis of equality and non-discrimination.

Our Mission: To promote and protect human rights and women's rights, gender equality, and good governance through the empowerment of civil society and the promotion of access to justice and rule of law.

Our Strategic Objectives are:
- To promote human rights, women's rights, gender equality, and good governance,
- To facilitate access to justice and the rule of law.
- To build capacity of civil society to demand accountability from leaders and policy makers.
- To facilitate networking, collaboration and partnerships among civil society organizations, and between government and civil society organizations.

Our Values: Resilience, Mutual Respect, Integrity, Transparency and Accountability, Education and Empowerment, Equality and Equity.

Program Focus Areas
- Education and Empowerment
- Democracy & Governance
- Human Rights and Women's rights
- Gender Equality
- Conflict Resolution
- Violence against women and HIV/AIDS

Our methods/strategies: research and publications, capacity building/training workshops, civic education, legal awareness/outreach programs, legislative and social advocacy, tribunals on the violations of human rights, paralegal scheme, legal aid, library/resource centre services, seminars/conferences, database developments management, judicial colloquia, civil forum and community information centres, media events.

Activities: outreaches, rallies, workshops, seminars, conferences, moot court competitions, research, documentation and publication, tribunals, public hearings, civic forum, litigation, counseling and advice, civil education and voter education, budget literacy, advocacy and monitoring.

CIRDDOC is seeking to establish new alliances and partners for human rights work worldwide. Please contact the Executive Director at the address below if you would like to collaborate with us.

Civil Resource Development & Documentation Centre (CIRDDOC) Nigeria
No. 9 Second Avenue, Off Bisalla Road, (Opp. Roban Stores), Independence Layout, Enugu.
P.O. Box 1686, Enugu, Enugu State, Nigeria.
+2348033132493, +2348078558166
Website: http://www.cirddoc.org
Email: <cirddoc@aol.com>or<cirddoc96@yahoo.com><info@cirddoc.org>

Ebonyi Office
27 Afikpo Road, Abakaliki
+2348037787250
cirddoc_ebonyi@yahoo.com

Anambra Office
19 Oranma Street, Amaenyi, Awka
+2348033326385
cirddoc_anambra@yahoo.com

Abuja Office
Suite B1 Victory Plaza
Onitsha Crescent
Off Gumbiya Street
Area II Garki
+2348034539760
cirddoc_abuja@cirddoc.org

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A POLICY BRIEF

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ADDRESSING THE EFFECT OF COVID-19 ON WOMEN AND GIRLS A POLICY BRIEF

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SECTION ONE: BACKGROUND

The Civil Resource Development and Documentation Centre (CIRDDOC) Nigeria is an independent, non-governmental and not-for-profit organisation established in 1996 for the protection and promotion of human rights and women's human rights and the strengthening of civil society. CIRDDOC is also committed to the institutionalization of good governance, gender equality and the rule of law.

CIRDDOC with support from AmplifyChange is working with partner organisation, Coalition of Eastern Non-Governmental Organisations (CENGOS) and relevant stakeholders to end Gender Based Violence (GBV) and Increase Young People's Access to Sexual and Reproductive Health Information and Services in 9 states – Abia, Akwa Ibom, Anambra, Bayelsa, Cross River, Ebonyi, Enugu, Imo and Rivers.

Humanitarian crises and health emergencies

affect men and women differently. As COVID-19 continues to ravage the world, there are concerns over its impact on women and girls, with vulnerabilities feared to worsen as the pandemic overwhelms health systems. Women and girls and those living with disabilities may be particularly affected by the impacts of COVID-19 outbreak.

This Research was commissioned by CIRDDOC Nigeria in collaboration with CENGOS, with the support of Amplify Change. The purpose of the study was to determine the impacts of COVID-19 on women and girls in Nigeria. The scope was limited to six states in the South East and East of Nigeria: Akwa Ibom, Cross River, Ebonyi, Enugu, Imo and Rivers. The specific objectives were to:

i) Determine the health impacts of COVID-19 on women and girls;
ii) Determine the social and economic impacts of COVID-19 on women and girls;
iii) Determine the effects of the COVID-19 containment policies and protocols on the

vulnerable populations especially as it concerns Sexual and Reproductive Health Rights (SRHR) and Gender-Based Violence (GBV);
iv) Make recommendations from the findings for sustainable programming on addressing SGBV during and after COVID-19 and similar emergencies

SECTION TWO: RESEARCH FINDINGS

1. Majority of respondents were in the age bracket of 24-41. Indeed for women and girls, this bracket represents the most active years, therefore it was not surprising to see that in spite of the overall inclusion of all age groups in the survey design, this group was the most easily accessible at the time. For girls younger than 24, reception of strangers especially during the lockdown may have been seen in many instances as consequential. Many women in Nigeria are basically breadwinners in their families and under such grave

economic circumstances resulting from the pandemic, they are also likely to lose their voices and hope. It is also important to note that the initial data on COVID-19 suggested that younger people were less likely to fall ill than older more matured adults. Hence, it is unsurprising that this age bracket is more forthcoming in knowledge and the quest for more.

