Integrating Gender into Nigeria's COVID-19 Response

4 April 2020

Executive Summary

By April 13 2020, Nigeria had 343 confirmed COVID-19 cases, with a high likelihood that these cases could be the start of a widespread outbreak. While President Buhari announced that movement in the Federal Capital Territory, and Lagos and Ogun states should stop from 30 March for an initial 14 days and measures would be taken to ameliorate the impact of this order on the most vulnerable, governmental response to date has assumed that COVID-19 and related measures would affect people of all genders the same. Yet, health crises in Nigeria and the impact of COVID-19 worldwide show that the pandemic will affect people differently as well as magnify existing inequalities along lines of age, class, disability, gender and income. **For measures to be effective, the COVID-19 response must integrate understanding of gender norms, roles, and relations from the start.**

This policy paper outlines the key reasons why gender must be integrated into COVID-19 response. They include the fact that infection and mortality rates vary according to age, class, gender; effective location and diagnosis, treatment and recovery will depend on access to healthcare. **Crucially, gender-based violence (GBV) will increase while services struggle to function.** Women will see caring responsibilities increase whilst the extensive focus on COVID-19 will mean that other critical healthcare needs may not be met even as mental health and psychosocial support (MHPSS) needs increase. The economic impacts of COVID-19 and related restrictions will be different for women and men. Food insecurity will disproportionately affect women and girls and the lack of access to water and sanitation will increase transmission risk. Access to education will be affected by the closure of schools. Prevention efforts will be limited by unequal access to reliable information and the spread of rumours and fake news. Women are predominantly excluded from COVID-19 decision making, leading to a less effective response. Suspicion and attacks against individuals perceived to have COVID-19 is increasing and taking ethnic dimensions. Finally, COVID-19 may be used to curtail human rights and civic space by state actors.

We welcome the establishment of the Presidential Taskforce for the Control of Coronavirus (COVID19) in Support of a Stronger Government Response. On health, we recommend that the Taskforce should: ensure equitable access to high quality healthcare for all, ensure the health and well-being of health and other workers involved in the response, and recognise women's unpaid care of family members who fall sick. **The Taskforce should prioritise a cross-government strategy on GBV prevention and response.** On economic steps, we recommend gender sensitive people-oriented economic stabilisation and stimulus measures. Further recommendations address the need to mitigate the impacts on education, to engage in effective communication with the public, advance the meaningful inclusion of women in decision making, and mitigate negative impacts on human rights, public safety and security. Additional recommendations address donors as well as civil society.

Context

The world is currently experiencing a pandemic on an unprecedented scale. By April 2020, Nigeria had 174 confirmed COVID-19 cases,[1] with a high likelihood that these cases could be the start of a widespread outbreak. Nigeria has good experience in curtailing the spread of Ebola[2] and federal and state governments have acted, most notably with a presidential order to cease movement in the Federal Capital Territory, and Lagos and Ogun states from 30 March for an initial 14 days. While President Buhari announced measures to ameliorate the impact of this order on the most vulnerable, for example directing that conditional cash transfers for the next two months be paid immediately, governmental response to date has been based on assuming COVID-19 and related measures will affect people of all genders the same.

Yet, health crises in Nigeria and the impact of COVID-19 worldwide show that the pandemic will affect people differently as well as magnify existing inequalities along lines of age, class, disability, gender and income. For measures to be effective, the COVID-19 response must integrate understanding of gender norms, roles, and relations from the start.

This policy paper outlines the key reasons why gender must be integrated into COVID-19 response and provides recommendations for the Presidential Taskforce for the Control of Coronavirus (COVID19) in Support of a Stronger Government Response, donors and civil society actors. At the time of writing, most diagnosed COVID-19 cases were in the cities of Abuja and Lagos but this policy paper envisages the spread of this disease to other states, including into rural areas, and provides analysis and recommendations accordingly.

