RAPID GENDER ANALYSIS

OF THE IMPACT OF COVID-19 ON HOUSEHOLDS IN NIGERIA:

A NATIONAL SURVEY

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WOMEN ADVOCATES RESEARCH & DOCUMENTATION CENTRE (WARDC)

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@Women Advocates Research and Documentation Center (WARDC)

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Centre for Democracy and Development

CENTER FOR COMMUNICATION PROGRAMS NIGERIA

UKaid from the British people

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Abbreviations

ACDC:	Africa Center for Disease Control
AFTCOR:	Africa Taskforce for Novel Coronavirus
BAME:	Black, Asian, and Minority Ethnic
BVN:	Bank Verification Number
COVID-19:	Corona Virus Disease – 2019
FCT:	Federal Capital Territory (Nigeria)
GBV:	Gender Based Violence
NCDC:	Nigeria Center for Disease Control
RGA:	Rapid Gender Analysis
SDGs:	Sustainable Development Goals
UN:	United Nations
UNFPA:	United Nations Funds for Population Activities
WASH:	Water, Sanitation and Hygiene
WHO:	World Health Organization

Contents

Executive Summary

The World Health Organization (WHO) declared the Novel Coronavirus Disease (COVID-19) a pandemic on 11 March 2020. The disease's sudden onset was in Wuhan, the capital city of Hubei Province in China in December 2019. Covid-19 was initially categorized as a global emergency on 30 January 2020. Subsequently, due to its speed and scale of global transmission; it became a pandemic.

The Federal Ministry of Health confirmed the first case of COVID-19 in Nigeria on 27 February 2020. To enhance a comprehensive response to the crisis, the Federal Government of Nigeria established the 'Presidential Task Force for the Control of Coronavirus (COVID-19) Disease' on 07 March 2020. The Task Force is responsible for implementing Government's National COVID-19 multi-sectoral pandemic response plan.

Government measures to address COVID-19

01

Enforcement of movement restrictions in Lagos State, FCT and Ogun State - the regions initially at the epicenter of the pandemic in the country.

02

Closure of educational institutions at all levels;

03

Banning of inter-state movements;

04

Closure of domestic and international flights;

05

Announcement of economic stimulus plans for post-pandemic recovery.

These measures have been accompanied by the announcement of Government's approval of N15 billion ($38.6) million to support national efforts to fight the COVID-19 pandemic

The Women Advocates Research and Documentation Center (WARDC) has been supporting gender equality interventions in Nigeria and has been strengthening the voices of women in the "Strengthening Citizens Resistance Against Prevalence of Corruption" (SCRAPC) project in seven states across Nigeria, including Lagos, FCT, Kano, Akwa Ibom, Enugu and Borno. With the negative impact of COVID-19 on the society, it became critical to do a holistic assessment of the effect on indigent women who represent the majority of WARDC targeted beneficiaries, therefore a Rapid Gender Analysis (RGA) became imperative.

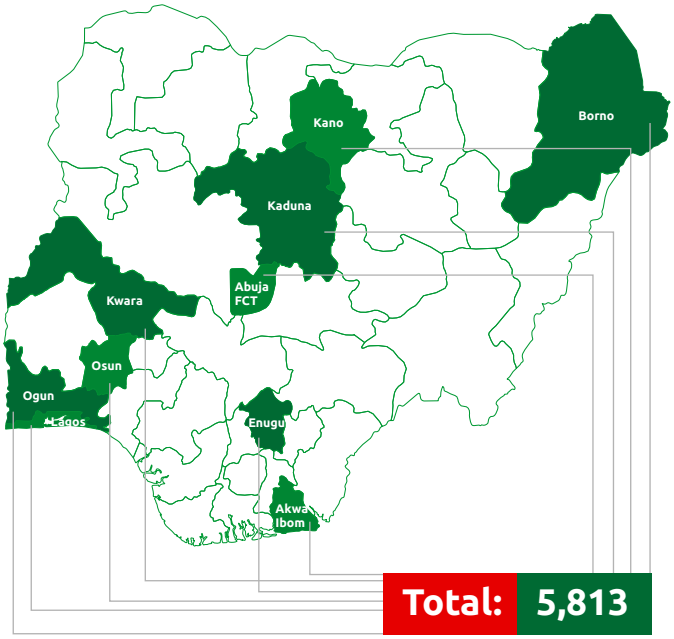
RGA provides information about the different needs, capacities and coping strategies of women, men, boys and girls in a crisis situation like COVID-19. RGA highlights the gendered impacts of COVID-19 crisis on households in Nigeria and generates data on the differential impacts of the crisis for effective planning and implementation of national emergency response. The study adopts gender accountability (GA) as analytical framework for the RGA.

Promoting transparency and accountability in government institutions is critical for effective implementation of gender equality commitments and service delivery. Women are often more dependent on basic services, such as healthcare, education, water and sanitation, because of their domestic roles. Corruption in basic services can have disproportionate and negative consequences for women and girls. The specific objectives of this RGA were to:

Methodology

The study adopted mixed methods, involving collection and analysis of quantitative and qualitative data. Primary data was sourced through questionnaires and key informant interviews while secondary data was obtained

from agencies reports, journal articles and internet resources. A total number of 5,813 respondents were sampled across nine states plus the federal capital territory in Nigeria (Lagos, FCT, Kano, Akwa Ibom, Enugu, Borno, Osun, Ogun, Kwara and Kaduna).



The questionnaires were distributed to women in randomly selected households across the selected states. For adequate representation, three local government areas were purposively selected from three Senatorial Districts of each state. The local governments were selected on the basis of urban; semi-urban and rural socio-economic categorization. Some of the questionnaires were administered physically while the others were done through phone calls and video calls based on the prevailing situations of lockdowns, physical distancing and movement restrictions. A follow-up key informant interviews with purposively respondents were undertaken in each of the ten locations. The respondents were selected from: indigent women; civil society activists, and; government officials. In all, a total number of 100 follow-up interviews were conducted in ten states. For the household survey: A 'Rapid Gender Assessment Covid-19 Tool on Households' was developed. There were 10 sections of the tool covering socio-economic, health, governance, and psychological issues.

Key Findings:

From the data analysis, (63.6%) of the households across the selected states were headed by men. The state with the highest number of male headed household is Borno (68.3%) while Lagos State (61.2%) had the least number of households headed by male. Patriarchal ethos/norms are often the characteristics of male-headed households as confirmed in previous studies (Niels Spierings, 2014; Abeda Sultana, 2011). The exclusion of women from decision making both at households and community levels is symptomatic of a patriarchal society, which also breeds political corruption that pervades Nigerian politics where women are marginalized in political participation and representation

From the data analysis, 53.3% of the respondents across the ten states had basic knowledge of Covid-19 while about 47% of the respondents across all the selected states had poor knowledge of what COVID-19 really entails. From the selected states, the results showed that Lagos State (80.1%) had the highest number of respondents with basic knowledge of COVID-19. This is followed by Ogun State (76.3%); while about one-fifth of the respondents in Kaduna (18%) and Kano (13.1%) states had poor knowledge of COVID-19. Lack of access to social services and facilities in the rural communities, occasioned by corruption, and poor infrastructural development hindered the rural poor from accessing information

As presented in the results, only 1 in every 10 respondents across all the selected 10 States earned a monthly income of #60, 000 or more. The results showed that two-thirds (65.6%) of the respondents in Borno States earned < #30,000 every month while at least 1 in every 4 respondents from Kwara (28.6%), Enugu (27%), Lagos and Akwa Ibom (26.4%) have no stable income. The results clearly revealed that majority of the respondents live below the poverty line. The poverty scourge in Nigeria is particularly severe among women especially those in the rural and semi-urban areas, where majority continues to live below the poverty line and with limited access to social services and infrastructures. A major causative factor that exacerbates poverty is lack of transparency and accountability in governance. Successive efforts by governments to address the scourge of poverty through various empowerment programmes have not achieved the desired objectives because of corruption.

Results across selected states revealed that about 60% of the respondents were fully engaged in children's care during the pandemic. The findings demonstrated a gendered distribution of labour within households, which further worsened because of the lockdown that forced children to stay home. Women's unpaid labour especially domestic care work tend to increase exponentially during national emergencies, thereby worsening women's economic disempowerment.

As indicated in the results, the proportion of respondents that participated in community decision making before the COVID-19 outbreak declined from 77.6% to 21.3% during the crisis across the selected states. From the findings, it was obvious that crucial decisions taken during the pandemic revolved around security and economic issues, where women are mostly marginalized due to dominance of men. The marginalization of women from crucial community decisions often result into arbitrariness and insensitivity to women issues in decision-making. The exclusion of women from community participation in decision making is an indication on asymmetrical power relations between men and women. Male-dominated political participation has been associated with lack of transparency, accountability and endemic corruption.

The results further showed that three-quarters (75.8%) of the respondents across all the selected states did not receive any supports from the government during the crisis. Similarly, none of the respondents from Akwa Ibom and Enugu received cash as form of support from the government while only an insignificant proportion of respondents from Lagos (2.4%), Ogun (3.9%) and Borno State (2.6%) received facemasks and sanitizers as token palliatives. The study revealed that accountability principles did not provide guiding framework in the management of palliatives during the lockdown. Accountability principles require openness and transparency in information sharing and distribution of resources as enunciated by the WHO. However, the Nigerian experience clearly negates those principles due to secrecy that shrouded information and sharing of palliatives. In addition, the handling of Covid-19 donations by the Federal Government and different States have not been transparent. While the Central Bank of Nigeria has announced a total sum of sum of N25.8 billion as donation by 107 Nigerian companies and notable individuals, as relief fund to combat Coronavirus in the country as of April 18, 2020, only few states like Kwara, Ekiti and Kaduna have published the amounts received as donations from individuals and private sectors to fight the pandemic. While almost all the states mobilized and received supports from the public, the amount received and spending were largely kept secretive, negating the principle of transparency inherent in accountability framework.

Assessment of government in the dissemination of information about COVID-19 indicated that the highest proportion of respondents who were dissatisfied with the dissemination of information were from the FCT (83.3%), followed by respondents from Enugu (77.2%) and Kaduna State (77.2%) respectively. The results across all the selected states revealed that more than two-thirds (68.4%) of the respondents were not satisfied with the dissemination of information about COVID-19. Effective communication system as a key component of accountability framework as developed by the WHO was disregarded in the distribution of palliatives. Information obtained from the key informant interviews also confirmed that citizens, especially women had limited information about distribution of palliatives by governments across the states. In most cases, the distribution was shrouded in secrecy and only known to people close to

those in power. In all, transparency and openness were lacking.

Results across the selected states, and FCT revealed that 51.8% of the respondents gave lack of money to pay for healthcare services as the major reason for the non-utilization of healthcare services by girls and women in the households covered by the survey. The pandemic glaringly exposed the collapsing state of healthcare facilities in Nigeria. The non-utilization of basic principles of accountability in the procurement of health equipment and setting up of facilities have led to non-functioning of many basic healthcare services across many hospitals in Nigeria. Huge sums allocated to health sectors over the years have not materialized into improved healthcare service delivery.

As indicated in the results, about 24% of the respondents across all the selected States, and FCT admitted to have passed through depression and state of hopelessness during the crisis, while about 40% maintained that they had experience tiredness and frustration due to the outbreak of the pandemic.

Results across all the selected States, and FCT showed that almost three-quarters of the respondents regularly washed their hands under running water (70.6%) and (74%) had access to materials and facilities for menstrual hygiene (74%).

The highest proportion of girls and women that were sexually abused were female respondents from FCT (58.8%), Kaduna (47.2%) and Lagos State (46.5%) respectively. Domestic violence was least experienced by female respondents from Kwara (27.9%) and Kano State (28.4%) respectively. Results across all the selected States, and FCT showed that more than one-third (37.8%) of the female respondents were sexually abused while another 45.2% experienced domestic violence during the COVID-19 crisis. Further evidence from key informant interviews and secondary literature confirmed the upsurge in security challenges faced by women and girls during the lockdown period. Incidence of harassment by security personnel; rape; assault and battery; ritual killings were reported in several parts of the country. The pervasive incidence of rape attracted the attention of Governors Forum, who rightly declared it 'a national emergency' (CNN: June 12, 2020).

Conclusion

- Covid-19 exacerbates pre-existing structural inequalities in income, decision-making between men and women. The pandemic further marginalizes women and exposed them to plethora of security challenges and domestic violence
- Distribution of palliatives became avenue for corrupt practices especially officials of the state, who simply hijacked the process and diverted palliative materials to their cronies and family members.
- Emergence response taskforces across the states were not gender-sensitive in the composition of team members and decision making
- Principles of transparency and accountability did not provide the guiding framework for Nigeria's emergence response to Covid-19
- Upsurge in cases of domestic violence and gender based violence against women were reported during the lockdown and
- Healthcare facilities and services were dysfunctional in the management of Covid-19, due to poor funding and pervasive corruption.
- The Nigerian state lacks the required institutional capacity for effective response to pandemic of such magnitude and thus had to follow the model from the western countries in the national response

Policy Recommendations

Open Governance and Accountability Framework in Emergency Management

- Government should incorporate accountability and transparency principles into the National Emergency Response Framework
- Expand the space for citizen's participation in emergency response by promoting transparency and accountability in the health sector thereby reducing inequality experienced in the sector.
- Inclusion of media and civil society actors in the various COVID-19 task forces across board to strengthen transparency, accountability and diversity in the process.
- Promoting the public's right to information as a strategic entry point for open governance and accountability framework in emergency response.
- Supporting public-sector reforms that increase transparency, set performance monitoring standards for service delivery, increase public-sector actors' gender awareness and increase the gender responsiveness of service delivery
- Implementing participatory monitoring of service delivery, including the use of community score cards

- Incorporate Anti-Corruption Agencies in the National Emergency Response Team
- Institutionalize Open Tendering/ Competitive Bidding for procurement in a transparent manner
- Establish appropriate legislative framework that incorporate accountability principles, including necessary safeguards for emergency response plan
- Establish clear, objective and transparent criteria to protect the interests and needs of the vulnerable groups in the society.
- Innovative technological platforms should be deployed for funds tracking and transparent assessment of disbursements
- Ensuring accountability in financial management and procurement through budget transparency and robust internal/ external auditing

Women Inclusion in Decision-making and Participatory Governance

- Increase awareness of gender issues in government policy, planning and budgeting
- Implement 50% women representation in national emergency response team and other taskforces at state and community levels
- Incorporate the 50% women political representation into electoral reforms with legislative backing
- Institute gender-budgeting framework into national emergency budgetary allocation to address specific gender issues, especially women concerns
- Incorporate women rights organization and community based groups in the identification of vulnerable people and disbursements of palliatives
- Increase the number of women in government's, public service and at the frontline of service delivery
- Develop gender-sensitive tools, sex-disaggregated data and measurements for undertaking gender assessment of programs
- Children's issues and concerns should be mainstreamed into gender framework for policy interventions, especially during national emergencies.

Community participation in Emergency Response

- Community mobilization for support system in a 'bottom-up' approach as alternative to government's 'top-down' approach during national emergencies
- Reinforce and strengthen the existing community structures such as traditional institutions, community-based organizations to be used as platforms for effective response during national emergencies.

- Community-based platforms should be incorporated into social-protection and support services for the most vulnerable groups during emergencies
- Community healthcare (primary health centers) should be adequately staffed and equipped to provide first line of response during national health emergencies.
- Support women's groups such as market associations and cooperative societies as platforms for distribution of food palliatives, direct cash transfer and other palliatives to vulnerable women

Security Sector Reforms for Effective Emergency Response

- Incorporate gender mainstreaming framework into security sector national emergency response strategy
- Strengthening structures to accommodate gender interests such as gender desk office, juvenile units etc
- Eliminate operational frameworks and guidelines that inhibit women's access to justice
- Strengthening the operational capacity and institutional preparedness of security agencies to respond effectively to gender based violence and violence against women during emergencies

Healthcare Facilities/Social Support Services during Emergencies

- Government should invest in provision of facilities to cater for women hygiene such as provision of accessible portable water, toilets and fumigation of public places during health crisis
- Institutionalization of social support services should be entrenched in state structure and not operate on the framework of 'fire brigade'.
- Include mental health care and psychosocial supports into national emergency response strategies.
- Expand access to affordable healthcare for all, irrespective of economic status
- Provide necessary PPE for frontline workers during emergency
- Facilitate access to basic health services such as immunization clinic, ante-natal and post-natal care and family planning clinic without interruption during emergencies
- Upgrade infrastructures and prioritize continuous facilities building before emergency

GBV Prevention and Response during Emergency

- Appropriate prevention and response measures should be put in place for GBV, including: hotline for reporting incidents; counselling supports and safe shelter
- Ensuring proper training and capacity building for security personnel for effective response to GBV during emergencies
- Collaborate with women's right groups and community based organizations to provide awareness and necessary sensitization to GBV to the most vulnerable groups in the society
- Provide necessary supports for survivors of GBV such as rehabilitation, counselling and other support services
- Ensure adequate provision of funds to support GBV response strategy during emergencies.

01

Contextualizing Covid-19 Pandemic

The World Health Organization (WHO) declared the Novel Coronavirus Disease (COVID-19) a pandemic on 11 March 2020. The disease's sudden onset was in Wuhan, the capital city of Hubei Province in China in December 2019. Covid-19 was initially categorized as a global emergency on 30 January 2020. Subsequently, due to its speed and scale of global transmission; it became a pandemic. By 31th June, total cases of 10, 538, 577 and 512,689 deaths were reported globally (John Hopkins University).

WHO and Africa Center for Disease Control ACDC) have led a continental preparedness and response initiatives. African governments have established a taskforce to coordinate the response - Africa Taskforce for Novel Coronavirus (AFTCOR) with the following pillars:

Preliminary evidence from China, Italy, New York, United Kingdom, among other places reveals that men are at higher risk of contraction and death from Covid-19 – more than 58% of Covid-19 patients were men with over 60% higher rate of fatality over women (China CDC Weekly 2020:113; Lancet 2020: 846; Brookings 2020:1). In addition, studies have revealed that Black, Asian and Minority Ethnic (BAME) communities are significantly more likely to die than people of white colour from Covid-19 disease.

However, certain preexisting socio-economic and political conditions of women make them more vulnerable to indirect consequences of the pandemic, 'requiring specific policy responses to mitigate their plight' (Brookings 2020:1). Not only are women, men, girls and boys affected differently by Covid-19, the longer-term impact of the pandemic will continue to exacerbate and reproduce gendered inequalities across the globe. The projected short- and long- term gendered impacts of the pandemic are further compounded in low-income countries. Women's vulnerability to marginalization exponentially increases due to their socially-ascribed caretaking roles, especially in times of crisis and peace.

Thesis of the Study

Recognizing the extent to which a pandemic affects women and men differently is a fundamental step to understanding the primary and secondary effects of a health emergency on different individuals and communities, and for creating effective, equitable policies and interventions (Smith, 2019). Covid-19 pandemic outbreak in Nigeria has exposed the existing structural inequalities in the society, with devastating

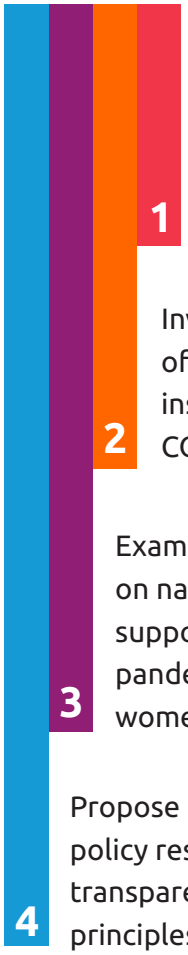
and disproportionate effects on women and girls in a number of ways including adverse impacts on food and nutrition, health, livelihoods, security and protection.

If the national response to disease outbreaks such as Covid-19 is to be effective and not reproduce or perpetuate gender and health inequities, it is important that gender norms, roles, and relations that influence women's and men's differential vulnerability to infection, exposure to pathogens, and treatment received, as well as how these may differ among different groups of women and men, are considered and addressed (UN Women, 2020).

1.2. Purpose of Rapid Gender Analysis (RGA) Framework

Gender analysis is a socio-economic analysis that reveals how inequality in gender relations and opportunities affect development issues in the society. Rapid Gender Analysis (RGA) provides information about the different needs, capacities and coping strategies of women, men, boys and girls in a crisis situation like COVID-19. The analysis was undertaken to explore the current and potential gendered dimensions of COVID-19 and highlights the ways in which women, girls and other marginalized people are likely to suffer from the pandemic.

Specific Objectives of Rapid Gender Analysis (RGA)



1. Document the experience of women during COVID-19 in relation to decision-making, and access to information, socio-economic services and palliatives.
2. Investigate women's experience of gender based violence and insecurity before and during COVID-19.
3. Examine the impact of corruption on national response and social support services during the pandemic with specific focus on women's vulnerability
4. Propose people-oriented emergency policy response that incorporates transparency and accountability principles.

1.3. Key Findings from the Literature/ Analytical Framework

Covid-19 as a deeply gendered and development crisis finds relevance in the literature on Sustainable Development Goals (SDGs) especially the gender equality goals within the framework of SDGs. Various UN agencies such as WHO, UN-Women and UNFPA have undertaken a gender analysis of Covid-19 and its impact on issues affecting women such as: women reproductive and maternal health; economic hardship of the pandemic on women; marginalization of women in decision making; teenage pregnancy during prolonged lockdowns and attendant school drop-outs; increase in gender based violence and general

insecurity for women; and unpaid care work (UN, 2020; UNFPA, 2020; WHO, 2019). A gender analysis framework is an integral part of the broad literature on development analysis, governance and human development approach.

Within human development framework, gender, poverty and the delivery of basic services, such as healthcare, education and social protection, are closely interwoven. Delivery of public services is essential for helping women and men to reach their full potential and realize their human rights (Corner, L. and Repucci, S. 2009; World Bank, 2012). Women are often more dependent on basic services, such as healthcare, education, water and sanitation, because of their domestic roles. However, gender-specific biases in the way services are designed and delivered are failing women in many countries. For example, a lack of separate toilets (or any toilet facilities) in schools can deter adolescent girls from attending school (World Bank, 2012)

Gender accountability framework (GAF) requires public accountability from senior managers to ensure gender mainstreaming in the allocation and management of resources in achieving equitable outcomes for all persons of concern. Tracking financial allocations and monitoring how and where they are spent is key to increase accountability in financing for gender equality. Accountability framework aims to demonstrate organizational leadership by placing accountability with senior management in a transparent manner (UNHCR, 2019). Transparency is a key component of the WHO accountability framework (WHO, 2015). Transparency refers to an organization's openness about its activities, providing reliable and timely information that is accessible and understandable on what it is doing, where and how its activities take place, and how the organization is performing, unless the information is deemed confidential (WHO, 2015). Promoting transparency and accountability of government institutions is critical for effective implementation of gender equality commitments.

Accountability is the obligation of an organization and its staff members to be answerable for delivering specific results that have been determined through a clear and transparent assignment of responsibility, subject to the availability of resources (WHO, 2015). Accountability includes achieving objectives and results in response to mandates, fair and accurate reporting on performance results, stewardship of funds, and all aspects of performance in accordance with regulations, rules and standards, including a clearly defined system of rewards and sanctions (WHO 2015:13).

The four pillars of WHO accountability framework for delivering results and expected outputs are interconnected: human resources management; financial and asset management; information management; and partnership management (WHO, 2015). The human resources management pillar refers to the organization's responsibilities and accountabilities for managing human resources effectively, including attracting talent, retaining, and developing talent, and providing a quality work environment. The financial and asset management pillar refers to managers' responsibilities to demonstrate stewardship of funds, safeguarding of assets and the effective, efficient and economical use of financial resources entrusted to them.

Financial resources are therefore managed with prudence and probity to achieve the organization's objectives founded on sound internal controls, timely and reliable reporting (WHO, 2015:13).

Development practitioners are expanding traditional definitions of corruption to include actions that are disproportionately experienced by women, such as sexual extortion and human trafficking (UNDP, 2010; Transparency International, 2010). Corruption in health and education provision can have disproportionate and negative consequences for women and girls. It can compromise their access to quality schools and clinics, their own social and economic empowerment, and their country's prospects for economic and social development (Transparency International, 2010). Some forms of corruption in public services, such as health and education, are specific to women and girls. This may take the form of petty corruption, where women and girls are compelled to make informal payments for services that are supposed to free, or through the use of sex as a form of payment in return for public services. It may also be less direct where existing inequalities and patriarchal structures are exploited to commit abuses. Mainstreaming gender in anti-corruption work ensures that women are represented at all stages of service delivery and thus less vulnerable to negative impacts of corruption (Transparency International, 2010).

