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SEXUAL HEALTH

Sexual and reproductive health and rights in the era of COVID-19: a qualitative study of the experiences of vulnerable urban youth in Ethiopia

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ABSTRACT

Background. Youth who have migrated from rural to urban areas in Ethiopia are often precariously employed, lack access to sexual and reproductive health services, and are at heightened risk of sexual violence. However, little is known about the sexual and reproductive health consequences of the coronavirus disease 2019 (COVID-19) pandemic, and associated lockdowns and service disruptions for urban-dwelling socially disadvantaged youth. **Methods.** This paper draws on qualitative virtual research with 154 urban youths aged 15–24 years who were past and present beneficiaries of United Nations Population Fund-funded programs, and 19 key informants from the city bureaus and non-governmental organisations in June 2020. Semistructured interviews by phone explored the impact of COVID-19 on young people's sexual and reproductive health and rights. **Results.** The pandemic has affected the availability of sexual and reproductive health information and services, and exacerbated fears about attending clinics, particularly disadvantaging youth living with HIV and those involved in commercial sex work. Many young people have also lost their livelihoods, with some moving into transactional and survival sex. Sexual violence further undermines the rights and well-being of youth who are already marginalised, with street-connected youth, young people involved in commercial sex work and youth with disabilities particularly at risk. **Conclusion.** There is an urgent need to quickly resume front-line services, and social assistance measures must include young people, if Ethiopia is to continue meeting its own objectives around adolescent and youth sexual and reproductive health.

Keywords: commercial sex work, disability, domestic workers, Ethiopia, pandemic, SRHR, street-connected, vulnerability, youth.

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Introduction

When the coronavirus disease 2019 (COVID-19) pandemic was declared, the response within Ethiopia was quick. Driven by an awareness that the country's health system would struggle to cope with an extensive outbreak, the measures announced were designed to contain the spread of the virus while not having too great an impact on the economy. These included a 5-month state of emergency, travel restrictions and partial lockdowns in some cities, and total closure of schools and universities. Although initial analyses suggest that the government's approach has successfully avoided too great an economic shock, others have called for the government to take additional measures to protect the most vulnerable social groups.[1] Of particular concern is the impact on the young urban poor, who were struggling even before the pandemic; the youth urban unemployment rate was 22% in 2018, and one-quarter of all urban jobs are in the informal sector,[2] such as street vending, domestic service and day labouring. Characterised by poor pay and conditions, often in risky environments and without social security, these types of work are incompatible with the promotion of young people's well-being, rights and capabilities, even under normal circumstances.

Limited opportunities to engage in traditional agricultural livelihoods, rural poverty and aspirations for a better quality of life, as well as a desire to avoid child marriage and abuse within families, have driven many rural Ethiopian young people to migrate to urban areas in the past two decades.[3,4] However, Ethiopia has high rates of urban unemployment, and the main source of employment for young people is in the informal economy. Opportunities for realising aspirations are limited by discriminatory gender norms that limit work choices for young women; with young women's negative experiences of exploitation and low pay in domestic service being well-documented,[5–7] sex work can provide young women with alternative, risky but sometimes successful pathways to independence.[8] Some young Ethiopian men who have migrated to urban areas find informal work as labourers, but jobs are physically arduous, with low pay, long hours and often in dangerous conditions, and little support if they become injured or unwell.[9] Because COVID-19 can be asymptomatic,[10] there is also the concern that internal migrant workers who return to rural areas may take the virus with them and transmit to others, thus worsening the crisis.[11] Faced with such limited employment opportunities, many young migrants to urban centres engage in a variety of street-based activities to make money for subsistence.[12]

