

# THE IMPACT OF COVID-19 ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS:

Youth-led Perspectives and Solutions for a Gender-Equal World



# **TABLE OF CONTENTS**

Acknowledgements  Acronyms/Abbreviations  Glossary of Key Terms  Executive Summary  Introduction  Conceptual Framework		3
		4
		5
		6
		10
		11
Meth	odology	12
Back	ground and Context	15
Key F		17
Α.	Macro Level: Impacts of the COVID-19 Pandemic on SRHR and Health Systems	17
В.	Meso Level: Impacts of the COVID-19 Pandemic on Social Norms, Stigma, Discrimination, and GBV	24
C.	Individual Level: Impacts of the COVID-19 Pandemic on Girls' and Women's Access and Demand for SRHR Services, Information, and Products	29
Conc	clusions and Policy Recommendations	34
Refe	rences	43
Photo References		46
	Annex A: Further Details on Methodology	47
	Annex B: Research Questionnaires	49
	Annex C: Women Deliver Young Leader Co-Facilitator Biographies	52
	Annex D: List of Youth Advocate Research Participants	53

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Women Deliver is a leading global advocate that champions gender equality and the health and rights of girls and women, in all their intersecting identities. Through its advocacy, Women Deliver drives investment — political and financial — to improve the lives of girls and women worldwide. The organization harnesses evidence and unites diverse voices to spark commitment to gender equality. Anchored in sexual and reproductive health, we advocate for the rights of girls and women across every aspect of their lives.

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# **ACRONYMS/ABBREVIATIONS**

AGIP ----- Adolescent Girls Investment Plan

ASRH ..... Adolescent sexual and reproductive health

AYSRHR ---- Adolescent and youth sexual and reproductive health and rights

AUC-WGDD ...... African Union's Women, Gender, and Development Directorate

CEFM ..... Child, early, and forced marriage

CSE ----- Comprehensive sexuality education

Civil society organization

**EAC** East African Community

FGD ----- Focus group discussion

FGM----- Female genital mutilation

GBV Gender-based violence

GFF Global Financing Facility

HIV ..... Human immunodeficiency virus

HIV/AIDS Human immunodeficiency virus/acquired immunodeficiency syndrome

**ILO** ..... International Labour Organization

IPC ..... Interpersonal communication

IPPF ..... International Planned Parenthood Federation

KELIN ...... Kenya Legal & Ethical Issues Network on HIV and AIDS

KII ---- Key informant interview

LGBTQIA+ Lesbian, gay, bisexual, transgender, queer, intersex, asexual. The plus symbol (+)

represents a number of different gender identities and sexual orientations that are

not already present in the lettered acronym

LMICs ----- Low- and middle- income countries

MSF----- Médecins Sans Frontières

NGO ----- Non-governmental organization

PSI A360 Population Services International Adolescents 360

RMCAH Reproductive, maternal, child, and adolescent health

RMNCH ----- Reproductive, maternal, newborn, and child health

SBC ---- Social and behavior change

**SRH** Sexual and reproductive health

SRHR----- Sexual and reproductive health and rights

SRMNCAH ...... Sexual, reproductive, maternal, newborn, child, and adolescent health

**STI** Sexually transmitted infection

UHC ----- Universal health coverage

UNFPA ----- United Nations Population Fund

WEI ----- Women Enabled International

WHO ---- World Health Organization

# **GLOSSARY OF KEY TERMS**

#### **Adolescents:**

Individuals between 10 and 19 years of age.1

#### **Key informants:**

Global- and national-level experts who were interviewed for this study and who are working at the intersection of gender equality, SRHR, and COVID-19 recovery and response, including on evidence-generation and implementation measures.

#### Meaningful youth engagement and co-leadership:

A transformative, intentional process in which adolescents and youth are in positions of power and leadership alongside other stakeholders who may be traditional power-holders. This includes power to design and create policies, programs, and initiatives, to make decisions and set agendas, and to hold leaders and decision-makers accountable. As part of this process, adolescents and youth are provided with adequate and fair financial compensation in recognition of their expertise and energy, and with any technical or capacity support needed to be successful in their role. Lastly, an enabling and inclusive environment is created such that adolescents and youth are seen as experts and treated with respect as equals. Robust safeguarding ensures the mental, emotional, and physical safety of adolescents and youth; that information is shared in a transparent, timely, and youth-friendly way; and that youth engagement and co-leadership is integrated into the design or structure of a process at its conception.

#### Sexual and reproductive health (SRH):

The Guttmacher-Lancet Commission defines SRH as "physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity." SRHR topics include contraceptive services, sexually transmitted infection (STI) care, the prevention and treatment of HIV/AIDS, sexual education, abortion care, issues associated with gender-based violence (GBV), and general sexual health and wellbeing. The study explores different elements of SRHR as they emerge in primary and secondary data. The definition of SRHR is based on the tenet that sexual and reproductive health depends, in part, on the realization of the rights that support it.

#### Sexual and reproductive health and rights (SRHR):

The ability of an individual to make their own choice as it relates to their sexual and reproductive health.

#### Youth:

Individuals between 15 and 30 years of age.

#### Youth advocates:

Throughout the report, the term "youth advocates" is used to refer to the youth who participated in this research, including Women Deliver Young Leaders and youth engaged in SRHR advocacy outside of the Young Leaders Program.

#### **Women Deliver Young Leaders:**

Women Deliver Young Leaders are part of the Women Deliver Young Leaders Program, which connects young advocates with the platforms, people, and resources needed to amplify their influence on a larger scale in service of gender equality, with a strong focus on SRHR. The Young Leaders Program is open to advocates between 15 and 29 years of age.

<sup>1</sup> WHO. https://www.who.int/health-topics/adolescent-health#tab=tab\_1. Accessed April 25, 2022

<sup>2</sup> Accelerate Progress: Sexual and Reproductive Rights for All - Executive Summary," Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights, 2018, accessed April 7, 2022, https://www.guttmacher.org/guttmacher-lancet-commission/accelerate

# **EXECUTIVE SUMMARY**

The COVID-19 pandemic has had a disproportionate impact on girls and women, in all their intersecting identities, and has deepened existing gender inequalities worldwide. The realization of girls' and women's sexual and reproductive health and rights (SRHR) has been profoundly affected. This study is one of the first of its kind to directly highlight the first-hand experiences, insights, and perspectives of adolescents and youth on the gendered impact of the COVID-19 pandemic on SRHR. Specifically, this study examines the effects of the pandemic on access to SRHR services, information, and products in low- and middle-income countries (LMICs), with a particular focus on India, Kenya, and Nigeria.

The insights and perspectives of adolescents and youth are often absent from global evidence reviews. Throughout each phase of this study, Women Deliver intentionally compared the insights and perspectives of adolescent and youth to the global evidence base by gathering qualitative stories from youth advocates in India, Kenya, and Nigeria.

# APPROACH AND METHODOLOGY

The study brings together global evidence, data, and critical insights from global and national experts working on gender equality, SRHR, youth, and/or COVID-19 response and recovery, and youth advocates engaged in the Women Deliver Young Leaders Program and other youth networks in LMICs and beyond. This report is catered to gender equality and SRHR advocates, decision-makers in government and the private sector, implementing partners, and policymakers.

This study was carried out through a combination of secondary data analysis and primary qualitative data collection. Specifically, a desk review of literature on SRHR and the COVID-19 pandemic in LMICs informed the development of data collection tools. Subsequently, interviews were conducted with key informants working at the intersection of gender equality, SRHR, and COVID-19 recovery and response. Interviews and a focus group discussion were also conducted with youth advocates from India, Kenya, and Nigeria. Finally, a validation workshop was held with youth advocates from LMICs in order to validate the study's findings and generate policy recommendations.

Women Deliver Young Leaders were deeply involved in co-creating and co-designing the study, including in co-facilitating the above-mentioned focus group discussion and validation workshop. This further enabled meaningful youth engagement and co-leadership throughout the research process.

### **KEY FINDINGS**

The study generated key findings that highlight challenges and barriers to accessing SRHR. At a structural or systems level, the study explored the impact of COVID-19 on the health sector as well as government and policy responses to address the pandemic's adverse effects on SRHR. At the community level, the study examined data and evidence on how the pandemic may have impacted social and gender-based norms, the incidence of gender-based violence (GBV) and other harmful practices, as well as stigma and discrimination experienced when accessing SRHR services, information, and products. At the individual level, the study explored how the pandemic has altered individuals' access to and demand for SRHR services, information, and products.

1.

The ripple effects of deprioritizing SRHR were felt globally

There were multiple and interrelated SRHR challenges that emerged during COVID-19 due to the deprioritization of SRHR before and during the pandemic. These challenges have been noted globally and have manifested, for example, in the disruption of contraceptive and safe abortion services. Youth advocates reinforced that reproductive health was sidelined and seen as non-essential in many contexts in order to prioritize pandemic response.

2.

Under-resourced health systems were hard hit

Under-resourced health systems struggled to maintain and provide sexual and reproductive (SRH) services before the pandemic. During the pandemic, critical funds were diverted away from girls' and women's health. Girls and women of every age, and particularly youth, struggled to access essential SRHR services, information, and products. While gaps in SRHR policies existed pre-pandemic, insights from youth advocates reinforced how a lack of investment in SRHR and gaps between policies and implementation were compounded during the pandemic.

3.

Non-state actors stepped up to fill gaps

The pandemic heightened the dependency of governments on non-state actors, who played a critical role in filling new and existing gaps and delivering essential SRH services throughout the pandemic. Youth advocates highlighted that non-governmental organizations (NGOs), especially international NGOs, were essential for upholding SRHR in communities by providing essential SRH services. Youth advocates also noted that local civil society organizations (CSOs) are essential to advocating for SRHR and holding governments accountable because of their deep understanding of local needs and realities.

4.

Marginalized girls and women were most affected by the pandemic and related policy responses Girls' and women's rights were restricted during the pandemic, limiting their decision-making power in the household and hindering their ability to realize their SRHR. Adolescent married girls and women living with disabilities faced more violence, discrimination, and barriers to accessing SRHR services, information, and products. Many youth advocates highlighted how during – and even prior to the pandemic – stigma and discrimination around accessing SRH services and information prevented adolescents and youth from seeking the services and information they needed.

5.

As gender-based violence increased, pandemic restrictions severely limited GBV services

Despite its global prevalence, GBV has been one of the most neglected outcomes of the pandemic. The study highlights a dangerous inverse relationship that emerged during the pandemic: as the global incidence of GBV increased, GBV-related prevention and support services decreased. Youth advocates reinforced that GBV increased during the pandemic, putting adolescents and youth, and particularly young girls and women, at risk owing to an inability to access essential protection services and social networks. They emphasized how pre-existing harmful social norms and gender inequalities, economic and social stress induced by the COVID-19 pandemic, and restricted movement and social isolation measures, led to an increase in GBV.

6.

COVID-19 had a negative impact on SRHR outcomes for girls and women

The pandemic negatively impacted people's ability to access SRHR services, information, and products. Additional barriers to accessing SRHR services, information, and products resulted in an increase in maternal deaths and unintended pregnancies. Many youth advocates shared that there was an increase in unintended pregnancies in their community during the pandemic owing to difficulties accessing and purchasing SRH services and contraception, respectively.

7.

The use of digital technologies to access SRHR increased during the pandemic, but left many excluded due to the digital divide

International and local NGOs increased their reliance on digital technologies to facilitate access to SRHR during the pandemic, and many adolescents and youth accessed online sources to obtain SRHR information and SRH services owing to movement restrictions, school and university closures, and out of fear of contracting COVID-19. Digital technologies were effective in disseminating SRHR information, but did not reach those without access to digital technologies — who are often already experiencing discrimination and marginalization. Youth advocates also revealed that organizations and models based on digital technology were effective in disseminating SRHR information, but were often inaccessible for hard-to-reach and low-income communities.

### **CONCLUSIONS AND POLICY RECOMMENDATIONS**

Worsening SRHR have been both a cause and a consequence of increased gender inequalities. This study analyzes global evidence of the impact of COVID-19 on SRHR and highlights youth's first-hand experiences and perspectives. The evidence points to multiple and diverse intersecting impacts at the structural, community, and individual level.

As COVID-19 threatens to reverse important gains in SRHR, while also widening existing disparities, it is crucial that stakeholders, including governments, donors, the private sector, and CSOs, recognize the disproportionate impact of the pandemic on girls and women, in all their intersecting identities. As part of this process, it is important to ensure that adolescents and youth have meaningful roles in shaping program, policy, and research initiatives. Their involvement is crucial to ensuring that SRHR programs and policies are relevant and sustainable.

