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ARTICLE (REFEREED)

Covid-19 and Sexual and Reproductive Health of Women and Girls in Nigeria¹

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Abstract

Copious literature exists on how COVID-19 is affecting the sexual and reproductive health of women and girls in the world. Not much is known about the case of Nigeria. Using secondary data in peer-reviewed and grey literature, as well as insights from web searches, this paper explores the impact of measures such as lockdown, closure of schools, travel bans, and social distancing on the sexual and reproductive health of women and girls in Nigeria. The impact varies between urban and rural dwellers amidst pre-existing patriarchal norms and severe health care deficiencies and limited access for people and worse for women and girls with needs. Decision-making about family planning, contraceptive use, safe delivery, antenatal care, prenatal care and treatment of victims of rape which have been mainly areas in which men's power has been demonstrated in the past only got worse with pandemic-related lockdown and restrictions.

Keywords

Nigeria; Covid-19; Women; Girls; Sexual and Reproductive Health

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Context

Generally, awareness of the sexual and reproductive health of females in Africa has increased in recent times ([Ahonsi 2017](#)). Knowledge has also expanded as a result of the fast-evolving human rights framing of sexual and reproductive health of women and girls in international regimes and advocacy activities of state and non-state actors in individual African countries. Paradoxically, the question of agency or power of women and girls to make decisions about their sexual and reproductive health has remained primarily poorly addressed in many cultures in the continent due to multiple factors that can easily be summarised as patriarchy in behavioural, attitudinal and structural life of society, and slow pace of change. The point of departure inferred from studies is that there is yet no significant improvement in the empowerment of women and girls in their sexual and reproductive health in the majority of communities in African countries. Indicators such as whether women and girls can make decisions about family planning freely, access to healthcare services, use contraceptives of choice, and access skilled assistance during childbirth, have remained low, especially in rural and semi-urban populations, with several socio-economic, political, policy and cultural issues identified as barriers.

Meanwhile, empowerment, which scholars and development experts continue to argue is key to improvement in sexual and reproductive health of women and girls, at the moment is also abysmally low for women in the majority of countries in Africa. Women in Africa are more likely to die from sexual and reproductive health problems than their counterparts in other regions of the world ([Nkwonta & Messias 2019](#)).

The COVID-19 pandemic, which originated in Wuhan, China, in December 2019, soon spread to over 216 countries in the world. The European Centre for Disease Control and Prevention (ECDC) reported that as of 14 December 2020, the world had recorded 71,503,614 cases and 1,612,833 deaths. Out of this number, Africa's share was 2,379,827 cases with the worst in South Africa, Morocco, Egypt, Ethiopia, and Tunisia. Likewise, it has recorded 56,334 deaths with 5 countries having the most deaths as follows: South Africa, Egypt, Morocco, Tunisia, Algeria (ECDC 2020). The first case in Africa was detected on 19 February 2020. The African Centre for Disease Control created an initial response platform. Not long after that, governments in Africa started imposing travel bans, compulsory quarantine and other restrictions. [Stein and Cannon \(2020\)](#) have argued that the response strategies of governments in Africa exacerbated the impact of the pandemic and created vulnerabilities. In the same vein, a group of scholars have argued that these strategies have potentially harmed society in several ways ([Glover et al. 2020](#)).

In Nigeria, as of 18 December 2020, a total of 76,207 cases had been confirmed, with a total of 1,201 deaths. In the same vein, Kenya had recorded a total of 72,853 confirmed cases and 1,614 deaths. The United States of America, in the same period, recorded 17.2 million confirmed cases and 311,000 deaths. Despite comparatively low fatality in Sub-Saharan Africa, women and girls are the least likely to escape the severe social, economic, and political effects of the pandemic.

The impact on women and girls from past pandemics such as ebola, zika and other diseases has been highlighted in the literature as having stressed economies and worsened pre-existing inequalities ([Brolin Ribacke et al. 2016](#); [Elston et al. 2016, 2017](#); [Heymann et al. 2015](#); [Legrand et al. 2007](#); [Maphanga & Henama 2019](#); [Marston et al. 2017](#); [Menéndez et al. 2015](#)). One study carried out by Nanthini and Nair (2020) found that 3600 maternal, neonatal and stillbirth resulted from the ebola pandemic in Sierra Leone from 2014-2015 because of the reduction of health services during the pandemic.

