Developing data-based advocacy strategies for the inclusion of adolescents and young people of all sexual orientations and gender identities in Uganda, Senegal, Kenya and Zimbabwe

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Investigators: Human Sciences Research Council

Dr Jacqueline Mthembu (Principal Investigator)

Ms Nomthandazo Mbandazayo (Project Manager)

Ms Tsidiso Tolla (Co-investigator)

Ms Nombuso Khanyile (Co-investigator)

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ABBREVIATIONS

Adolescents and young people	AYP
Adolescent Sexual and Reproductive Health	ASRH
Adolescent girls and young women	AGYW
Civil society organisations	CSOs
Comprehensive sexuality education	CSE
Corona virus disease	COVID-19
Eastern and Southern Africa	ESA
Female genital mutilation	FGM
Family life education	FLE
Gender-based violence	GBV
International Conference on Population and Development	ICPD
Intimate Partner Violence	IPV
International Planned Parenthood Federation	IPPF
International Planned Parenthood Federation Africa Region	IPPFAR
Lesbian, gay, bisexual, transgender or intersex	LGBTI
Men who have sex with men	MSM
Right Here Right Now	RHRN
Sexual and reproductive health	SRH
Sexual and reproductive health and rights	SRHR
Sexual orientations and gender identities	SOGI
Sexually transmitted infections	STIs
Sustainable Development Goals	SDG
South African Broadcasting Corporation	SABC
United Nations Educational, Scientific and Cultural Organization	UNESCO
United Nations Population Fund	UNFPA
United Nations Programme on HIV and AIDS	UNAIDS
Voice of America	VOA

1. EXECUTIVE SUMMARY

The International Planned Parenthood Federation (IPPF), and the International Planned Parenthood Federation Africa Region (IPPFAR), partnering with the Right Here, Right Now (RHRN) platform and other civil society organisations (CSOs), advocate for the implementation of good quality, sustainable, youth-friendly and accessible sexual reproductive health and rights (SRHR) services and programming for adolescents and young people (AYP).

This report aims to generate evidence needed for advocacy and building a case for the protection of SRHR for AYP of all sexual orientations and gender identities (SOGI) and reflects on the contributions the RHRN platform made in relation to SRHR-related programme implementation and advocacy efforts. The report highlights the SRHR-related human rights violations against adolescents and young people, of all SOGI during COVID-19, and the impact made by the RHRN project in Uganda, Kenya, Senegal and Zimbabwe, to deter injustices. The report finally recommends key advocacy strategies that the RHRN platform members, or SRHR advocates, could use to improve their context specific SRHR programming for AYP of all SOGI, going forward. What follows in this section is a summary of key questions and discussions that this report attempts to contend with.

The SRHR of young people across the African continent remain profoundly contested. While the health and wellbeing of young people is recognised as a key pillar in national and continental development, the actualisation of this broader vision remains piecemeal for a number of reasons. Although countries across the continent, including those involved in this review, are signatories to a broad range of national, regional, continental and global frameworks on the health of AYP, the full domestication and implementation of these agreements remains severely hampered. The reasons for uneven domestication are multiple, as outlined in this report, and include social and cultural norms around youth, attitudes towards sexual and gender diversity, gender inequality, funding constraints, the ongoing negative impact of the HIV pandemic, the role of religious belief and the effects of the COVID-19 pandemic in terms of a redistribution of already limited resources.

The contestations around adolescent and youth SRHR are nowhere more apparent than in relation to comprehensive sexuality education (CSE) and sexual and gender minorities,

including Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people, especially LGBTI young people. The review of the Eastern and Southern Africa (ESA) Commitment on the implementation of CSE points to both successes and challenges in relation to implementation. In terms of **successes**, the CSE curriculum framework that is currently in place offers a quality and robust foundation from which to build and 17 of the 21 ESA countries have CSE programmes for both in- and out-of-school youth. Of the teachers trained in the delivery of CSE, high proportions (76% of primary and 56% secondary school teachers) taught CSE in the past year. The majority (n=16) of signatory countries furthermore have a learner pregnancy and re-admission policy framework and protective policies against child marriages. Less tolerance of school-based and intimate partner violence (IPV) was reported and a 30% decrease in HIV incidence among AYP aged 10 – 24 years also occurred within the six years post ESA 2013. (Machawira, Castle & Herat, 2020).

