



I feel that things are out of my hands

How COVID-19 prevention measures
have affected young people's sexual and
reproductive health in Ghana, Indonesia,
Kenya, Nepal, Uganda and Zimbabwe

Rutgers

For sexual and
reproductive health
and rights

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About this report

This report was developed within the context of the Right Here Right Now (RHRN) and Get Up Speak Out for Youth! (GUSO) programmes, with the aim of learning about how to ensure the availability of and access to sexual and reproductive health and rights (SRHR) information and services to young people during and beyond the COVID-19 pandemic.

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RIGHT NOW

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Acronyms	
ARV	Anti-retroviral
COVID-19	Coronavirus disease 2019
FDC	Fixed dose combination
FGD	Focus group discussion
GUSO	Get Up, Speak Out for Youth Rights!
HIV	Human immunodeficiency virus
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LGBTQ	Lesbian, gay, bisexual, transsexual and queer
MSI	MSI Reproductive Choices
PCR	Polymerase chain reaction
PLWHIV	People living with HIV
PPE	Personal protective equipment
PrEP	Pre-exposure prophylaxis
PSI	Population Services International
RHRN	Right Here, Right Now
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UNPFA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UTI	Urinary tract infection
WHO	World Health Organisation
YPLWHIV	Young people living with HIV

Key highlights

The COVID-19 pandemic’s impact on young people’s sexual and reproductive health and rights is big, interlinked and lays bare and exacerbates existing inequalities.

Disruptions in income and schooling have had negative and gendered effects on young people’s SRHR, as economic hardship puts young women at greater risk of unwanted pregnancies and early marriage.

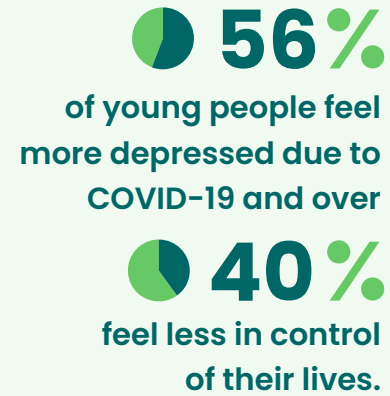


of young people could not attend school due to COVID-19 and as such did not receive comprehensive sexuality education.

Online teaching, when available, was difficult to access for young people living in rural areas or those living with a disability due to lack of internet connection or lack of appropriate learning tools.



76 %
of young people feel more worried about money because their income has been affected by the COVID-19 crisis.

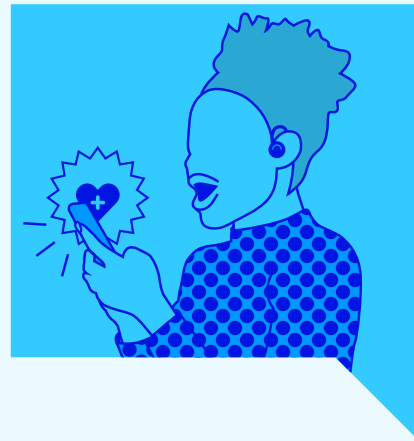


56 %
of young people feel more depressed due to COVID-19 and over
40 %
feel less in control of their lives.



50 %
of young people missed reliable information on sex and COVID-19, many used online sources for SRH information.

WhatsApp, Facebook and Twitter were commonly used in many settings to request and acquire information about specific SRH issues and services though many young people were in doubt about the quality of the information.



30 %
of young women were not able to access the family planning services they needed due to COVID-19.

SRHR services, like STI/HIV testing and/or treatment, and abortion services were difficult to access due to COVID-19. Fear of catching COVID-19 in health facilities, lack of transport, and health facilities closures was reported by young people as the main barriers to services during the pandemic.



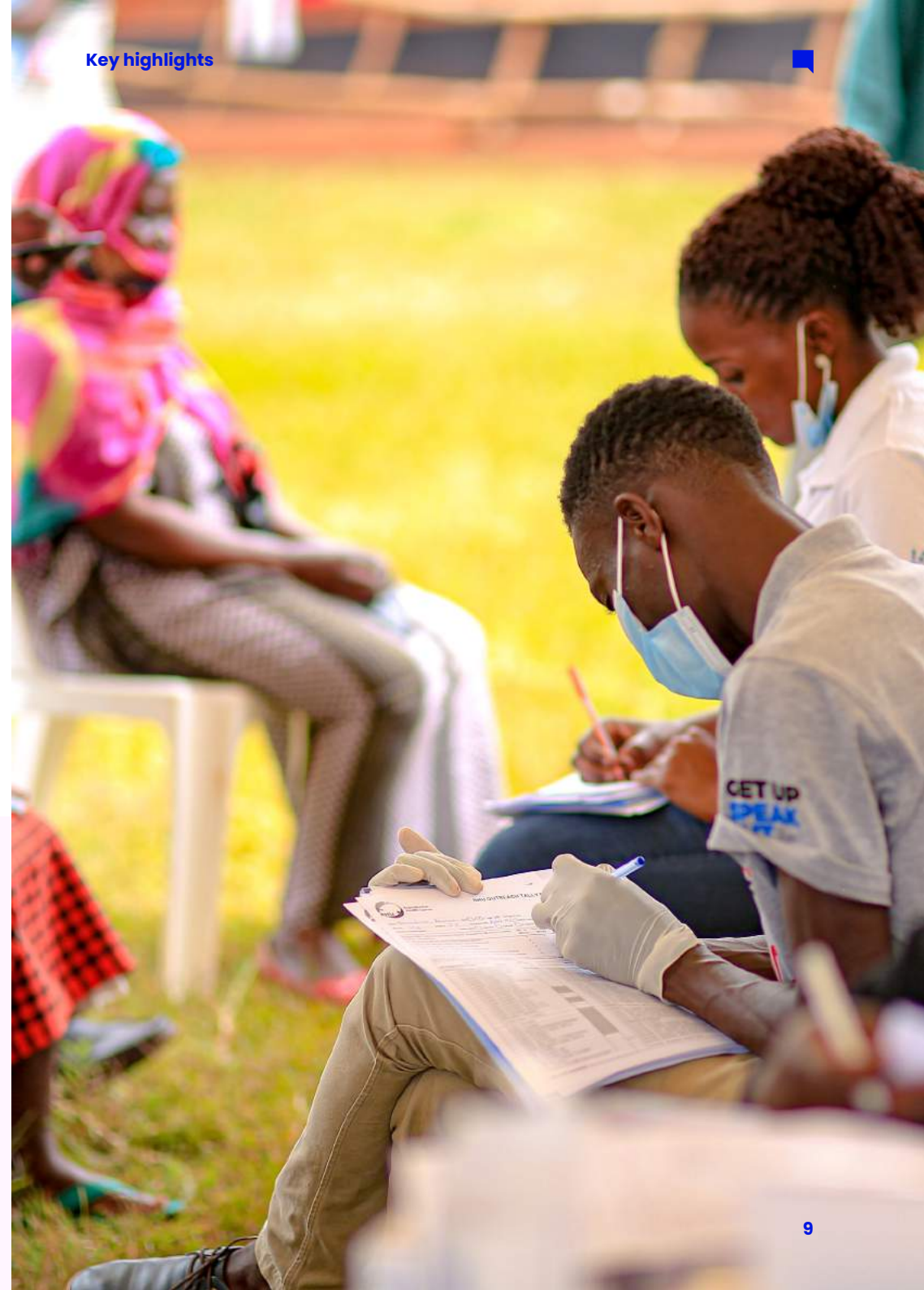
33 %

of young people feel more vulnerable to sexual harassment, or sexual, physical, emotional or financial abuse, compared to before COVID-19.

Economic difficulties caused by unemployment, as well as the stay at home orders during lockdown, have led to tensions within the household, leaving young people vulnerable to violence. Young LGBTQI people and young people living with a disability also mentioned being subject to physical and psychological abuse as a result of the COVID-19 restrictions.

COVID-19 has made young people more vulnerable. People at risk before the pandemic often faced additional hardship and challenges.

Examples of increased vulnerability during COVID-19: increased stigma and harassment for young LGBTQI people, increased difficulties in accessing ARV drugs for HIV-positive young people, increased harassment for transgender youth and sex workers, and more marginalisation for young people living with a disability when, for example, no appropriate measures were in place for them to access online learning.



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Nepal

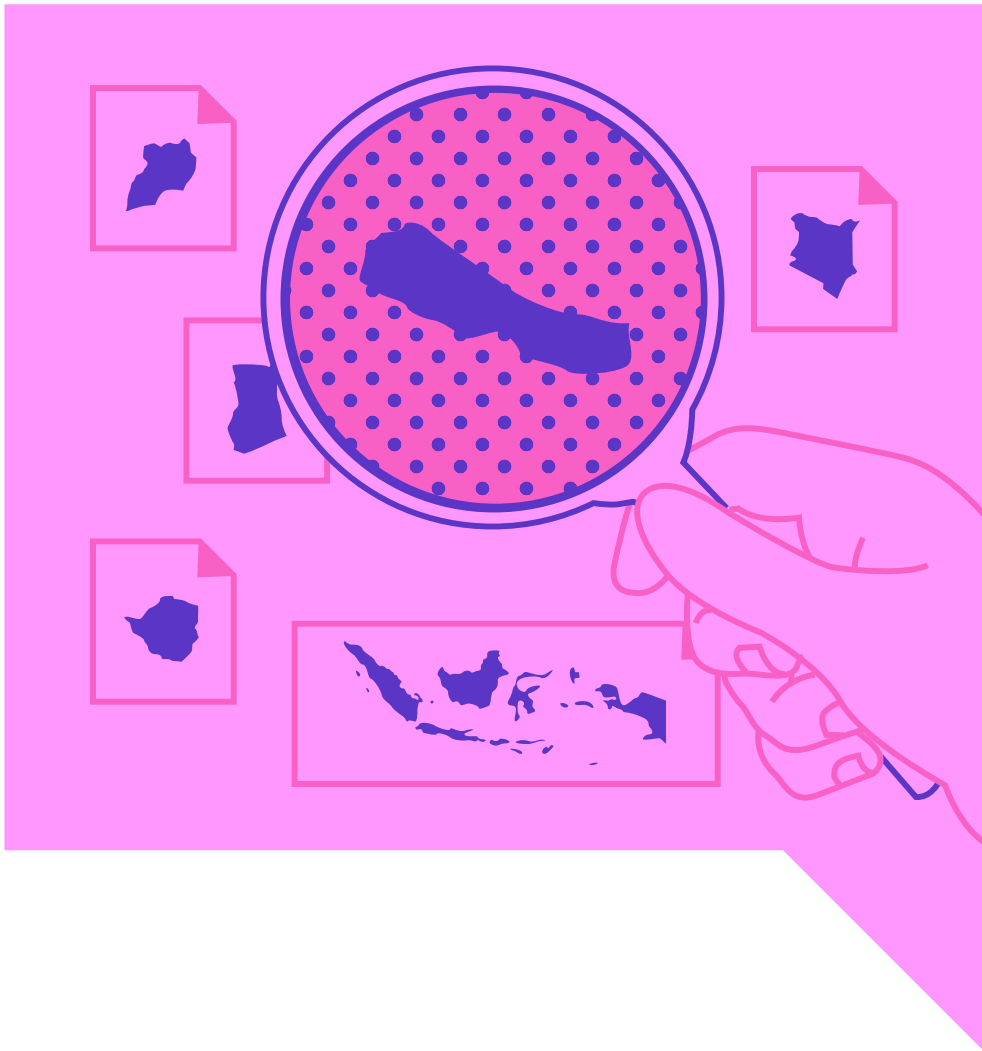
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1 Introduction

The global COVID-19 pandemic has disrupted all aspects of young people's lives, including their schooling, livelihoods and gender relations, as well as their access to youth-friendly sexual and reproductive health (SRH) services.¹⁻³ COVID-19 infection prevention and management measures (including, for example, lockdowns, self-isolation, restrictions on movement) appear, in many settings, to have had a significant impact on young people's access to SRHR information and services.⁴⁻⁵

The study presented here was carried out by Rutgers in collaboration with its partners in two global initiatives: Right Here, Right Now (RHRN), and Get Up, Speak Out for Youth Rights! (GUSO). The mixed methods participatory research took place with young people in Ghana, Indonesia, Kenya, Nepal, Uganda and Zimbabwe. It sought to understand the logistical, cultural and psycho-social barriers to young people's SRHR during the pandemic. Recommendations, largely formulated by the young people themselves, suggest how these can be addressed, including among vulnerable groups such as lesbian, gay, bisexual, transsexual and queer (LGBTQ) youth and young people living with disabilities.

1.1 What is the impact of COVID-19 on young people's SRH: evidence from literature

Whilst COVID-19 has disrupted access to health care provision for many people, it has also possibly exacerbated challenges for adolescents who, even



before the pandemic, often had difficulty accessing SRH services.⁶⁻⁷ However, as the COVID-19 pandemic is little over a year old, peer-reviewed publications on its impact on young people's SRH knowledge, attitudes and practices are somewhat scant.⁸ Nevertheless, there are, for example, significant amounts of informal information in the media and on social media, in blogs and in non-peer reviewed or rapidly reviewed publications, which we will also draw upon here. In addition, Rutgers' project partners who work directly with young people have first-hand experience of some of the difficulties that COVID-19 has posed for SRH service provision. A number of partner organisations have commissioned studies in order to better respond to these new challenges, and they provide important background evidence, which is presented below.

Changes in service provision and in the availability of commodities

On International Youth Day 2020, FP2020 and the International Association of Adolescent Health specified that during the COVID-19 pandemic, it is essential to ensure that adolescents are able to obtain quality health information and services. They noted that *"this must include sexual and reproductive health (SRH) information and services so that adolescents can prevent, delay, or space a pregnancy, and avoid sexually transmitted infections, including HIV"* and that *"continued inattention to identifying and addressing their health and social needs will have far-reaching consequences for adolescents as well as their families and communities"*.⁹

Evidence suggests that COVID-19 has had an impact on contraceptive and abortion services, STI and HIV management, as well as the way in which young people acquire SRHR information. It is estimated that in low and middle income countries, COVID-19 will lead to a 10% proportional decline in the use of short- and long-acting reversible contraceptive methods.¹⁰ This will result in an additional 49 million women with an unmet need for modern contraceptives and an additional 15 million unintended pregnancies over the course of a year.

The impact of COVID-19 also risks disrupting supply chains and national and local stocks of contraceptive methods, particularly long-acting methods.¹¹ MSI Reproductive Choices estimates that across the 37 countries worldwide where it provides contraception and safe abortions, COVID-19 disruptions could lead

to an additional 1.3 - 3 million unintended pregnancies, 1.2 - 2.7 million unsafe abortions and 5,000 - 11,000 pregnancy-related deaths.¹² These are particularly likely to affect young women.¹³ In addition, those requiring STI diagnoses and treatment may not be able to access services and HIV-positive individuals may experience ruptures in the provision of their life-saving antiretroviral (ARV) medicines. The WHO reports that seventy-three countries have warned that they are at risk of stockouts of ARVs as a result of the COVID-19 pandemic. Twenty-four countries have reported having either a critically low stock of ARVs or facing disruptions in supply.¹⁴

In many settings, services have had to change their mode of delivery (for example, by using telemedicine or doing telephone consultations) or have even been suspended or curtailed.¹⁵ It is discussed below how this creates issues of accessibility for young people and may also affect their acquisition of SRHR information so they can protect themselves from unwanted pregnancies, STIs and HIV, as well as from gender-based violence.

The UNFPA recommends creative and flexible outreach strategies to reach young people through digital platforms – which many organisations are already using – to promote, for example, comprehensive sexuality education and social and behavioural change communication.¹¹ Without being able to physically access health services for health information, young people may also become increasingly reliant on social media platforms such as Facebook or WhatsApp. Although these widely-used channels may disseminate information about both COVID-19 and SRH, they may also propagate ‘fake news’, rumours and poor quality information.¹⁶ In addition, there is a gender disparity in phone ownership, particularly in terms of smartphones. Research indicates that globally, a woman is 21 percent less likely to own a mobile phone than a man.¹⁷ This is likely to have both direct and indirect implications for SRH. Owning a phone can be empowering for a woman, allowing her to access both health and other types of information that she would be unable to gain otherwise.¹⁸ Possessing a mobile phone or being able to access the internet is of great importance, particularly when other sources of information, such as comprehensive sexuality education programmes in school, are no longer available due to closures because of COVID-19. Not having a phone or being unable to access the internet in the era of COVID-19 is therefore likely to



be disadvantageous for young people seeking SRH information and support.

Finally, it is important to acknowledge that adolescents are not a homogenous group and that the pandemic poses unique challenges for marginalised communities, including young people who identify as LGBTQ, those living with disabilities, and those who are migrants, refugees or living in humanitarian settings.¹⁹ The findings presented below provide particular insights into the challenges faced by the LGBTQ community, disabled young people and those who even before the pandemic were enduring poverty and hardship.

The impact of COVID-19 prevention measures on young people's psychological well-being

Early research indicates that the COVID-19 crisis and its prevention measures may be having a significant impact on young people's psychological well-being. For example, in Wuhan, China, where the virus was first identified and mitigation measures were implemented on a large scale, it has been found that the long-term quarantine policies had a complex influence on young people's mental health.²⁰ They resulted in increased risk behaviours such as smoking and drinking, as well as feelings of isolation and a lack of control. A survey of young people by Indonesia's Youth Advisory Panel found that ninety percent of young people have felt anxious during the COVID-19 pandemic, with social distancing measures forcing schools and workplaces to close. The analyses reveal a number of reasons for this anxiety, ranging from a perceived lack of improvement of the situation (70%) and an inability to socialise (58.7%), to financial issues (40%) and feeling unsafe in their environment (38%).²¹ In Nepal, RHRN affiliate Visible Impact carried out research on the impact of COVID-19 on young people. It found that as the nationwide lockdown started and educational institutions, employment, sport or recreation opportunities and travel were no longer operational, respondents found coping with the imposed restrictions as well as with the fear of the disease itself stressful.²² The Visible Impact study reveals that the pandemic has had an impact on young people's mental, psychological and emotional health; for example, interviewees stated that "Losing our daily routines, having the bare minimum of things to do and coping with the idle hours were exhausting!"

The impact of the closure of workplaces and schools

School closures due to COVID-19 have affected more than a billion students worldwide. Using data on 157 countries, a World Bank simulation found that COVID-19 decreased the years of basic schooling that students will achieve during their lifetime from 7.9 years to between 7.0 and 7.6 years.²³ Close to 7 million students from primary up to secondary education could drop out due to the income shock of the pandemic alone. The authors note that exclusion and inequality will likely be exacerbated, as already marginalised and vulnerable groups, such as girls, ethnic minorities and persons with disabilities, are more adversely affected by school closures.

The closure of schools does not only present learning challenges but also removes the possibility of peer group interactions, which usually create and consolidate SRH norms and the exchange of information among youth.²⁴ In the slums of Nairobi, Kenya, where schools have closed, a study by the Population Council noted that 89% of adolescents think that they will return to school when they reopen. However, among those who reported being unsure of whether they would return to school, 59% said it was because of difficulties in paying school fees.²⁵ Girls were less confident they would return than boys and there were fears that families may prioritise sending boys back to school or that girls may be pregnant by the time schools start up again. In the Nepali study described above, RHRN network member Visible Impact noted importantly that after the closure of educational institutions, comprehensive sexuality education was not prioritised in online learning. In addition, it was found that for many young women, particularly those with disabilities, it was difficult to access menstrual hygiene products, which were often obtained at school.²²

Regarding the closing of workplaces, it should be noted that globally, only those in non-manual occupations could attempt to work from home. Those with jobs as labourers, market traders and others operating within informal economies, for example, were likely to find themselves unemployed and consequently to suffer financial hardship.²⁶ In a number of settings, the economic consequences of COVID-19 have resulted in an increase in sex work and transactional sexual relations – by men, women and children – which entail a heightened risk of STI and HIV infection as well as gender-based violence.²⁷



The gendered impact of COVID-19

UNFPA projections suggest that six months of COVID-19-related disruptions and lockdowns will result in an additional 31 million cases of gender-based violence worldwide. The interruption of programmes to prevent child marriage, as well as the negative effects on household economic status, are likely to result in an additional 13 million child marriages.¹¹ UNICEF (2020) documents how families may consider earlier marriage a viable option if the pandemic has caused or exacerbated food insecurity and economic hardship within their households.³ The consequences of the pandemic for young women also include an increase in child labour among adolescent girls, loss of income and reduced financial empowerment, increased household work, reduced access to healthcare alongside increased maternal deaths, together with greater food insecurity and malnutrition.²⁸

The tendency of infectious disease outbreaks to increase gender-based violence have been well-reported during other major recent epidemics, including Zika, SARS and Ebola.³ Early evidence indicates that COVID-19 is no different in this respect, with providers of services for survivors of gender-based violence and community groups noting a sharp increase in incidents of intimate partner violence in many settings.²⁹ Adolescent girls are particularly vulnerable. Reach a Hand, Uganda (RAHU), a member of the RHRN network, recently completed a study that found that the increasing number of gender-based violence cases in homes requires urgent attention from both the government and civil society organisations to ensure that young people can access psycho-social support and counselling services whilst they are in isolation.³⁰

The impact of COVID-19 on LGBTQ communities

Turning to the situation of LGBTQ communities (which often already faced profound discrimination pre-COVID-19), evidence suggests that the pandemic, and the measures taken to combat it, may increase their vulnerability.³¹ For example, due to stay-at-home restrictions, many LGBTQ youth are confined in hostile environments with unsupportive family members or co-habitants. This can increase their exposure to violence, as well as their risk of anxiety and depression.³² In Pakistan, an RHRN partner Forum for Dignity Initiatives carried out a study on the impact of COVID-19 on reproductive health services for

sexual and gender minorities.³³ This comprised interviews with young people and those involved in service delivery. The analysis of youth interviews revealed a high level of knowledge regarding COVID-19 and its preventive measures yet a relatively low self-assessment of risk. Most young people considered their social relationships and mental health to be adversely affected by the pandemic, and almost a third of respondents shared negative impacts of COVID-19 on their economic situation or on their income generation. The results also showed a very low utilisation of health services of any kind, including SRHR services, by young people during the pandemic. The findings suggest this is due to a perception of reduced need, a fear of stigma or discrimination, or simply because of a lack of knowledge about what services are available.

In Zimbabwe, GALZ, an association of LGBTQ people affiliated to RHRN, documented the nature and extent of the impact of COVID-19 on young LGBTQ people's access to SRHR services.³⁴ They noted that the pandemic and its associated measures, such as lockdowns, curfews and pass letter requirements, restrict the spaces where LGBTQ groups can operate and make them more vulnerable as a result. These groups have faced difficulty in accessing credible information from trusted sources like the GALZ centres or have failed to access medicines via 'key population-friendly' facilities, often being subjected to stigma as they travel to them. In addition, due to power differentials and financial need, some have engaged in unprotected sex with older persons, further exposing them to HIV and STIs. However, despite this hostile environment, some young LGBTQ people have created networks with facilities offering services to deliver medications at home. Others have been able to get services from GALZ's new COVID-19 intervention clinic for key populations, where there is a pool of officers and peer educators who can offer support.

1.2 How was the course of the COVID-19 pandemic in the six study countries?

The COVID-19 pandemic has followed a roughly similar timescale in each of the countries enrolled in the study. Table 1 below shows the number of cases testing positive and the number of confirmed COVID-19-related deaths in each of the national settings, as recorded officially by WHO. The lower numbers in

the African countries may reflect reduced testing capacity and weak health and vital registration systems. However, there are also a number of emerging clinical and epidemiological hypotheses as to why COVID-19 appears not to be so widespread on the continent, such as the fact that the young age structure of the population may result in more mild and asymptomatic cases, as the disease seems to be more severe in older populations.³⁵⁻³⁶

Table 1: Number of confirmed COVID-19 cases and deaths in the countries selected for the study.

