RESTLESS DEVELOPMENT
POWERED BY YOUNG PEOPLE

# EXECUTIVE SUMMARY:
# SEXUAL HEALTH AND RIGHTS ADVOCACY IN THE FACE OF COVID-19

## OVERVIEW

Our previous research as part of the programme design shows that young women and adolescent girls (15-30 years) are disproportionately affected by discrimination, sexual violence, unplanned pregnancy, gender based violence; even more so when they are at the intersection of multiple stigmatised identities. Yet, SRH-R services including support in case of gender-based violence are often inaccessible to them because of costs and lack of understanding and sensitivity by service providers. Rightsholders told us that civil society plays a crucial role in pushing for an inclusive society that guarantees SRH-R for all. To support the youth civil society in this complex journey, the Community of Action needed to learn more.

In this research we listened to rightsholders in Lebanon, Guatemala, Mozambique, Uganda and Nigeria: to how CSO's adapted to meaningfully provide SRH-R services to young women whilst riding out the wave/ effects of the COVID-19 pandemic. We sought and listened to responses to 3 related questions:

1. What was young women's experience of SRH-R? What was it like pre COVID-19 compared to post COVID-19?
2. What was young women's involvement in SRH-R advocacy? What was their take on CSOs and policymakers/ duty bearers' involvement in SRH-R advocacy during the COVID-19 period?
3. What adaptive advocacy changes did CSOs come up with during the COVID-19 pandemic to address the SRH-R needs of young women? How effective were these changes?

# METHODOLOGY

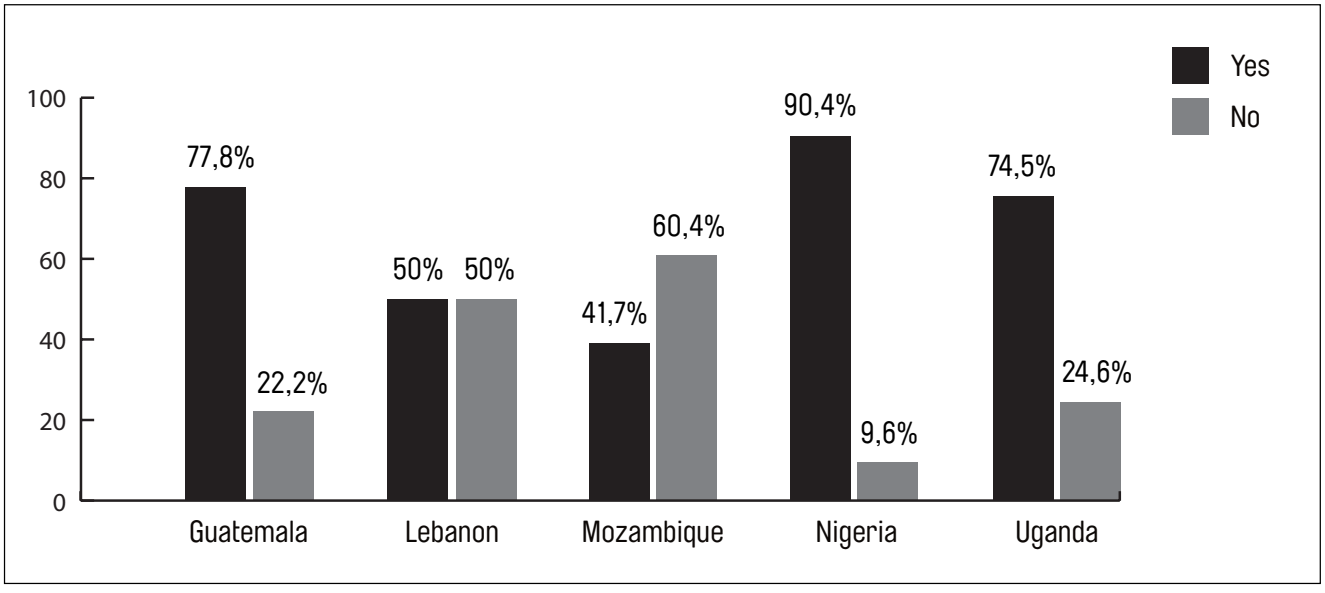
Grounded in Restless Development's participatory youth-led research approach, a diverse group of **11 vibrant youth researchers** from 5 countries collected data electronically using KoboCollect. Mixed methods approach was used to gather data both virtual interviews via phone calls and in-person interviews were done. The youth researchers built great rapport with the rightsholders which enabled them to get detailed accounts of experiences and opinions from the rightsholders. Qualitative methods enabled us to capture understandings, perspectives and detailed experiences of 227 young women assessing emerging patterns and trends of certain observations.