One reason for corruption's disproportionately negative impact on women is because women form the majority of the global poor. The poor, reliant on publicly provided services, disproportionately suffer when corruption depletes the amount of resources available to those services (Schimmel and Pech, 2004; Khadiagala, 2001).

In contexts, where bribery has become a prerequisite to accessing services, rights and resources, women's relatively weaker access to and control of personal resources has meant that they are more frequently denied access to these services (Nyamu-Musembi, 2007). Women's statistically lower literacy levels, which often result in a relative lack of knowledge of rights and entitlements to services and public programmes, leaves themmore vulnerable to extortion and abuse of laws (UNDP 2008a).

Gender–responsive governance is also relevant as analytical framework for explaining a gender analysis of the national response to Covid-19 pandemic in Nigeria. The participation of women and men in formal and informal decision-making structures varies greatly between countries, but generally in favour of men (Krook, M. L. and Norris, P. 2014). Women's low political representation is therefore often used as an indicator of gender inequality (Hoare, J. and Gell, F. (eds). 2009).The pandemic and response to it are likely to affect women's and girls' participation in decision-making within and outside the household. With fewer women and girls represented in decision-making bodies at all levels than men, the risk that economic, financial, and political entities will not include a gender lens in their recovery plans is high (post-pandemic economic recovery).

Experience from past disease outbreaks have shown the importance of incorporating a gender analysis into preparedness and response efforts to improve the effectiveness of health interventions and promote gender and health equity goals. For example, during the 2014-2016 Ebola disease outbreak in West Africa, gendered norms meant that women

were more likely to be infected by the virus, given their predominant roles as caregivers within families and as frontline health-care workers. Data from the State Council Information Office in China suggests that women, emphasizing the gendered nature of the health workforce and the risk that predominantly female health workers are exposed to (WHO, 2019).

Despite the WHO's recommending the need to include women in decision making on community and national response, there is glaring marginalization of women's representation and participation in the national response to Covid-19 outbreak in Nigeria. This is not peculiar to Nigeria as similar trend could also be seen across the world. The United State White House Coronavirus Taskforce is a typical example of women's marginalization in Covid-19 interventions.

02

Methodology

The study adopted mixed methods involving quantitative and qualitative data. Primary data was sourced through questionnaires and key informant interviews while secondary data was obtained from agencies reports, journal articles and internet resources. A total number of 5,813 respondents were sampled across nine states plus the Federal Capital Territory (FCT) in Nigeria. The questionnaires were distributed to women in randomly selected households across the selected states. To ensure adequate representation, three local government areas were purposively selected from the three Senatorial Districts of each state. The local governments were selected on the basis of urban; semi-urban and rural socio-economic categorization

For data collection, 50 Enumerators were mobilized in each of the 10 states. Each Enumerator was expected to administer at least 10 questionnaires, thereby returning a minimum number of 500 questionnaires from each state. Some Enumerators administered more than the required instruments and that is why we have close to 6,000 respondents. Some of the questionnaires were administered physically while the others were done through phone calls and video calls based on the prevailing situations of lockdowns, physical distancing and movement restrictions. A one-day training on data collection, assessment tools and ethical considerations was organized for all the Enumerators

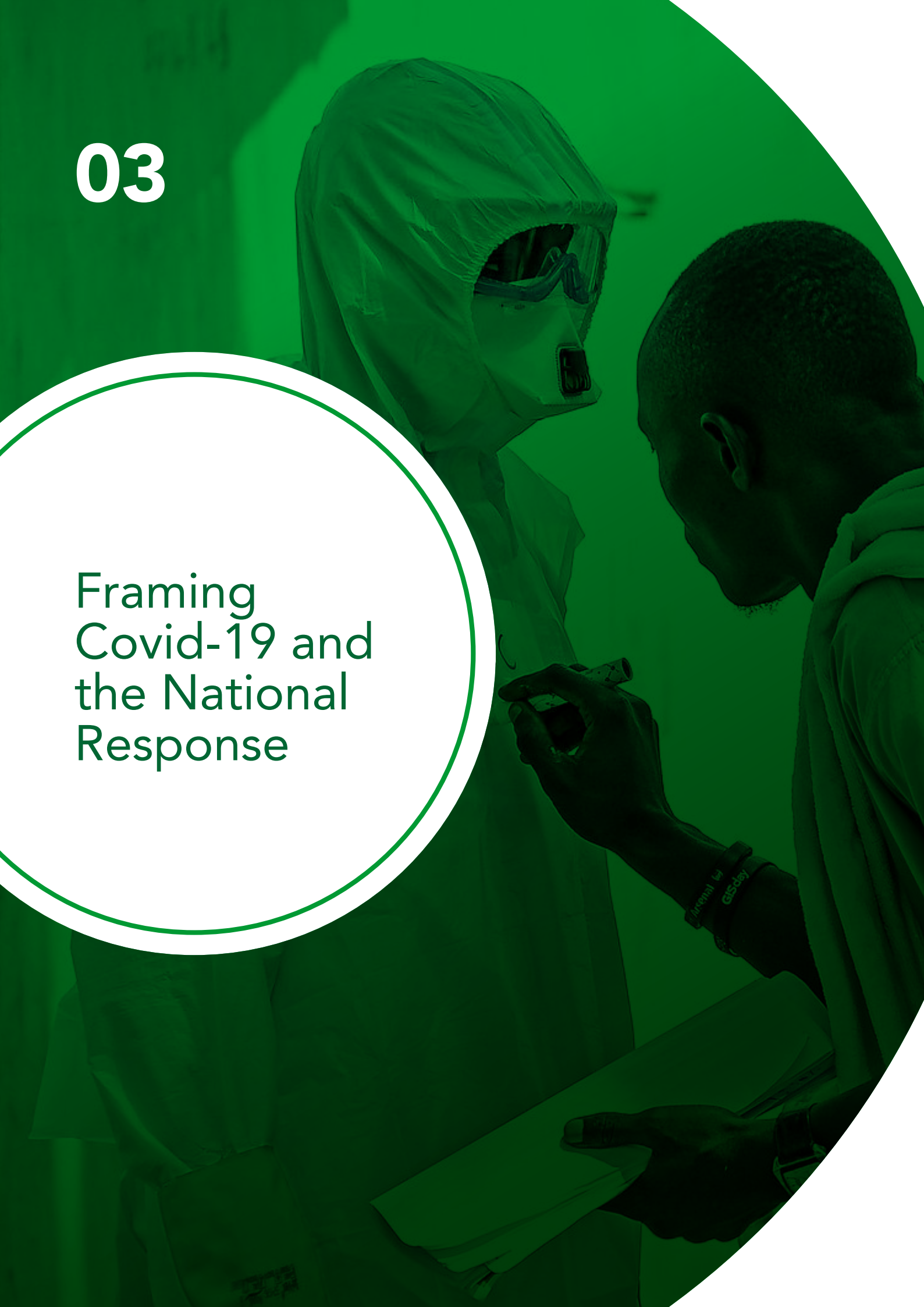
A follow-up key informant interviews with 10 purposively respondents were undertaken in each of the ten locations. The respondents were selected from: 4 indigent women; 3 civil society activists, and; 3 government officials. In all a total number of 100 follow-up interviews were conducted. For the household survey: A 'Rapid Gender Analysis of Impacts of Covid-19 on Households Tool was developed.

TABLE 1: A 'Rapid Gender Analysis of Impact of Covid-19 on Households'

SECTIONS	VARIABLES
1	Socio-Demographic Characteristics of Respondents
2	Respondents' Knowledge of Covid-19
3	Respondents' Livelihoods and Income
4	Impact of Covid-19 on Participation in Household & Community Decision making
5	Covid-19 and Corruption
6	Covid-19 and Health (Men and Women)
7	Covid-19 and Mental Health
8	Covid-19, Water, Sanitation and Hygiene
9	Impact of Covid-19 on Women's Security and Gender Based Violence (GBV)
10	Respondents' Recommendations for Policy Design

03

Framing Covid-19 and the National Response



The Federal Government of Nigeria established the 'Presidential Task Force for the Control of Coronavirus (COVID-19) Disease' on 07 March 2020. The Task Force is responsible for implementing the Government's National COVID-19 multi-sectoral pandemic response plan. Among the measures to address the escalating COVID-19 crisis in Nigeria include the enforcement of movement restrictions in Lagos State, FCT and Ogun State - the regions initially at the epicenter of the pandemic in the country; closure of educational institutions at all levels; banning of inter-state movements; closure of domestic and international flights; and announcement of economic stimulus plans for post-pandemic recovery. These measures have been accompanied by the announcement of the Government's approval of N15 billion ($38.6) million to support national efforts to fight the COVID-19 pandemic.

The National Taskforce on Covid-19 established by the Federal Government was largely constituted by cabinet members and dominated by men. The 12 member taskforce has only one member outside cabinet ministers and two women representatives. It is however, interesting to note that critical stakeholders such as medical associations, civil society representatives, women's interest groups and community based organizations are not represented. Out of the two women in the taskforce, one is a cabinet minister while the second one is a representative of an international agency (WHO). Gender mainstreaming into the national response becomes a distant consideration in a group where women are not adequately represented

By Tuesday 30th June, 2020, the total confirmed Covid-19 cases in Nigeria were 25,694 of which 9,746 cases had been successfully managed and discharged; while confirmed fatality were 590 (Nigeria Centre for Disease Control). In addition, a total number of 138,462 samples had been tested by that date. Of the total confirmed cases, 17,040(66%) were male while confirmed female were 8,654(34%).

The media's framing whether conventional or social media has influenced global response in a 'predictive manner'. One of the ways of media framing is in the deployment of language used to describe the virus and corresponding state's responses. Such terms as 'flattening the curve', 'pandemic', 'peak', 'modelling', 'invasion', 'lockdown', 'social distancing', 'isolation', 'palliatives' originated in the west, and projected globally by the media leading to the adoption of some of these measures in many countries with contrasting consequences. Many states, including Nigeria, on account of western media framing panickly adopted measures that were inconsistent with socio-cultural and economic realities. This has led to policy inconsistency and reversal in many countries. The lockdown measures adopted by many non-western countries with weak welfare system have imposed economic hardship on the poor in developing countries as seen in India and many African countries

3.1 Covid-19 in Selected States and Summary of Responses

The Nigeria Center for Disease Control (NCDC) in its report for 30th June confirmed that Covid-19 had spread across 36 states including the FCT in Nigeria. Although the Federal Government had sent up a 'Presidential Taskforce on Covid-19', state governments are directly responsible for implementing specific national action plans in their respective states.

TABLE 2: States' Incidence of Covid-19 and Summary of Responses

S/N	STATE	INCIDENCE OF COVID-19	MEASURES/ ACTIONS TAKEN
1	**Akwa-Ibom**	• 86 confirmed cases were reported by 30th June of which 30 were active; 54 successfully managed and discharged; and 2 deaths recorded.	• Covid-19 Medical Management Team headed by Commissioner of Health inaugurated • Gender desk of Ministry of Agriculture and Women Affairs funded to manage Gender Based Violence and related matters • Setting up isolation center, lockdown imposition and distribution of palliatives
2.	**Bornu**	• Index case recorded on 18th April, 2020 at Maiduguri • By 30th June, 493 cases identified in the state : 39 active cases; 422 recoveries and 22 deaths	• Borno State COVID 19 Response Team chaired by Deputy Governor inaugurated • Massive awareness campaign in the state • Distribution of masks, sanitizers and food materials. • Movement restrictions, lockdown and setting up isolation centers.
3	**Enugu**	• First confirmed case announced by the government on February 27th 2020 • By 30th June, the state had a total of 261 cases: 182 active; 73 discharged cases; and 6 deaths.	• Setting up the State Respond Team headed by the Commissioner for health • Designating specialist isolation centers for treatment • State wide mobilization for awareness • Distribution of palliatives • Imposition of lockdown and restriction of movements
4	**FCT**	• Index case of COVID-19 patient recorded on March 13, 2020 • By June 30, 2020, 1,870 cases were recorded of which 1,267 were active; 570 discharged, and; 33 deaths recorded	• Inauguration of FCTA Ministerial Advisory Committee on Covid-19 with different sub-committees • Lockdown of the state from March 27 to May 15, 2020 • Distribution of palliatives across FCT • Provision of boreholes across the state
5.	**Kaduna**	• By 30th June 2020, 766 cases were confirmed in Kaduna of which 532 discharged; 222 active; and 12 deaths recorded. • Majority of the cases recorded in Kaduna were deported Almajiris from Kano state	• Activation of Emergency Operating Centre for surveillance of COVID 19 in Kaduna. • Partnership with UNFPA & CSOs to track gender based violence through "Kaduna State GBV Actors." • Setting up isolation/quarantine centers and distribution of palliatives • Frequent enlightenments and community mobilization for sensitization
6.	**Kano**	• First index case was recorded on 11th April 2020 • By 30th June 2020, 1,216 cases were confirmed in Kano of which 931 discharged; 231 active; and 52 deaths recorded.	• A Taskforce Committee on Covid-19 was inaugurated by the state government headed by the deputy governor • The first lockdown was announced on 16th April to minimize the spread of the virus. • There are currently four isolation centers, including a female only isolation center • A fund raising committee on Covid-19 has received a total amount of N353, 909,118 donated by the members of public & corporate organizations

			• NCDC has established a molecular testing center for Covid-19 at Bayero University Kano
7.	**Kwara**	• Kwara State, as at June 30, 2020, had 217 confirmed cases of Covid-19; 131 of the patients had been discharged after treatment; 80 cases were active; and 6 deaths recorded.	• A COVID-19 Technical Committee consisting of health care professionals and officials headed by the Deputy Governor was set up • Imposition of lockdown and restriction of movements • Fumigation of public places and community enlightenment campaigns • Distribution of palliatives to vulnerable groups
8.	**Lagos**	• On 27th February 2020, a 44-year old Italian citizen was diagnosed of COVID-19 in Lagos State. The case was the first to be reported in Nigeria • By 30th June, 2020, Lagos had recorded 10,510 cases of which 8,779 were active; 1,603 discharged and 128 deaths recorded.	• A Taskforce headed by the Commissioner for health was inaugurated to coordinate the state response • Isolation centers were set up in different parts of the state • Mobilization of funds from the public and private sector • Distribution of palliatives across the state Imposition of lockdown by the FG
9.	**Ogun**	• Nigeria's Index case confirmed on 27th February worked in Ogun state. By June 30th 2020, total confirmed cases were 826 of which 571 had been discharged; 236 were active and 19 deaths recorded.	• FG imposed a total lockdown of the state to prevent community spread • Mobilization of funds from the public and private sector • Distribution of palliatives • Women economic empowerment scheme implemented • Renovation of 20 Primary Health Centers and isolation centers
10	**Osun**	• By 30th June, 127 confirmed cases were reported of which 74 were active; 48 discharged; and 5 deaths recorded.	• Imposition of lockdown and restriction of movements • Distribution of palliatives and community enlightenment campaign

Sources: NCDC website and qualitative reports from fieldwork

From the information provided in Table 2, there were similar patterns and directions in the responses of states to Covid-19. The responses were predictive and modelled after the national response. In addition, only few women-focused/specific interventions were observed in few states like Kaduna, Kano, Ogun and Lagos.

04

Analysis of Household Survey
(Quantitative & Qualitative)

4.1. Socio-Demographic Characteristics of Respondents

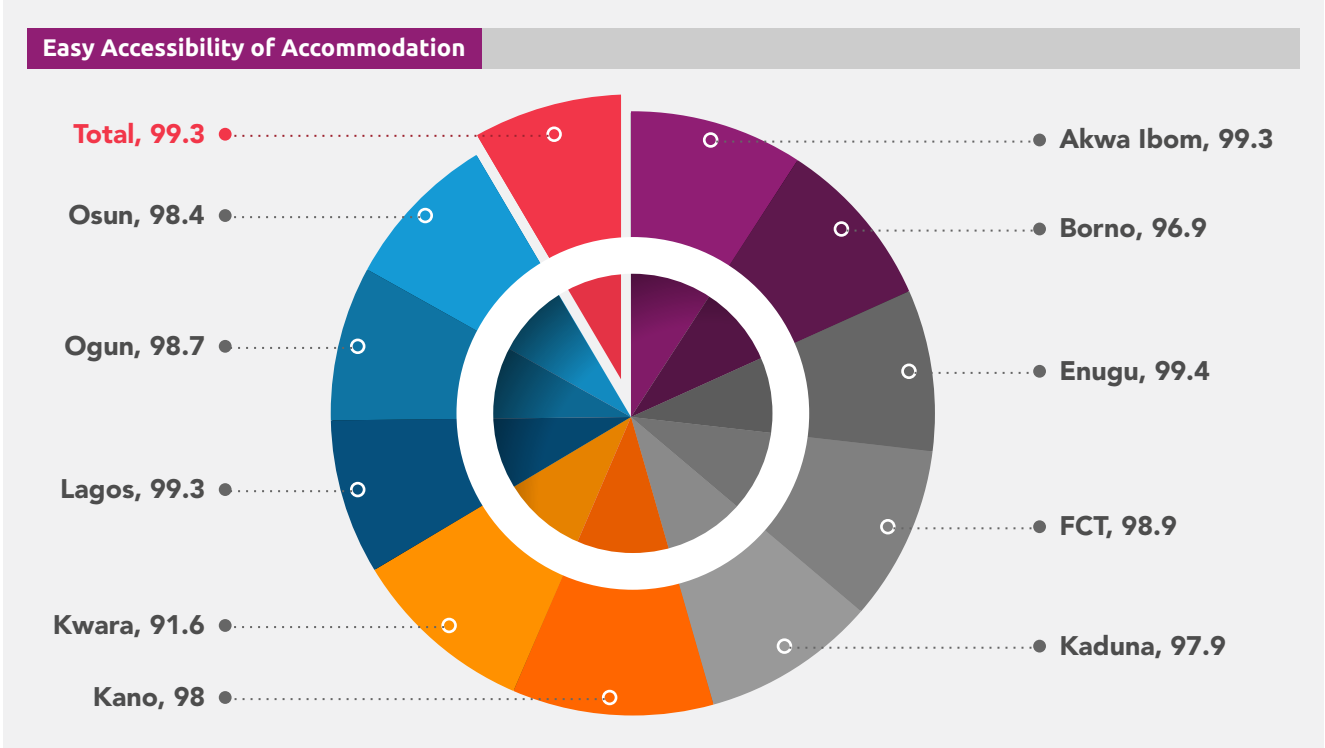
Table 3: Distribution of Respondents by States of Residence across Selected States

S/N	STATE OF RESIDENCE	NUMBER (5813)	PERCENTAGE (%)
1	Akwa-Ibom	565	9.7
2	Borno	657	11.3
3	Enugu	539	9.3
4	FCT	588	10.1
5	Kaduna	581	9.9
6	Kano	731	12.6
7	Kwara	570	9.8
8	Lagos	544	9.4
9	Ogun	540	9.3
10	Osun	498	8.6

As shown in Table 1, the sampled population was nearly proportionately captured across the selected states for the study. The least sampled state by population sample was Osun (498 Respondents, which represented 8.6% of total sample size of the study) while the largest sampled population was Kano State (731 Respondents, which represented 12.6% of the total sampled population).

4.1.2. Distribution of Respondents by Accessibility of Accommodation

Figure 1: Distribution of Respondents by Easy Accessibility of Accommodation



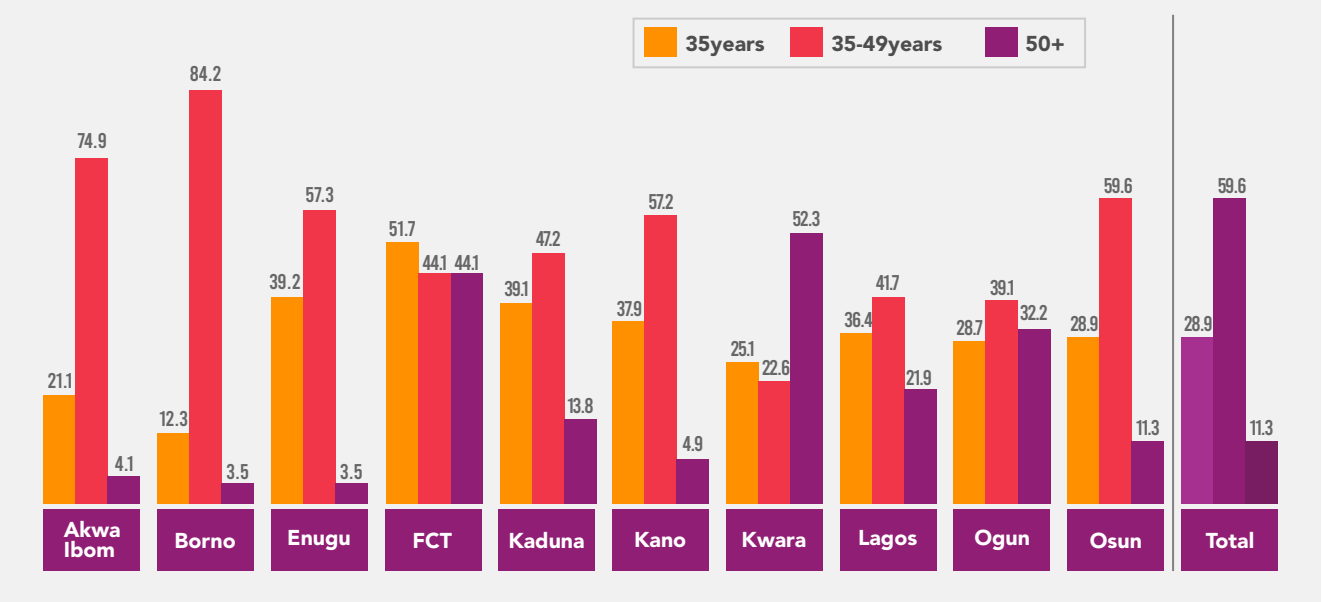
As indicated in Figure 1 above, respondents with least easily accessible house or place of living were those from Kwara State (91.2%) while over 99% of the respondents from Enugu (99.4%), Akwa Ibom (99.3%) and Lagos State (99.3%) could be easily located. Results across all the selected States, and FCT showed that only 0.7% of the respondents lived in a house that could not be easily accessed.

Although, the quantitative data presented above indicate that majority of the respondents have accessible accommodation, this does not necessarily amounts to house ownership. Several national and international data have indicated inadequate housing for majority of Nigerians and this situation disproportionately affects women (OECD, 2019; World Bank, 2016; Nigeria Demographic and Health Survey, 2018). A prejudice exists against women concerning their ability to pay for rent and also cultural and religious beliefs discourage women's ownership of property.

According to the Nigeria 2018 Demographic and Health Survey, 'men are more than three times likely to own a house or land as women'. In many parts of Nigeria, and especially in rural areas, women's enjoyment of the right to adequate housing continues to be dependent on their access to and control over land and property. Women's direct access to land is often limited in traditional societies where men remain central heirs and holders of land rights in patrilineal communities. Furthermore, income dictates the quality of housing and women are often associated with lower income and are thus disadvantaged in housing delivery efforts. Meanwhile, to secure housing loan and mortgages, there is always a criteria for qualification; e.g. formal employment, educational level and regular monthly income. The nature of collateral and securities often demand by the housing agencies (both public and private) tend to be beyond what many women can provide in an environment lacking transparency and where pervasive corruption is associated with land ownership, securing certificate of occupancy and housing loans.

