

FINDING HOPE

Experiences of women, children and adolescents
during the COVID-19 pandemic in their own words



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Acronyms and abbreviations

C3	Centre for Catalyzing Change
FGM	female genital mutilation
IPPFWHR	International Planned Parenthood Federation, Western Hemisphere Region
PAHO	Pan American Health Organization
PMNCH	Partnership for Maternal, Newborn & Child Health
PPE	personal protective equipment
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

The multifaceted implications of the COVID-19 pandemic on the well-being of women and adolescents are increasingly reported. However, as the COVID-19 pandemic continues to evolve, we need to better understand the lived realities of women and adolescents. What are the main challenges? How are they coping with COVID-19-related restrictions? What information is coming from communities on actions needed in the short and long terms? We need to allow the people behind the numbers and statistics to speak for themselves.

This advocacy brief illustrates the lived experiences of women and adolescents from April to August 2020, many of which occurred during countries' initial attempts to curb the transmission of COVID-19, including lockdown measures. It also documents solutions being implemented and puts forward policy asks to help shape national, regional and global responses to the challenges faced by women and adolescents during and beyond the COVID-19 pandemic.

This brief is based on the analytical work of five in-country organizations – Amref Health Africa; the Centre for Catalyzing Change (C3); the Graça Machel Trust; International Planned Parenthood Federation, Western Hemisphere Region (IPPFWHR); and Profamilia (Colombia) – as well as the Pan American Health Organization (PAHO/WHO) and UNICEF (Latin America and the Caribbean). Using various methods, these organizations collected and reported on the lived

experiences of 29,246 women and adolescents in 43 countries. While there have been many changes since the period of this analysis, the findings remain highly relevant, particularly as many countries are experiencing another increase in the number of infections.

Lived experiences: key findings

This analysis shows that women and adolescents are bearing a disproportionate burden during this crisis. The challenges they reported span: impact on mental health and well-being due to disruption of life; limits on access to education; food insecurity; loss of livelihoods; lack of access to health information and services; limitations on sexual and reproductive health and rights; and increased violence, lack of safety and reduced agency.

Movement restrictions and social distancing measures have not only caused people to feel isolated and anxious, but have also cost millions their livelihoods, especially women working in the agricultural sector or the informal economy. Families around the world have been forced to reduce their spending, even on essential food items.

With entire families confined to the home, women and girls not only have additional household chores, including childcare and providing meals with minimum resources, but have also lost their privacy and mobility.



Violence against women and adolescents, especially girls, has increased since the start of lockdown. Many victims are confined with their abusers with little or no support. Even where support is available through helplines or digital platforms, many are unable access it due to limited privacy or lack of digital connection.

Educational institutions, including schools, colleges and vocational training centres, have been closed, jeopardizing the futures of many young people. As countries have shifted to distance learning, students with limited or no access to the internet have been missing out on education. School closures have also prevented school feeding programmes, exacerbating food insecurity and placing millions of children who depend on school meals at risk of malnutrition.

As financial and human resources are redirected to respond to COVID-19, fewer resources are available for other health and well-being needs, placing millions of lives at increased risk. The disruption and shutdown of sexual, reproductive, maternal, newborn, child and adolescent health and nutrition (SRMNCAH+N) information and services in many countries, combined with fear of contracting the virus at health facilities, is affecting the health and well-being of women and adolescents, especially girls, and will continue to do so after the pandemic. Limited access to essential preventive, promotive and curative sexual and reproductive health care will extend beyond the pandemic, damaging women's human rights and deepening gender inequality.

Strategies and solutions to address challenges

The range of strategies and approaches being implemented in different countries to address the significant challenges facing women and adolescents during and beyond the pandemic include:

- economic measures in response to loss of livelihoods;
- inclusion of SRMNCAH+N services in lists of essential services;
- using a range of digital tools and traditional media has been essential for maintaining health, social and educational services and for reaching different population groups with health messages and psychological support;
- civil society, humanitarian and non-governmental organizations, as well as self-help groups, frontline and community workers,

working together to provide essential services to affected families and marginalized groups during lockdown;

- strengthening dialogue and activities that bring the family together to reduce intra-household violence and stress; and
- support networks and community solidarity are helping to address many of the gaps and inequities within countries.

Policy asks

COVID-19 has revealed grave inequalities within our societies and exacerbated many of the existing challenges facing women and adolescents. We have an unprecedented opportunity for innovative and large-scale action to transform the lives of the most vulnerable. We must build back better, using contextually appropriate strategies that take account of a range of factors, including gender, age and access to resources. This is essential to ensure that the short, medium and long-term benefits produced outweigh any potential harms.

Women and adolescents must be consulted and engaged in decision-making processes at global, regional, national and local levels, including in taskforces, to ensure that their lived experiences are meaningfully addressed in the COVID-19 response and recovery pathways.

Drawing on the [PMNCH Call to Action on COVID-19](#), and based on the lived experiences of women and adolescents analysed for this brief, we call for a collaborative approach across governments and all stakeholders to address the following seven policy asks.

1. Maintain essential SRMNCAH+N services, products and information, including for contraception, safe abortion, immunization, safe delivery, stillbirth prevention and mental health.
2. Address gender inequality, including gender-based violence, and ensure the safety and security of women and adolescent girls in integrated response and recovery plans.
3. Increase attention to the mental health needs of those, especially women and adolescents, who have been severely affected by the pandemic.
4. Adopt and scale up social and economic relief measures that are gender-responsive and reduce inequities.
5. Address adolescents' needs for education and vocational training.
6. Address the digital divide within countries and between genders.
7. Collect and report disaggregated data (by age, sex, income, disability, geography) and gender statistics.

Introduction

Women and adolescents have unique health needs, but during pandemics such as COVID-19 they are less likely to have access to essential health information, products and services, or insurance coverage for routine or catastrophic health costs. This is especially true of those in rural and marginalized communities. These challenges are compounded by intersecting inequalities, such as ethnicity, socioeconomic status, disability, age, geographic location and sexual orientation, among others.

The multifaceted implications of the COVID-19 pandemic on the well-being of women and adolescents are increasingly reported by researchers, academics, the media, civil society organizations and others. However, as the pandemic continues to evolve, we need to better understand the lived realities of women and adolescents. What are the main challenges? How are they coping with COVID-19-related restrictions? What information is coming from communities on actions needed in the short and long terms? We need to allow the people behind the numbers and statistics to speak for themselves. This is important, not only in itself, but also to inform systematic advocacy for effective policy and programme measures to address the immediate and long-term impacts of the crisis on women and adolescents.

This advocacy brief illustrates the challenges and lived experiences of women and adolescents from April to August 2020, many of which occurred during countries' initial attempts to curb the transmission of COVID-19, including lockdown measures. While there have been many changes since this period, the findings remain highly relevant, particularly as many countries are experiencing another increase in the number of infections.



Purpose of this advocacy brief

This brief is based on the analytical work of five in-country organizations – Amref Health Africa; the Centre for Catalyzing Change (C3); the Graça Machel Trust; International Planned Parenthood Federation, Western Hemisphere Region (IPPFWHR); and Profamilia (Colombia) – as well as the Pan American Health Organization (PAHO/WHO) and UNICEF (Latin America and Caribbean Regional Office). It documents and provides insights into the lived experiences of women and adolescents during the COVID-19 pandemic in order to inform the respective programmatic responses. The brief also documents solutions being implemented and puts forward policy asks to help shape national, regional and global responses to the challenges faced by women and adolescents during and beyond the pandemic.

This brief supports the Call to Action on COVID-19 coordinated by the Partnership for Maternal, Newborn & Child Health (PMNCH). It will also be translated into a range of communication and advocacy products, including op-eds, journal commentaries, social media messaging tiles/infographics and virtual events/webinars.



Methods

Between April and August 2020, each partner organization was examining how women and adolescents were being affected by COVID-19 as part of their ongoing programme work. Using different methods (e.g. surveys, social media, webinars), partners collected and reported on the lived experiences of 29,246 people in 43 countries (Annex 1). Each organization applied its own ethics protocols.

Partners came together in April and June 2020 to discuss the issues and challenges facing women and adolescents during the pandemic and their work to document experiences on the ground.^a Despite the difference in country contexts and methods used (e.g. surveys, social media, webinars), these initial discussions revealed many common themes in the challenges faced by women and adolescents as well as the solutions they identified.

A simple analytical framework was used by each team to collate its data and programme information and to group emerging themes into three categories. The first category was challenges/ issues facing women and adolescents relating to: livelihoods; food security; mental health; violence, safety and security; autonomy, decision-making and mobility; sexual and reproductive health and rights (SRHR); and access to social services,

including education, health and technology. Additional challenges, both country-specific and common to all the countries, were also identified. The second category focused on what has worked to address each challenge. The final category focused on services and support needed to respond to the identified challenges during the pandemic and beyond.

A series of follow-up calls were held between May and July to discuss the framework and to address any problems or difficulties with the

analysis. Each team prepared its own report on the lived experiences of women and adolescents and developed country-specific policy asks for alleviating the short- and long-term negative impacts of COVID-19 on women and adolescents. The reports are available at <https://www.who.int/pmnch/knowledge/publications/lived-experiences-covid19/>.

The findings from the reports were collated, summarized and analysed to inform the development of this advocacy brief.



a. The team from PAHO/WHO facilitated the inclusion of data from two online regional surveys conducted by UNICEF's Latin America and Caribbean Regional Office.

Lived experiences

This section is in two parts. The first illustrates the COVID-19-related challenges experienced by women and adolescents. The second part presents proposed solutions to address these challenges, informed by their perspectives and lived experiences. Although partner organizations focused on the experiences of women and adolescents, in some cases they also reported impacts of COVID-19 on children: where relevant these findings are highlighted in this brief.