	Number of confirmed cases of COVID-19	Cumulative number of confirmed COVID-19-related deaths
Ghana	55,168	335
Indonesia	797,723	23,520
Kenya	97,398	1,694
Nepal	263,605	1,903
Uganda	36,702	294
Zimbabwe	17,804	431

Source: www.Covid-19.who.int, accessed 8th January 2021

As part of the research presented here, each country team was asked to describe what measures had been taken to prevent the spread of the virus in their national setting. These are shown in Table 2, which indicates that each country took broadly similar preventive steps to combat the pandemic, including lockdowns (of varying timing and duration), social distancing, the use of face coverings and hand washing/sanitiser. Where possible, people were encouraged to work from home, although, as described above, this was only obviously feasible for those who had office jobs in the tertiary sector. In many countries, restrictions on transport meant that people could not travel freely. Further on in the report, it is discussed how this has had an impact on both young people's sexual activity (making it difficult to meet with their partners, for example) as well as on their potential to access SRH services.

Table 2: COVID-19 prevention restrictions for the six countries selected for the study

	LOCK-DOWN STATUS PER 29TH OCTOBER 2020	SELF-ISOLATION IF INFECTED	SOCIAL DISTANCING	LIMITING GATHERINGS	WORKING FROM HOME	CLOSING OF SCHOOLS	REDUCTION IN PUBLIC TRANSPORT	OBLIGATORY FACE COVERINGS	HAND WASHING/USE OF SANITISER	NIGHTTIME CURFEW	
	START OF LOCK-DOWN										
Ghana	30/3/20-19/4/20	None	✓	✓	✓	✗	Partial reopening	✗	✓	✗	✓
Indonesia	3/4/20 (partial)	Regional	✓	✓	✓	Regional	Partial reopening	✓	✗	✗	✓
Kenya	16/5/20-7/6/20	None	✓	✓	✓	✓	Partial reopening	✓	✓	✓	✓
Nepal	24/3/20-21/7/20	Varies by local government	✓	✓	✓	✓	Yes (some private schools have resumed)	✗	✓	✗	✓
Uganda	1/4/20-2/6/20	None	✓	✓	✓	✓	Open for exam candidates only	✓	✓	✓	✓
Zimbabwe	30/3-21/7	None	✓	✓	✓	✓	Open for exam candidates only	✓	✗	✓	✓

Sources comprise official government websites and/or national media in each country and are available on request.

As the impact of COVID-19 on schooling is likely to disproportionately affect young people, it is worth exploring in more detail what steps have been taken in each country regarding education. In all countries, lockdown meant, in principle, the full closure of all schools. After lockdowns were lifted, there was some selective re-opening of schools in all national settings, mainly because of examinations. For example, in Ghana, schools were closed on 30th March 2020, though special arrangements were made for those in universities and high schools to complete their examinations. At the time of writing the report, primary schools and universities are completely closed, whilst high schools are only open for second year students. In Indonesia, some areas reopened schools after lockdown, but if infection rates are seen to rise, they will close again. In Kenya, all schools were closed after lockdown was announced, but there has since been a phased reopening for certain grades. In Uganda and Zimbabwe, all schools were closed during lockdown, but have since reopened for exam candidates only.

During school closures in Indonesia, pupils were encouraged to follow classes online. In Ghana, Uganda and Zimbabwe, some teaching was also delivered on the radio and television, as well as via the internet. However, it is discussed in section 3 how in all countries, young people's access to the necessary technology (phone, internet, TV, radio) has often been problematic and has frequently resulted in little or no learning during periods when schools were closed.



2 What methodology is used?

In each country, the general objective of the study was to better understand the effects of the COVID-19 pandemic on young people's SRH decision-making and access to services. This objective was studied via a mobile web survey and via qualitative data collection. Details about these methods as well as insights on ethics, data analysis and study limitations are shared in the sections below.

2.1 Objectives

In each country, the general objective of the study was to better understand the effects of the COVID-19 pandemic on young people's SRH decision-making and access to services. The specific objectives comprised the following:

- ▶ To shed light on the changed SRHR realities of young people in light of the COVID-19 pandemic in order to better address their SRHR needs;
- ▶ To generate information for health services and health care providers in order to make them better aware of the concerns and needs of young people;
- ▶ To construct a broader picture of the interconnectedness of young people's SRHR, the risk of gender-based violence and their psychological well-being.





The study used both quantitative and qualitative research techniques. The former consisted of a mobile web survey and the latter of FGDs. The field methodologies, participant selection procedures and limitations for each approach are described in detail below. The generic quantitative and qualitative research instruments are available upon request.

2.2 Mobile web survey

In Ghana, Kenya, Nepal, Uganda and Zimbabwe, a mobile web survey was conducted by GeoPoll (www.geopoll.com), which has significant expertise in this field. A standardised questionnaire was designed, pre-tested with young people and, if needed, modified in each country setting. This was done by Rutgers and an external consultant. GeoPoll then translated the survey into the relevant local languages and pre-tested it again before running the complete survey. After collecting basic socio-demographic information, the questionnaire addressed the following areas: adherence to COVID-19 prevention measures; access to SRH information; relationships; the last sexual partner; contraception; STIs and HIV; abortion (post-abortion care in Zimbabwe); gender-based violence; early marriage; and general well-being. All survey data was collected between October and December 2020.

The survey aimed to reach a minimum of 500 young people aged 18 to 30 in each country. In order to achieve a sample representative of the population of young people, GeoPoll researchers compared recent census data, mobile network operator data, and publicly available population data to inform the sampling approach. Population distribution data enabled the stratification of the sample by age and sex. Respondents were first contacted via an initial text (SMS) message containing a link to the survey, which was hosted by GeoPoll on an external platform. To complete the survey, respondents needed a smartphone or access to the internet. Respondents could reply to the text saying that they wanted to participate or not, or indeed they were free not to reply to the SMS at all and thus not to participate. Because participation required the possession of a mobile phone and access to an internet connection, the sample was biased to phone owners and therefore more highly educated individuals.



In Nepal, GeoPoll programmed the survey into their mobile web platform and generated a link to the survey, which RHRN platform members in Nepal forwarded to hundreds of young people. In Zimbabwe, some technical issues slowed the pace of data collection for the survey, resulting in a lower number of respondents. In Indonesia, programme partners were already conducting a survey on COVID-19 and young people (reaching over 800 young people; the report is not yet available at the time of writing); we therefore only include the qualitative research (FGDs) that we and our partners carried out in Indonesia in this report.

Among all survey invitations sent, the survey completion rate ranged from 0.1% (Zimbabwe) to 2% (Kenya and Uganda). These response rates are comparable to those for other mobile web surveys that GeoPoll has carried out.

2.3 Qualitative data collection

The qualitative research comprised of four to six FGDs per country and was collected between August and November 2020. The participants were chosen purposively by local partners. Particular attention was given to include groups that we anticipated would not be represented well in the quantitative research due to poor connectivity. In addition, the qualitative research included groups that are central to the partners' programmes, such as young people living with HIV, LGBTQ youth, lower-income youth and young people living with a disability. The profiles of the chosen groups thus differed slightly by country, as shown in Annex 1 and further discussed in section 3.2 below.

A generic interview guide for the FGDs was developed by Rutgers and the consultant, and the questions related to the entire duration of the pandemic so far (from the first lockdown up to the time of interview). This interview guide was then modified by local partners to accommodate cultural specificities within the groups they intended to interview. Thus, although the broad themes remained similar across national settings, the actual questions in each country's discussion guide(s) varied slightly in order to best capture the optimal way to frame the issues identified. It should be noted that the generic guide contained a number of questions for all groups about the challenges faced by LGBTQ youth in relation to COVID-19 and SRH services. However, in all countries, these



questions were in most instances only asked to LGBTQ groups themselves, as it was deemed too sensitive a topic for general questioning in contexts where such individuals are highly stigmatised and same-sex relationships are illegal.

An online qualitative training of young researchers connected to RHRN and GUSO partner organisations took place in August 2020. Ongoing support, when requested, was provided by Rutgers and the consultant. As Indonesia and Nepal were still subject to rules which forbade or discouraged the mixing of non-household members, the discussions were carried out using Zoom. Care was taken to protect the identities of participants by hiding their names from the screen. In other countries, the names of those participating in the face-to-face interviews were also not noted for reasons of confidentiality. All participants (whether interviewed face-to-face or remotely) were issued a screening sheet to check their eligibility for the discussion in question. This screening also collected information about their age, sex, relationship status, education and occupation, which was subsequently used to contextualise the quotations presented in the findings below.

The researchers chosen by the RHRN and GUSO partners for this project were young people connected to the two programmes, who had previously carried out SRHR-related research. There were significant advantages to involving young people as researchers. Most importantly, they allowed for meaningful youth engagement in the study, as they were considered peers by those participating and were therefore, in principle, more likely to gain their trust than adult interviewers. However, as discussed below, there were some minor difficulties related to their recruitment in contrast to more experienced interviewers, in that sometimes the probing or transcribing of responses was, at first, incomplete or problematic. However, with support from Rutgers and the consultant, they were coached to gain and record meaningful and original insights, which would probably not have been possible with older researchers.

Once all the FGDs had been completed, the researchers filled out a summary sheet that noted what had worked and what had not worked with their approach. The summary sheet also pulled together key issues which had emerged from the exchanges, including suggestions by young people themselves about how





COVID-19-related barriers to accessing SRHR services could be overcome. These and others emerging from the discussions have been incorporated into the recommendations presented towards the end of the report.

2.4 Ethics

All the study materials, including survey instruments, FGD guides and consent forms, were reviewed and approved by the relevant ethics committees in each country, together with the study protocol. In Zimbabwe, questions on access to abortion services were amended to questions on post-abortion care in response to requests by the ethics committee. Regarding the mobile web survey, GeoPoll never gives out respondent phone numbers and stores each respondent's information using an anonymised unique user ID, ensuring their privacy and data security. As described above, participation was voluntary, as young people received an SMS with a link to click on that would direct them to the survey. They could decline to participate or choose to fill in the survey at a time and place (safe space) appropriate for them. After participation, GeoPoll sent them a refund for the cost of data usage. Participants in the quantitative and qualitative research were adequately informed about the aim of the study and methods that would be used, the institutional affiliations of the research, the anticipated benefits, the potential risks and follow-up of the study, their right to decline to participate in the study or to withdraw from it at any time without reprisal, and measures to ensure the confidentiality of the information provided. The FGD participants were read an informal consent sheet and, if physically present, were asked to sign two copies of a consent form. One copy was retained by the respondent, the other by the local partner. Those participating in discussions remotely provided oral consent.

The FGDs were carried out in the context of prevailing COVID-19 prevention measures in each country. As noted above, because of these measures, it was sometimes difficult to convene groups under 'normal' conditions given limitations around movement and social distancing. This meant, in many cases, conducting physically distanced discussions while adhering to prevention measures, such as wearing face masks and using hand washing/sanitiser. Alternatively, in Nepal and Indonesia, as described above, discussions were conducted using Zoom.



2.5 Analysis

Quantitative analysis

Data were received from GeoPoll in separate Excel files for each country. These files were imported into Stata 16.0 and the data were cleaned. Data were analysed as one dataset. As the aim of this report is to describe the implications of COVID-19 for respondents' well-being, their access to SRH services and their sexual behaviours, descriptive statistics were used to present the findings by country. Where findings appeared to differ by age group (18 to 24 and 25 to 30) or sex, results are presented further stratified by age group and/or sex. Three individuals in Nepal who preferred not to disclose their sex were excluded from analyses stratified by sex. For sexual behaviours, analyses were restricted to respondents who were single or single but currently dating (referred to in this section as single).

Qualitative analysis

Digital recordings of the FGDs were uploaded to portable computers by the data collectors. The interviews were transcribed word-for-word and then translated from the local languages into English, with expanded field notes included as necessary. The socio-demographic details of the respondents(s), as recorded on the screening instruments, were then inserted at the beginning of each transcription, so that each response could be linked with the characteristics of the person who gave it. Transcriptions were analysed using qualitative data analysis software. Following the coding of interviewer notes and transcripts, a grounded theory approach allowed for the key concepts to be further refined into defined categories, to facilitate in-depth data analysis and to identify the common patterns and salient themes presented below.

2.6 Limitations

Any study addressing SRH concerns among young people can lead to challenging issues of data collection, particularly in settings where pre-marital sexual activity is to some extent socially taboo and where, for example, same-sex relationships may be illegal. Under such circumstances, respondents may



be reticent to participate in the study and/or to talk openly or enter responses about their beliefs and behaviours. Thus, there may have been a self-selection of individuals to the study who were more willing to talk about such topics, and who may not represent general opinion. In the six country settings presented here, young people under the age of 18 were not included in either the qualitative or quantitative research, even though they may have had difficulties with SRH outcomes or access to services, as this would have required complex ethical approval which was not feasible given the short time frame for the study.

Regarding the quantitative research, it is noted above that because in most countries the sampling was done by mobile phone, there will be significant bias among those recruited into the study. Those who do not possess a mobile phone or do not have access to an internet connection were excluded; these groups are likely to comprise poorer and more rural populations and women. The ability to complete the survey also required respondents to be literate, which excluded those with little or no schooling. An additional limitation could have been fatigue; as the questionnaire included over 80 questions, responses towards the end of the survey may be less reliable.

Regarding the qualitative research, as described above, in many cases it was difficult to carry out discussions under 'normal' conditions given limitations around movement and social distancing associated with COVID-19. In Nepal and Indonesia, FGDs were conducted online using Zoom and this, again, may have excluded populations living in areas where internet connections are limited.

In addition, in Ghana and Kenya, the qualitative study recruited a purposive sample of groups known to the RHRN and GUSO partners, such as peer educators or SRH champions. These individuals may be more aware of SRH issues than other young people, which reduces the ability to generalise the findings outside the study population.



3 How do young people deal with COVID-19 prevention measures?

This section presents the individual-level socio-demographic characteristics of the respondents. It also describes their adherence to the country-level COVID-19 prevention measures described above, and the reasons why they may not have been able to adhere.

3.1 Characteristics of survey respondents

Overall, this report includes data from 2,693 young people, who completed the survey in Ghana (N=596), Kenya (N=782), Nepal (N=234), Uganda (N=640) and Zimbabwe (N=441). In all countries, between 49% and 54% of respondents were female, the exception being Zimbabwe, where 19% of respondents were female. Three respondents in Nepal preferred not to disclose their sex.

In Ghana, Kenya, Uganda and Zimbabwe, more than 60% of respondents were aged 25-30 years. Conversely, in Nepal, survey respondents were younger,

with over 70% aged 18-24 (Table 3). Across and within the countries, there was variation in terms of where the respondents lived. Few respondents lived in rural areas, with the exception of in Kenya and young men in Nepal. The majority of respondents (74%) had lived in their current place of residence for over two years.

Table 3: Socio-demographic characteristics of survey respondents, by sex

	GHANA N=596 N (%)		KENYA N=782 N (%)	
	MALE (N=292)	FEMALE (N=304)	MALE (N=362)	FEMALE (N=420)
Age group (years)				
18-24	61 (20.9)	89 (29.3)	118 (32.6)	148 (35.2)
25-30	231 (79.1)	215 (70.7)	244 (67.4)	272 (64.8)
Place of residence				
(Capital) city	134 (45.9)	129 (42.4)	50 (13.8)	81 (19.3)
Town	124 (42.5)	133 (43.8)	186 (51.4)	226 (53.8)
Rural area	34 (11.6)	42 (13.8)	126 (34.8)	113 (26.9)
Relationship status				
Single/single but currently dating	236 (80.8)	206 (67.8)	222 (61.3)	229 (54.5)
Stable (unmarried) relationship	22 (7.5)	37 (12.2)	50 (13.8)	77 (18.3)
Married	34 (11.6)	54 (17.8)	85 (23.5)	105 (25)
Divorced/Widowed/Other	0 (0)	7 (2.3)	5 (1.4)	9 (2.1)
Educational attainment				
None or (in)complete primary	2 (0.7)	4 (1.3)	9 (2.5)	3 (0.7)
(In)complete secondary	67 (22.9)	62 (20.4)	51 (14.1)	42 (10)
(In)complete college/university	221 (75.7)	234 (77)	301 (83.1)	372 (88.6)
Other	2 (0.7)	4 (1.3)	1 (.3)	3 (0.7)
Reports having a disability	14 (4.8)	14 (4.6)	13 (3.6)	11 (2.6)

Over 55% of respondents in all countries reported that they were single or single but currently dating. One quarter of respondents in Kenya and Zimbabwe reported being married. Over 70% of respondents in all countries had incomplete or complete college or university level education and were thus much more highly educated than the general population. Three to ten percent of all respondents reported having a disability. Among these young people, the most commonly cited disability was a physical disability (40%).

	NEPAL N=231* N (%)		UGANDA N=640 N (%)		ZIMBABWE N=441 N (%)	
	MALE (N=104)	FEMALE (N=127)	MALE (N=314)	FEMALE (N=326)	MALE (N=358)	FEMALE (N=83)
Age group (years)						
18-24	77 (74.0)	107 (84.3)	107 (32.8)	103 (32.8)	101 (28.2)	22 (26.5)
25-30	27 (26.0)	20 (15.7)	219 (67.2)	211 (67.2)	257 (71.8)	61 (73.5)
Place of residence						
(Capital) city	57 (54.8)	97 (76.4)	152 (46.6)	119 (37.9)	224 (62.6)	53 (63.9)
Town	15 (14.4)	20 (15.7)	110 (33.7)	119 (37.9)	95 (26.5)	24 (28.9)
Rural area	32 (30.8)	10 (7.9)	64 (19.6)	76 (24.2)	39 (10.9)	6 (7.2)
Relationship status						
Single/single but currently dating	83 (79.8)	108 (85.0)	244 (74.8)	193 (61.5)	221 (61.7)	51 (61.4)
Stable (unmarried) relationship	13 (12.5)	12 (9.4)	35 (10.7)	49 (15.6)	42 (11.7)	5 (6)
Married	7 (6.7)	6 (4.7)	42 (12.9)	58 (18.5)	91 (25.4)	20 (24.1)
Divorced/Widowed/Other	1 (1)	1 (0.8)	5 (1.5)	14 (4.5)	4 (1.1)	7 (8.4)
Educational attainment						
None or (in)complete primary	2 (1.9)	0 (0)	7 (2.1)	10 (3.2)	2 (0.6)	1 (1.2)
(In)complete secondary	16 (15.4)	16 (12.6)	91 (27.9)	73 (23.2)	85 (23.7)	15 (18.1)
(In)complete college/university	86 (82.7)	110 (86.6)	227 (69.6)	226 (72)	266 (74.3)	66 (79.5)
Other	0 (0)	1 (0.8)	1 (0.3)	5 (1.6)	5 (1.4)	1 (1.2)
Reports having a disability	5 (4.8)	0 (0)	33 (10.1)	22 (7.0)	9 (2.5)	0 (0)



3.2 Characteristics of participants in the qualitative study

As described above, the participants in the qualitative research (shown in Annex 1) comprised groups that we anticipated would not be represented well in the quantitative research due to poor connectivity, as well as groups that are central to the partners' programmes. These included young people living with HIV, LGBTQ youth, lower-income youth and young people living with a disability. Participants also included young mothers, young sex workers, young manual workers, unemployed youth, as well as those working or volunteering in the field of SRH as peer educators, champions and mentors. The number of participants in each country was as follows: Ghana (21 young men, 14 young women, 1 non-binary), Indonesia (12 young men, 11 young women, 1 non-binary), Kenya (16 young men, 28 young women), Nepal (15 young men, 15 young women, 1 non-binary), Uganda (14 young men, 22 young women, 3 non-binary) and Zimbabwe (11 young men, 18 young women). Most had some secondary schooling, although in Zimbabwe university students were also interviewed. Those providing sensitisation and advocacy with young people, such as peer educators in Ghana and SRH champions in Kenya, also had higher levels of education than the general population. However, in each setting, groups with low or no education also participated in the discussions; for example, kayaye (female market porters) in Ghana and rural youth in Indonesia. Most participants in each country lived in urban or peri-urban communities, except for in Indonesia where, as described, rural youth also took part in the discussions. It should be noted, however, that many participants had rural origins and had moved to cities for educational or employment purposes.



3.3 Young people's adherence to COVID-19 prevention measures

Table 2 shows the country-level measures put in place to combat the spread of COVID-19. Table 4 indicates what prevention measures the survey respondents said were in place in their country, and indicates their adherence to these measures.

Across all countries, hand washing/use of sanitiser was the most commonly cited measure (>80%) in place to prevent the spread of COVID-19. This was followed by social distancing, recommended face masks and limiting the number of people gathering in one place. Working from home was cited as a measure by half of the respondents in Nepal, one-third of respondents in Kenya and Zimbabwe, and a quarter in Uganda, but was not commonly reported in Ghana.

Hand washing/use of sanitiser was adhered to by almost all respondents, alongside recommended face masks and social distancing. Working from home was less commonly adhered to, perhaps as people were in employment that did not allow them to work from home, as was self-isolation if infected in Ghana and Kenya, with just over 50% of respondents there adhering to this measure. The relatively low adherence to this measure could, of course, be because these young people had not been sick with COVID-19 and therefore were not required to self-isolate.

Table 4: Measures in place to prevent COVID-19 and adherence to these measures among young people

	GHANA N=596 N (%)	KENYA N=782 N (%)	NEPAL N=234 N (%)	UGANDA N=640 N (%)	ZIMBABWE N=441 N (%)
Prevention measures in place					
Social distancing	397 (66.9)	531 (67.9)	160 (68.4)	444 (69.4)	310 (70.3)
Self-isolation if infected	247 (41.7)	320 (40.9)	168 (71.8)	303 (47.3)	272 (61.7)
Limiting the number of people gathering in one place	330 (55.6)	489 (62.5)	154 (65.8)	410 (64.1)	301 (68.3)
Working from home	92 (15.5)	270 (34.5)	126 (53.8)	149 (23.3)	140 (31.7)
Recommended face masks	365 (61.6)	537 (68.7)	148 (63.2)	426 (66.6)	307 (69.6)
Hand washing/use of sanitiser	488 (82.3)	661 (84.5)	201 (85.9)	523 (81.7)	370 (83.9)
Among respondents mentioning the prevention measures, whether they adhered to them					
Social distancing	331 (83.4)	462 (87.0)	141 (88.1)	355 (80.0)	254 (81.9)
Self-isolation if infected	136 (55.1)	169 (52.8)	127 (75.6)	184 (60.7)	199 (73.2)
Limiting the number of people gathering in one place	236 (71.5)	376 (76.9)	125 (81.2)	282 (68.8)	220 (73.1)
Working from home	53 (57.6)	157 (58.1)	88 (69.8)	68 (45.6)	85 (60.7)
Recommended face masks	308 (84.4)	465 (86.6)	122 (82.4)	344 (80.8)	263 (85.7)
Hand washing/use of sanitiser	468 (95.9)	631 (95.5)	186 (92.5)	486 (92.9)	349 (94.3)

The qualitative data reveal some of the reasons why the prevention measures were sometimes difficult for young people to implement. In Ghana, some respondents found the wearing of masks constraining and perceived it to impair their breathing. Others reported that they were laughed at if they wore a mask or that there was doubt that the virus even existed.

When I started wearing the face mask, I was not able to breathe. Some of the hand sanitisers also smell of alcohol and I don't drink alcohol. But I am able to do the hand washing because it keeps me neat!

Young woman, 20 years old, Ghana

When you look at Tamale it is different from other places. Young people in other cities are complying, but the ones in Tamale don't. Some people even say the virus is not in Ghana. Others also laugh at you for wearing face masks!

Young man, 23 years old, Ghana

Other respondents noted that young people had followed the preventive measures well at the beginning of the pandemic. However, as the number of cases of COVID-19 infection was perceived to have gone down, they became more relaxed and less likely to take precautions.

I think in the beginning people followed the measures because they were afraid to die, but when the cases began reducing, people became sloppy. Especially in the rural areas, people are not following these measures.

Young man, 24 years old, Kenya



Nepali respondents reported that social distancing was problematic in household settings which were overcrowded. Individual measures were easier to implement, but those that required the cooperation of other people were more difficult to adhere to.