Why Gender Matters

Infection and mortality rates vary according to age, class, gender, and location. People living in conflict affected areas may not have had proper nutrition and healthcare for some time, leaving them with weakened immune systems and heightened risk. People with pre-existing conditions and the elderly are most likely to die. Men have a higher mortality rate than women, potentially due to sex-based immunological or gendered differences (such as patterns and prevalence of smoking, higher incidence of chronic illnesses such as cardiovascular disease, hypertension and chronic lung disease, and different travel patterns)[3] yet women may be more at risk of contracting COVID-19 due to their caring responsibilities.[4]

Diagnosis, treatment and recovery depend on access to healthcare. While the virus seems currently limited to urban areas, there is a high possibility it may spread. Many people in Nigeria, particularly those who experience poverty, are in rural areas and live with disabilities, struggle to access healthcare. Women and girls have lesser access to health for a range of factors including lack

[1]Nigeria Centre for Disease Control, https://twitter.com/NCDCgov/status/1245425774439600128?s=20, last visited 02.04.2020.
[2]Please see Kristin Peterson and Morenike Folayan, 'How Nigeria Defeated Ebola,' *Africa Is A Country*, December 2017.
[3]Clare Wenham, Julia Smith and Rosemary Morgan, 'COVID-19: The Gendered Impacts of the Outbreak,' 2020 *The Lancet* 395 (10227) 846-848; Carmen Niethammer, 'Do Women and Men have a Coronavirus Risk Gap?' *Forbes* 6 March 2020.
[4]For example, during the 2014–16 outbreak in West Africa, women were more likely to be infected by Ebola due to their roles as caregivers within families and as front-line health workers: Sara Davies and Belinda Bennett, 'A Gendered Human Rights Analysis of Ebola and Zika: Locating Gender in Global Health Emergencies,' 2016 92 (5) *International Affairs* 1041-1060.

of finances to pay hospital bills, restrictions imposed on them by husbands and social norms that mean they are prevented from being treated by male healthcare workers.

Women see caring responsibilities increase. Women constitute the majority of those who provide healthcare, either to family members or as health workers. Closure also brings more care work for women who tend to look after out of school children and so are forced to decrease participation in work outside the home. Women are also more likely to be burdened with household tasks which increase as more people stay at home during lockdown measures.

Gender-based violence (GBV) increases while services struggle to function.[5] Less than 36 hours after the start of lockdown measures, the Lagos State Domestic and Sexual Violence Response Team said it had seen increased reporting on its telephone hotline.[6] Data from other countries shows the pandemic leads to higher GBV levels. Countries where movement is restricted see increased physical, emotional and sexual abuse and controlling and coercive behaviour. For example, police reports of domestic violence tripled in China and increased by 36 percent in the first week of lockdown measures in Paris. Men can engage in new, more frequent or more violent abuse in a context of increased fear and economic stress. Women and children are trapped with abusers for weeks on end. Measures related to the pandemic also create conditions for increased abuse of sex workers and domestic workers. In camps for displaced people, outbreaks spread quickly and lead to more women being sexually exploited and abused. In countries where conflict related sexual violence is committed by armed forces, deployment of security agencies can create fear. There have also been reports of sexual exploitation by health workers, state officials, community members who enforce government measures and those who transport food and goods. Children who are separated from sick caregivers or out of school may face (more) violence in their homes. Particular groups of women and girls, for example those with disabilities may be more likely to experience GBV but find it more difficult to access help due to marginalisation, social isolation, and dependence on the perpetrator for mobility, communications and/ or access to healthcare.[7] Services including shelters and Sexual Assault Referral Centres see increased demand but limited resources. Police and justice systems can close down or become overwhelmed. Survivors find it difficult to access help due to restrictions on movement, increased controlling behaviour,[8] and fear of going to health clinics.

Due to focus on COVID-19, other critical healthcare needs may not be met. The risks posed by the virus do not mean other life-threatening health conditions stop. Yet, access to health services will be affected due to government restrictions on movement, people's fears of infection preventing treatment-seeking behaviour, and diversion of resources to COVID-19, with grave consequences. Women's access to contraception and reproductive health services will be affected. For example, in Sierra Leone, more women died of obstetric complications than Ebola and rates of maternal

[5]Erika Fraser, 'Impact of COVID-19 Pandemic on Violence against Women and Girls,' VAWG Helpdesk Research Report No. 284, (VAWG Helpdesk, 2020); Amber Peterman, Alina Potts, Megan O'Donnell, Kelly Thompson, Niyati Shah, Sabine Oertelt-Prigione, and Nicoele van Gelder, 'Pandemics and Violence Against Children,' Center for Global Development, *Working Paper 528*, April 2020.