The study outlines six policy recommendations, co-created by youth advocates, for stakeholders responsible for strengthening and upholding SRHR in emergency and non-emergency contexts, including pandemic response and recovery. The recommendations, below, are intended for diverse stakeholders, including governments, CSOs, and the private sector.

#### **POLICY RECOMMENDATIONS AT A GLANCE**

Ensure SRHR as an integral component of universal health coverage and resilient health systems.

Ensure adequate and fully protected budgetary allocation for SRHR, along with the society and youth-led budget advocacy.

Increase and maintain strong political and financial support for civil society partners that engage in SRHR service delivery and advocacy.

Ensure the financing and delivery of comprehensive, integrated, and survivor-centered gender-based violence prevention and response services for girls and women, in all their intersecting identities.

Maintain adolescent and youth-friendly SRHR services, particularly in emergency

contexts, in order to ensure continued access for those who face multiple barriers.

The use of digital technologies to disseminate and distribute SRHR services, information, and products must be combined with efforts to address the gendered digital divide.

## INTRODUCTION

The COVID-19 pandemic has had a disproportionate impact on girls and women, in all their intersecting identities, and has deepened existing gender inequalities worldwide. During the pandemic, access to critical and lifesaving sexual and reproductive health (SRH) services was severely curtailed, particularly in low- and middle-income countries (LMICs). Health sector supply issues coupled with disruptions in public transportation, stay-at-home orders, and school closures posed significant challenges for girls and women, and marginalized populations seeking sexual and reproductive health and rights (SRHR) services, information, and products. Adolescents and youth, who experience additional barriers and increased stigma when accessing SRH services, have been the hardest hit in many contexts. For example, pandemic-related lockdowns have exacerbated challenges related to autonomy, age, and access to youth-friendly services, negatively impacting reproductive health (Nanda, Tandon, and Khanna, 2020).

Restrictions on SRHR services, driven by the disruption of prevention programs and economic downturns during the pandemic, have had a devastating effect on SRHR outcomes for girls and women, and have led to an increase in unintended pregnancies, maternal deaths, and unsafe abortion (Lancet Global Health, 2020; UNFPA, 2021). The COVID-19 pandemic has been accompanied by a shadow pandemic: gender-based violence (GBV), including an increase in female genital mutilation (FGM) and child, early, and forced marriage (CEFM). These two pandemics have interacted to violate and limit girls' rights, choices, and prospects (UN Women, 2021).

This study explores the impact of the pandemic on SRHR, with a particular focus on youth and LMICs. In carrying out this study, a first of its kind, Women Deliver sought to contribute a youth perspective to the global evidence base by gathering qualitative stories from youth advocates concerning their experiences, insights, and perspectives on the gendered impact of COVID-19 on SRHR. Specifically, this study examines the effects of the pandemic on access to SRHR services, information, and products in LMICs, with a particular focus on India, Kenya, and Nigeria.

Designed for gender equality and SRHR advocates, decision-makers in government and the private sector, implementing partners, and policymakers, this report brings together global evidence and data with critical insights from key practitioners and youth advocates engaged in the Women Deliver Young Leaders Program and other youth networks.

#### The report is made up of five sections.

- Section 1 describes the conceptual framework that informed the study's design.
- Section 2 provides an overview of the study's methodology, including limitations.
- Section 3 offers background and context to support with understanding the framing and key findings of this study.
- **Section 4** presents the study's key findings.
- Section 5 presents conclusions and key policy recommendations for advancing SRHR in current and future pandemics.



# **SECTION 1:**

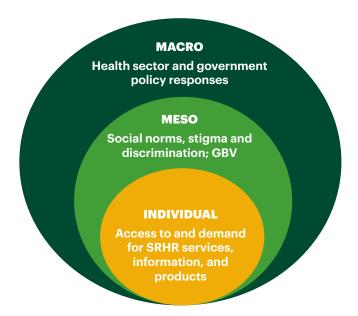
### **CONCEPTUAL FRAMEWORK**

# SOCIOECOLOGICAL FRAMEWORK

The study was guided by a socioecological framework, which considers SRHR outcomes as being influenced by a complex interplay of individual, household, community, and systems/structural factors. The framework conceptualizes SRHR as a comprehensive, integrated, and interdependent set of civil, political, economic, social, and cultural human rights. This framework helps break down factors that act as barriers or enablers to achieving SRHR in the context of the COVID-19 pandemic. The framework also highlights power dynamics, structures, and systems that reinforce gender inequalities.

The framework focuses on three levels of interacting enablers and constraints (see Figure 1). The macro level encompasses the health sector and government policy responses. The meso level includes gender and social norms, stigma and discrimination, and GBV. The individual level focuses on access to and demand for SRHR services, information, and products. The conceptual framework informed the overall design of this study, including research questions, data collection tools, and data analysis. The framework also supported an examination of how barriers at each level may have been exacerbated by the pandemic, and how factors at the macro and meso level interact to constrain individual level access. For example, at the individual level, an adolescent girl may face challenges buying menstrual products due to a decrease in availability and rising prices (macro-level factors); these barriers may result in increased social stigma due to the need to collect SRH products from centralized distribution points (a mesolevel factor).

FIGURE 1: Socioecological framework for breaking down the impact of COVID-19 on SRHR



# **SECTION 2: METHODOLOGY**

The section below describes the primary and secondary research phases that informed this study. Further details on the methodology can be found in Annex A.

### **RESEARCH QUESTIONS**

The study was designed to explore the following three questions:



#### 1. Macro level:

How has the COVID-19 pandemic impacted SRH-related health systems and supply chains?



#### 2. Meso level:

What has been the impact of the pandemic on social norms, discrimination, and stigma in relation to accessing SRHR services, information, and products?



#### 3. Individual level:

How has the COVID-19 pandemic impacted demand and access to SRHR services, information, and products?

### **DATA COLLECTION AND ANALYSIS**

i. Rapid desk-based review of global literature on the impact of COVID-19 on SRHR in LMICs (Primarily July - November 2021)

A rapid desk review was carried out prior to primary data collection to narrow the scope of the study, define research questions, and inform the design of data collection tools. The research team conducted a quick review of available evidence on the research topic and identified key search terms. Search terms used included: 'sexual and reproductive health' and 'covid'. The rapid desk review also included countryfocused searches using the aforementioned terms and the following countries: India, Kenya, and Nigeria. In total, over 100 documents were reviewed primarily between July and November 2021, and some thereafter, including published literature (academic and grey) available online. Relevant documents, in English, were identified through open-source search engines and databases, including Google and Google Scholar. The study's key findings were developed from a synthesis of published literature, and have been validated by key informants.

ii. Primary qualitative research with youth advocates in India, Kenya, and Nigeria, as well as key informants (September 2021-March 2022)

The research questions used in the primary qualitative data collection phase of this study were formulated using the findings of the rapid-desk based review described above. Qualitative data collection enabled Women Deliver to gather rich youth and expert perspectives on the study's three research questions. In-depth, semi-structured interviews were conducted with nine key informants working at the intersection of gender equality, SRHR, youth, and COVID-19 recovery and response, including on evidence-generation and implementation measures. In addition, in-depth, semi-structured interviews were conducted with 15 youth advocates from India, Kenya, and Nigeria. These interviews posed open-ended questions, which enabled the experts, including youth experts, who participated in this study to speak to their own lived experiences and views on the impact of the pandemic on SRHR.

Finally, a focus group discussion was held with nine youth advocates from Kenya and Nigeria, for further reflections (see Annex B for further details on the research questionnaires used for data gather).

#### iii. Validation and co-creation workshop with youth advocates (March 2022)

A validation workshop engaged 13 youth advocates from India, Kenya, Nigeria, and other LMICs to: 1) elicit feedback on the research, 2) discuss and validate key findings, and 3) shape policy recommendations. The process of translating research findings into key messages and developing policy and advocacy recommendations is a challenging one. This interactive validation workshop, co-led by two Women Deliver Young Leaders and the research team, also served as a capacity strengthening opportunity for youth to learn about this process in a participatory and empowering way.

The validation workshop had two main objectives. First, the workshop sought to validate the seven key findings that emerged from the study. The workshop gave youth advocates an opportunity to review each key finding and to validate its relevance and whether or not it warranted a policy advocacy

recommendation, as well the criteria being used to inform their decisions. Youth advocates were encouraged to consider the factors underpinning their reasoning, the policy and/or legal frameworks that impact SRHR in their context, as well as the sociopolitical and cultural factors shaping their perspective. Youth advocates then began formulating policy recommendations toward better prioritizing and integrating SRHR as an essential component of health service delivery during pandemic response and recovery. In developing the policy recommendations, youth advocates were guided through an in-depth process involving three discrete steps: 1) identifying the SRHR-related policy problems or challenges, 2) identifying the actions needed to address the problems or challenges, and 3) identifying the target audience for each recommendation. Inputs were then brought forward to finalize policy recommendations

#### iv. Peer review (April 2022)

This study has been peer reviewed by three representatives of organizations focused on gender equality, SRHR, youth, and/or COVID-19 response and recovery, in order to further validate findings and policy recommendations (see Annex A for further details on research methodology).

#### SAMPLING

The sampling for this qualitative research was purposeful (neither random nor representative). A set of key informants that could speak to the research questions in a meaningful way and offer insights to validate, challenge, or complement the published literature used in the study was identified. Youth with expertise and a background in SRHR advocacy from the three focus countries (India, Kenya, and Nigeria) were identified through the Women Deliver Young Leaders Program. Following this, Women Deliver reached out to youth advocates from the Adolescent Girls Investment Plan (AGIP) and the Coalition for Adolescent Girls via an expression of interest application form. The overall recruitment process identified a significant number of youth from Kenya and Nigeria, but a limited number from India. Thirteen youth - from India, Kenya, Lithuania, Nigeria, Liberia, Uganda, and the Philippines - were recruited for the validation workshop. Several workshop participants also took part

in the primary data collection phase of the study. In total, 46 participants (key informants and youth advocates) contributed to the study.



#### **CO-CREATING RESEARCH WITH YOUTH ADVOCATES**

To ensure that youth advocates were engaged as co-creators in this research, two Women Deliver Young Leaders, Liz Guantai from Kenya and Isaac Iyinoluwa Olufadewa from Nigeria, were significantly involved in co-designing this study. Liz and Isaac worked with the research team from September 2021 to March 2022 to design research questionnaires and to co-facilitate a focus group discussion and a workshop to validate key findings and policy recommendations. Co-designing the research with Liz and Isaac ensured that the research design, including questions and data collection tools, were designed with and by youth engaged in SRHR policy advocacy, and particularly those living in LMIC contexts. Youth engagement was critical to eliciting the perspectives of youth advocates during the validation workshop and to understanding where there was convergence and divergence among youth around the study's key findings. An important part of this process involved establishing a supportive atmosphere for youth advocates to interact with each other and to respond to research questions. Liz and Isaac played a lead role in facilitating the validation workshop, including by supporting the formulation of policy recommendations. Their biographies can be found in Annex C, and a full list of study participants can be found in Annex D.

#### **LIMITATIONS**

The desk review was conducted as a rapid scan of existing evidence on how the COVID-19 pandemic has impacted SRHR of girls, women, and marginalized populations in LMICs. This was not a systematic review. The study's primary qualitative research included a sample of 33 participants, is not statistically representative, and is not intended to provide a comprehensive picture of the views of adolescents and youth in India, Kenya, and Nigeria. Rather, this research provides a snapshot of the insights and perspectives of adolescents and youth, which, more often than not, are absent from global evidence reviews.

To the extent possible, the findings presented in this report are analyzed using an intersectional lens. The research sought to understand how marginalized populations were impacted by the pandemic and whether they experienced compounded challenges. However, the experiences of the most marginalized populations, for example, lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) individuals, are often hidden within available data and evidence on the impact of COVID-19 on SRHR. Further,

while some of the interviews carried out highlighted how specific socioeconomic groups experience significant challenges in accessing SRH services, not all participants were able to offer an intersectional perspective or analysis. Throughout this report, we have sought to highlight gaps in evidence relating to hard-to-reach groups. These gaps warrant further research.



## **SECTION 3:**

### **BACKGROUND AND CONTEXT**

The COVID-19 pandemic significantly impacted health systems and supply chains globally. During the initial phases of the pandemic, data collected by the World Health Organization (WHO) in five regions between March and June 2020 reveals that almost all countries (90 percent) experienced disruptions to their health services, with LMICs reporting the greatest difficulties (WHO, 2020a). Family planning services were reported as being one of the most disrupted areas. Sixty-eight percent of countries in the global WHO-led survey reported disruptions (WHO, 2020a). Overall, disruptions to health services were the result of both supply and demand factors. For example, in 2020, the cancellation of elective services was the most reported factor (66 percent), followed by staff redeployment, the unavailability of services due to closings, and interruptions in the supply of medical equipment and health products (WHO, 2020b).