2. Majority of the respondents had tertiary and secondary education. This can be seen in both positive and negative ways. Positive in the sense that it is heart-warming and cheering data on the educational status of women and girls, a sharp contrast to the dark years of societal neglect of the girl-child; indeed most communities have opened up to the realisation of girl-child education. On the flip-side is that the education they have received may not have prepared them for the pandemic in terms of life and vocational skills.

3. All categories of marital statuses were covered by respondents. The target audience was generally varied in composition and comprehensive in nature, to the cachet of the overall scorecard of the research.
4. Majority of respondents were working before the pandemic. Most of the participants were employed or engaged on some form of work. It is pretty difficult to find women outside these categories, except of course for young girls in the sample who were unemployed because they were in school. This data speaks volumes for women who in the face of high unemployment, have resorted to enterprise to create self-employment. A lot of women had personal businesses and going concerns, petty trading, even beside their white collar jobs, most of which were shut down during the pandemic.
5. The research participants showed high knowledge of Corona virus, in terms of

nature, mode of spread, protocols and effects on humanity in general. The elitist/western entry point of the virus enabled an intense and worldwide campaign that educated people in all the nooks and crannies of the globe. This is true, considering the fact that in Africa and most of the third world, HIV, Malaria, still rank highly amongst killer diseases. Pertinently, the narratives as well as conspiracy theories around the origins and intent of the virus (COVID) made for a mouth watery discussion and comprehension among women. It was as novel as it was dangerous and its devastating global effect resulting in the lockdowns was enough to give it global attention. The plethora of information available on the mass media and internet as well as oral narratives from family and friends was also a source of anxiety which led to poor mental health among women and girls.

6. The major source of information was mass media: radio, TV, Newspaper, then Internet. This is a recognition of the impact of Radio and TV on especially rural dwellers in Nigeria. While this may also be explained along the lines of costs, knowing that the cost for internet subscription is rising daily in Nigeria, it is also factual that most women still prefer to listen (hear) their news/information.
7. Non-Governmental Organisations (NGOs) were the least source of information why? The impact of NGOs has been minimally recorded as a result of some correlated factors. To start with, most NGOs are terrestrial in nature, meaning that they rely mostly on movement which was restricted by the lockdowns and the inability of government to properly recognise the work that they do as “essential service” and thus grant same ease of access during this period. Secondly, NGOs usually ignore the element of Communication and Visibility in

terms of their identity and the work that they do. It is therefore not surprising that the efforts and work of NGOs was mostly diffused, mellowed or sometimes completely dissipated as Governmental action. Moreover, the lack of visibility of NGOs and Civil Society Organisations (CSOs) could be linked to government's lack of engagement with them in the response to the pandemic. As non-for profit organisations, they may not have the needed resources to disseminate information on a large scale; and being mostly donor-driven, their response to the pandemic would have had to go through some processes of re-programming and approvals by their donors.

8. Key messages received were mostly preventive. No information on the event of someone falling ill and basic first aid and where to go. The inferno of Corona overtook the world like a raging fire, with little or no knowledge/research on specific

modalities for handling and treatment. This vacuum accounted for the original design and logic of the messages that were crafted for mass media. This also resulted in some conflicting and confusing messages that participants might have received.

9. The most difficult rule to keep was the lockdown. While the lockdown was useful against the spread of the virus, the fact that people were not prepared for it made it difficult for them. For women and girls whose means of livelihood revolved around outdoor businesses, it was suicidal to lockdown their business spaces. This was what happened in most cases. The result of this lockdown could be seen in the lack of food experienced in most homes. The popularity of food vendors and road-side restaurants, popularly called “mama put” also meant that most people relied on them for their daily meals and may not have kitchens in their homes, especially in high density areas.