One aspect of the literature that has stood out is the risk of extreme poverty linked to pandemics. Poverty is used here to refer to a variety of social and economic conditions with indicators of lack and inability of households to access basic personal income, food, shelter, education, healthcare, and so on. To be poor, therefore, can mean a life of hardship ([Ammar et al. 2020](#); [Lalthapersad-Pillay 2002](#); [Mukumbang et al. 2020](#); [UN Women 2020](#)).

What needs to be sufficiently explored, however, in all this, is whether COVID-19 is or is affecting women and girls sexual and reproductive health and worsening their poverty. Against this background, this paper explores the impact of the pandemic on the sexual and reproductive health of women and girls in Nigeria.

Defining sexual and reproductive health

The temptation to define sexual health with reproductive health or vice versa is strong because of the intricate conceptual interconnectedness. The World Health Organisation (WHO) defined it as “a state of physical, emotional and social wellbeing in relation to sexuality” ([World Health Organisation, 2019](#)). Sexual health does not necessarily mean the absence of disease. Instead, its realisation consists in the respect, protection and fulfilment of sexual rights which in itself is measured in terms of nature of sexual relationship devoid of force, violence, discrimination, disrespect and freedom in decision-making about issues such as family planning, access to health services, sex, etc. On the other hand, reproductive health, as defined by WHO is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes” (ibid). The paper adopts key properties of these definitions and sees sexual and reproductive health as the power and freedom that females have to make decisions about their lives and future.

The WHO, in a bid to provide more understanding of the concept of sexual identified 5 environmental factors of influence, namely, 1) laws, policies, and human rights, 2) education, 3) society and culture, 4), and 5) health systems. Thus, the assessment of progress with sexual and reproductive health can contribute to knowledge in the area. This paper attempts to document how the pandemic has affected sexual and reproductive health outcomes in Nigeria.

COVID-19, Poverty and Violence

As of 30 March 2020, 46 out of 49 countries in Sub-Saharan Africa had either fully or partially closed borders because of the pandemic. A total of 44 countries had responded with social distancing measures, closure of schools, and restricted movements and public gatherings (Fletcher & Rouget 2020). In Ghana, for example, a mere 3 weeks lockdown caused a 27.9 per cent decrease in Gross Domestic Product (Amewu, Asante & Thurlow 2020). The recovery in that country as much as with the rest of the countries in Africa is likely to be slow for many people. In Nigeria, according to [Olaseni et al. \(2020\)](#), apart from a gendered effect in the area of economic insecurity, increased cases of rape and other forms of violence against women were reported, as well as a general expansion of inequality across the country. They argue that Nigerians were psychologically distressed from the weeks of lockdowns and restrictions which lasted from 20 March to 10 April.

Research conducted by [UN Women \(2020\)](#) is one among few with profound findings on the experiences of women and girls during the pandemic. Widening gender and economic inequalities, as noted in its report, are seen through the pathway of socio-economic effects or impacts on women and girls. They are losing income, facing increased violence on the home front, confronted with increased unpaid care, and facing challenges concerning their health due to the risk of shifting of funds and services from women reproductive health to combating the pandemic ([Bowleg 2020](#); [Mayai et al. 2020](#); [Ramírez & Lee 2020](#)) The report further argues that more than 435 million women and girls will live on less than \$1.90 day-to-day by 2021, and out of this number, 47 million will be in extreme poverty ([UN Women 2020](#)).

People observed the gender policy blindness in decisions made early in the COVID-19 pandemic and argued that it had the potential to reverse modest progress made in the last two decades regarding gender equality. The economic effects on women and girls through exposure to extreme poverty in the case of

Nigeria, and the deepening of inequality through different channels including weak recovery from the loss of income, sexual violence, denial of rights to health, educational and social setbacks, lack of social safety nets, and food insecurity, are urgent short term and long term policy matters with opportunities to prevent rather than deflate gains already made in the last 22 years with regards to gender inequality.

Women and girls are far more prone to loss of income from crises because of the nature of the labour workforce in Nigeria. They are mostly in the informal sectors providing services such as family caregiving, petty trade, small-holder farming, and several others that are not captured in the Gross Domestic Product of countries, let alone reckoned as important for their economic, social and utility value chains. Lockdowns affected women whose livelihoods and family wellbeing have always depended on daily income earned mostly from these informal economic activities. Restriction of movements had far-reaching impacts, making livelihoods much more unpredictable and difficult for women ([Ahmed et al. 2020](#); [Bultcha et al. 2020](#); [Stein & Cannon 2020](#)).