**Setting the framework** → **Designing the questions** → **Collecting the data** → **Analysing the findings** → **Conducting validation exercises** → **Sharing to catalyse discussion and action**

# KEY FINDINGS

There is still a lack of systematic knowledge about which initiatives work in practice especially in Mozambique where there were 41.7% of respondents who had knowledge on sexual and reproductive health and rights. While in Lebanon, the proportion was 50%, which provides COAs with a basis to ensure that more is done around SRH-R education guidelines and decisions at both the local and national levels. In Guatemala, Uganda and Nigeria 67.5% had knowledge of their SRH-R expressing that it was *"all decisions you make about your own body should be yours"*. The highest level of SRH-R related knowledge was about pregnancy and the least was about contraception.

**Figure. Rightsholders responses on their knowledge of their SRH-R.**



**33%**

**encountered barriers preventing them from receiving information and services around SRH-R**

**46%**

**felt the pandemic worsened their experience in accessing healthcare**

**65%**

**of young woman didn't participate in advocacy work**

# Here is what we learned:

Young women described social norms which included being stigmatized for being sexually active and SRH-R laws and policies including limiting access to contraceptives as being particularly restrictive. A third (33%) of rightsholders agreed to having encountered barriers preventing them from receiving information and services around SRH-R. Disruption of social services, sexual and gender-based violence, the lack of formal sources of information, stock out of drugs and contraceptives, the long journeys to health facilities and lack of affordable transport options were all accessibility and availability challenges young women encountered. Young women with disabilities and young LBTI women in particular faced discriminatory attitudes from health care professionals. The fear of contracting COVID-19 coupled with COVID-19 lockdown restrictions (mainly travel restrictions) kept young women away from seeking basic SRH-R services and left nearly half (46%) feeling the pandemic worsened their experience in accessing healthcare.

**Young women recognised CSOs' successful SRH-R campaigns and actions noting adaptive advocacy strategies CSOs made towards addressing their SRH-R needs.**

Majority of the young women (65%) however, didn't participate in this advocacy work highlighting a lack of training and forums to engage in implementing advocacy actions. Even so, those who participated in advocacy work were part of multidisciplinary groups working primarily at grassroot levels (as peer educators, camp coordinators, counsellors).

Young women also appreciated joint CSO initiatives and the work they did, recognizing these had an impact in terms of discussing SRH-R needs within their communities though the young women felt they needed to do more as per taking action on these identified SRH-R needs. The findings show that there is a need for CSO movements/joint initiatives to address a range of issues surrounding the current advocacy efforts around SRH-R. Some of the notable issues include: the retrogression in policy development in SRH-R; disjoined CSOs working on SRH-R and the invisible powers opposing the progressive realisation of SRH-R.

**The push vis-a-vis pull attitude of policy makers/ duty bearers towards addressing the SRH-R needs of young women was disheartening.**

Young women decried the lack of support and involvement from duty bearers/ decision makers in addressing their SRH-R needs especially in Lebanon, Guatemala and Mozambique. Policy makers actions towards young women's SRH-R were mainly being driven by advocacy from CSOs and rarely of their own will.

**Better SRH-R health outcomes for rightsholders are attainable through available, accessible, acceptable, and quality SRH-R information and services.**

The findings showed that providing young women and girls with the means to attain high standards of health, in ways that ensure equality, non-discrimination, privacy, and confidentiality, is an integral part of respecting and protecting globally accepted human rights.

## MOZAMBIQUE

Same-sex sexual conduct was decriminalized in Mozambique in 2015. The legal framework includes sexual orientation as grounds for employment equality and non-discrimination at the workplace.[1] Despite this enabling environment, LGBTI persons still face stigma and discrimination.

Child marriage is another widespread issue in Mozambique, with the country having one of the highest rates of early marriage in the world with almost 50% of girls married before the age of 18 years. Child marriages force girls to drop out of school, exposes them to violence (physical, sexual and psychological), early sex and STIs including HIV/AIDS, and drastic life changes including childbirth and motherhood. To curb this, Mozambique introduced Law No. 19/2019, making it illegal to marry or enter into union prematurely or before the age of 18.[2]

During Covid, the government partnered with civil society, by creating an enabling environment for the work of CSOs, the response to the spread of COVID-19 was much more effective. This was highlighted by the COAs, where they successfully partnered with the ministry of health to promote awareness about COVID-19, using social media and other communication channels like radio to reach vulnerable and excluded groups around COVID-19 and SRH information.