According to the third round of the WHO's global pulse survey on the continuity of health services during the COVID-19 pandemic, despite early evidence of service recovery, nearly all countries were still affected by the COVID-19 pandemic, with 92 percent of 129 countries reporting some kind of disruption at the end of 2021. This was similarly reported in the WHO's first and second global pulse surveys. Across all three global pulse surveys, some improvement across most health areas, including sexual, reproductive, maternal, newborn, child, and adolescent health (SRMNCAH) was reported: 33 percent of countries reported disruptions in round three (Q4 2021), compared to 37 percent in round two (Q1 2021), and 55 percent in round one (Q3 2020). Despite some improvement, health systems are still not recovering or transitioning beyond the acute phase of the pandemic, and COVID-19 continues to disrupt health services in almost all countries (WHO, 2022).

In 2021, the most reported supply side factors were modifications to service delivery and access, and challenges related to the health workforce and supply chain (WHO, 2021). Moreover, disruptions in logistics and supply chains have impacted the provision of medicines, including contraception (UN Women, 2020 in CARE,

2020a; Quintela, 2020 in Dasgupta et al., 2020; IPPF(a), 2020, Purdy, 2020, and UNFPA (b), 2020 in Pratt and Frost, 2020; UNICEF in Center for Reproductive Rights, 2020b) and medicines such as antiretroviral therapy for people living with HIV (Both et al., n.d.). The pandemic caused disruptions at all functional levels of the SRH supply chain including manufacturing, freight and logistics, procurement, and service delivery (UN Women, 2020 in CARE, 2020a). At the healthcare facility level, movement restrictions also created operational challenges for providers and health staff (Church, Gassner, and Elliot, 2020), while negatively impacting people's ability to access SRH services (MSI, 2020a).

Pandemic restrictions and supply chain disruptions exacerbated and undermined healthcare delivery from both public sector and private providers. These providers include schools and universities, which serve as critical conduits for youth to access health services, and non-profit and non-governmental organizations (NGOs) that play a critical role in filling gaps and strengthening health systems in LMICs. COVID-19 protocols also disrupted private service provision, including SRH services that are provided by MSI, International Planned Parenthood Federation (IPPF), and Médecins Sans Frontières (MSF) (MSI, 2020, IPPF, 2020, Purdy, 2020 in Riley et al., 2020; Church, Gassner, and Elliot, 2020; IPPF, 2020; IPPF(b), 2020 in Pratt and Frost 2020; UNFPA, 2020 in Fotheringham, Gill, and Brown, 2020). MSI experienced operational and managerial challenges as large numbers of both support and frontline staff were unable to work due to movement restrictions, illness, family demands, or poor internet connectivity. Moreover, movement restrictions impacted the ability of frontline providers to reach the most vulnerable with SRH services (Church, Gassner, and Elliot 2020). The closure of schools and universities, including youth-friendly health centers, further restricted adolescents' and youth access to SRHR services, information, and products (UNESCO, 2021). Overall, the COVID-19 pandemic exposed how health systems lack the resilience to address a pandemic without significant losses in SRH services (Dasgupta et al., 2020).

The COVID-19 pandemic has exposed the deeply rooted health and social disparities that impact the most marginalized and vulnerable populations. A lack of access to health services, including SRH services — exacerbated by the pandemic and restrictive policies — has perpetuated and deepened inequitable health outcomes for the most marginalized populations. Service disruptions, lockdowns, and restrictions on movement have disproportionately affected girls and women, in all their intersecting identities, and particularly adolescents, people living with disabilities, sexual or ethnic/racial minorities, refugees, and immigrants. A global survey conducted by the International Labour Organization (ILO) found that the pandemic has had

a disproportionate impact on adolescents and youth, particularly young women from LMICs (ILO, 2020). A Rutgers International survey of 2,700 adolescents and youth from Ghana, Indonesia, Kenya, Nepal, Uganda, and Zimbabwe concluded that the indirect impacts of COVID-19 have made adolescents and youth, particularly those at risk before the pandemic, more vulnerable. The pandemic has disrupted all aspects of adolescents' and youth's lives, including their access to youth-friendly SRH services (Both, Castle, and Hensen 2021). Although some evidence has shown that COVID-19 has had a disproportionate impact on marginalized and vulnerable populations, more research is needed to understand barriers in different contexts (Mukherjee et al., 2021).



## **SECTION 4: KEY FINDINGS**

The findings below are organized around the conceptual framework used for the study (See Section 1 for further details). At the macro level, the report explores the impact of COVID-19 on the health sector as well as government and policy responses to address the pandemic's adverse effects on SRHR. At the meso level, the report explores data and evidence on how COVID-19 may have impacted social and gender-based norms, stigma, and discrimination as it relates to access to SRHR services, information, and products. At the individual level, the review explores evidence of how the pandemic has altered access to, and demand for, SRHR services, information, and products. In each section, key findings are supported by the global evidence base and supplemented by primary research from youth advocates and global experts.

### MACRO LEVEL: HOW HAS THE COVID-19 PANDEMIC IMPACTED SRH-RELATED HEALTH SYSTEMS AND SUPPLY CHAINS?

In this section, we explore the impact of COVID-19 on the health sector, as well as government and policy responses to address the pandemic's adverse effects on SRHR.

### **KEY FINDING 1: THE RIPPLE EFFECTS OF DEPRIORITIZING SRHR WERE FELT GLOBALLY**

There were multiple and interrelated SRHR challenges that emerged during COVID-19, due to the deprioritization of SRHR. These challenges have been noted globally and have manifested, for example, in the disruption of contraceptive services. Adolescents and youth have been some of the hardest hit. When responding to the pandemic, governments excluded crucial services such as safe abortion, contraception for adolescents, and outreach programs within national policies and plans to address the SRH needs of marginalized populations (Dasgupta et al., 2020). These omissions have been documented across countries with differing income levels and health systems, exposing a global lack of prioritization, attention, and funding for SRH-related services and programs (Benova et al., 2020). Similarly, safe abortion services were affected. For example, clinics in many LMICs shut down due to strict lockdowns and were unable to provide safe abortion and post-abortion care services; in Ethiopia's second largest hospital, safe abortion services and comprehensive abortion care services reduced by 16.4 percent and 20.3 percent, respectively (Banke-Thomas, 2021). In Nepal, the number of women who visited the largest teaching

hospital for safe abortion services during lockdown was 47 percent lower than after movement restrictions were lifted in the country (Banke-Thomas, 2021). A Marie-Stopes International (MSI) survey commissioned in India showed that awareness of available abortion services decreased from 61 percent before to 44 percent during the pandemic (Banke-Thomas and Yaya, 2021).

In Kenya, many barriers impacted the safeguarding of SRHR during the pandemic. Many of the county health centers that served as primary sources of family planning services were closed. Research involving GBV and SRH service providers found that in counties with high incidences of COVID-19, such as Nairobi and Mombasa, SRH services were disrupted, health facilities were converted into quarantine centers, and healthcare workers were redeployed to COVID-19 guarantine and isolation centers (Columbia University Mailman School



of Public Health, 2020). Over half of young women (52 percent) reported challenges procuring menstrual health products due to a lack of money (45 percent) (Decker et al., 2021). Similar findings were reported by Plan International (2020), who found that there have been severe shortages of menstrual health management products and services in LMICs during the pandemic, as well as an increase in the prices of pads and tampons, due to the limited supply of sanitary products and the general inflation of prices. Insights from key informant interviews (KIIs) in Kenya highlighted how gaps in safe abortion provision were exacerbated during the pandemic:



Another gap in policy was on access to safe and legal abortion - we know this is a huge problem for women. A significant portion of problems with unsafe abortion is with women 19-24 years. When we brought this to the government's attention, they were not responsive. We were in court over this. We have a hearing in a few weeks."

- Key informant, Kenya

In Nigeria, a reduction in reproductive, maternal, child, and adolescent health (RMCAH) services was noted. Before the lockdown, between 76 and 97

percent of the primary health centers offered RMCAH services. Except in antenatal, delivery, and adolescent care, Adelekan et al. (2021) noted a decline of between two and six percent in all RMCAH services offered during the lockdown and up to a 10 percent decline in services offered after the lockdown. A key informant from Nigeria further added that:



During the lockdown, there was little accessibility. There were reported cases of harassment, rape cases, teenage pregnancies, HIV — only to mention a few disruptions."

- Key informant, Nigeria

In India, the pandemic led to disruptions in SRH services, with a notable impact on access to contraceptives. The Foundation for Reproductive Health Services, India, estimated that 26 million couples would be unable to access contraceptives in India, and disruptions could lead to an additional 2.3 million unintended pregnancies and 800,000 unsafe abortions (Economic Times in Center for Reproductive Rights, 2020b). In India, the government stopped exporting all progesterone-based products, which had a significant impact on the global supply of intrauterine devices (Pratt and Frost, 2020). A key informant in India elaborated:



During the lockdown, entire attention went to COVID[-19] prevention and response. Frontline healthcare workers were focused on COVID[-19] awareness and they stopped carrying family planning kits with them. This was particularly relevant in [sic] first round of pandemic. Service providers only looking [sic] at COVID[-19]. Health centers were not very open for family planning support and counseling services. This caused a lot of increase in unmet need for family planning."

- Key informant, India

Although SRHR was deprioritized globally, there are cases where health systems responded to girls' and women's SRHR needs. In Uganda, the government collaborated with development partners to protect women's access to maternity services and to provide access to more SRHR

information and services. The government also recruited an additional 200 healthcare workers to reduce pressure on its healthcare system and to ensure the delivery of routine services like family planning. Though a temporary decrease in the use of family planning by Ugandan women, aged 15-19, was recorded in April and May 2020, there was sustained increase in use throughout the remainder of 2020, reinforcing the strength of Uganda's overall healthcare system (Makumbi et al., 2021). In Nepal, in the early months of the pandemic, the government endorsed interim guidance to deliver reproductive, maternal, newborn, and child health (RMNCH) services in the pandemic. The guidance included how to access related services, including emergency services for newborns and child-bearing persons; protect staff, newborns, and pregnant persons from COVID-19; and ensure the continued supply of commodities and equipment to provide related services. Nepal's Ministry of Health and Population, Family Welfare Division, also launched a tollfree number for SRHR services and information during the pandemic and operated in government hospitals and in health facilities of the Family Planning Association of Nepal (Center for Reproductive Rights, 2020a).

#### Youth advocates reinforced the challenges that emerged owing to the deprioritization of SRHR as part of COVID-19 response efforts.

- "The government is focusing more on COVID[-19] and is ignoring the health of girls. The state of girl child's health was bad before but now it is worse. They are moving funds that were supposed to be for girls' and women's health to COVID[-19]." - Youth advocate, Nigeria
- "Any existing machinery in SRHR/public delivery was diverted [to] COVID[-19] immediate relief causing further disruptions and adding to the burden of SRHR delivery." - Youth advocate, India
- "There is a need for policymakers that make policies for SRHR services for [adolescents and youth]. This will mean limited disruption [for adolescents and youth] even during a pandemic. We need good policies in place that protect adolescents and youth access to SRHR."- Youth advocate, Kenya
- "During the pandemic there were lockdowns [and] you could not go to hospital. SRHR were not considered emergency [sic] - they were considered pleasure" - Youth advocate, Focus Group Discussion
- "On contraceptive care, non-emergency services were suspended because they were not considered life threatening. People were discouraged from coming to hospitals, which were the hotbed of COVID[-19]." - Youth advocate, Nigeria
- "Reproductive health and women's health become secondary, no one cares about it. All health infrastructure diverted to COVID[-19]. SRH got crushed - the issues and stories did not come out. Women were unable to access abortion or contraceptives. Basic maternal health suffered." - Youth advocate, Nigeria



Under-resourced health systems that grappled with the continued provision and maintenance of SRH services were especially hard hit during the COVID-19 pandemic. Critical funds were diverted from girls' and women's health to the COVID-19 response. In LMICs, SRHR are an area that has long been poorly resourced, and has regularly faced significant political opposition. SRHR are often not included within essential packages of services or within universal health coverage (UHC) (Samuels and Daigle, 2021). The pandemic has exposed weaknesses in under-resourced health systems, including the continued provision and maintenance of SRH services during times of crisis. The pandemic placed additional strain on healthcare systems, many of which were already overburdened and under-resourced. The vulnerabilities and critical healthcare concerns of highrisk population groups, including youth, often went unaddressed (Ameyaw et al., 2021).