4.1.3. Distribution of Respondents by Age

Figure 2: Distribution of Respondents by Age

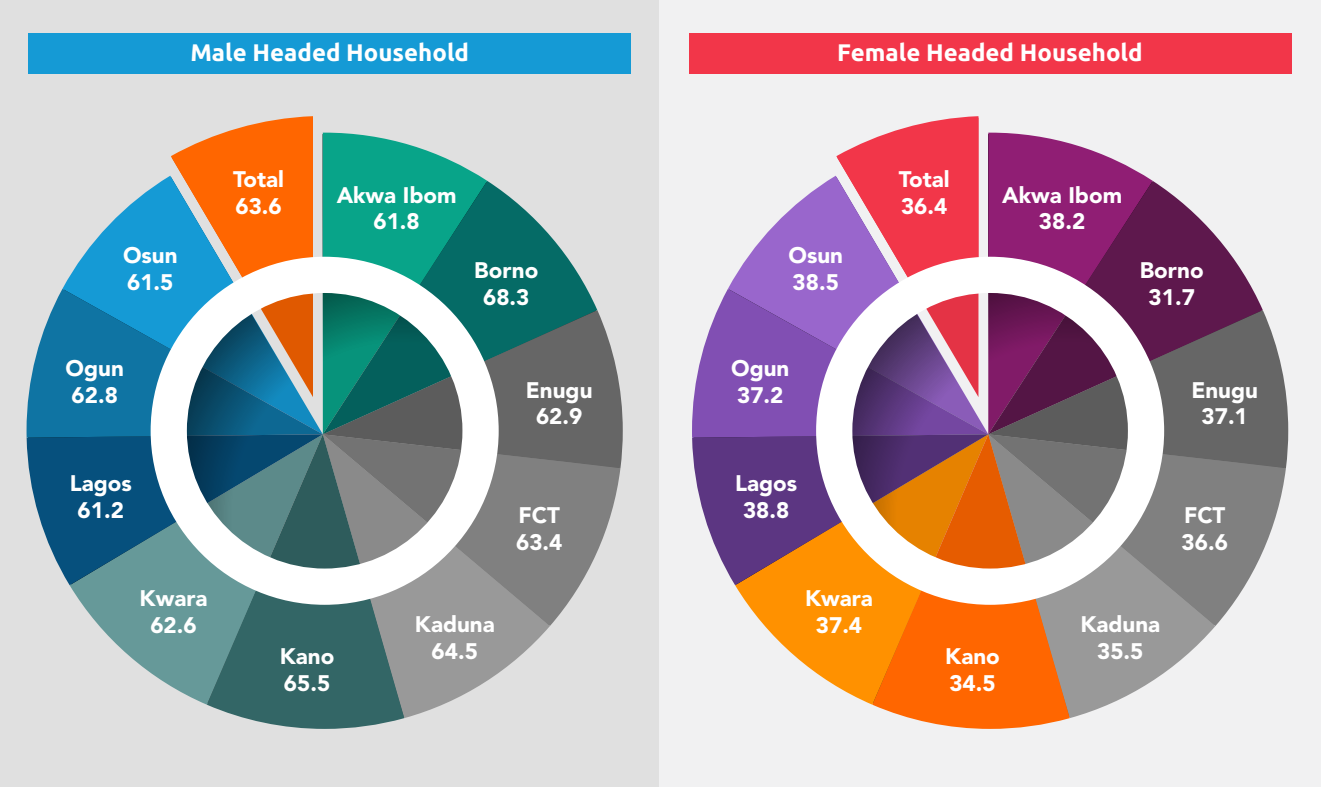


Analysis of Household Survey (Quantitative & Qualitative)

Figure 2 presents the distribution of the respondents by age. Results across the selected states, and FCT revealed that more than half (53.3%) of the respondents were in the age group of 35 to 49 years, while about one-third (32%) were less than 35 years old. The results showed that the largest proportion of respondents in the age group 35 to 49 years were from Akwa Ibom (74.9%), while the state with the least proportion of the youngest age group (<35 years) was Borno (12.3%) and the state with largest proportion of oldest respondents was Kwara (52.3%).The total results indicate that majority of the respondents were still in economically productive age groups.

4.1.4 Distribution of Respondents by Sex of Household Headship

Figure 3: Distribution of Respondents by the Sex of Household Headship



As indicated in Figure 3, three in every five households in all the states were headed by men. The state with the highest number of male headed household is Borno (68.3%) while Lagos state (61.2%) had the least number of households headed by male. On the other hand, while Kwara state (37.4%) had the highest number of households headed by women, the results showed that Lagos state (28.8%) had the least number of female headed households. From the data analysis, (63.6%) of the households across the selected states were headed by men. According to the 2018 Nigeria Demographic and Health Survey (NDHS), 14.7 percent of rural households and 21.8 percent of urban households were headed by women. Studies have shown that female headed households, especially those headed by adolescents females, who are forced into the role of breadwinners are exposed to many

'vulnerabilities' such as poverty, poor living conditions, inadequate health care, sexual exploitation among others (EU, 2019, UN, 2018). In addition, patriarchal ethos/norms are often the characteristics of male-headed households as confirmed in previous studies. Decision-making in such households are largely taken by men. In male-headed households, men often retained exclusive power over critical decisions such as finance, child's education, size of the family, healthcare, investment, among others. Power analysis within male-headed households portrays a picture of marginalization which is often transferred into public domain resulting into women's exclusion from decision-making and low political representation.

05

Respondents Knowledge of COVID-19, Livelihood and Income

5.1. Analysis of Respondents' Knowledge of COVID-19 across Selected States

Figure 4: Distribution of Respondents by their knowledge of Covid-19

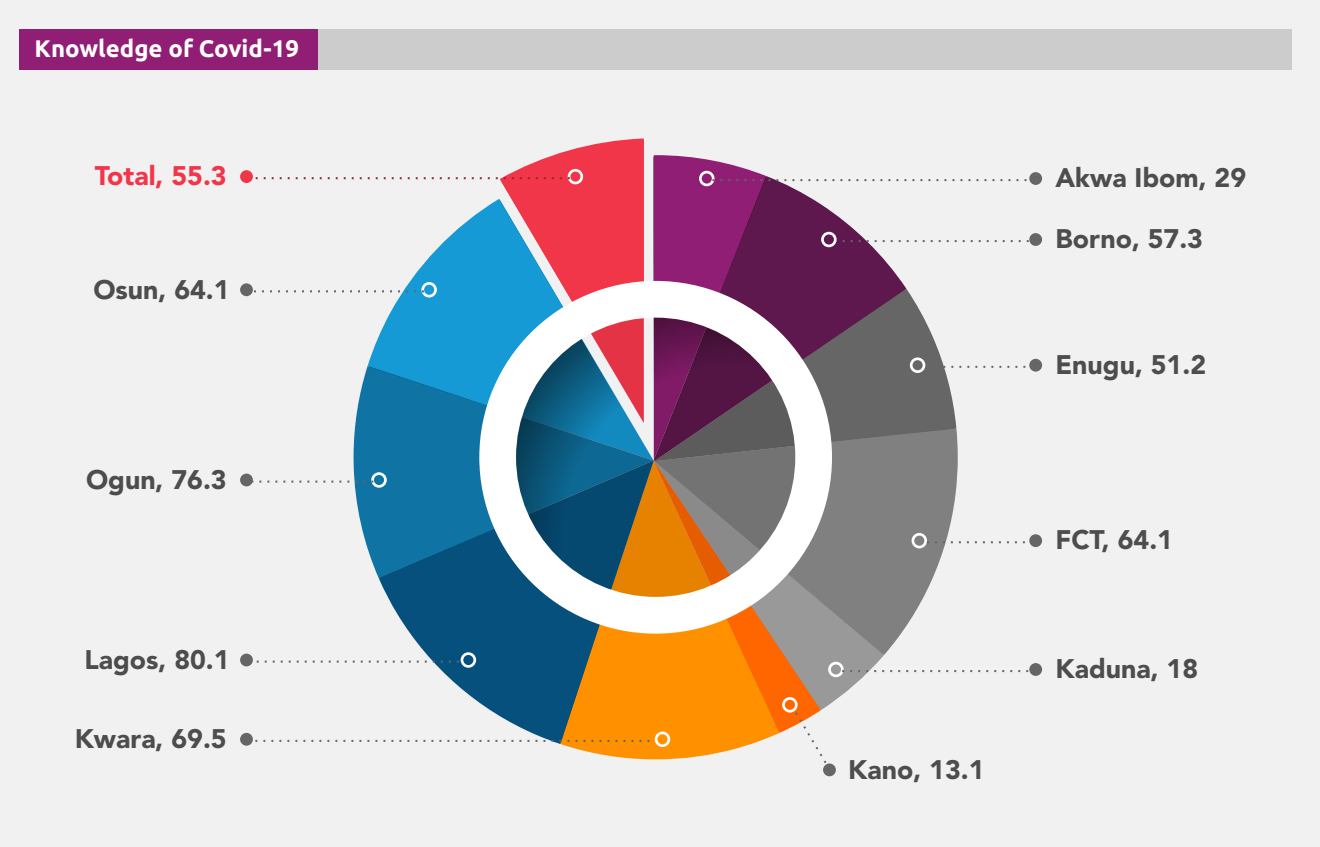


Figure 4 shows the proportion of the respondents with basic knowledge of COVID-19. The results showed that Lagos state (80.1%) had the highest number of respondents with basic knowledge of COVID-19. This is followed by Ogun state (76.3%); while less than one-fifth of the respondents in Kaduna (18%) and Kano (13.1%) states had good knowledge of COVID-19. As indicated in Figure 2 about 53.3% of the respondents across all the selected states had good knowledge of what COVID-19 really entails. The findings of the study confirm the status of Lagos as the epicenter of coronavirus disease in Nigeria which could be responsible for the adequate knowledge displayed by respondents from Lagos. The poor knowledge displayed by respondents from Kano, Kaduna, Akwa-Ibom, Bornu and Enugu also indicates poor literacy, and limited access to information. As confirmed in the literature, women are disproportionately affected by access to basic services such as education and information. In many of the rural and semi-urban setting, the pervasive corruption in the society depletes the amount of resources available to social services and infrastructure such as electricity, television access, which constrained women's knowledge of current affairs. Many poor women in the rural settings also cannot afford television set and often rely on third-party information that are not often reliable and accurate. From a woman respondent in Akwa-Ibom:

"Coronavirus is a myth and I can never be affected by the virus because it is the sickness of the rich. Even, if there is corona, it is not my portion"

However, a civil society activist from Bornu state reported Covid-19 thus:

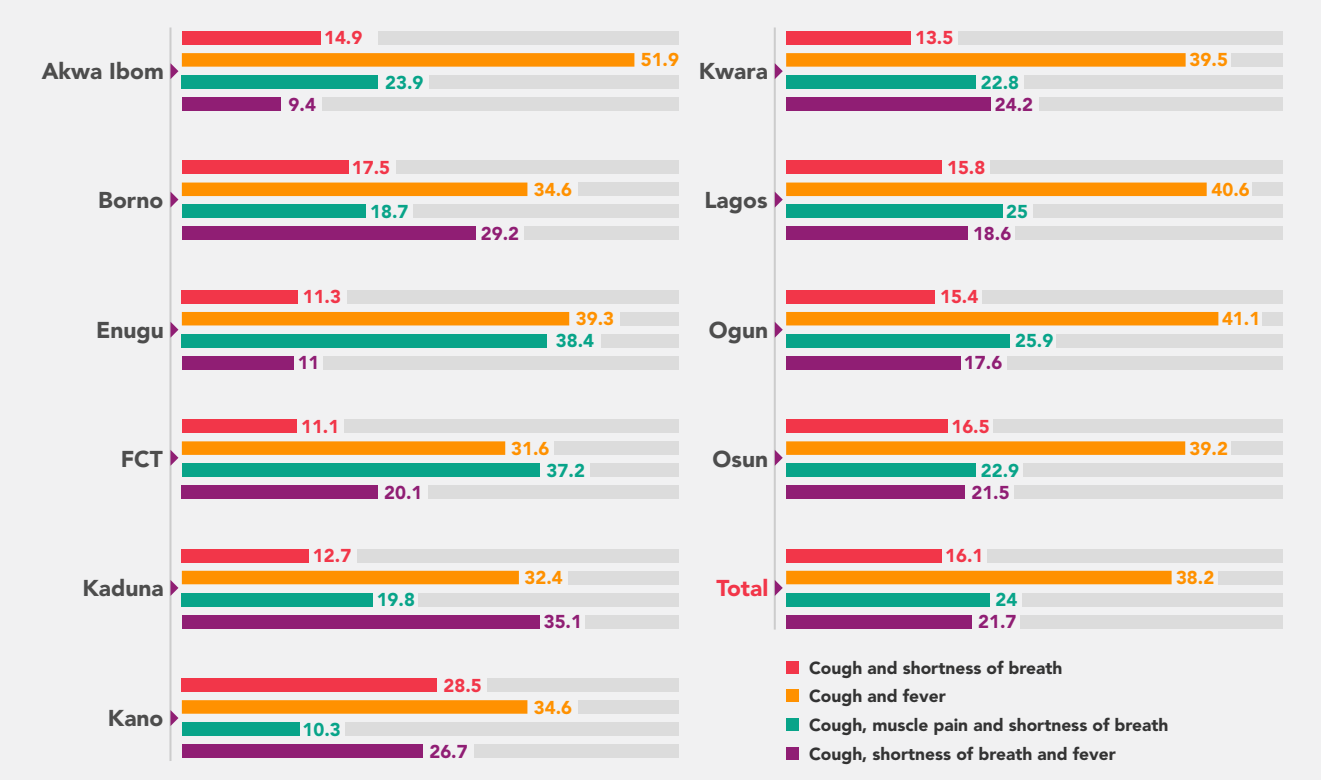
Corona virus is a disease that causes respiratory problems in human beings. The infection is caused by a newly discovered coronavirus, the first Covid - 19 case was reported in Wuhan China, where the victim is said to have had contracted the virus from the animal market in the city of Wuhan. The virus can be transmitted through the mouth, nose of the eyes after a contact with an infected person and/or object.

Another respondent from Lagos declared about Covid-19:

Covid19 is otherwise known as corona virus that affects the respiratory system and cause death if not taken care of and can be transmitted from an effected person through droplets or objected to another and yet no cure has been found yet. The virus originated from Wuhan in China. And has overtime spread through other parts of the world and Africa, Nigeria and effected more than 6000 persons across states

5.2. Distribution of Respondents by Knowledge of Main Symptoms of COVID-19

Figure 5: Distribution of Respondents by knowledge of Main Symptoms of Covid-19



As indicated in Figure 5 above, 38.2% of the respondents identified cough and fever as the main symptoms of the virus, while less than one-quarter (21.7%) stated cough, shortness of breath and fever as the main symptoms of COVID-19. Specifically, the results showed that the highest proportion of respondents who identified cough and and fever as the main symptoms of COVID-19 were from Akwa Ibom (51.9%) and Ogun states (41.1%). The results demonstrated that a good number of the respondents had basic knowledge of the main symptoms of COVID-19. As indicated under the state analysis of Covid-19, many states embarked on massive community enlightenment campaign, which enhanced the knowledge of respondents about the main symptoms of Covid-19. Responses from interview respondents varied on their knowledge of symptoms of Covid-19.

Perceptions of Respondent:

Kaduna state:

According to my understanding the COVID-19 is like an epidemic from the Almighty himself but through some people with wicked heart and also as a punishment for disobedience. I believe that is what's going on.

For another respondent from Kaduna:

What I understand by this disease is that it is deadly and we should avoid what will make us contract this disease. We can protect our self by avoiding crowd, shaking hands. If you notice someone coughing or sneezing too much avoid that person or someone that has fever

For a FIDA representative that participated in the survey in Osun state:

Covid-19 is a deadly infectious viral disease that original in China. It is a pandemic that is transmitted from person to person through physical contact, sneezing, touching infected surface and by touching of one's face, eyes, nose or mouth after the contact. It is not air born.

A civil society practitioner from Enugu state declared:

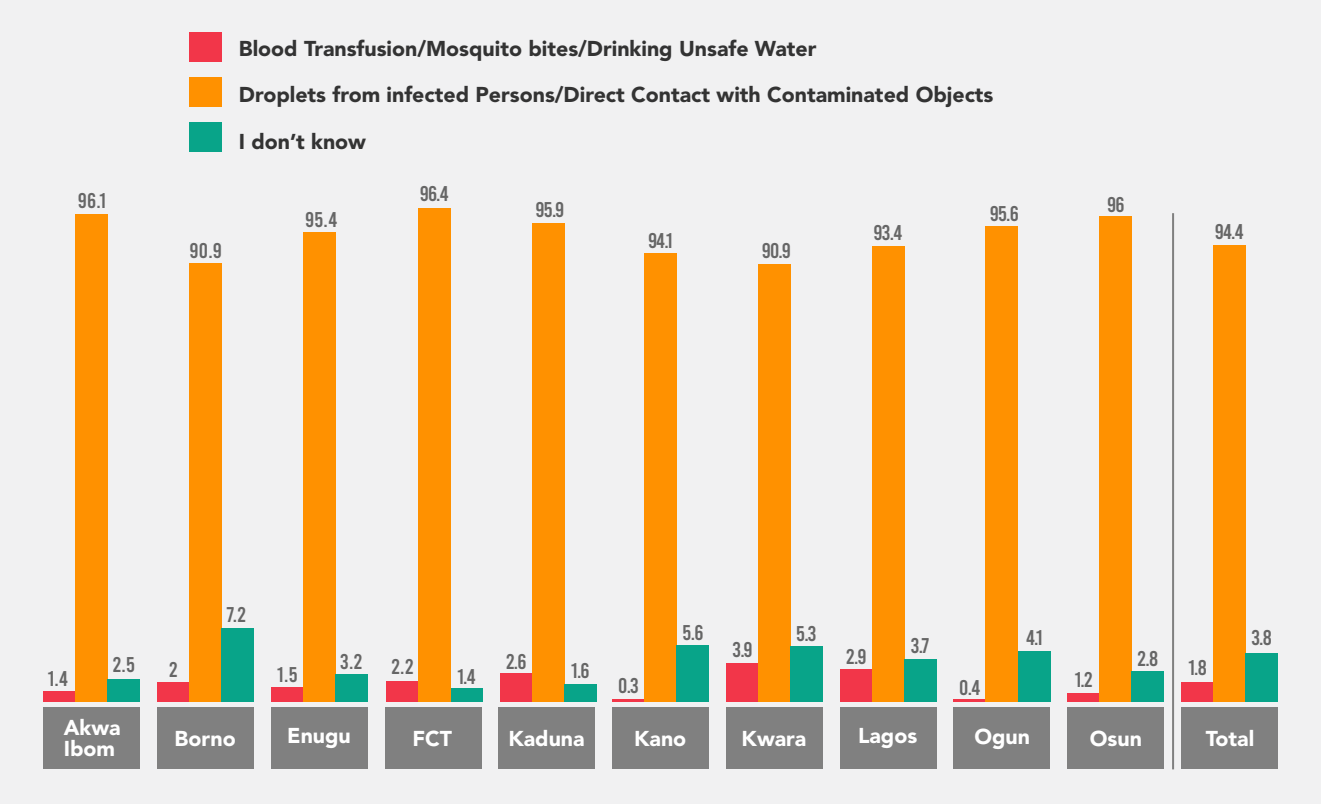
COVID-19 as I understand is a virus that mainly attacks the lungs which results to shortness of breath. It is contracted through droplets, or touching either the eye, nose or mouth". It also spreads through contacts with people or surfaces and the prevalence rate in Nigeria is low compared to the western countries.

Another respondent from Enugu affirmed:

COVID-19 it is a disease from China to reduce the population of people. It is contracted through touching the eyes, nose or mouth and also staying close to the person that has it

5.3. Distribution of Respondents by Knowledge of Transmission COVID-19

Figure 6: Respondents knowledge of the Mode of Spread of Covid-19



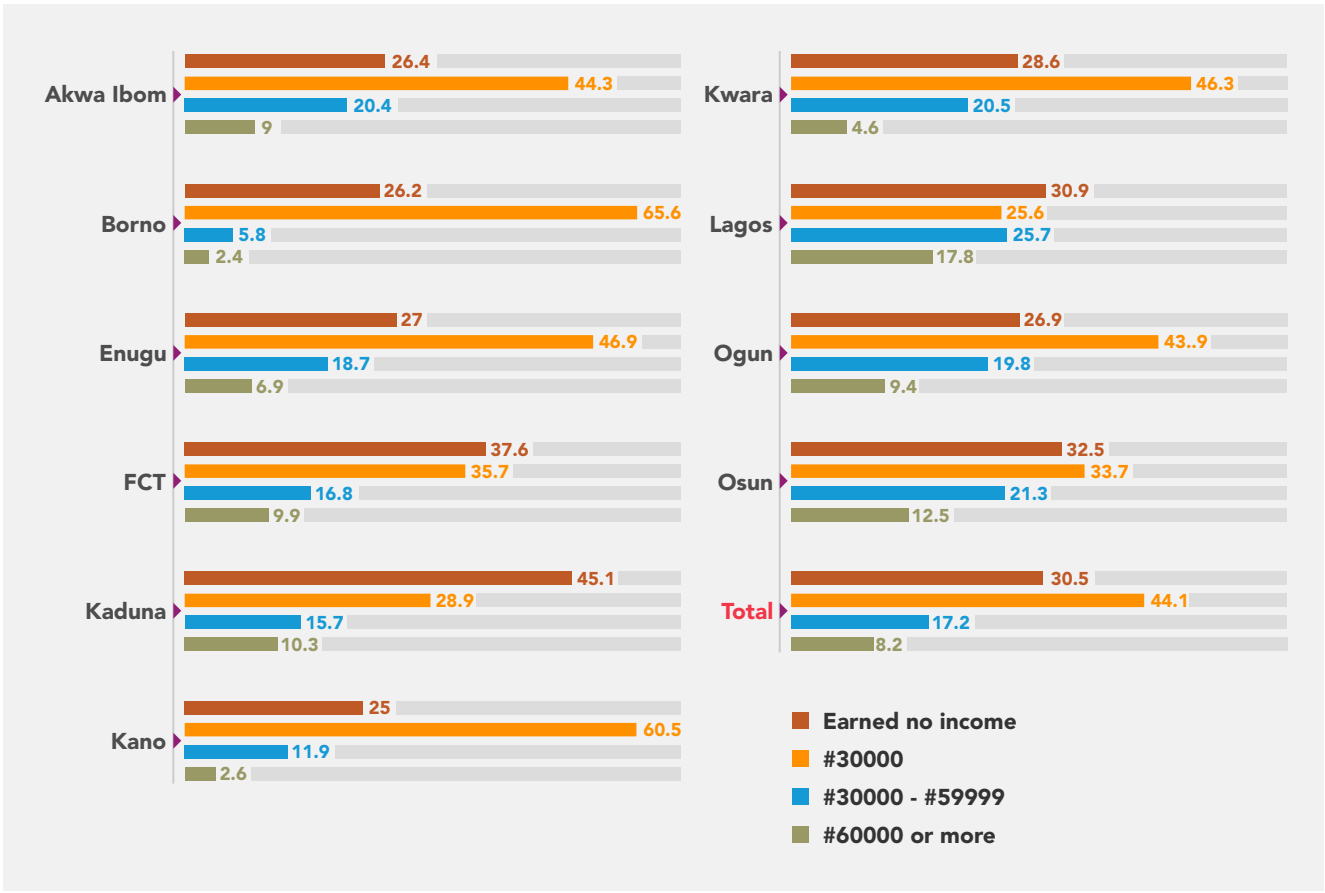
As indicated in Figure 6, virtually (94.4%) the respondents across the selected states, and FCT identified droplets from infected individuals, as well as direct contact with contaminated objects as the means through which COVID-19 could be spread. On the other hand, Borno (7.2%) and Kano states (5.6%) had the highest proportion of respondents who admitted that they had no knowledge of the mode of spread of the virus while Kwara state (3.9%) had the highest proportion of respondents who claimed that COVID-19 could be spread through blood transfusion, mosquito bites or drinking of unsafe water. The findings demonstrated that majority of the respondents were knowledgeable about the transmission of COVID-19. The disparity in the knowledge across the states, especially in Kano, Borno and Kwara where many respondents claimed ignorance of the mode of the spread of Covid-19 indicates the gap in literacy and access to information in those states. The national educational policy has identified Kano, Borno and Kwara among the 'educational-disadvantaged states'. Many rural communities in the North lack social facilities and infrastructures because of low investment, conflicts and corruption. A key informant respondent from Enugu state declared that:

COVID 19 is a disease that is transmitted from one person to another. It is caused by a virus and it originated from China and spreads through direct contact with an infected person and through touching contaminated objects or surfaces". He said the containment measures in Nigeria is to stay at home, maintain social distancing and by wearing of face masks as well as washing one's hands regularly with soap.

A respondent from Kaduna state declared on the transmission of the virus:
Covid-19 is mainly transmitted through droplets generated when an infected person coughs, sneezes. These droplets are too heavy to hang in the air, and quickly fall on the floors or surfaces. A person can be infected by breathing in the virus if he/she is within close range with an infected person or by touching contaminated surface and then eyes, nose or mouth.

5.4 Respondents by Income Distribution

Figure 7: Distribution of Respondents by Income Earned Monthly across States



As presented in Figure 7, only 1 in every 10 respondents across all the selected 10 States earned a monthly income of #60, 000 or more. The results showed that two-thirds (65.6%) of the respondents in Borno States earned less than #30,000 every month while at least 1 in every 4 respondents from Kwara (28.6%), Enugu (27%), Lagos and Akwa Ibom (26.4%) have no stable income. Also, the results showed that one-quarter of the respondents from Kano earned no income as well. The results clearly revealed the economic status of the respondents as that of indigent women.