Challenges experienced by women and adolescents during the COVID-19 pandemic

Impact on mental health and well-being due to disruption of normal life



(144/886) reported suffering depression, anxiety or insomnia since the beginning of the pandemic. A survey explored 7,239 adolescents' feelings about and behaviours during COVID-19 in the Latin America and Caribbean region. The survey found that 18% (1,015/5,641) felt nervous, 18% (1,015/5,641) suffered from anxiety, 17% (959/5,641) felt worried about other people and 15% (846/5,641) felt bored. Thirty-two per cent (1,672/5,971) of respondents were also concerned about the spread and impact of the pandemic, while 28% (1,672/5,971) expressed concern over the unstable economic situation.

“The pandemic has been very sad for me because I have been working in a family home for one month, one hour away from my house. I feel depressed because I had many plans and I cannot visit my family.”

18-year-old woman, Colombia

The disruption is also causing financial stress and food insecurity, increasing pressure on women and girls in Africa who are often responsible for providing household food and water.^[2]

“I feel depressed because I had many plans and I cannot visit my family.”

COVID-19 and the ensuing quarantine and social distancing measures have had a range of psychological impacts on people's well-being, including emotional disturbance, depression, stress, low mood, irritability, insomnia, post-traumatic stress, anger, emotional exhaustion and irritability.^[1]

Partners' reports revealed that many people are suffering mental and psychological symptoms due to the disruption of daily activities, education and work, as well as mobility restrictions.

“Not being able to work like I used to has stressed me out. It makes me sad. Confinement affects me too.”

—28-year-old woman, Colombia

Lockdown measures have imposed additional burdens on women struggling to work remotely on a full-time basis, while continuing to shoulder their household and childcare responsibilities. Many women, especially those working in the informal

sector (e.g. in India and South Africa), reported feeling increased stress, anxiety and tension due to unemployment and having to spend more time at home. The psychological strain of financial hardship and curtailed economic opportunities was telling:

“Emotionally, I am depressed because I don't have a source of income. I almost committed suicide because I didn't know who to turn to or what to do to put food on the table for my children.”

40-year-old single mother, South Africa

Mental health is deeply affected by social distancing and mobility restrictions. Adolescent girls in India reported feeling isolated because they cannot meet their friends, and they worry about their future. Sixty-seven per cent (597/886) of women aged 18-29 in Colombia were concerned about the risk of anxiety or depression, and 16%

Limits on access to education

“I may never finish high school; who knows.”

In mid-April 2020, UNESCO reported that 1.5 billion students (from pre-primary to higher education) were affected by educational institutions closures in 195 countries.^[3] While those measures were necessary to prevent pupils from contracting the virus, it is estimated that 20 million more secondary school-aged girls risk dropping out of school due to the crisis.^[4] A survey of young people in Jharkhand and Chhattisgarh in India (April 2020) revealed that 46% (961/2,090) of the girls who participated believed that COVID-19 and lockdown would negatively affect their future plans to study.

In order to cope with lockdown measures, many educational institutions provided online classes in place of in-person instruction; this created a clear divide between those with access to the internet, who could continue learning at home, and those without that option. For example, in Colombia, 11% (130/1,168) of young people did not have a computer or internet access. In Nigeria, South Africa and Uganda, children from poor households, without access to technological devices and connectivity, were unable to continue their schooling during lockdown.

In IPPFWHR's survey among youth networks in 19 Latin American and Caribbean countries, 50% (544/1,088) of young people reported facing challenges in pursuing remote studies due to limited access to technology caused by financial

constraints. This could directly affect their plans for future education, especially endangering the prioritization of higher education.

“I can't go to school at all and I feel my life is just on standstill. Nothing is moving. I may never finish high school; who knows.”

—18-year-old woman, South Africa

Teachers in India also reported that students without access to the internet were at increased risk of dropping out of school. Many students struggled with unreliable internet connections, hindering their ability to follow classes without interruption, catch up with their classmates and communicate with their teachers. Online classes also increased costs for both students and teachers at a time when most households were struggling financially.

“I'm finishing my semester. It's been a little hard for me because I only have a cell phone to communicate. It's not working well, so that's why it's a little hard, and they've disconnected our internet service twice.”

—18-year-old woman, Colombia

Several other issues were caused by the shift to distance learning. Teachers reported being under-resourced and lacking the capacity to use new technologies to conduct online classes. For example, in Bihar and Chhattisgarh, India, 80% (91/113) of government teachers who participated in the survey in April 2020 reported lack of access to resources essential for conducting online classes. Students in Colombia also thought these factors could affect the quality of their education.

Teachers in India reported that distance learning was decreasing students' engagement and interest, and that students felt fatigued by the combined burden of homework and increased household chores.

Distance learning and reliance on digital technology pose additional challenges for students with disabilities or special educational needs. Specialized, time-sensitive education and support are necessary to ensure their inclusion and access to educational services. Home-schooling and e-learning may not be suitable for them and could result in their exclusion if no special measures are in place.

The requirement of distancing measures when schools reopen after lockdown is another challenge for the education sector, especially in countries with poor infrastructure. Schools in South Africa, for example, expect to face problems in accommodating returning children.

Food insecurity

“There are days when there’s not much food ... we have to decide who can eat.”

In April 2020 it was estimated that an extra 130 million people would face acute food insecurity due to the impact of COVID-19. Labour shortages (due to movement restrictions and social distancing measures), factory closures, disrupted supply chains, food protectionism and border closures are affecting food availability and prices. In addition, job losses and reduced remittances (salary earners sending income to family members in their home community) have reduced people’s ability to buy food.^[5, 6] It is widely accepted that children and young adolescents are at higher risk of being affected by food insecurity. As of May 2020, 368 million school children around the world were missing out on daily school meals, increasing their risk of malnutrition.^[7]

Food insecurity caused by financial constraints and limited availability of essential food items was reported as a significant concern by families in Colombia, India, Nigeria, South Africa and Uganda.

“Life has been miserable. My mom is not working; some nights we go to sleep with no food, without eating the whole day. My mom ends up going to borrow money which she can’t pay back.”

— 18-year-old woman, South Africa

IPPFWHR’s survey found that 52% (566/1,088) of respondents rated their concern about food security at six or above (10 being the most concerned). Twenty eight percent (305/1,088) of respondents said they were unaware of any initiatives or programmes to mitigate this situation.

Families in Colombia reported that the quantity and variety of their food had reduced and that they were prioritizing small children to receive larger portions or more nutritious foods. Migrants and refugees have been heavily affected by the pandemic in Colombia. In a survey targeting migrant and refugee households, 10% (74/737) of respondents had reduced their meals from three per day to one per day; nearly 70% (516/737) had gone from three to two daily meals. Just 22% (162/737) of households were still able to serve three meals per day. Most migrant households reported needing food aid.^[8]

Nine Indian states^b reported similar situations in the weeks following the first lockdown. Many families were forced to reduce the quantity and variety of their food to cope with job losses, food shortages and decreased financial resources.

b. Uttar Pradesh, Jharkhand, Chhattisgarh, Odisha, Maharashtra, New Delhi, Madhya Pradesh, Tamil Nadu and Bihar.

c. Fried snack (fritter) made with vegetables and flour.

“Earlier we used to have two side dishes for a meal; but now we manage with only one dish. We do not prepare any snacks like pakodas.^c My younger brother used to have milk twice a day, now he only has it once a day. Thus, we have minimized our food consumption to manage within the available resources.”

— Adolescent girl, India

Market closures and stock-outs in village shops increased people’s vulnerability to food shortages during lockdown. Many women in India reported difficulties in accessing essential food items during the initial phase of lockdown. Women belonging to marginalized castes reported poorer access than others. Implementing relief measures for families affected by food insecurity has been challenging. Women farmers in Uganda reported difficulties in accessing financial assistance in response to disrupted production. In India, in the first weeks of lockdown, respondents reported issues including eligibility for relief, the quality and quantity of rations, lack of reliable communications about distribution times and inability to maintain social distancing when accessing relief.

“The quality of the rice was pathetic. It should have been of better quality. And [the government] could have continued to provide free rations in the following month or so too.”

— 27-year-old woman, India

Loss of livelihood

“Just after lockdown ... my work and my father’s and my brother’s work were stopped.”

Early in the pandemic concerns were raised that half of all workers worldwide were in danger of losing their livelihoods^[9]. For millions of people, no income means no food, no security and limited access to services.

In Colombia, an online survey with 1,287 participants aged 18-29 years found that 23% (96/415) of women and almost 21% (36/175) of men who were employed lost their jobs during the pandemic. Forty one percent of respondents to IPPFWHR’s survey said the pandemic had negatively affected their financial status. In five Indian states (Bihar, Jharkhand, Chhattisgarh, Odisha and Gujarat), 75% of women (8,366/11,154) responding to a survey in June 2020 said an earning member of their household had lost their livelihood since lockdown. In another survey, over 91% (1,047/1,150) of participants in Bihar reported that COVID-19 and lockdown had adversely affected their income.

Workers in the informal economy worldwide are estimated to have lost 60% of their earnings in the first month of the crisis. The incomes of such workers are predicted to fall by 81% in Africa, 21.6% in Asia and the Pacific, and 70% in Europe and Central Asia.^[9] The country reports informing this brief showed that street vendors in Colombia, India, Nigeria, South Africa and Uganda were

among the worst affected by mobility restrictions and market closures. Many women in the three African countries were unable to operate because they could not acquire permits or meet registration requirements during lockdown.