The current review, however, found some **shortfalls** in terms of CSE implementation. Notably, cultural norms and values continue to be leveraged against progressive approaches to LGBTI inclusion, which undermines the strides made to increase the accessibility of SRHR support and services for all AYP. Pervasive patriarchal norms continue to undermine gender equality.

This report highlights the dearth in African literature on the SRHR of AYP, including LGBTI+ experience, across the continent. It shows that knowledge production on the state of the continent regarding the SRHR of AYP of all SOGI is necessary for evidence-based policy making and implementation. It is also clear that the multisectoral approach encouraged by the ESA Commitment is imperative and allows all stakeholders (governments, CSOs and researchers) to be custodians of SRHR knowledge production, programme development and programme implementation. Furthermore, the importance of how best to frame the work on youth SRH is key. The local contexts call for a panAfrican framing that is vigorous enough to contend with pervasive norms and cultural values that lead to significant tensions when discussing human rights. In particular, the rights of LGBTI people, young people and rights related to gender and sexuality more broadly, need strategic framing. Much work still needs to be done in terms of synergizing efforts in education and health ministries to ensure linkages between young people, SRH support and service providers. Finally, any analysis of policy and programming in the pan African space must be cognisant of the funding landscape. Continued lack of domestic funding support for the implementation of a SRHR youth framework is evident. It is therefore

imperative that civil society, particularly youth-led civil society, amplifies its voice and advocacy efforts to ensure that the goal set beyond ESA 2013 -2020 are achievable.

2. Introduction

The African Youth Charter defines AYP as “every person between the ages of 15 and 35 years”. AYP aged 10-24 years is estimated to comprise 23.6% of the current 7.9 billion global population. The proportion of this age cohort hovers around 33% for each of the four countries reviewed in this report (Uganda, Senegal, Kenya and Zimbabwe); each with unique sexual and reproductive health needs.

The sexual agency and autonomy of young women and sexual and gender minority youth are highly constrained in the ESA region, leading to numerous cases of human rights violations (Ferguson & Desai, 2018). Several regional and international frameworks, such as the Maputo Plan of Action (MPoA), the Southern African Development Community (SADC) Reproductive Health Strategy, the Adolescent Sexual and Reproductive Health (ASRH) guidelines, and the International Conference on Population and Development (ICPD) advocate for the realisation of comprehensive SRH rights, services and support of AYP, while the Regional Strategy for HIV and Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations specifically caters for the needs of sexual minority groups. These strategies commonly emphasise the importance of ensuring the improvement of SRHR of young people across the continent.

In December 2013, ministers of health, education and youth from 21 member states in the ESA region met in Cape Town, South Africa to endorse and become signatories to the ESA Commitment. The 21 member states that participated were Angola, Botswana, Burundi, DRC, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Member countries committed to strengthen their local SRHR, services and support efforts with a focus on improving health outcomes for AYP. Using a multi-sectoral approach to providing quality CSE and youth-friendly SRH services in the ESA region, countries committed to partner with young people, parents, civil society, local and regional communities and faith leaders to achieve the goals set out in the 2013 ESA Commitment (Report on Eastern and Southern Africa (ESA) Ministerial Commitment Meeting, 2013).

The ESA Commitment stipulated specific short-term (2013 – 2015) and longer-term (2013 – 2020) goals[1]. The 2015 ESA Commitment targets were adopted to ensure that a good quality CSE curriculum framework was in place and implemented in each of the member countries; that pre- and in-service SRH and CSE training for teachers, health and social workers was established and being implemented in all member countries and lastly, to halve the number of AYP who do not have access to SRH services, which includes HIV-positive AYP. Figure 1 summarises the ESA Commitment targets, expected to have been reached by 2020.

Figure 1: ESA Commitment targets by 2020

As the implementation term came to a close last year, the RHRN programme reflected on the contributions made to achieve the ESA Commitment goals, as well as how best to contribute to the ensuing regional commitment.

3. Purpose

The purpose of this research initiative is to generate evidence needed for advocacy and building a case for the protection of the SRHR of AYP, of all SOGI in ESA with a specific focus on Uganda, Senegal, Kenya and Zimbabwe. Furthermore, the study highlights the human rights violations against LGBTI AYP during COVID-19, and how these restrictions exacerbated

[1] The 2015 and 2020 goals are set out in the Key SRH policy framework section on page 10

their existing vulnerabilities with regards to accessing comprehensive SRHR in the four study countries. The report recommends key advocacy strategies that RHRN platform members can use to improve their context specific SRHR programming for AYP, of all SOGI.