The World Bank has reported that Nigeria is now home to the largest number of poorest people in the world (World Bank 2017). Women constitute over 60% of the poorest people in Nigeria and going by the statistics that Nigeria has over 87 million people in extreme poverty translates to approximately 52 million women on the clutches of extreme poverty. Nigeria has thus overtaken India's 70 million poor thus attaining the unenviable status of the 'poverty capital of the world'. Most of the poorest people live below $2 a day and according to the Nigeria Demography and Health Survey, Northern Nigeria remains the poorest region where predominant poor women live. Although there have been efforts by successive governments in Nigeria to improve the livelihood of women and lift them out of poverty, the facts on the ground are not encouraging as a large number of women continues to wallow in extreme poverty.

Moreover, according to IMF Report (2017), it is also becoming difficult to achieve the United Nations Sustainable Development Goal No. 1 (SDG1), which is ending extreme poverty by 2030. The poverty scourge in Nigeria is particularly severe among women especially those in the rural and semi-urban areas, where up to 80 percent of the population continues to live below the poverty line and with limited access to social services and infrastructures. A major causative factor that exacerbates poverty is lack of transparency and accountability in governance. Successive efforts by governments to address the scourge of poverty through various empowerment programmes have not achieved the desired objectives because of corruption.

The current administration's National Social Intervention Programme (NSIP) with components such as 'conditional cash transfers' N-power, TraderMoni among others were designed to tackle poverty by providing millions of jobs every year, such that, it was projected that by the end of 2018, a total of 12 million new jobs would have been created. However, the National Bureau of Statistics (NBS) in its December, 2018 Report recorded an increase in unemployment rate from 18.8% in the third quarter of 2017 to 23.1 % in the same quarter of 2018. The National Assembly recently confirmed that it had appropriated Two Trillion Naira (2tn) for the implementation of the NSIP between 2016 and 2019 (The Punch, May 23, 2020). However, lack of transparency and accountability in the implementation of various government's poverty alleviation programmes has worsened the crisis. As observed by the Executive Director of CISLAC, Musa Rafsanjani: “an increased influx of money, also increases the risks of corruption” (The Punch, May 23, 2020). For another observer, 'Covid-19 merely exposed the fact that government's social welfare programmes have achieved little or did not reach the targeted population” (The Punch, May 23, 2020). A respondent from Enugu state declared during interview:

Covid-19 is affecting our livelihood and income. Since the lockdown sale of goods are not done, so there is no money for feeding due to minimal income.

Another respondent from Bornu commented on the impact of Covid-19 on income:

Livelihood activity of any kind is inactive due to lock down, inflation rate increased drastically; too much money chasing fewer goods. Commodity price sky rocketed within few days. Small businesses cannot be sustained due to restriction on vehicular movement. The pandemic changed the life style of individuals within the space of three weeks which makes life unbearable to all and sundry.

From the responses from the key informant interviews across the ten states, it was gathered that most women operate small scale businesses without sufficient cash back-up. Covid 19, thus left them with nothing to fall back on and many women were forced to divert business capital into feeding and general housekeeping. During the lockdown, the women's husbands /partners were not able to go out for work thereby reducing the family income. In some cases, some women became the bread winner many of them claimed had to start small scale farming as an alternative means of livelihood.

5.4.1. Additional and Sharing of Income by Respondents

Figure 8: Proportion of Respondents that Earned Additional income, Paid Income to Source(s) not Comfortable with and Shared All Earned Income with Partner

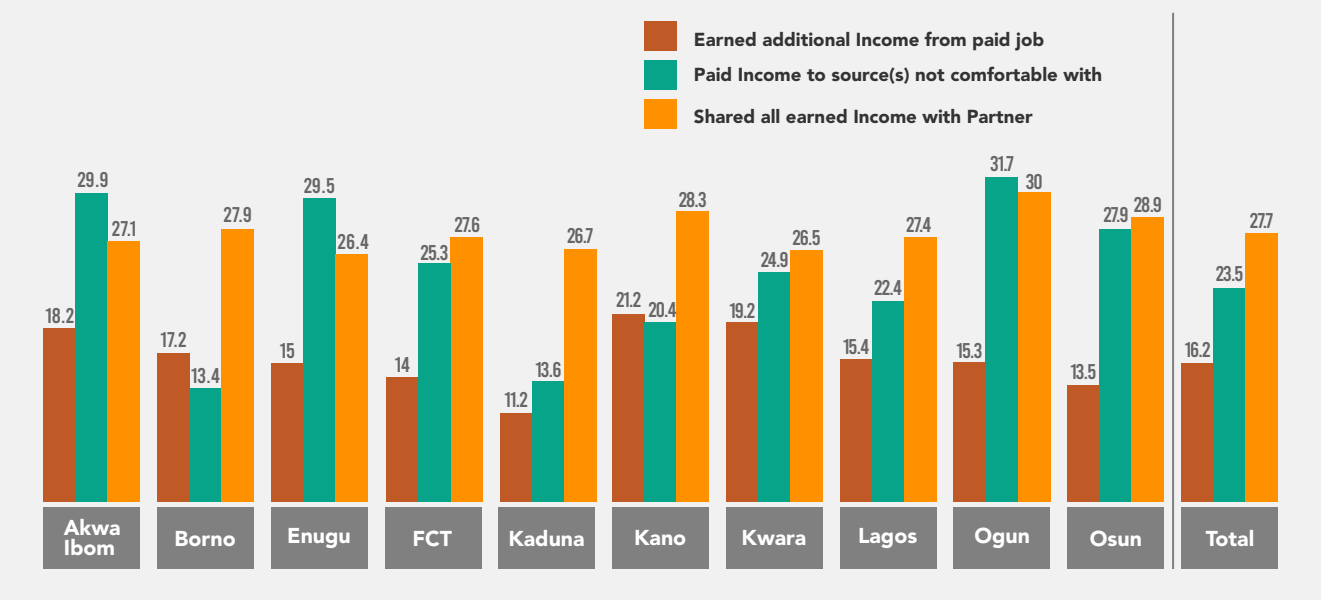
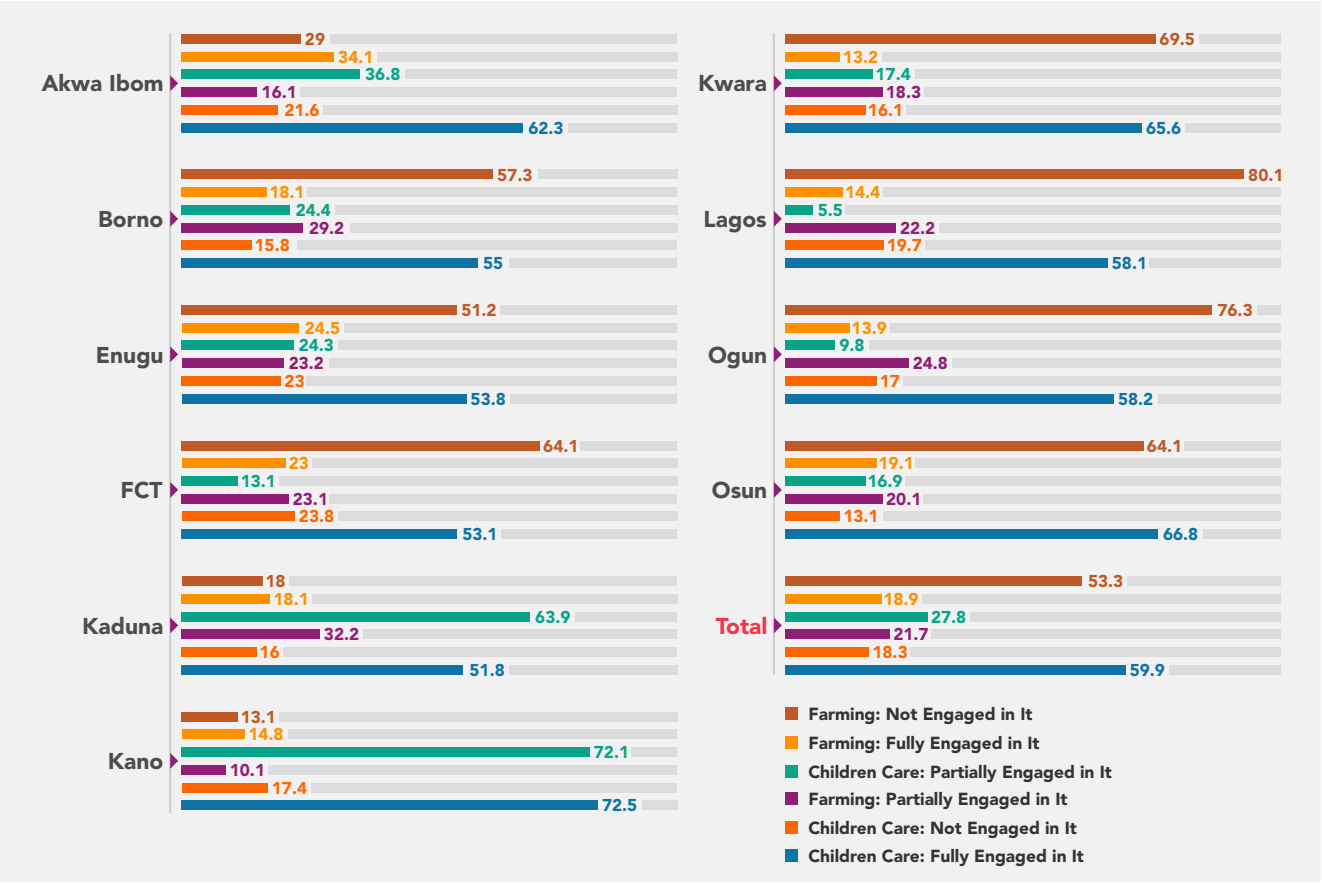


Figure 8 revealed that while Kano (21.2%) had the largest proportion of respondents who earned the highest additional income during the COVID-19 outbreak, Kaduna had the least additional income (11.2%). The results further showed that highest proportion of respondents who shared all earned income with their partners were respondents from Ogun state (30%) while the least proportion where those from Kwara state (26.5%). Results across all the selected states, and FCT showed that less than one-quarter (23.5%) of the respondents paid income to sources that they were not comfortable with while no fewer than 1 in every 4 (27.7%) respondent shared all earned income with partner. The vast majority of women's employment – 70 per cent – is in the informal economy with few protections against dismissal or for paid sick leave and limited access to social protection. These works often depend on public space and social interactions, which were restricted to contain the spread of the pandemic. The results further demonstrated the patriarchal nature of male-headed households, which subordinated women, economically. The fact that most of the respondents declared to share all the money earned with their partners indicates lack of financial autonomy for women in a patriarchal male-headed households. The absence of financial autonomy also tends to worsen poverty cases among women. As stated previously, many men in male-headed households found it difficult to fulfil their responsibilities during the lockdown and women had to take up the challenge of sharing their income with their husband for housekeeping.

5.4.2 Engagement in Livelihood Activities during Covid-19

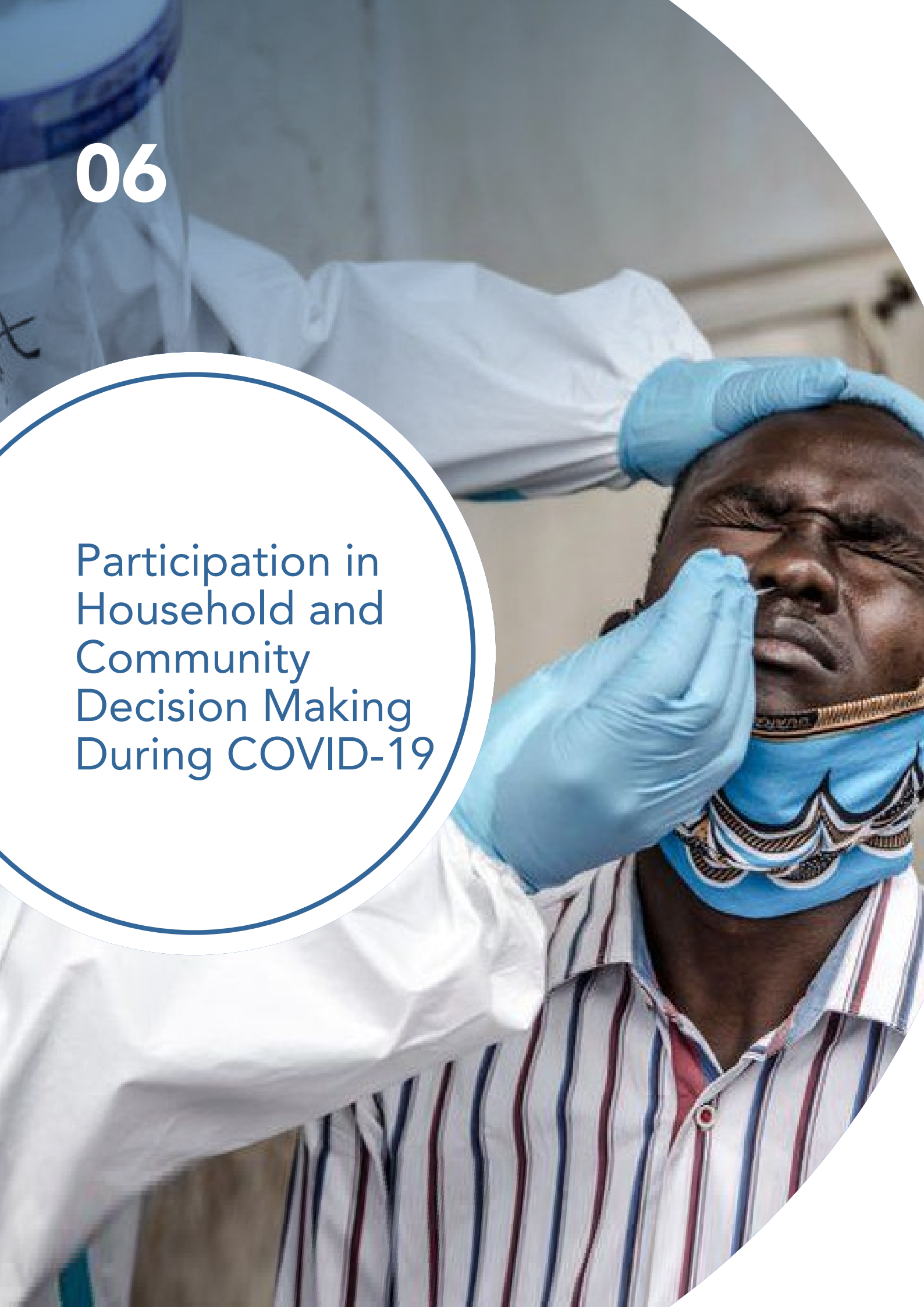
Figure 9: Distribution of Respondents by Engagement in Farming and Children Care during Covid-19 Outbreak



Results across selected states revealed that about 60% of the respondents were fully engaged in children's care during the pandemic. Some disparities were, however noticed across the states. As presented in Figure 4, less than 2 in every 5 respondents in Akwa Ibom (16.1%), Kano (10.1%) and Kwara (18.3%) fully engaged in taking care of their children during the pandemic. On the other hand, the results showed that 72.1% and 63.9% of the respondents from Kano and Kaduna states were fully engaged in farming, while less than a quarter of the respondents from Borno (24.4%) were fully engaged in family as a result of the COVID-19 pandemic. The findings demonstrated a gendered distribution of labour within households, which further worsened because of the lockdown that forced children to stay home. It is instructive to note that studies have confirmed that women unpaid labour increased during the pandemic, especially care work and domestic labour (UN-Women, 2020). Women's unpaid and underpaid care work, a driver of inequality, has always left women with precarious jobs, insecure incomes, and no social safety, thus marginalizing women to the informal economy.

06

Participation in Household and Community Decision Making During COVID-19



6.1. Participation in Household Activities during Covid-19

Figure 10: Distribution of Respondents by Engagement in House Cleaning/Laundry and Purchase of Food during Covid-19 Outbreak

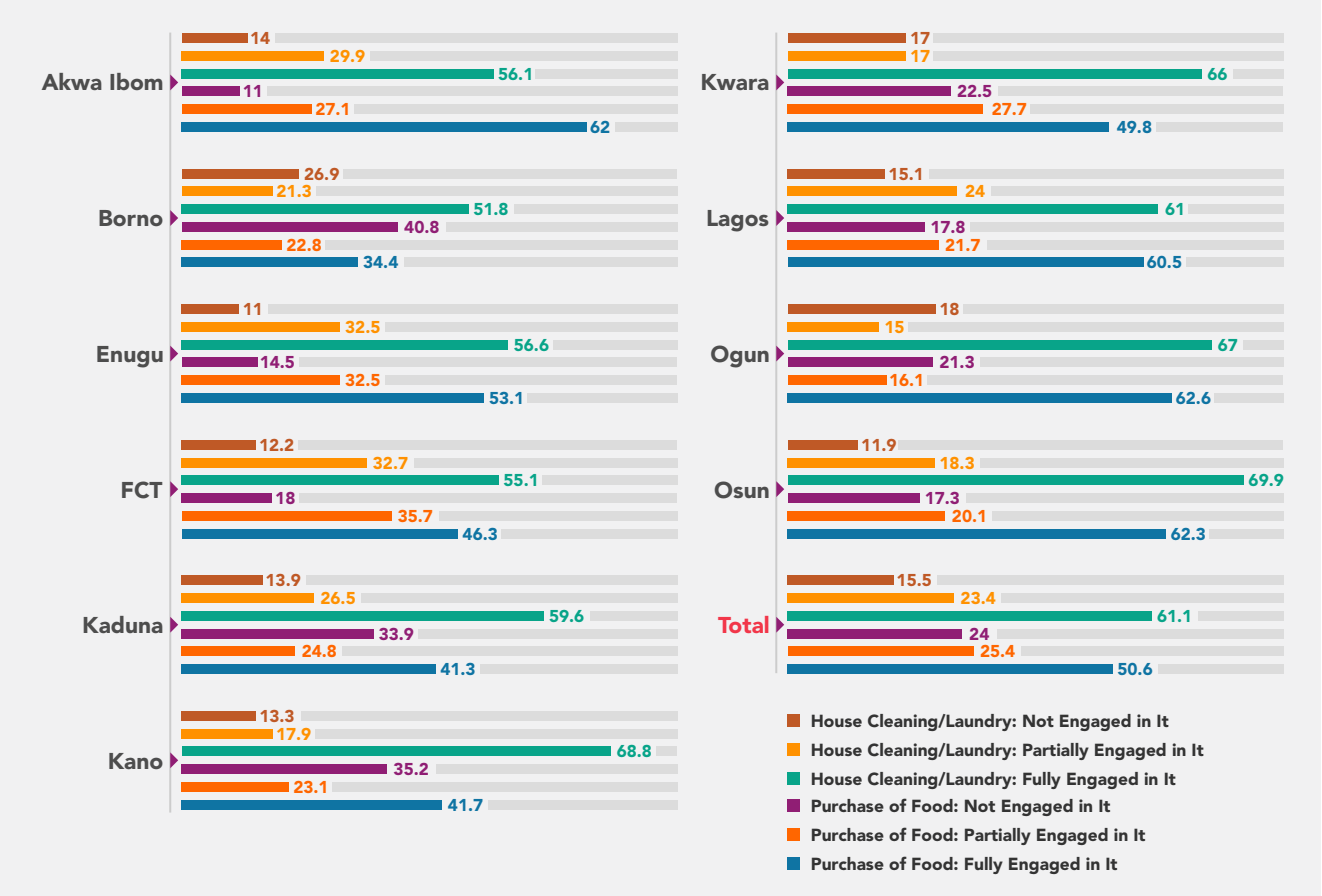


Figure 10 presents the results of gendered distribution of labour before the outbreak of COVID-19. Results across all the selected states, and FCT revealed that while no fewer than 3 in every 5 (61.1%) respondents were fully engaged in house cleaning and laundry, about half (50.6%) of the respondents were fully engaged in purchase of foods during COVID-19. The results further showed that Osun (69.9%) and Kano state (68.8%) had the highest proportion of respondents that were fully engaged in house cleaning and laundry, while the three states with the least proportion of respondents that were fully engaged in purchase of foods the outbreak of the pandemic were Borno (34.4%); Kaduna (41.3%); and Kano (41.7%) respectively. The findings further demonstrated the patriarchal division of labour within households, which arrogated menial household chores to women while critical decisions are taken by men. According to a respondent from Borno:

> ***Decision making as you know in this community is been taken by men, I don't think much has changed. In my family we have collective discussion on what will be best for the family. Decision making differs from family to family, that depends on what system has been in place before the pandemic.***

Another respondent from Bornu further corroborated the view that men assumed the responsibility for decision making before and during the pandemic:

> *As usual, women have the major role to play when it comes to labour within the household. Based on my observation, women mostly the married ones with school aged children are faced with more domestic work; cleaning, cooking, water, laundry etc. alone without the support of their husbands and male children.*

Supporting the views earlier expressed by other respondents, a respondent from Akwa-Ibom declared that decisions in the family are taken solely by her husband: According to her:

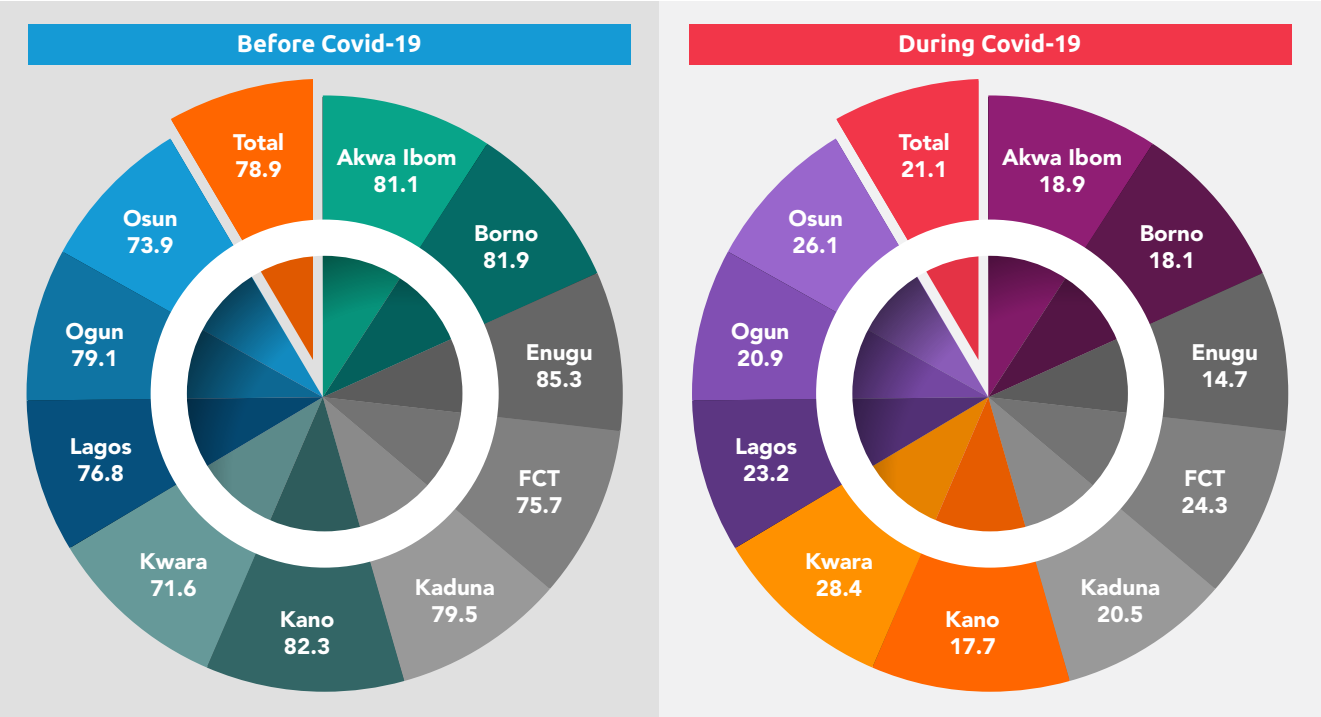
> *There is no difference now that there is Covis-19 because decisions have always been taken by the head of the household (men).*

However, other respondents claimed that because of the lockdown that forced many men to at home, some decisions were jointly taken with women:

> *The level of participation in decision making in the home for women and men has increased, since the care of the family depends on them during this period. Most of the women now have their husbands staying at home. Many appears to have joint participation in decision-making.*

6.1.2. Participation in Community Decision Making Before and During Covid-19

Figure 11: Proportion of Respondents that Participated in Community Decision Making Before and During Covid-19



As indicated in Figure 11, the proportion of respondents that participated in community decision making before the COVID-19 outbreak declined from 77.6% to 21.3% during the crisis across all the selected states. However, the highest decline in community decision making during the crisis was reported in Kaduna state (9.3%), followed by Borno (16.4%) and Enugu (17.8%) respectively. The emergency nature of the pandemic is shoring up authoritarian power of the states across the world, which has further marginalized women's participation in decision making. Women's under-representation in politics is not necessarily because they are less disposed to politics, but because they often lack access to the important (and often corrupt) networks that mediate entry into politics. This compounds factors such as gender stereotypes that men, not women, should be leaders and decision-makers. From the findings of the study, it was obvious that crucial decisions taken during the pandemic revolved around security and economic issues, where women are mostly marginalized due to dominance of men. The marginalization of women from crucial community decisions often result into arbitrariness and insensitivity to women issues in decision-making.