“I cannot go and buy stock to sell because the market is closed to individuals who [run] informal businesses ... they only sell to people who have cards to buy in bulk. I cannot put food on the table for my children.”

— 40-year-old woman, South Africa

Increased job losses in the agricultural sector were reported by participants in India, Nigeria and Uganda. Farmers in India said that their losses were due to interrupted supply chains in the initial phase of lockdown. Delayed deliveries and lack of reliable logistics meant that produce could not reach the market quickly enough and had to be thrown away.

It is estimated women perform almost 50% of all agricultural activity on the African continent.^[10] In Uganda, the African Women in Agribusiness Network reported that their agricultural enterprises were at risk, anticipating income

losses due to production either stalling or ceasing altogether. Women’s enterprises, hiring mostly women, were unable to operate at full capacity because of physical distancing.

“We are in the planting season and currently we cannot access the fields due to lockdown. As for those harvesting, we are facing losses in one way or another as there is no option of post-harvest handling, coupled with closure of markets.”

— Steering Committee Deputy Chair,
Graça Machel Trust’s Women’s Economic and
Social Advancement Project, Uganda

In Nigeria, the New Faces New Voices Network were concerned that most micro, small and medium enterprises would collapse without economic relief. The great majority of these businesses are woman-owned.

Families in India reported that remittances have decreased since the beginning of the pandemic. Many people working in the unorganized sector^d lost their jobs due to the closure of factories and construction sites. Those who remained in employment reported late payment of their salaries.

d. The unorganized sector consists of private enterprises owned by individuals or households that produce or sell goods and services and employ fewer than 10 workers.

Lack of access to health information and services

“If I go to the emergency room, I know they’ll send me home because this isn’t an emergency for them: I know, I’ve tried.”

The spread of COVID-19 has had a profound impact on already constrained health-care systems across the globe. Considerable scale-back of non-COVID-related health care occurred as governments and public health systems focused on containing the spread of the virus.^[11] In addition, people have been reluctant to seek health-care, including immunization services, due to service reduction or fear of contracting the virus at health-care facilities.^[12]

Inadequate knowledge about and awareness of the virus is an ongoing challenge. For example, a survey in the Latin America and Caribbean region examining the knowledge, attitudes and perceptions of COVID-19 among 10,796 participants aged 13 and 29 years revealed that only 33% (2,908/8,811) knew how COVID-19 was transmitted, and 53% (3,882/7,324) did not know the address of their country’s official virus information website. Young people also reported not knowing what to do if they needed health services and intended to avoid those services for fear of exposure to the virus.

In the same survey, 41% (3,594/8,767) of participants reported receiving information on COVID-19 from traditional media, while 25% depended on social media for information and 14% sought information online.

Some young people in Colombia advocated self-care in order to stay healthy during lockdown.

“What I have done is taken care of myself. Which means maintaining a good level of health. For example ... in the morning I eat a proper meal, which is essential for health. I take a lot of vitamin C, for the immune system, and that kind of thing.”

— 20-year-old woman, Colombia

For others, even those with information on how to avoid the virus, lack of running water and proper handwashing facilities made it difficult to follow health guidance.

In Colombia, 83% (978/1,172) of young people were very concerned that a family member might have a medical emergency and not receive medical care because of the disruption to health services. Surgeries and appointments were postponed and prevention services and treatment of non-communicable diseases, such as cancer, cardiovascular disease and diabetes, were interrupted or reduced.

“We are supposed to be washing our hands constantly. But because there are more than 100 of us sharing one tap for water it’s difficult and we end up putting a dish by the door for handwashing.”

— 40-year-old woman, South Africa

Similarly, 52% (566/1,088) of respondents in IPPFWHR’s survey countries were very concerned about not being able to access health-care services (rating their concern at six or more out of a maximum of 10). Forty-six per cent (500/1,088) of the respondents in the same survey said they were unaware of any initiatives in their communities to address barriers related to accessing health-care services.

“I had to take my daughter to the paediatrician to get her surgery authorized. She has an umbilical hernia, and we haven’t been able to do any of that because they’re only treating emergencies in hospitals.”

— 27-year-old woman, Colombia

Interruption of health services was also reported in Kenya. In April 2020, the Population Council and the Ministry of Health conducted a phone survey of 1,769 people (63% female; 37% male) from five informal settlements (Kibera, Huruma, Kariobangi, Dandora and Mathare) on COVID-19 knowledge, attitudes, practices and needs. Twenty-seven per cent (478/1,769) of respondents reported

they had not accessed treatment for acute illness since the start of the pandemic.^[13]

Between March and April 2020, Jacaranda Health, Kenya, conducted a survey of 1,275 pregnant women and new mothers in five Kenyan counties (Bungoma, Kiambu, Makueni, Murang'a and Nairobi). Sixty per cent of respondents reported that COVID-19 had impacted their decision to seek care, either in terms of the location or frequency of care-seeking. Women reported they were confused about how to seek care during times of curfew and were unsure about what services were still available. Women also reported being turned away from facilities.^[14]

“I am worried because I’m not sure if I will find the facility open or if I will find nurses during delivery.”

— Pregnant woman, Bungoma County, Kenya

COVID-19 is also disrupting immunization services around the world. It is estimated that at least 80 million children are at risk of diseases such as diphtheria, measles and polio.^[12] In India, for example, frontline workers reported that all immunization services were suspended in early April 2020 except for BCG vaccinations^e for babies delivered at a facility. In the above-mentioned survey conducted by the Population Council and Kenya’s Ministry of Health, 17% of the 1,769 respondents reported forgoing immunization and child health services.

The pandemic has also increased health workers’ workloads and put them at direct risk as countries struggled to provide them with personal protective equipment (PPE).^[15, 16] The burden on health workers is expected to affect women disproportionately because they make up 70% of the health workforce.^[17]

Frontline workers in India, in addition to their usual tasks, were having to track and trace suspected patients and deliver essential health-care services. In a telesurvey in Chhattisgarh and Jharkhand in late April, 40% (106/264) of responding frontline workers reported being involved in contact tracing; almost 36% were identifying people for quarantine/isolation centres, and 30% were escorting people to health centres.

In the same survey, 80% of frontline workers said they were conducting home visits without full PPE; in Jharkhand and Chhattisgarh, 80% of frontline workers reported having access to masks, but only 40% had gloves.

In India, community-based Anganwadi workers, who work on health and nutrition, became accredited social health activists; auxiliary nurse midwives shared many of the frontline workers’ concerns and also took on increased workloads.



e. Bacillus Calmette–Guérin vaccine is primarily used against tuberculosis.

Limitations on sexual and reproductive health and rights

“Girls in quarantine tore up and used their own clothes as they didn’t have access to sanitary pads.”

COVID-19’s impact on SRHR is not always evident because the effects of service interruption and redirected resources are indirect.^[18] According to WHO, a decline as modest as 10% in the provision of family planning, pregnancy and newborn services could result in an additional 28,000 maternal deaths, 168,000 newborn deaths and millions of unintended pregnancies.^[19] A report by UNFPA concluded that a six-month interruption of SRH services could prevent 47 million women in 114 low- and middle-income countries from obtaining modern contraceptives, and lead to 7 million unintended pregnancies.^[20]

“I have polycystic ovarian syndrome, and I haven’t been able to get any kind of medical appointment, and for some reason I stopped getting my period, and I want to find out what’s going on, but I can’t.”

— 18-year-old woman, Colombia

The pandemic’s impact on access to SRHR services, products and information was reported by all partners. In the phone survey of 1,769 Kenyans conducted by the Population Council

and the Ministry of Health, 9% said they had not accessed prenatal care and 15% said they had not accessed family planning services.

In Colombia, 16% (141/886) of women aged 18-29 were unable to make appointments for gynaecological check-ups, and 17% (149/886) were unable to obtain contraceptives.

Because of the impact on access to SRHR services, products and information, participants in the Colombian survey felt unable to continue their usual sexual activity due to fear of getting pregnant. In the Latin American regional youth consultation, young people were also concerned about not being able to maintain romantic and sexual relationships due to lockdown. Young people felt a need for open discussions and acknowledgement of the impact of COVID-19 measures on sexual health and rights.

Lockdown and mobility restrictions have also reduced the availability of menstrual hygiene products. For example, adolescent girls in India reported feeling anxious about not being able to obtain sanitary napkins at community centres or medical shops during the initial phase of lockdown. Those who were quarantined were forced to

use less hygienic substitutes. Only 10% (5/51) of government teachers in Bihar and 19% (12/62) in Chhattisgarh reported in early April that sanitary napkins were available in their communities. Similar concerns were raised by women and adolescent girls in Colombia.

“Girls in quarantine tore up and used their own clothes as they didn’t have access to sanitary pads. They were afraid to ask for these things as families used to scream and threaten them, so no one could say anything much.”

— Adolescent girl, India

Health resources worldwide are being redirected to the pandemic: this is likely to produce a drastic deterioration in other health outcomes, including safe pregnancies and childbirth.^[18] Provision of essential commodities is also affected, for example most girls who relied on free sanitary pads distributed at schools can no longer access them.^[21]



Increased violence, lack of safety and reduced agency

“I am afraid of being confined because my husband is very violent. He even tried to hang me a few days ago.”

Emerging data shows that violence against women and girls, particularly domestic violence, has increased since the outbreak of COVID-19. It was estimated that a six-month lockdown could result in 31 million additional cases of gender-based violence.^[20]

School closures across sub-Saharan Africa have exacerbated girls' vulnerability to physical and sexual assault as well as their risk of early marriage.^[22] Anecdotal reports from Kenya suggest an increase in gender-based violence since the beginning of lockdown. Sexual exploitation, including transactional sex, and cases of early marriage, rape and defilement have been rising, especially against girls in informal settlements and during curfew hours.