Prior to the pandemic, the Government of Ethiopia had identified key priority areas in its adolescent and youth strategy that included strengthening and scaling up social protection for the most vulnerable youth, expanding services (including for sexual and reproductive health), and tackling sexual and gender-based violence,[13] with the Ministry of Health providing sexual and reproductive health services and information specifically for youth through Regional Health Boards. However, in practice, even prior to the pandemic, research finds certain groups of young people were already struggling to realise their sexual and reproductive health rights. For example, young people with disabilities face significant sexuality-related stigma in Ethiopia because of the widely held perception that they are not capable of engaging in sexual relationships.[14] This creates barriers to their access to sexual health information and services, even during non-pandemic times.[15] Youth who have migrated to work in urban factories or as domestic labour are often female and poorly educated, and vulnerable to sexual and gender-based violence and a lack of access to services, such as HIV testing, family planning and counselling.[16] Young people who are involved in commercial sex work, living on the street, or both, are vulnerable to substance abuse, food insecurity and exposure to unprotected sex.[17] High levels of stigmatisation among young people living with HIV also act as a critical barrier to service uptake.[18]

Crises have historically contributed to rising levels of poor health, with young people at heightened risk of poorer sexual and reproductive health outcomes, including increased engagement in transactional and commercial sex by young women for survival.[19–22] At the global level, the United Nations Population Fund (UNFPA) has warned of the heightened risk of poor adolescent sexual and reproductive health outcomes during the pandemic, including higher rates of intimate partner violence, pregnancy and sexually transmissible infections (STIs)/HIV.[23] Ensuring that vulnerable urban youth are able to access adequate support *in situ* is essential, but lower- and middle-income countries, such as Ethiopia, have far fewer resources available to cope with external shocks to their economies and health systems. Understanding the sexual and reproductive health consequences of the COVID-19 pandemic and associated lockdowns and service disruptions for urban-dwelling marginalised youth can allow insights into priority actions by service providers, and support the government of Ethiopia in meeting its own objectives around youth sexual and reproductive health.

Methods

The findings in this article are based on a rapid qualitative research approach[24] using interview tools by phone in June 2020; this approach aims to quickly gather evidence during ongoing crises with the objective of informing the public health response. Socially disadvantaged youth were interviewed in the major urban centres of Ethiopia's three largest regional states: Adama (Oromia region), Bahir Dar (Amhara region) and Hawassa (Southern Nations, Nationalities and Peoples region), and the federal capital of Addis Ababa.

The sample was drawn from a list of past and present beneficiaries of UNFPA-funded programs implemented by non-governmental organisations (NGOs) in the four locations, as well as through snowballing to ensure balanced coverage of each category of youth by age, sex, disability, HIV and marital status. UNFPA gave written permission to use this list to contact participants. Table 1 gives a breakdown of these demographics. These categories are not mutually exclusive, but reflect the sampling process through NGOs whose programming targeted specific groups of youth. The estimated HIV prevalence rate is 2.9%, affecting >610 000, with young women three times as likely to be living with HIV as their male counterparts (4% vs 1.7%).[25]

We sampled two age cohorts: adolescents aged 15–19 years, and young people aged 20–24 years. In total, 154 youths were sampled: 100 females and 54 males, with 79 in the adolescent cohort and 75 in the older cohort. Of the total sample, 47 were living in Addis Ababa, 22 were in Adama, 51 were in Hawassa and 34 were in Bahir Dar.

A qualitative research tool that consisted of semistructured interview questions was used to explore young people's experiences since the start of the pandemic, including their knowledge about COVID-19, their experiences of the public

Table 1. Research sample by sex, marital status, age and vulnerability.

	Total sample for all sites					
	Street-connected youth	Youth in commercial sex work	HIV-positive youth	Domestic workers	Youth with disabilities[A]	Factory workers
Sex						
Female	15	20	17	16	16	16
Male	12	0	16	0	15	11
Marital status						
Never married	22	18	29	14	29	26
Married	3	0	4	1	2	1
Divorced	2	2	0	1	0	0
Age						
15–19	18	10	21	8	11	8
20–24	9	10	12	8	20	19
Total	27	20	33	16	31	27

[A]Youth with disabilities included those with visual, hearing and physical impairments, but due to ethical concerns did not include youth with cognitive impairments.

health response including limitations on mobility and service disruptions, as well as the impact on their sexual and reproductive health and right to bodily integrity (including freedom from age- and gender-based forms of violence and abuse) more specifically.