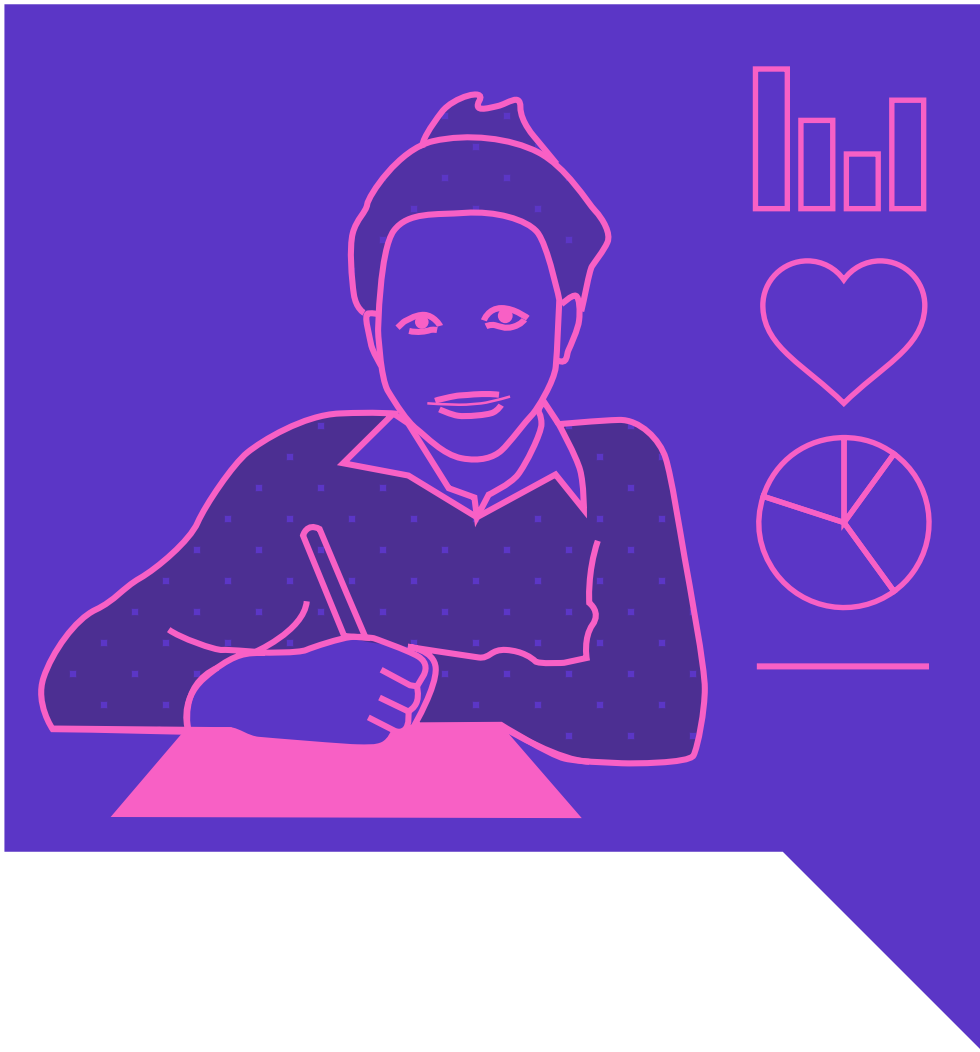
Normally, with regard to using sanitiser and other measures, I am following those things personally, but in case of physical distancing it is very difficult as I live in a big family. Many people work outside and might get the virus.

Young woman, 25 years old, Nepal

In Uganda, some respondents living with HIV reported that taking preventive measures against COVID-19 was sometimes perceived by others as meaning that they were infected with COVID-19. Such accusations are likely to be hard to bear given the stigma that HIV-positive people already face in many settings.

I have realised that the young people in my community have not accepted the measures because they even think that me, who always has a mask on and sanitiser in my bag, is the one who will infect them with the virus.

Young man, 21 years old, Uganda



4 What is the impact of COVID-19 on young people's lives?

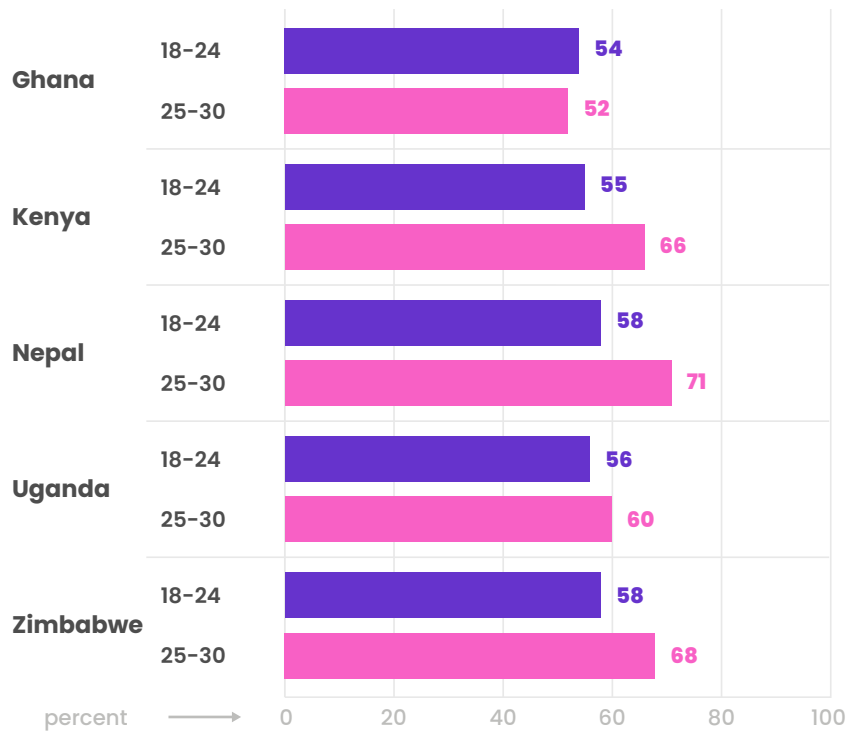
In order to contextualise the pandemic and understand its effect on their life experiences, both the quantitative and qualitative research asked about its impact on young people's schooling, income and general well-being. As shown below, the findings indicated that these impacts (lack of schooling, curtailed income and poor mental health) are interlinked and, in some cases, have profoundly negative consequences for young people, including increasing their vulnerability.

4.1 Schooling

As shown in Table 2, in many countries, schools were closed or were only open for limited purposes, such as exams. In the survey, only 38% of respondents

reported still being in school (range: 35% in Uganda and Zimbabwe to 59% in Nepal). Overall, 58% of all respondents still in school reported that their school had been closed at one point due to COVID-19. In all countries except Ghana, more respondents aged 25-30 reported that their school had been closed due to COVID-19 than respondents aged 18-24 (Figure 1).

Figure 1. Percentage of young respondents currently in school who reported COVID-19-related school closures, by age group (18-24 and 25-30)



If schools closed due to the pandemic, teaching was, in principle, often done **online or via the radio or television**. In practice, however, students found the educational material very difficult to access, frequently because they lacked an internet connection or money to pay for it.

To be honest, learning online and being physically at college is different, because when I look at (the course work for) student teachers, there are topics such as planning. Planning is not easy to teach over the phone, because when lecturers teach us (in person), they write on the board, so you understand these topics better. If you are taught online, maybe on that day you don't have (internet) bundles, so it's difficult for you to keep up. It's a challenge, especially to look for bundles.

Young woman, 23 years old, Zimbabwe

I'm a student, I have challenges with internet. In fact, I had to buy a phone to be able to access the online classes. That is expensive for me, because I have to pay school fees and, on top of that, buy access to the internet to join the classes.

Young woman, 23 years old, Kenya

After I gave birth, my parents had to take me back to school, but I am now sitting at home without schooling and am losing out because I hear that our colleagues in Kampala are using the internet to study, which we cannot afford in the villages. So we may not be able to compete when it comes to final exams.

Young woman, 18 years old, Uganda

Those in rural areas not only often **lacked an internet connection** but also had trouble accessing a radio to listen to their classes on air.

There are young people who live in the rural areas who will have problems travelling to where they can access a radio – the distance will be long and this will be a huge disadvantage to them, and they will lag behind when others will be learning. A pupil who lives in the city knows that if they go into any shop they can ask for permission to listen to the radio. Even on a smartphone, one can also listen to the radio. So we are seeing that it's a big disadvantage to those who live in the rural areas, since most of them do not own a radio.

Young man, 17 years old, Zimbabwe

Students living with disabilities appeared to be particularly disadvantaged by online teaching, as little or no provision had been made for them.

I can talk about people with visual loss regarding education. They used to have Braille books. The government has already prepared Braille print books, but now not every student from class 1 to class 10 has books. And for online classes also they do not have devices. It affects learning – our research showed that more than 95% (of) people with visual loss do not have access to online education.

Young man, 22 years old, Nepal

These challenges have meant that some students have **dropped out** of school during the pandemic, either because they could not follow the classes online or via mass media, because they had become demotivated, or because their parents or relatives could no longer pay the fees.

It has caused a lot of problems, like school dropout, especially in junior high school and senior high school – some pupils have just withdrawn from school. Some are thinking of not going back to school – we don't know when school will resume, so it is like they have just dropped out of school because of the Corona virus.

Young woman, 23 years old, Ghana

My mother has made it clear that she has used up all the money she had saved up for my school fees when I got sent home during the lockdown. Now I don't know if I'm going back to school.

Young woman, 24 years old, Uganda

During our regular physical education classes we get some information about SRHR, but now, in lockdown, the main focus subjects in online classes are math, science and Nepali subjects.

Young man, 20 years old, Nepal

Across all the study countries, respondents reported a large number of consequences of school closures for young people's SRH. In Nepal, students remarked that **they had not received any comprehensive sexuality education** since they had started learning online, whilst in Zimbabwe, SRH clubs that had met in school were no longer accessible now that students had been sent home. The loss of these important sources of information and peer exchange have left young people less prepared for relationships and less able to look after their own well-being.



There are clubs, like in schools, which give us information about relationships. How to go for the right person and not to just make a move before thinking. But now that we are at home, the person says to you that "I want to have sex with you", and you don't have anyone to ask and share that information with or to discuss the issue with. So you are on your own. You just tell yourself that he is my boyfriend, I can go for it. So it's actually a disadvantage, because at times we end up doing things that we regret.

Young woman, 19 years old, Zimbabwe

Because schools are closed and young people who are supposed to be at school are home, there is more freedom. They have taken that opportunity to also do bad things like engaging in sexual activity, which will end up with the children who are supposed to be at school getting pregnant. If they were at school, they would have been at a low risk of getting pregnant.

Young woman, 25 years old, Zimbabwe

In many settings, female **school pupils who become pregnant are not allowed to return to school** after giving birth, thus they must forfeit their education.

When I look at COVID-19, it particularly affected the girl child. If a girl child doesn't go to school, it affects them because they can be a school dropout, because a girl cannot take her child to school when she gets pregnant. Six months being home and sitting idle has disadvantaged her in that she can no longer go to school and parents can no longer pay fees for her, so her future will be bleak.

Young woman, 23 years old, Zimbabwe

Across all national settings, one of the biggest impacts of school closures and/or lockdown has been that **girls could not access sanitary products** or information about menstrual hygiene. Sanitary protection is often given out within schools, but when young women were confined at home, they were unable to access what they needed to manage their menstruation.

Before COVID-19, I used to see our women's representative giving girls sanitary towels, but now they are home it's very difficult for them to receive sanitary protection. We even conducted research recently and we found out that they are really suffering. For example, you find a girl living with her grandmother and she can't access the pads. While they're in school it's easy to distribute, because they get them every two weeks.

Young man, 21 years old, Kenya

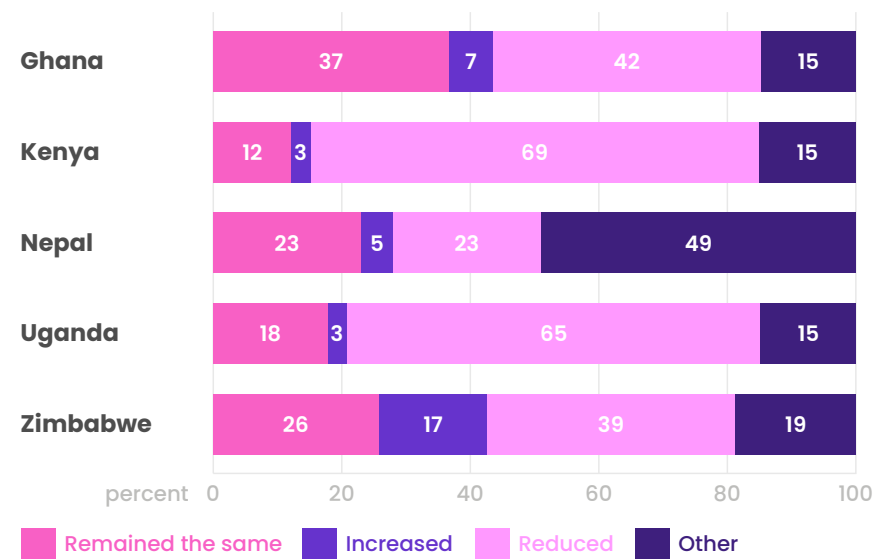
I used to get money from my parents for sanitary pads when schools were open, but they lost their jobs in the lockdown and now I no longer get anything from them except for food. They say my menstruation needs are not as urgent as food!

Young woman, 18 years old, Uganda

4.2 Income

In many countries during the pandemic, individuals have been encouraged to work from home where possible. However, as described above, this has generally only been feasible for those employed in the secondary or tertiary sectors. Those working in the primary sector, for example, such as street or market traders or manual labourers, have often found themselves unemployed or with severely diminished incomes. Among survey respondents, 54% were in full- or part-time employment (range: 36% Nepal to 61% Ghana). Overall, between 23% (Nepal) and 69% (Kenya) reported a reduction in their income (Figure 2). Although respondents were not asked what type of employment they were in, considering their level of education, their employment was likely to be low-risk compared to those with lower educational attainment. Had our survey included more individuals with lower educational attainment, an even higher percentage of respondents would likely have reported reduced income.

Figure 2: The effect of the COVID-19 crisis on individuals' income compared to before the pandemic among young survey respondents





The widespread problem of a loss of income was born out by the qualitative data, which also noted that respondents frequently complained of **diminished earnings or unemployment**, or of the fact that their clients also had less money and were unable to pay for their services.

My work has been affected a lot by COVID. Many people have resigned or been laid off and working hours have been reduced, which has led to crazy workloads. During the pandemic, the company has used a rotation system, where employees are scheduled to work according to company needs, regardless of their department. Wages are adjusted according to our working days; recess has been reduced as well.

Young woman, 21 years old, Indonesia

I am a beautician and I come from a community where the festival of Eid is associated with beauty and glamour. During the 2020 Eid celebration, our area was locked down. We also had a curfew and shops were also shut. That made me lose considerable income, because I could no longer have my clients coming in for make-up, either because they feared contracting the virus or because they never had enough money to do so.

Young woman, 23 years old, Kenya

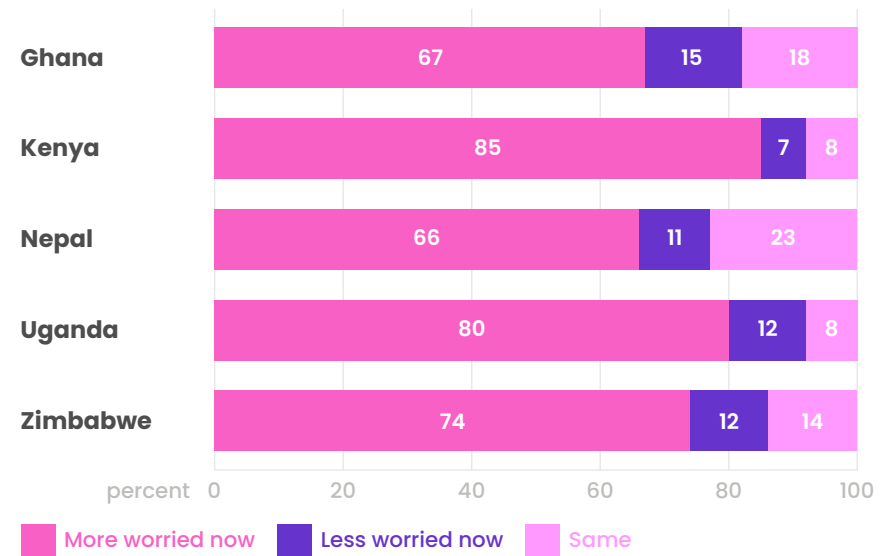
Those employed in informal economies, including **sex work**, appeared to have been particularly badly affected by the COVID-19 restrictions, as they have had fewer customers. In addition, in certain instances they were ineligible for the state subsidies given to those in the formal sector who had been affected by the pandemic.

Trans women in our community who work 'on the street' are also impacted economically, financially and health-wise. They are not eligible for government aid because their residency, as written in their ID, does not match the city they are currently living in. They are also having trouble paying rent. Customers have stopped coming due to fear of getting infected by COVID-19.

Young woman, 26 years old, Indonesia

In addition to reduced incomes, survey respondents found themselves more **worried about money** during the COVID-19 crisis (Figure 3), with 76% of respondents reporting more concern overall. By country, levels of concern regarding money were highest in Kenya and Uganda, with at least 80% of respondents more concerned about money now than before the COVID-19 crisis.

Figure 3. Current levels of concern regarding money compared to levels of concern in the month before the COVID-19 crisis



In Uganda, uncertainty about the future and the current need for economic survival was connected to the fact that, because of the virus, the money needed for young people's future education or for small enterprise initiatives had been **diverted to acquire food**.

My parents had saved money for my studies for the next term, but when COVID-19 came, they diverted the money to food because they lost their income, and now I don't know if they will even be able afford my school needs when schools open.

Young woman, 23 years old, Uganda

Other young people who had been working either had to change their occupation or found their economic opportunities to be severely curtailed, particularly by **border closures**.

I am a single mother, and the fact that my work (as a student mentor) largely revolved around meetings meant that I lost a source of income due to the ban on gatherings. This meant that I had to look for alternative sources of income – for example, washing clothes for people. This has been super stressful.

Young woman, 24 years old, Kenya

I feel that things are out of control and out of my hands, because I had plans at the beginning of the year. I would have done something in June, but then COVID-19 broke out and now, due to the restrictions, I cannot travel to South Africa, which is what I planned to do. I also wanted to travel to Harare, but have had to put that on hold as well. I don't know anymore when COVID-19 will end, and this leaves me with so much uncertainty about the future

Young woman, 25 years old, Zimbabwe

4.3 Well-being

Survey findings suggest that the psycho-social consequences of the pandemic, particularly in terms of isolation and disrupted social networks, have had a significant impact on young people (Figure 4). Over 60% of respondents in Ghana, Kenya, Uganda and Zimbabwe, for instance, reported that they were unable to see their friends and family. In Nepal, just over half of the respondents reported being unable to see friends or family, and complained that they were bored.

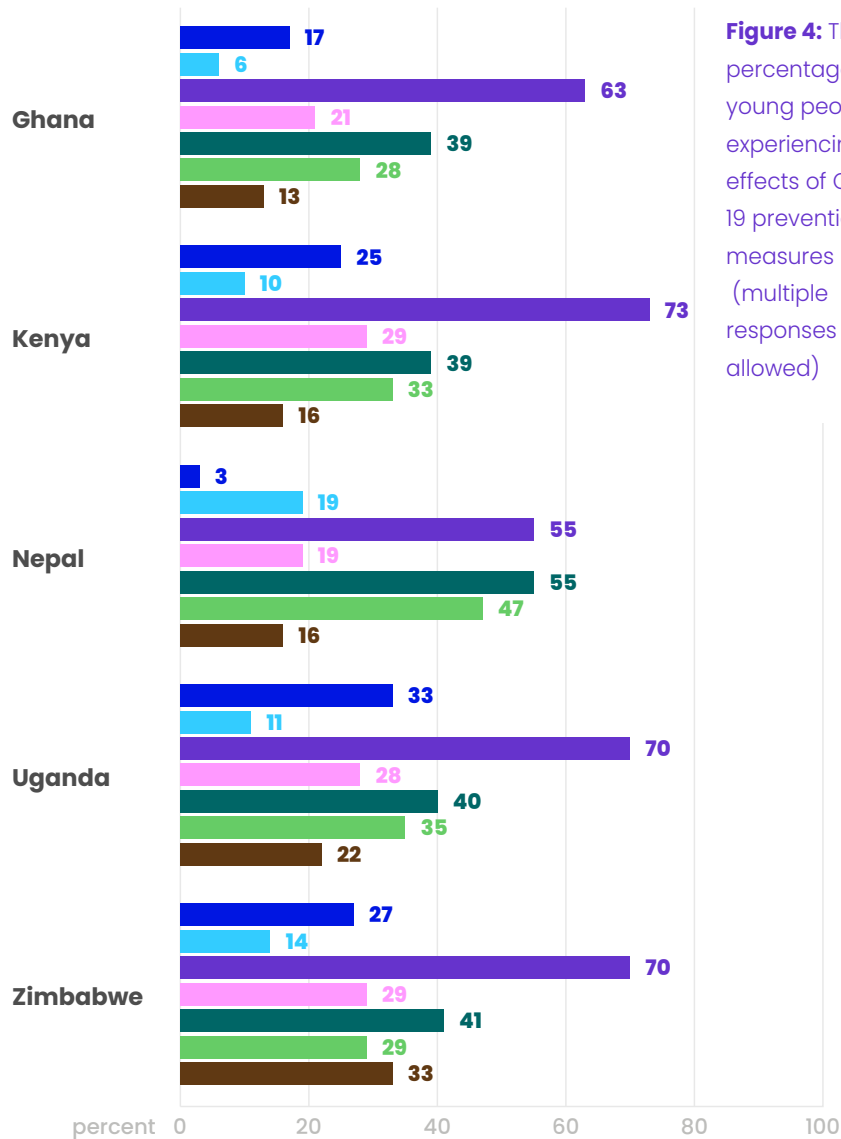
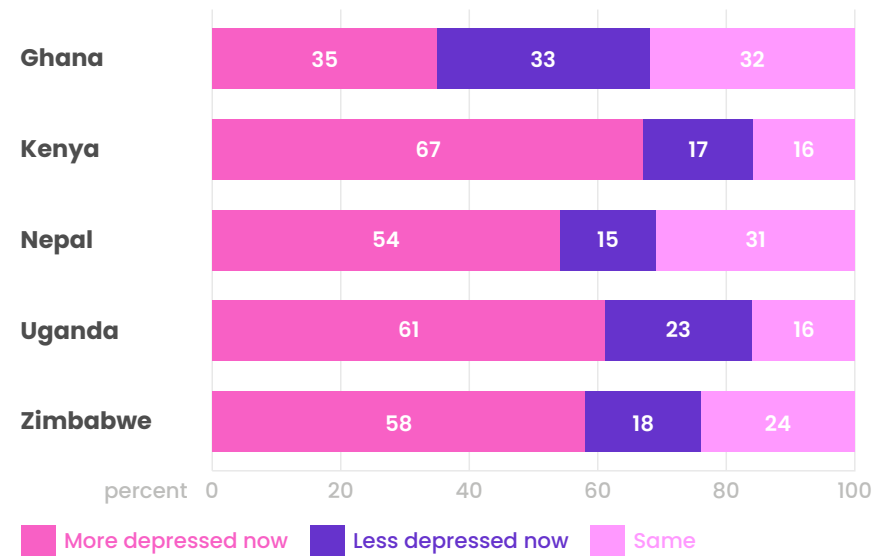


Figure 4: The percentage of young people experiencing effects of COVID-19 prevention measures (multiple responses allowed)

- Short of food
- Unable to access healthcare
- Don't see friends/family
- Lonely
- Bored
- Worried
- Depressed

When asked directly about their levels of depression during the COVID-19 crisis compared to the month before the crisis, 56% of young all respondents across all countries reported feeling **more depressed** now (range: 35% in Uganda to 57% in Kenya; Figure 5).

Figure 5: The percentage of young people reporting feeling more, less or a similar level of depression during the COVID-19 crisis compared to the month before



The psychological consequences of the pandemic and its associated restrictions shown in Figures 4 and 5 are also evident in the qualitative data. Respondents spoke of mental health problems emerging due to **worries about income** or because of **interruptions to their education**.



Online classes also bothered us – we lost our interest in studying. Shops were also closed, so we had to stay alone at home – we couldn't go outside. When we get bored, lots of negative thoughts come into our minds. We enjoyed the beginning of lockdown, but later we wished things would open up. We worried about our study – there was nothing discussed about our education, so negative thoughts came into our mind.