10. Participants' personal experience (most prevalent) was closure of schools for children. For a number of reasons, schools serve a multilateral partnership with parenthood (motherhood). Aside from tutelage and pedagogy, the school time gives mothers just about enough time to cleanup, wash, tidy up, school, work, do business etc. The closure of Schools for children was therefore disturbing especially from the angle of economic burden. Many schools resorted to online teaching and learning, and many mothers had to struggle to keep up the pace, adding this to their household work. In the rural areas, life seemed to have gone on as before the pandemic in terms of farm-work.
11. There was evidence of induced poor mental health during the pandemic due to the effects on economic, social and health concerns including concerns about business, work and social life. The lockdown, loss of jobs, crowded homes

(with all children and relatives locked in) created an environment for conflict among family members.
12. Most participants resorted to praying about their worries. The pandemic was indeed a strange phenomenon that need spiritual intervention having taken so much from our very human nature that even to touch one's own face was a source of infection.
13. Family members experienced health challenges during the COVID-19 pandemic. Although this was a normal thing to happen, it was particularly distressing to have a family member fall ill during the lock down; in the face of all the challenges, including reduced access to medical services. Most participants reported that they could not do anything about the situation: possible (fear/phobia of hospitals), victimization as COVID-19 related cases, and lack of funds.
14. There was evidence that most participants resorted to self- medication; including

herbs. The fear of COVID-19 in the sense that it symbolised a pathway to death, coupled with the idea of quarantine associated with being infected which in truth in most African countries, meant complete abandonment, created a scenario of mass self-help strategies of self- medication including the use of herbs and mixtures. The notoriety of a homegrown herbal mixture by Madagascar also fueled this approach. Given the economic chagrin at the time, it was also not surprising that participants preferred to manage their health problems by themselves, perhaps on account of ease and cost-effectiveness.

15. Most of the participants did not receive any form of social support during the pandemic. It is still unclear the level of preparedness of the country for such a momentous event, yet what was clear from the data is that most women and girls did not receive any palliatives from the government, except for

some locations where NGOs and philanthropists filled the void.

16. Participants reported that there was an increase in crime rate during this period. The economic and social consequences of the pandemic created an environment conducive for the flourishing of criminal acts and behaviours. In spite of the increased crime rate, participants felt safe walking in the communities during the day, possibly in response to the dislike to the lockdowns as perceived bondage. Typically, many crimes and criminal activities are active during the cover of darkness so on the average, participants did not feel safe walking alone in the communities at night. Safety at home was generally accepted as okay.
17. All forms of Sexual and Reproductive Health Rights (SRHR) violations and Sexual and Gender Based Violence (SGBV) were reported to have been directly or indirectly experienced. Physical

violence ranked 1st followed by early pregnancies probably due to coercion or rape. 3rd ranking was unplanned pregnancies and sexual violence ranked 4th.

18. On SRHRs, participants responses revealed that on the average, discussions on sexual matters with partners ranked 1st (probably because of the lockdown and increased demands by male partners for sexual activity) The practice of safe sex ranked second in spite of evidence of unplanned pregnancies.

SECTION THREE: CURRENT FEDERAL AND STATE POLICIES

The novel coronavirus entered Nigeria and Ogun State precisely, through an infected Italian citizen who came in contact with a Nigerian citizen, who was subsequently infected with the virus. It then spread to other citizens in Lagos and to other parts of the country. As at 26th November 2020, Nigeria

Centre for Disease Control, which is the Government Agency responsible for COVID-19 preparedness and response activities reported 66,805 confirmed cases of COVID-19 and 1,169 related deaths and 63,493 patients discharged and since then, over 756,237 samples have been tested (Nigeria Center for Disease Control, 2020). Most cases have been registered in Lagos, Federal Capital Territory (FCT), Plateau, Oyo, Kaduna, Rivers and Edo States, while states like Kogi, Cross River and Zamfara have recorded fewer cases. Currently, all the 36 states have reported COVID-19 cases (Nigeria Center for Disease Control, 2020). According the World Health Organization, in the Africa was likely higher than initially reported, due to limited testing and deficiencies in emergency preparedness (World Health Organization, 2020b).

With the corona virus raging on in its increasing variants, the importance of good healthcare

system becomes a critical point in controlling the pandemic. A good health system is a basic human right, and should be available to everyone, regardless of sex, where they are born or how wealthy they are. The poorest and most vulnerable people in society, especially women and girls, are often most dependent on the public health system, and are therefore most likely to be affected by how public resources are allocated.