[6]Kehinde Olatunji, 'There is Increase in Sexual, Domestic Violence Reports Despite Lockdown, says DSVRT,' *The Guardian,* 1 April 2020.

[7]Studies from other countries show women with disabilities are two to four times more likely than non-disabled counterparts to experience intimate partner violence, that disability also increases risks of non-partner sexual violence, that probability of intimate partner and non-partner sexual violence rises with higher severity of disability but stigma both compounds risk and reduces ability to seek help: Kristin Dunkle, Ingrid van der Heijden, Erin Stern and Esnat Chirwa, 'Disability and violence against women and girls: Emerging evidence from the what works to prevent violence against women and girls global programme,' (What Works, July 2018).

[8] Catania in Italy saw a 60 percent decrease of calls to anti-violence centres as women had less freedom to make telephone calls: 'Covid-19, Allarme Violenza Domestica: Quando Casa è Sinonimo di Prigione', University of Catania, 24 March 2020.

mortality increased by 70 percent during the outbreak.[9] The West African Ebola outbreak also saw more women pushed into using unsafe and dangerous methods to terminate pregnancies[10]

Mental health and psychosocial support (MHPSS) needs will increase.[11] In any epidemic, people feel stressed and worried – of themselves or loved ones falling ill and dying, losing livelihoods, and having insufficient food. Health workers may experience added stress due to stigmatisation, higher volume of work, reduced capacity to use social support, and fear of infection. This mental health impact has gendered dimensions. For example, women healthcare workers in China were more likely to have depression, anxiety and insomnia than male colleagues as they did most of the caring work for patients and had higher risks of infection from close, frequent contact.[12] High levels of fear can lead to stigma against those seen as having COVID-19 and their family members and neighbours, anger against health workers, mistrust of government information, increased reliance on alcohol and drugs, and deterioration of social networks.

COVID-19 and related restrictions will economically impact women and men differently. Unemployment, underemployment and loss of income affect people of all genders but women will be particularly affected. Women in Nigeria consistently earn less than men, have higher economic insecurity, are more likely to live in poverty, and less able to build up savings that can take them through times of economic hardship. Women, who compose the majority of informal sector workers,[13] are significantly affected by closing of public spaces, due to loss of markets. Even in formal employment, COVID-19 counter-measures hit people differently according to gender and women may be the first to be dismissed from employment or not paid. While dealing with reduced incomes and increased caring responsibilities, women will face increased burden to provide particularly if income earning family members fall ill or lose jobs. The economic effects of the Ebola outbreak for example, led to exacerbated risks of sexual exploitation and forced sex work for women and girls[14] and men's incomes recovered faster than women's incomes.

Food insecurity will disproportionately affect women and girls. Panic-buying means those with disposable income are more able to purchase large quantities of goods which limits availability for those on lower incomes who may face shortages further down the line. Moreover, restrictions on movement and the closure of borders and markets may also lead to food insecurity, particularly for those already experiencing poverty. Scarcity of food may force households to engage in negative coping mechanisms including women and girls engaging in sex work and/ or eating food last and least. Both these strategies have been observed in parts of Nigeria that are affected by food insecurity caused by violence such as Borno and Zamfara.

Lack of access to water and sanitation will increase transmission risk. Personal hygiene, handwashing in particular, is the primary way individuals reduce transmission risk but not all have access to clean water. People with disabilities are likely at greater risk of contracting COVID-19 due

[9]Julia Smith, 'Overcoming the 'Tyranny of the Urgent': Integrating Gender into Disease Outbreak Preparedness and Response,' 2019 27(2) *Gender and Development* 355-369.

[10]Kailee Jordan, 'Reflections of An Aid Worker In the Time of COVID-19,' *Gender At Work*, 2 April 2020, available at https://genderatwork.org/news/reflections-of-an-aid-worker-in-the-time-of-covid-19/, last visited 03.02.2020.

[11]IASC, 'Briefing Note on Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak,' (IASC, Feb 2020).