The work of the COAs therefore should aim to continue raising awareness on the negative aspects of child marriage and to change the gender norms and practices that drive child marriage. There's a need to educate girls and keep them in school, as well as encourage communities to speak up for girls' rights. They should also aim at campaigns against stigma and discrimination against LGBTI persons since they have an enabling environment to do this.

## NIGERIA

Based on the findings, 55% of the respondents accessed SRH-R services in the IDP Primary Health Care centres which had been the efforts of the COA's and other CSO's. According to the Alma Ata Declaration of health for all by 2020 and beyond, Primary Health Care centres are community based at the grassroots level designed to provide essential care made universally accessible and at a cost the individuals, families and communities can afford. The findings also showed that most of the services like contraceptives, menstrual kits were not readily available and if they were, cost of purchase or such services seemed huge, expensive and non-affordable. This is because most of the rightsholders have little or no economic activity they engage in as a means of livelihood.

People-led, mutual responses were key during the pandemic. COA's ensured they worked together with their own neighbourhoods, schools and individuals to meet the needs of vulnerable people, and those most at risk of infection, sharing community resources

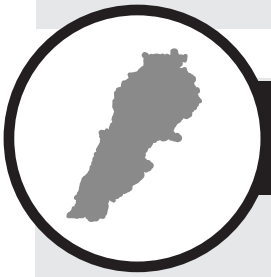
Empowered CAOs can effectively advocate for the implementation of reproductive health policies and programmes. Emphasis on the need for evidence on the nature, extent, and implications of discrepancies between national legislation on the age of consent to SRH-R services and the age at marriage, which are topical issues on the continent. The key informants highlighted the need for research to track the extent of implementation of existing laws, policies and strategies/guidelines, at regional, subregional and country levels.

## UGANDA

The findings show that 42% out of 57 respondents in Uganda were young women and girls with disabilities who face financial, social, and psychological barriers to accessing adequate reproductive healthcare. Even before the COVID-19 pandemic, accessing SRH-R care was more challenging for young women and girls with disabilities as compared to other persons for several reasons. The healthcare equipment and facilities in SRH-R settings are often not physically accessible or located near the homes of women with disabilities, without accessible and affordable transportation options, and healthcare providers may demonstrate a lack of sensitivity, courtesy, and support for them.

To enhance SRH-R services among girls and young women with disabilities, all SRH-R programmes need to be intentional about integrating young women and girls with disabilities. Most persons with disabilities can benefit from inclusion by SRH-R programmes designed to reach the general community. There is a need for the COA to monitor closely and follow up the government efforts to promote inclusive health care for PWDs through various health programmes and projects (MFPED, 2019). This would provide accountability for good governance around addressing the needs of PWD's. The Uganda National Social Protection Policy (2015) which established a set of strategies to mitigate the barriers and hindrances of PWD's access SRH services, in line with existing human rights commitments need to be put into more practice. The COA can ensure that they use these strategies in their advocacy activities in the communities.

Furthermore, the Persons with Disability Act 2020 – which was restarted by the Ministry of Gender, Labour and Social Development in 2019, prioritizes areas of focus such as accessibility, participation, capacity building, awareness raising, prevention and management of disabilities, care and support, socio-economic security, research, communication (sign language, tactile and Braille literacy) and budgeting. These need to be reinforced at all levels starting from community level to national level in all sectors to make sure that all legislation and regulations affecting SRH-R reflect the needs of persons with disability.



## LEBANON

58% out of 40 of the rightsholders interviewed were young women affected by displacement and 70% of them had never accessed SRH-R services.

***"I think the society that I live in, I didn't even know that SRH-R exists..."*** **a young woman affected by displacement in Lebanon detailed.**

Findings highlight that while young women and girls affected by displacement experience similar barriers to SRH-R as other rightsholders, many of these barriers are exacerbated by the refugee context. There is a need for the COA to come up with protection strategies for young women and girls affected by displacement such as moving in groups, while 50% of adolescents' girls with disabilities requested to be taught empowerment-based activities to increase their autonomy and decision-making in relation to SRH-R.

***"They should search for disabled people and give them a chance to get more information on all SRH-R topics. They can be more innovative, inciting more people to talk about these things and feel more safe and included."*** **a 24 year old young woman with disabilities from Lebanon shared.**

While antenatal, mental health and HIV-related services were available, these services were not designed for young women and girls, which discouraged them from utilizing services and confiding in service providers hence including the training of health service providers to respond to the specific SRH-R needs of all rightsholders.

## GUATEMALA

The findings showed that 70% of rightsholder groups suffer from poor quality SRH-R services. Service providers often behave in a discriminatory way towards LBTI women.