On community decision making, a respondent from Lagos declared:

It's only in few situations they call women. Men always take all the decisions. We hear of billions being shared, which we didn't see. Only men take decisions.

While speaking on the efforts of her chairman on isolation centers, another respondent from Lagos observed:

Even in my area, the Chairman does not care about anybody now. He is pre occupied with other things. His focus is on the isolation center. He coordinates efforts at the isolation center {i.e for infected patients.

Another respondent from Bornu also commented thus:

Decision making in the community is mostly taken by traditional and religious leaders, even though politics has taken its toll on the power of these group on individuals. In this community, men are always in charge and we women just followed them. Some of the issues involved are often too complicated for women's understanding.

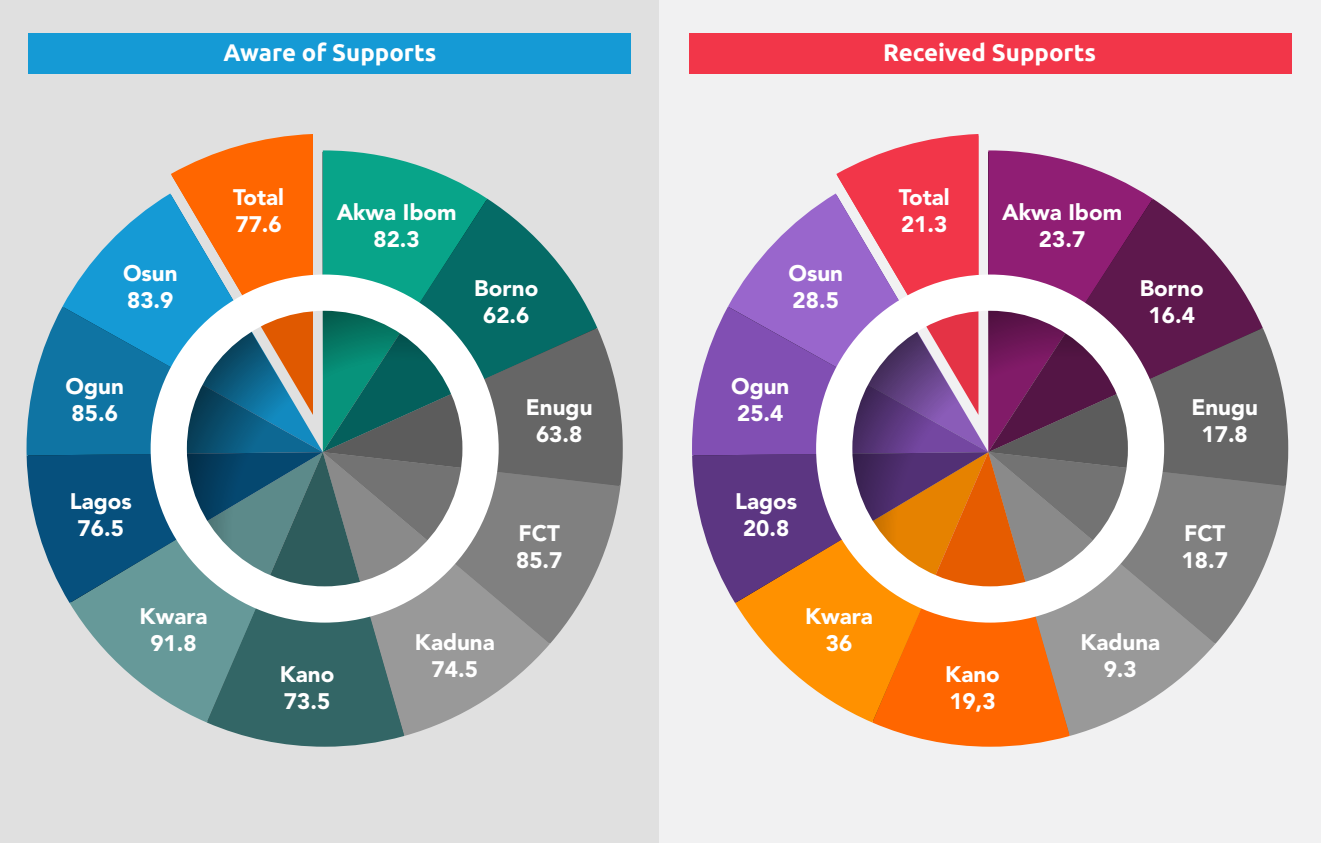
A respondent from Bornu also declared:

Men are the ones who take decision for the family even decisions that are supposed be personal to the woman. This does not seem to have changed. Covid-19 has made it more difficult for women to participate in community decision making.There is no meeting (meetings are banned) so there is nothing right now like community decision making

There seems to be a unanimous agreement among respondents across the ten states that Covid-19 has further relegated women to the background in community decision making. And as rightly observed by one of the respondents, the fact of the lockdown and restricted movements has put constraints on community meeting on critical issue. It is now community leaders, who mostly are men, taking decision on behalf of the community. The exclusion of women from community participation in decision making is an indication on asymmetrical power relations between men and women. It has been found that when women have less decision-making power than men, either in households, community or in government, women's needs during an epidemic are less likely to be met. Male-dominated political participation has been associated with lack of transparency, accountability and endemic corruption. At the front-line community level, women should be contributors to identifying local trends and responsive policies. At a national level, the WHO has recommended the inclusion of women in national and global COVID-19 outbreak preparedness and response policy and operational spaces.

6.2. Respondents' Awareness and Accessibility to Government COVID-19 Supports

Figure 12: Distribution of Respondents by Awareness and Accessibility to Government Covid-19 Supports



As indicated above, results across all the selected states, and FCT revealed that while more than three-quarters (77.6%) of the respondents were aware of COVID-19 supports distributed by the government, less than one-quarter (21.3%) received supports from the government. Specifically, the results showed that respondents from Borno (62.6%) and Enugu State (63.8%) were least aware of any forms of COVID-19 supports provided by the government. Also, the results revealed that Kaduna (9.3%), the FCT (18.7%) and Kano state (19.3%) had the least proportion of respondents who received supports from the government during the crisis.

Corroborating the sentiments expressed in the quantitative data, respondents from Enugu state confirmed through key informant interviews their lack of awareness of and exclusion from government's palliatives: A civil society representative declared:

> ***Information on the distribution of palliatives was not adequately disseminated to people. The government did not share palliatives as I did not receive any.***

Another respondent from Enugu also affirmed:

> ***Governments are not transparent in the distribution of palliatives, which is a sign of corruption.***

Summing up the experiences of women in Enugu, a respondent expressed thus:

> ***Palliatives were not enough and did not get to most poor people. Government was not transparent about how distribution of palliatives and the funds received. While there is a lot of awareness about COVID-19, government's action has actually made people to live in denial of COVID-19. There is no transparency and accountability, it is beclouded by secrecy. Consequently rather than reducing corruption, Covid-19 management teams have inadvertently created more suspicion in the minds of the populace.***

A respondent from Lagos also shared her experience thus:

> ***Most information are acquired via social media and internet. The government did not give information to keep people safe. Looking at countries who were successful at arresting the spread of covid-19, massive information sharing with their citizens were key. We only heard from the Federal Government, the State tried a bit, but Local Governments were not involved. They fumigated my community, no one was told what it was all about. Nobody stayed indoors during the fumigation exercise. Information need to be timely. There is disconnect between information coming from the government to the people (community development association).***

From Borno state, a respondent declared on information received:

There are lot of misinformation and also withheld information on COVID-19 from members of the public and it really caused more harm than good. Because of the misinformation, people don't believe that COVID-19 is real. The level of transparency with regards to confirmed COVID-19 cases is very low and that is one of the reasons why people believe the government is faking result just to get fund allocation. We see figures of cases but have not seen isolation centers with confirmed cases that have been reported.

Concerning palliatives, another respondent from Bornu reported:

I have heard of government distribution of palliatives but have not seen it physically and most people don't even know the approach the government adopted for the distribution. It is worrisome that there might be mismanagement of funds and high level of corruption regarding government management of COVID-19. To allay people's suspicions, the palliative distribution committee should be reconstituted to include CSOs, traditional and religious leaders, women and youth organizations.

Sharing her personal experience in the distribution of palliatives, a respondent from Kaduna reported:

There are so many issues associated with the aid the government is providing, I witnessed a scenario where they brought food spaghetti, indomie and rice but they were only considering houses without gates unfortunately those with gates were ignored. Even in our house there were orphans who were not given anything. The distribution process isn't supposed to be handled like that. I believe that the government has provided the palliative but those who are to share are not doing it right and government can't do anything about it. They have done their own part.

The harvest of different experiences of women across the states on the awareness and distribution of palliatives by government contradict the principles of accountability as discussed earlier under analytical framework. Accountability principles require openness and transparency in information sharing and distribution of resources as enunciated by the WHO. However, the Nigerian experience clearly negates those principles due to secrecy that shrouded information and sharing of palliatives. In addition, the handling of Covid-19 donations by the Federal Government and different States have not been transparent. While the Central Bank of Nigeria has announced a total sum of sum of N25.8 billion as donation by 107 Nigerian companies and notable individuals, as relief fund to combat Coronavirus in the country as of April 18, 2020, only few states like Kwara, Ekiti and Kaduna have published the amounts received as donations from individuals and private sectors to fight the pandemic. While almost all the states mobilized and received supports from the public, the amount received and spending were largely kept secretive, negating the principle of transparency inherent in accountability framework.

The absence of transparency and accountability framework is evidently glaring in the management of various funds mobilized as stimulus package for economic recovery as part of Covid-19 response. Among these funds are:

01 N50 Targeted Credit Facility for MSMEs as well as N100 billion Stimulus Fund for the Healthcare sector targeting pharmaceuticals, manufacturing of medical equipment, kits, building and equipping and upgrading of medical facilities

02 N2tn stimulus package for the economy

03 $3.4 billion IMF Credit Facility.

In addition, many states have also announced their own versions of stimulus packages and palliatives to cushion the hardship of Covid-19. However, like the Federal Government, all the principles of accountability are not been implemented, giving rise to citizens' suspicions and mistrust of government's actual intention on Covid-19.

6.3. Supports Received from the Government during COVID-19 Outbreak

Figure 13: Distribution of Respondents by Forms of Supports Received from the Government during Covid-19 Outbreak

As indicated above about three-quarters (75.8%) of the respondents across selected states claimed that they did not receive any forms of supports from the government during the crisis. Similarly, none of the respondents from Akwa Ibom and Enugu received cash as form of support from the government while only insignificant proportion of respondents from Lagos (2.4%), Ogun (3.9%) and Borno State (2.6%) received facemasks and sanitizers from the government. Approximately, only 1 in every 5 respondents from Osun (21.9%) and Kwara state (23.2%) received food stuff as a form of supports from the government. The key informant interviews conducted across the states also confirmed the above findings that token palliatives were distributed across the selected states. The palliatives were in some cases hijacked by politicians and their cronies while deserving vulnerable people were denied access.

07

Corruption and Covid-19

7.1. Assessment of Government in the Dissemination of Information on Covid-19

Figure 14: Distribution of Respondents by Assessment of Government in the Dissemination of Information About COVID-19

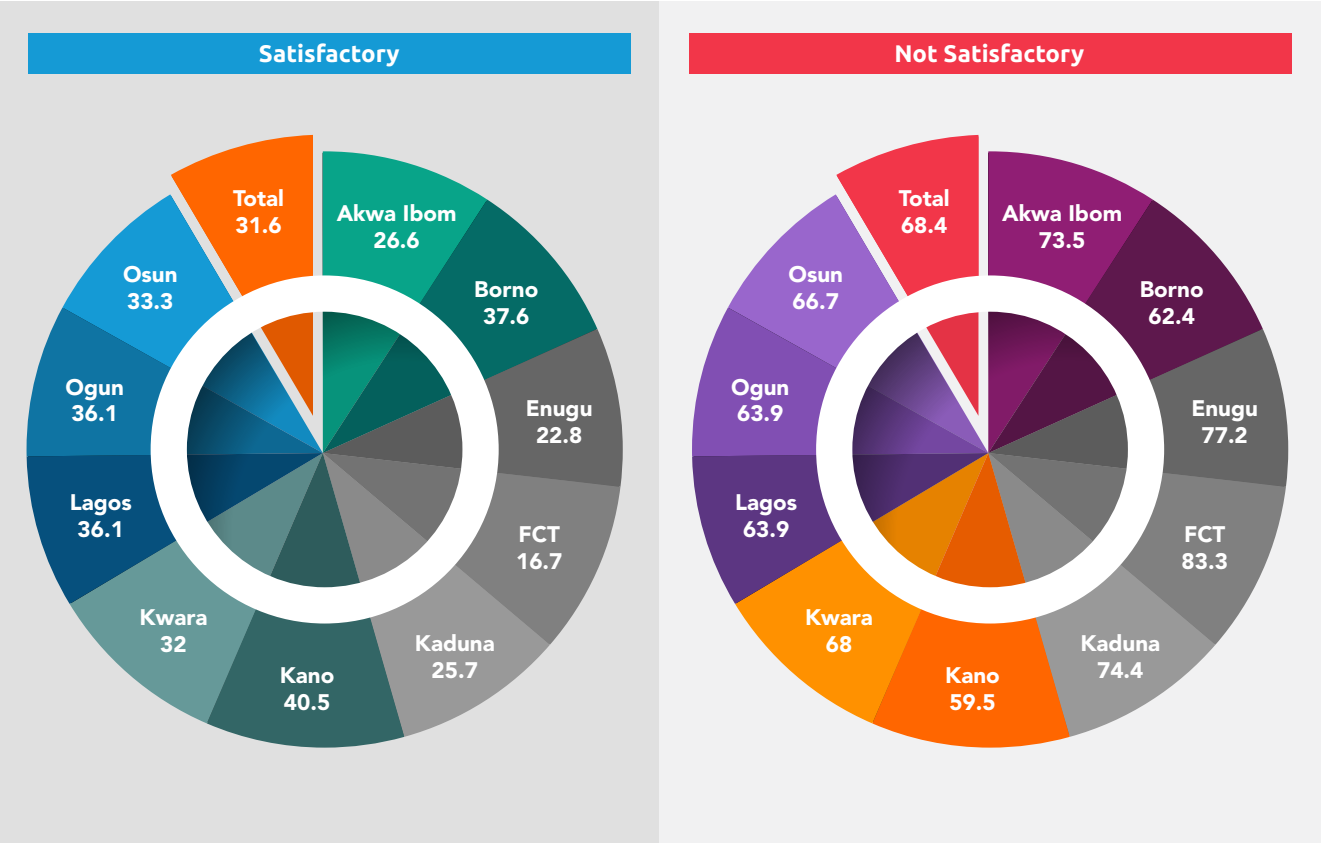


Figure 14 presents the results of the assessment of government in the dissemination of information about COVID-19 palliatives. As indicated below, the highest proportion of respondents who were dissatisfied with the dissemination of information were from the FCT (83.3%); followed by respondents from Enugu (77.2%); and Kaduna states (77.2%) respectively. The results across the selected states revealed that more than two-thirds (68.4%) of the respondents were not satisfied with the dissemination of information on palliatives by the government. Information obtained from the key informant interviews also confirmed that citizens, especially women had limited information about distribution of palliatives by governments across the states. In most cases, the distribution was shrouded in secrecy and only known to people close to those in power. In all, transparency and openness were lacking.

7.2. Impact of Corruption on Access to Healthcare Services by Women during Covid-19

Figure 15: Distribution of Respondents by Impact of Corruption on Healthcare Services

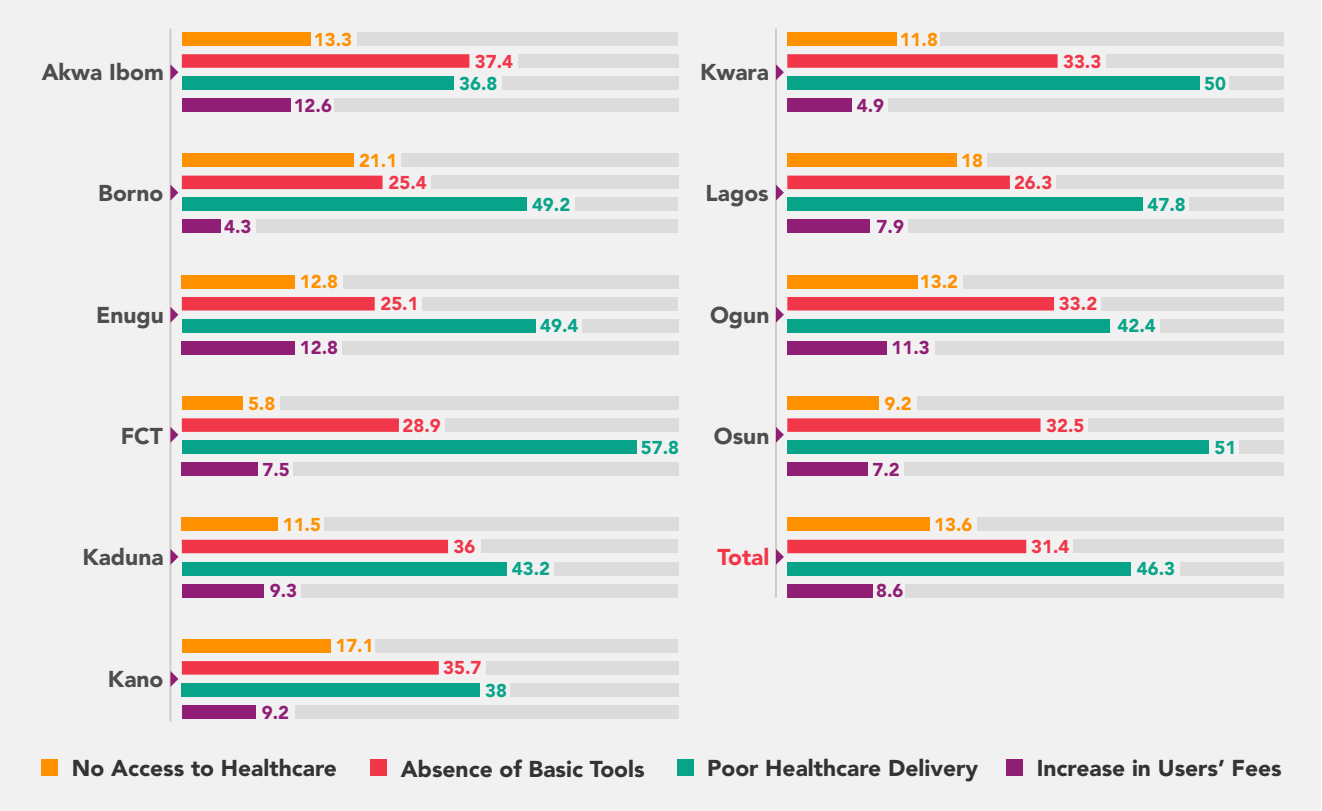


Figure 15 presents the results of the impact of corruption on healthcare facilities. As indicated from the data, all the selected states attributed corruption to poor healthcare service delivery and the highest scores were recorded from FCT (57.8%); Osun (51%); Kwara (50%); Enugu 49.4%; Bornu (49.2%); and Lagos (47.8%). The three states that largely attributed the absence of basic tools in health facilities to corruption were Akwa Ibom (37.4%), Kaduna (36%) and Kwara State (33.3%). On the other hand, increase in users' fees was least attributed to corruption in Borno (4.3%) and Kwara state (4.9%). Total results across selected states, and FCT revealed that 46.3% of the respondents attributed poor healthcare service delivery to corruption; 31.4% attributed absent of basic tools to corruption, while 13.6% blamed corruption for lack of access to healthcare services. Further findings from follow-up interviews and reports confirmed from government hospitals across the country where patients are made to provide basic necessities such as facemasks, hand-sanitizers, gloves and hand-washing liquid soap as part of the conditions for accessing health-care during this Covid-19 period. The pandemic glaringly exposed the collapsing state of healthcare facilities in Nigeria. The non-utilization of basic principles of accountability in the procurement of health equipment and setting up of facilities have led to non-functioning of many basic healthcare services across many hospitals in Nigeria. Huge sums allocated to health sectors over the years have not materialized into improved healthcare service delivery. Rampart cases of industrial actions among health workers have become a defining feature of industrial relations in the sector. The

situation was shameful to the extent that even during Covid-19, doctors and other health workers embarked on strikes due to non-payment of basic allowances, lack of personal protection equipments (PPE) and non-conducive working environments. Various views were expressed by respondents on healthcare access during Covid-19 thus:

There is no enough space in the hospital for patient and even if they go to the doctors they are always busy on suspected patients. Everybody is scared of going to hospital because of fear of being tested covid-19 positive. It has come to public notice that whoever goes to hospital is been declared covid-19 positive during this outbreak making the public to be scared of going to hospitals.
(Respondent from Kaduna)

Patient with varied forms of ailments including asthma cough, malaria, hypertensive heart disease and other life threatening conditions including pregnant women are being turned down by the government and private hospitals during the Covid-19 lock-down and pandemic. Sometimes, on the pretense of none-availability of the doctor in-charge. Many of the pregnant women were attended to by the traditional birth attendants (TBAs) in their locality
(Respondent from Osun).

Other respondents have also commented thus:
Mothers cannot easily access hospital care for the children even the community level immunization has stopped in the face of the pandemic. Not many mothers could afford taking their babies to private hospitals for immunization in the State. Pregnant women also have difficulties accessing anti-natal clinic. Even if they sent out to the hospitals, the law enforcement agencies in the state (police and Amotekun) do prevent their free movement
(A Respondent from Osun State)

Health workers are now scared to attend to patients in the clinic be it a man, woman, boy, girl, physically challenged or elderly. At some point in Maiduguri when COVID-19 case confirmed, health workers refused to attend to patients due to fear on being infected. Access to health care is now more challenging; all attention is given to COVID-19 and every patient is a potential suspect, pregnant women can no longer freely go for CAN; common fever would be mistaken for COVID-19. The older people now live in fear as it was said that they are most vulnerable to the virus; physically challenged are now more neglected because they aren't considered nor involve in planning preventives measures.
(A Respondent from Bornu State)

While Covid-19 has not overwhelmed our healthcare facilities as witnessed in Europe and the United States of America, the parlous state of our facilities have imposed heavy burdens on the health workers , many of who, sadly have contracted the virus on the line of duty.