The interviews lasted between 30 and 60 min, and were conducted either in Amharic or Afaan Oromo depending on the city and background of the respondent, by highly experienced social researchers (working at Quest Consulting, an independent research organisation, and also at Addis Ababa University, who spoke the respective languages and who have worked extensively with youth). The interview guide was developed drawing on the Gender and Adolescence: Global Evidence (GAGE) conceptual framework on adolescent capabilities, which takes a holistic socioecological approach to exploring what works in empowering adolescents, and in consultation with the GAGE Ethiopia research team, UNFPA and the Ministry of Women, Children and Youth, so as to nuance the questions depending on the specific urban context in question. We have not included the interview guide in an annex, given limited space, but it is available upon request from the GAGE program office.

In addition, we conducted virtual interviews with 19 key informants from the city bureaus of Health, Labour and Social Affairs, Women, Children and Youth Affairs, as well as representatives of NGOs working with vulnerable urban youth in each city to better understand the context dynamics that are shaping young people's sexual and reproductive health experiences during the pandemic, and the balance of governmental and NGO service provision for sexual and reproductive health services pre- and post-pandemic onset.

During the data collection process, the research team participated in thematic debriefing sessions via Zoom calls to tease out preliminary findings, and to compare and contrast insights across the four urban sites. The findings were then translated and transcribed, and coded thematically using the qualitative software package, MAXQDA.

Ethical review and permission for this research was granted by the Overseas Development Institute Research Ethics Committee, London, UK. In Ethiopia, the research tools and ethics considerations were shared with the Ministry of Women, Children and Youth, who gave feedback on how to respond to any sensitive issues that might arise during fieldwork and on referral pathways. The research team underwent training with GAGE on engaging with vulnerable youth appropriately and responsively on sensitive issues in a virtual setting.

Before each interview commenced, participants were briefed as to the confidentiality of their identity in presentations and publications that might follow the research, and that their participation was voluntary and could be revoked by them at any time. Verbal informed consent was obtained from respondents aged >18 years, and assent was obtained from those aged <18 years, with consent given by caregivers. Researchers followed protocols that should protection issues arise during interviews, they would report these to the team lead, who would in turn follow up with UNFPA and NGO implementing partners to provide referrals to appropriate services.

Results

Street-connected youth

Among street-connected youth, especially young men, our data showed limited uptake of government and

non-governmental sexual and reproductive health services, including testing for HIV and STIs. The exceptions were several young women living on the streets with either current or past boyfriends, or individuals who had learned from 'the mistakes' of their friends who had become pregnant or HIV-positive. These youth noted that they were tested regularly for HIV and used injectable contraceptives – practises that were continuing during the pandemic. Street-connected[A] young people who moved to urban areas recently, however, had little awareness about their rights to contraceptive and other health services.

Both male and female street-connected youth emphasised that during the initial lockdowns, they were particularly at risk of physical and sexual violence, and threats by police. An 18-year-old adolescent girl involved in commercial sex work in Hawassa explained:

> The policemen threaten us with their gun to sleep with them. When we are walking in [a group of] five, they choose one or two girls and they take us with them. After raping us, they give us money. They don't use a condom.

Youth engaged in commercial sex work

Many young women involved in commercial sex work spoke of strong links to certain sexual and reproductive health programmes and counsellors or 'condom mothers', from whom they could get regular HIV and STI tests, condoms and, more recently, face masks. However, other young people noted that they were having to purchase condoms themselves, as NGO centres were temporarily closed in some urban centres. As an 18-year-old young woman involved in commercial sex work living in Bahir Dar noted:

> I used to get condoms from 'Wise Up' (nationwide HIV prevention programme aimed at expanding HIV prevention amongst sex workers and their clients) for free, but now I have to purchase them from the kiosk (small shop).

Whereas a common theme among young women involved in commercial sex work was the challenges they encounter in negotiating condom use, several noted that they were more successful negotiating the use of face masks with clients. As an 18-year-old young woman in Bahir Dar explained: 'I give my clients a "use and throw" mask if they are not already wearing one.'