Young man, 18 years old, Nepal

In some cases, these stresses have resulted in drug-taking or even suicidal ideation.

Before COVID-19, I was going to school using my own transport and I could do side hustles, so this time around I cannot do my side business and transport people. Now I cannot go to those areas. Mentally, it's affecting me, that I end up doing things that are not proper, for example selling these drugs, and some days I also end up taking the drugs, which is not healthy for my body.

Young man, 22 years old, Zimbabwe

Due to corona, people are affected not only physically but also emotionally and mentally. I also suffered from lockdown. At the beginning of the lockdown, for about one month, I was good, but after that I felt alone, stayed silent, didn't want to talk with friends, and wanted to be by myself. Not only me but my other friends also felt depressed and went through (the) same feelings as I experienced. Where I live, seven people committed suicide.

Young woman, 22 years old, Nepal

The specific consequences of the COVID-19 pandemic on the **mental health of already vulnerable groups**, such as youth living with disabilities or young sex workers, was also evident from the discussions.

We have not been taught about coping mechanisms. Before COVID, schools were safe spaces for young people with disabilities, because schools have facilities.

Young woman, 22 years old, Kenya

I was crying and dejected. I felt so miserable because I don't know what to do in this kind of situation. This is an outbreak and a disaster. I've been living off my savings from my last work in Singapore. I was there for 15 days and have been using that money since. I sold my jewellery and all that's left are the items I am wearing. I feel upset because I had a plan to build a house – I had calculated my income and everything. Now my plan has been ruined because of COVID.

Young man, 26 years old, Indonesia

Those LGBTQ respondents who, due to the COVID-19 restrictions, have been **forced to return to live with relatives** who find their sexuality unacceptable often suffered great mental health challenges, particularly in the absence of supportive services.

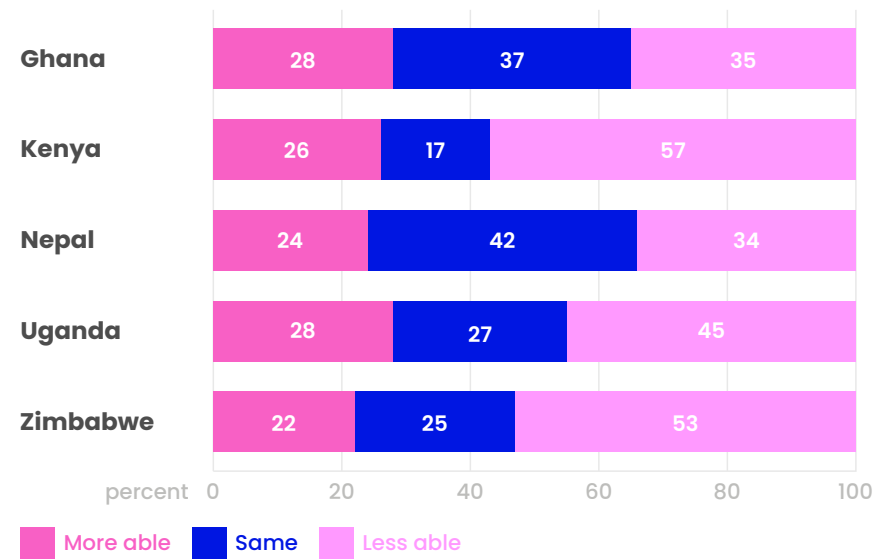
I have realised that the LGBTQ community is not something that is acceptable in Zimbabwe and Africa, and when parents start to suspect, when they have an idea that they think you are like this with regard to your sexual orientation, they will be against you. But they judge me and tell me all these words that are about demons, Satanism and such like. It affects me emotionally and I have to think about it. I am stressed and depressed, which might actually lead to suicidal thoughts. Some can actually commit suicide because they cannot stand it. Unlike when this whole thing (COVID-19) was not there, we know that you could go to centres, like LGBTQ centres where they could help people. Now, when you go home, you greet your parents and you have to sleep, but you are forced to be under the same roof with people who don't accept you. Aaah, it's really hard to survive.

Young woman, 19 years old, Zimbabwe



In the survey, when asked whether they currently felt more or less in control of things generally than before the COVID-19 crisis, over half of the respondents in Zimbabwe and Kenya felt they had less control (Figure 6). Similarly, in Uganda, 45% of respondents felt **less able to control what happened to them**. In Ghana and Nepal, although around 35% of respondents felt less able to control events, approximately 40% felt they had the same level of control currently as they did before the COVID-19 crisis.

Figure 6: The percentage of young people perceiving they are more, less or similarly able to control what happens in general compared to the month before the COVID-19 crisis



The qualitative findings reveal that the young people's perceived feelings of stress were directly related to COVID-19 and the fear of infection. However, they were also related to the **lack of social contact** that the prevention measures had imposed, and were associated with the economic consequences of the pandemic.

There is a psychological impact. At first I felt anxious, like, what if I got COVID? I was also afraid of touching things. After I touched something, I would rush to wash my hands. Another consequence is that we couldn't visit our family in our hometowns, as the South Sulawesi government started to implement large-scale social restrictions and forbade homecoming. A lot of workers were also being laid off during that time, but they were not allowed to go back to their hometowns. Not to mention that people from our community could not receive government aid because their residency on their ID card isn't South Sulawesi. That also added to our stress.

Young woman, 30 years old, Indonesia

It is shown above how the pandemic and the associated precautionary measures have affected young people's schooling, and how this is associated with wider feelings of uncertainty and in some cases despair. The closure of schools has affected young people's **aspirations and plans for the future**, and their other options, including turning to trading or starting up small businesses, have also been severely curtailed by the pandemic.

It is like when you are a school-goer, you have your aims and your goals that you will be expecting to achieve – that is to say that if I pass this stage, and go on to this one, my life will progress. You will not be waiting for your parents to support you all the time. I was saying to myself that if I go to school and pass (my exams), I will become someone, and will be able to get by without asking for help from my parents. It has affected us now because you don't know what to do. Even if you decide to sell goods, the borders are closed. You will not be able to go out of the country so that you can buy things for re-selling to make a living for yourself.

Young man, 17 years old, Zimbabwe



5 How about dating, relationships and sexual activity?

This section discusses changes to sexual activity, dating and relationships brought about by COVID-19 and its prevention measures. The pandemic has had an effect on young people's engagement in casual sex as well as their relationships with regular partners. Discussion participants also noted how physical pandemic restrictions, such as the closure of schools, have had an impact on their sexual activity, whilst others spontaneously mentioned the impact of the prevention measures on non-sexual relationships with their friends and acquaintances.

5.1 History of sexual activity

In Ghana, Kenya, Uganda and Zimbabwe, more than 70% of young respondents reported ever having had sex. In Nepal, fewer than half of respondents, who were younger overall, reported ever having had sex.

Among the respondents who reported ever having had sex, over 65% of young males and females in Ghana, Kenya, Uganda and Zimbabwe reported having had sex during the COVID-19 crisis. In Nepal, this was less; 43% of young men and 29% of young women reported having had sex during the pandemic.

Table 5: Respondents' history of ever having had sex

**Excludes three individuals who preferred not to disclose their sex.*

	GHANA N=596 N (%)		KENYA N=782 N (%)		NEPAL N=231* N (%)		UGANDA N=640 N (%)		ZIMBABWE N=441 N (%)	
	MALE (N=292)	FEMALE (N=304)	MALE (N=362)	FEMALE (N=420)	MALE (N=104)	FEMALE (N=127)	MALE (N=314)	FEMALE (N=326)	MALE (N=358)	FEMALE (N=83)
Ever had sex	251 (86.0)	240 (78.9)	338 (93.4)	400 (95.2)	44 (42.3)	34 (26.8)	288 (88.3)	270 (86.0)	301 (84.1)	60 (72.3)
Had sex during COVID-19 pandemic (among those who had ever had sex)	166 (66.1)	159 (66.3)	267 (79.2)	304 (75.8)	19 (43.2)	10 (29.4)	220 (76.4)	177 (65.6)	245 (81.4)	49 (81.7)

5.2 Changes in dating and relationships

In terms of dating and relationships, during the FGDs some respondents said that there had been **more casual dating during the COVID-19 pandemic**. An FGD participant in Uganda said that this was because when there was no school, couples were more able to get together, rather than being limited by the need to study.

When I was in school, we used to give each other distance with my boyfriend because we had to concentrate on our books. But now that we don't attend school, we have a lot of time for each other and I meet him a lot.

Young man, 18 years old, Uganda

I often met my boyfriend before COVID-19, but now he seems to have little time for me. When he went back to his village, he would stay there for a long time. I tried to have a nice chat with him but he doesn't seem to care. Now I haven't talked to him for 3 days.

Young woman, 23 years old, Indonesia

Others claimed that there were **more breakups** during the pandemic. This was either due to a lack of money on the part of young men, which meant that they were unable to accommodate their girlfriend's material needs, or because the couple was separated by distance.

I think my relationship was affected because before lockdown I could do some selling and meet my girlfriend's needs, but due to the lockdown I am failing to do so. Now my relationship is shaky.

Young man, 19 years old, Zimbabwe

Perhaps due to breakups or the absence of available partners, many young people, especially in Indonesia, reported turning to **internet porn** to relieve their desires and boredom. This may influence the way they perceive sex and could encourage risky behaviour, such as not using condoms.

I rarely watched porn before corona, since I had lots of activities. But now I just stay home and do nothing, so I watch porn to refresh my mind and feel relaxed.

Young man, 19 years old, Indonesia

This is one of the longest holidays I have seen in our education system. Now the kids are at home, they have had a lot of free time for TV, some even in the absence of their parents. For those with access to internet, a number of them have gone further to watch pornographic content and because of curiosity they want to explore and go have sex in risky ways.

Young man, 19 years old, Kenya

More generally, across all settings, young people said that they also missed being able to **hug and shake hands** with friends and acquaintances with whom they have non-sexual relationships. They found the ban on physical contact hard to bear and wished for the day when it would come to an end.

Some measures to prevent COVID-19, like hugging and shaking hands, are a sign of showing friendship in our communities and therefore are hard to get rid of. It would mean a lot if you met a friend you have not seen in a long time and were able to hug them or shake hands.

Young man, 23 years old, Uganda

Before the pandemic we did not wear masks, did not wash our hands frequently and could hug each other when we meet. This is what we do culturally. That used to be our behaviour. Now we are experiencing effects of COVID-19 and we do not hug when we meet. We wear masks and keep distance.

Young woman, 27 years old, Nepal

A Kenyan respondent noted how the harsh conditions imposed by COVID-19 meant that young people's attention was focussed upon their family and survival rather than on sexual experimentation.

COVID-19 shifted attentions to family and survival and little has been given to romantic relationships, exploration and learning one's sexual identity.

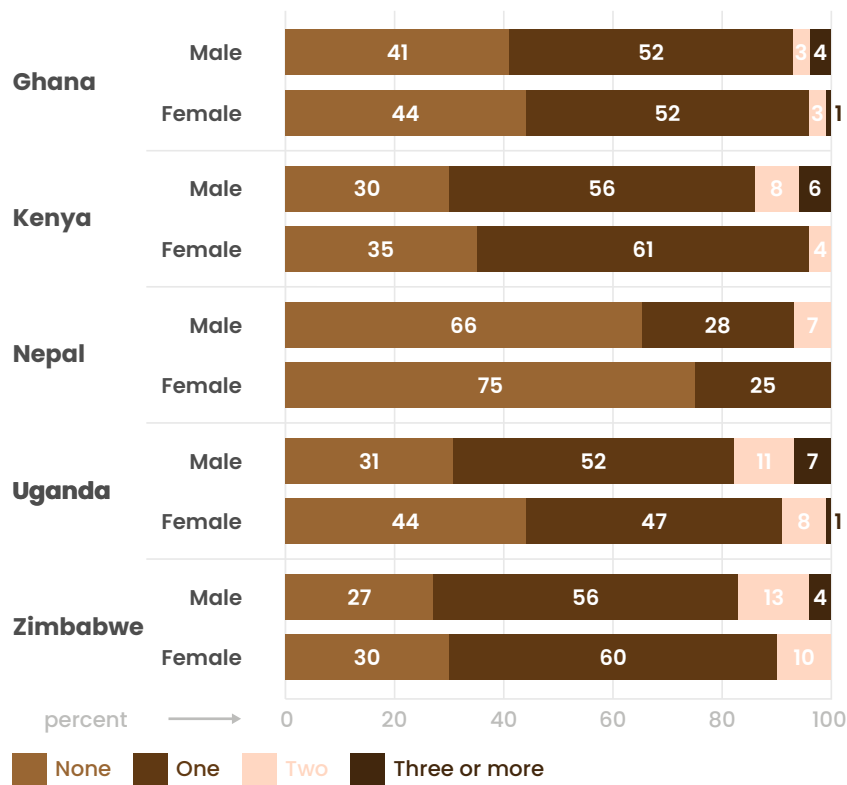
Young woman, 22 years old, Kenya

5.3 Sexual activity before and during the COVID-19 pandemic

Among young survey respondents **who reported being single and who had ever had sex**, between 9% (Kenya) and 19% (Zimbabwe) of young men and 9% (Kenya) and 29% (Nepal) of young women reported having had no sexual partners in the **month before the beginning of the COVID-19 crisis**. In the **month prior to the survey and with COVID-19 restrictions still in place**, between 27% (Zimbabwe) and 66% (Nepal) of single young men and between 30% (Zimbabwe) and 75% (Nepal) of single young women reported having

had no sexual partners (Figure 7), despite ever having had sex. These findings suggest that in all five countries, the COVID-19 crisis has had an impact on sexual activity among single young people, with a higher percentage reporting no sexual partners in the last month than in the month before the onset of the COVID-19 crisis.

Figure 7: Number of sexual partners in the last month during the COVID-19 crisis among single young people. Percentages under 5% not numbered on the graph



The reason why these single respondents reported having had no sex, despite having had sex before the beginning of the COVID-19 crisis, are presented in Figure 8. Among single young men, approximately one-third in Ghana, Kenya, Nepal and Uganda and 40% in Zimbabwe reported being unable to see their sexual partner(s). Fear of getting COVID-19 was cited by between 26% (Nepal) and 42% (Kenya) of young men (Figure 9). In Uganda and Zimbabwe, not meeting anyone to have sex with was reported by approximately 40% of young men.

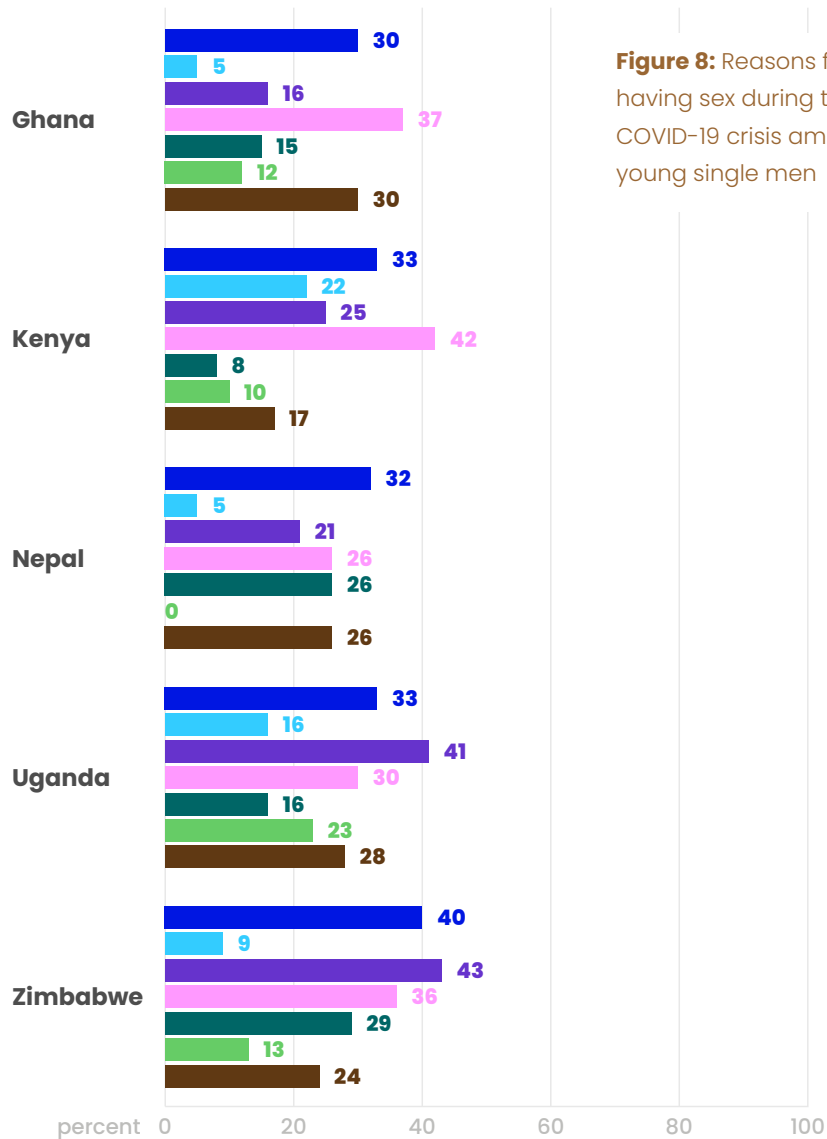


Figure 8: Reasons for not having sex during the COVID-19 crisis among young single men

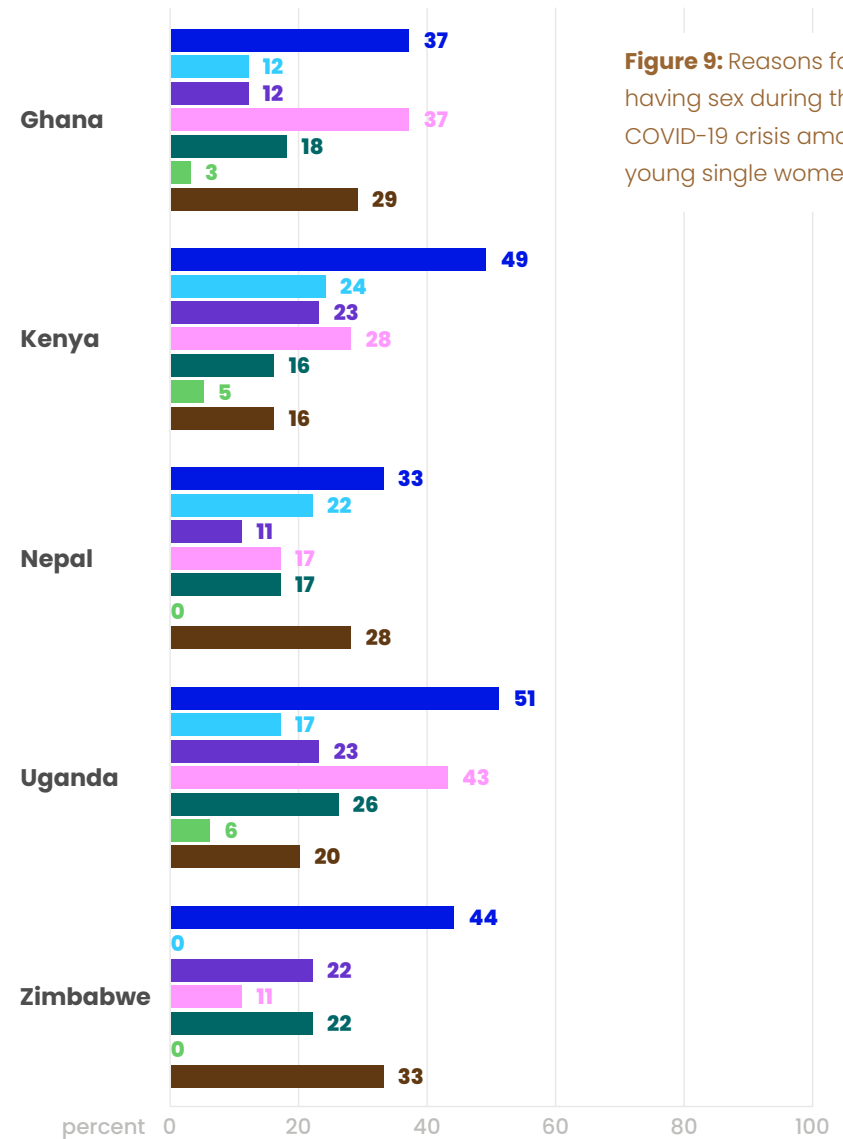


Figure 9: Reasons for not having sex during the COVID-19 crisis among young single women

- Not been able to see partner
- Can't leave my house
- Moved away when COVID-19 started
- Don't have any money
- Didn't meet anyone
- I/partner didn't feel like it
- Afraid of getting COVID-19

- Not been able to see partner
- Can't leave my house
- Moved away when COVID-19 started
- Don't have any money
- Didn't meet anyone
- I/partner didn't feel like it
- Afraid of getting COVID-19

The qualitative data also reveal that in some cases, respondents have had **more sexual encounters** than before the onset of the COVID-19 crisis. For young unmarried youth, a **lack of parental/caregiver supervision** during the COVID-19 pandemic has meant that more opportunities for intercourse have presented themselves than before the pandemic.

There are many young people who take their courtship to another level. Lack of parental supervision or spending too much time at home probably lead to sexual encounters.

Young woman, 21 years old, Indonesia

Other respondents concurred with the figures shown above and said that many young people were **unable to see their regular sexual partners** because of lockdown. For some who found themselves in a different location to their regular partner, however, especially in Kenya, this meant that they looked for casual, and often unprotected, sex with someone else.

People are also having sex with other people who are not their partners. There are cases where the partners are affected by cessation of movement or lockdown in some cities and they end up having sex with other people. Most of the time, they do it without protection.

Young woman, 22 years old, Kenya

The cessation of movement between counties has led to people opting to have sex with other people apart from their partners, who have been locked in other regions, which has led to high infection rates and divorce.

Young woman, 21 years old, Kenya

5.4 Transactional sex

In the survey, between 25% (Zimbabwe) and 42% (Ghana and Uganda) of respondents reported that at least one of their sexual partners in the last month was a partner with whom they had had sex in exchange for money and/or a gift. Between 25% (Zimbabwe) and 53% (Ghana) of young men and 10% (Nepal) and 37% (Uganda) of young women reported that at least one of their sexual partners in the last month had been a transactional sex partner.

Across all countries, it emerged strongly from the qualitative data that there has been an **increase in young women engaging in transactional sex**. In many settings, transactional sex had occurred frequently before the pandemic, but the economic hardship associated with the restrictions on economic activity makes it likely that many more young women have resorted to sex in exchange for money or gifts to cover their basic needs and those of their families. As well as leading to more formal sex work, it is likely that the pandemic has resulted in women engaging more frequently in informal transactional sex, as well as getting together with better-off partners (who are likely to be older) or

In addition, some are even getting married to or engage in sexual activities with boda-boda (motorcycle) riders in exchange for money, necessities and to help their families. Parents have also been affected as they have lost their jobs.