7.3. Perception on Corruption in the Management of COVID-19 Funds

Figure 15: Distribution of Respondents by Perception on Corruption in the Management of Covid-19 Funds by Government

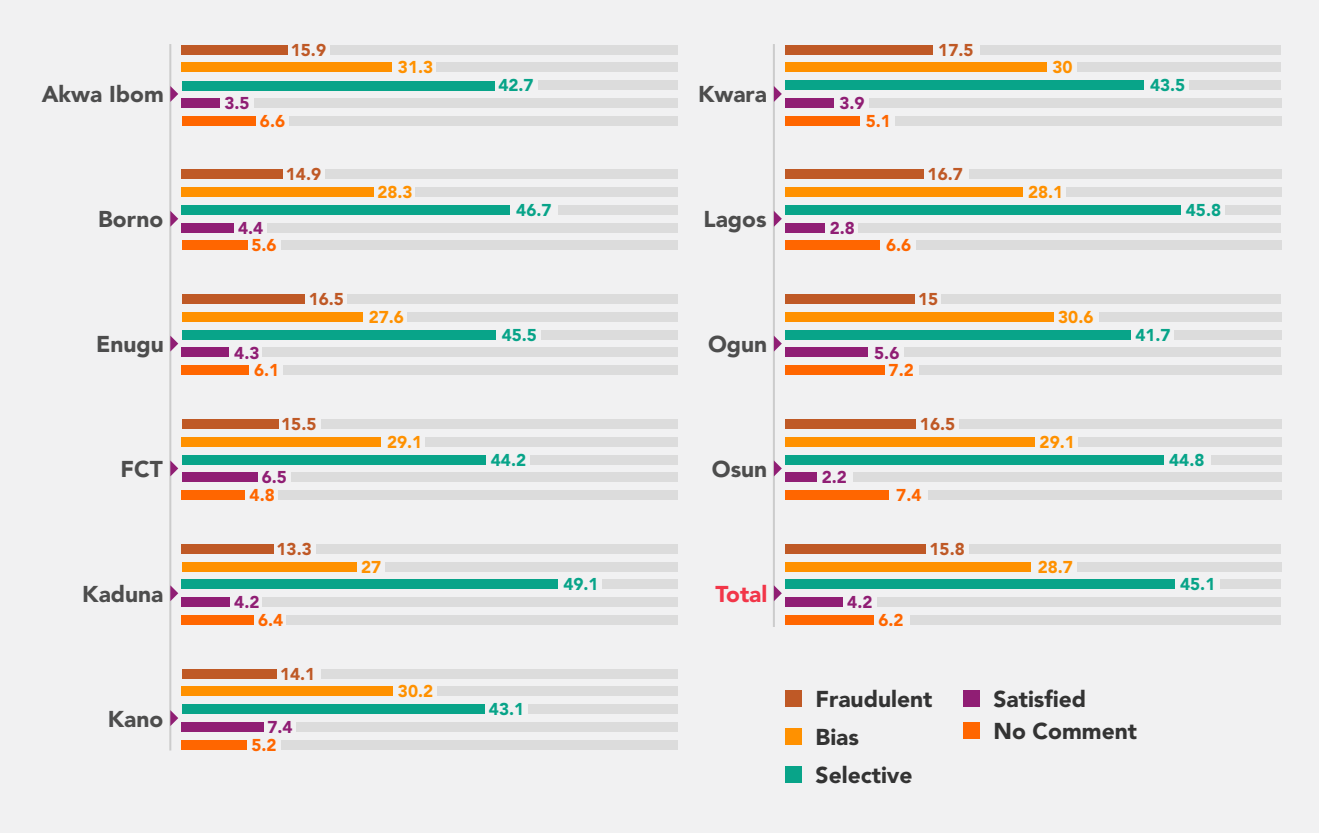


Figure 16 indicates more than 45.1% of respondents perceived that government was selective in the management of Covid-19 crisis funds; 28.7% claimed that government was biased in the management of COVID-19 funds; while 15.8% perceived that the government was fraudulent in the management of the crisis funds. The three states with highest incidence rates of fraudulence in the management of COVID-19 funds were Kwara (17.5%), Lagos (16.7%) and Osun (16.5%) respectively while the least reported corruption rate was from Kaduna state (13.3%).The results from Kaduna state further confirmed the operation of 'open governance and transparency' initiatives of the state government in reducing corruption and enabling service delivery and citizens' participation. The negative perceptions observed in the data were largely due to the non-implementation of accountability principles in government's management of Covid-19 funds as previously explained.

7.4 Irregularities Observed in the Sharing of Government Palliatives

Figure 17: Irregularities Observed during the Sharing of Government Palliatives

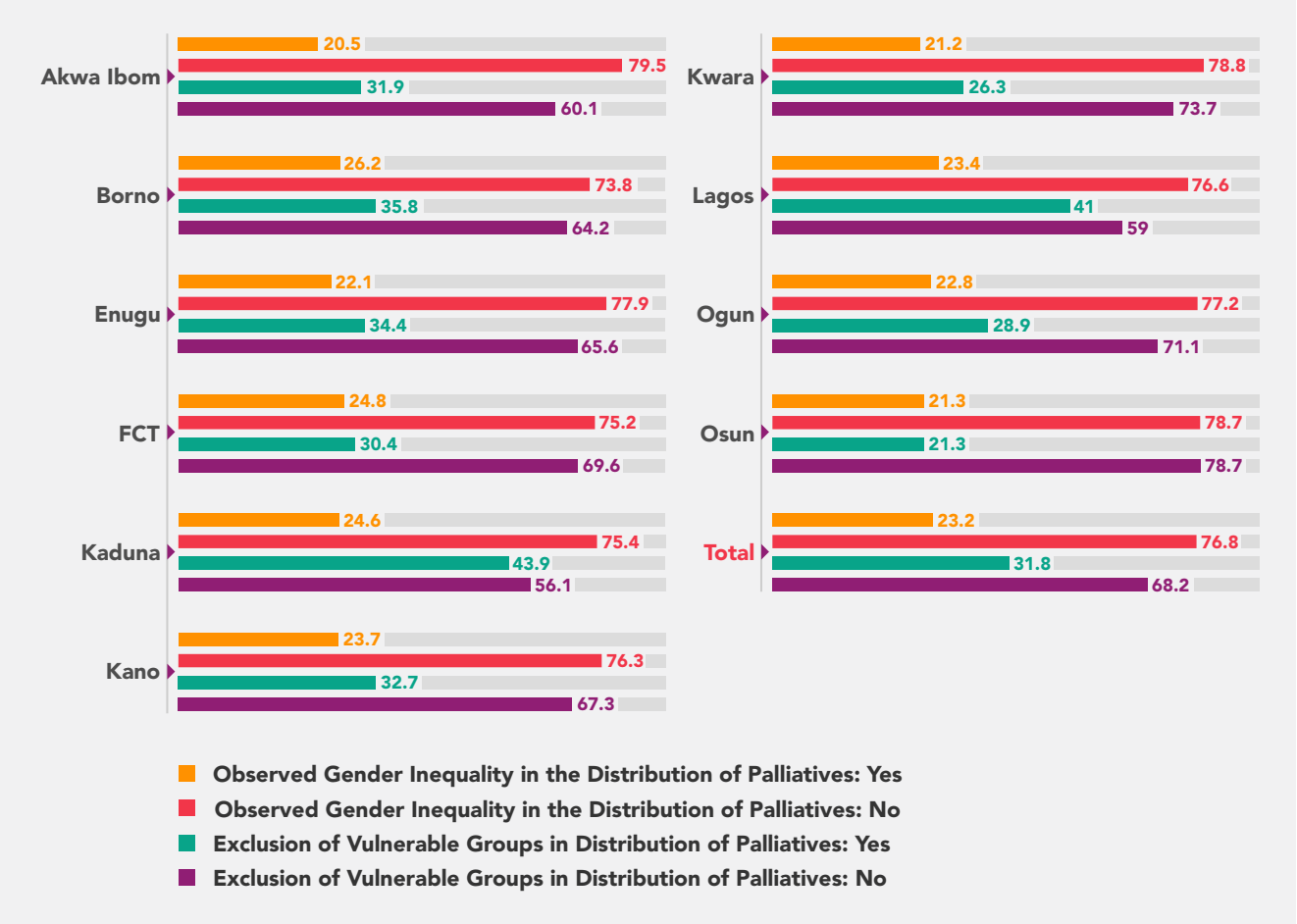


Figure 17 presents some of the irregularities observed in the sharing of government palliatives. The results revealed that prevalence of gender inequality in the distribution of palliatives was least reported by respondents from Akwa Ibom (20.5%) and Kwara State (21.1%), while three states with highest prevalence rates were Borno (26.2%), FCT (24.8%) and Kaduna (24.6%). The exclusion of vulnerable groups in the distribution of palliatives was least reported by respondents from Osun (21.3%) and Kwara (26.3%), while three states with the highest incidence rates of exclusion were Kaduna (43.9%), Lagos (41%) and Enugu (34.4%) respectively. From the follow up interviews conducted across the states, exclusion of women and people with disability were cited as common occurrences in the distribution of palliatives. In addition, there were reports of poor quality of rice distributed across the states by the Federal Government as palliatives. Some states like Oyo, Ondo and Akwa-Ibom publicly condemned 'expired rice' donated as palliatives for distribution to citizens. In some states, the materials donated as palliatives became object of public scorn like the 'loaves of bread' donated by the Speaker of Lagos State House of Assembly, which were turned into football by youths on Lagos streets. Some respondents across the states expressed their views thus:

The secrecy shrouding information on the management of the COVID19 pandemic in the state leaves much to be desired. The level of sensitization and awareness creation, especially in rural communities isn't commensurate with the seriousness that Covid19 should be accorded. The State Government distributed palliatives to all the 31 Local Government areas of the state. The items included: rice, beans and garri. The total quantity of these items donated by the State government is not known but what was observed was that each household received two cups of each of those items. The State received 1800 bags of rice and undisclosed amount of vegetable oil from the federal government. It has been discovered that the rice isn't fit for consumption and the state government says they will not distribute such items. Our investigation reveals the rice was to come with a consignment of vegetable oil. But there has been no mention of the arrival of that consignment to date.
(A Respondent from Akwa Ibom)

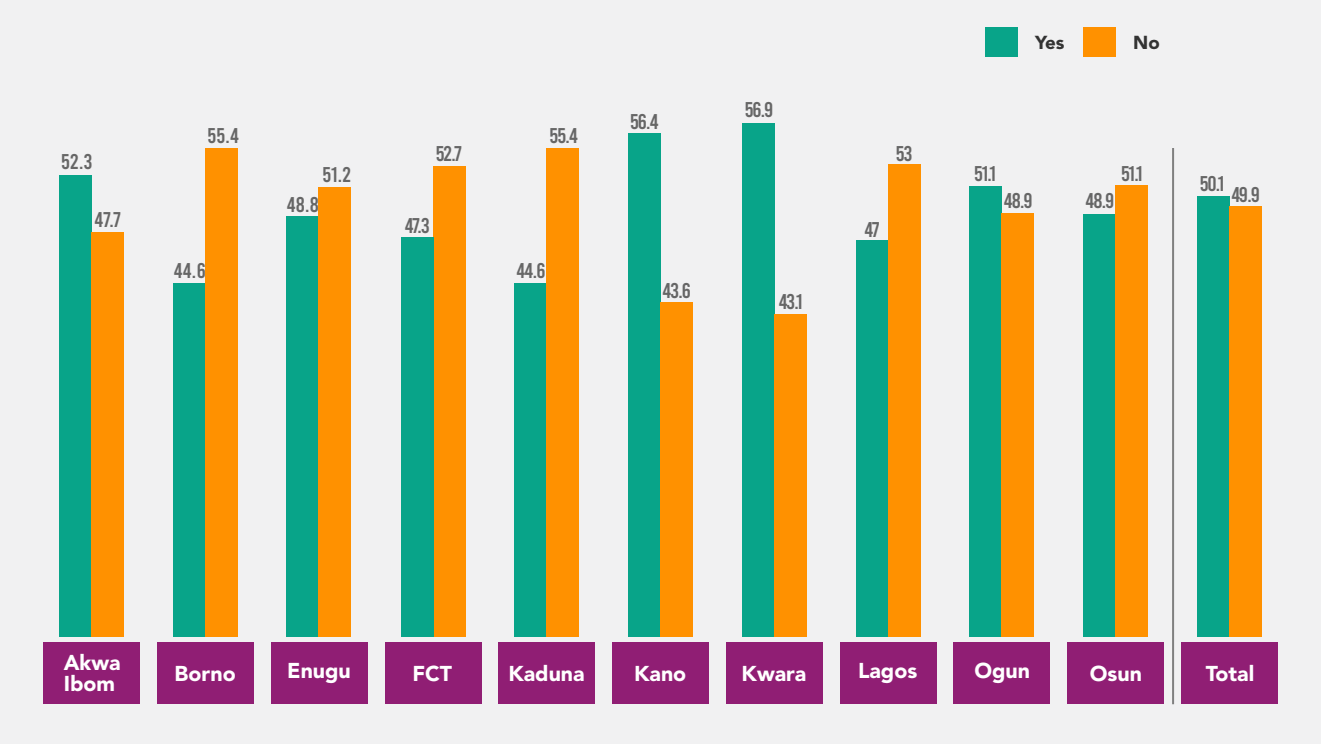
CSOs have asked Government to increase accountability and transparency measures in its COVID-19 Intervention funds utilization. They also note that the value of COVID19 expenditures in the state has not been made public. The value of total cash donations by individuals and corporate organizations have not been made public. Also, CSOs noted that the value of COVID19 expenditures in the state has not been made public. For instance, did the state receive support from the Federal government? How has the state derived the funds it is spending, is there a budget estimate for COVID19 expenditures currently being made?
(A CSO Representative from Akwa-Ibom)

I have heard of government distribution of palliatives but have not seen it physically and most people don't even know the approach the government adopted for the distribution. It is worrisome that there might be mismanagement of funds and high level of corruption regarding government management of COVID-19. To allay people's suspicions, the palliative distribution committee should be reconstituted to include CSOs, traditional and religious leaders, women and youth organizations.
(A Respondent from Bornu State)

It is instructive to note from above that most of the issues raised by various respondents across the states bother on lack of transparency, poor communication and non-representation of stakeholders in the distribution of palliatives.

7.5 Perception that Politicians were the Targets in the Distribution of Palliatives

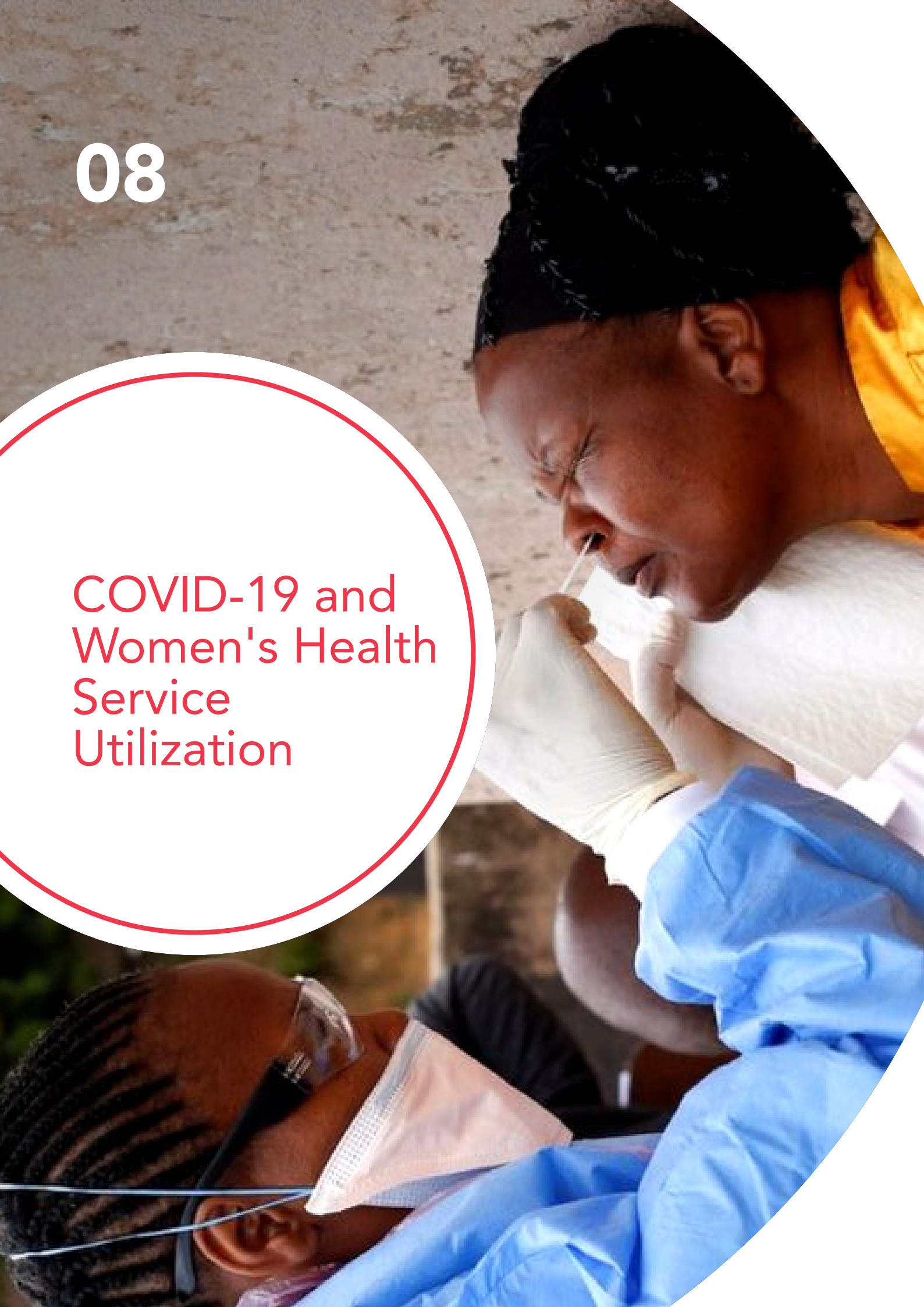
Figure 18: Proportion of Respondents with the Perception that Politicians and CDC were targets in the distribution of Palliatives



As indicated in Figure 18, Kwara (56.9%), Kano (56.4%) and Akwa Ibom states (52.3%) had the highest proportion of respondents who perceived that politicians and the Community Development Council (CDC) were the targets of the government in the distribution of the COVID-19 palliatives. Contrary to this, the perception was least shared among respondents from Kaduna (55.4%) and Borno state (55.4%) respectively. Results across all the selected states, and FCT further showed that approximately half (50.1%) of the respondents were of the perception that the main targets of the government in the sharing of the COVID-19 palliatives were the politicians and CDCs. While government may not intentionally targeted politicians as the main beneficiaries of palliatives, however, by saddling the responsibility of palliative distributions in the hands of politicians and excluding participation of women groups and civil society actors, a wrong message is being convened of the actual intention of government in the distribution of palliatives. In many states across Nigeria, wives of governors, commissioners, and house members were the main actors in the distribution of palliatives.

08

COVID-19 and Women's Health Service Utilization



8.1. Reasons for the Non-utilization of Healthcare Facilities by Women and Girls

Figure 19: Distribution of Respondents by Reasons for the Non-utilization of Healthcare Facilities by Women or Girls In their Households

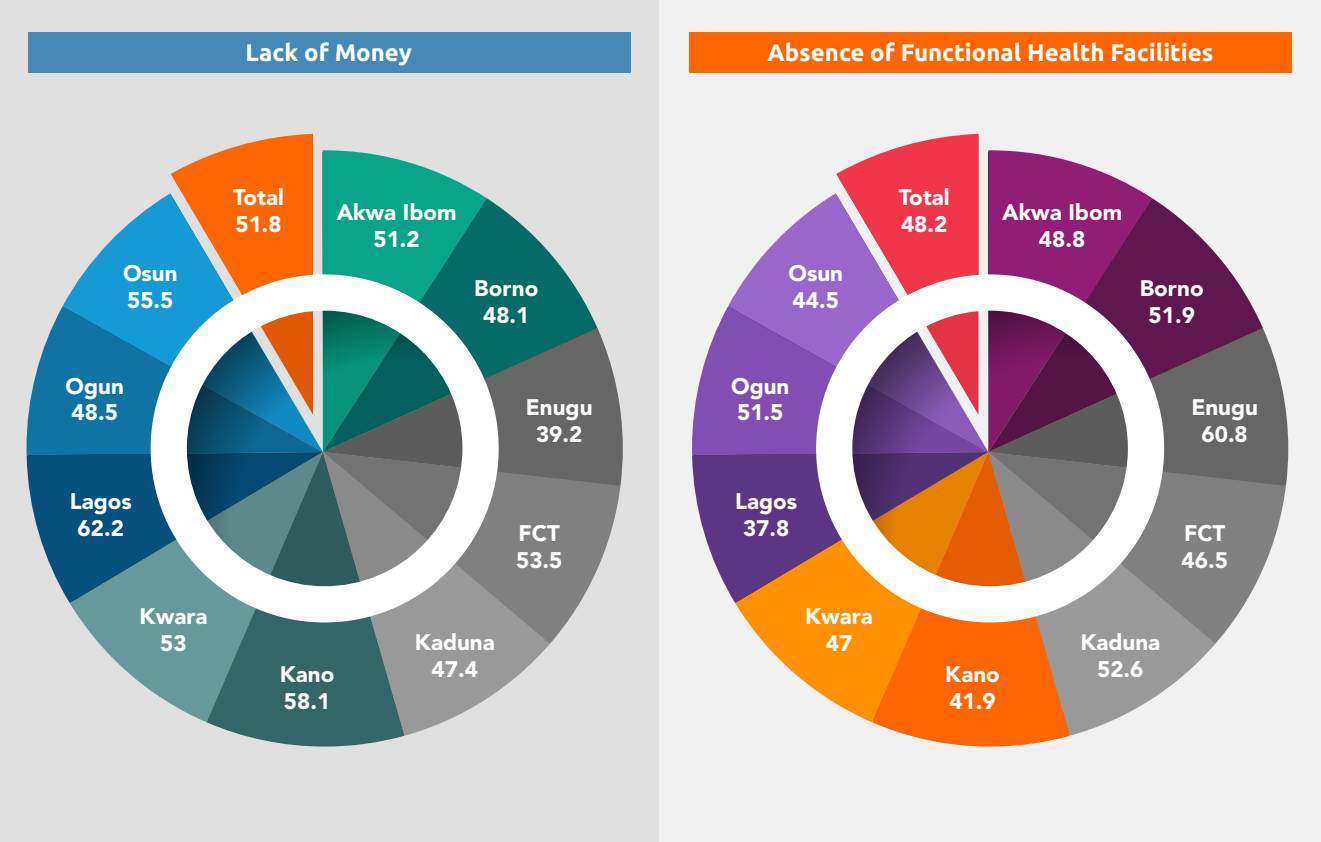
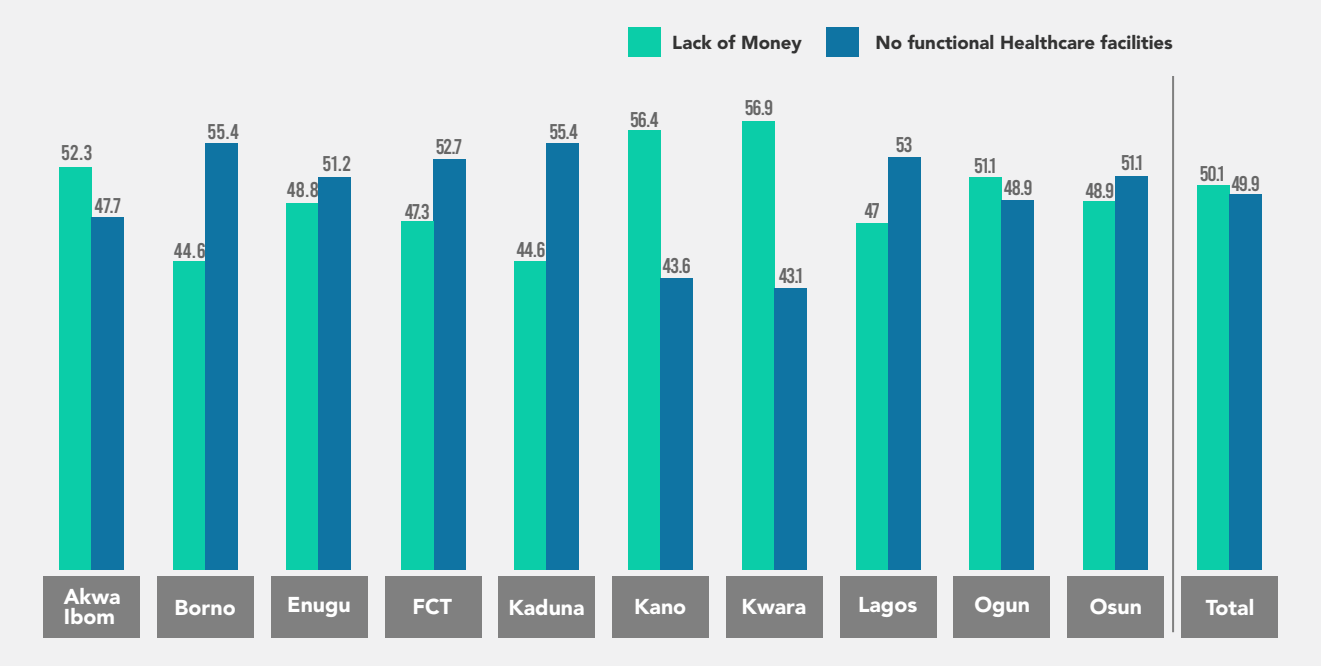


Figure 20: Distribution of Respondents by Reasons for the Non-utilization of Family Planning by Women in their Households

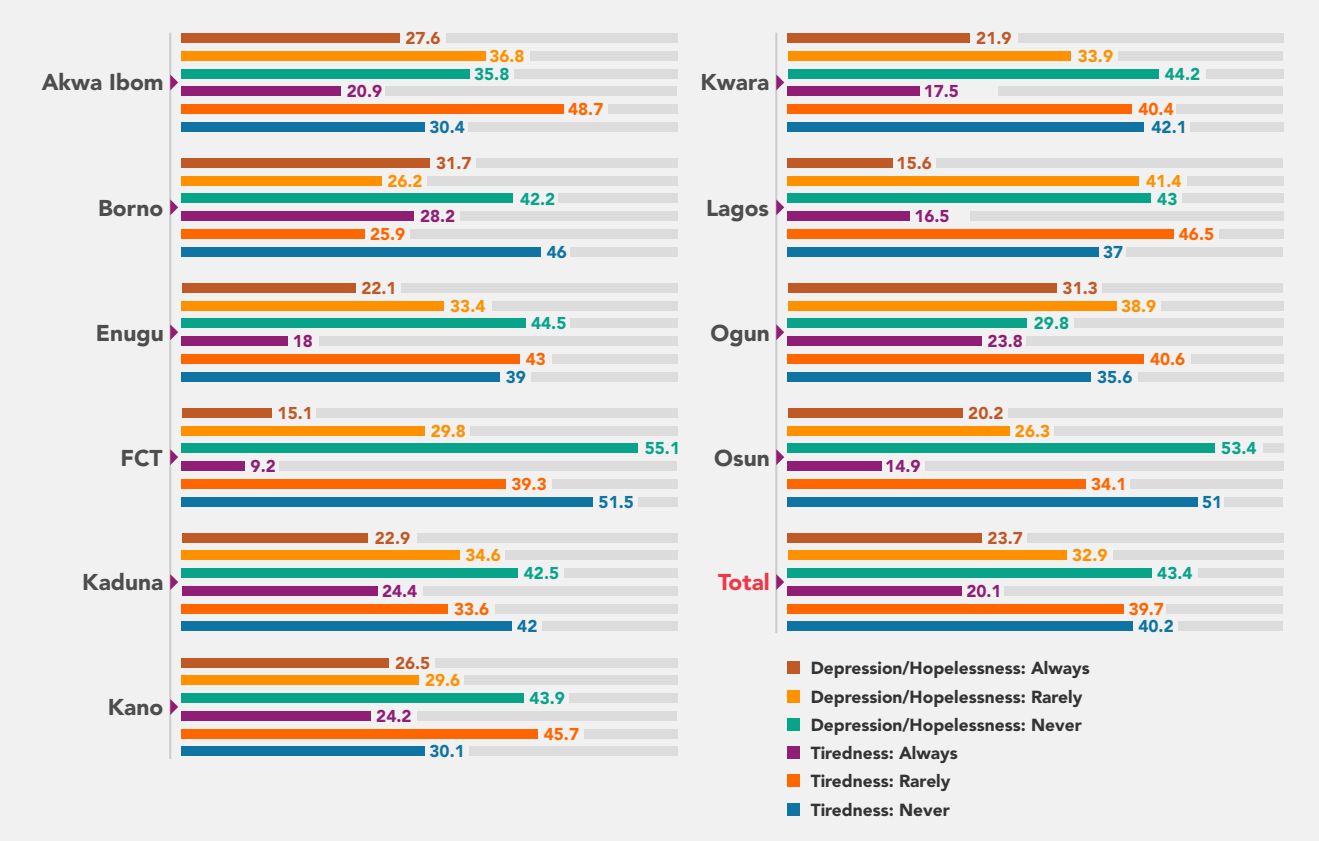


As indicated in Fig.19 &20, majority of the respondents in Enugu (60.8%), Kaduna (52.6%) and Osun states (55.5%) gave non-availability of functional healthcare facilities than the inability to pay for the services as their reasons for the non-utilization of healthcare facilities by girls and women in their households respectively. Conversely, the inability to pay for healthcare service was cited by the majority of the respondents in Lagos (55.5%), Kano (58.1%) and FCT (53.5%) for the non-utilization of healthcare facilities by girls and women in their household respectively. The results across selected states, and FCT revealed that 51.8% of the respondents gave lack of money to pay for healthcare services as the major reason for the non-utilization of healthcare services by girls and women in the various households.