Domestic workers

The experiences of domestic workers varied considerably, with live-in respondents highlighting that they rely primarily on their employers to take them to a clinic or pharmacy for medication and, in some cases, even for menstrual hygiene products. This limited privacy prevents them seeking out sexual and reproductive information and services. Indeed, although a key informant from the Bureau of Labour and Social Affairs in Adama noted that prior to the outbreak of COVID-19 they had organised training for domestic workers on sexual and reproductive health issues at night schools (together with the Bureau of Women, Children and Youth Affairs, and funded by UNICEF), most respondents noted that they had little access to sexual and reproductive health education, and had not been tested for HIV or STIs. Only one respondent from this sample spoke about the risk of sexual violence, noting that she had recently had to change houses, because her previous male employer had repeatedly come into her room when his wife was working late: 'I started to feel increasingly uncomfortable and unsafe around my employer's husband, especially when he made excuses to visit my room in the evenings when she was out'. Accordingly, she was thankful that at her current house of employment, she has a separate room in a separate building and feels safe.

Factory workers

Youth factory workers highlighted that sexual and reproductive health services in the industrial parks were limited, both prior to and during the pandemic. They noted that there are first aid corners and, in some larger factories, clinics staffed by nurses, with some young women explaining that they were able to obtain information on sexual and reproductive health issues, such as contraception or HIV prevention, and acquire sanitary pads. However, respondents underscored that there were no family planning services on the factory site.

Male respondents complained about limited awareness-raising and outreach efforts on sexual and reproductive health issues, and the fact that there was no HIV or STI testing available, despite many factory workers being migrants and living on-site. Clinics in the industrial parks usually do not provide condoms, and factory officials do not permit those who permanently live in the compounds to leave and buy them. Several male respondents noted that some NGO providers had visited the industrial park to provide information and raise awareness, but only a few respondents had been able to attend, as the sessions were limited. They also noted that even when condoms are available, workers seldom access them due to stigma about sexual behaviour out of wedlock and its association with sin.[26,27]

This lack of access to services had been exacerbated during the pandemic, as workers living on-site were banned from leaving during lockdown. Moreover, several respondents noted that youth having unprotected sex was common

[A]'Street-connected' refers to any person who spends some or all of their time working or living on the streets.

among those living in dormitories in the industrial parks. As a 19-year-old male factory worker from Addis Ababa explained:

> It is very worrying, while travelling [around the park] in the evening, you can see boys and girls having sex openly . . . They don't use condoms or contraceptives, as many of them don't have the awareness.

By contrast, live-out factory workers reported having access to condoms and contraceptives from local community clinics, although some noted that they have temporarily stopped seeing their partners until the COVID-19 situation is resolved for fear of contracting the virus and transmitting it to their families.

Youth living with HIV

Respondents living with HIV in our sample expressed mixed views about the impact of the pandemic on their access to sexual and reproductive health services and supplies. Some explained that in the initial stages, antiretroviral (ARV) users had struggled to access medication due to health centres focusing on the COVID-19 emergency, but that over time this had been resolved through concerted outreach by health workers. A 23-year-old male youth living with HIV in Bahir Dar noted:

> At the beginning, many ARV users missed out on receiving their medication. However, the health workers made great efforts in linking with them through telephone communication either with the users or their families . . . Besides, ARV users are now receiving their medication for six months at once to avoid defaulting. So now, all are receiving their medication . . .

However, other young people and key informants had a less positive perception of the accessibility of health services during the pandemic, including because of the need to secure an appointment or referral, given that the focus of the health sector had been diverted to responding to COVID-19. They emphasised that health service providers were less available due to staff absences, and general fears about contracting the virus from public places. A 20-year-old male youth living with HIV in Addis Ababa explained that fears about visiting health facilities and risking coming into contact with someone with COVID-19 constituted a key barrier:

> The community fears to go to health facilities due to fear of contracting the virus in the hospital, in particular ART [antiretroviral therapy] users are very afraid and many defaulted from the service.