The COVID-19 pandemic is also eroding efforts to reduce female genital mutilation (FGM). Anti-FGM advocates in Kenya report that its proponents are taking advantage of lengthy school closures to submit girls to FGM while they have time to recover before returning to school.^[23]

Women and adolescent girls from nine Indian states reported increased verbal and sexual abuse since the start of lockdown. The reopening of liquor and wine shops was identified as a contributing factor.

“When shops selling alcohol were closed, why did the government re-open them? If they hadn't re-opened, it would have been fine. Because when they sit jobless ... they get drunk and create a ruckus. It has a lot of effects. They call out dirty abuse, which is hard to explain to my younger siblings.”

— Adolescent girl, India

In India it was also feared that parents would see lockdown as an opportunity to arrange marriages at low cost, with a dowry to be received after lockdown. Respondents from India reported anecdotal evidence of increasing rates of early marriage among adolescent girls.^[24] Similarly, key informants in Kenya reported many stories of families marrying off their adolescent daughters in order to reduce the cost to the household and so stave off hunger and homelessness.

Reports from India and the Latin America and Caribbean region confirm that lockdown has confined many women and girls at home with their abusers. Women and girls have reported feeling anxious and fearful, especially about their inability, due to limited mobility and reduced transport services, to access police or other bodies to protect them from violence.

“Life here with COVID-19 has been very hard. I am afraid of being confined because my husband is very violent. He even tried to hang me a few days ago. I just left home to visit my neighbour, who is the pastor's wife. She knows what I am living through, so she gave me a note about where to get help. She called the number because I don't know how to use the phone. It is a service to help victims of violence against women.”

— 28-year-old woman, Ecuador

Women's and adolescent girls' decision-making and autonomy have also been adversely affected by COVID-19. For example, Indian women whose husbands were previously working and living away, but were now staying at home, were having to cede authority to them as head of the household, and women who lost earning power thereby also lost control over their own assets. In other cases, women still in work thought that their unemployed partners begrudged them this benefit.

“Her co-workers are scared because their husbands have become unemployed: in addition to becoming poorer, they also feel resentment from their partners for being the main breadwinners during the crisis.”

— 50-year-old woman, Belize

Indian women living apart from their families reported receiving threatening calls from landlords demanding rental payment; others were evicted when they lost their jobs and were unable to pay rent. Travelling alone on public transport was another concern, with some women and adolescent girls fearing they might be raped while travelling. Similar fears were reported in Kenya.

**“What will I do if I go into labour at night?
The police are s o brutal, and I’m afraid I
might be beaten for breaking the curfew.”**

— Pregnant woman, Kenya

Violence against transgender people has also risen. Transgender people in Colombia felt less safe during lockdown and reported transphobic incidents since the start of the pandemic, including police threats and abuse. Some fear being assaulted when walking alone.

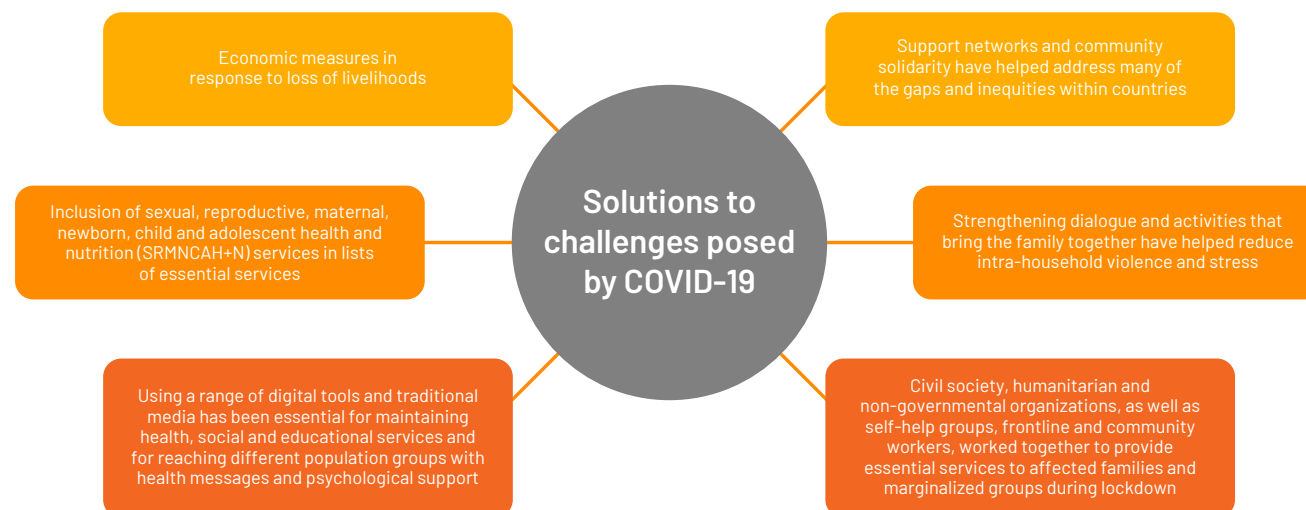
**“Well, since quarantine started, there have
been more robberies because people
are looking to cover their needs, and
those who cannot work steal. ... there
were more than 20 cases of violence
in supermarkets, a trans woman was
stabbed ... there’s a wave of transphobia
in many social networks.”**

— 27-year-old woman, Colombia



Solutions and solutions to address challenges

Figure 1. Summary of solutions to challenges posed experienced by women and adolescents during COVID-19



A range of strategies and approaches are being implemented in different countries to address the significant challenges facing women and adolescents during and beyond the pandemic. Figure 1 summarizes the most common solutions identified by partner organizations. These solutions are not exhaustive but reflect the perceptions and experiences of those who participated in the country-specific activities.

Many of the solutions, such as the use of digital technologies and peer support networks, are being used to address a range of challenges. See Annex 2 and individual organizations' reports for further examples of solutions and approaches used to address challenges across different countries.

Economic measures in response to loss of livelihoods

Economic relief measures helped reduce pressure on low-income households and vulnerable groups. Measures to mitigate food insecurity were adopted across countries through social services, such as government-led food distribution interventions, food stamps and vouchers. Economic relief measures focusing on women and girls, in the form of cash transfers and home-based income generating activities, have also been pivotal for stemming the negative economic impact and loss of livelihoods.

“We got free dry rations for three months with the help of the Mukhiya [Village Elected Leader] and the PDS [Public Distribution System].”

— Adult woman, 40 years old, India,

Inclusion of sexual, reproductive, maternal, newborn, child and adolescent health and nutrition (SRMNCAH+N) services in lists of essential services.

Many countries very quickly provided high-level guidance for maintaining high-quality and equitable SRMNCAH+N services during the COVID-19 pandemic. This enabled strategic and operational actions to ensure the rapid resumption of services.

Using a range of digital tools and traditional media has been essential for maintaining health, social and educational services and for reaching different

population groups with health messages and psychological support.

All countries reported using helplines, social media, apps and digital platforms to provide psychosocial services and support, telemedicine and guidance, including for SRH, and support to victims of violence. In South Africa many gatherings, community forums and professional and business networks served as channels for psychosocial support. Primary, high-school and university education was also delivered online. However, access to those services requires access to digital devices and internet connection. The nature of the support offered also varied, depending on the resources available, especially to the service providers.

“We need more access to an internet connection so that we can communicate with all our friends daily and ease the financial burdens of acquiring data; most of us rely on our friends to be our support system.”

— 18-year-old woman, Jamaica

Traditional media channels have provided an effective alternative to digital tools, reaching people without access to the internet.

Television, radio and print media were used to disseminate health information about COVID-19 and SRHR. National educational channels were used to broadcast classes for schoolchildren. Educational TV channels were used to reach students unable to use distance learning platforms.

“Classes on TV, like in Kerala, would be good. On a dish TV a channel costs 1 rupee per day so it will be cheaper. Can be done throughout the day. Government should do that. Or the network signal should be improved, and plans should become cheaper for online classes.”

— 18-year-old woman, India

Civil society, humanitarian and non-governmental organizations, as well as self-help groups, frontline and community workers, worked together to provide essential services to affected families and marginalized groups during lockdown.

To address the short-term consequences of lockdown, services were provided at home and in communities. These included providing basic food items and cooked meals to marginalized groups and the worst affected families, distributing menstrual sanitary products to vulnerable girls and women, ensuring pregnant women's access to facility-based delivery services, and vaccination services at home. Although the past months saw a surge in such activities, some countries reported that outreach in remote villages and communities needed to be strengthened.

“I met Ray of Hope who gave me food and an opportunity to volunteer and have a purpose in my life: to give back to other women, distributing food to vulnerable families in my community.”

— 42-year-old woman, South Africa

Strengthening dialogue and activities that bring the family together have helped reduce intra-household violence and stress.

Families reported that redistributing household tasks and defining responsibilities to involve all family members have helped reduce friction between family members.

“Now he comes home from work, he starts to play with his daughters: that is, we have joined together in more things, things that he did not do before, like helping them with tasks. He spends more time at home now; during the quarantine he ... is no longer out and about.”