4. Key Research Questions

The key research questions driving this report are as follows:

1. What are the key policy frameworks that inform quality SRHR for AYP, of all SOGI?
2. What was the impact of COVID-19 restrictions on SRHR violations experienced by AYP, of all SOGI?
3. What are the possible advocacy strategies that RHRN platform members, and SRHR advocates, can use to improve their context specific SRHR programming for AYP of all SOGI?

5. Methods

This review comprises a critical policy analysis and secondary analysis.

5.1 Critical policy analysis

An analysis of gaps and opportunities across the participating countries included in the study, and an in-depth understanding of the challenges that CSOs currently face at implementation level, directly inform the prioritisation of key advocacy areas for future RHRN programmatic strategies, tailored for each of the four countries. Methodologically, the study focuses on policy and presents a critical policy analysis (Anfara & Mertz, 2015) of the relevant policies across the four countries, highlighting strengths, weaknesses, gaps and silences, and opportunities for leveraging and implementing existing policies including a focus on policy formulation, policy administration and planning, and policy implementation. The analysis of existing policies includes both a mapping of current laws and agreements, as well as a snapshot on how policy domestication of policies and relevant global commitments is applied.

5.2 Secondary analysis

Using the RHRN African regional forum virtual meeting data (26 – 29 October 2020), and key systematic and programmatic documents and reports, the research team compiled an

operational report on what has happened over the last four and a half years of RHRN programme implementation in Uganda, Kenya, Senegal and Zimbabwe and presents the current SRHR challenges experienced in these countries. Consequently, the experiences of implementers in the current social and political contexts associated with youth SRHR vulnerability, is summarized. Key recommendations for future research provide data to aid the development and production of key advocacy messages, that advocate for the right of AYP of all SOGI, to access quality comprehensive SRH services and support that are void of stigma and discrimination.

6. Results

There has been increasing recognition of the importance of young people's SRHR in the global South generally, and in Africa specifically. The full realisation of young people's SRHR has been identified as a regional priority through a number of frameworks and agreements, including the Maputo Plan of Action, the Africa Health Strategy, the African Charter on the Rights and Welfare of the Child, the African Youth Charter, the SADC's SRHR Framework and the ESA Commitment. These agreements stress the provision of comprehensive, integrated SRH services for young people as a key objective.

While these agreements are intended to ensure that all young people have full access to SRHR services and support, the practice falls short in many contexts leading to a situation in which young people across ESA struggle to access and claim their SRHR (Starrs et al., 2018). Hence, many young people in ESA still face severe SRHR constraints. Research in the region point to persisting levels of high HIV and other STIs; increasing rates of early and unintended pregnancies; access barriers to SRH information and services; and pervasive gender-based violence, including homophobic and transphobic violence, amongst other challenges (Lynch, 2020; Solomons, 2020; Starrs et al., 2018; UNESCO, 2016). Some regional drivers of poor SRHR outcomes for young people include extreme poverty and inequality; overburdened and under-resourced health and education systems; and deeply engrained harmful gender and socio-cultural norms. Significantly, another key driver is a lack of enabling law and policy, with the needs of young people still largely overlooked in national SRHR legislative frameworks in the region (Starrs et al., 2018).

6.1 Summary of key SRH Legal and Policy framework

<table>
<tr><th colspan="2">KEY POLICY FRAMEWORK</th></tr>
<tr><td>THE KEY TARGETS OF THE ESA COMMITMENT</td><td>The UN agencies and partners including youth and religious organisations led the establishment of the initiative known as ESA Commitment. This initiative seeks to accelerate access to CSE and health services for young people. The initiative is a strategic tool that brings together, for the first time, Ministries of Education and Health towards measurable and time bound targets, to strengthen HIV prevention efforts and foster positive health outcomes through advocating for access to quality comprehensive education as well as SRH services for young people in the ESA region. As such, the Ministers committed to improving SRH outcomes and strengthening HIV prevention through access to CSE as well as integrated SRH services for young people in the region. Specifically, ministers pledged to reduce, by 2020, new HIV infections among young people by 90%, unplanned pregnancies among young women by 75%, and to eliminate child marriage and gender-based violence.