[12]Shira Feder, 'Frontline Healthcare Workers in China report high rates of anxiety, stress, depression, and insomnia since the coronavirus outbreak began,' *Insider*, 23 March 2020.

[13]'Gender in Nigeria: Improving the Lives of Women and Girls in Nigeria,' (British Council, 2012).

[14]As Pandemic Rages, Women and Girls Face Intensified Risks,' UNFPA, 19 March 2020.

to barriers in accessing handwashing facilities and/ or performing handwashing tasks.[15] The responsibility for procuring water and maintaining hygiene standards often falls to women and girls as part of their care giving role. This crisis increases the burden on women and girls in poor households who have to leave their houses to find clean water especially in rural areas.

Closure of schools affects access to education. Education will be affected by these measures and many girls in particular may continue to stay out of school after the crisis, experience sexual exploitation and abuse, and become pregnant.[16] The impact will exacerbate an existing crisis where 10.5 million children, most of them girls, are already out of school.[17]

Unequal access to reliable information and spreading of rumours and fake news will limit prevention efforts. Already, there is uncertainty amplified by lack of verified information. Misinformation led to a surge in demand for chloroquine, leading to chloroquine poisoning of those who took it. Narratives spread on social media say COVID-19 has been caused by increased women's freedoms. Further, women are less able to access reliable media sources, including radio, to obtain information on the outbreak, how to protect themselves, and availability of services, as are other marginalised groups such as people with disabilities who have specific communication needs and can be socially isolated. Younger children may find it difficult to access and understand information from government and/ or medical sources. Some elderly people may not understand information provided or struggle to follow instructions. There are public outreach models from West Africa that can be useful here. For example, in Liberia, door to door canvassing by local volunteers spread valuable information, changed public practices, and increased public trust in and compliance with government measures during the Ebola outbreak.[18]

Women are currently excluded from COVID-19 decision making, leading to a less effective response. Nigeria sees very few women in leadership in the COVID-19 response at present. Women need to be meaningfully represented at every level of the response from federal and state government taskforces to community prevention and response efforts. Not only do women have the right to be part of decision-making processes but gender balance leads to better, more effective and more representative decisions. In other health crises, for example the West African 2014-2016 Ebola outbreak, women were less likely than men to have power in decision making and their needs were largely unmet.[19] Given women are in a key position to identify trends at local levels, incorporating their voices and knowledge improves preparedness and response.

Suspicion and attacks against individuals perceived to have COVID-19 is increasing and taking ethnic dimensions. We have already seen panic and action targeted at those rumoured to have COVID-19 and racialised verbal and physical abuse against people of East Asian descent and other non-nationals. Group action has forced people suspected of having COVID-19 from homes and barred them from accessing medical care. In other countries, attacks have been racialised and

[15]Emma Pearce, 'Disability Considerations in GBV Programming During the COVID-19 Pandemic,' *GBV AoR Helpdesk Research Query*, March 2020.

[16]Teenage pregnancies in some communities in Sierra Leone increased by 65 percent and sexual assault of children increased during Ebola related school closures: 'Assessing Sexual and Gender Based Violence During the Ebola Crisis in Sierra Leone,' (UNDP, 2015).

[17]Please see https://www.unicef.org/nigeria/education, last visited 02.04.2020.

[18]Lily Tsai, Benjamin Morse and Robert Blair, 'Building Credibility and Cooperation in Low-Trust Settings: Persuasion and Source Accountability in Liberia During the 2014-2015 Ebola Crisis,' 2020 *Comparative Political Studies*, pre-published online.

[19]Sophie Harman, 'Ebola, Gender and Conspicuously Invisible Women in Global Health Governance, ' 2016 37(3) *Third World Quarterly* 524-541.

sexualised with women more attacked than men.[20] As matters develop and if COVID-19 spreads, there is significant risk of rumours spreading, people of particular ethnic or geographical backgrounds (for example those from Lagos) seen to be 'virus carriers', and mob action, restriction of movement and violence against them in the name of preventing infection.