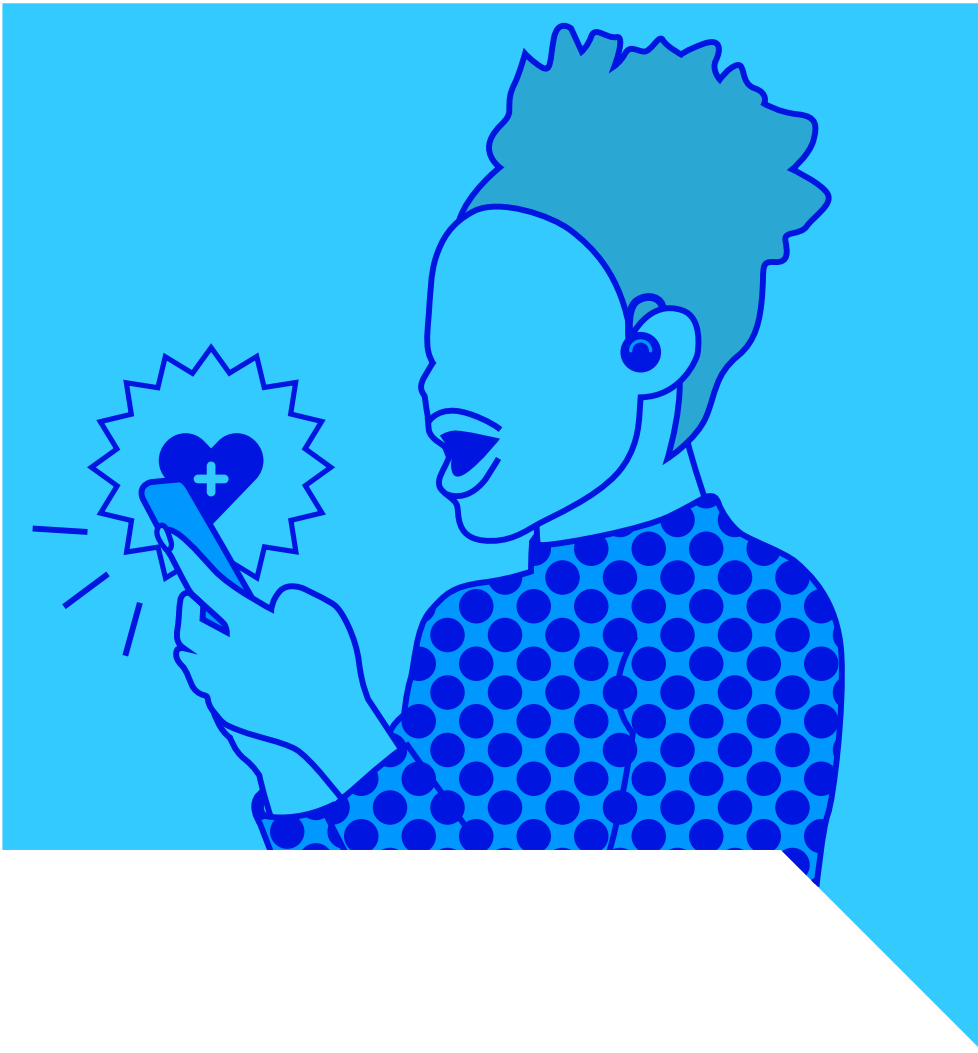
Young woman, 20 years old, Kenya



getting engaged or married to make sure that they and their families are taken care of economically. Unfortunately, this means that they may be at higher risk of HIV, STIs or unwanted pregnancy.

There are changes that have taken place with regards to children who are going to school during this time of COVID-19, especially most of the children at the rank [bus terminus] who are engaging in sex. This has resulted in high rates of STIs and HIV continuing to increase because they are looking for money since they don't have other sources to get it. Some are running away from their homes and many child pregnancies are seen in these children going to school.

Young woman, 24 years old, Zimbabwe



6 Access to sexual and reproductive health information

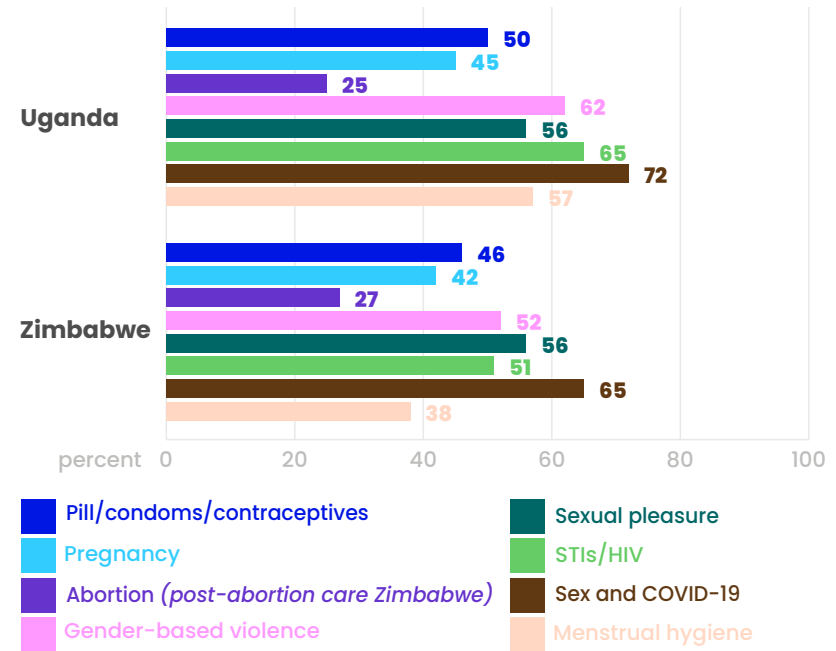
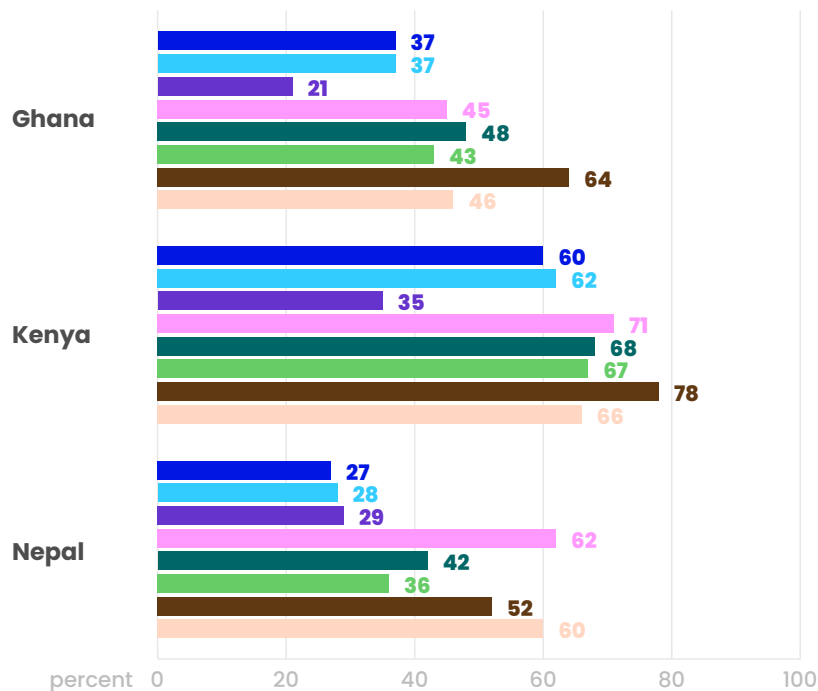
This section discusses the findings related to young people's needs and desire for information on SRH and related services during the COVID-19 pandemic. It discusses the kind of information they said that they wanted and/or needed, and if or how their information sources have changed during the COVID-19 crisis given that services, comprehensive sexuality education sessions and peer education activities have in many cases been reduced.

In the survey, respondents were asked about whether they needed/wanted information on specific SRH-related topics, and whether they had received sufficient information during the COVID-19 crisis. In all countries, over 40% of young people needed/wanted information on at least four of the SRH-related topics (Figure 10), including contraceptives, gender-based violence

and menstrual hygiene. Over half needed/wanted information on **sex and COVID-19**, presumably related to the risk of getting infected with COVID-19 through sexual intercourse. Between 45% (Ghana) and 71% (Kenya) needed/wanted information on **gender-based violence**, and over 30% needed/wanted information on **sexual pleasure** and **STIs, including HIV**.

Unsurprisingly, more young women (69% overall) than young men (41% overall) needed/wanted information on **menstrual hygiene** (range for young women: 60% Zimbabwe to 79% Kenya). Overall, 30% of young men (range: 24% Ghana to 38% Kenya) and 26% of young women (range: 18% Ghana to 33% Kenya) wanted information on **abortion** (or post-abortion care in Zimbabwe).

Figure 10: The percentage of young people who wanted/needed information on SRHR-related topics during the COVID-19 crisis (multiple responses allowed)



Survey findings highlight that there is a **gap regarding the provision of information on SRHR-related topics** to young people during the pandemic. Although a high percentage of young people wanted/needed information on sex and COVID-19, 57% (Kenya) or fewer young people considered that they had received sufficient information on this topic. Between 26% (post-abortion care, Zimbabwe) and 63% (menstrual hygiene, Nepal) of young people felt they had received sufficient information on the SRHR-related topics that they wanted/needed information on (Figure 11).

Among young women, between 26% (Zimbabwe) and 51% (Kenya) who wanted/needed information on (post-)abortion services had received sufficient information. Among young women wanting information on menstrual hygiene, between 44% (Zimbabwe) and 68% (Nepal) felt they had received sufficient information.

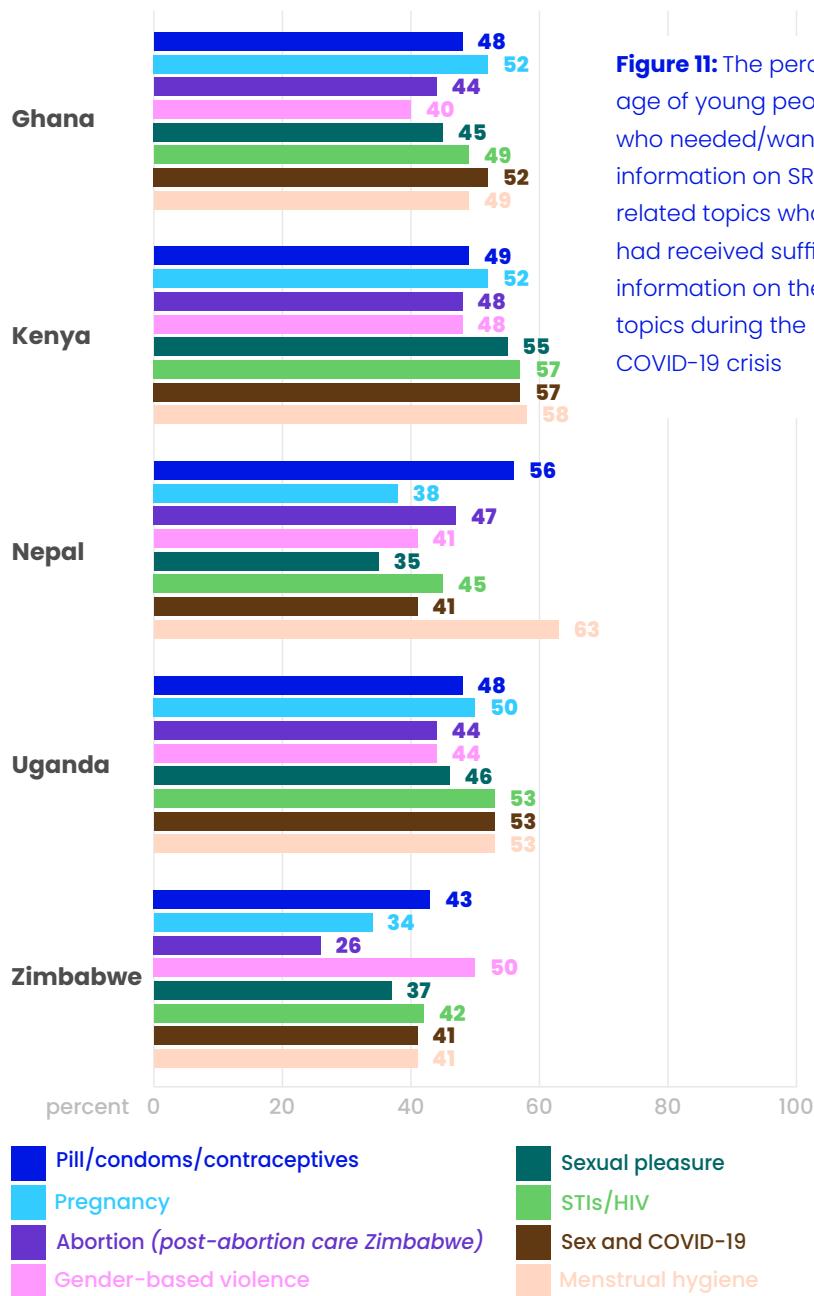


Figure 11: The percentage of young people who needed/wanted information on SRHR-related topics who had received sufficient information on these topics during the COVID-19 crisis

Concurring with the quantitative survey data, the qualitative data also reveals that young people frequently sought information about sex and COVID-19, specifically pertaining to how to have intercourse and still be safe from a COVID-19 infection.

Yesterday, I had a chance to discuss about sexuality with my community friends. "How did you have sex during pandemic?" "Did you wear a mask or use hand sanitiser first, or take a rapid test before meeting up, or wear PPE?" There is a difference in how we have sex during pandemic. That's not a problem for married couples, but what about unmarried ones? Can we do that? That's what we discussed yesterday. The information is unclear, like wearing PPE while having sex would be deemed as a joke. How could you wear PPE and have sex? That's not funny! When it comes to health information, I'd like to ask the providers at the public health centre, "Is the information true or not?"

Young man, 26 years old, Indonesia

The qualitative testimonies also indicate that another commonly reported subject about which young people needed information was **contraception, and condoms in particular.**

I'd like to know how to have sexual intercourse during pandemic. Is it safe or not?

Young man, 19 years old, Indonesia

They need information about contraceptives, because we've seen some of the girls at home getting pregnant, and when you ask them, they tell you "I know nothing about contraceptives."

Young woman, 32 years old, Kenya

As indicated in the figures above, many young women in all settings have also sought information about **menstruation and menstrual hygiene** during the pandemic. However, the experience of going to get information or products at health centres where health workers wore personal protective equipment (PPE) was sometimes off-putting.

The pandemic has also had an impact on the reproductive organs, as when we get stressed, the menstrual cycle becomes irregular. If we want to get counselling at PKPR (youth health service), the staff wear PPE and that makes us uncomfortable.

Young woman, 22 years old, Indonesia

Most young girls needed information on menstrual hygiene information and related commodities and services.

Young woman, 29 years old, Kenya

In addition, **drug use** was also a subject about which young people wanted to be better informed during the COVID-19 pandemic.

6.1 Sources of information accessed

The qualitative findings reveal that the sources of SRHR information accessed by young people during the COVID-19 crisis included **health facilities** (even though opening hours may have changed).

There have been no changes for me. I still get most of my information from health institutions and services. I used to accompany my partner to take the HIV test, but now the service hours have been reduced.

Young man, 28 years old, Indonesia



Churches also provided SRHR information, especially when school-based comprehensive sexuality education programmes were no longer functioning. However, they did not allow for the same relaxed atmosphere for open discussion.

You knew that you would learn about sexual and reproductive health. Like what happens when you get an STI and how to protect yourself during sex. So, now (with the pandemic) it has changed. Yes, you will be a member of a church group, but for you to ask about these issues it is difficult because these are religious groups. You ask yourself, if I ask such a question, what will people say? At times, maybe you want to help a friend, but you become scared, which is different from school. At school you are free to ask and no one will judge you, even at college. But when it comes to church, there are other questions you will not be free to ask, so things have changed.

Young woman, 22 years old, Zimbabwe

Others sought information from the **radio and TV**. However, the cost as well as the non-interactive nature of TV and radio programmes was frustrating to many young people.

I think the local radio stations have really tried, like Central Radio. I think there is a show in the morning, in which is broadcast a dialogue with the youth, where they discuss how young people can survive during this time and also giving them advice on what they can do and how they can make their own money without having to look to their parents. I think radio stations are doing well.

Young woman, 22 years old, Zimbabwe

There are always sessions on radio and TV, but some of us can't access radios or afford TVs, and even when I get a chance to listen or watch, it is not participatory and engaging because you can't ask any questions to the presenter.

Young man, 23 years old, Uganda

In certain countries such as Kenya and Zimbabwe, **telephone hotlines** with assigned counsellors, which have continued to run during the pandemic, were seen as very useful sources of information about SRHR and services.

The 'Aunty Jane' hotline really came through – this consists of a counsellor who can tell you about SRHR services 24 hours a day.

Young man, 26 years old, Kenya

I wanted to say, if you call the likes of Youth Advocate Zimbabwe, their hotline is for free. You can ask all the information you wish to know. They are free to talk to you and it costs nothing!

Young woman, 22 years old, Zimbabwe

6.2 Online sources of information used

By far the greatest source of SRHR information for young people during the pandemic has been the internet and social media. **WhatsApp discussion groups, Facebook and Twitter** were commonly used in many settings to request and acquire information about specific SRH issues and services.



Since COVID-19 began we have been accessing SRHR information through online platforms such as WhatsApp, Facebook and Twitter chats.

Young woman, 25 years old, Kenya

Regarding family planning information, the WhatsApp groups are arranged in such a way those participants are classified according to age and there are doctors in them to ensure the information being passed is accurate. Also, people in the WhatsApp groups are people we had interacted with prior (to) this. This made them feel more free to share their experiences and give feedback.

Young woman, 20 years old, Kenya

Others gained information from watching TV programmes streamed online.

I look for information about reproductive health on the internet, for example, from Facebook or Twitter. But if I am curious about a certain subject, I would go to a public health centre nearby and ask the staff, "Ma'am, is it true that this will result in this?" I usually asked about STIs or diseases. But now, since I've got more time and nothing to do, I randomly search about anything on the internet. One time I ended up reading about women's menstruation. When I find something interesting, I dig deeper, asking myself "Is it true?" I keep searching and browsing. Otherwise, I look it up on YouTube, since discussions about sexual health are usually held on the Tonight Show.

Young man, 26 years old, Indonesia

However, many respondents were sceptical about the quality of the information they found online.

I think we are not really sure if the stuff that is online is really credible. It may be just a way to drive many young people to their websites. So we are not really sure if what we read on the internet is it always true at all times or whether sometimes it will not be true. It is just a way of advertising – a way of getting more viewers for the people who provide the information.

Young woman, 22 years old, Zimbabwe

They log on to YouTube, and start posting their stuff and just come up with their own topic and then they start telling people what they think and they don't tell people what is correct but just tell them what they think is correct, so that they can make money off of it. When I come and really need help and I go and watch videos, but I am not sure whether it is true or not. But I just go for it because I think that the fact that the person posted it means that they were really sure that it's true or maybe that they have done it.

Young woman, 19 years old, Zimbabwe

Some NGOs have carried out their **sensitisation sessions and held their meetings on Zoom** instead of in person. Not only has this reduced the likelihood of infection with COVID-19, but it has also addressed the problem of young people being afraid to seek information from health facilities where staff are in full PPE.

COVID has many disadvantages! However, due to COVID-19, here in Nepal, we realise that digitisation is very essential and important. Before this, all programs were conducted with people's physical presence – hence people from remote and far-away areas couldn't attend the program. But now these types of programs are conducted online and we can join them from our home, even (when) we are very far away – we can learn many things. Thus, it (COVID-19) has some advantages too!

Young man, 26 years old, Nepal

However, the cost of having a computer or smartphone and of an internet connection has prevented some young people from taking part.

I used to be called by some NGOs to attend their youth sensitisation and engagement meeting, and that's how I used to gain some crucial information about SRHR. However, now I hear that they use Zoom and webinars to hold such meetings, but I cannot afford a computer or a good phone!

Young woman, 23 years old, Uganda



7 How about access to sexual and reproductive health services?

This section presents quantitative and qualitative data in relation to young people's access to and use of SRH services during the pandemic. It describes the challenges they have experienced in trying to access services and the potential effects of these challenges on their SRH outcomes. In the survey, **only young women** were asked about their need for and access to family planning and (post-) abortion services during the COVID-19 crisis.

7.1 Family planning

In the survey, the need for family planning services during the COVID-19 crisis was most commonly reported by young women in Kenya (53%; Table 6). In Zimbabwe, 45% of young women needed family planning services, followed by

40% in Uganda, 30% in Ghana and 5% in Nepal. In all countries, with the exception of Zimbabwe, the most commonly cited family planning method that women wanted to acquire during the COVID-19 crisis was condoms (44% Ghana; 49% Kenya; 67% Nepal; 43% Uganda). In Zimbabwe, the pill was the most commonly cited method (43%). In Ghana, Kenya, Nepal and Uganda, young women also wanted to acquire the pill, with between 17% (Nepal) and 43% (Zimbabwe) citing this method. Emergency contraception was required by approximately 15% of women in Ghana, Kenya and Zimbabwe and one-quarter of women in Uganda.

Among young women needing family planning services during the COVID-19 pandemic, and who were able to access these services, over 40% of women had accessed these services at a pharmacy. Over 30% of young women in Ghana, Kenya, Uganda and Zimbabwe who needed family planning services reported that the COVID-19 crisis had affected their access to family planning. In Nepal, only one woman reported that the crisis had affected her access.

The qualitative data reveal that in general and also during the pandemic, **condoms were indeed preferred** by many young men and women (especially those in key populations), particularly during the COVID-19 crisis. This was largely because they were easier to access; for example, from pharmacies (which were still open during the crisis) or from friends. Sex workers in Indonesia were even able to get them delivered.

I think (my preferred method) is the condom, because it does not require a technical knowledge to use it and you can easily get it in pharmacies.

Young man, 22 years old, Ghana

Table 6. Need for family planning services during the COVID-19 crisis among young women

	GHANA N=302 N (%)	KENYA N=417 N (%)	NEPAL N=127 N (%)	UGANDA N=301 N (%)	ZIMBABWE N=88 N (%)
Yes, I needed family planning during COVID-19 crisis	91 (30.1)	222 (53.2)	6 (4.7)	119 (39.5)	37 (44.6)
Method I wanted to acquire during COVID-19 (whether acquired or not)					
Male condom	40 (44.0)	109 (49.3)	4 (66.7)	51 (42.9)	9 (24.3)
Female condom	1 (1.1)	8 (3.6)	1 (16.7)	5 (4.2)	3 (8.1)
Pill	31 (34.1)	50 (22.6)	1 (16.7)	28 (23.5)	16 (43.2)
Injectable	7 (7.7)	17 (7.7)	0 (0)	11 (9.2)	4 (10.8)
Implant	1 (1.1)	31 (14.0)	0 (0)	10 (8.4)	2 (5.4)
Intrauterine device (IUD)	1 (1.1)	19 (8.6)	0 (0)	10 (8.4)	1 (2.7)
Emergency contraception	14 (15.4)	36 (16.3)	0 (0)	29 (24.4)	6 (16.2)
No, COVID-19 didn't stop me from accessing family planning, I accessed services from:					
Public health centre	4 (6.7)	38 (28.8)	0 (0)	8 (12.5)	4 (17.4)
Private health centre	1 (1.7)	18 (13.6)	2 (40.0)	16 (25.0)	2 (8.7)
Pharmacy	50 (83.3)	69 (52.3)	2 (40.0)	32 (50.0)	11 (47.8)
Community health worker/peer educator	4 (6.7)	3 (2.3)	0 (0)	4 (6.3)	3 (13.0)
Bar/shop	0 (0)	4 (3.0)	0 (0)	1 (1.6)	1 (4.3)
Yes, COVID-19 crisis stopped me accessing family planning	31 (34.1)	90 (40.5)	1 (16.7)	55 (46.2)	14 (37.8)

I always use condoms. My friends were given condoms from the public health centre in Yogyakarta. It's not difficult to get condoms, just ask at the public health centre. Sometimes I went somewhere to buy condoms, the other time I just ordered at the public health centre and they would deliver the condoms to me.

Young woman, 28 years old, Indonesia

Injectables were also preferred by respondents during the pandemic, as they are available in the community and thus still accessible despite COVID-19 restrictions. They can also be self-injected and thus allow for secret use.

Young girls prefer injections, especially Sayana Press, because there are a lot of fellow young people in their communities who are trained in administering them.

Young woman, 25 years old, Uganda

I have always wanted to use condoms, but my girlfriend has known about Sayana Press and it is what she prefers. She says she is comfortable with it and she can even inject herself, unlike other methods which require her to go to the health centre.

Young man, 23 years old, Uganda

Long-acting reversible contraceptive methods were also favoured, especially as their long-term effectiveness means that frequent visits to health facilities (which were often perceived to be dangerous in the era of COVID-19) are not required.

Informed young people opted for long-term contraception because of the uncertainties around the distribution of family planning commodities.

Young woman, 22 years old, Kenya

Barriers in accessing family planning

Among young survey respondents that were unable to access family planning during the pandemic (Table 6), the most commonly cited reason among young women in Ghana (52%) and Kenya (59%) was being afraid of COVID-19 (Figure 12). In Uganda, lack of transport was most commonly cited (44%), with a similar percentage (38%) afraid of COVID-19. In Zimbabwe, 43% of young women cited curfews and 36% fear of COVID-19.