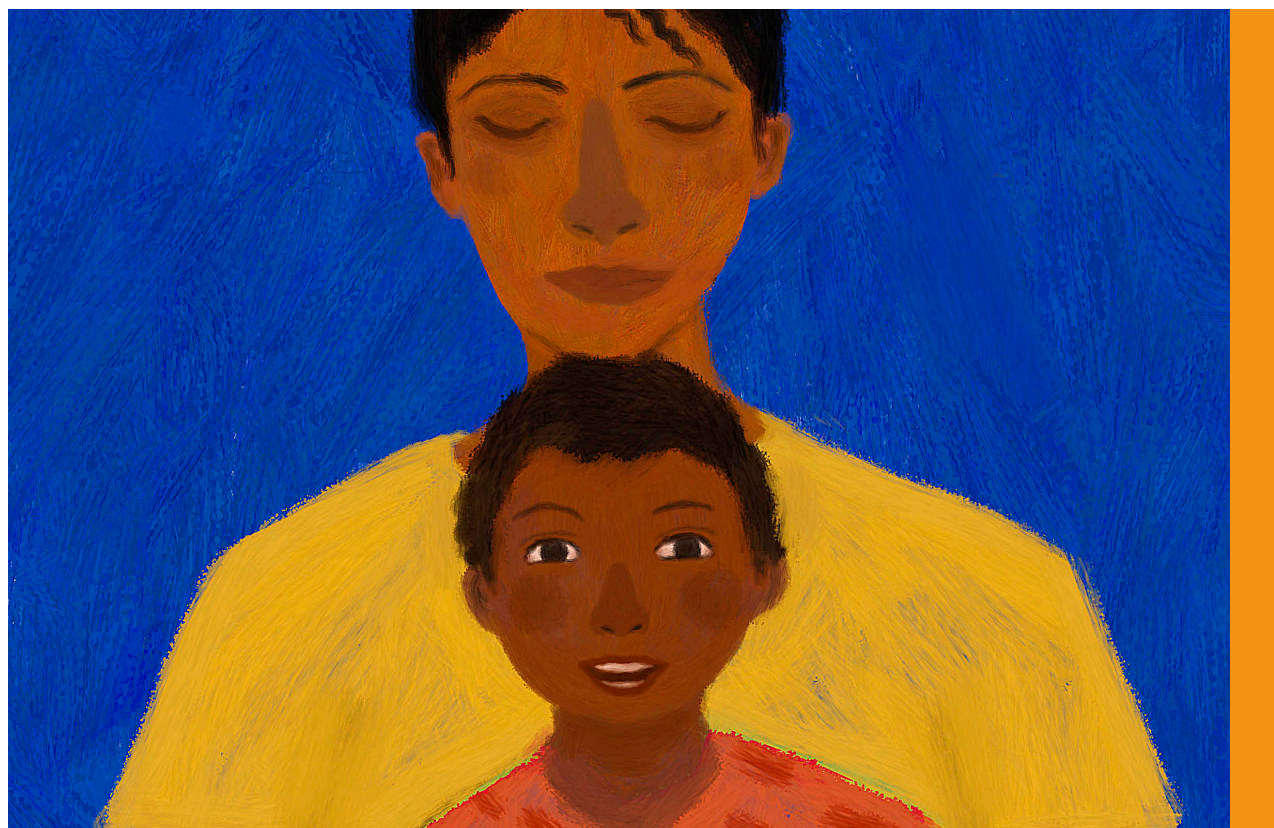
— 27-year-old woman, Colombia

Support networks and community solidarity have helped address many of the gaps and inequities within countries.

Communities have come together and established emergency funds to help families pay for food and utility bills during lockdown. There are also examples of young people negotiating payment agreements with their landlords. Community networks of students have been collecting donations and food to distribute to those most in need. Neighbours and peer support networks have organized themselves, using social media and other means, to develop community strategies to protect each other from COVID-19, as well as from physical threats to their safety within and outside the home.

“The support groups that we started are sort of street community strategies that we called the anti-discrimination and anti-violence squads. We created a network of love and care among different activists and transsexual leaders in different districts.”

— 27-year-old, transgender woman, Colombia



Policy asks

COVID-19 has revealed grave inequalities within our societies and exacerbated many of the existing challenges facing women and adolescents. Responding to the consequences of COVID-19, both immediate and long-term, presents an unprecedented opportunity for innovative and large-scale action to transform the lives of the most vulnerable.

We must build back better, using contextually appropriate strategies that take account of a range of factors, including gender, age and access to resources. This is essential to ensure that the short, medium and long-term benefits produced outweigh any potential harms.

We need threefold policy action: short-term relief and mitigation measures, medium-term recovery and long-term development. A gender lens will be required when designing socioeconomic relief measures. The upheaval caused by the pandemic and the amplification of inequalities and vulnerabilities affecting women's and adolescents' lives, health and well-being require transformative action to address a number of social, cultural and economic factors.

Women and adolescents must be consulted and engaged in decision-making processes at global, regional, national and local levels, including in taskforces, to ensure that their lived experiences are meaningfully addressed in the COVID-19 response and recovery pathways.

Supporting the [PMNCH Call to Action on COVID-19](#), and based on the lived experiences of women and adolescents analysed for this brief, we call for a collaborative approach by governments and all stakeholders to address the following seven policy asks. See Annex 3 for a more detailed list of actions in response to the main challenges experienced by women and adolescents. Annex 4 provides additional details on each partner organization's work in response to COVID-19.

1. Maintain essential SRMNCAH+N services, products and information, including for contraception, safe abortion, immunization, safe delivery, stillbirth prevention and mental health

Governments at national and subnational levels must ensure that women, adolescent girls and children continue to receive these services during the pandemic and beyond. Neither domestic nor donor resources for SRMNCAH services and supplies should be diverted elsewhere during the crisis and recovery periods. Guidance and notices must be circulated in all public and private facilities to reflect this. Increased investment in digital platforms, telemedicine tools and traditional media channels to ensure equitable access to information and guidance is essential. Training and safe working conditions, including PPE, for frontline and community health workers are imperative.

2. Address gender inequality, including gender-based violence, and ensure the safety and security of women and adolescent girls in integrated response and recovery plans.

Prevention and redress services that reach out to women and adolescent girls facing violence and distress must be classified as essential services and fully maintained. These services, including women's helplines, counselling, police intervention, shelter homes, legal aid and advice, access to courts, health services and economic support, must be easily accessible, properly funded and widely promoted. Official guidelines and advice should be published to ensure that these are implemented in partnership with relevant partner organizations.

3. Increase attention to the mental health needs of those, especially women and adolescents, severely affected by the pandemic.

It is essential to recognize and promote community-based provision of psychosocial support to address the emerging mental health needs of communities and the potential long-term impacts on health and general well-being. Adequate financial and human resources must be allocated to ensure proper and equitable provision of psychosocial support and services.

4. Adopt and scale up social and economic relief measures that are gender-responsive and reduce inequities.

Food insecurity and job losses are having devastating impacts, especially on women, young people and vulnerable households. Those working in the informal economy, daily wage earners, farmers and those living on the margins are particularly affected. There is an urgent need to provide food rations in the absence of safety nets, and direct cash transfers through established schemes. Investments are needed in income-generating opportunities to improve agency and health and to alleviate poverty. Beyond the immediate term, food and nutrition support will be essential for vulnerable families. This includes developing alternatives to school feeding programmes interrupted by school closures and increasing investments in the agricultural sector.

5. Address adolescents' needs for education and vocational training.

As schools and other learning institutions reopen, students and teachers must be reintegrated. It will be important to work with parents and gatekeepers to ensure that younger children and adolescents, especially girls from vulnerable and marginalized communities, continue their education. Re-enrolment campaigns and measures preventing drop-outs must be put in place to ensure that education continues, especially for girls.

6. Address the digital divide within countries and between genders.

Internet access and connectivity should be a basic service. Investments must be made to bridge the digital divide, allowing women and girls to access basic services and information, including on health and finance. This will require targeted investment and the strengthening of public-private partnerships. Services should be provided through a combination of high tech (digital platforms and tools), low tech (SMS and telephone calls) and no-tech (communities, teachers and parents' groups) to reach all community groups and ensure inclusivity.

7. Collect and report disaggregated data (by age, sex, income, disability, geography) and gender statistics.

Such data must be adapted to the COVID-19 response, enabling the development of recovery plans that address the needs and issues of women and adolescents. Better data can better inform advocacy efforts. In the process of response and reconstruction, better data enable resources to be prioritized for women and adolescents, who are disproportionately affected by the pandemic.



Conclusion

COVID-19 and the consequent lockdown measures have affected people worldwide. This advocacy brief and the reports that informed it document the burdens that women and adolescents are bearing during this crisis.

Movement restrictions and social distancing measures have not only caused people to feel isolated and anxious, but have also cost millions their livelihoods, especially women working in the agricultural sector or the informal economy. Families around the world have been forced to reduce their spending, even on essential food items.

With entire families confined to the home, women and girls not only have additional household chores, including childcare and providing meals with minimum resources, but have also lost their privacy and mobility.

Violence against women and adolescents, especially girls, has increased since the start of lockdown. Many victims are confined with their abusers with little or no support. Even where support is available through helplines or digital platforms, many are unable to access it due to limited privacy or lack of digital connection.

Educational institutions, including schools, colleges and vocational training centres, have been closed, jeopardizing the futures of many young people. As countries have shifted to distance

learning, students with limited or no access to the internet have been missing out on education. School closures have also prevented school feeding programmes, exacerbating food insecurity and placing millions of children who depend on school meals at risk of malnutrition.

As financial and human resources are redirected to respond to COVID-19, fewer resources are available for other health and well-being needs, placing millions of lives at increased risk. The disruption and shutdown of SRMNCAH information and services in many countries, combined with fear of contracting the virus at health facilities, is affecting the health and well-being of women and adolescents, especially girls, and will continue to do so after the pandemic. Limited access to essential preventive, promotive and curative SRH care will extend beyond the pandemic, damaging women's human rights and deepening gender inequality.