The pandemic continues to have the potential to worsen women's pre-existing poverty and the threat of extreme conditions. People are affected differently in many ways based on gender, though adequate disaggregated data is still lacking. The intelligent impression circulating in many quarters is that the little advances made with regards to changes in the social, economic and political conditions of women now face a setback if not a risk of complete reversal. The World Bank has warned that the pandemic will intensify poverty in the developing world amidst an indisputable suggestion that women have been the face of poverty in Africa ([Gerzon Mahler et al. 2020](#)).

The University of Port Harcourt, Rivers State, Nigeria, is located within the Aluu communities where women constitute the largest segment of people involved in selling farm produce. They are the most visible on roadside mini businesses, trading in all kinds of agricultural produce, including banana, groundnut, plantain and so on. The period of the lockdown drove them all away from the streets. Even lock-up markets in these communities and those in the entire city of Port Harcourt, extending to villages in all 23 local government areas, were locked down for weeks. Also, the closure of schools meant that families would stay at home more, with a tendency to eat more food. Families exhausted food in their homes without a way to replenish it because food preservation is a major problem, especially for the poor in urban settings without adequate electricity. This complaint was heard from some citizens during informal conversations on the impact of the response of the government to the pandemic. Radio discussions and social media were awash with issues of rape and women beating which could not receive public security attention. The education of children was badly hit, with girls suffering the greatest impact. Some girls were soon pregnant and unable to return to school. Schools were the last to be opened in many states in Nigeria several weeks after easing lockdowns and restrictions, even if public gatherings such as weddings and burials have remained controlled.

The enforcement of lockdowns and restrictions saw resistance and created tension in some parts of Africa. In Nigeria, Rivers State and the federal government provided palliatives in the form of a handout of token foodstuff which was mostly criticised by the civil society. Not only were the food items grossly inadequate to meet the needy population, but some politicians hijacked the process and cornered most for themselves, their friends and family members. The EndSARs protest in October 2020, exposed many places where government food stores had been hidden and looted by hungry protesting citizens.

The World Bank has argued that dealing with the impact of the pandemic on the price of oil, which the country depends on for national revenues and foreign exchange, and paying attention to the pre-existing health crisis is crucial for preventing a deepening of poverty (The World Bank 2020). Before the outbreak of the pandemic, four out of ten Nigerians lived below the poverty line, with millions at the risk of poverty. It is much worse now with oil revenues falling progressively lower.

In a similar vein, results of a monthly survey on the socio-economic impact of the pandemic, for September 2020 conducted by the National Bureau of Statistics (NBS), which focused among others

factors, on indicators of the employment situation in households, shows that the pandemic has entrenched pre-existing gender inequality in the labour market. The baseline, as of 2018 was 83 per cent for men. On the other hand, it was 72 per cent for women of working age. The survey also disclosed that women are the lowest at economic recovery. This result corroborates previous Rounds and reinforces an impression that the share of women working and earning income during the pandemic reduced in favour of men (Siwatu, et al, 2020)

In the aftermath of the 8-week lockdown in Nigeria (March to June 2020), household income fell by a quarter. This led to an increase in the national poverty rate of 9 per cent (Adam, Edeh, Oboh, Pauw and Thurlow 2020; Amewu, S.A., Asante, S., Pauw, K. & Thurlow, J. 2020). Women were not going to hospitals or health centres for antenatal care because of the pandemic.

Policy Response

Everyone is vulnerable to the pandemic but the impact of policy response is not equal on people. This reality has been suggested as one way to think about how gender equality can be addressed by governments during the pandemic and in the future. The government in Nigeria, like several others in Sub-Saharan Africa, were quick to respond in the short term to the crisis with lockdowns, restrictions to movements, travel bans, social distancing, closure of schools and other workplaces, washing of hands and wearing of face masks, and banning of public gatherings, to check the spread of the virus. A segment of the literature highlights the impact of all this on women and girls and conclude that these measures did not only affect them disproportionately but were also insensitive to their special needs (Olaseni et al. 2020). These authors have argued that social distancing, self-isolation, quarantine and treatment had psychological outcomes that were not considered in the emergency response to the crisis in the case of Nigeria (Ahmed et al. 2020; Bultcha et al. 2020; Gender in Humanitarian Action 2020; Ghoshal 2020; Mbunge 2020; Olaseni et al. 2020; Stein & Cannon 2020; Tang et al. 2020; Thompson 2020; UNFPA 2020).