COVID-19 may be used to curtail human rights and civic space by state actors. While effective government action is necessary to mitigate a public health emergency, this threat must be addressed in line with human rights frameworks. Elsewhere, governments have used this crisis as a pretext to infringe rights.[21] Movements restrictions have increased opportunity for extortion and sexual harassment by security agents.[22] There is a risk of disease containment approaches adopted, especially by state governors, being used to deliberately clamp down on rights.[23] State governors are taking action reserved for the federal government, introducing stringent measures with no end-date specified. The pandemic risks passage of emergency legislation giving the executive wide-ranging powers with little parliamentary, media or public oversight and discussion. While the directive by the Inspector General of Police warning against unnecessary arrest and detention during this outbreak is welcome, concrete steps to mitigate human rights violations by security agents in this present context have yet to be put in place.

Recommendations

This pandemic has highlighted the importance of social infrastructure in terms of healthcare, food security, decent housing, and reasonable living standards. These lessons should not be lost but instead, should inform government action in a post pandemic world towards transformation of systems and equitable redistribution.

For the Presidential Taskforce for the Control of Coronavirus (COVID19) in Support of a Stronger Government Response

We welcome the establishment of this Presidential Taskforce. The Nigerian government must work effectively in a multi-sectoral manner as competition and lack of coordination will cost lives.

I. IMPROVE THE HEALTH RESPONSE

i. Provide equitable access to high-quality healthcare for all and:

- Collect, analyse and report data, including infection and mortality rates, disaggregated by age, disability, sex and relevant COVID-19 vulnerability factors to inform response.
- Prioritise in the National Response Strategy the need for continued provision of healthcare, including efforts to end maternal and child mortality, provide comprehensive immunisation, and distribute contraception and other reproductive services.
- Ensure that 50 percent of doctors and nurses from states across Nigeria, who are to be trained by the Nigeria Centre for Disease Control and the Lagos State Government, are

[20]Erika Fraser, 'Impact of COVID-19 Pandemic on Violence against Women and Girls,' VAWG Helpdesk Research Report No. 284, (VAWG Helpdesk, 2020).

[21]Douglas Rutzen and Nikhil Dutta, 'Coronavirus and Civic Space: Preserving Human Rights During a Pandemic,' (ICNL, 2020).

[22]For example, in India, there have been reports of police officers sexually harassing and assaulting women doctors on their way to the hospital: Nishita Jha and Pranav Dixit, 'A Doctor Was Assaulted on Her Way to The Hospital. She's Not the Only Medic Being Attacked,' *Buzzfeed*, 25 March 2020.

[23]Spaces for Change, 'COVID19, Human Rights and Civic Space in Nigeria,' *Policy Briefing Paper 011*, 27 March 2020.

women and include those in rural areas to ensure access to healthcare for all in case the virus spreads.

- Expand access to healthcare regardless of ability to pay, particularly to women, people with disabilities, and others who usually face barriers.
- Prioritise screening, monitoring and treatment for urban poor communities.
- Mitigate women's and girls' barriers to obtaining care by engaging community leaders (male and female) on the importance of women accessing healthcare.
- Facilitate access to family planning and menstrual hygiene products by maintaining adequate stocks at healthcare and community facilities and integrating products into healthcare packages.
- Comply with the Discrimination Against Persons with Disabilities (Prohibition) Act 2018 in the construction of any new health facilities.
- Include mental health and psychosocial support (MHPSS) as a core component of the response through information campaigns, health services, pre-existing community structures, formation of virtual support groups, telephone hotlines and counselling services, and care for acute cases.[24]
- Reach out to people with disabilities and the elderly to share information and help access care.
- Build clean water infrastructure in underserved areas, including through building handwashing stations in communities and supporting all to access them.

ii. Ensure the health and well-being of health and other workers involved in the response and:

- Ensure that all health workers – doctors, nurses, auxiliary staff, paramedics, those dealing with dead bodies, other staff, volunteers - treating patients with high risk of COVID-19 receive adequate training and equipment (which fits women and men) to protect their own health.
- Assess and meet the specific needs of women health workers.
- Support the mental health and well-being of health workers, case identifiers, workers involved in dead body management, and other staff and volunteers involved in the response.[25]
- Provide workers involved in the response with easy access to food and other necessities, for example through dedicated shopping hours or working with food stores to deliver directly.
- Counteract potential stigma, isolation and ostracism due to fear of infection with campaigns stressing the importance of health and other workers' service and measures taken to protect them from infection.
- Assist health and social care workers with childcare and putting in place safeguarding measures to ensure that these children are not at risk.

iii. Recognise women's unpaid care of family members who fall sick and:

- Run information campaigns on how caregivers can reduce risk of infection.
- Provide necessary equipment, training and psychosocial support.
- Include women in response decision making and leadership roles (see below).