Budget advocacy is crucial to advancing SRH service delivery, with determining factors being both the allocations of funds and the release of funds. While participatory and consultative SRHR public policymaking is important for developing policies that uphold SRHR,

these policies must be backed with fiscal resources to advance implementation. A historical lack of investment in realizing SRHR contributed to shortfalls in SRH service delivery during the COVID-19 pandemic. A key informant from Kenya added:



If I look at Kenya, those issues [have] always been there and [the] pandemic made them worse. Health facility coverage was never sufficient. Healthcare workers were already stretched...Budget allocations have shifted to respond to COVID[-19] and other health needs were not prioritized. If there was [a] health facility with youth friendly services, they are now prioritizing COVID[-19] response. Service provision has been drastically disrupted"

-Key informant, Kenya



While gaps in SRHR policies existed pre-pandemic, insights from youth advocates reinforce how a lack of investment in SRHR and gaps between policies and implementation were compounded during the pandemic.

Youth advocates highlighted how funds were diverted from girls' and women's health to the COVID-19 response. They described how, prior to the pandemic, despite concerted advocacy and lobbying efforts to create and action adolescent and youth-friendly SRHR policies, many policies were never implemented due to a lack of political commitment and insufficient budgetary resources. In Kenya, youth advocates noted that many county health centers that serve as primary sources of family planning services were closed.

"One of the challenges that we have noticed is a shift in SRHR funds. Governments created a supplementary budget that redirects from reproductive, maternal, newborn, and child health (RMNCH) towards COVID[-19]. There was little to no priority given to SRHR - it [became] a 'nonissue.'- Youth advocate, Kenya

Youth advocates collectively emphasized that SRHR policymaking is only one piece of the solution fiscal resources determine SRHR implementation. While budget advocacy is important for advancing SRHR service delivery, both the allocation and release of funds are also essential.

- "Government must invest in healthcare. COVID[-19] has revealed to all nations even if we lose everything, we should not lose our health systems." - Youth advocate, Nigeria
- "In Nigeria, the budgetary allocation to SRHR was minimal, so the pandemic worsen[ed] the situation, as policymakers were forced to reallocate resources to fight the pandemic." - Youth advocate, Nigeria
- "Unfortunately, most of the government in Northern Nigeria does not consider adolescent sexual and reproductive health (ASRH) as a need or a concern...The government does not consider adolescent and sexual and reproductive health as a health issue that needs to be considered or budgeted for." - Youth advocate, Nigeria



### **KEY FINDING 3:**

### **NON-STATE ACTORS STEPPED UP TO FILL GAPS**

The pandemic exacerbated the dependency of governments on non-state actors, who played a critical role in filling new and existing gaps and delivering essential SRH services throughout the pandemic. In a majority of LMICs, governments are responsible for providing healthcare to their citizens, even when they are not the sole provider. Beyond the public sector, there are many non-state health actors, including NGOs, civil society organizations (CSOs), religious institutions, individual care providers, shopkeepers, and broader private sector actors, that provide SRHR services, information, and products. These actors played a crucial role in filling gaps in service provision during the COVID-19 pandemic.3 For example, in Madagascar, MSI Reproductive Choices negotiated with the government and accessed government permits to allow their buses to deliver services to women in their homes and to transport women to health facilities. In Uganda, the MSI Reproductive Choices team set up a pilot project, in partnership with the United Nations Population Fund (UNFPA), to deliver healthcare products using the SafeBoda ride-hailing mobile app. The app enabled women to order contraceptives and have them delivered to their door by motorcycles, known as 'boda bodas' (MSI, 2020b). Despite the benefits of innovative initiatives, a dependence on NGOs to meet sexual and reproductive needs and rights is not a sustainable or viable long-term solution. This point was reinforced by key informants in India and Nigeria:



SRHR is [sic] very deprioritized point for the community to be bothered about...Only very dedicated organizations worked on [adolescents and youth] SRHR. Civil society organizations raised the need for SRHR with government through media or print media."

-Key informant, India



There is a lot that hinges on the presence of international partners, like FP2030. It's one thing to have a policy, and another to implement and support. There are beautiful policies, technical meetings etc., but the gaps are in delivery. That is where we step in. We provide some complementary services, but we cannot cover all...we are only able to provide mobile clinics... Non-state actors have stepped in to close the gap, CARE has been very forward in providing services."

-Key informant, Nigeria

Within this report, NGOs, in particular international NGOs, are conceptualized differently than local CSOs. Research participants highlighted the importance of differentiating between the advocacy and service delivery role of CSOs and international NGOs. Local CSO were observed by research participants to be particularly important in representing and championing local needs and realities as concerns SRHR.



Youth advocates highlighted that non-state actors were essential for upholding SRHR in communities by providing essential SRH services.

A youth advocate from Nigeria noted that while organizations such as Pathfinder were "doing their best to reach communities and grassroots organizations, there is not much that we can do without the government."

Youth advocates noted that NGOs, especially international NGOs and local CSOs, have overlapping but distinct roles to play in strengthening access to and upholding SRHR. While youth advocates noted that international NGOs were critical in addressing SRH service delivery gaps, local CSOs have a deep understanding of local needs and realities and are essential for advocating for SRHR and holding governments accountable for SRH service delivery.

- "AMREF Kenya supported the formulation of a county specific policy in Siaya County to ensure [adolescents and youth]'s access to SRHR are not interrupted during the pandemic."- Youth advocate, Kenya
- "Any immediate and long-term visioning is currently coming from CSOs in SRHR, even through advocacy." - Youth advocate, India



### MESO LEVEL: WHAT HAS BEEN THE IMPACT OF THE PANDEMIC ON SOCIAL NORMS, DISCRIMINATION, AND STIGMA IN RELATION TO ACCESS TO SRHR INFORMATION PRODUCTS AND SERVICES?

This section explores data and evidence on how the COVID-19 pandemic may have impacted social and gender-based norms, stigma, and discrimination. These meso-level findings further highlight the ways in which the pandemic has impacted adolescent and youth SRHR and increased vulnerability to GBV and other harmful practices.

### **KEY FINDING 4: MARGINALIZED GIRLS AND WOMEN** WERE MOST AFFECTED BY THE PANDEMIC AND RELATED **POLICY RESPONSES**

There is evidence showing that the pandemic has exacerbated gender inequalities and vulnerabilities. This has impacted girls' and women's - and particularly married adolescent girls' ability - to access SRHR services. In Nigeria, during the pandemic, 79 percent of married adolescent girls experienced a loss of control over their own healthcare decision-making (Taiwo et al., 2020). For example, some married adolescent girls were denied access to SRH services and faced pressure to become pregnant. Husbands sometimes withheld contraceptives or resorted to physical abuse, such as beating, to force their wives to cooperate. For many married adolescent girls, decisions around when to access healthcare during lockdowns were made by their husbands, who exercised authority in granting or not granting access to sexual and reproductive health. Sixty-seven percent of married adolescent girls reported that their husbands prevented them from accessing healthcare without seeking prior

permission and would punish them if they did so (Taiwo et al., 2020).

In some contexts, girls and women living with disabilities, who needed to access SRH services, products, and information, were treated poorly and dismissively by healthcare providers, which led them to avoid accessing further care (UNFPA, 2021a). Healthcare providers did not always offer persons living with disabilities an opportunity to make informed decisions about their SRHR (UNFPA, 2021a). For example, a woman living with a disability from India shared that when she went to a gynecological appointment, the hospital staff were afraid she would expose them to COVID-19, as it was difficult to sanitize her wheelchair completely. These discriminatory attitudes and behaviors influenced her decision to forgo treatment for a serious gynecological condition (WEI, n.d.).

Many youth advocates highlighted how during – and even prior to the pandemic – stigma and discrimination around accessing SRH services and information prevented adolescents and youth from seeking the services and information they needed.

In health facilities, stigma manifested in shaming, scolding, and excessive questioning by healthcare providers, and sometimes refusal of service.

- A youth advocate from Nigeria shared, "Many government officials are sensitized, but community people are not. Primary healthcare attitudes and the attitudes of health service providers is a problem. If the health service provider is in the church choir or your mother's friend, you know it will get back to your mother. At the community level the cultural norms and religious bias is a problem."
- A youth advocate in India explained, "There are primary health clinics to access these services. These are not very popular among [adolescents and youth], because of taboos associated with contraceptives and gynecological services. [They are] embarrassed or ashamed to access... even if in their community. They might consider going further away, so that people cannot identify them."

Youth advocates highlighted how factors such as poverty, religion, culture, and disability all shape the way that stigma and discrimination are perceived, anticipated, or experienced.

- A youth advocate from Nigeria reinforced the challenges overcoming stigma and discrimination when accessing family planning: "We have two different perspectives and after training, they give unbiased services, but some still believe it is not the right thing to do to give unmarried [adolescents and youth] access to contraceptives. It goes against the religion of Islam. We still have some providers who believe that providing adolescent sexual and reproductive health (ASRH) services is not good for them."
- During the pandemic, stigma and discrimination was compounded, as highlighted by a youth advocate in Nigeria, "There
  has been a lot of harassment by law enforcement if you leave your house. This made it even more challenging for
  women to access services."
- Another youth advocate in Nigeria added, "[The] pandemic worsened the situation for [adolescents and youth] in Northern Nigeria because of limited primary healthcare sites. Facilities were closing and there was already stigma for [adolescents and youth] to access SRH services. People would go and find facilities locked. They would be told there are no commodities and no health providers around... The society is conservative, and a majority are Muslim, so it is very hard for [adolescents and youth]. We are trying to make family planning [sic] a social norm. We are working with religious leaders to impart information on services and say it is not prohibited and to integrate messages into their services."





Despite its global prevalence, GBV has been one of the most neglected outcomes of the pandemic (UN Women, 2020). The research highlights a dangerous inverse relationship that emerged during the pandemic: as the global incidence of GBV increased, GBVrelated prevention and response services decreased. Furthermore, marginalized groups, including people living with disabilities, faced increased risk factors for GBV and compounded barriers to accessing GBV support services, police, and justice mechanisms during the pandemic (UNFPA, 2021a).

Extended confinement measures and restrictions on movement in most countries across the globe, compounded by economic and social stresses brought on by the pandemic, coincide with increased rates of GBV globally (UN Women, 2021). The pandemic worsened harmful gender practices, significantly increasing rates of GBV, child marriage, and FGM. Calls to domestic violence and GBV hotlines increased by 25 to 111 percent in some countries, and essential support services became harder to reach. Adolescent girls are particularly at risk of experiencing GBV during times of crisis due to being pulled out of school, not being able to access SRH information and services, and being forced to marry early. Ten million more girls are at risk of becoming child brides by 2030, and with COVID-19 disrupting attempts to intervene, an additional two million cases of FGM are expected in the same time span (Harvey, 2021).

UNFPA projections suggest that due to the disruption of programmes to prevent FGM during the pandemic, two million additional cases of FGM might occur over the next decade (The Lancet Public Health, 2021).

At the same time, globally, pandemic-related health sector disruptions impacted the availability of services for GBV survivors (UN Women, 2020 in AUC-WGDD et al., 2020; Peterman et al., 2020 in AUC-WGDD et al., 2020). For example, in Kenya, during the first two weeks of April 2020, there was a 35 percent increase in GBV cases and a 50 percent increase in violence against girls (World Vision, 2020b in Rafaeli and Hutchinson, 2020). The East African Community (EAC) Partner States reported a significant increase in the number of GBV cases in the East African region. Ministries responsible for gender equality across the region documented a 48 percent increase in GBV cases reported to the police or via GBV toll-free lines. According to Kenya's National Council on the Administration of Justice, there was a significant spike in sexual offences in many parts of the country. Research and evidence show that, in Kenya, just under half of adolescent girls felt more vulnerable to sexual harassment and violence during the pandemic (44 percent) than before the pandemic (Both et al., n.d.). Movement restrictions in Nairobi have also made it harder for GBV survivors to seek help (Lakam, Singh, and Abdi, 2021, accessed on 21 Jul 2021).

In India, research conducted by MSI Reproductive Choices & Ipsos MORI found that one in 10 women surveyed reported needing domestic abuse services during the pandemic (MSI, 2020b). The research also found that there has been an increase in child marriage, adolescent pregnancy, and FGM (UNFPA, 2020b).

A key informant from India noted that in India, GBV increased as migrant men returned home and subjected their wives to intimate partner violence.