The WHO played a crucial role and continues to do so in sensitizing the world with relevant information to correct misconceptions around the behaviour of the pandemic and provided policy guide (WHO 2019). The declaration of the virus as a pandemic with the enormous threat to public health spurred action in many parts of the world. The organisation has consistently warned that the impact would have a long-term effect on people, including women and girls, especially in developing countries where health institutions are rudimentary and grossly insufficient to respond to the crisis. In the same vein, UNAIDS has consistently called on governments to respond to the crisis with policies that are not gender-blind. Specifically, it identified six ways to place gender equality at the centre of the response to the pandemic. They are: 'differing needs of women and girls, particularly those most marginalised; access to essential health services; the neglected epidemic of gender-based violence against women and girls; misuse of criminal and punitive laws; adolescent girls and young women's education, health and wellbeing; and valuing women's work and making unpaid care work everybody's work' (UNAIDS 2020).

Addressing the different needs of women and girls, paying specific attention to the marginalised, as proposed here, means protecting the rights of women and girls during and after the pandemic. The government in Nigeria, as do those in some developed countries, lacks a human rights approach to dealing with gender inequality, providing health services and handling economic insecurity. The pandemic has exposed these inequities, which seems an opportunity to insist on a human rights approach to dealing with these issues.

The second principle proposed by UNAIDS, of ensuring access for women and girls to essential health services is based on the existential structural drivers of inequality. The aspects of misuse and abuse of criminal and punitive laws and problems in the education of girls in the face of the pandemic highlighted existing gender inequities, which have become worse under the COVID-19 pandemic. School closures

and the risk of failure of law enforcement institutions to address with seriousness cases of rape and other forms of gender-based violence have been observed in Nigeria. Attention to sexual health and the general wellbeing of young girls took a downward turn. As the lockdowns and restrictions persisted, the likelihood of women and girls seeking justice for crimes committed against them by men became untenable. Pre-existing gender-based violence has been described as a ‘shadow epidemic’ which has long been mainly neglected ([Young & Aref-Adib, 2020](#)). Rape cases, for example, increased during the period, but without police intervention. Policy responses could be expected to take into full consideration women’s work or the already skewed nature of the workforce in favour of men. Any policy that overlooks this impact in response to the pandemic is likely to lead to outcomes that further worsen existing gendered effects of the pandemic on women.

Although the context is may be different, the response by governments in Sub-Saharan Africa seems to have followed some similar patterns. Stein and Cannon’s discussion of the strategies, policies or responses to the pandemic in their study ‘Africa and the Economic Pathologies of the COVID-19 Pandemic’ ([2020](#)) is an attempt to critique these measures. They explain that it is the systemic conditions inherent in the strategies that have created economic pathologies that ultimately intensified the impact of the pandemic in the south-south to which Africa belongs. The inference is that measures or policies have systemic problems that needed more sensitivity to the needs of vulnerable groups in the short and long term. As also argued elsewhere, measures including workplace closures and travel bans, caused physical, psychological, economic, health, and harm to groups ([Glover et al. 2020](#)). Lockdowns in the case of Nigeria resulted in a drop of GDP by 34.1 per cent, to the tune of USD16 billion mainly from the service sector. The agricultural sector is Nigeria’s main source of livelihoods for which women account very highly as participants. The sector lost about 13.1 per cent in productivity. An estimated loss of income by households stands at 33 per cent. About 27 million people in Nigeria retracted into poverty (Andam, Edeh, Oboh, Pauw, & Thurlow 2020).

Impact on Sexual and Reproductive Health of Women and Girls

Nigeria provides an example of a country with existing structural inequities in sexual and reproductive health matters which got worse during the lockdown. Between the northern and southern states, the health services seeking behaviour of women and girls differ markedly according to the level of awareness and degree of influence of patriarchal cultures and traditions. The idea is that the pre-existing conditions have implications for the impact the pandemic and responses to it had on women and girls state of sexual and reproductive health. One study conducted in 2017 argues that northern Nigeria has one of the worse records when it comes to demand for health services ([Blanc 2001](#); [Blanc et al. 2016](#); [Blanc 2001](#)).