With these policy asks we call for a collaborative approach across governments to address the significant short-, medium- and long-term impacts of the COVID-19 pandemic on women and adolescents.



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ANNEX 1.

Overview of the different methods used by partners

Table 1. Quantitative methods used to explore lived experiences

Organization	Method	Sample		Participating countries
		Size	Demographics	
Asociación Profamilia	Online survey April 2020	1,287	Age group: 18-29 Females: 866 Males: 288 Non-binary: 13	Colombia
Centre for Catalyzing Change (C3)	Telesurvey April 2020	3,329	Age group: 10-20 Females: 2,090 Males: 1,239	India
International Planned Parenthood Federation, Western Hemisphere Region (IPPFWHR/ Colombia)	Online survey May and June 2020	1,088	Age group: 10-29+ Females: 805 Males: 261 Non-binary: 22	Argentina, Barbados, Belize, Bolivia, Brazil, Chile, Costa Rica, Colombia, Dominica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, The Dominican Republic, Trinidad and Tobago, Uruguay, Venezuela
Amref Health Africa	Online survey April-June 2020	2,153	Age group: 18-35 Females: 1,072 Males: 1,061 Non-binary: 20	Ethiopia, Kenya, Malawi, Senegal, Tanzania, Uganda, Zambia
UNICEF Latin America and Caribbean Regional Office	Online survey May 2020	7,239	Age group: 13-29 Females: 45.8% Males: 53.7% Non-binary: 0.5%	Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, Ecuador, El Salvador, Guyana, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Saint Vincent and the Grenadines, Saint Lucia, The Dominican Republic, Trinidad and Tobago, Uruguay, Venezuela
	Online survey April 2020	10,796	Age group: 13-29 Females: 5,290 Males: 5,398 Non-binary: 108	

Table 2. Qualitative methods used to explore lived experiences

Organization	Methods		
Asociación Profamilia	Interviews (June 2020)		
	Participants	Demographics	Country
	23	Age group: 15-25 Females: 18 Males: 5	Colombia
	Literature review of national and local data sources by governments, non-governmental organizations, researchers and Profamilia		
C3	Interviews (April to May 2020)		
	Participants	Demographics	Country
	2,342	Female youths and adolescents: 26 Women: 2,316	Nine states in India (Uttar Pradesh, Jharkhand, Chhattisgarh, Odisha, Maharashtra, New Delhi, Madhya Pradesh, Tamil Nadu, Bihar)
IPPFWHR	Documenting stories, sharing live conversations through Instagram (from May, ongoing initiative) Countries in Latin America and the Caribbean		
Graça Machel Trust	Countries: Nigeria, South Africa and Uganda		
	13 webinars (April to June 2020) Total number of participants: 525 Key webinar themes included: sustaining sexual and reproductive health and rights; food systems and food security; the impact of COVID-19 on women and girls; and leading through change focused on women entrepreneurs. <ul style="list-style-type: none"> • COVID-19 and food systems in the Eastern and Southern African Region, 15 April 2020 • Youth being left behind in accessing sexual and reproductive health and rights, 5 May 2020 • Getting your business online, 12 May 2020 		

Graça Machel Trust	<ul style="list-style-type: none"> • Sustaining sexual reproductive health and rights through intersections of social protection policies and programmes during COVID-19, 15 May 2020 • Building resilience: women's leadership in times of COVID-19, 20 May 2020 • Approaches to ensure continuation of sexual and reproductive health and rights during COVID-19 and beyond, 20 May 2020 • The disproportionate burden of COVID-19 on women and girls in the Africa region, and their voices and actions in shaping the discourse, 27 May 2020 • Lead through change: business in the time of COVID-19, 26 May 2020 • Advocating for nutrition during COVID-19, 3 June 2020 • Time to confront the threats of COVID-19 on access to quality primary education in sub-Saharan Africa, 4 June 2020 • Business continuity planning, 9 June 2020 • Fuelling action towards achievement of the sexual and reproductive health agenda, 11 and 25 June 2020
	<p>8 live Instagram conversations Total number of participants: 347</p> <p>Discussions of the role of civil society organizations, gender-based violence, sexual and reproductive health and rights and women's leadership during the crisis</p> <ul style="list-style-type: none"> • Expanding equality in times of uncertainty, 14 April 2020 • The rise of consequential leaders, 17 April 2020 • NGO COVID-19 programmatic work, 21 April 2020 • African philanthropy: an imminent response to COVID-19, 28 April 2020 • Media and the mental health narrative during COVID-19, 30 April 2020 • Gender-based violence: the rising pandemic, 8 May 2020 • Coping with COVID-19, 15 May 2020 • Fighting the shadow pandemic that is gender-based violence, 26 May 2020
	<p>5 community field visits</p> <ul style="list-style-type: none"> • Two field visits in South Africa (Alexandra Township), May and June 2020 • Three field visits in Nigeria (Katsina, Kaduna and Kano states, Nigeria), August 2020
	<p>Documentary analysis of human-interest stories and country responses to the pandemic, 12-14 June 2020</p>

Amref Health Africa	<p>Literature review of studies conducted by Amref Health Africa and other partners, media reports and blogs (May to June 2020)</p> <ul style="list-style-type: none"> • COVID-19 knowledge, attitudes and practices: responses from 2,010 households in five Nairobi informal settlements (Kibera, Huruma, Kariobangi, Dandora, Mathare). Population Council. • COVID-19 effects on health care-seeking behaviours and other social economic effects in Nairobi. Amref Health Africa. • COVID-19 in Kenya: maternal and newborn health insights from partner counties. Jacaranda Health. • Short-term socioeconomic effects of COVID-19. The Amsterdam Institute for Global Health and Development, the African Population and Health Research Center, Amref Health Africa and PharmAccess Foundation. <p>News and blogs</p> <ul style="list-style-type: none"> • Women living in Kajiado County respond to the COVID-19 pandemic. Her Word. White Ribbon Alliance; 2020. • Ajayi A. The potential impacts of COVID-19 on teenage pregnancy in Kenya. APHRC; 17 June 2020. • Maichuhie K. West Pokot records dramatic rise in FGM cases. Daily Nation newspaper; 11 June 2020. • Mwangi MG. Multiple risks faced by adolescent girls in Kenya during the COVID-19 pandemic. LVCT Health Kenya; 7 May 2020. • Ministry of Gender and Social Services. The situation of teenage pregnancies in Kenya. National Council for Population and Development; 2019. • SDG Kenya Forum. Spotlight on the impact of COVID-19 on women and girls. Newsletter Vol XIII: May 2020. <p>Interviews with key informants: Amref Health Africa executive and programme staff, beneficiaries and other partners, including national governments and county and NGO representatives (May to June 2020)</p> <p>Participants: 17 Locations: Ethiopia, Kenya, Malawi, Senegal, Tanzania, Uganda and Zambia</p> <ul style="list-style-type: none"> • Amref Health Africa representatives from Kenya, Tanzania, Uganda, Senegal, Ethiopia, Malawi and Zambia (10) • NGO representative (1) • County representatives (3) • Women (2) • Adolescents (1)
PAHO/WHO	Consultations with 100 young people from Latin America and the Caribbean, in informal focus groups, May-June 2020

ANNEX 2.

Illustrative examples of solutions and approaches used to address challenges across different countries

Mental health

- Communicating with friends and family; participating in family activities.
- Using digital tools and telephones to provide psychological support.
 - a. In Colombia, the digital platform SOS Sinculpa was used to provide services related to mental health and well-being.*
 - b. The trans community network in Colombia created support groups which, through WhatsApp and with the help of psychologists of the Red Feministas association, tend to the needs of the trans community throughout Colombia.
 - c. In India, helplines have replaced peer support and community forums which have been helpful in the past in reaching out to women and adolescents needing help and support to counter stress and anxiety.

Education

- During lockdown, alternative solutions were adopted to reach students without internet access.
 - a. In India, teachers reported using mobile phones to send messages to communicate with their students and provide guidance and counselling to those without access to the internet. The government increased its efforts to ensure inclusion of all students through traditional media channels. The educational channel of the national TV service, Doordarshan, broadcast classes. The informative and explanatory content can be accessed by anyone possessing a smartphone or computer. Videos of these classes are available in several languages. Teachers confirmed that the classes have proven beneficial and are helping many of their students.



- b. In order to boost resources for teaching, in July 2020, the Indian government released the “Pragyata” guidelines to support new online teaching methods.
- c. In Colombia, using traditional communication methods (printed pamphlets, phone calls), accessing public internet hotspots and granting students free access to phone data services helped many students overcome challenges posed by school closures.

Livelihoods and food security

- In India, government schemes launched during the COVID-19 period include the Jan Dhan Account (Financial Inclusion) initiative: direct cash transfers of Rs 500 (US\$ 6.8) into women's Jan Dhan accounts have proved useful to support families. The government is also providing free cooking gas cylinders through the Ujjwala Yojana initiative. Some income-generating activities to support women have also been established, such as the home gardening programme in Jharkhand.
- In India, the government implemented a stimulus package worth Rs 20 lakh crore (US\$ 265 billion) including: free cereal grains to the poor; cash to poor women

and the elderly; tax relief for small businesses; and incentives for domestic manufacturing. The cost of the combined package is roughly 10% of India's GDP, making it among the most substantial in the world, after those announced by the United States (13% of its GDP) and Japan (over 21% of its GDP).