Closure of the place where women accessed family planning was reported by between 25% (Uganda) and 39% (Ghana) of young women, and by the one woman in Nepal who reported that COVID-19 had affected her access to family planning.

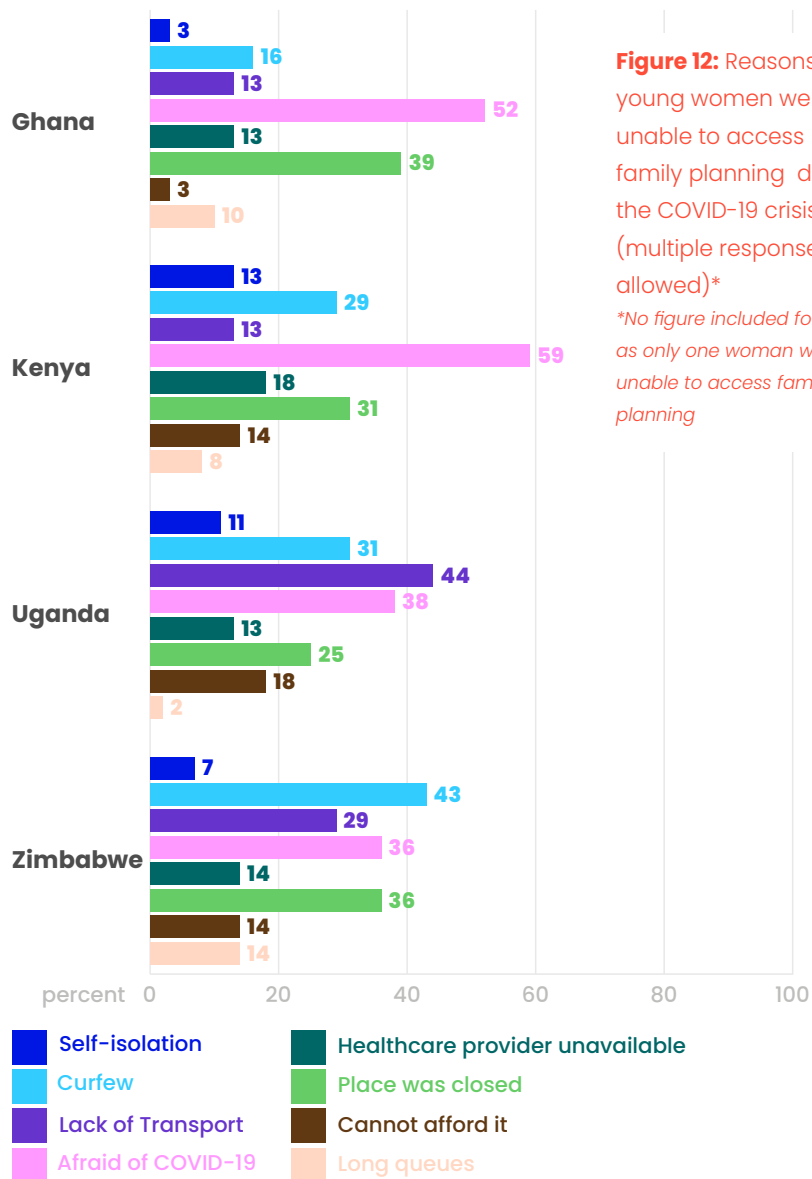


Figure 12: Reasons why young women were unable to access family planning during the COVID-19 crisis (multiple responses allowed)*

*No figure included for Nepal, as only one woman was unable to access family planning

These perceived barriers to acquiring family planning were confirmed by the qualitative data. Fear of going to health facilities during the pandemic because of the fear of getting infected with COVID-19 was cited by a large number of respondents, not only in relation to family planning services, but with regard to accessing all health services. In addition, some young people had problems accessing their usual sources of family planning, even those available in the community, as many services had closed or had reduced their opening hours due to COVID-19 restrictions.

There's a limit on the health facilities' opening times during the pandemic. Normally, they're open from 8 to 12 while teenagers are still at school. But nowadays, they still have online classes around those times as well. Other issues are that teenagers are afraid of getting infected with COVID-19 at the health centre, thinking that many sick people would be in the same place. They also feel uncomfortable talking to counsellors who wear full PPE. Therefore, they rarely go to the health centre to get counselling. People still think that instead of getting contraceptives, they'd get COVID-19!

Young man, 23 years old, Indonesia

COVID-19 changed a lot of things, especially for us the youth, because we are sexually active. Before COVID-19, at the college where we used to stay, condoms were readily available everywhere. They were easily accessible. But now, where can we get them? In bars? And colleges are closed, so the only option is to go and buy them. But the shops close early and as such activities are normally done at night, this will lead to a high number of unwanted pregnancies.

Young man, 22 years old, Zimbabwe

A number of respondents said that during the pandemic, their usual providers were less available and that there had been **stockouts** of family planning commodities.

Health centers, offices and business were closed and movement was restricted which made commodities like condoms, lubricants, and treatment to STIs inaccessible. Also, open health centers were out of stock because they were flooded due to high demand.

Young non-binary, 18 years old, Uganda

In addition, providers cited **transport problems** due to COVID-19-related restrictions, which had impeded their clients' access to their services.

Normally, I supply some people with contraceptives, but it was difficult to provide this service during the lockdown, because whenever I would go to the health centre, the in-charge would tell me she doesn't have any oral methods around but only has injectables. When I told a client to go to the health centre to get an injectable, they would claim they don't have any means of transport to go there and I believe this was because of the COVID-19 crisis.

Young woman, 23 years old, Uganda

7.2 STI/HIV testing and treatment

Among survey respondents, over 40% in Ghana, Kenya, Uganda and Zimbabwe had ever had an STI test. In Nepal, 9% of young men and 1% of young women had ever had an STI test. Levels of ever testing for HIV varied, from 1% among young women in Nepal to 90% among young women in Uganda.

Between 2% (young women in Nepal) and 47% (young men in Uganda) had wanted to access STI/HIV testing and/or treatment services during the COVID-19 crisis. Approximately 50% of these young respondents (except young women in Nepal) had been unable to access services due to COVID-19. Fear of catching COVID-19 was the most commonly cited reason for not being able to access these services. In Uganda, a lack of transport was cited by one-quarter of young respondents; in Zimbabwe, 19% of young men and 25% of young women reported that places where these services were available were closed.

Table 7. History of STI/HIV testing and the need for STI/HIV testing and/or treatment services during the COVID-19 crisis among young people

*Excludes three individuals who preferred not to disclose their sex.

	GHANA N=596 N (%)		KENYA N=782 N (%)			NEPAL N=231* N (%)		UGANDA N=640 N (%)		ZIMBABWE N=441 N (%)	
	MALE (N=292)	FEMALE (N=304)	MALE (N=362)	FEMALE (N=420)		MALE (N=104)	FEMALE (N=127)	MALE (N=326)	FEMALE (N=314)	MALE (N=358)	FEMALE (N=83)
Ever had a test for an STI	137 (46.9)	135 (44.4)	213 (58.8)	237 (56.4)		9 (8.7)	1 (0.8)	230 (70.6)	232 (73.9)	178 (49.7)	34 (41.0)
Ever tested positive for an STI	26 (19.0)	29 (21.5)	53 (24.9)	49 (20.7)		2 (22.2)	0 (0)	65 (28.3)	87 (37.5)	32 (18.0)	8 (23.5)
Ever tested for HIV	117 (40.1)	159 (52.3)	295 (81.5)	370 (88.1)		15 (14.4)	1 (0.8)	287 (88.0)	283 (90.1)	265 (74.0)	65 (78.3)
Ever tested HIV-positive	3 (2.6)	2 (1.3)	1 (0.3)	5 (1.4)		1 (6.7)	0 (0)	8 (2.8)	9 (3.2)	4 (1.5)	1 (1.5)
Needed/wanted to access STI/HIV testing or treatment during COVID-19 crisis	48 (16.4)	37 (12.2)	148 (40.9)	170 (40.5)		10 (9.6)	3 (2.4)	153 (46.9)	146 (46.5)	99 (27.7)	24 (28.9)
COVID-19 stopped access to STI/HIV services	25 (52.1)	17 (45.9)	73 (49.3)	85 (50.0)		5 (50.0)	0 (0)	86 (56.2)	80 (54.8)	65 (65.7)	12 (50.0)
Main reason for not being able to access services during COVID-19											
Self-isolation	1 (4.0)	0 (0)	4 (5.5)	3 (3.6)		1 (20.0)		3 (3.5)	5 (6.3)	3 (4.6)	1 (8.3)
Curfew	4 (16.0)	0 (0)	4 (5.5)	7 (8.3)		0 (0)		10 (11.8)	7 (8.8)	9 (13.8)	1 (8.3)
Lack of transport	0 (0)	1 (5.9)	4 (5.5)	1 (1.2)		0 (0)		21 (24.7)	21 (26.3)	4 (6.2)	1 (8.3)
Afraid of catching COVID-19	14 (56.0)	10 (58.8)	40 (54.8)	44 (52.4)		1 (20.0)		29 (34.1)	23 (28.7)	14 (21.5)	5 (41.7)
Health care provider unavailable	4 (16.0)	1 (5.9)	4 (5.5)	11 (13.1)		0 (0)		3 (3.5)	6 (7.5)	11 (16.9)	0 (0)
Place was closed	1 (4)	3 (17.6)	11 (15.1)	11 (13.1)		0 (0)		9 (10.6)	7 (8.8)	12 (18.5)	3 (25.0)
Cannot afford it	0 (0)	1 (5.9)	1 (1.4)	4 (4.8)		2 (40.0)		5 (5.9)	6 (7.5)	3 (4.6)	0 (0)
Long queues	1 (4)	1 (5.9)	5 (6.80)	3 (3.6)		0 (0)		5 (5.9)	4 (5.0)	2 (3.1)	0 (0)

The qualitative data reveals that because of changes in health service provision related to COVID-19 measures and obstacles to access (as discussed above), young people often **delayed getting treatment** for actual or suspected STIs, and often used informal rather than formal providers.

We have one friend, he is just 17/18 years old. He has an infected penis. But he is not going to a health centre to receive treatment. I think he is afraid of getting seen by other people and also scared of the corona. Maybe because he also does not have money to come to the centre. Also, I think he is not very educated as well.

Young male, 25 years old, Nepal

The changes in service provision seem to have compounded what was already perceived to be a **highly stigmatising** issue.

In my community, I have seen that some young people have got infected with STIs, but they wait until it's too late (to seek treatment). I have seen several cases where I think the people concerned have not visited a provider about their STI because it affects their private parts, so some people hide until it becomes too painful that they cannot even stand.

Young woman, 32 years old, Kenya

As described above, the fear of contracting COVID-19 at health centres made some people afraid to seek the diagnosis and treatment of STIs.

I happen to have friends who have gotten STIs. What they fear during this pandemic is seeking medical treatment. Why? Because the transmission of COVID-19 at hospitals and health centres is rampant. There are a lot of sick people and my friends are afraid of being infected while at the hospitals. So, they have a dilemma between wanting to recover from their STI or getting exposed to another disease. People are more afraid to go to hospitals or health centres. There are a lot of stories that make people anxious, like easily getting infected by COVID-19 at the hospitals.

Young man, 26 years old, Indonesia

In settings where health service accessibility has been compromised, and where there is a reliable and affordable internet connection, it was suggested that **telemedicine** could possibly be used for the syndromic management of STIs during the COVID-19 pandemic, and even beyond.

It isn't difficult to get medicine during lockdown. However, it is difficult to go to hospital if we have a problem – even some of the hospitals told us to come only after a PCR (COVID-19) test. Before COVID-19, it was very easy to visit a hospital, even with a small problem, whereas now we are scared of getting infected if we visit a hospital and this causes mental stress. To overcome this problem, it would be good to introduce telemedicine by STI specialists for the diagnosis and treatment of simple STI problems and for counselling.

Young man, 26 years old, Nepal

7.3 Challenges for young people living with HIV/AIDS

Fewer than 10% of respondents across all countries self-reported an HIV-positive status. Among the 34 individuals living with HIV, 38% reported not needing access to HIV/STI-related testing and/or treatment services during the COVID-19 crisis. Among the 21 individuals requiring access to these services, 29% had received some but not all of the required medication, and 29% had received different medications and/or some of their usual medication had been substituted. One-third had received all their medication, while 10% had not taken any medication. The twelve individuals who reported not getting all of their medication resided in Kenya, Nepal, Uganda and Zimbabwe. The reasons why they had been unable to access their medicine included: the medicine was out of stock (25%), lack of transport (17%), being afraid to catch COVID-19 (17%), and the place where they usually obtained their medicine was closed (17%).

The qualitative interviews also reveal that **people living with HIV often experienced great difficulty accessing medicines such as ARVs** due to COVID-19 prevention measures. These measures have led to stockouts, transport difficulties and to people being afraid to go to health centres as they considered their HIV infection to be an 'underlying condition' that would make them more vulnerable to COVID-19.

We also heard about the scarcity of ARVs in Jawa Barat (West Java) or elsewhere, but fortunately they are still accessible in Surabaya. Some friends from Bandung say that they were only given ARVs every two weeks because the stock is limited. I feel sorry for them who live in the rural areas and outside Surabaya, because ARV is getting hard to obtain.

Young man, 26 years old, Indonesia

We were made to understand that the virus (COVID-19) kills people who have HIV and other underlying health conditions. So people are afraid to go to the hospital.

Young woman, 18 years old, Ghana

There is a general hospital where most young people who are HIV-positive get their medicines. That means there are young people who come from far away and have to use public transport. When COVID came, there was a hike in the price of public transportation. With no jobs and no money for fares, it meant that some people were unable to go for their medicines.

Young woman, 20 years old, Kenya

Unfortunately, this led some of those living with HIV to **stop taking their ARVs**, which is likely to have extremely detrimental consequences for their health.

There are many HIV-positive people, and most do not have a means of transportation. During the COVID-19 lockdown, many could not travel to hospital due to lack of transportation. Some people are skipping their medicine for 10-15 days. This has been very problematic. People are very scared. They think they will be safe and will survive if they do not get the medicine. But with COVID, we are very doubtful if we can survive from COVID-19.

Young man, 23 years old, Nepal



For those of us who could access our medication, the long distances affected us. Sometimes I didn't have the energy to walk all that long distance and I decided to put my medication on hold. When I went back to the health centre, they found out that my viral load had gone up and I'm now struggling to suppress it.

Young woman, 24 years old, Uganda

Others, as confirmed in the quantitative data discussed above, had to **change or substitute** some of their medication.

There was a time when FDC (fixed dose combination)³⁷ type drugs became scarce and some friends had to change their medical treatment. Sometimes your body must adapt to a different medicine. There are several friends who were affected by the stockouts of ARVs. Fortunately, I wasn't affected. Maybe because of the quota restriction and service hours.

Young non-binary, 22 years old, Indonesia

People living with HIV who had to move back home to live with their parents or extended families during the pandemic (for example, because of unemployment or school closures) often experienced difficulties in adhering to their HIV treatment schedules. Living in close quarters with family or community members often meant that they were more observed and lacked the privacy to take their medicines discretely. For those who had not divulged their status to their relatives, **taking the medicines risked exposing the fact that they are living with HIV** and thus increased their chances of experiencing stigma. Respondents in Uganda described how in some cases, because of stigma,

individuals stopped taking their ARVs, which would probably have severe consequences for their health.

Some young people have had to put their medication on hold during the COVID-19 crisis because of the presence of family members at home. They do this because they don't want these family members to know that they are taking ARVs.

Young man, 21 years old, Uganda

Some clients have been taking their drugs in secret and now that they have a lot of people in their homes, they have had to put their medication on hold until further notice, because of fear of stigma and discrimination from those around them.

Young non-binary, 23 years old, Uganda

In addition, **viral load testing** and the management of the psycho-social aspects of HIV infection have, in many cases, stopped during the pandemic. This has particularly affected those who discovered their HIV status more recently.

You are supposed to do your viral load test every six months, but because of the pandemic they don't do viral load tests anymore. In addition, there is also no education for people who have newly contracted HIV to be able to manage their depression when it happens.

Young man, 23 years old, Ghana

Adherence to ARV medication has also been compromised during the pandemic, as support groups for those living with HIV are no longer meeting up.

Due to restrictions in places against gathering, they (YPLWHIV) are unable to meet their support groups where they get encouragement. Because of this, they might end up feeling discouraged or lazy and fail to take them (ARVs) as prescribed.

Young woman, 24 years old, Kenya

Many young people who were previously using **PrEP** to prevent HIV infection have had difficulty accessing the medication during the pandemic (and the food with which to take it). This has therefore increased their risk of exposure. Similarly, providers of PrEP have also been limited by the consequences of COVID-19 in terms of being able to provide their clients with sufficient supplies.

I work at a health facility where I have to initiate PrEP and do follow-up on ART clients to check their adherence status. However, one way or the other, I stopped going to the facility because of the transport and everything that came about.

Young woman, 25 years old, Uganda

I am a PrEP user and taking it was so hard because I need to eat well all the time, and yet the food was also scarce.

Young woman, 23 years old, Uganda



7.4 Challenges for transgender individuals

The qualitative data also reveal that those in the transgender community who were transitioning as the pandemic hit have been **unable to access the hormones** required.

Talking about SRH, from the LGBTI community, transgender individuals are facing more difficulties during this pandemic because they need hormones and it is difficult to visit different hospitals and they have to face problems like itching and weakness. Hospitals have no understanding about our health problems. They have not heard and seen cases like this. It is difficult to provide documents to the hospital at this point of time.

Young non-binary, 28 years old, Nepal

I want to add that things are especially difficult for the transgender community, as we use hormones regularly. After lockdown, there has been a shortage and they are not easily available in Nepal. We get it from abroad. Hence some of us are facing health problems.

Young non-binary, 24 years old, Nepal

7.5 Abortion

As described in Section 6, between 18% (Ghana) and 33% (Kenya) of young women wanted/needed information on (post-)abortion services. Over half of these women reported getting either no information or insufficient information on (post-)abortion (care). Since the onset of the COVID-19 crisis, between 1% (Nepal) and 7% (Zimbabwe) of young women have needed (post-)abortion services. Among these young women (n=39), over one-third reported that the crisis had prevented them from accessing services (Ghana: 33%, n=2; Kenya: 55%, n=6; Nepal: 100%, n=1; Uganda: 53%, n=8; Zimbabwe: 100%, n=6).

For half of the women needing (post-)abortion services in Ghana, fear of COVID-19 was the most commonly cited reason for not accessing services. In Kenya, one-third of women cited fear of COVID-19 and a further one-third said that the place they had wanted services from was closed. Similarly, one-third of women in Zimbabwe who had wanted post-abortion services said that the service provider had been closed. Lack of transport was most commonly cited in Uganda (38%). In Nepal, the curfew had stopped the one young woman in need of services from accessing them. Two women in Ghana reported that they would terminate their pregnancy at home or at the health facility after the COVID-19 measures had been lifted, while half of the young women in Uganda and Kenya planned to continue with the pregnancy. The one young woman in Nepal who had been unable to access services had “other” plans for what she would do regarding the pregnancy.

The qualitative data also reveal that young women have faced challenges in accessing abortion services, firstly because, due to the COVID-19 restrictions, they have **lacked peer group support**, and secondly, because the **public facilities offering terminations were closed**. Some respondents remarked that private facilities had increased their fees for terminations in response to this situation.

Some young people could not access safe abortion because it's costly, fear of being judged, they don't know who to talk to hence end up seeking backstreet services. COVID-19 made it difficult to get abortion services, because they were locked at home and had no friends to talk to. Especially those at the university level, like they used to do while they were at the campus and friends could easily refer them where they can get help. I think also some private facilities which were depended on took advantage of the situation and raised prices.

Young woman, 27 years old, Kenya

However, other **private providers** have continued to provide accessible abortion services during the COVID-19 crisis.

Private facilities such as Marie Stopes and NGOs such as Nena Na Binti have really come in handy and helped with referrals for safe abortions.

Young woman, 22 years old, Kenya

It is likely that **medical abortions** (for example, using mifepristone and misoprostol) can still safely be carried out at home during COVID-19. Women testified that while this had occurred, it was going undocumented and lacked follow-up.

Some women in the early pregnancy have medical abortions at home. But we do not know what the outcomes are – we are not aware of it.

Young man, 23 years old, Nepal

During the COVID-19 pandemic, in some settings pharmacies have been able to supply the necessary medication for home abortions.

Some are even going to private doctors or even to pharmacies. They just go, and maybe the parents will not be aware of what they are doing? That is what their child is doing. Of which they would have discussed about it with their boyfriend or the man, to find a way to get the pill or the medicine to terminate the pregnancy.

Young woman, 25 years old, Zimbabwe

However, in the absence of public services, both in settings where abortions are legal and where they are illegal, some young women have resorted to **home abortions with local products**, which could be extremely harmful.

In my community, there is a girl who got pregnant. She went and bought quinine tablets and swallowed plenty of them. Fortunately, she aborted but almost died. advantage of the situation and raised prices.

Young non-binary, 26 years old, Uganda

Someone told me a coat hanger would work, I do not know how they use it. But it may affect the womb or she may end up being infected, because she may not (know) whether this coat hanger is carrying germs – it may add bacteria into her body. These would be especially damaging to the womb and affect her when she actually wants to have a baby later in life.

Young woman, 25 years old, Zimbabwe

Others tried to terminate their pregnancies with **local, informal providers**, whose methods could lead to serious health problems.

I think a lot of young people with unwanted pregnancies have resorted to having unsafe abortions. Like one is told that the house by the corner – you can go and have your abortion there. And yet such things are unsafe, and maybe you can get other infections which can lead to long-term effects, such as being barren for life. And all for what? It's not really worth it.

Young woman, 22 years old, Zimbabwe

When those who attempted to induce an abortion at home or with an informal provider suffered problems, the transport restrictions imposed by lockdown meant that some experienced **delays in seeking help**, which could possibly be fatal.

There are people who attempt to do an abortion at home, but face challenges or fear the high risk of bleeding to death, because they are doing it with backstreet providers. They are facing challenges because of the long distance between their home and the health facility. Now, because of the lockdown and COVID-19 restrictions, they may die on their way to hospital.

Young woman, 22 years old, Zimbabwe



8 Gender-based violence

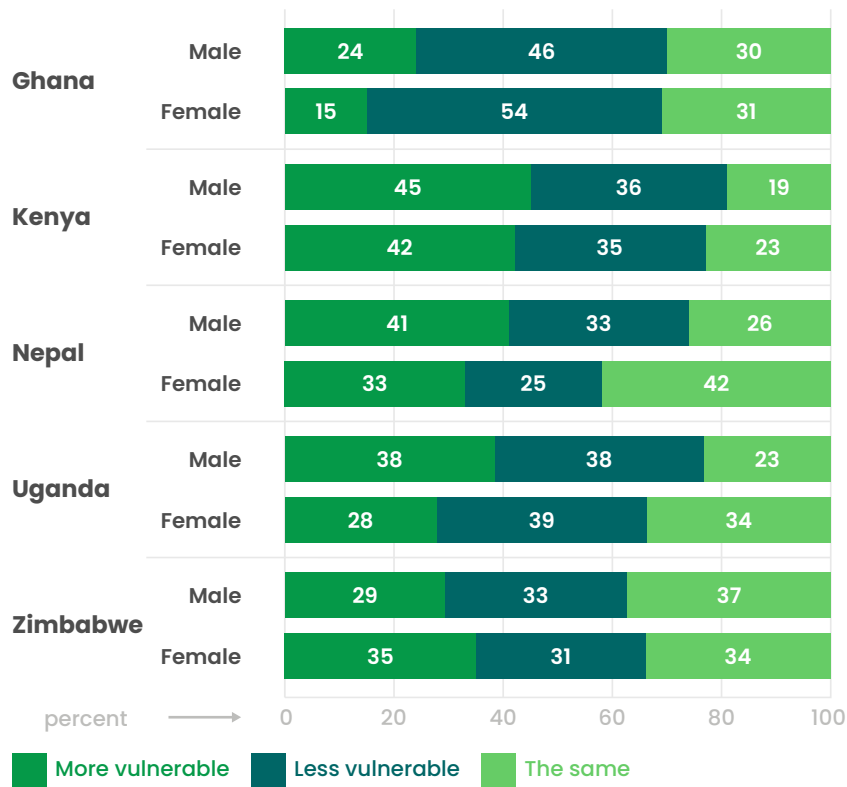
The following analyses reflect the experiences of young people of sexual harassment, or sexual, physical, emotional or financial abuse, during the pandemic. Lockdown, economic hardship and the associated recourse to transactional sex have all increased vulnerability. Socio-cultural barriers to reporting are discussed, together with ways they could potentially be overcome.