Key elements are:

By end 2015:
1. A good quality CSE curriculum framework in place and implemented in all 20 countries;
2. Pre- and in-service CSE and SRH training for teachers, health and social workers in place and implemented in all 20 countries;
3. A 50% decrease in the number of AYP who do not have access to youth friendly SRH services, including HIV, that are equitable, accessible, acceptable, appropriate and effective.
By the end of 2020:
1. Consolidate recent gains in the reduction of HIV prevalence in ESA, and push towards eliminating all new HIV infections amongst AYP aged 10-24;
2. Increase to 95% the number of AYP, who demonstrate comprehensive HIV prevention knowledge levels;
3. Reduce early and unintended pregnancies among young people by 75%;
4. Eliminate gender-based violence (GBV);
5. Eliminate child marriages;
6. Increase the number of schools and teacher training institutions that provide CSE to 75%.</td></tr>
<tr><td>THE KEY ELEMENTS OF THE MAPUTO PLAN OF ACTION</td><td>The MPoA 2007 - 2015 expired in 2015 at a time when the African Union's plan for Africa's structural transformation in the next fifty years "Agenda 2063: The Africa We Want" and its 10 year implementation plan were in place to influence and accelerate further Africa's transformation and development beyond 2015. After an extensive review, the Maputo Platform of Action (MPoA) 2016–2030 was put in place. The Maputo Platform of Action (MPoA) 2016–2030 is a robust policy commitment by African leaders that aims to guarantee women's universal access to SRH and rights. The MPoA 2016–2030 as a plan of action addresses women's outcomes throughout the entire life cycle to address the poor SRH outcomes on the continent. Importantly, the MPoA 2016–2030 also aligns itself with the United Nations 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) and the AU Agenda 2063, both of which have situated women's health as a priority within the development agenda.

Key elements are:
1. Integrating STI/HIV/AIDS, and SRHR programmes and services;
2. Repositioning family planning as an essential part of achieving the health Millennium Development Goals (MDGs);
3. Addressing the SRH needs of adolescents and youth as a key SRHR component;
4. Addressing the issue of unsafe abortion;
5. Delivering quality and affordable services in order to promote Safe Motherhood, child survival, and maternal, new-born and child health; and</td></tr>
</table>

	6. Strengthening African and south-south co-operation for the attainment of ICPD and MDG objectives across the continent.
PROTOCOL ON THE RIGHTS OF WOMEN IN AFRICA	The AU Protocol on the Rights of Women in Africa was inspired by a recognised need to compensate for the inadequate protection afforded to women by the African Charter on Human and Peoples' Rights (African Charter). While the African Charter guarantees non-discrimination on the basis of sex, equality before the law, and the elimination of discrimination against women, it does not articulate specific violations of women's rights which result from discrimination. Moreover, by providing for the elimination of discrimination against women in the context of the family, 'the custodian of morals an tradition' which, in some cases, is the very domain whereby discrimination against women flourishes, it inadvertently conflicts with the attainment of gender equality. **The Protocol requires states to "ensure that the right to health of women, including sexual and reproductive health, is respected and promoted."** **Article 14 of the protocol also calls upon states to protect individuals' rights and adopt and implement:** 1. Reproductive health services, including: The right for individuals to: a. control their fertility; b. decide whether to have children, the number of children and the spacing of children; c. choose any method of contraception; d. self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; e. be informed on one's health status and on the health status of one's partner, particularly if affected by sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; have family planning education; and the obligation for States to: f. provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; g. establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding. 2. Abortion rights and services, including: a. protecting the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. 3. HIV/AIDS rights and services, including: a. the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS b. the right to be informed on one's health status and on the health status of one's partner, particularly if affected by sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices. 4. Sexual education, including a. the right to have family planning education. b. providing adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.