[24]Please see International Federation of Red Cross and Red Crescent Societies, 'Remote Psychological First Aid During the COVID-19 Outbreak,' *Interim Guidance*, March 2020.

[25]For example, China set up a dedicated mental health telephone line for hospital workers.

- Encourage family and community members to spread the care burden more equitably among people of different genders, and model men and boys sharing household tasks including care for children not in school and sick family members.

II. **PRIORITISE THE DEVELOPMENT OF A CROSS-GOVERNMENT STRATEGY ON GBV PREVENTION AND RESPONSE** as part of the National Response Strategy and:

- Ensure GBV services stay open and are able to refer to other services, including clinics, police, and social workers. Put in place mobile and remote services to provide case management, psychological support and referrals to meet immediate needs of survivors, and expand shelter and temporary housing for survivors.
- Clarify that those working in GBV services are exempt from movement restrictions.
- Provide extra funding and other resources for GBV services as reporting will increase.
- Work with women's disability rights organisations to increase outreach and service provision for women and girls with disabilities who face increased risk of GBV.
- Update GBV referral pathways so as not to overwhelm tertiary hospitals; inform key individuals, service providers, and women's rights organisations about the updated pathways.
- Train first responders including nurses, doctors, police officers, pharmacists, and social workers to recognise signs of GBV, handle disclosures, and refer to services.[26]
- Ensure GBV risk-mitigation measures are in place in quarantine facilities and health clinics.
- Launch a communications campaign, working with women's rights organisations, and ensure that information is disseminated in accessible formats to raise awareness of steps which survivors, their family and friends can take to protect their safety, know how to access support, and for prevention.
- Encourage informal (and virtual) social support networks of friends, family, colleagues and neighbours since they are likely to be the first source of disclosure for those experiencing violence.
- Set up a national GBV helpline, which (potential) perpetrators can call if they are concerned about their behaviour, and which survivors and their families can use to report violence.
- Channel men's energies positively, for example towards support of those most vulnerable in their communities to mitigate feelings of powerlessness which can lead to increased domestic abuse.
- Direct the police to respond to GBV reports and connect survivors with appropriate services.

III. PUT IN PLACE GENDER-SENSITIVE AND PEOPLE-ORIENTED ECONOMIC STABILITY AND STIMULUS MEASURES and:

- Undertake a rapid gendered analysis of the economic impacts of COVID19 to inform response measures.
- Stabilise prices, counter panic-buying, and clamp down on profiteering and hoarding that disproportionately affects those experiencing poverty, for example by banning price increases and requiring vendors to limit the number of the same item that shoppers can buy.
- Provide women in the informal economy with financial support to cushion for loss of income in areas affected by COVID-19 counter measures.

[26] In France and Spain, those experiencing domestic violence can report at pharmacies by asking for a 'Mask 19'.

- Ensure relief materials deployed to residents of satellite and commuter communities reach women and girls and contain materials such as family planning and menstrual hygiene items.
- Implement moratoriums on evictions due to rental and mortgage arrears and deferrals of payment for those affected, directly or indirectly, by COVID-19.
- Institute guaranteed basic income for those who test positive for COVID-19 during their treatment, to incentivise testing and reporting, and ameliorate financial impacts.
- Invite informal workers, particularly women, to participate in discussions during and after the pandemic to suggest measures to support them maintain and recover livelihoods.
- Ensure that women benefit from any cash for work schemes, including through recognising care work as work and by including women carers in such schemes.
- Send food supplies to rural areas to be stored and distributed as needed to safeguard against delays in supply and shortages.
- Develop a database of high-risk people (the elderly, people with pre-existing conditions, people with disabilities) in areas affected by COVID-19, maintain regular contact with them and establish systems to deliver food and other supplies.
- Be transparent in how the N33 trillion borrowed by the nation[27] is being spent and ensure that it meets the needs of all women and men.