8.1 Harassment and violence

Survey respondents were asked how vulnerable they felt they were to sexual harassment, or sexual, physical, emotional or financial abuse, compared to before the COVID-19 crisis. Among all survey respondents, one-third felt more vulnerable, with more young people in Kenya (44%) feeling more vulnerable during the COVID-19 crisis (Ghana: 19%; Nepal: 37%; Uganda: 33%; Zimbabwe: 30%).

In all countries except Zimbabwe, fewer young women (range: 15% Ghana to 42% Kenya) reported feeling more vulnerable to sexual harassment and/or sexual, physical, emotional or financial abuse than young men (range: 24% Ghana to 45% Kenya; Figure 13). This may be explained by the very broad nature of the question, which encompassed financial and emotional abuse, which young men may have felt more vulnerable to. In Zimbabwe, 29% of young men and 35% of young women felt more vulnerable to harassment and/or abuse.

Figure 13: The percentage of young people who perceived themselves as more vulnerable to sexual harassment and/or emotional, physical or financial abuse during the COVID-19 crisis, by sex



When asked whether they had experienced specific forms of abuse during the COVID-19 crisis, respondents in Ghana, Kenya and Uganda commonly cited having had money taken from them without their consent, particularly young men (range: 15% to 22%), which again may explain why more men reported feeling more vulnerable to abuse/harassment (Figure 14). Online sexual harassment was reported by 10% of young women in Nepal and approximately 15% of young men in Kenya and Uganda.

Young men and women reported similar levels of physical/sexual abuse. Being touched by someone against their will was reported by between 2% (Zimbabwe) and 10% (Uganda) of young men, and 2% (Nepal and Zimbabwe) and 9% (Kenya and Uganda) of young women. Forced sexual intercourse was reported by between 3% (Zimbabwe) and 8% (Uganda) of young men, and 2% (Nepal) and 9% (Uganda) of young women.

Gender-based violence

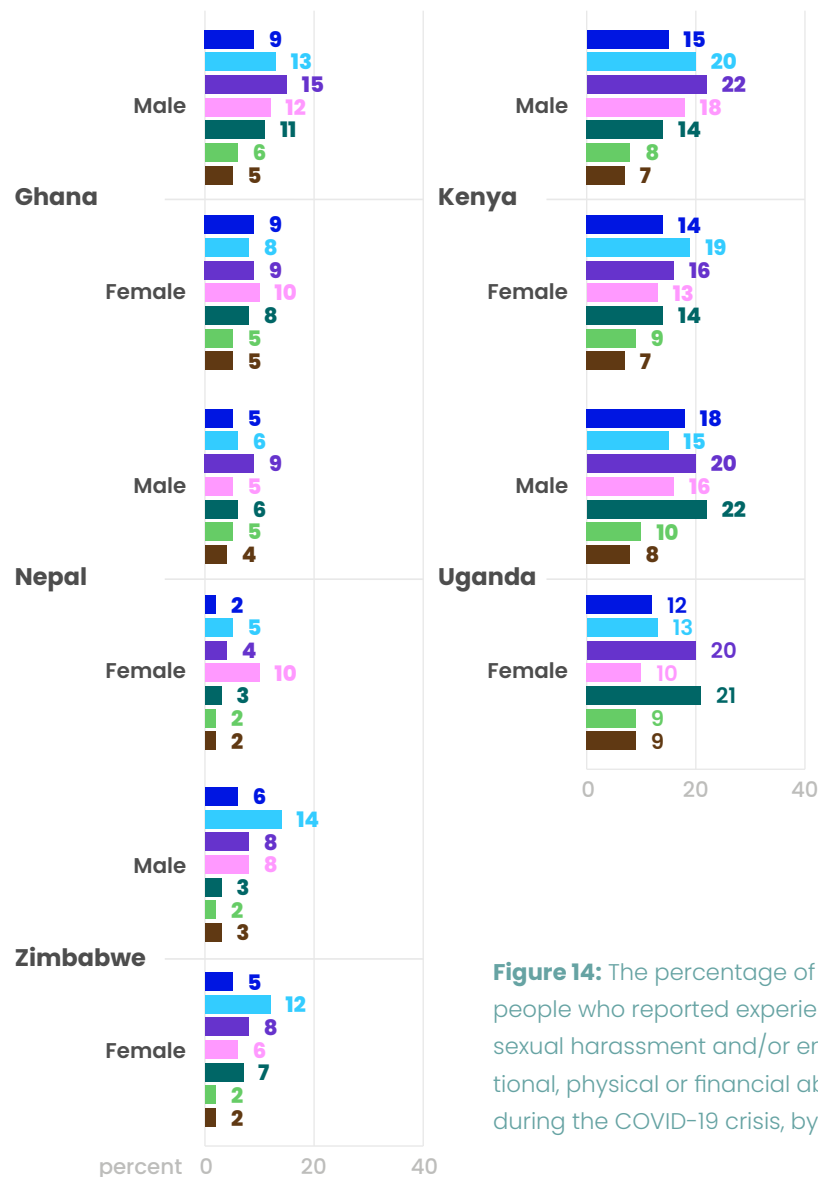


Figure 14: The percentage of young people who reported experiencing sexual harassment and/or emotional, physical or financial abuse during the COVID-19 crisis, by sex

Gender-based violence

Among the survey respondents who had experienced violence and/or abuse during the COVID-19 crisis, partners and friends were most commonly cited as the perpetrators (Table 8). A family member was cited by between 12% (young men, Zimbabwe) and 23% (young men, Uganda) of young people, while “other” was reported by a high percentage of young people, particularly in Nepal (65% young men; 61% young women) and Zimbabwe (42% for both young men and young women).

Over 50% of all young people, except respondents in Zimbabwe, stated that they had spoken to a friend about the abuse they experienced. Between 17% (young women, Nepal) and 38% (young women, Ghana) had spoken to a relative. The majority of young people (range: 61% for young men in Uganda to 96% for young women in Nepal) had not filed a complaint regarding their experience.



Table 8: Perpetrators of the violence that young people experienced during the COVID-19 crisis, whom young people spoke to about their experience, and whether they filed a complaint

	GHANA N=210 (N=113) MALE (N=97) FEMALE	KENYA N=408 (N=197) MALE (N=211) FEMALE	NEPAL N=44 (N=20) MALE (N=23) FEMALE	UGANDA N=334 (N=176) MALE (N=158) FEMALE	ZIMBABWE N=60 (N=48) MALE (N=12) FEMALE					
Perpetrator of the violence experienced during the COVID-19 crisis										
Partner	35 (31.0)	29 (29.9)	64 (32.5)	45 (21.3)	5 (25.0)	2 (8.7)	64 (36.4)	55 (34.8)	15 (31.3)	5 (41.7)
Family	22 (19.5)	16 (16.5)	28 (14.2)	31 (14.7)	3 (15.0)	5 (21.7)	41 (23.3)	26 (16.5)	6 (12.5)	0 (0)
Friend	46 (40.7)	31 (32.0)	90 (45.7)	105 (49.8)	7 (35.0)	5 (21.7)	88 (50.0)	62 (39.2)	12 (25.0)	2 (16.7)
Teacher	14 (12.4)	4 (4.1)	10 (5.1)	3 (1.4)	1 (5.0)	0 (0)	18 (10.2)	8 (5.1)	1 (2.1)	0 (0)
Other	28 (24.8)	30 (30.9)	48 (24.4)	52 (24.6)	13 (65.0)	14 (60.9)	30 (17.0)	39 (24.7)	20 (41.7)	5 (41.7)
Whom did you speak to about the violence experienced during the COVID-19 crisis										
Relative	38 (33.6)	37 (38.1)	56 (28.3)	63 (29.7)	4 (20.0)	4 (17.4)	71 (40.3)	64 (40.5)	10 (20.8)	3 (25.0)
Friend	56 (49.6)	54 (55.7)	131 (66.2)	135 (63.7)	12 (60.0)	12 (52.2)	116 (65.9)	89 (56.3)	20 (41.7)	3 (25.0)
Helpline	11 (9.7)	5 (5.2)	18 (9.1)	7 (3.3)	2 (10.0)	2 (8.7)	27 (15.3)	10 (6.3)	4 (8.3)	1 (8.3)
Social services	15 (13.3)	5 (5.2)	39 (19.7)	11 (5.2)	4 (20.0)	2 (8.7)	25 (14.2)	24 (15.2)	8 (16.7)	1 (8.3)
Police	9 (8.0)	3 (3.1)	14 (7.1)	4 (1.9)	1 (5.0)	1 (4.3)	23 (13.1)	3 (1.9)	6 (12.5)	0 (0)
None of the above	29 (25.7)	18 (18.6)	39 (19.7)	38 (17.9)	7 (35.0)	7 (30.4)	21 (11.9)	28 (17.7)	14 (29.2)	8 (66.7)
Did you file a complaint about these experiences during the COVID-19 crisis?										
Yes	23 (20.4)	12 (12.5)	26 (13.2)	17 (8.0)	1 (5.0)	0 (0)	44 (25.0)	16 (10.1)	8 (16.7)	2 (16.7)
No, wanted to but services/ police unavailable	10 (8.80)	8 (8.3)	30 (15.2)	21 (9.9)	2 (10.0)	1 (4.3)	24 (13.6)	12 (7.6)	5 (10.4)	2 (16.7)
No	80 (70.8)	76 (79.2)	141 (71.6)	174 (82.1)	17 (85.0)	22 (95.7)	108 (61.4)	130 (82.3)	35 (72.9)	8 (66.7)



In all settings, participants in the FGDs indicated that **gender-based violence had increased** markedly during the pandemic. It is important to note that the qualitative discussions focussed on physical violence, whereas the survey allowed for the reporting of physical, financial and emotional abuse.

The increase in gender-based violence reported during the FGDs was largely attributed to the fact that spouses and partners spent more time together due to lockdown or job loss and ended up irritating each other, leading to conflict.

Before, in an abusive environment, there was some relief when the partners were going to work. Now physical violence is on the rise because perpetrators and victims spend most of their time together. A lack of money leads to frustrations and then to verbal abuse, depression and anxiety.

Young woman, 22 years old, Kenya

I know of a young mother in the neighbourhood whose husband is so jealous that he checks all her calls to know who talks to her. This leads to a lot of physical and verbal fights between them. I believe this is because of the COVID-19 crisis, because it never used to happen before the lockdown when the man was working and wasn't at home a lot.

Young woman, 18 years old, Uganda

Others said that **economic difficulties** caused by unemployment and price rises have led to tensions within the household, which have resulted in physical violence between men and women.

But during this time, husbands and wives spend more time at home together and there are financial challenges. This causes more fights, as when the husband and the wife have no money, the kids will be hungry and there will be more conflict. Hence, there has been an increase in gender-based violence during this COVID-19 period.

Young woman, 25 years old, Zimbabwe

Respondents indicated that the majority of victims were women, who were subject not just to beatings but also to **forced intercourse**.

This problem has increased greatly during this COVID-19 crisis; I know a couple that used to live separately but later started living together in the man's house. The woman later reported to police that the man beats and rapes her.

Young man, 22 years old, Uganda

Girls who were out of school appeared to be more at **risk of unwanted pregnancy**, sometimes as a result of **gender-based violence**.

Partners are currently forced to come home because of the national curfew. At times, most want sex and when we decline, this leads to fights and violence.

Young woman, 24 years old, Kenya

Schools act as a safe space for adolescent girls and children, and their being at home has exposed them to predators, hence the high amount of gender-based violence. During the earlier months of the pandemic, apart from the COVID-19 updates from the Ministry of Health, something else that always came up on TV and radio was news about the high number of teenage pregnancies – some girls were being impregnated by their immediate family such as by uncles or even fathers.

Young man, 19 years old, Kenya

In addition, respondents reported an **increase in child abuse**, which has also particularly affected girls whose schools have closed.

A lot of children are facing abuse in most households where we are staying. Not all of us are staying with biological parents. Some are staying with step-parents and some with relatives. I think, when we are at school, we don't face some of these problems, like always being beaten up, but now that we are at home, we are now facing this abuse. Some girls are now in relationships. In fact, they are not really relationships but more like sex work to get food or other minor things. They have sex in order to get food because maybe at home things are not stable.

Young man, 25 years old, Zimbabwe

LGBTQ individuals, including trans people and those engaged in sex work, have also been subject to physical and psychological abuse during the COVID-19 pandemic.

For those engaged in sex work, gender-based violence was worse during the lockdown because the men who buy the services didn't have money to pay. A friend of mine recently died of gang rape and violence after she refused to give free sex to one of her routine clients who had wanted her to "pay him back some of his money".

Young woman, 25 years old, Uganda

Sometimes violence was **instigated by family members** with whom LGBTQ and trans individuals were obliged to live during lockdown.

One of my 19 year old friends decided that they were transgender. So they bought make-up and skincare products but got caught by the family. After being caught, they received psychological abuse from a judge as well as from their parents, uncle, aunt and other family members. All their cosmetics, wigs and skincare products were thrown away and burned. Finally, they felt uncomfortable staying at home so then ran away from the house. They now live in the Inti Muda's shelter. They were traumatised for up to 2 months, mentally depressed and didn't want to eat. Finally, Inti Muda helped them to see a psychiatrist and, thankfully, they are getting better now and can express themselves more.

Young man, 26 years old, Indonesia

Others in LGBTQ and transgender communities have been subject to increased harassment and **rights violations by the police** during the pandemic.

During the pandemic, there were many police raids in Surabaya, while transgender friends were out on the street looking for customers in order to get some cash to make ends meet. When Satpol PP make an arrest, they usually get rough and violent and there were many transgender folks who got detained. Satpol PP also made sudden raids on boarding houses and, if they found transgender among residents, they would make them pay some money or go to Liponsos (a social rehabilitation centre).

Young man, 26 years old, Indonesia

In addition, **people living with disabilities** have also been subjected to abuse as a result of the COVID-19 restrictions and their consequences.

During this time of COVID-19, we are aware of gender-based violence and we heard that there are many cases of gender-based violence among people with hearing loss – mainly women, who are victim of such incidents like rape. Now, I think we should know how we can report those incidents to the government and through other organisations.

Young man, 25 years old, Nepal

Abuse was not restricted to physical assault but also occurred **online**. This and sexting was mentioned by young people in a variety of settings, and they implied that it had increased during the pandemic.



As for online harassment, it happens all the time. During lockdown people get itchier to write about bad things. Simply put, in today's society, it is easier to insult other people than try to understand. I experienced that. Easier for them to abuse us by calling names like transgender, gay or lesbi. For example, there's a Tik Tok video and has a bit of gay content like discussing about being gay. It generates lots of comments and hate speech, more like verbal abuse. "Oh, he's cute but different."

Young man, 26 years old, Indonesia

Gender-based violence in dating relationships still exists in our village. A case that has gone viral nowadays during the pandemic is that the girl was asked to send some nudes to her boyfriend and when she wanted to break up, he threatened her saying that the pictures would be posted online and become viral. I was wondering why she was willing to send him that kind of picture? She's the one who gets the disadvantages. My friend was one of the perpetrators. I gave him some advice about this harassment towards his girlfriend.

Young man, 19 years old, Indonesia

As found in the quantitative survey, most abuse went unreported, especially as victims were more likely to be **economically dependent on the perpetrator** due to the pandemic.

The perpetrator may be your guardian and when you report you will not get your basic needs from them again.

Young woman, 22 years old, Ghana

Many people need support from their spouse in raising their kids, thus one ends up not reporting the case.

Young man, 22 years old, Kenya

Others were afraid of catching the virus if they ventured out to report the violence. They also feared the reaction of the police and other authorities, who often disclose victims' identities or demand money to pursue a case.

Because of the corona virus, people are not able to go to the police station.

Young woman, 19 years old, Ghana

(They do not report it because of) poverty, especially on the part of women and children, because the police usually ask them for some money to carry out investigations whenever a case is reported.

Young man, 24 years old, Uganda

For LGBTQ and trans people, the incidents often went unreported due to a perceived need to protect their families' reputation.

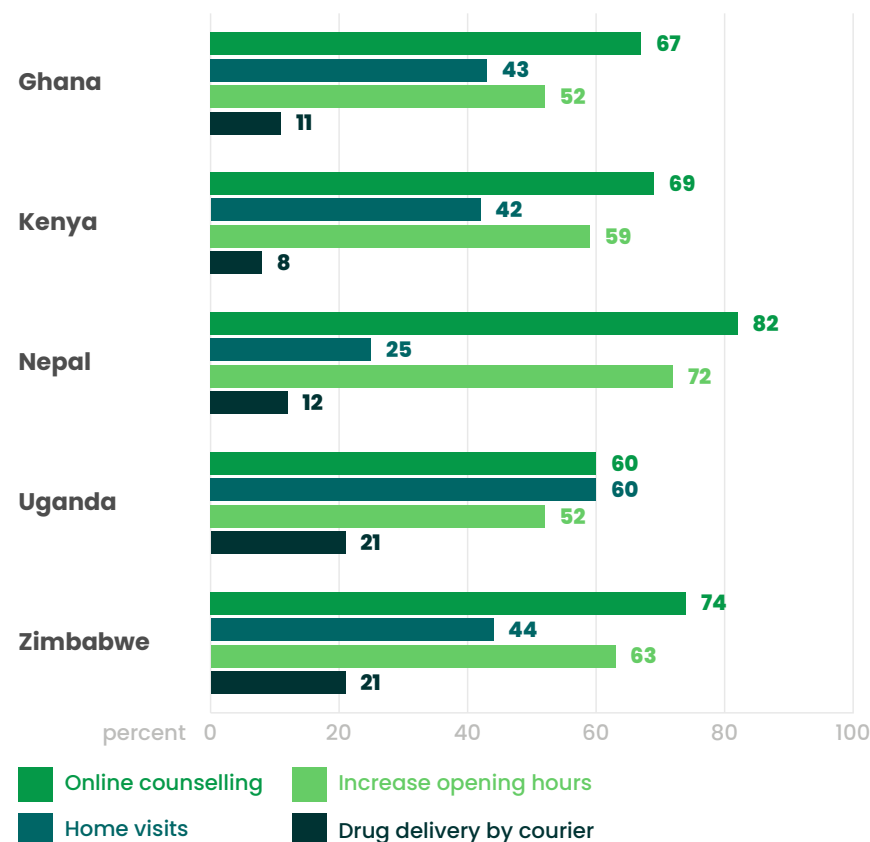
Many cases of gender-based violence against LGBTQ cases involve their family members, and so the victims keep their experience to themselves because they feel they may harm their family's reputation. There was even a case where the perpetrator was their own grandfather.

Young woman, 30 years old, Indonesia

8.2 Addressing gender-based violence

When asked how gender-based violence services should be offered to young people during the COVID-19 crisis, the majority thought that services should be delivered through online counselling, with this approach being particularly popular among young people in Nepal (82%; Figure 15). Home visits and extending opening hours of gender-based violence services (including helplines and social services) were also commonly cited as approaches for improving service delivery.

Figure 15: How gender-based violence services should be delivered during the COVID-19 crisis according to young people



FGD participants were asked how those who have experienced gender-based violence could best be supported after their ordeal. Many suggested that initiatives should be put in place to facilitate victims to report the incident to the police.

To help the victims we should listen to them and understand them properly, rather than going against them. Facilitate things so they can reach the police station, NGOs and other organisations or people working in this field.

Young woman, 22 years old, Nepal

Part of the problem seems to be that even pre-COVID-19, many victims **did not realise that gender-based violence is a criminal offence** or that their rights had been violated. This requires more awareness-raising and community support to enable them to seek justice.

Those who witness these vices should help the victims to report them to the police, since some of them lack the confidence to report the incidents.

Young man, 23 years old, Uganda

People need to be educated, because you may be beaten but you do not know that it's wrong to be beaten. So people need to be educated, so that if such a situation happens, this is how you should act.

Young woman, 22 years old, Zimbabwe

LGBTQ and trans groups require specific support, as the abuse they experience is often compounded by deep-rooted stigma related to their sexuality/gender identity, while the pandemic has further exacerbated their vulnerability. Since many in these communities are migratory and do not live where they were born or have citizenship, during the lockdown many were not entitled to receive any support or benefits offered by the state – though it is important to note that this lack of entitlement or access to state assistance is not limited to times of COVID-19 but has long been an issue.

Even in Kathmandu, LGBTQ people are not getting citizenship due to their sexuality. Thus, during lockdown, when organisations distribute food to the people, LGBTI people don't get it due to lack of citizenship. They suffer from extreme bullying and as a result suffer mental torture and some of them even committed suicide. I think most of them are suffering from mental problems due to bullying during COVID-19.

Young man, 19 years old, Nepal



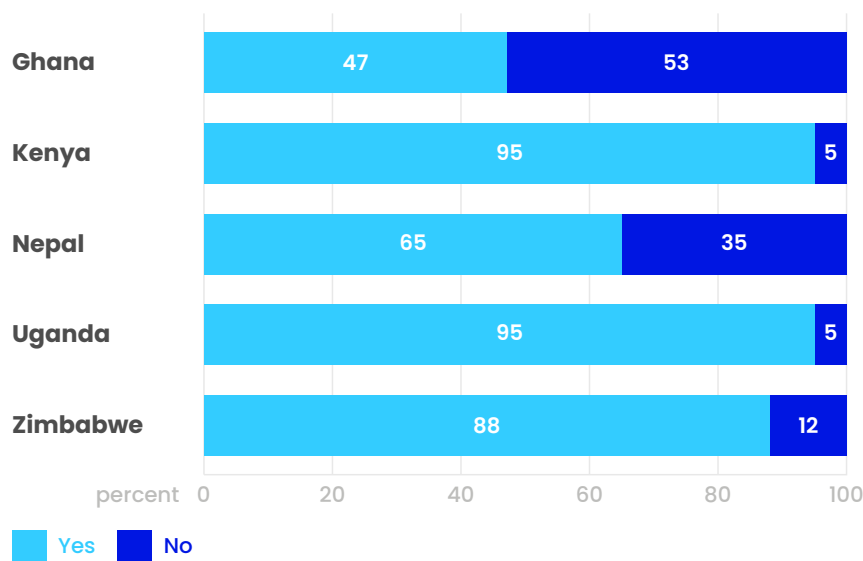
9 Effects on early marriage

The study also explored whether the COVID-19 pandemic has had an effect on perceptions of the practice of early marriage, which, even under normal circumstances, is still quite widespread in many of the communities concerned, despite often being prohibited by law.*

When asked whether, in general, early marriage (aged <18) happens frequently in their community, between 12% (Ghana) and 35% (Uganda and Zimbabwe) of young people thought this practice happened frequently. Most respondents reported that the practice happened sometimes (range: 22% Ghana to 31% Kenya and Zimbabwe) or rarely (range: 23% Zimbabwe to 27% Ghana and Nepal). Between 12% (Zimbabwe) and 39% (Ghana) of young people reported that the practice did not happen in their community. However, when asked whether girls were at increased risk of early marriage because of COVID-19, **over 85% of young people in Kenya, Uganda and Zimbabwe responded yes – they perceived girls to be at higher risk of early marriage** (Figure 16).

* It should be noted that the study looked at whether the young people interviewed thought that their peers were at increased risk of early marriage. It did not look at whether there had been real increases in the actual practice or examine the personal experiences of the sampled young people.

Figure 16: The percentage of young people who perceived/did not perceive girls to be at increased risk of early marriage due to COVID-19



FGD respondents in all settings, especially in African countries, said that **early marriage had increased** because of the COVID-19 pandemic, as parents sought to transfer the economic costs of their daughters to other households or alternatively sought to receive food and gifts in exchange for their offspring. Many of these unions appeared forced or involuntary.

It (early marriage) has increased because of economic hardship – vulnerable young people in rural areas are being married off in exchange for food and commodities, especially girls from large families.

Young man, 25 years old, Kenya

A friend and a classmate of mine was forced to get married to a random man by her parents because they needed money to survive during the lockdown.