THE STRATEGY FOR SRHR IN THE SADC REGION (2019 - 2030)	The Sexual and Reproductive Health Strategy for the SADC provides a framework for developing reproductive health policies or for harmonization for countries who do not yet have such policies. It also guides interventions by the SADC Member States, the Secretariat, donors and other stakeholders in the region. The strategy is aligned with the global frameworks such as the 1984 International Conference on Population and Development (ICPD) and the Millennium Development Goals. **Key elements include:** 1. Reducing maternal mortality to less than 70 deaths per 100,000 live births. (SDG 3.1.) 2. Reducing newborn mortality to 12 per 1,000 births in every country. (SDG 3.2.) 3. Recognising HIV and AIDS as a public health threat and aiming to end new infections by 2030. (SDG 3.3.) 4. Eliminating sexual and gender-based violence and other harmful practices, especially against women and girls. (SDG 5.1; SDG 5.2.; SDG5.3) 5. Reducing rates of unplanned pregnancies and unsafe abortion. 6. Reducing rates of teenage pregnancies. 7. Ensuring universal access to integrated, comprehensive SRH services, particularly for young people, women and, and other key and vulnerable populations, including in humanitarian settings. (SDG 3.7; SDG 5.6) 8. Strengthening health systems, including community health systems, to respond adequately to SRH needs in the region. (SDG 5.6) 9. Creating and ensuring an enabling environment for AYP to make healthy sexual and reproductive choices that enhance their lives and well-being. (SDG 4.7; SDG 5.6) 10. Eliminating barriers, including policy, cultural, social and economic, that act as an impediment to the realisation of SRHR in the region. (SDG 5.1; SDG 5c)
INTERNATIONAL HUMAN RIGHTS CONVENTIONS	The United Nations has developed a body of binding conventions stemming from the 1948 Universal Declaration of Human Rights aiming at protecting human beings rights and dignity in war and in peacetime. These rights are protected under international law and it is the duty of states to ensure they are respected, protected and fulfilled. Articles relevant to AYP SRHR and LGBTI: **Article 2:** Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. **Article 5:** No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. General Comments from the Human Rights Treaty Bodies related to AYP SRH and Gender issues: **Committee on Elimination of Discrimination Against Women**: Gender-based violence against women remains pervasive in all countries, with high levels of impunity. In many States, legislation addressing gender-based violence against women is non-existent, inadequate or poorly implemented. **Committee on the Right of a Child:** The potential of adolescents is widely compromised because State parties do not recognize or invest in the measures needed for them to enjoy their rights. Data disaggregated by age, sex and disability is not available in most countries to inform policy, identify gaps and support the allocation of appropriate resources for adolescents. Generic policies designed for children or young people often fail to address adolescents in all their diversity and are inadequate to guarantee the realisation of their rights. The costs of inaction and failure are high. The foundations laid during adolescence in terms of emotional security, health, sexuality, education, skills, resilience and understanding of rights have profound implications not only for their individual optimum development, but also for present and future social and economic development.

	Committee on the Elimination of Discrimination against Women's key recommendations related to AYP SRHR (adopted by member states including Kenya, Senegal Uganda and Zimbabwe) are: 49. To adopt a transformative approach, promoting gender equality and the empowerment of women, in order to dismantle the structural and systemic conditions that deprive women and girls of their fundamental rights, the consequence of which places them in situations of vulnerability to all forms of trafficking and sexual exploitation. 53. To eradicate patriarchal norms and values formalized in legislation, including family laws, which facilitate trafficking of child and forced marriages. Measures must be adopted that prevent families from agreeing to the indefinite or temporary "marriage" of their daughter in exchange for financial gain. **Conventions relevant to young people SRHR are:** ▪ The International Covenant on Civil and Political Rights (ICCPR), Articles 12, 18, 19, 21, 22; ▪ The international Covenant on Economic, Social and Cultural Rights (ICESCR), Articles 10; ▪ The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Articles 10, 11, 12, 14; ▪ The Convention on the Rights of the Child (CRC), Articles 3, 10, 13, 14, 15, 17, 23, 24, 25, 32, 39.
Adolescent Sexual and Reproductive Health (ASRH) recommendations	The World Health Organisations (WHO) recommendations were developed and enacted to support the implementation of a Global Strategy for Women, Children and Adolescents Health (2016 to 2030). These serves as a gateway to WHO guidelines on Adolescents Sexual Reproductive Health Rights (ASRHR) to inform advocacy, policy and programmes, project design and research. These recommendations are aligned to several strategies related to ASRHR including Operational Framework on Sexual Health and linkages to reproductive health. **Key elements:** ▪ Comprehensive sexuality education provision ▪ Contraception counselling provision ▪ Antenatal, intrapartum and postnatal care ▪ Safe abortion care ▪ Sexually transmitted infections prevention and care ▪ HIV prevention and care ▪ Violence against women and girls: prevention, support and care ▪ Harmful traditional practices prevention