"There was a huge return of migrants (men) who returned home. The demand for sexual encounters increased and bodily autonomy curtailed during this time. There were a lot of issues of sexual violence. Support system for violence also broke down. Either you have a family level system or you go to the legal system where you approach the police. In our patriarchal scenario, partner violence is not considered violence. The police were responding only to COVID-19."





Youth advocates reinforced that GBV increased during the pandemic, putting adolescents and youth, and particularly young girls and women, at risk owing to an inability to access essential protection services and social networks. They emphasized how pre-existing harmful social norms and gender inequalities, economic and social stress induced by the COVID-19 pandemic, and restricted movement and social isolation measures, led to an increase in GBV in their respective contexts.

Youth advocates shared, for example, how before the pandemic, school was an escape for some young girls and women who endured GBV at home, and how school closures in the context of national lockdowns increased girls' vulnerability.

- A youth advocate in Nigeria noted, "The health system is not strong in Nigeria... For example, support services and clinics for teen mothers were closed. GBV centers were closed down. SRHR was receiving little or no attention."
- A youth advocate in Kenya described how sexual and GBV cases increased due to school closures and families and relatives spending increased time at home together.
- "We don't know the impact on other vulnerable communities such as migrants/LGBTQ[IA]+/ refugees etc." - Youth advocate, India
- "It will be hard to determine the extent of this problem, but girls and women struggled to get access to services due to other related barriers in addition to the pandemic-imposed barriers in Nigeria." - Youth advocate, Nigeria
- "In Nigeria, data about GBV is still not strong enough, as many cases go unreported, but there w[ere] many reported incidence[s] of GBV during the pandemic." - Youth advocate, Nigeria
- "This was observed in Nigeria as there were more media reports on [GBV] during the pandemic." - Youth advocate, Nigeria

Youth advocates from India discussed how the police in India are not receptive to addressing GBV, and the implications that this has for combating GBV.

"Increased incidence has been reported in India, however, not translating into police reports as is the trend, rendering visibility a challenge. Interruptions in daily lives meant reduction in access to GBV allied services." - Youth advocate, India



### **INDIVIDUAL LEVEL:** HOW HAS THE COVID-19 PANDEMIC IMPACTED DEMAND AND ACCESS TO SRHR INFORMATION, PRODUCTS, AND SERVICES?

This section explores evidence of how macro and meso-level factors have contributed to impacts at the micro level on individual access to and demand for SRHR services, information, and products and the impact on SRHR outcomes.

### **KEY FINDING 6: COVID-19 HAD A NEGATIVE IMPACT** ON SRHR OUTCOMES FOR GIRLS AND WOMEN

The pandemic and related policy responses have been shown to have a negative effect on the accessibility of SRHR services, information, and products. (Larki et al., 2021). This lack of access experienced during the pandemic has resulted in an increase in maternal deaths and unintended pregnancies. Barriers identified in accessing SRH services in Nigeria include women and girls not being able to leave their houses during the lockdown, lack of transportation, a lack of affordability, and a lack of SRH services due to lockdowns (Balogun et al., 2021; GFF, 2020 in UNFPA, 2021b). As a result of multiple and interconnected barriers, evidence shows that girls' and women's access to SRHR services, information, and products was negatively impacted by the pandemic. For example, a systematic review and meta-analysis of 40 studies done on maternal and perinatal outcomes concluded that global maternal and fetal outcomes worsened during the COVID-19 pandemic, with a significant increase in maternal deaths, stillbirths, ruptured ectopic pregnancies, and maternal depression during the pandemic. The data reveal considerable disparities in health outcomes between high-resource and low-resource settings (Chmielewska

et al., 2021). In a simulation study focusing on the six most populous countries in South Asia, disruptions caused by the pandemic reduced coverage of maternal and child health services by more than 50 percent across the region in the second quarter of 2020. These disruptions may have contributed to an additional 239,000 maternal and child deaths. This equates to a 14 percent and 16 percent increase in child and maternal mortality, respectively (Rutter and Bhutta, 2021).

Access to contraception during the pandemic was disrupted by the closure of essential services, including those offered at schools. According to UNFPA (2021b) an estimated 12 million women may have been unable to access family planning services as a result of the pandemic, with disruptions of supplies and services lasting an average of 3.6 months. Because of these disruptions, as many as 1.4 million unintended pregnancies may have occurred before women were able to resume the use of family planning services. For adolescents and youth, access to contraceptives was particularly impacted. For example, in Nigeria, a study by CARE International found a steep decline in the

use of contraceptive services among adolescent girls because of pandemic-related movement restrictions. Contraceptive use among adolescent girls declined by 66 percent as compared to a decline of 46 percent experienced by adult women, suggesting adolescent girls faced more limited access to essential care (CARE, 2020b). With the closure of schools during COVID-19, critical services, including SRH services, that were previously provided in school settings became inaccessible to the people who need them most: adolescents and youth. Prolonged school closures due to the COVID-19 pandemic significantly disrupted girls' access to SRH information and services as well as comprehensive sexuality education (CSE). A review of literature suggests an increase in early marriages and unwanted pregnancies during lockdowns, due to the closure of schools (Hoffman and Miller, 2020). A study conducted in Kenya found that adolescent girls who remained out of school for six months due to lockdowns had twice the risk of becoming pregnant and three times the risk of dropping out of school (Zulaika et al., 2022). A key informant from India highlighted how the disruptions led to negative impacts on girls' and women's SRHR outcomes:



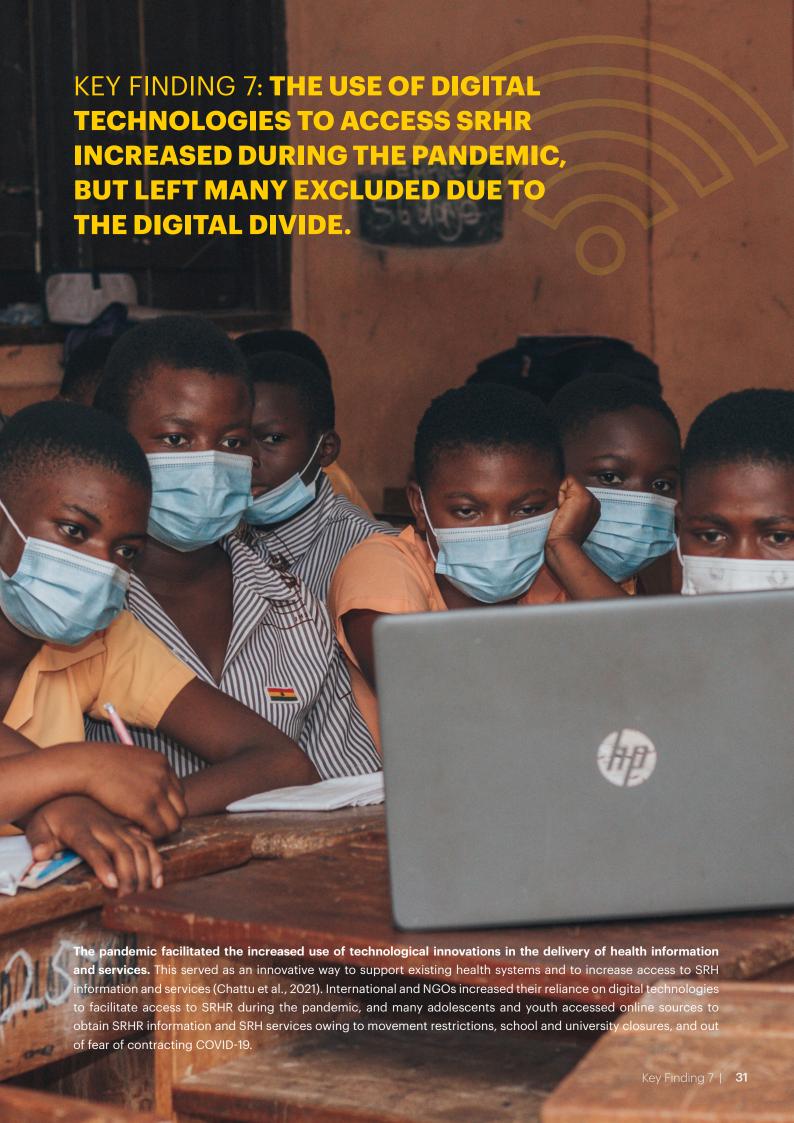
"The COVID-19 pandemic and the response to it have resulted in a number of effects on adolescents. It has caused stress and uncertainty, interfered with friendships and relationships, disrupted education and health services, created economic hardship and food insecurity, increased domestic work and care obligations, increased violence, and exacerbated inequalities. It is having a devastating impact on the lives of adolescents, including their SRH. The most vulnerable adolescents are the worst affected."

- Key informant, India



Youth advocates shared the challenges with access to contraceptive services during the COVID-19 pandemic.

- A youth advocate from Kenya shared that, "[Adolescents and youth] were asking for supplies for contraception. There was a shift in priorities when the COVID pandemic started. Adolescents and youth were really complaining that they could not get services. Mostly males complaining about condoms and females about birth control and IUD. It was basically condoms and birth control and lack of them in the hospital and health facilities."
- "During COVID there was a diversion of staff to other clinical services... For instance, the clinics only have SRHR services one day per week - only one day a week you can access family planning or counseling services." - Youth advocate, Nigeria
- "I don't think that the problems are different from before the COVID era, but COVID exacerbated them, [and] made them more visible. COVID increased [their] magnitude." - Youth advocate, Kenya



One of the greatest sources of SRHR information for adolescents and youth during the pandemic was the internet and social media. WhatsApp discussion groups, Facebook, and Twitter were commonly used in many settings to request and acquire information about specific SRHR issues and services (Both, Castle, and Henson, 2021). For example, international NGOs, such as Population Services International Adolescents 360 Project (PSI A360), deployed digital solutions during the pandemic to support improved access to family planning and information for adolescents and youth. These solutions included a Facebook promotion campaign, which attracted 70.000 followers, and provided access to a digital family planning curriculum in a manner that protected users' anonymity and privacy. In Nigeria, WhatsApp was used to facilitate referrals to family planning services, while in Kenya, WhatsApp was used to generate awareness around the availability of family planning services. In India, PSI, A360 partnered with Docterz.com to provide customized e-counseling on contraceptive methods. As part of this program, clients are linked to an e-pharmacy which allows them to choose and purchase the contraceptive method of their choice and have it delivered directly to their home (Banke-Thomas and Yaya, 2021).

Key informants noted that social media, TV, and radio with entertaining and engaging content can be used to facilitate SRHR awareness-raising amongst adolescents and youth. Specifically, key informants noted that:



There has been an increase in GBV. Everyone was at home. Husbands of adolescent girls who normally travel were forced to come home and live at home. There were reports of GBV in the media. Because of this we had to key into the digital space to churn out messages about GBV and violence against women and use SMS to girls to give contact information about where they could go."

-Key informant, Nigeria



Organizations such as UNFPA have been adopting digital technologies during the pandemic and this has been an emergent phenomenon. In some contexts, UNFPA used a digital approach for service reminders for SRHR information, while in other cases, help lines were being used to disseminate information on family planning and menstrual health."

-Key informant, Kenya

While digital technologies were effective in disseminating SRHR information, they did not reach those without access to digital technologies - who are often already experiencing discrimination and marginalization. The reliance on digital technologies to deliver healthcare during the pandemic has exacerbated pre-existing disparities in digital access for marginalized populations (Litchfield, Shukla, and Greenfield 2021). Inequitable access to technology means that new digital solutions to SRHR are difficult or impossible to implement in many settings, and may even exacerbate existing inequalities, especially for marginalized girls and women living in hard-to-reach areas.

This is particularly true for marginalized girls and women living in remote and rural areas (Litchfield, Shukla, and Greenfield, 2021). A youth advocate in Kenya explained that while the internet infrastructure in the country is well developed, the costs to use the internet are high, and not everyone has the capacity or familiarity needed to use platforms such as Google Meet or Zoom.



Youth advocates shared how social media platforms such as WhatsApp, Facebook, and Twitter were used to mobilize adolescents and youth for SRHR advocacy, provide SRH information, and conduct chat sessions with SRHR experts.

- "We had a WhatsApp group to identify champions for SRHR. We interact with them and impart information and ask what we need to include in our messages and address misconceptions...We used young women to ask them to mobilize [adolescents and youth] who want to learn about ASRH and we got a lot of people to join the group." - Youth advocate, Nigeria
- "We created a WhatsApp Group a topic about SRHR was raised every weekend and we had a SRHR expert provide information to youth and do Instagram Live sessions. We introduce a topic and youth get to ask questions." - Youth advocate, Kenya
- Paradigm Youth Network, an SRHR advocacy organization created by youth advocates in Kenya, designed a Chatbot that uses artificial intelligence to provide information to adolescents and youth on SRH. The Chatbot works on Facebook. "What was realized about the online platform is that it is very vital especially during times of pandemic. During lockdowns people cannot walk around and they rely on online platforms. We saw an increase in online use in 2020. We appreciate the platform as a form of information sharing." - Youth advocate, Kenya

Other youth advocates noted how MSI Reproductive Choices ran Twitter campaigns to provide access to family planning.