A follow-up interactions and observations across revealed that the problem of access to basic healthcare for women was critical during the lockdown period. Some of the health services that were either unavailable or difficult to access were family planning clinic, ante-natal and post-natal care, children immunization clinic among others. Many women had to find alternatives in private clinics with the attendant high costs that were not affordable for many indigent women. As explained previously, one of the negative impacts of corruption on women is the denial of basic services such as healthcare. Because of the failure of the government to provide (PPE) to many hospitals, doctors and other health workers decided to shut down some basic clinics because of fear of contracting Covid-19.

8.2. Covid-19 and Mental Health

Figure 21: Respondents who had Mental Health Related Issues such as Depression and Tiredness during Covid-19 Outbreak



As presented in Figure 21, approximately 3 in every 10 respondents from Borno (31.7%) and Ogun states (31.3%) admitted to experience depression and hopelessness during the Covid-19 crisis period. Relatively, the results revealed that about one-quarter of the respondents from Kaduna (24.4%), Kano (24.2%) and Ogun (23.8%) claimed that they always felt tired as a result of the Covid-19 crisis. As indicated in the results, about 24% of the respondents across the selected states, and FCT admitted to have passed through depression and state of hopelessness during the crisis, while about 40% maintained they had experienced tiredness due to the outbreak of the pandemic. The absence of social service supports worsened people's psychological experiences during the lockdown period. Many families experienced unprecedented hardship due to hunger, lack of money and again palliatives. Women were excessively burdened, which most likely affected their mental well-being. The closure of schools further add more stress to women's daily activities that included taking care of children and providing some basic home-lessons for them. The state also failed to provide counselling support services through hotlines as being operated in other countries. The absence of psychosocial supports compounded the negative mental experiences of many Nigerians.

A respondent from Bornu commented thus:

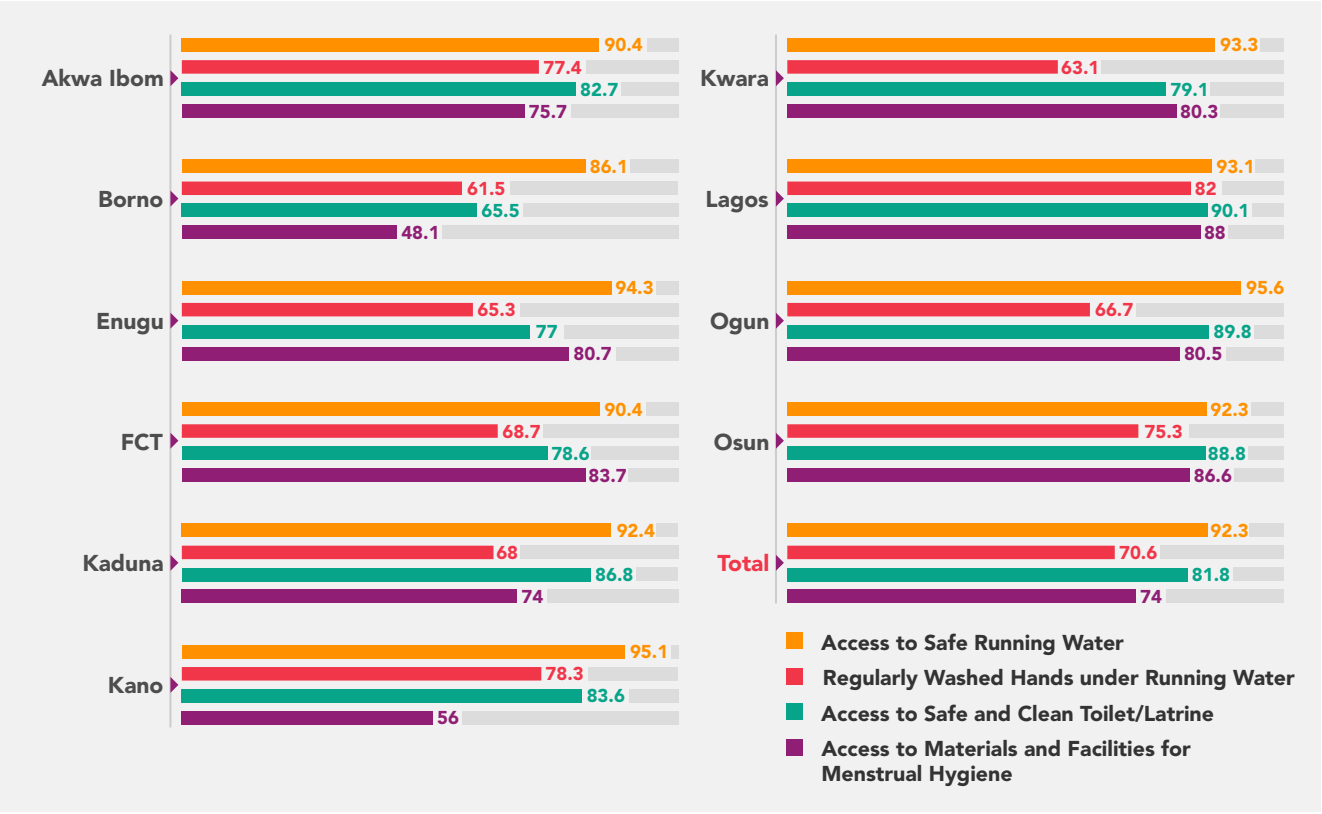
> ***A lot of families more especially women feel depressed because of the pandemic, fear of the unknown, anxiety, panic and the new culture of social distancing which is making the families to stay apart from each other. Psychologically it has affected women, according to source though not verified some women even committed suicide.***
>
> ***People are frustrated and there is lot of panic in them. The pandemic has caused some level of psychological problem to people like health workers, physically challenged and elderly people who underlying medical problems like cardiovascular disease and cancer. The fear of infected by the virus has put so many people in a traumatized situation. Again, due to loss of livelihood and other means of generating income or sustaining one's family, people go hungry and traumatized thinking of how to provide for their families on daily basis. Such people will either end up in traumatized situation or end up being violent aggressive and frustrated.***
> ***(A CSO Representative from Bornu)***

09

Women's Access to Water, Sanitation and Hygiene

9. 1 Women's Access to Water, Sanitation and Hygiene

Figure 22: Distribution of Respondents by Women's Hygiene, Sanitation and Access to Water during Covid-19 Outbreak



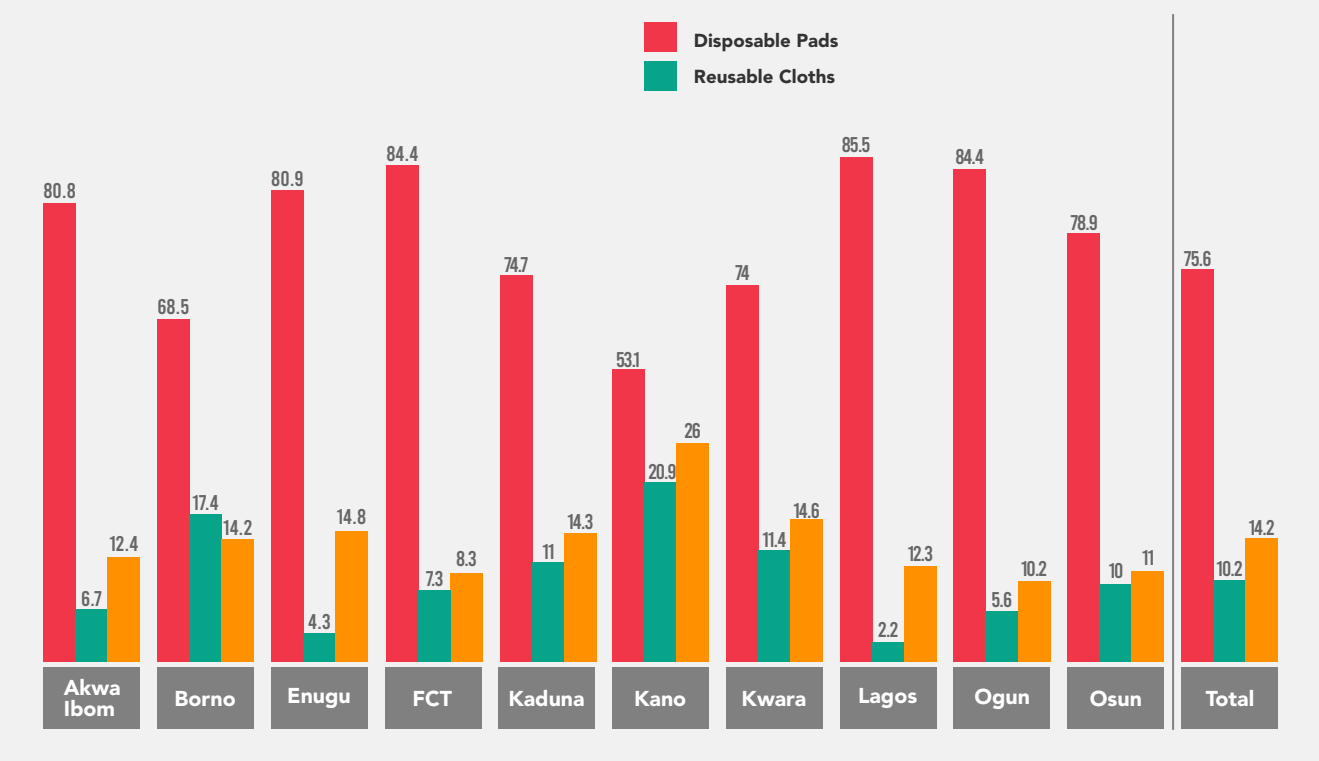
From Figure 21, respondents from Borno (48.1%) and Kano state (56%) had women with the least access to material and facilities for menstrual hygiene. Evidence from the outcomes of the study revealed that respondents from Borno, Kwara and Enugu states least comply with regularly washing of hands under running water. For instance, 63.1% out of 93% of respondents who had access to safe running water washed their hands regularly under running water in Kwara State. For Borno and Enugu, 61.5% and 65.3% out of 86.1% and 94.3% of respondents who had access to safe running water washed their hands under it respectively. Results across all the selected states, and FCT showed that about three-quarters of the respondents regularly washed their hands under running water (70.6%) and had access to materials and facilities for menstrual hygiene (74%) respectively.

As previously explained, majority Nigerians, especially those living in rural areas and even urban centers have no access to safe running water. According to UNICEF, the use of contaminated drinking water and poor sanitary conditions result in increased vulnerability to water-borne diseases. Only 26.5 per cent of the population use improved drinking water sources and sanitation facilities (UNICEF). Again, based on World Bank estimates, Nigeria will be required to triple its budget or at least allocate 1.7 per cent of the current Gross Domestic Product to WASH to achieve the SDGs Goal 6. According to the statistics from WaterAid:

116 million people do not have basic sanitation; 37.8 million people practice open defecation;
55 million people are without clean water; and 110 million do not have basic hygiene facilities (WaterAid@ https://www.wateraid.org/ng/). The pervasive corruption in the country has constrained the provision of safe drinking water and basic sanitation for millions of Nigerians, especially those living in rural areas. In many areas, some solar-powered boreholes dubiously constructed as 'constituent project' by politicians have either broken down completely or in a state of disrepair

9.2. Women's Menstrual Hygiene Needs

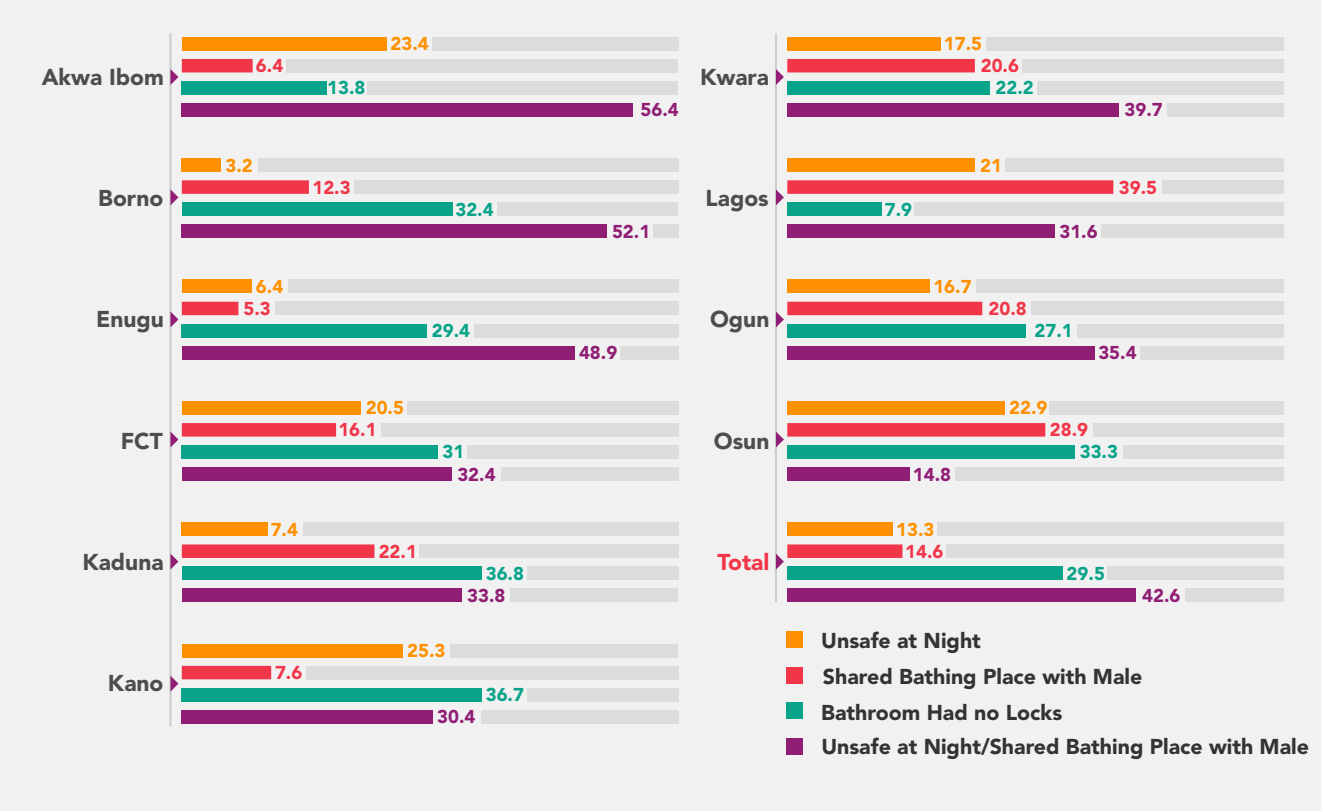
Figure 23: Distribution of Respondents by Women's Menstrual Hygiene Needs



As indicated in Figure 22, respondents from Kano (68.5%) and Borno state (68.5%) had the least access to disposal pads for their menstrual needs. The results thus revealed that reusable cloths were most used among respondents from Kano (20.95), Borno (17.4%) and Kwara state (11.4%) respectively. The results further showed that washing and disposable facilities were least available for respondents from FCT (8.3%) and Ogun state (10.2%) respectively. Results across all the selected states, and FCT revealed that approximately three-quarters (75.6%) of the respondents had access to disposable pads, while 1 in 10 respondents (10.2%) made use of the reusable cloths during their menstrual period. The results confirmed that despite the low socio-economic status of the respondents, they could still afford to take care of their hygiene

9.3. Non-Utilization of Household Bathroom Facilities by Women

Figure 24: Distribution of Respondents by Non-utillization of Household Bathing Place



From the findings in figure 23, respondents from Akwa-Ibom and Bornu states had the highest number of respondents that claimed that insecurity at night/sharing bathroom facilities prevented them from using them. In all, 42.6% of the total respondents across the ten states reported that insecurity at night/sharing facilities with men prevented them from using bathroom. The finding is really significant taking into consideration the upsurge in cases of rape, sexual harassment witnessed during the lockdown. Sharing of bathroom facilities with men may also exposed women to gender based violence especially at night. A significant number of the respondents further claimed that their bathroom facilities had no lock (30%), which may also made women vulnerable to sexual predators, especially within same neighbourbood.

10

Security Challenges of Girls and Women during Covid-19 Outbreak

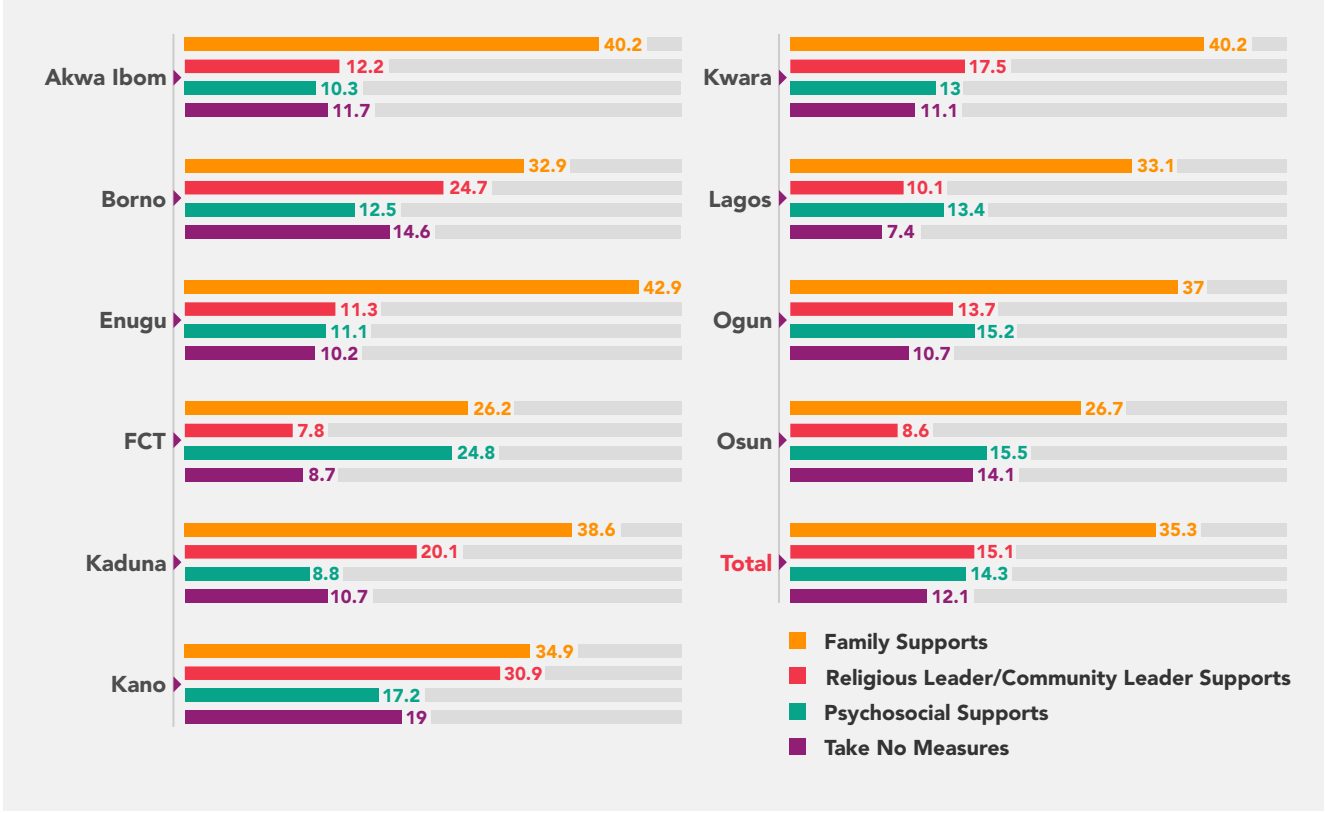
10. Security Challenges of Girls and Women during Covid-19 Outbreak

Figure 25: Distribution of Respondents by Security challenges faced by girls and women during Covid19

Figure 24 presents security challenges during COVID-19. As indicated, the highest proportion of girls and women that were sexually abused were female respondents from FCT (58.8%); Kaduna (47.2%); and Lagos state (46.5%) respectively. About two-thirds (64.7%) of the female respondents from Kaduna and nearly 60% of their counterparts from Borno state lamented that it was not safe for them to travel at night. Results across the selected states, and FCT showed that more than one-third (37.8%) of the female respondents were sexually abused while another 45.2% experience domestic violence during the COVID-19 crisis. Further evidence from key informant interviews and secondary literature confirmed the upsurge in security challenges faced by women and girls during the lockdown period. Incidence of harassment by security personnel; rape; assault and battery; ritual killings were reported in several parts of the country. The Inspector-General of Police reported 'that 717 rape incidents were reported across Nigeria between January and May, 2020 while about 799 suspects were arrested during the period; 631 cases conclusively investigated and charged to court; while 52 cases are still left under investigation' (Punch: June 15,2020). The incidence of rape had also attracted the attention of Governors Forum, who rightly declared it 'a national emergency' (CNN: June 12, 2020). The pervasive corruption within the security agencies also limit their effectiveness in providing security and protection for women. It is public knowledge that extortion, sexual exploitation and bribery are so rife within security agencies that made it difficult for them to respond effectively to security challenges, especially violence against women.