IV. MITIGATE IMPACTS ON EDUCATION and:

- Implement President Buhari's undertaking to continue school feeding programmes despite school closure.
- Direct educational institutions to prepare review packages for children to keep them academically engaged and provide guidance for parents on the use of the material.
- Create educational radio programming appropriate for school-age children.
- Adopt measures to ensure children continue to receive food by making sure it can be delivered or collected.
- Provide extra financial and mental health support for families caring for children with disabilities.

V. COMMUNICATE EFFECTIVELY WITH THE PUBLIC IN ACCESSIBLE WAYS and:

- Provide clear, concise and accurate information about COVID-19 (including how to mitigate risks of infection and access help if one becomes unwell) using (local) languages, formats and channels understood and trusted, with a focus on reaching the urban poor in Abuja and Lagos.
- Set up channels for two-way communications so people can feed back questions and concerns in their own languages to be addressed.
- Develop public health messages focused on younger children and adolescents, using language they can understand and with an emphasis on reducing their levels of fear and worry.
- Reach out to people with disabilities, including through working with local disability rights organisations and providing information in accessible formats.
- Ensure that women with less access to media get information about how to prevent and respond to the pandemic using existing channels of communication such as adashe groups.

[27] Henry Umoru, 'Nigeria's Total Debt Now N33trn – Senate,' *Vanguard*, 17 March 2020.

- Integrate positive messages emphasising strength and resourcefulness rather than weakness and vulnerability of communities, to mitigate mental health impacts and encourage cohesion.
- Normalise feelings of sadness, distress, worry and anger, and encourage ways for people with restricted movement to maintain physical and mental health while at home (proper diet, sleep, exercise, social contact, limited time exposed to media coverage).
- Provide information on what people can do to help themselves and others, such as setting up virtual support networks, maintaining contact with those isolated, sharing factual information and countering rumours, and providing practical assistance to those in need.
- Assist parents to strengthen skills in positive parenting, handling their own anxieties and help in managing children's anxieties to mitigate mental health impacts and child abuse.
- Avoid inadvertent stigmatisation of particular groups, for example through the use of terms such as 'Wuhan virus,' 'victim,' 'suspected cases,' 'infecting,' 'spreading,' and 'Lagos virus' to mitigate the risk that COVID-19 will be identified with one geopolitical zone or ethnic group.
- Undertake sensitisation and other measures to educate people not to demonise, insult or attack those they think may have COVID-19, including those with East Asian appearance.
- Adapt public outreach campaign models that use door to door canvassing by local volunteers.

VI. MEANINGFULLY INCLUDE WOMEN IN DECISION-MAKING AROUND THE RESPONSE and:

- Ensure that 50 percent of members of decision-making bodies addressing the COVID-19 outbreak are women at national, state, LGA, and community levels, including in leadership positions.
- Have representation from women's rights organisations, including those who provide GBV services, on COVID-19 national and state taskforces
- Identify and work with women's community groups and networks to share information, relay concerns, complaints, and ideas, inform the design of measures, and take part in decision making.
- Include the voices and suggestions of women health and relevant other workers in preparedness and response discussions, policy development and practice.
- Employ women to distribute assistance and ensure strong presence of women at service points so they are accessible to women and girls, facilitate GBV disclosure, and mitigate risks of sexual exploitation and abuse.

VII. MITIGATE HUMAN RIGHTS, PUBLIC SAFETY AND SECURITY IMPACTS and:

- Integrate science and the reality that viruses know no ethnicity into public health messaging
- Clearly communicate a strong justification for derogating from certain human rights and specify a time period so this can be understood by the public.
- Define and publicise mandates for security agencies so roles and accountability are clear.
- Provide guidance for the police and military on how to implement restrictions in movement and other response measures in line with protection of human rights.
- Monitor and investigate human rights violations by security agents during the pandemic and refer cases for trial/ court martial.
- Ensure enough time is allocated for public, parliamentary and civil society consultation and scrutiny into passage of public emergency legislation related to the pandemic.
- Commit publicly to discontinuing emergency laws and powers once the pandemic subsides.