Generally, while lockdown measures did not make much difference in the behaviour of women and girls in northern Nigeria, those in the south-east, south-south and south-west with a higher level of awareness and previously relatively less trapped in the powerlessness of making decisions about the safe delivery, antenatal care, contraceptive use and methods were affected in many ways that impacted their health. Problems such as intimate partner violence, however, have to be noted as common for every part of the country because lockdown meant men saw women and girls at home much more and had many more opportunities to harass them. Girls who were forced to stay at home had no choice to be anywhere else. Neighbourhoods and families with men with gender-violence tendencies demonstrated their power as shown in many media reports about the state of gender-based violence across the country during the period.

Lockdown affected the availability of contraceptives and caused a decline in maternal care or skilled delivery assistance following a lull in healthcare services and systems. Even in countries with laws permitting abortion, access to services such as post-abortion care became difficult due to the shifting of attention to the pandemic. Hazardous abortions and unplanned pregnancies increased ([Riley, T., Sully, E., Ahmed, Z. and Biddlecom 2020](#)). These authors used data from 132 countries including those in Africa

and Asia to assess the impact of the pandemic on the sexual and reproductive health of women and girls, in national health survey documents, including Nigeria.

The lockdown period in Nigeria lasted over four months and can be classified into three major phases with key indicators of varying levels of restrictions, namely, March 1-June 3, 2020 (first phase); May 4- June 1, 2020 (second phase); and June 2-September 3, 2020 (third phase) A fourth phase has been conceptualised in the literature although without indicators such as travel bans, night-time curfews nor closure of schools at the moment ([Dey, Dehingia and Raj 2020](#)). Each phase had different levels of restrictions. Unintended pregnancies were highest in the first phase amidst increased cases of rape across the country during that period. This suggests an impact on the question of agency in decisions about family planning and the number of children in the family. In the same vein, the literature has suggested an increase in demand for abortion, perhaps due to unintended pregnancies and rape. For example, UN Women argues that under lockdown in Nigeria, a significant number of women experienced gender-based violence in 23 states (cited in [Taiwo, Hussaini, Yahaya, Muhammad and Adesina 2020](#)). In their study of whether the pandemic affected the decision-making power of adolescents in northern Nigeria, the majority indicated that they have more losses of power to men as husbands during the pandemic.

The restrictions produced different outcomes that have had implications for the sexual and reproductive health of women. First, the sexual and reproductive needs of women and girls in Africa look generally similar but vary between those in rural and those in urban locations. A comparative study of the impact of response to the pandemic on slum communities in three countries that included Nigeria suggest the urgent need for policies addressing the sexual and reproductive health of women ([Taiwo, Hussaini, Yahaya, Muhammad and Adesina 2020](#)).

For those in rural communities where functional public and private hospitals or clinics are lacking, pregnant women rely on native or traditional care during delivery and try to cope without prenatal care. Access to skilled support during delivery remains an issue. In the same vein, household poverty makes the potential of a husband taking his pregnant wife to a distant hospital for healthcare almost impossible, and in case of emergency during delivery, the survival of the woman almost completely depends on fate.

Rural women, especially those in the north, face a condition of recalcitrant patriarchal norms that tend to make men claim rights over decisions about the number of children to have which continue to limit the freedom of women to make independent decisions about family planning. Even contraceptive use and methods are critical areas of decision-making married women of reproductive age are battling with little success under conditions of domineering masculinity. On the other hand, urban women and girls, with better awareness and knowledge of rights face lesser threats to denial of opportunities for accessing sexual and reproductive health services and systems.

Measures were taken by governments to tackle the spread of the pandemic and treatment such as lockdowns and closure of public spaces and discouraged transportation and travelling had impacts on the situation of women and girls when it comes to meeting sexual and reproductive needs across Nigeria. It worth noting that although public hospitals were not closed to the public, the Nigerian situation faced a general distrust of politicians and the institutions of government to provide reliable information on the pandemic.

Many citizens perceived the politicisation of government response to the pandemic. This political nature of the response was seen in the policy conflict that emerged between Rivers State and the federal government. Instructions on compliance with lockdown and restriction of movements in which even aeroplanes were not to enter the state conflicted with federal laws that give the federal government aviation powers. Oil workers who flew into Port Harcourt via chartered helicopters for work in the industry were seen by the government to have violated state law.