Many African countries lack adequate and standard medical facilities when compared to developed nations such as USA, the UK and China, that all have advanced health care systems but are still a long way from coping with the current pandemic (Mo Ibrahim Foundation, 2020). Issues such as limited testing capacity, shortage of trained staff required for diagnostics and intensive care units (ICU), inadequate ventilators and ICU facilities (needed in severe cases of the novel coronavirus), lack of

personal protective equipment (PPE) for health-care workers and scarcity of funds for the health sector make the African continent more susceptible to the novel coronavirus pandemic (Mo Ibrahim Foundation, 2020).

Nigeria's health care system has been described in many climes as poor, weak, lacking coordination, fragmented in provision of services, lacking in resources, including drugs, decaying in infrastructure and allocated meagre resources (Menizibeya, 2011). Participants in the study resorted to self-medication, many using herbal medicines. This brings to mind the efforts of the Federal Ministry of Health in promoting and standardizing the practice of traditional herbal medicine in Nigeria, there is no any clear-cut legally empowered federal regulatory body that controls the practice of traditional medicine in Nigeria.

According to Iyioha (2016) although Nigeria boasts of a national policy on 'traditional

medicine', a close examination of laws and policy instruments governing medical practice in Nigeria, including the National Health Act, the National Health Insurance Scheme Act and the Medical and Dental Practitioners Act, reveals that the legal framework governing medical practice is skewed towards privileging biomedicine as the dominant healthcare system in the country over non-biomedical systems. The practice of indigenous medicine, more commonly known as 'Traditional Medicine' in Nigeria is primarily governed by the Traditional Medicine Act, which sets the general legal framework for the recognition of this system of medicine, and signals the country's acceptance of a pluralistic healthcare system.

The Federal Government of Nigeria has thus demonstrated commitment to the health of its citizens by enacting policies and developing strategic frameworks through which health programmes can be implemented. However, women and young people are still largely

denied their sexual and reproductive health rights information and services through a systematic failure in which such information and services are either non-existent or domiciled in inaccessible locations such as health clinics where health workers' attitudes and capacities make it impossible for youths to access them.

In addition, lack of awareness of laws protecting youths from SGBV is inhibiting youths' ability to exercise their SRH rights. Ignorance of such laws leaves youths highly vulnerable to Sexually Transmitted Infections (STIs) and HIV infections because they lack back-up knowledge of the laws that support their building up defenses against sexual coercion, rape, and other forms of abuses. There also exist some subtle discriminatory upbringing and socialisation processes of girls and boys to the disadvantage of girls as a result of which girls tend to develop low self-esteem and inability to negotiate sex. Many of them end up with early

and/or unintended pregnancies and eventually drop out of school, jeopardising their future and depriving the nation of their contribution to national development. This gap in knowledge, skill and enabling environment to attain good sexual and reproductive health has been widened by the COVID-19 pandemic which continues to ravage the world, bringing down health systems even in advanced countries.

There are international legal frameworks that support SRHRs. It is considered to be a corner stone of development by the United Nations Population Fund (UNFPA) and is also included in the Convention on the Elimination of Discrimination Against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities. SRHRs include the right to life and survival; autonomy and confidentiality; information and education; equality and non-discrimination, and privacy, amongst others, (UNFPA, 2004). Nigeria is signatory to some of

these international treaties that uphold the dignity of the person.

At state level, many bills have been processed, some passed into law, others awaiting passage by the lawmakers. These include Violence Against Persons Prohibition, Child Rights, Laws against Female Genital Mutilation, Laws to Abolish Dehumanizing Practices Against Women etc. At community levels, there are also laws that are supposed to protect human dignity. These plethora of laws remain largely unknown to the population, both literate and non-literate, so neither victims are able to leverage on the laws to seek justice nor do perpetrators have them as a point of reference to restrain themselves from causing so much havoc to vulnerable populations.

In the face of the COVID-19 pandemic that has brought on new health, economic and social challenges, especially regarding increased

SRHRs violations and Sexual and Gender-Based Violence, there is need to call attention to what need to be done urgently by all stakeholders.

SECTION FOUR: POLICY IMPLICATIONS/ RECOMMENDATIONS

Key Findings on Negative economic impacts; Lose of learning time & keeping children safe in schools.

Negative economic impacts: loss of jobs, reduced access to farmlands, reduced earnings from businesses, depletion of capital as they had to support their spouses/family through the lockdown.