For Donors

- Prioritise the need to integrate gender in engagement with Nigerian ministries, departments and agencies and with programme partners.
- In line with the recommendations above, integrate gender into support to government and civil society actors for response to COVID-19, namely:
    - Providing equitable access to high quality healthcare for all
    - Ensuring the health and well-being of health and other workers involved in the response
    - Recognising women's unpaid care of sick family members
    - Developing a cross government strategy on GBV prevention and response
    - Establishing gender sensitive people-oriented economic stability and stimulus measures
    - Mitigating impacts on education
    - Spreading public health information in accessible ways
    - Meaningfully including women in decision making around the response
    - Mitigating human rights, public safety and security impacts
- Communicate with and reassure partners that donors will provide flexible funding.
- Fund women's rights organisations to mitigate, respond to and prevent GBV.
- Ensure that partners, including those working on GBV, information campaigns and social cohesion, do not face unnecessary burdens on reporting and pressure to achieve targets.
- Push for and grant relief for governments dealing with high debt burdens in line with the recent recommendation made by the World Bank and International Monetary Fund.[28]
- Support the tracking and monitoring of the response by civil society groups and organisations.

For Civil Society Organisations

- Responses to COVID-19 should integrate awareness that the pandemic and counter-measures affect people of different ages, genders, and income levels differently, whilst being accompanied by increased levels of violence against women and girls.
- Emphasise to government the pivotal yet unrecognised and unremunerated role of women in providing food, healthcare, and sustenance of families; this role needs to be supported and taken seriously beyond the pandemic.
- Advocate for measures which address the impacts of economic and social lockdown.
- Work across sectors to mitigate the impact of the lockdown on poor households, especially those headed by women.

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[28] Andrea Shalal, 'World Bank, IMF Urge Debt Relief for Poorest Countries,' *Reuters*, 25 March 2020.

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17. Titus Orngu
18. Gloria Nagun Thomas
19. Mariya Saleh, public health physician
20. Chinedu Anarado
21. Nurudeen Muhammad
22. Itoro Ekanem
23. Fatima Shehu Imam, Rehabilitation Empowerment and Better Health Initiative
24. Ariyo-Dare Atoye, Adopt A Goal
25. Ayesha Imam
26. Babagana Ali
27. Mustapha Shettima
28. Hauwa Shekarau, Women, Law and Development Initiative (WOLDI)
29. Kikiope Oluwarore, Education as a Vaccine
30. Ifeoma Malo, Clean Technology Hub
31. Priye Diri, Dorothy Njemanze Foundation
32. Ndi Kato, Dinidari Foundation
33. Augusta Yaakugh, Lex Community Initiative
34. Vincent Dania
35. Maina Yahi
36. Toyin Ajao
37. Lesley Agams
38. Abiodun Baiyewu, Global Rights
39. Chioma Ogwuegbu
40. Barbara Ekprikpo
41. Zikora Ibeh
42. Nneka Egbuna, Let's Help Humanitarian Foundation
43. Chinelo Onwualu
44. Albert Yusuf
45. Ballama Mustafa
46. Ayisha Osori
47. Agbodemu Ishola Musbau, Lifeshield Security Limited
48. Eleanor Nwadinobi
49. Lois Auta, Cedar Seed Foundation

50. Network of Disabled Women
51. Disabled People in Leadership Initiative
52. Centre for Impact Advocacy
53. Lauratu Omar Abdulsalam
54. Cesnabmihilo Dorothy Nuhu-Aken'Ova, International Centre for Sexual Reproductive Rights
55. Vina Theo-Adams
56. Talatu Isah, Bege Widows Organization
57. Jite Phido, ARDA Development Communication Inc.
58. Oteikwu Eleojo Rachel, Pamibolo Right Life Foundation
59. Grace Markus, Bege Orphan Foundation
60. Simeon Temitope Olaku
61. Hassana Joan Kpetu, Hurting Hearts Foundation
62. Apolmida Tsammani, Haly Hope Foundation
63. Kerri Leeper
64. Wumi Asubiaro Dada
65. Iheoma Obibi, Alliances for Africa
66. Azeenarh Mohammed
67. The Initiative for Equal Rights
68. Osai Ojigho
69. Ngozi Amanze
70. Itunu Omolara Oriye