Young woman, 18 years old, Uganda

In other cases, **girls themselves sought out early marriage**, as they perceived that it would increase their economic security in these difficult times when their families were unable to support them.

The corona virus has caused financial loss to families and, as a result, some girls have to depend on men for income and that will lead to early marriage.

Young man, 23 years old, Ghana

A lack of basic needs pushed a lot of girls in my community to get into relationships that later turned into marriages that they did not expect at that time. I think COVID-19 has caused those girls nothing but regret because they are living with a person they didn't want to be with.

Young woman, 18 years old, Uganda

School closures have also served as a catalyst for early marriage. Girls enrolled in school were able to delay getting married, but with schools closed they have had no excuse or choice.

Initially, school was the excuse people were using to not get married, but because it was closed due to COVID they have no more excuses to hold off marrying.

Young man, 18 years old, Ghana

Respondents in Zimbabwe also remarked that because of the COVID-19 pandemic and its preventive restrictions, **early marriage has increased**, often because young women have been short of food. Those with disabilities were said to be particularly likely to enter into such abusive relationships out of need.

I can say the closing of schools has caused children to enter into early marriage because of hunger. Some would just do it for a bucket of maize. In particular, those with disabilities can be manipulated into believing that the man really loves them, or (get married) for the sake of getting money for the family to survive. So, sometimes you will be left with no choice. So the issue of abuse has increased.

Young woman, 19 years old, Zimbabwe

I see it like this: before the lockdown, many young people would spend most of their time in school, but now they spend most of their time at home doing nothing. They will see it as if getting married will be better.

Young woman, 22 years old, Zimbabwe

As noted above, anecdotal evidence in a number of settings implies that pregnancies appear to have increased among out-of-school girls, which in turn precipitate marriage with the men concerned.

I will say it (early marriage) has increased, because schools are closed and a lot of young girls got pregnant, so their parents advised them to get married.

Young woman, 23 years old, Ghana

Peer influence has led so many girls to get married at an early age. They get tempted to try out unsafe sex and this leads many into early marriages because of the teenage pregnancies, especially during this lockdown.

Young man, 23 years old, Uganda

The negative social, psychological and physiological impact of early marriage was perceived to be considerable and many said that it was likely to lead to irrevocable consequences for the girls concerned. Some respondents felt that young girls were **not mature enough to enter marriage** and that this would affect their relationship with their spouse and their ability to look after any offspring.

Early marriage has increased now. During lockdown, young people are more active online and they fall in love online and get married at an early age. But this decision will harm them in future. Due to early marriage they may suffer from relationship problems because they are immature.

Young woman, 22 years old, Nepal



10 Conclusions and recommendations

The innovative and timely research presented here shows both the direct and indirect impacts of COVID-19 and its prevention measures on access to SRH information and services by young people. It should be noted that these sensitive themes were successfully explored in great detail during the FGDs because of the choice to engage young people as researchers. Their empathetic and non-judgemental approach appears to have generated very rich, culturally-relevant information which can be used to better understand their peers and address their concerns.

The direct impact of COVID-19 has often led to health centres being closed or under-staffed. Alternatively, some facilities have changed or reduced their opening hours. In cases where facilities have stayed open, young people feared visiting them as they were afraid of catching COVID-19. SRHR information has also been hard to acquire and many young people have relied on social media platforms such as WhatsApp and Facebook to inform themselves. However, the accuracy of the content posted is often questioned.

The indirect impact of the virus has also had a number of severe repercussions for young people's education and employment. Online learning is often inaccessible to those without computers, smartphones or money to pay for an internet connection. Respondents complained that their sexuality education sessions were no longer taking place. Testimonies also indicated that school closures have led to an increase in teenage pregnancies, as well as gender-based violence.

COVID-19 has also had many economic consequences for individuals and households, which means that many young people have been short of food and basic necessities. Some have resorted to transactional sex to pay for items necessary for survival. The impact of the economic blow delivered by COVID-19 among our respondents was often highly gendered. In all settings, respondents reported increases in early marriage during the pandemic, particularly among girls who were no longer in school. Similarly, gender-based violence was said to have increased during the pandemic, as couples were confined together and experiencing financial difficulties, which exacerbated tensions and led to violent disputes. Socio-cultural factors that existed before COVID-19, which lead to a preference to 'resolve' such cases informally, have meant that also now women have little recourse to report incidents and only rarely seek legal prosecution of the perpetrator.

Although COVID-19 appears to have increased vulnerability across all groups of young people, those who were particularly at-risk before the pandemic often have to endure additional hardship during it.

In summary, in the six study countries, COVID-19 has both exposed inadequate SRHR services and has laid bare simmering inequalities and societal prejudices that are likely to be very harmful to young people's SRH, as well as their psychological well-being. Barriers to optimal SRHR that emerged during the research, such as poor access to menstrual health information, stockouts of family planning and ARVs, gender-based violence and forced marriage, and the persecution of LGBTQ communities by the police, should be addressed in a systemic way so that they do not continue to occur once the pandemic is over. COVID-19 has served to shine a light on the challenges that many young

people face in daily life. Rectifying injustice and inequity, which are clearly the root causes of many health problems, particularly among groups who were vulnerable even before the arrival of COVID-19, should be as much an integral part of the pandemic response as addressing SRH service quality and delivery.

10.1 Recommendations

The following comprises recommendations for addressing the impact of COVID-19 on young people's SRHR. Some address the direct impact of the pandemic on access to information and services. Others, importantly, seek to counter the inequalities and vulnerabilities that make specific groups (such as young people out of school, or those living with HIV) more at risk. For the most part, the recommendations were suggested by the young people themselves and, if implemented, would thus facilitate their ownership of the crisis and the solutions to it.

Health

- 1. Improve community-based SRHR information channels and support:** Community-based initiatives such as peer education would improve access to information by young people, also under COVID-19 restrictions. If face-to-face sessions are not possible, they could be done online or using WhatsApp. Information and support groups are particularly important for those living with HIV and appear to improve adherence to ARV regimens.
- 2. Ensure contraceptive availability:** During the pandemic, those needing contraceptives should be able to make a free and fair choice from among a range of methods. This has not always been possible in many settings when stockouts of certain methods have occurred. These stockouts need to be addressed by ensuring functioning supply chains and the availability of trained providers so that those needing to prevent a pregnancy can do so. Sayana Press (DMPA-SC), an injectable contraceptive which can be self-administered, may be suitable for community distribution, for example through pharmacies, community health workers or peer educators, and could help address unmet needs

and reduce unsafe abortions. Online or telephone ordering of condoms for home delivery has also appeared to work well in some settings during the pandemic and serves to provide double protection for those who wish to avoid pregnancy and/or STIs.

3. **Initiate and strengthen telemedicine in settings with adequate and affordable connections for providers and clients:** Telemedicine may be an efficient way for providers to diagnose relatively simple health problems and advise on treatment (for example, the syndromic management of STIs). Clients who fear coming into the health centre because of COVID-19 may prefer this method of consultation.
4. **Make health facilities COVID-19-secure:** Many young people are reticent to visit health facilities out of fear of catching COVID-19. Health services should make sure they are COVID-19-secure by ensuring providers have proper protection and that prevention measures such as social distancing, the wearing of masks and the disinfecting of surfaces are in place. Staff should reassure young people that although there is never zero-risk of infection whilst seeking care, the likelihood of infection is much reduced if such steps are taken. Delays in seeking treatment, for example for an incomplete abortion or an STI, may be more dangerous in some cases than the risk of infection with COVID-19.
5. **Address stockouts, distribution and adherence issues around ARVs:** Young people who are living with HIV and are unable to access their medication or whose providers have experienced stockouts need to be supported. It may be possible to initiate door-to-door service delivery of ARVs and other commodities (including condoms and lubricant) by peers in order to reach all those affected by the COVID-19 crisis. However, care must be taken to maximise discretion in order not to expose such individuals' HIV status, which could lead to significant stigmatisation by their families and communities.





6. **Hormone supplements for transgender young people:** Transgender people have faced difficulties in accessing hormone supplements during the COVID-19 crisis. Local organisations can work with government supply chains to ensure their availability.
7. **Ensure access to pre-exposure prophylaxis (PrEP):** Access to PrEP appears to have been compromised during the pandemic. Providers must ensure that PrEP is available either at their facility or via community distribution channels.
8. **Prioritise menstrual hygiene:** In all country settings, access to sanitary towels has been highly problematic for vulnerable girls and young women during the pandemic. It may be that local NGOs can coordinate the distribution of information and dignity kits, which include sanitary pads, particularly to those who no longer receive sanitary protection at school.
9. **Include comprehensive sexuality education in online learning:** To date, online classes have largely included only academic subjects. Young people expressed the need for comprehensive sexuality education sessions, as they wanted to express their SRHR concerns or ask questions in a safe space. However, it should be noted that necessary internet safety protocols must be put in place to ensure confidentiality and discretion.
10. **Prioritise young people's mental health:** Isolation, job loss and school closures appear to have taken a big toll on the mental health of many young people. Some have turned to drugs and others have experienced suicidal feelings. Health care providers and community mobilisers need to be aware that the pandemic and its prevention measures can have severe psycho-social as well as physical consequences. Mental health support through counselling (in person or on the telephone) needs to be available.



Economic well-being

1. **Ensure affordable internet access:** The research indicates that many young people are unable to access their online classes or more general SRHR information via the internet, as they cannot afford a connection. It may be possible to work with telecommunication companies to enhance access by providing affordable 'bundles' for students.
2. **Provide economic support for young people:** The COVID-19 pandemic has had a severe impact on young people's economic well-being and livelihoods. This has sometimes resulted in an increase in transactional sex to cover basic needs. Young people should either be given financial support from the state (for example, in the form of cash payments or food subsidies) or be helped to start up small-scale, COVID-19-secure businesses in order to generate income so that they can support themselves and their families.

Rights

1. **Combat stigma:** Many young people, particularly those living with HIV or who are LGBTQ, reported that the stigmatisation of their communities has been very problematic during the pandemic. As described above, it has caused some people who are HIV-positive to stop taking their life-saving ARVs for fear of family members discovering their status. Others have been forced to live with relatives who openly disapprove of their sexuality/gender identity, which has impacted their mental health. It is vital that sensitisation programmes and support systems are established for these vulnerable groups, during and beyond the pandemic, to ensure that they have recourse to vital assistance.
2. **Allow pregnant schoolgirls and those with young babies to continue their studies:** Anecdotal evidence suggests that the closure of schools has led to an increase in pregnancies among female pupils. In many settings, young women are not allowed to return to school after they have given birth, and thus they drop out and subsequently face very uncertain futures. It is recommended that schools support pregnant pupils and young mothers and enable them to continue their lessons



by, for example, providing on-site childcare, such as crèches, for those whose relatives are unable to look after their babies. It is vital that pregnant schoolgirls and young mothers continue their learning and have the same educational opportunities as their peers, rather than being disadvantaged and stigmatised.

3. **(Re)create youth-friendly facilities:** Youth-friendly centres and services provide a vital lifeline to many young people, especially those in potentially marginalised groups. They can provide support for young people living with HIV and can help them come to terms with their diagnoses, as well as facilitate their adherence to medication. They can also offer psycho-social support to LGBTQ youth facing stigma and violence. Such facilities could still open in a COVID-19-secure manner or move their support and counselling online for those who need it.
4. **Support survivors of gender-based violence:** In all settings, it was reported that the incidence of gender-based violence has increased since the start of the pandemic. As in pre-lockdown times, survivors are often reluctant to report violence to the police and have little faith that the authorities will act to bring the perpetrator to justice. It is vital that survivors of gender-based violence (both men and women) are supported with both legal advice and medical care through community initiatives, including telephone hotlines and counselling.
5. **Prevent early marriage:** Despite early marriage being against the law in many countries, it appears to have increased during the pandemic. This is often due to the financial hardship experienced by parents who prefer to marry off their daughters so that they have fewer mouths to feed. Both traditional and state authorities need to be mobilised to prevent early and non-consensual marriage and to provide parents and young women with the economic means to support themselves both during and beyond the COVID-19 crisis.



6. **Ensure disability-friendly spaces:** Many young people with disabilities have been hampered during the pandemic from physically accessing services because, for example, public transport or drop-in centres are not accessible. In addition, young people with hearing or vision loss have difficulty accessing online learning and have therefore fallen behind with their schooling. It is therefore a priority that both physical and virtual spaces are accessible to all.
7. **Stop police violence and harassment:** In a number of settings, key populations such as LGBTQ communities and sex workers have reported increased harassment from the police during the COVID-19 crisis. Raids and excessive provocation, which have been carried out under the guise of enforcing COVID-19 restrictions, rather serve to breach individuals' rights and civil liberties.



What are the effects of COVID-19 and its prevention measures on young people's sexual and reproductive health?

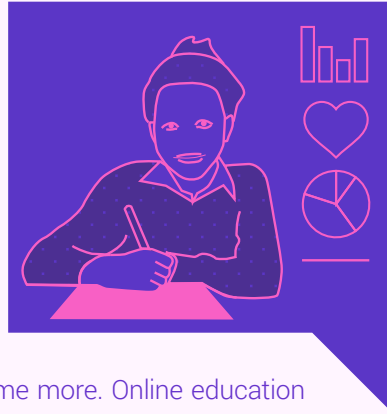
Evidence suggests that the global pandemic has disrupted all aspects of young people's lives. Infection prevention and management measures (such as lockdowns, self-isolation and restrictions on movement) appear to have had a significant impact on young people's access to sexual and reproductive health (SRH) information and services, and a negative impact on their mental health.

We undertook a mobile web survey with 2,693 respondents ages 18-30, as well as focus group discussions, across groups that are central to the partners' programmes: lesbian, gay, bisexual, transsexual and queer (LGBTQ) youth, youth living with HIV (YPLWHIV) and young people living with disabilities. Engaging young people as researchers has helped to address sensitive topics such as HIV, AIDS or abortion. Their empathetic and non-judgmental approach appears to have generated rich, culturally relevant information that can be used to address their concerns.



Impact of COVID-related school closures on young people's sexual and reproductive health and rights (SRHR):

The pandemic has severe repercussions for young people's education, employment, and consequently on their SRHR. Among young survey respondents in full-time education, 58% reported that their school had closed due to COVID-19. With schools closed, young people stayed at home more. Online education was often inaccessible to those without computers, smartphones or money to pay for an internet connection. Classes were limited to academic subjects, leaving out comprehensive sexuality education sessions. Consequently, respondents felt they were missing out on opportunities for dialogue with peers about SRH concerns in a 'safe space'. Testimonies also indicated that school closures led to an increase in teenage pregnancies and gender-based violence. School closures even had a significant impact on menstrual hygiene, as female pupils often received sanitary products for free in school or relied on sexuality education classes to learn how to manage their periods.



Impact on mental health. Many respondents reported feeling depressed, even suicidal due to isolation and feelings of loneliness. Between 35% (Ghana) and 67% (Kenya) of respondents reported feeling more depressed than before the COVID-19 crisis. In Kenya, Uganda and Zimbabwe, over 40% of respondents felt less in control of their lives in general than before the crisis.

The economic impact of the COVID-19 crisis on SRHR.

Two-thirds of respondents in Kenya and Uganda and approximately 40% in Ghana and Zimbabwe reported reduced incomes. Some resorted to transactional sex to pay for basic necessities for survival, leading to higher SRH risks. For example, young women received money for intercourse with older men, increasing their chance of HIV infection. In all countries, respondents considered girls to be at an increased risk of early marriage during the pandemic; in Kenya, Uganda and Zimbabwe, over 85% of young respondents perceived this to be the case. This often appeared to be a deliberate economic strategy by parents to have one less mouth to feed whilst facing financial hardship during the pandemic. School closures also served as a catalyst for early marriage.



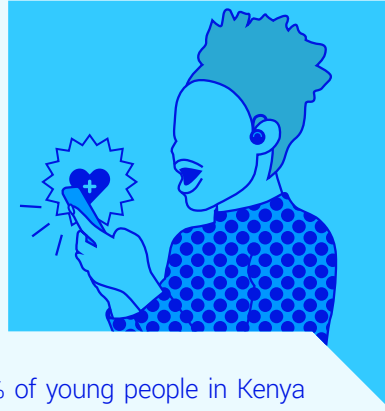
Impact of the pandemic on sexual activity, dating and bonding.

Over 65% of sexually active male and female respondents in Ghana, Kenya, Uganda and Zimbabwe reported having had sex during the COVID-19 crisis, while in Nepal, this was only 43% of young men and 29% of young women. Among single respondents, fear of contracting COVID-19 and not being able to see one's partner(s) were commonly cited reasons for sexual inactivity. However, some respondents reported more casual dating and more sexual encounters than before COVID-19. In nearly all settings, young people missed being able to hug friends and shake hands, which they felt are culturally required expressions of bonding.



Barrier to available, accurate SRHR information.

With youth-friendly health services reduced and drop-in centres or face-to-face support groups put on hold, SRHR information was hard to find. Many young people had to rely on social media such as WhatsApp and Facebook for information. However, the accuracy of the content was often unsure. Young people were asked what SRHR information they needed during the pandemic. Over 70% of young people in Kenya and Uganda wanted information on sex and COVID-19. Over 60% of young people in Kenya and Uganda wanted information on STIs, including HIV. Between 42% (Nepal) and 68% (Kenya) wanted information on sexual pleasure and 45% (Ghana) to 71% (Kenya) wanted information on gender-based violence. Among young women, 60% (Zimbabwe) to 79% (Kenya) needed/wanted information on menstrual hygiene. Despite young people needing/wanting information on a range of SRHR topics, only between 26% (post-abortion care, Zimbabwe) and 63% (menstrual hygiene, Nepal) of young people felt that they had received sufficient relevant information, highlighting gaps in delivering adequate information during the pandemic.



Necessary SRHR services for young people during the pandemic.

In the survey, over 30% of women in Ghana, Kenya, Uganda and Zimbabwe who needed family planning services during the crisis reported that the pandemic had restricted their access to family planning. Being afraid of catching COVID-19 and closure of the place where women accessed family planning were the most commonly cited reasons for being unable to access family planning.



Among survey respondents who stated that they had needed STI/HIV testing and/or treatment services during the pandemic, between 49% (Ghana) and 63% (Zimbabwe) reported that the COVID-19 crisis had prevented them from accessing such services. The main reason for over 25% of respondents was fear of contracting COVID-19.

A number of HIV-positive young people who had been taking antiretroviral medications (ARVs) reported stopping or changing their regimen because of a lack of access to their ARVs or an inability to travel the long distances needed to obtain them. Abortion services were reduced in many settings. Over half of young female survey respondents who reported a need for information on abortion had received either insufficient information or none at all. Some turned to traditional methods of termination likely to be extremely harmful to their health and fertility.

Increase in gender-based violence. Among young survey respondents, between 24% (Ghana) and 45% (Kenya) of young men and 15% (Ghana) and 42% (Kenya) of young women considered themselves more vulnerable to sexual harassment and/or emotional, physical or financial abuse during the COVID-19 crisis compared to before.

For couples confined together, financial difficulties and exacerbated tensions led to violent disputes. Among young respondents who reported experiencing harassment or abuse, partners were reported as the perpetrators by 9% of young women in Nepal and 42% of young women in Zimbabwe. The majority of young people confided in a friend, but over two-thirds did not file a formal complaint.

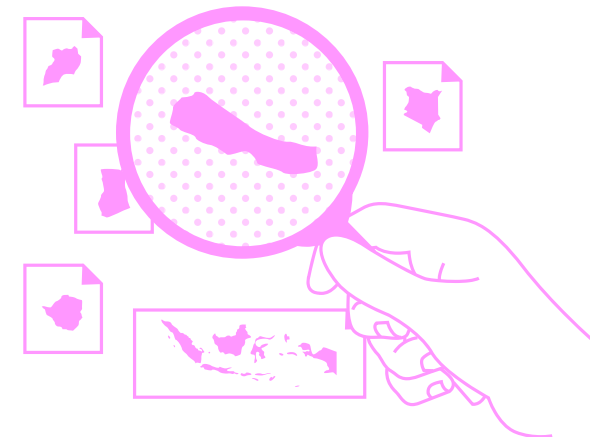


Qualitative findings confirm that young women (and men) have little recourse to report their experiences and only rarely seek legal action against the perpetrator. Over 60% of respondents suggested online counselling as a way of offering gender-based violence services during the pandemic.

Conclusion

COVID-19 has shone a light on the challenges that many young people face. Challenges to optimal SRHR —poor access to SRHR and menstrual health information, inadequate community distribution of family planning methods, and recourse to unsafe abortion— underscore the weaknesses that existed in health systems before the pandemic and have since been exacerbated by it. Structural social issues —gender-based violence, the persecution of the LGBTQ community by the police, and more— reflect broader societal factors that accelerate and increase marginalisation and risk.

Rectifying injustice and inequity, which were clearly at the root of many health issues particularly among vulnerable groups even before COVID-19, should be as much an integral part of the pandemic response as addressing SRH service quality and delivery. To optimise young people’s SRHR, strengthening health systems—particularly community-based distribution networks and services—and reducing social inequality and stigmas revealed by the pandemic, will leave countries and communities in a more robust position after the crisis has ended.



Recommendations

This report provides recommendations suggested by young people themselves, the implementation of which facilitates their ownership of the crisis and the solutions to it. Some address the direct impact of the pandemic on access to SRHR information and services, while others seek to counter the inequalities and vulnerabilities that leave specific groups at greater risk. At the end of the report, more recommendations can be found.

Ensure continuous access to contraceptives.

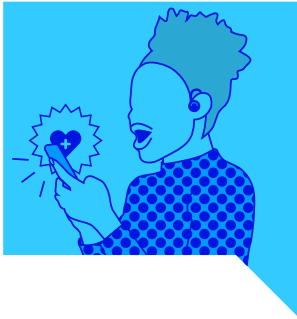
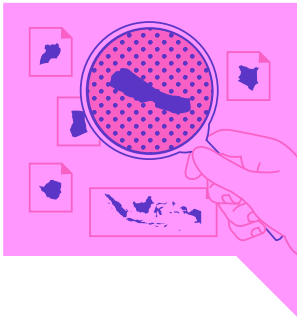
Provide students with affordable internet access.

Support the continuous education of pregnant and young mothers.

Prioritise young people's mental health through counselling (in person or on the telephone or online).

Support survivors of gender-based violence (both men and women) with both legal advice and medical care through community initiatives, including telephone hotlines and counselling.





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ANNEX 1: Focus group discussions carried out in each country

	Group	Number of participants			Location(s)	Face-to-face or remote
		M	F	N-B		
Ghana	SRHR peer educators	3	4	-	Talensi	Face-to-face
	SRHR peer educators	4	3	-	Gushegu	
	Young people living with disabilities (deaf)	4	3	-	Savelugu	
	Kayaye (female market porters)	7	-	-	Tamale	
	Young people living with HIV	3	4	-	Tamale	
Indonesia	LGBTQ young people	2	3	1	Jakarta	Remote (Zoom)
	Young people living with disabilities (deaf)	3	3	-	Bali	
	Young people living with HIV*	1	1	1	Jakarta	
	Rural youth*	2	2	-	Multiple	
	Sex workers	4	2	-	Multiple	
Kenya	SRHR champions**	3	7	-	Kisumu	Face-to-face
	SRHR champions	3	5	-	Nairobi	
	Young people living with disabilities	4	4	-	Kisumu	
	Young people living with HIV	2	5	-	Kisumu	
	Young mothers	0	10	-	Nairobi	
	Mixed group of young people***	4	4	-	Nairobi	
Nepal	Young people living with disabilities	2	6	-	Province 3	Remote (Zoom)
	Young people living with HIV	5	1	-	Provinces 1 and 3	
	LGBTQ youth	0	0	7	Province 3	
	Young men	8	0	-	Province 1	
	Young women	0	8	-	Province 1	
Uganda	Young people living with HIV	4	5	-	Iganga	Face-to-face
	Young mothers	0	10	-	Jinja	
	School pupils	6	4	-	Mayuge	
	LGBTQ young people	4	3	3	Mbale	

* Two additional participants who had confirmed their participation did not show up for the discussion.

** Including three women with hearing loss.

*** Including youth advocates, peer educators, teachers, artists and other professionals.