***"They discriminate against many of us LBTI women, assuming we are HIV positive."*** **said a young woman from Guatemala.**

To address this, COAs in Guatemala need to actively campaign against this discriminatory and unfair policy to all key policymakers. There is a need to address sociocultural norms and improve communication between young women and girls with their parents to facilitate an open attitude towards talking about SRH-R which can assist young people and their families to navigate the differing socio-cultural attitudes.

To overcome these challenges, the COAs need to employ several strategies, including linking their strategies to legal accountability, budgetary expenditures, or other institutionalized processes; taking steps to ensure inclusion, including consultation with excluded or stigmatized groups; (all rightsholders) throughout the program design and implementation process; specific outreach and support to integrating rightsholders into program activities; and the creation of separate spaces to ensure confidentiality and safety.

# CONCLUSIONS

Providing young women and girls with the means to attain high standards of health, in ways that ensure equality, non-discrimination, privacy, and confidentiality, is an integral part of respecting and protecting globally accepted human rights.[3] Ensuring that rightsholders have access to sexual and reproductive health services requires extending the availability, accessibility, acceptability, and quality of the information and the services.

The range of interventions suggested included strengthening the enabling environment, and providing information and services and support programs or organisations to build resilience and assets.

Generally, health systems and individuals can take a number of actions to safeguard reproductive health. These actions differ from many other health interventions in that the motivation for their use is not necessarily limited to better health but involves cultural and societal norms. Programs to improve life skills and build resilience to risk factors among adolescents have shown promising results.[4]

It is therefore important that interventions focus on building protective factors to promote success rather than eliminating factors associated with failure, which should include a mix of community awareness and engagement of community leaders; assistance to link rightsholder with significant adults in their lives, most notably parents, religious traditional leaders; provision of safe spaces for rightsholders; and provision of information, services, and the building of skills.

# RECOMMENDATIONS

More effort around multi-tiered structures and the selection and representation of young women and girls from community to national levels, primarily the key mechanisms involving young women and girls in SRH-R policymaking processes are geared up especially in Lebanon, Guatemala and Nigeria.

Within joint CSO initiatives, there's need to broaden the understanding of collaborative accountability, promote scale-up of best practices, strengthen capacity of local CSOs to implement effective accountability efforts, and ensure that recent and reliable country-specific SRH-R data is accessible to local advocates.

Key in implementation by CSOs is addressing the limited appreciation of the broader context of issues on SRH-R amongst key stakeholders through primarily training of policymakers/ duty bearers.

Community based interventions for strengthening young women SRH-R; The joint initiatives and movements like in Lebanon, Guatemala, and Mozambique should look into having Integration of SRH-R services into the community health system as this can help make the SRH-R services compatible with the local structures and thus appropriate and accessible by both young women and girls.[5]

Practical lessons for bringing policy makers on board in SRH-R research; the need to translate research into policy, i.e., making research findings a driving force in agenda-setting and policy change, is increasingly acknowledged. However, little is known about translation mechanisms in the field of sexual and reproductive health (SRH-R). Therefore, there will be a need for the COA to ensure that there is an early and steady involvement of policymakers in research to have a common context, creating locally-adapted responses which are deemed key to overcoming SRH-R issues.

# NEXT STEPS

Building on the findings of this study, it is important that governments, private sector, and development practitioners meaningfully engage young women and girls, including those in rural areas in policy conversations from the community level to the national level. Their engagement must not focus on mere participation but should intentionally seek to incorporate their SRH-R needs into the next round of policies and policy implementation.

# ACKNOWLEDGEMENTS

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IMAGE CAPTIONS:

Cover: Shadiah Namuwaya, a respondent, shares with Rahma Nansubuga, a youth researcher, during a research session conducted in Kampala, Uganda.

Page 2: Rahma Nansubuga, a youth researcher with the *We Lead* programme, interviews Namagembe Kaneema, a respondent, during a research session in Kampala, Uganda.

Page 3: Image 1: Notes taken by Namaganda Flavia, a youth researcher, during a research session. Image 2: Ligia María Destephen Lavaire, a COAF facilitator in Honduras.

Page 6: Noerine Naigaga, a respondent, shares with a youth researcher during a research session in Uganda.

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[3] UNFPA 2020

[4] Kanesathasan and others 2018

[5] Hallfors D, Cho H, Rusakaniko S, Iritani B, Mapfumo J, Halpern C. Supporting adolescent orphan girls to stay in school as HIV risk prevention: evidence from a randomized controlled trial in Zimbabwe. Am J Public Health. 2015; 101:1082–8.

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