Youth advocates and key informants noted that while these technology-based solutions were filling a gap, they also had limited reach and excluded the most marginalized groups who have limited digital literacy and infrequent access to technology and connectivity. Youth advocates shared how reaching underserved youth in rural or hard-to-reach areas requires outreach activities and physically going to distant locations.

- "In Kenya most people live below [the] poverty line therefore internet and smartphone is a *luxury."* - Youth advocate, Kenya
- "Pivoting with remote services virtually continued to keep the most vulnerable outside in terms of access." - Youth advocate. India
- "Women living in rural areas, those living in informal settlements, also known as the slums, women with disabilities, and adolescent girls were among the hard[est] hit by [the pandemic and] somewhat paralyzed." - Youth advocate, Kenya



# SECTION 5: CONCLUSIONS AND **POLICY RECOMMENDATIONS**

Worsening SRHR have been both a cause and a consequence of increased gender inequalities. This study analyzes global evidence of the impact of COVID-19 on SRHR, and is one of the first of its kind to directly highlight the first-hand experiences, insights, and perspectives of adolescents and youth on the gendered impact of COVID-19 on SRHR.

The evidence points to multiple and diverse intersecting impacts at the macro, meso, and individual levels. Amongst other things, this research reinforces the need to commission, support, and advocate for the collection of additional data, disaggregated by gender and other variables of marginalization, including age, race, sexuality, location, displacement, and disability, to better understand and address the far-reaching and compounding consequences of crises on SRHR.

The section below outlines six policy recommendations, co-created by youth advocates, for stakeholders responsible for strengthening and upholding SRHR in emergency and non-emergency contexts, including pandemic response and recovery. Each recommendation is accompanied by a section highlighting key takeaways presented by the youth advocates involved in this study. Gathered during the data collection and validation phases of the research, these takeaways also informed the policy recommendations presented below. The recommendations are formulated for governments and duty-bearers who are responsible for upholding SRHR, as well as for rights-holders, including women's rights organizations, CSOs, and NGOs, who play an essential role in holding governments accountable for maintaining and protecting SRHR, amongst other roles. The recommendations identify relevant stakeholders and position them to take meaningful action in partnership with youth.



#### Policy Recommendation 1:

Ensure SRHR as an integral component of universal health coverage (UHC) and resilient health systems.

MOST RELEVANT FOR: Governments (national, sub-national, and local levels) and the private sector.

This study finds that the COVID-19 pandemic significantly impacted health systems and supply chains globally, and has had a devastating impact on girls' and women's SRHR. To this end:

- Resilient, integrated, and well-funded health systems are a prerequisite to realizing SRHR.
- UHC policies, focusing on both financial protection and service protection, underpin and provides a framing for the rebuilding and strengthening of national health systems, including vital primary and community healthcare, and delivering quality healthcare to all. This is particularly important for adolescents and youth, marginalized, and hard-to-reach populations, who were severely impacted by the pandemic.
- SRH services are foundational for furthering gender equality and girls' and women's health. These services should be part of UHC and should include the full range of SRH services, including adolescent- and youth-friendly services, access to modern contraception, self-care, programs to prevent GBV and harmful practices, and safe abortion services. SRH services must be prioritized in UHC plans, essential services packages, as well as in a minimum initial service packages (MISPs). The WHO's UHC Compendium (WHO, n.d.) and related SRH Interventions in the WHO UHC Compendium (WHO, 2021) offer guidance on integrating a comprehensive package of SRH services into health benefit packages.

- Integrating SRH in UHC must consider how health services are implemented at different governmental levels, as well as the resource and capacity requirements needed.
- Resilient SRH supply chains and emergency stock management systems that are integrated with pandemic response and related budgets can reduce disruptions to access, particularly during crises. Transparent and responsible partnerships between governments and the private sector are key for this.

#### Reflections by youth advocates:

- Robust and resilient health systems are important. Governments must invest more in health systems strengthening.
- Governments must consider how UHC and SRH services are implemented in different contexts. Youth advocates observed that there is misalignment between policies, technical planning, and budgetary allocations, and inadequate community and youth involvement in priority setting.
- Health systems were severely impacted, which delayed access to critical SRHR commodities, in particular contraceptive supplies.
- The increase in unplanned pregnancies during the COVID-19 pandemic was a consequence of prolonged home stays, lack of access to contraceptive services, and financial difficulties in purchasing condoms or contraceptive pills.
- Access to SRH commodities must be protected during a pandemic, and policies need to be put in place that safeguard adolescents' and youth access to SRH commodities, including contraceptives.



#### Policy Recommendation 2:

Ensure adequate and fully protected budgetary allocation for SRHR, along with the release of funds, to drive the full realization of SRHR. A key mechanism for this is civil society and youth-led budget advocacy.

MOST RELEVANT FOR: Governments, youth-led organizations, civil society organizations, and non-governmental organizations, including educational institutions.

The research finds that under-resourced health systems were especially hard-hit during the pandemic. The impacts of the pandemic on under-resourced health systems were compounded by a lack of investment in SRHR and gaps between policies and implementation.

- Investment and implementation components for the realization of SRHR must be taken into consideration to inform policy-making at national and local levels.
- Ensure adequate and protected budget allocations for comprehensive SRHR under UHC. This should be informed by real cost estimates and aligned with UHC objectives (leaving no-one behind, services for all, and no financial hardships). Adequate and protected budget allocations must be firmly rooted in data, disaggregated by gender, age, and other key socioeconomic stratifiers, with an intersectional lens, to inform budgetary allocations and financial commitments that are more accurate, targeted, and gender-sensitive.
- It is important to strengthen budget accountability and transparency mechanisms to hold governments accountable, at all levels, and to ensure that they plan, cost, and fund SRHR in their budgeting and planning processes.
- Civil society and youth-led budget advocacy are needed to ensure that governments prioritize and finance SRHR. These efforts involve increasing awareness of the importance of SRHR amongst government officials, health, and gender ministries, as well as finance ministries who are responsible for allocating funds.

#### Reflections by youth advocates:

- Many governments in LMICs reduced SRHR spending during the pandemic. Governments need to dedicate increased resources, including financial resources, for SRHR.
- Under many decentralization frameworks in countries such as in Kenya, it is often local and county governments that are responsible for ensuring SRHR services are being implemented, while fiscal authority remains with the national government.
- Advocacy initiatives designed to influence budget priorities and efforts to improve the transparency of the budget process are needed. Youth advocates urged civil society groups to advocate for budget transparency and accountability by bringing public awareness to SRHR cuts.
- Decision-making and planning processes must include the perspectives of adolescents and youth. Youth advocates recommended leveraging existing mechanisms, such as Technical Working Groups, or establishing a SRHR Youth Taskforce that meaningfully includes adolescents and youth to ensure youth SRHR are prioritized, integrated, and safeguarded in pandemic response and recovery efforts.



## Policy Recommendation 3:

Increase and maintain strong political and financial support for civil society partners that engage in SRHR service delivery and advocacy.

MOST RELEVANT FOR: Governments (gender, health, and youth ministries), non-state actors, and donors.

This research finds that while governments hold ultimate responsibility for upholding SRHR, non-state actors play an important role in filling critical gaps. To this end:

- As rights-holders, non-state actors have an important role to play in holding governments accountable for SRHR, especially service provision, and ensuring adequate resources are in place to drive the full implementation of SRHR.
- Local CSOs and women- and youth-led organizations have a footprint in their communities and play an important role in meeting the immediate needs of girls and women, and youth, in communities. Their deep and localized understanding of contextual realities, and strengths in responding to the pre-existing gender inequalities that arise from crises, must be respected and leveraged.
- CSO networks should be leveraged, and their innovations should be built upon, to offer context-relevant guidance on how SRH services can be brought to adolescents and youth in their communities. CSOs must be supported in safely delivering SRH services at the community level, in coordinating with other parts of the referral and care chain, and in monitoring and adjusting to emerging opportunities and constraints.
- Government must closely collaborate with, and support, civil society and establish a robust multi-stakeholder approach to maintain SRHR during crises. Targeted funding by governments is critical to reach the "last mile" and leave no one behind.

### Reflections by youth advocates:

- Increase funding for youth engagement in SRHR advocacy, youth-led service delivery to address critical SRHR needs, and collaboration between youth and governments to realize SRHR.
- Adolescents and youth have a concrete role to play in holding governments accountable for SRHR. Funding should be designated for youth-led SRHR service delivery and advocacy. Young advocates observed a need for increased support for youth-led projects and organizations in order to ensure a youth lens is embedded in SRHR policies and plans.
- International NGOs played a critical role in filling a gap in SRHR service delivery, while local civil society organizations were essential in identifying local SRHR needs. Youth-led organizations were critical in maintaining and defending SRHR services.



Policy Recommendation 4:

Ensure the financing and delivery of comprehensive, integrated, and survivor-centered gender-based violence prevention and response services for girls and women, in all their intersecting identities.

**MOST RELEVANT FOR:** Governments, donors, GBV-focused organizations (for example, domestic violence shelters), women's rights organizations, police force, legal aid, and health centers.

The research finds that as gender-based violence increased, pandemic restrictions severely limited GBV services. To this end:

- Survivor-centered GBV response services, within and beyond the formal healthcare system, must be included as part of the essential package of government response to crises and within longer-term pandemic preparedness and response measures.
- Ensure GBV response services prioritize access to safe shelters, legal assistance, safe abortion, emergency contraception, domestic violence helplines and other online reporting mechanism, and mental healthcare, including for marginalized populations facing violence.
- Support quality primary, secondary, and tertiary GBV prevention programs that are comprehensive, evidence-based, and accessible to girls and women, in all their intersecting identities. These programs include CSE, in- and out-of-schools, and gender transformative programs that engage boys and men.
- Support a range of contextually relevant solutions that combine digital and in-person information and service offerings to strengthen the capacity of local healthcare providers and actors outside of the healthcare system, including community and religious leaders, to address GBV.
- Support and ensure the meaningful participation of adolescents, youth, and women, including people living with disabilities, and LGBTQIA+ individuals, in decision-making processes across the entire spectrum of GBV prevention and response services.

### Reflections by youth advocates:

- Addressing GBV requires documenting cases and strengthening youth-friendly reporting mechanisms for GBV cases.
- Youth advocates shared the perspective that gender ministries should collaborate with non-state actors to address GBV and harmful practices.
- Youth advocates noted the importance of developing policies and guidelines for healthcare facilities to integrate GBV within health services and to sensitize healthcare providers to address GBV.



## Policy Recommendation 5:

Maintain adolescent and youth-friendly SRHR services, particularly in emergency contexts, in order to ensure continued access for those who face multiple barriers.

MOST RELEVANT FOR: Civil society (schools, universities, non-governmental organizations, youth-led organizations), and health service providers.

The research finds that adolescents and youth, particularly from marginalized populations, faced challenges in accessing SRHR services during the COVID-19 pandemic. These challenges were compounded by stigma and discrimination. To this end:

- Adolescents and youth need services that are accessible, acceptable, equitable, appropriate, and effective, even during a pandemic. These services should take into consideration the barriers faced by adolescents and youth in accessing high-quality sexual and reproductive health services, particularly sociocultural barriers such as restrictive norms and stigma around adolescent and youth sexuality. These services need to ensure access to safe abortion services and prevent harmful traditional practices in both non-emergency and emergency contexts.
- Pandemic response must consider issues of equity. Adolescents and youth from marginalized populations experience heighted barriers and challenges in upholding SRHR because of their gender, ethnicity, religion, sexual orientation, and other characteristics.
- Adolescent and youth SRHR (AYSRHR) must be offered in an environment where service providers are non-judgmental and have the competencies needed to deliver youth-friendly and youth-responsive SRHR services. Health facilities or centers located in school and university settings are one means to advance AYSRHR.
- Implementing adolescent and youth-friendly SRHR includes training service providers, increasing awareness of services among adolescents and youth, and reaching youth with SRHR information through innovative methods (for example, mobile applications). These efforts also require using social and behavior change interventions (SBC) that strengthen community support and include approaches such as interpersonal communication (IPC), community mobilization, as well as multimedia and mass media campaigns.
- Ensuring adolescent and youth-friendly SRHR services also requires engaging boys and men in discussions, policies, and activities with the power to affect positive change. In addition, it requires engaging parents, religious leaders, healthcare workers, and others, to dispel myths and reduce stigma around SRHR, particularly for adolescents and youth.