- In India, to overcome issues caused by food shortages, the government introduced the Garib Kalyan relief package, which includes cash transfers and food provision.
- The Indian government introduced the “One Nation, One Ration” concept in its Public Distribution System, to ensure that food reaches the needy.
- The Kenyan government is providing tax relief (reduction of VAT, income and business tax) together with the Inua Jamii (Uplift Families) programme, which provides social security in the form of cash transfers to orphans and vulnerable children, the elderly, people with severe disabilities and people living in the arid northern counties.
- Civil society organizations (CSOs), humanitarian organizations, non-governmental organizations, frontline workers and self-help groups have been playing important roles in reaching affected families and marginalized groups.
 - a. In Nigeria, CSOs and philanthropic organizations have provided support to families, especially those displaced by the religious conflict in Kaduna state.
 - b. In Colombia, CSOs and community associations have provided essential food to families.
 - c. In India, CSOs, women's self-help groups and frontline workers have been distributing hygiene items, food items and cooked meals to families, especially children and pregnant and lactating women, through the Take Home Ration initiative. Elected women representatives have addressed issues related to limited access to the national distribution of rations, by identifying families without ration cards and finding alternative ways to include them.
- Government-led initiatives, such as food distribution interventions, food stamps and vouchers, were implemented during the height of lockdown. Those measures have been reported in India, Nigeria, South Africa and Uganda.

- In Colombia, people started to grow their own food as a mitigation strategy to adapt to the crisis. Indigenous populations highlighted the success of growing produce and sharing seeds, a practice that has adequately met the needs, not just of individuals, but of whole communities.

Health and SRHR services

- Digital technology, mobile phones and media have been important channels of support, guidance and information during lockdown.
 - a. In India, C3 organized regular telephone meetings about menstrual hygiene, sexually transmitted infections, etc. Elected women representatives had access to information on service availability and raised awareness about antenatal care and the importance of iron and folic acid supplementation for pregnant women.
 - b. Reports from Senegal have shown increased use of mHealth and eHealth platforms for monitoring appointments of women of reproductive age and children aged under 5.
- In Latin America, IPPFWHR has supported partner organizations in Argentina, Chile, Guatemala and Peru in developing platforms to provide online counselling and support to people with unplanned pregnancies.
- Reports have also confirmed the use of traditional media to provide health information and messages.
- The Ugandan Family Planning Consortium worked with Uganda's Ministry of Health to develop and disseminate family planning and SRHR messages on television and radio and in print media.
- In Latin America, messages and information about COVID-19 were disseminated through traditional media channels.
- Youth networks and CSOs have been active in responding to some of the SRH needs during lockdown. In Kenya, the Youth Act Network has been providing referrals for quality SRH services and distributing menstrual sanitary products to vulnerable girls and women in Kisumu.

- Ministries of Health in Kenya and Zambia issued protocols to guide continuity of essential maternal and newborn health services at health facilities and in communities during COVID-19. The protocols also aimed to ensure patients' and providers' safety and protection from COVID-19 infection.
- The Indian government released guidelines on "Enabling delivery of essential health services during the COVID-19 outbreak" on 14 April 2020. Its list of essential health services included: pregnancy care and management, newborn care and childhood illness management, immunization services, management of severe acute malnutrition in children, family planning services, comprehensive abortion care services and adolescent health services.
- In April 2020, India's Ministry of Health and Family Welfare issued guidelines declaring immunization an essential health service and instructing states to resume routine immunization services.
- In May 2020, the Indian government issued additional guidelines on rational use of personal protective equipment (PPE) for health-care workers and others in non-COVID treatment areas and hospitals with COVID blocks.
- In Kenya, Amref Health Africa partnered with the Kenya Health Federation to establish the Wheels for Life initiative, which brings together transport and essential service providers specifically for maternal health to ensure that women in need of maternal care or who are in labour can access services during both curfew and non-curfew hours.
- The Ministry of Health in Kenya developed new guidelines in response to COVID-19, focusing on the use of telemedicine and digital technology to provide medical care to women and girls.
- In Ethiopia, Amref has supported the implementation of the essential health services package set out in Ethiopia's national health guidelines.
- In Zambia, health facilities have a handwashing facility at each entrance. In some facilities visitors' temperature is taken, and social distancing is encouraged by health-care providers.
- In Kenya, menstrual health and hygiene practitioners are convened by the Ministry of Health's Hygiene Technical Working Group for joint advocacy planning and learning.
- Senegal is using innovative strategies to continue outreach activities. Health workers use technological platforms for monitoring appointments of women of reproductive age and children aged under 5. This is complemented by the creation and distribution of digital content by media and social networks.
- In Uganda, some organizations provide PPE, including face masks, on credit, enabling women to obtain face masks for their household members with a small deposit.

Violence, safety and agency

- Digital platforms (apps and WhatsApp) and helplines have been important means of reaching individuals suffering from violence.
 - a. In India, the National Commission for Women and various state governments advertised helpline numbers widely, including WhatsApp-based support services for reporting incidences of violence. In Bihar, the Bandhantod (Break the Bond) app reflected increased complaints of child marriage during lockdown, enabling it to be successfully addressed.
 - b. In several Latin American countries, "Purple" telephone helplines assisted women and girls who had experienced violence; in Brazil, tools such as the Partiu Papo Reto app were developed to support survivors of sexual and gender-based violence.
 - c. In Colombia, La Red Comunitaria Trans, a transgender community group, created an anti-discriminatory, anti-violence group on WhatsApp to support trans people during quarantine. This enables people to share their location and itinerary when they leave home, and to report any incidents of concern.
- In Colombia, teenagers and young women indicated that the tight social bonds between neighbours have been vital in generating community strategies of vigilance and mutual support. Neighbourhood meetings have established measures to protect residents, not only from COVID-19, but also from threats to their safety.

- In Ethiopia, Amref's Youth Advisory Parliament initiated an awareness-raising campaign on gender-based violence, with the motto "NO MORE VIOLENCE".
- In Kenya, Tunawiri, a grassroots gender justice movement, supports community networks to respond effectively to sexual and gender-based violence, through communication, advocacy and monitoring and evaluation. Tunawiri has uploaded a petition on change.org and mobilized grassroots organizations to support the campaign.



* An online platform providing services related to mental health and well-being. Services are also provided via phone or text messages free of charge.
<https://sites.google.com/sinculpa.com.co/sossinculpa/inicio>.

+ India's Rs 20 lakh crore COVID-19 relief package one among the largest in the world, Economic Times, 15 May 2020.
<https://economictimes.indiatimes.com/news/economy/finance/latest-stimulus-package-among-largest-in-the-world/articleshow/75701976.cms>

ANNEX 3.

Actions in response to challenges experienced by women and adolescents

The reports which form the base of this analysis provide more information about the actions described below.

Mental health and well-being

- Increase attention to mental health needs, especially those of women, children and adolescents.
- Allocate resources (financial and human) to ensure proper and equitable provision of psychosocial support and counselling.
- Sensitize training programmes targeting frontline and community health workers to enable them to identify people at risk and in need of help.
- Provide training and capacity building to teachers to enable them identify the emotional needs of schoolchildren and provide guidance and support to help them cope with stressful events and circumstances.
- Invest in online and offline tools for the provision of psychosocial services to ensure equitable and uninterrupted access to support in both stable and unstable circumstances. Examples include toll-free helplines and virtual support groups.
- Conduct awareness-raising campaigns during emergencies on mental health care, healthy lifestyles, recognizing feelings and sensations, managing grief and anxiety and establishing routines during isolation.
- Provide parents with information on how to create a supportive and safe home environment to help children and adolescents cope with isolation and stress.
- Support and promote entertainment, cultural and sporting activities that can be conducted safely during enforced isolation.



- Develop alternative methods for students to engage with peers during school closures and continue accessing informal opportunities for learning and development.

Education

- Develop and diversify educational modules for deployment in emergencies, replacing traditional teacher-centric education. Traditional media channels remain an effective tool and should continue to be used to ensure equitable access to education by overcoming digital divides and resource constraints.
- Invest in resourcing, training and enabling teachers to adapt their teaching methods in response to learning conditions during COVID-19, in order to maintain the continuity and quality of education services.
- Develop strategies, implement awareness-raising campaigns and outreach programmes and engage community organizations in promoting education, and address the issue of school drop-outs during lockdown, especially for girls. Those strategies could include providing scholarship programmes, school supplies and transportation costs.

Food security

- Continue providing food and nutrition beyond the short term, maintaining effective interventions to support vulnerable families and groups.
- Establish alternatives to replace school feeding programmes interrupted by school closures and support agricultural stimulus.
- Promote food delivery initiatives and the growing of food by households and communities.
- Create campaigns promoting healthy diets and proper nutrition, even for those with limited resources.

Livelihoods

- Develop gender-sensitive and inclusive social protection and income support measures to reduce the vulnerability of daily wage earners, farmers, workers in the informal sector and those living on the margins. These could include cash transfers, food stamps, small loans, vocational training and skills development programmes. Adolescent mothers must be recognized as a vulnerable population needing assistance from government support programmes.
- Ensure effective implementation of relief measures during the pandemic and equitable access to economic support.
- Spread awareness of and provide information on the availability and benefits of economic support schemes throughout the population.
- Engage self-help groups and community organizations to identify vulnerable women, children and adolescents who should be prioritized to receive support.
- Adopt tax and financial packages to stimulate small businesses, especially those run by women and young people.
- Invest in the agricultural sector and support agrarian supply chains, strengthen local producer-market links and develop channels to connect producers with

consumers, e.g. by promoting home deliveries, connecting farmers with distributors, and organizing small-scale local fairs (while limiting the number of consumers per hour to protect communities' health).