What to do:

a) On a medium/long term, the Ministry of Education (MoE) through the Nigerian Educational Research and Development Council (NERDC) should review the school curriculum at ALL levels to intensify the life

and entrepreneurial component and to align these with other programmes of study at higher levels. At the same time a cross-curricular approach to instruction should be encouraged. Teachers at all levels should be trained and retrained using evolving technologies. CIRDDOC may begin to advocate to the MoE for review of the education policy to include pertinent issues arising from the pandemic;

b) Children who were not reached via online teaching during the lockdown should get an opportunity for catchup/remedial learning. There is need to establish community reading and numeracy hubs/groups for catchup- learning. Most learners in the rural communities did not benefit from radio, TV, online teaching and learning programmes

c) It should be made mandatory for schools to give parents/guardians orientation on how

to adhere to COVID-19 protocols as well as provide enabling environment for their children's/wards learning at home and in the community;

d) Government should scale up School Feeding Program to cover rural areas to mitigate the hunger being felt by the rural communities due to reduced farming activities induced by the lockdown.

e) To reduce grave economic impact on women and girls, advocacy for the non-politicization of palliatives and for the involvement of NGOs and traditional and religious institutions in the distribution of same. Funding can be sourced for empowering women and girls through vocational skills training and kitting with work tools such as: sewing machines, food processing machines and soft loans that will enable them to engage in small

businesses without necessarily breaking the protocols.

Key Findings on Unequitable Distribution of Palliatives; Non Involvement of NGOs

Most participants did not get any palliatives from federal, state or local governments. NGOs were mostly not involved by government and its agencies in the distribution of palliatives.

What to do?

f) Advocacy for equal representation of males and females in government's COVID-19 response teams will go a long way to ensuring that women and girl concerns are taken care of – especially in the face of a second wave of the pandemic;

g) Continued advocacy for the passage of Equal Opportunities Bill as the resilience and resourcefulness demonstrated by women and girls in the face of the

pandemic is evidence of leadership qualities which should be tapped by government and the entire society;

h) Advocate for a regulatory framework that will engender a synergy between government and CSOs/NGOs/CBOs to work in mutual understanding of what national development really means. There is need for a closer partnership between government and CSOs/NGOs, INGOs/ CBOs in the response to COVID-19 especially in terms of distribution of palliatives, sensitization activities in rural areas, educating the locals and the community leaders, providing validated information about the virus. Being grass root-friendly, if properly funded, NGOs have the capacity to reach out to people in the remote areas and to vulnerable populations;

Key Findings on Negative Health Impacts of COVID-19 on Women and Girls: Reliance on Self-medication and use of Traditional Medicine

The research revealed that most participants developed poor mental health during the lockdown due to restrictions, decreased earnings, cramped living conditions and ensuing spousal conflicts. Most of them reported that family members fell ill during the period and they did mostly nothing or self-medicated; some used herbs. A few sought treatment from hospitals or family doctors/nurses. There was reduced access to healthcare/SRHRs information and services and by implication, the many victims of SGBV may not have had access to healthcare during the lockdown.

What to do?

i) Advocacy for increased budgetary allocation to the health sector should be

continuous to increase access to medical care. The country may not be able to control the pandemic if this does not happen. Funds are needed to revamp the health sector at all levels.

j) Government should support the evolution of a sustainable traditional medicine development in Nigeria by funding research. This will help standardize the medicines.

Key Finding on Information on COVID-19

There was a lot of information on COVID-19 caused anxiety among women and girls in the study. It was reported that the information was only on daily new infections and deaths, preventive measures and protocols. No authentic information was received on what to do in the event of infection.

What to do?

k) There should be continuous information

dissemination; NGOs should engage with media to disseminate information through community education on the prevention. Sensitization should be carried out in churches, markets and communities to let them know the need to go to hospital for treatment rather than staying at home to do self-medication

l) There is need to establish community information centres to provide authentic, and relevant information that can also serve as counseling centres. In addition, online and phone services can be provided for those seeking therapeutic interventions, counseling or any other form of sexual rights and services or general Medicare during the lockdown.

Key Findings: Increased Crime Rate, increased SRHRs Violations and SGBV

All forms of Sexual and Reproductive Health

Rights (SRHR) violations and Sexual and Gender base Violence (SGBV) were reported to have been directly or indirectly experienced by women and girls. Physical violence was most prevalent, including rape and child defilement.

What to do?

m) There is need to continually create public awareness and to train and retrain law enforcement personnel and those involved in enforcing COVID-19 protocols as well as religious leaders, traditional rulers, market leaders and community educators on SRHR and SGBV as they relate to COVID-19 and its protocols.

n) Set up clusters in public places in the community markets, churches, etc., to enable victims of gender and family violence to alert the authorities/care givers. They may also alert the friends and family about the required help by using code

words or signals that have been introduced and taught to women and children. This will help family and friends to support the victims and push for the perpetrators to face the wrath of the law.

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