### Reflections by youth advocates:

- Adolescents in Nigeria face discrimination when trying to access SRH services.
   Youth advocates shared the perspective that greater efforts must be made to sensitize community elders and healthcare providers.
- It is important to understand how SRHR access for adolescents and youth is mediated by multiple, intersecting, and overlapping systems of discrimination.
   Solutions must consider the diversity of adolescent and youth SRHR needs and consider the specific attributes, circumstances, and experiences of adolescents and youth.
- Adolescent and youth-friendly health centers in high schools and universities
  are considered as a safe space to access SRHR information and products. Youth
  advocates shared the perspective that access to such centers must be maintained
  during periods of crises.
- Adolescents and youth face stigma and discrimination in accessing SRHR services. Youth advocates observed that stigma and discrimination prevented many adolescents and youth from accessing SRHR services during the pandemic. Many youth advocates observed that, even prior to the pandemic, stigma and discrimination around accessing SRHR services and information prevented many adolescents and youth from seeking the services and information they needed. In health facilities, youth advocates noted that stigma manifested through shaming, scolding, and excessive questioning by healthcare providers, and sometimes refusal of service.





Policy Recommendation 6:

The use of digital technologies to disseminate and distribute SRHR services, information, and products must be combined with efforts to address the gendered digital divide.

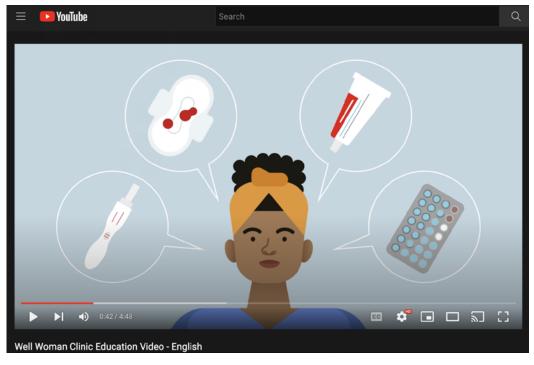
MOST RELEVANT FOR: Governments, healthcare professionals, civil society organizations, and the private sector (particularly content and application developers, which includes adolescents and youth).

The research finds that use of digital technologies to access SRHR services and information increased during the COVID-19 pandemic, but left many excluded due to the digital divide. To this end:

- The use of digital technologies to advance SRHR offer significant opportunities for advancing health and empowerment. The use of mobile technology to access SRH information and services is especially widespread amongst adolescents and youth. While technology can be used to deliver SRHR services, information, and products to people in a simple and accessible manner, these technologies must consider issues of gender equity and assess the risk of harm online.
- Digital technology provides an entry point for comprehensive sexuality education (CSE), which is essential for improving the SRHR of adolescents and youth. Digital tools, such as innovative technologies, websites, messaging apps, and social media platforms can enable private, personalized, and accessible answers to critical questions about SRHR that may not otherwise be accessible to adolescents and youth.
- Ensure that digital solutions providing SRH knowledge and services are accurate, comprehensive, youth-friendly, and accessible to hard-to-reach and low-income communities. Meaningfully engage youth in the design of digital SRHR resources and in the testing of online SRHR platforms to make them accessible, youth-friendly, and to encourage their use. Link online SRHR information to appropriate youth-friendly medical and community services to raise awareness of trustworthy digital platforms and encourage follow-up with services. Ensure there is accurate and comprehensive SRHR information online, across varied digital platforms, and note when information is medically verified.
- Institutionalize digital health technologies, as part of national health systems and UHC, by developing and carrying out a digital health action plan to ensure that digital solutions for SRH services and knowledge are accessible to hard-to-reach and low-income communities.
- Invest in efforts to overcome the major challenges LMICs face in accessing digital health technologies. This includes investing in financial and material resource to create an appropriate enabling environment, as well as infrastructure to support with the digital transformation, education, human capacity, and internet connectivity.

### Reflections by youth advocates:

- Youth advocates shared the perspective that a lack of mobility negatively impacts the uptake of and access to SRHR services, especially for underserved youth in hard-to-reach and rural communities.
- Youth advocates observed that online models are needed to reach adolescents and youth with SRHR information. They also noted, however, that there are challenges associated with relying on digital technologies, such as inequities in digital access, especially for marginalized groups in rural areas.



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## **LOOKING AHEAD:**

As COVID-19 threatens to reverse important gains in SRHR, while also widening existing disparities, it is crucial that stakeholders, including governments, donors, the private sector, and CSOs recognize the disproportionate impact of the pandemic on girls and women, in all their intersecting identities. While the scope of this research covers a range of issues, it is not comprehensive of all of the inequalities that girls and women, in all their intersecting identities, face when it comes to the full realization of their SRHR. It is important to recognize the larger ecosystem and to work on addressing contributing factors towards inequalities that do not fall within this work (for example, larger conservative forces pushing back on SRHR globally or enabling legal and policy frameworks in-country). In any related action, investment, policy, or programming, the experiences, expertise, priorities, and needs of girls and women must be centered to make informed and evidence-based decisions. Efforts to uphold and ensure girls' and women's SRHR as the bedrock of gender equality must entail meaningful youth engagement and co-leadership. To disrupt power structures that exist and that perpetuate gender inequalities, youth must be in the decision-making seat to point out patterns of exclusion and to introduce and implement more progressive and inclusive policies and practices.

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## PHOTO REFERENCES

#### **Cover Photos:**

Adolescents and youth participating in a training on sexual and reproductive health in Ghana. Photo credit: Joseph Amoako-Atta, Women Deliver Young Leader, Class of 2020.

A group of students participate in a training on promoting gender equality and providing safe spaces for vulnerable girls in Freetown, Sierra Leone. Photo Credit: Alimamy Fofanah and Nnamdi Eseme John, Women Deliver Young Leaders, Class of 2016.

Ashlee Burnett, a Women Deliver Young Leader and Founder of Feminitt Caribbean, and Chanelle Beatrice, Head of Content at Feminitt, put together period kits as part of their work to address period poverty in Trinidad and Tobago. Photo credit: Ashlee Burnett, Women Deliver Young Leader, Class of 2020.

### Page 18, Key Finding 1:

A group of students participate in a training on promoting gender equality and providing safe spaces for vulnerable girls in Freetown, Sierra Leone.

Photo Credit: Alimamy Fofanah and Nnamdi Eseme John, Women Deliver Young Leaders, Class of 2016.

### Page 20, Key Finding 2:

Lilian Sospeter, Women Deliver Young Leader, leading a training in order to equip healthcare workers with skills and knowledge on the provision of Adolescent and Youth Friendly Services (AYFS) at Temeke Municipal in Tanzania.

Photo credit: Lilian Sospeter, Women Deliver Young Leader, Class of 2020.

### Page 23, Key Finding 3:

Ashlee Burnett, a Women Deliver Young Leader and Founder of Feminitt Caribbean, and Chanelle Beatrice, Head of Content at Feminitt, put together period kits as part of their work to address period poverty in Trinidad and Tobago.

Photo credit: Ashlee Burnett, Women Deliver Young Leader, Class of 2020.

### Page 24, Key Finding 4:

Lilian Sospeter, Women Deliver Young Leader, leading a training in order to equip healthcare workers with skills and knowledge on the provision of Adolescent and Youth Friendly Services (AYFS) at Temeke Municipal in Tanzania.

Photo credit: Lilian Sospeter, Women Deliver Young Leader, Class of 2020.

#### Page 25, Key Finding 4:

Nojus Saadullah Ramadhan, Women Deliver Young Leader, exchanging ideas about how to end domestic violence and honor killings within communities in Iraq as part of the Religious Leaders Initiative

Photo credit: Nojus Saadullah Ramadhan, Women Deliver Young Leader, Class of 2020.

### Page 26 & 27, Key Finding 5:

Darshana Rijal, Women Deliver Young Leader, meeting with community members to discuss child marriage and violence against women in Nepal.

Photo credit: Darshana Rijal, Women Deliver Young Leader, Class of 2020

### Page 29, Key Finding 6:

Lucia Berro Pizzarossa, Women Deliver Young Leader, speaking with newly elected government officials about the importance of ensuring access to SRHR in Uruguay.

Photo credit: Lucia Berro Pizzarossa, Women Deliver Young Leader, Class of 2016.

### Page 31, Key Finding 7:

Adolescents and youth participating in a training on sexual and reproductive health in Ghana. Following the training, students contributed to a policy paper to revise the Ghana Adolescent Reproductive Health Policy and the COVID-19 response for young people in their community and country.

Photo credit: Joseph Amoako-Atta, Women Deliver Young Leader, Class of 2020.

### Page 40, Conclusions and Policy Recommendations:

Adolescents and youth participating in a training on sexual and reproductive health in Ghana.

Photo credit: Joseph Amoako-Atta, Women Deliver Young Leader, Class of 2020.

### Page 42, Conclusions and Policy Recommendations:

https://womendeliver.box.com/s/ qa9wpos2kreiee7zof01c2vovcy4wcao

Video still from a six-minute animation on sexual and reproductive health refugee populations in Canada created by the Halifax Newcomer Well Women Clinic, as part of Aditi Sivakumar's Women Deliver Young Leader Small Grants project. The animation is available in five different languages and is now being distributed to refugee clinics across the nation.

# ANNEX A: FURTHER DETAILS ON **METHODOLOGY**

### Rapid desk-based review

A rapid desk-based review was undertaken to gain an overview of the existing data and evidence on the impact of COVID-19 on SRHR. This rapid scan of global literature was broad in scope. While the scan focused broadly on populations in LMICs, particular attention was paid to the impact of COVID-19 on adolescents and youth, girls and women, and marginalized communities.

### **Primary research**

Qualitative research included KIIs with global and country-level experts, as well as in-depth, semi-structured interviews and a focus group discussion with youth advocates. Youth included persons between 19 and 30 years of age who are engaged in SRHR policy advocacy. The qualitative interviews offered an opportunity to elicit perspectives from youth SRHR advocates in India, Kenya, and Nigeria, and offer localized and contextualized perspectives on how the pandemic has impacted SRHR in their respective country contexts. The qualitative interviews were in-depth, semi-structured interviews which posed open-ended questions allowing for an understanding of participants' views about the impact of the pandemic on SRHR, and to hear their views and insights in their own words.

**Interviews** were conducted with nine key informants. Key informants were identified in collaboration with Women Deliver. These interviews captured the perspectives of individuals who are currently engaged in evidencegeneration or implementation measures that focus on gender equality, SRHR, youth, and/or COVID-19 response and recovery. Key informants were recruited from the following organizations: CARE Nigeria, KELIN (Kenya), Population Council (India), Project Concern International (India), PSI A360 (Kenya), PSI A360 (Nigeria), UHAI EASHI (Kenya), UNFPA, and the World Health Organization. A tailored interview guide was used to inform the key informant interviews. The interviews focused on the impact of the pandemic on SRHR, challenges and solutions, and responses being used to mitigate these challenges.

Semi-structured interviews were conducted with a sample of 15 youth from across the three focus countries.

The interviews were based on a semi-structured interview guide, which was co-designed with two Women Deliver Young Leaders, to ensure that certain basic information was collected from all youth, while also leaving opportunities to raise or explore previously unidentified topics that emerged during the interviews.

To ensure a more in-depth understanding of how the COVID-19 pandemic has impacted adolescents and youth and their SRHR, one focus group discussion (FGD) was conducted with nine youth. The FGD allowed for the research team to listen and observe as youth interacted, led to a better understanding of key themes, issues, barriers, and challenges, as they pertain to the impact of COVID-19 on SRHR and offered an opportunity to probe key issues that emerged from the rapid desk review. The FGD was conducted using an interactive Mural Board, which allowed for effective engagement and participation from multiple participants from across the globe in a remote data gathering exercise. This interactive and facilitative process proved to be catalytic in fostering critical reflection, and advancing learning, collaboration, and dialogue amongst youth advocates across different geographies.

## RESEARCH **PARTICIPANTS**

Table one, below, outlines the sample of participants that participated in the research. In total, 46 individuals were involved in the primary research phase of this study, which involved 24 individual interviews, one focus group discussion, and one validation workshop. This included nine KIIs with representatives from international organizations and CSOs in India, Kenya, and Nigeria, including PSI A360, CARE, KELIN, Population Council, Project Concern International, UHAI, UNFPA, and the WHO. In addition, fifteen youth were interviewed across the three focus countries,5 and one focus group discussion was conducted with nine youth from Kenya and Nigeria.