Similarly, a 21-year-old female youth living with HIV in Hawassa explained:

> I have heard the hospital does not let anyone in. I have to look for contacts in the hospital to get the ARV medicine. If I do not get that, I am not going there. I do not want to expose myself to corona[virus].

Other youth noted that in some health facilities and NGO-run clinics, free services and training for HIV-positive people had been discontinued during the pandemic. As a 24-year-old female youth living with HIV in Hawassa reflected:

> They used to give us free medical service, but now it has stopped. That worries me. Now I have to pay in private clinics . . . Because I work on the street under the sun, I fear getting checked. What if my temperature is high because of the sun and gets mistaken as corona[virus]?

Similarly, an expert from HAPCO [HIV/AIDS Prevention and Control Office] in Addis Ababa noted:

> Before the outbreak of COVID, our office was working closely with different clubs (especially anti-HIV, and sexual and reproductive health clubs as well as girls' clubs) in secondary schools and TVET [technical and vocational education and training] colleges in Addis Ababa in preventing and controlling the transmission of HIV among the youth. But these activities are not functional because of the closure of educational institutions following the outbreak of COVID.

Key informants also underscored that although some young people living with HIV had been included in the support provided through rehabilitation centres for vulnerable children and youth – the government's main social assistance as part of the urban public health response to the pandemic – HIV status was only one among several criteria. As such, these services had predominantly focused on HIV-positive youth who were also destitute and street-connected.

Youth with disabilities

On account of the deep-rooted stigma surrounding issues related to persons with disabilities and sexuality, youth respondents with disabilities were reluctant to discuss sexual and reproductive health issues during the virtual interviews. Many of the respondents with disabilities, however, emphasised that they often faced accessibility barriers to health facilities, and that these constraints had intensified during COVID-19 due to the large queues outside hospitals as a result of mandatory temperature checks. Some noted that they were not in a relationship – partly due to the stigma surrounding persons with disability and issues of sexuality, although for some, due to COVID-19 restrictions, their mobility had been limited and, thus, their relationships had also stopped. Service access was therefore not a major concern.

In other cases, limited service uptake stemmed from heightened economic vulnerabilities during the pandemic. A 19-year-old young woman with a physical disability from Bahir Dar, with a 4-year-old child, explained how she had had an unplanned pregnancy during the pandemic, but had recognised it too late due to her worries about household finances.

> Because of the disease, I was all focused on getting money and did not observe the changes in my body. It was too late when I learned I was pregnant … Everyone exploits my weak side. He [her boyfriend] came back begging for forgiveness. I believed him and took him back. I did not want to get pregnant, but it happened.

Although youth respondents did not raise personal experiences of sexual violence, key informants noted that they anticipated heightened vulnerability among young women to sexual assault following the pandemic, especially given reports of a growing trend towards sexual abuse of young women with disabilities on account of their perceived 'purity'. An expert from the Association of Persons with Disabilities in Addis Ababa pointed out:

> Previously, men didn't want to have sex with them [girls with disabilities] because of the wrong assumption that they are not good for sex. But recently, men prefer to have sex with them, because they assume that they are not infected with HIV, since they were not liked by men due to their disability. So these girls, especially migrant girls in rented rooms … are highly exposed to rape and some of them are getting infected with HIV because of rape.

Similarly, an expert from the Bureau of Women and Children's Affairs in Addis Ababa noted that officials are now disaggregating sexual assault statistics by disability to monitor increasing levels of vulnerability.

Discussion

Our findings show that the COVID-19 pandemic exacerbated the challenges facing already disadvantaged groups of young people in realising their sexual and reproductive health rights. This is largely due to existing gaps and failures in the protection and well-being of urban youth, which means that the impact of lockdowns and other restrictive measures were quickly and keenly felt. This is evidenced in various ways, including reduced availability of face-to-face sexual and reproductive health services, and the fear young people express about going into clinics, and their increased engagement in higher-risk sexual behaviour. Young people have not only been overlooked within policy responses, but their existing vulnerabilities – especially that of young women – means that they have also been subjected to and targeted for sexualised violence.