10.1: Measures to Address Security Challenges of Girls and Women during Covid-19

Figure 26: Distribution of Respondents by Measures Taken to Address the Security Challenges of Women and Girls during Covid-19 Outbreak



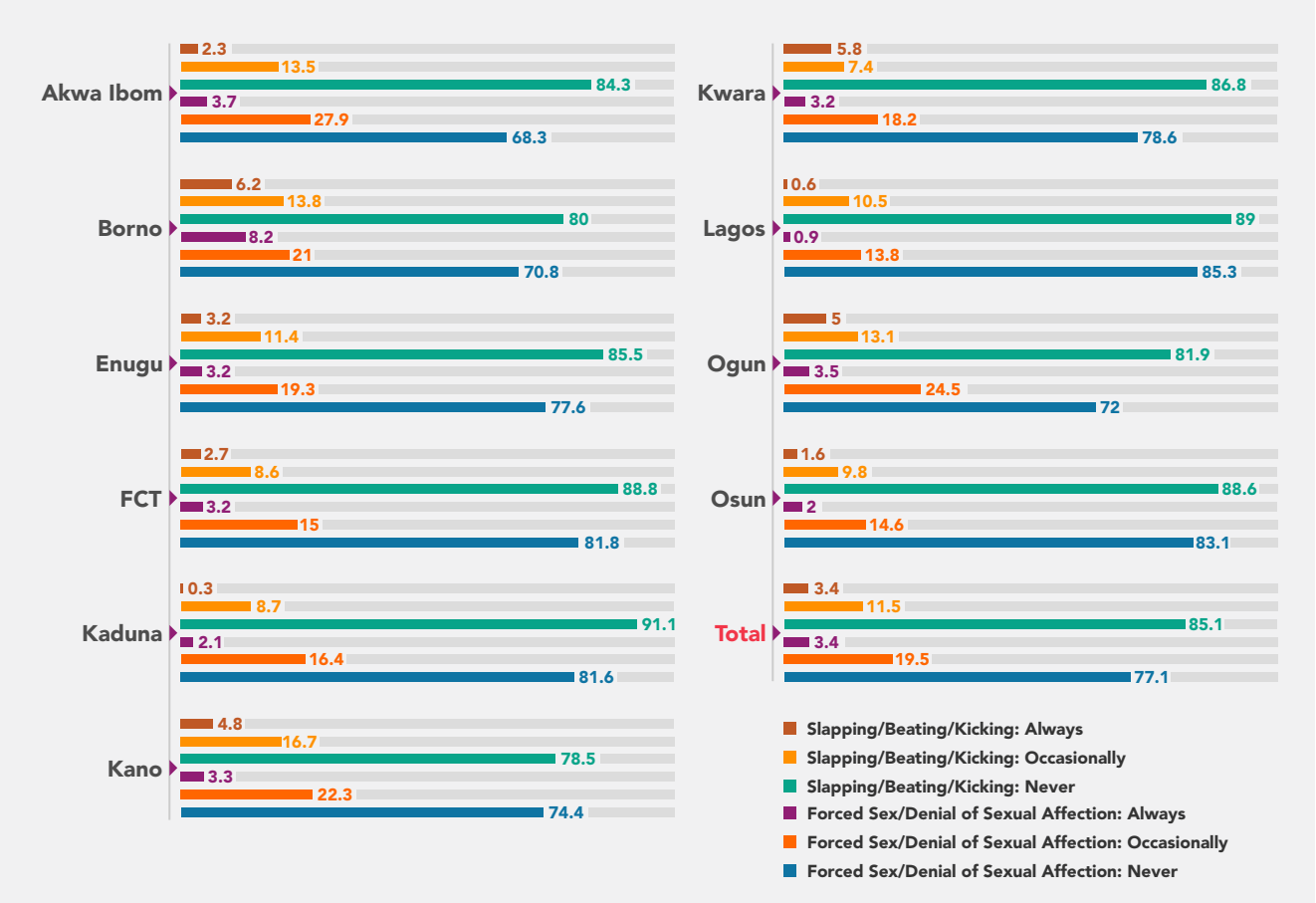
Majority of respondents across the ten states had to rely mostly on family supports to address security challenges faced during the lockdown period (35.3%). The next line of support was received from religious/ community leaders (15.1%). These findings clearly reveal the weakness or rather absence of social-support services by the state for victims of insecurity, especially women.

11

Gender based Violence during Covid-19

11. Gender based Violence during Covid-19

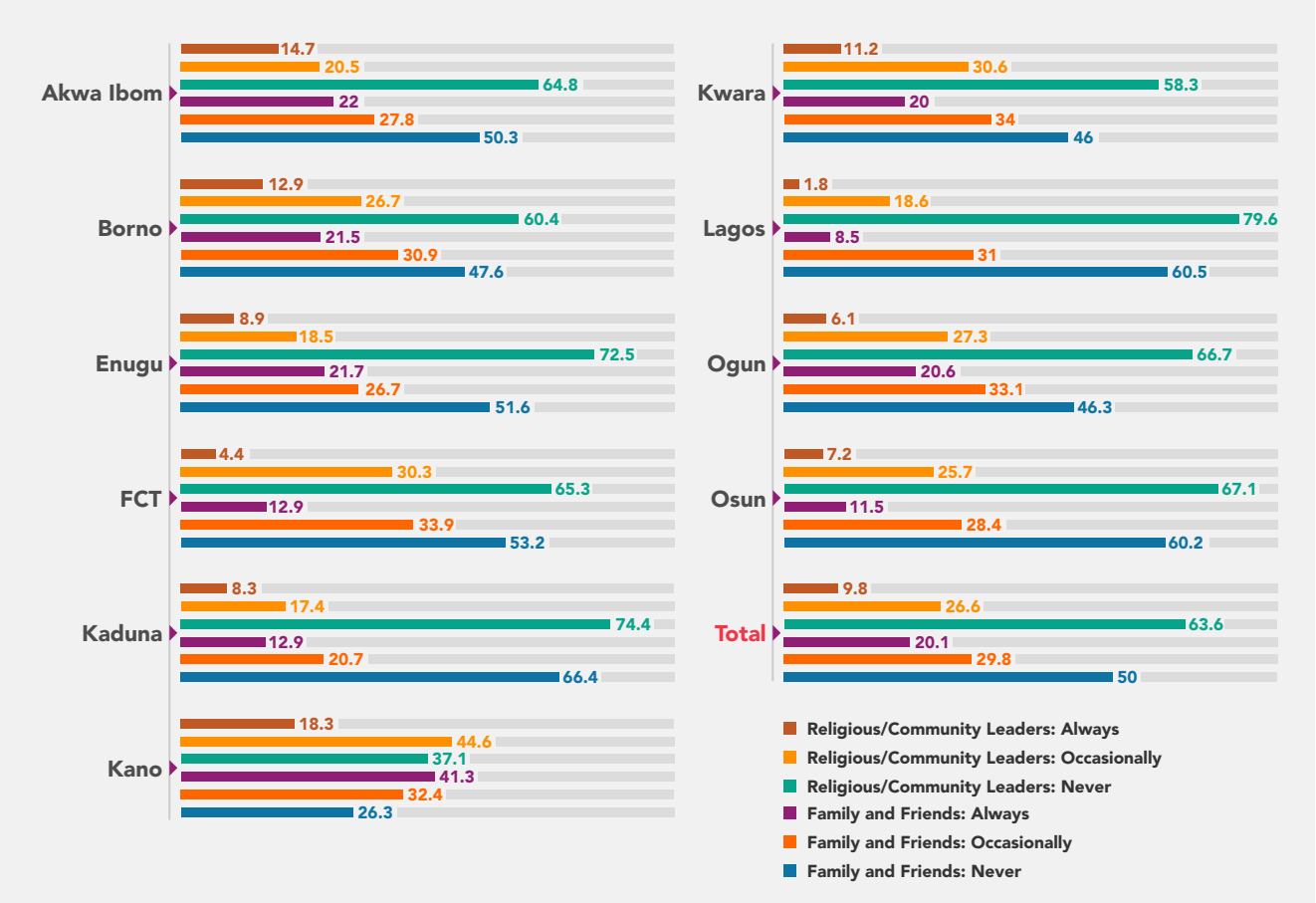
Figure 27: Distribution of Respondents by Incidence of GBV during Covid-19 Outbreak



Results across the selected states, and FCT revealed that 3.4% of the respondents were always slapped or beaten or kicked by their partners during the COVID-19 crisis. Equally, it is evident from the results that 3.4% of the respondents were coerced to having sex outside their wish or denied of sexual affection. Specifically, the highest incidence of assaults was reported by respondents from Borno (6.2%) and Kwara (5.8%); while the least cases were witnessed by respondents in Kaduna (0.35) and Lagos state (0.6%) respectively. For forced sex or denial of sexual affection, the highest incidence was reported by respondents in Borno state (6.8%), while the least cases were reported by respondents in Lagos state (0.9%). In all, incidence of gender based violence was not widely reported by respondents in across the selected states. This may not be unconnected with stigma associated with issues of GBV such as rape, sexual harassment and domestic violence. The lack of confidence in the ability of law enforcement agents to respond effectively also prevent many victims of GBV from approaching security services. In most cases, there is also capacity deficient and lack of facilities and equipments needed for appropriate response to GBV in Nigeria. It has also been observed that many states in Nigeria have not ratified the Violence Against Persons (Prohibition Act, 2015)

11.1. Approach to Resolving GBV with Spouse during COVID-19

Figure 28: Aproach to Resolving GBV with Spouse during Covid-19 Outbreak



Majority of respondents across the ten states had to rely mostly on religious/community leaders (27%) to address domestic violence/GBV faced during the lockdown period. The next line of support was received from family/friends (20%) These findings clearly reveal the weakness or rather absence of social-support services by the state for victims of domestic violence/GBV, during crisis situation, especially women.

12

Respondents' Recommendations

12. Respondents' Recommendations in Ensuring Supports for Women and other Vulnerable Groups During Covid-19

Figure 29: Distribution of Respondents by Recommendation

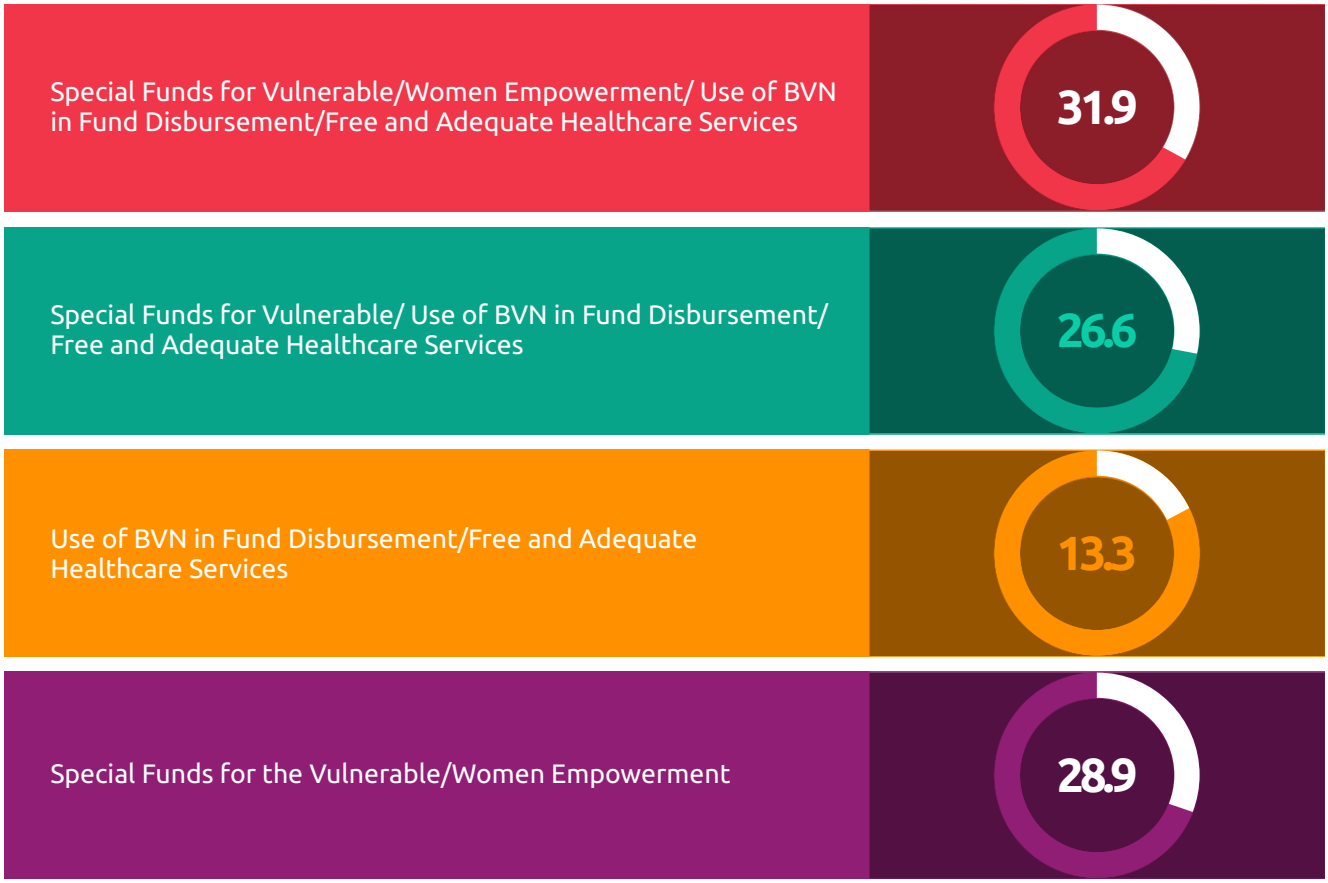


Figure 28 presents the recommendations by the respondents across the selected states, and FCT. About 28.9% of the respondents suggested that special funds should be made available and that women should be empowered as well; 3.3% of the respondents were of the opinion that the government should employ the BVN in fund disbursement in order to checkmate financial corruption, and that the government should provide the masses with free and adequate healthcare services. Approximately one-quarter (26.6%) of the respondents suggested that special funds should be provided for the vulnerable, use of BVN in fund disbursement, and the provision of free and adequate healthcare services for the masses. About one-third (31.9%) of the respondents suggested that special funds should be made available to vulnerable, women should be employed, use of BVN in fund disbursement, free and adequate healthcare services should be made available to the masses.

Key Findings: Framing Covid-19 Pandemic

- Covid-19 exacerbates pre-existing structural inequalities in income, decision-making between men and women. The pandemic further marginalizes women and exposed them to plethora of security challenges and domestic violence. From women's experience in Nigeria, Covid-19 has turned out to be a 'pandemic of marginalization and violence'.

- Distribution of palliatives became avenue for corrupt practices especially officials of the state, who simply hijacked the process and diverted palliative materials to their cronies and family members. Again, the widespread corrupt practices witnessed in the distribution of palliatives and the management of the crisis has framed Covid-19 into a 'pandemic of corruption'.

- Emergence response taskforces across the states were not gender-sensitive in the composition of team members and decision making

- Upsurge in cases of domestic violence and gender based violence against women were reported during the lockdown

- Principles of Accountability were clearly absent in the distribution of palliatives and management of Covid-19 relief donations.

- The Nigerian state lacks the required institutional capacity for effective response to pandemic of such magnitude and thus had to follow the model from the western countries in the national response

- Citizens' participation in critical decisions of the state was limited due to the authoritarian measures required to enforce lockdown and movement restrictions

- Civil society representatives, community-based organizations and other stake-holders were sidelined in the distribution of palliatives

- Critical healthcare services were shut down while attentions were wholly devoted to the containment of the pandemic thereby depriving women, children and other vulnerable groups, access to such services like antenatal and postnatal, family planning and immunization.

- Healthcare facilities and services were incapacitated to respond adequately to the challenges of pandemic due to pervasive corruption.

Policy Recommendations

Open Governance and Accountability Framework in Emergency Management

- Government should incorporate accountability and transparency principles into the National Emergency Response Framework
- Expand the space for citizen's participation in emergency response by promoting transparency and accountability in the health sector thereby reducing inequality experienced in the sector.
- Inclusion of media and civil society actors in the various COVID-19 task forces across board to strengthen transparency, accountability and diversity in the process.
- Promoting the public's right to information as a strategic entry point for open governance and accountability framework in emergency response.
- Supporting public-sector reforms that increase transparency, set performance monitoring standards for service delivery, increase public-sector actors' gender awareness and increase the gender responsiveness of service delivery
- Implementing participatory monitoring of service delivery, including the use of community score cards
- Incorporate Anti-Corruption Agencies in the National Emergency Response Team
- Institutionalize Open Tendering/Competitive Bidding for procurement in a transparent manner
- Establish appropriate legislative framework that incorporate accountability principles, including necessary safeguards for emergency response plan
- Establish clear, objective and transparent criteria to protect the interests and needs of the vulnerable groups in the society.
- Innovative technological platforms should be deployed for funds tracking and transparent assessment of disbursements
- Ensuring accountability in financial management and procurement through budget transparency and robust internal/external auditing

Women Inclusion in Decision-making and Participatory Governance

- Increase awareness of gender issues in government policy, planning and budgeting
- Implement 50% women representation in national emergency response team and other taskforces at state and community levels
- Incorporate the 50% women political representation into electoral reforms with legislative backing

- Institute gender-budgeting framework into national emergency budgetary allocation to address specific gender issues, especially women concerns
- Incorporate women rights organization and community based groups in the identification of vulnerable people and disbursements of palliatives
- Increase the number of women in government's, public service and at the frontline of service delivery
- Develop gender-sensitive tools, sex-disaggregated data and measurements for undertaking gender assessment of programs
- Children's issues and concerns should be mainstreamed into gender framework for policy interventions, especially during national emergencies.

Community participation in Emergency Response

- Community mobilization for support system in a 'bottom-up' approach as alternative to government's 'top-down' approach during national emergencies
- Reinforce and strengthen the existing community structures such as traditional institutions, community-based organizations to be used as platforms for effective response during national emergencies.
- Community-based platforms should be incorporated into social-protection and support services for the most vulnerable groups during emergencies
- Community healthcare (primary health centers) should be adequately staffed and equipped to provide first line of response during national health emergencies.
- Support women's groups such as market associations and cooperative societies as platforms for distribution of food palliatives, direct cash transfer and other palliatives to vulnerable women
  Security Sector Reforms for Effective Emergency Response
- Incorporate gender mainstreaming framework into security sector national emergency response strategy
- Strengthening structures to accommodate gender interests such as gender desk office, juvenile units etc
- Eliminate operational frameworks and guidelines that inhibit women's access to justice
- Strengthening the operational capacity and institutional preparedness of security agencies to respond effectively to gender based violence and violence against women during emergencies

Healthcare Facilities/Social Support Services during Emergencies

- Government should invest in provision of facilities to cater for women hygiene such as provision of accessible portable water, toilets and fumigation of public places during health crisis

- Institutionalization of social support services should be entrenched in state structure and not operate on the framework of 'fire brigade'.
- Include mental health care and psychosocial supports into national emergency response strategies.
- Expand access to affordable healthcare for all, irrespective of economic status
- Provide necessary PPE for frontline workers during emergency
- Facilitate access to basic health services such as immunization clinic, ante-natal and post-natal care and family planning clinic without interruption during emergencies
- Upgrade infrastructures and prioritize continuous facilities building before emergency

GBV Prevention and Response during Emergency

- Appropriate prevention and response measures should be put in place for GBV, including: hotline for reporting incidents; counselling supports and safe shelter
- Ensuring proper training and capacity building for security personnel for effective response to GBV during emergencies
- Collaborate with women's right groups and community based organizations to provide awareness and necessary sensitization to GBV to the most vulnerable groups in the society
- Provide necessary supports for survivors of GBV such as rehabilitation, counselling and other support services
- Ensure adequate provision of funds to support GBV response strategy during emergencies.

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WARDC Research Brief

Women Advocates Research and Documentation Center (WARDC) was founded to support research and documentation on gender and development issues, at a time when few organizations work around women issues in Nigeria. Since 2000, the organization has engaged in ground breaking research which has led to over twenty publications, including manuals and abridged resource on women's rights, governance, sexual and reproductive rights, gender budgets and conflict.

The following are the details of national research done by the organization:

1. Broken Promises Human Rights Accountability and Maternal Death in Nigeria (2008)– This report was done in collaboration with Center for Reproductive Rights (CRR), which focuses specifically on the Nigerian government responsibility for the dire state of maternal health in the country, it highlights the issues in the context of maternal health, how some of the factors from the findings have repercussion for the system overall and the general health of all Nigerians. The report is based on desk and field research conducted between October 2007 and May 2008, it involved a literature review of research publications such as books, journals, newspaper articles and documentary analysis, as well as synthesis of policies, legislation and national demographic and health surveys published by the federal and state governments of Nigeria. In addition, it included reviews of civil society and non-governmental organization surveys and publications on health and reproductive health care. https://www.reproductiverights.org/document/broken-promises-human-rights-accountability-and-maternal-death-in-nigeria

2. Engendering the Niger Delta Regional Development Plan: Panacea to Sustainable Peace… A Proposed Gender Strategy: Expanding the Space for Women in Niger Delta Master Plan.

This report provided a raison D'etre for the integration of gender into the the Niger Delta Master Plan. The research procedure involved mainly desk study that ran concurrently with a field study with data obtained from both primary and secondary sources.

Primary data was obtained through Focus Group Discussions (FGDs), in Depth Interviews (IDIs) and questionnaires while the secondary sources were an extensive literature review and search for existing records. Also consulted as baseline resource materials were publications on development issues in the Niger Delta, reports by non-governmental and community based organizations and human development reports prepared bu UNDP and various human rights organizations.

3. Renegotiating Aid for Effectiveness: Assessment of Gender Mainstreaming in New Aid Modalities in Nigeria… A Ghana High Level Forum Preparatory Process, Abuja Nigeria.

This report was analyzed using the generic framework utilized by other partners around the world especially on other developing countries. The objective of this research aimed at identifying approaches for effectively integrating gender equality into new modalities in the spirit of Paris Declaration on Aid Effectiveness. As part of the methodology, a literature review of available materials was undertaken, a list of selected documents i.e interview tools, questionnaire, mapping among others.

As part of this report, a CSO training workshop was organised, there were mapping exercise to strengthen shared CSO, government and Donor understanding of the mapping exercise and elicit cooperation of concerned partners- government, CSO and donors. Structured questionnaires were developed and administered on 23 informants. Information generated from the interviews were derived from a combination of donor agencies, government institutions and CSOs in the Federal Capital Territory, Abuja and constituted the bulk of materials for the analysis of the findings. It is important to mention that persons interviewed in these agencies were those working on gender issues. http://www.gendermatters.eu/images/gendermatters/documents/Nigeria_MD_draft.pdf

4. Gender Budget Analysis: A Case Study of Ogun and Kaduna States

This research looked at the system of government in Nigeria Development Plan (s) guiding the Budget with reference to the two selected states. The objective was to look at sectors given priorities, the budget process at the 3 levels, process of getting budget approval and stages in the budget process.

5. Rapid Gender Analysis of the Impact of COVID-19 on Households in Nigeria: A National Survey.

Rapid Gender Analysis (RGA) provides information about the different needs, capacities and coping strategies of women, men, boys and girls in a crisis situation like COVID-19. RGA highlights the gendered impacts of COVID-19 crisis on households in Nigeria and generates data on the differential impacts of the crisis for effective planning and implementation of national emergency response.

The study adopted mixed methods, involving collection and analysis of quantitative and qualitative data. Primary data was sourced through questionnaires and key informant interviews while secondary data was obtained from agencies reports, journal articles and internet resources. A total number of 5,813 respondents were sampled across nine states plus the federal capital territory in Nigeria (making 10 states in total). The questionnaires were distributed to women in randomly selected households across the selected states. For adequate representation, three local government areas were purposively selected from three Senatorial Districts of each state. The local governments were selected on the basis of urban; semi-urban and rural socio-economic categorization. Some of the questionnaires were administered physically while the others were done through phone calls and video calls based on the prevailing situations of lockdowns, physical distancing and movement restrictions. A follow-up key informant interviews with 10 purposively respondents were undertaken in each of the ten locations. The respondents were selected from: four indigent women; three civil society activists, and; three government officials. In all a total number of 100 follow-up interviews

were conducted in ten states. For the household survey: A 'Rapid Gender Assessment Covid-19 Tool on Households' was developed. There were 10 sections of the tool covering socio-economic, health, governance and psychological issues.

6. Scoping Study on SGBV in South West Nigeria

We also have an ongoing in-depth study being supported by Ford Foundation in 36 selected communities across the 6 states (Ekiti, Lagos, Ogun, Ondo, Osun, and Oyo) in the Southwest of Nigeria on the extent of vulnerability of women and girls to violence in the community and the impunity surrounding the scourge. This research employed the tools of questionnaires, Focus Group Discussion (FGD), Index Informants (IDIs) among others.

Other publications can be viewed at the link provided http://worldcat.org/identities/lccn-nr2004032269/