Women Deliver invited Young Leaders from the Young Leaders program to apply through a call for expressions of interest to participate in the research. In addition, youth advocates engaged in SRHR advocacy outside of the Women Deliver Young Leaders Program were also recruited as participants in the research.

All data collection was undertaken remotely via Zoom and Google Meet. All interviews and discussions were undertaken in English, and informed voluntary consent was obtained prior to the interviews. Semi-structured interview and focus group discussion guides were developed for data collection and are provided in Annex B.

TABLE 1: QUALITATIVE METHODS AND SAMPLE DESCRIPTION	
KEY INFORMANT INTERVIEWS	CARE Nigeria (1), KELIN, Kenya (1), Population Council, India (1), Project Concern International, India (1), PSI A360, Kenya (1), PSI A360, Nigeria (1), UHAI, Kenya (1), UNFPA, Global (1), WHO, Global (1)  Total: 9 participants
SEMI-STRUCTURED INTERVIEWS WITH YOUTH ADVOCATES	India (1), Kenya (3), Nigeria (11)  Total: 15 participants*  *7 Women Deliver Young Leaders
FOCUS GROUP DISCUSSION WITH YOUTH ADVO- CATES	Kenya (3) Nigeria (6) Total: 9 participants* *3 Women Deliver Young Leaders
YOUTH POLICY RECOMMENDATIONS VALIDATION WORKSHOP	Global (4) (Liberia, Philippines, Lithuania, Uganda), India (2), Kenya (3), Nigeria (3) Total: 12 participants* *10 Women Deliver Young Leaders

Thirteen youth participated in a workshop to validate the key findings that emerged from the research and to generate policy recommendations. The workshop was co-facilitated by two Young Leaders from Kenya and Nigeria.

### DATA ANALYSIS

Data and evidence was primarily generated through a desk review and primary research. The interview transcripts were coded using thematic content analysis. Codes for data analysis were created based on the study's desk review to reflect categories that were already of interest before the data collection began. Codes were also derived after the data had been collected through the primary research. The analysis considered not just the frequency of themes across the published and primary research but the analytic salience and relevance of themes for understanding how COVID-19 has impacted SRHR in LMICs. Some themes, such as access to contraceptives, presented in this report were identified based on their

presence in both the global literature as well as insights from primary research. In other cases, however, themes were only prevalent in the interviews but were selected for inclusion in the analysis due to their analytic relevance. For example, SRHR and fiscal investment was identified for analytic inclusion based on the salience of this theme in the interviews, and its importance in understanding how SRHR are to be advanced in pandemic response and recovery efforts.

### **PEER REVIEW**

To assess and evaluate the quality and credibility of the research, Women Deliver engaged a team of peer reviewers from teams and organizations focused on youth, gender, and SRHR. Rosamond Edmund, Head of Policy and Advocacy at Plan International, Silvia Guglielmi, Qualitative Researcher at Gender and Adolescence: Global Evidence (GAGE), and Joy Zawadi, Interim Executive Director at Akili Dada served as peer reviewers for this research.

## **ANNEX B:**

## RESEARCH QUESTIONNAIRES

### YOUTH SEMI-STRUCTURED INTERVIEW GUIDE

1. What type of problems have emerged for youth accessing SRH services and information during the pandemic? Are these problems different than before? If so, how?

### **Probes**

- Have these problems changed the type of SRH products, information, and services adolescents and youth are looking for? How are adolescents and youth meeting their SRHR needs during the pandemic?
- Has this led to a change in behavior/norms in using these services and information?
- 2. What are governments and other organizations doing to serve the SRHR needs of adolescents and youth during the pandemic?

#### **Probes**

- What were the gaps in service delivery? What were the consequences of these gaps? Were there any issues with accessing SRH products and services that were available?
- Which models are being used at the community-level to help adolescents and youth meet their SRHR needs during the pandemic? Are these models the same as before the pandemic, or different?
- Are community organizations playing a role in filling the gap to help adolescents and youth meet their SRHR needs? If so, how?
- Who are you and your peers relying on to meet your SRHR needs?
- 3. What do you believe the government and other organizations should be doing to better serve the SRHR needs of adolescents and youth?

### **Probes**

- How can the government work better with other organizations (for example, MSI) to provide SRHR services that meet the needs of adolescents and youth?
- What do you believe needs to be done in the community to better serve the SRHR needs of adolescents and
- 4. How has the pandemic affected your SRHR advocacy? How has the pandemic affected your ability to be an advocate?

### **Probes**

- Do you believe other youth advocates are facing similar challenges?
- What about wider SRHR advocacy led by youth? Has the pandemic changed your advocacy messaging? Are your messages different now than before the pandemic? If so, how?
- Which advocacy tactics are you using in your project? Have these changed at all during the pandemic?
- What has been the most effective advocacy tactic during the pandemic?

5. Have you been addressing SRHR stigma, norms, and discrimination through your advocacy during the pandemic?

### **Probes**

- Which advocacy tactics are you using in your project? Have these changed at all during the pandemic? Have you shifted messaging?
- What has been most effective in your advocacy during the pandemic?
- 6. Is there anything you would like to add?

### YOUTH FOCUS GROUP DISCUSSION GUIDE

1. What type of problems have emerged for youth accessing SRH services during the pandemic? Are these problems different than before? If so, how?

#### **Probes**

- Have these problems changed the type of SRH products and services adolescents and youth are looking for?
- How are adolescents and youth meeting their SRHR needs during the pandemic?
- 2. What are governments and other organizations doing to serve the SRHR needs of adolescents and youth during the pandemic?
- 3. Which government and/or private sector solutions have worked well for adolescents and youth in terms of meeting their SRHR needs?

### **Probes**

- Have solutions worked well? Which ones? Why do you think these are particularly effective? Have you found these solutions offered by the government and others to be adequate? If so, why? If not, why not? Which solutions need to be improved?
- 4. What do you believe the government and other organizations should be doing to better serve the SRHR needs of adolescents and youth?

### **Probes**

- How can the government work better with other organizations (for example, MSI) to provide SRHR services that meet the needs of adolescents and youth? What do you believe needs to be done in the community to better serve the SRHR needs of adolescents and youth?
- How has the pandemic affected your SRHR advocacy? How has the pandemic affected your ability to be an advocate?

### **KEY INFORMANT INTERVIEW GUIDE**

1. What type of problems have emerged for youth accessing SRH services during the pandemic? Are these problems different than before? If so, how?

### **Probes**

- What are the health systems strengthening implications of these challenges? Have these problems changed the type of SRH products and services adolescents and youth are looking for? How are adolescents and youth meeting their SRHR needs during the pandemic?
- 2. What are some of the solutions that are being implemented to address SRHR challenges that have arisen for adolescents and youth during the pandemic?

### **Probes**

- What solutions are being used by the government? Is the private sector playing a role? If so, how?
- 3. What has been the policy response to these challenges? Have new policies been drafted to address the SRHR challenges that have arisen or been exacerbated during the pandemic?

### **Probes**

- What are your thoughts on the policy response? Is it adequate? If not, what more needs to be done?
- 4. What type of solutions or models are being adopted at the community level to address adolescents and youth's SRHR needs during the pandemic?

### **Probes**

- Which of these models do you find to be particularly effective? Why?
- 5. How has CSE been impacted during the pandemic? How has this impacted adolescents and youth's access to SRHR?
- 6. Is there anything you would like to add that we have not covered but you believe is important to discuss?

## **ANNEX C:**

# WOMEN DELIVER YOUNG **LEADER CO-FACILITATOR BIOGRAPHIES**

### **CO-FACILITATOR BIOGRAPHIES**

Liz Guantai is a lawyer and development specialist from Nairobi, Kenya. Liz is passionate about economic empowerment, gender equality, and access to social-economic rights. She has extensively worked with movement building organizations notably INERELA+ Kenya, Liz was selected as a UN Women Global Champion for Women Economic Empowerment in 2015 and a Women Deliver Young Leader in 2020 following her contribution to the rights of girls and women in Kenya. Among the achievements recognized was her role in leading a community outreach and social media campaign on access to quality menstrual hygiene for disadvantaged girls and access to SRHR for adolescents and adolescents and youth in Kenya during the COVID-19 pandemic. In 2020, she was a project manager for INERELA+ Kenya USAID funded Faith Communities Initiative project on ending sexual violence against children in Nairobi's informal settlements. Until December 2020, Liz was a "Global South" staff partner for the US-based Social Movement Technologies, where she supported in training and campaign support of global social movement organizations to build progressive power in the digital age. Currently Liz works as a program manager facilitating economic empowerment, peacebuilding, and regional trade with a regional intergovernmental organization. Liz is an excellent trainer, facilitator, and moderator, and facilitates weekly sessions for the UNESCO Religious Leaders' Handbook on Adolescent SRHR. She has contributed chapters on national toolkits and handbooks on human rights, gender, and HIV, and has several publications on human rights. Liz holds a Master of Laws from the University of Cape Town and a Postgraduate qualification in Human Rights Law and Sustainable Development from the University of Antwerp. She is also an Advocate of the High Court in Kenya. Liz is an alumnus of the African Presidential Leadership Program and has been recognized as a promising African youth leader.

Isaac Iyinoluwa Olufadewa is a medical doctor, healthcare innovator, researcher, and social entrepreneur with over a decade of experience in advocating for health equity and social justice. His public health advocacy and research focus on infectious diseases (such as HIV/AIDS and COVID-19), SRHR and mental health. He is a Women Deliver Young Leader and an advocate for adolescents and youth access to SRHR services in Nigeria. He is also the Founder/Executive Director of the Slum and Rural Health Initiative (SRHIN), a registered organization that takes quality healthcare to underserved people in urban slums, IDP/refugee camps, and hard-to-reach communities. Isaac earned his medical degree at Nigeria's Premier University and his postgraduate degree at the Pan African University (PAULESI) on a fully-funded scholarship from the African Union Commission. He also has a certificate on Public Administration and Management from the University of Minnesota Twin Cities, USA on a fully-funded opportunity from the US Department of State. He has over 35 peer-reviewed publications in reputable journals such as the Lancet Global Health. Isaac is a Mandela Washington Fellow, the youngest International Expert on the Lancet COVID-19 Commission and a recipient of several awards, scholarships, and grants from reputable organizations which include the African Union, Royal Society of Tropical Medicine and Hygiene, Reckitt, NIHR, Grand Challenges Canada, and Harvard Global Health Institute among others.

## **ANNEX D:**

# **LIST OF YOUTH ADVOCATE RESEARCH PARTICIPANTS**

YOUTH ADVOCATE PARTICIPANTS: SEMI-STRUCTURED INTERVIEWS		
NAME	COUNTRY	
Boris 'Chebem Nwachukwu	Nigeria	
Mu'azu Muhammad	Nigeria	
James Oluwole	Nigeria	
Mary Adeoye	Nigeria	
Ife Elisha	Nigeria	
Jennifer Igomu	Nigeria	
Lois Sofa	Nigeria	
Ayo Elisha	Nigeria	
Victoria Ayomide Olajugba/Sade Musa	Nigeria	
Adebisi Adenipekun	Nigeria	
Poorvi Mehrotra	India	
Nick Oketch	Kenya	
Nurat Wamaya	Kenya	
Mark Gachagua	Kenya	
Grace Orao	Kenya	

YOUTH ADVOCATE PARTICIPANTS: FOCUS GROUP DISCUSSION		
NAME	COUNTRY	
Lilian Sospeter	Kenya	
Aishatu Alhajikabu	Nigeria	
Kevine Otieno	Kenya	
Odeniyi Abimbola	Nigeria	
Peace Ojo	Nigeria	
Odunayo Roseline	Nigeria	
Idyat Ayandeji	Nigeria	

YOUNG LEADER CO-FACILITATORS		
NAME	COUNTRY	
Liz Guantai	Kenya	
Isaac Iyinoluwa Olufadewa	Nigeria	

YOUTH ADVOCATE PARTICIPANTS: POLICY VALIDATION WORKSHOP		
NAME	COUNTRY	
Boris 'Chebem Nwachukwu	Nigeria	
Mu'azu Muhammad	Nigeria	
Nurat Wamaya	Kenya	
Nick Oketch	Kenya	
Joseph Teye Amoako-Atta	Uganda	
Bharti Kannan	India	
Rifat Mohi Ud Din	India	

Sruthi Chandrasekhar	India
Daren Paul Katigbak	Philippines
Eglė Janušonytė	Lithuania
Pauline Gartor	Liberia