The Nigeria health system predominantly lacks satisfaction for meeting the health needs of citizens. Although Nigeria has been commended to have done well in her response to the pandemic, it was under-prepared for meeting health needs, pressures imposed by covid-19 and responses. The response was also blind to existing health issues of people, among which are sex and reproductive health needs. The period of lockdown was reported to have recorded unusual cases of rape and pregnancy among married and unmarried women. Besides, it was reported that people with other ailments such as HIV AIDs, as well as high blood pressure and several other terminal diseases were not given adequate attention in health services centres.

The prevalence of intimate partner violence during the period of lockdowns was mainly attributed to the restriction of people to their homes. The much-talked-about shadow pandemic follows from the issues around gender-based violence which living under lockdown has orchestrated in many parts of the world. Lockdown is said to be potentially threatening 47 million women's future inability to access contraceptives ([Plan International, 2020](#)). Millions more are the risk of early marriages, unintended pregnancies and sexual abuse because of COVID-19 related lockdowns.

The situation in Nigeria is that of the dangerous pre-existing problem of unmet sexual and reproductive health needs gone downhill by the pandemic ([Dey, Dehingia and Raj 2020](#)). Women in Nigeria are more likely to die from reproductive health conditions than those from other parts of the world. Analysis of the situation shows that COVID-19 itself is not a consequential cause of death for women and girls in the country. Instead, it has posed risks and threats indirectly through the worsening of access to sexual and reproductive healthcare. This will remain a potential threat to the unmet needs of women, a problem that will not be fully tackled in the short term because of present neglect and lack of recognition of the problem as a human right by authorities.

Let us now dwell more on the aspect of the indirect impact of the pandemic on worsening the unbalance power relations between men and women, especially among those in rural settings. The likelihood that husbands in families will have the upper hand in decisions about whether a woman is to have sex when not ready, use contraceptives, visit the hospital for prenatal and antenatal care was strengthened during the lockdown. On the contrary, the likelihood that women will independently decide on contraceptive use and methods, visits to the hospital for antenatal and prenatal care, number of children, and whether to access skilled assistance during delivery is low under existing unbalanced power relations that continue to be fuelled by patriarchal traditions that promote masculinity and domination of men in family matters. It is noteworthy that there is such a variation between the southern and northern parts of Nigeria on these issues. For example, while in the latter, women in rural areas generally have no say concerning sex, the number of children, use of contraceptives and methods, the southern part of the country has a relatively better situation, depending on the level of awareness or education, especially of the girls and women. Generally, unmarried girls in the southwest, south and southeast aged 14-25 in school tend to be more aware of their sexual and reproductive health needs and more independently take decisions. However, in some cases, this leads to the risk of unsafe actions such as abortion, which, further, is illegal in Nigeria except for saving the lives of mothers. It is reported that the abortion rate among this age bracket was high during the lockdown.

The pandemic did not introduce new sexual and reproductive health problems in Nigeria, but it did make existing problems worse. It gave more powers to men in decision-making areas such as family planning, timing and number of children, access to health services. It aggravated gender-based power inequities demonstrated in increased intimate partner violence and abuse of girls forced to stay at home and in vulnerable neighbourhoods by lockdown, closure of schools and general restriction of movement of people.

The ascriptive nature of gender-based power meant that the outcome of relations between men and women and the level of intimate partner interactions as expected favoured the former more than the latter.

The increased report of rape cases during the period suggests an unbalanced power relation at work at physical levels. As [Blanc \(2001\)](#) argued many years ago, the ability to acquire information, decide and act are essential indicators in gender-based power relations in sexual and reproductive health needs and services ([Blanc, 2001](#)).

Conclusion

This paper has discussed the impact of COVID-19 through measures taken by authorities to address its spread in Nigeria on the sexual and reproductive health of women and girls. Insights drawn from secondary data show a reinforcement of pre-existing unmet needs and worsening of the situation, especially during the first phase of the lockdown and the associated restriction of movement. The response to the pandemic by authorities had direct and indirect impact and varied between urban and rural dwellers in the context of pre-existing patriarchal norms and severe health care deficiencies, especially for women and girls. In addition, the impact has been varied across states and regions. Addressing needs such as family planning, safe delivery, antenatal care, prenatal care and treatment of victims of rape were difficult. Lockdowns were very significant for women and girls. Cases of rape and unwanted pregnancies were reported and suggested to have increased. While access to sexual health services and decisions about the use of contraceptives became more difficult for women and girls in the southern part of the country, it was much worse for those in northern rural communities who, in addition, face debilitating violent conflict from those activities of bandits and terrorists.

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