The findings underscore that efforts to scale up sexual and reproductive health services should be accompanied by expanded social assistance support for migrant youth and youth-headed households to mitigate the underlying economic risks compelling the most vulnerable young people to resort to negative coping strategies. In other contexts where health crises have led to stringent measures designed to contain viral transmission, and where health services are underfunded, such as during the Ebola crisis in West Africa, negative socioeconomic consequences were immediate and augmented disadvantage for groups already at risk.[28,29] This is particularly the case for migrant urban youth, who have limited social resources to lean on and whose vulnerability during the pandemic has clearly been exacerbated. Our findings echo research elsewhere on how young people cope with crises; for example, in Zambia, younger women aged 15–19 years have been found to be more likely to engage in transactional sex than older women during difficult times, partly because they are less likely to be married and to have a spouse with whom they can share the burden of financial shocks.[30] A lack of places for urban migrant youth in Ethiopia to turn for support has been found to result in heightened vulnerability to sexual exploitation and other abuses.[31]

Youth living with HIV need support to access vital ARV medications and regular check-ups safely, but they also need to be able to continue to connect with counselling services and peer support networks. These are essential to their well-being, given that they may experience stigma and isolation as a result of their HIV status. Prior research has found that HIV-positive young people in Ethiopia are known to particularly struggle with mental health when they lack social support.[4] These services can be resumed during the pandemic and implemented either in a safe socially distanced way in person (for example, outdoors) or online, through virtual platforms that young people can access cheaply. For those who are facing severe economic constraints, programme implementers can enable access to counsellors and peer support by funding basic phones, and phone and internet cards.

The 2030 Sustainable Development Goals draw attention to the need to 'leave no one behind', including targets 3.7 ('Universal access to sexual and reproductive care, family planning and education') and 5.6 ('Ensure universal access to sexual and reproductive health and reproductive rights…'), which underline the need to attend to the barriers to good sexual and reproductive health outcomes that face those who are both at the most risk and the most marginalised. The government of Ethiopia has previously shown commitment to the sexual and reproductive health rights of young people. Yet, as evidenced here, drawing on findings from the early phases of the pandemic, there is a risk that areas of progress on sexual and reproductive

health and rights will stall, with young people's sexual health and rights being deprioritised in relation to the challenge of stopping the spread of the virus. As such, it will be critical going forward to also undertake further data collection to explore the evolution of the effects of the pandemic on young people's sexual and reproductive health rights, and the extent to which these are sustained or shift over time as the pandemic becomes more protracted.

Harnessing prior momentum will be key to integrating youth sexual health and rights into a COVID-19 response strategy that encompasses all young people, including those who are most vulnerable. Since the time of data collection, the Government of Ethiopia has launched the Minimum Service Package for Adolescents and Youth Health (2022), which recognises a minimum set of services that all adolescents and youth should enjoy, including in crisis contexts, and future research efforts will be important to assess the extent to which the package is contributing to addressing the sexual and reproductive health deprivations facing urban migrant youth in Ethiopia, and that were exacerbated during the pandemic.

Limitations

Because of the virtual format of the interviews, which means that conversations were generally shorter and that there was a risk that privacy may be compromised, our questions on sensitive issues focused on the contexts in which young people felt they had access to appropriate information and felt safe or unsafe. However, risk mitigation measures notwithstanding, findings may represent an underreporting of concerns related to sexual and reproductive health issues, and experiences of violence because of the challenges involved in developing rapport and probing in-depth in a virtual rather than in-person setting. Moreover, because this study reports findings from one moment in time during the early stages of the pandemic, it is important to be aware that while capturing the experiences of diverse socially disadvantaged urban youth, findings are not able to address the cumulative effects of the protracted nature of the pandemic and shifting public health responses on young people's sexual and reproductive health rights.

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Data availability. Readers can contact the GAGE program office at gage@odi.org.uk to apply for data on request.

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