Health

- Ensure the uninterrupted provision of high-quality health services and supplies, and maintain access to health care for women, children, adolescents and other vulnerable groups.
- Promote the dissemination of public health information through digital and traditional communication channels.
- Increase investment in digital platforms and telemedicine tools to provide medical support and guidance outside of health facilities.
- Facilitate administrative procedures and establish channels for swift enrolment, generation of travel permits, medication approval and appointment scheduling.
- Ensure the safety and well-being of frontline health workers, including psychological support to help them cope with work-related stress, stigma and increased workloads.
- Provide PPE to vulnerable households with infected members, to protect their health and prevent virus transmission.
- Scale up training of health providers and community health workers, including training on prevention and control of COVID-19. Digital platforms could be utilized to reach greater numbers of health workers.

SRHR

- Adopt strategies to ensure the uninterrupted provision of SRH services and products, including for the most vulnerable. These may include outreach campaigns and access sites for free contraceptives.

- Ensure the continuity of health services during the transitioning of transgender and non-binary people, such as endocrine care (hormone replacement therapy).
- Make best use of traditional and digital media channels to spread awareness of SRH and the availability of services.
- Deploy frontline health workers to encourage access to regular services, including prenatal care, institutional deliveries, contraception and family planning and nutrition.
- Ensure availability and affordability of menstrual hygiene products. Free delivery of menstrual hygiene products to individuals living in remote areas or humanitarian settings should be considered.
- Secure and strengthen the supply chain of SRH products and medications to prevent shortages.
- Train health-care personnel, including midwives, on protocols for SRH services during COVID-19, ensuring care and respect for all people's decisions and rights.
- Support and empower community and youth networks to promote and expand reporting channels and access to protection during quarantine.
- Train and build the capacity of front-line, social and community health workers to detect and refer victims and to report cases of violence and abuse.
- Strengthen security and justice officials' capacity to investigate and prosecute acts of violence and emphasize their responsibility to do so.
- Increase the number of women police officers trained to work sensitively with women and adolescent girls needing help.
- Conduct campaigns to promote non-violent conflict resolution within families and provide them with tools to foster family ties and build a safe environment, including learning new skills together, home recreational and entertainment activities, anxiety and anger management and communication, etc.
- Reformulate and adapt traditional response mechanisms to provide victims of violence during lockdown with support and information on service availability. These could include toll-free helplines, support groups, referral pathways and online counselling, etc, and should be easily accessible and well resourced.

Violence, safety and agency

- Classify prevention and redressal services that reach out to women facing violence and distress as essential services and ensure they remain fully functional. These services should form an integral part of COVID-19 response plans.
- Ensure that laws governing gender-based violence are adhered to, and perpetrators are dealt with efficiently and promptly.
- Disseminate guidelines and advisories on all types of violence, and ensure that community-level organizations, CSOs and other bodies working on the ground are well informed.
- Increase community-level awareness of what constitutes gender-based violence, legal provisions and rights of victims, service availability and reporting mechanisms.
- Support and resource organizations responding to sexual and gender-based violence to continue supporting women and girls during and after the pandemic.
- Put in place mechanisms for collecting sex-disaggregated data, and conduct gender-responsive analysis to inform inclusive and comprehensive COVID-19 prevention, response and recovery strategies.
- Ensure that Preparedness and Response Plans include campaigns against FGM where needed and scale up anti-FGM campaigns during the pandemic. One approach would be to ensure that information about FGM is included in dignity kits, which can serve as an entry point for providing information and messages about gender-based violence and FGM.

ANNEX 4.

Further work in countries to amplify the voices of women and adolescents

Amref Health Africa

Training additional health workers is essential in order to minimize the impact of COVID-19 on already fragile health systems. Diverting resources away from non-COVID health concerns could put whole systems at risk of collapse. Amref has been training health workers in sub-Saharan Africa through its learning platform [Leap](#), which functions on basic mobile telephones without the need for internet connectivity.

Between March and May 2020, 50,000 health workers were trained via this platform, and more workers are enrolling to reach rural and remote areas in Kenya. Amref Health Africa and collaborators have trained community health workers to manage stress within households and to offer psychosocial support to those affected by the pandemic.

Multilingual key messaging about COVID-19 helps to reduce misinformation within communities. Health workers will also be shown how to identify, isolate and refer suspected cases and how to maintain safety standards at points of entry and other high-risk areas to prevent transmission.

An estimated 1,849,432 households have already been reached with key messages via Leap, which has been rolled out in Malawi and South Africa. Ethiopia's Ministry of Health has adopted it as its go-to mobile learning platform.

Amref Health Africa has worked with governments to support their response to the pandemic, participating in committees and helping facilities to offer safe and high-quality services. Amref has also supported advocacy efforts to ensure that appropriate policies are adopted and implemented. It has worked with other stakeholders in Kenya to facilitate women's access to services, even during curfew hours, through its Wheels for Life initiative.

Together with the Uganda Family Planning Consortium, Amref has developed family planning and SRHR messages, approved by Uganda's Ministry of Health,

for dissemination through television, radio and print media. These messages are available for use by all stakeholders. Amref also organized a youth-led webinar to propagate advocacy for SRHR.

Centre for Catalyzing Change (C3)

C3 has been supporting those worst affected by the COVID-19 pandemic, the poor, the marginalized and the vulnerable, and providing relief to those who need it most. C3 is working on the ground to support women and adolescent girls, and to understand the impacts of loss of livelihood and income, loss of access to sexual and reproductive health services and education opportunities, and the consequences of gender-based violence. C3 is working in the Indian state of Bihar to prevent stigma for both health workers and those with COVID-19, in line with a government initiative.

C3 has created a bank of audio and video messages which are being circulated among communities and families via digital platforms such as YouTube and WhatsApp and on community radio. They developed and curated content specifically for adolescent girls on issues affecting them during the COVID-19 pandemic, including on menstruation hygiene, resilience building and mental stress. C3 has also developed campaigns for Facebook and Twitter highlighting issues facing adolescent girls, as well as audio and video messages for pregnant women on preventive care and busting myths. The first phase of a chatbot was piloted on their website, providing answers to 450+ questions about coronavirus: in its first month, over 3000 queries were received.

C3's field staff are working with community members to raise awareness of issues such as gender-based violence and menstrual hygiene. They are supporting health workers and reducing the stigma associated with the pandemic.

C3 is using platforms such as Zoom and Google to provide technical support to groups, including teachers, and creating training content to strengthen the delivery and impact of projects such as training teachers in life skills.

Graça Machel Trust

The Graça Machel Trust conducted a virtual brainstorming session about possible responses to COVID-19, using an integrated approach and including all relevant stakeholders. Focus group discussions were held with stakeholders including community leaders, young people, sector specialists and private sector players.

The outcomes are being used to inform collective action in response to the pandemic. The brainstorming sessions also enabled the sharing of ideas from across the African continent to inform Graça Machel Trust's response to COVID-19. Additionally, using the analysis and the key outcomes of the Ilizwi campaign (The voice: African women and children shaping policy discourse of the COVID-19 pandemic response), the Graça Machel Trust has developed policy asks to be put to state and regional institutions and key stakeholders in order to ensure that the immediate and short-term responses and longer-term re-investments reflect the needs of women and adolescents, advancing gender equality and recognizing women's contributions to economic development.

International Planned Parenthood Federation, Western Hemisphere Region (IPPFWHR)

IPPFWHR has been working with partners in Argentina, Chile, Guatemala, Mexico and Peru, countries with strict restrictions on abortion, to develop online platforms providing information on unplanned pregnancies, reduction of risk and harm, SRHR and pregnancy termination. Those platforms also offer free online counselling, delivered by qualified counsellors trained by IPPFWHR.

IPPFWHR is also creating a regional centre for digital health- to respond to the SRH needs of adolescents, young people and women. A [platform](#) has been established that allows the geolocation of adolescent-friendly and rights-based SRH services in the Latin American region and provides online counselling to adolescents and young people. This platform is available as a web and mobile app. IPPFWHR is providing additional training to partner organizations in Latin America and the Caribbean to scale up information provision to young people in the region, in partnership with other bodies that have expertise in these fields.

IPPFWHR has undertaken activities in line with the broader strategy of guaranteeing education, particularly high-quality, inclusive and comprehensive sexuality education (CSE). These include: (a) teaching educators to use digital platforms to display CSE content; (b) developing digital CSE interventions; (c) [youth-led digital CSE campaigns](#), addressing topics raised by young people; (d) producing short animated videos on CSE, including one on isolation, for adolescents and young people; (e) establishing regional partnerships to respond to adolescents' and young peoples' emotional needs through the Collective Care initiative; and (f) running webinars and workshops on CSE for families, teachers and others.



Asociación Profamilia

Asociación Profamilia has established [a platform](#) in Colombia that provides essential mental health services conducted in Spanish. Mental health professionals can be contacted by adolescents, young people and women suffering depression or anxiety caused by COVID-19 and its consequences. All services are provided free of charge and are easily accessible via the web or telephone. Callers requiring specialized assistance are referred to telemedicine platforms.

Profamilia is running a programme, Valiente, supporting children and adolescents, particularly vulnerable groups in rural and marginalized areas with little access to the internet. It aims to empower young people to exercise their sexual and reproductive rights, and to reduce gender violence, gender stereotypes and teenage pregnancy. During lockdown, this support was made available on cell phones via text messages and WhatsApp.

Profamilia also launched the Brave at Home initiative, focused on maintaining contact with all its service users during lockdown and finding ways to disseminate information and support widely, leaving no one behind.