Regional Strategy for HIV Prevention, Treatment and Care and SRHR among Key Populations	The purpose of the Regional Strategy is to guide the adoption and institutionalization of a standard, comprehensive package that addresses the unique challenges in providing equitable and effective HIV and SRH rights and services to key populations in SADC. Additionally, guide Member States in designing and implementing appropriate SRH and HIV prevention, treatment and care programmes for key populations focusing on the major issues that need to be addressed at policy, legal, institutional and facility levels. **Key elements:** Due to the heightened vulnerability of key populations, it is critical to focus on addressing the barriers they face in accessing HIV and SRH services. Effective strategies for increasing key populations' access to HIV and SRH services include: ▪ Addressing legal, policy, structural and socio-cultural barriers; ▪ Ensuring financial commitments; ▪ Empowering both the general community and key populations; ▪ Addressing stigma, discrimination and vulnerability to violence; and ▪ Ensuring the availability and access to comprehensive health services.
African Youth Charter	The African Youth Charter provides a strategic framework for youth empowerment and development activities at the continental, regional and national levels across Africa. It addresses key issues affecting youth, including employment, sustainable livelihoods, education, skills development, health, youth participation, national youth policy, peace and security, law enforcement, youth in the Diaspora and youth with disabilities. The Youth Charter affirms the need to promote and protect the rights and welfare of children as pronounced in the Convention of the Rights of the Child (1989) and the African Charter on the Rights and Welfare of the Child (1999). It also highlights the importance of improving the situation of African youth, who are marginalised from mainstream society and exposed to violence including gender-based violence. **Kenya:** Date of ratification: 11 August 2008 Date Deposited: 26 November 2008 **Uganda:** Date of ratification: 6 August 2008 Date Deposited: 22 October 2008 **Senegal:** Date of ratification: 17 September 2009 Date Deposited: 20 October 2009 **Zimbabwe:** Date of ratification: 16 March 2009 Date Deposited: 21 August 2009

6.2 Key SRHR challenges for adolescents and young people

Societies are made up of different structures that shape individuals' lives. Within these societies, individuals intersect with multiple factors at the individual and family levels. Young people are socialised into adopting specific desirable sexual identities and any deviation from these is punishable through social exclusion. Culture and religion have largely been used as tools to enforce certain ways of being. Culture "dictates what, when and how reproductive health information is transmitted to the youth" (Omweno, Ondigi & Ogolla, 2015, p. 153). Adolescent girls and young women (AGYW) seem to bear the brunt of restrictive cultural norms and beliefs on when, how and where they are able to express their sexuality. The 'taboo-ness' of free sexuality expression is what fuels numerous risky sexual practices that

are common-place in the ESA region. In addition, cultural beliefs make AYP of all SOGI more vulnerable (Babatunde et al., 2014). These include early/child marriages, tolerance of GBV and intolerance to persons with 'non-conforming' sexual orientations and gender identities (Adeola, 2021; Guilbert, 2017; Ninsiima et al., 2018). In many cultures, religion is an important governing factor in the delineation and implementation of sexual norms and values (Bartelink, 2015; Kemigisha et al., 2018; Towett & Ndungu, 2020; UNESCO, UNFPA & UNAIDS, 2016). **It is therefore important that countries work with cultural, religious and traditional leaders to find common ground**, in terms of eradicating cultural beliefs and norms that increase the vulnerability of young people.

Some of the regional frameworks such as the SADC Reproductive Health Strategy and the Adolescent Sexual and Reproductive Health (ASRH) strategy recognise the role of parents and societal norms in hindering or advancing the SRH of AYP. The connection between socio-cultural factors and sexual and reproductive health is well recognized in the global literature. Culture plays a significant role in shaping people's behaviour and attitudes. While the notion of strict and rigid cultural norms are shifting, many people continue to be guided by cultural norms.

Table 1 presents key sexual and reproductive health challenges for AYP across the countries studied, using four parameters namely, 1) Adolescent and youth population, 2) Contraceptive uptake, teenage pregnancy and access to safe abortion, 3) Gender-based violence, harmful cultural practices and child marriage and 4) Same-sex relations.

Table 1: SRHR situational analysis in Kenya, Senegal, Uganda and Zimbabwe

COUNTRY	CONTEXTUAL ANALYSIS
KENYA	**Adolescent and youth population** AYP between the aged of 10 – 24 years make up a significant proportion (33.4%) of the Kenyan population. https://www.unfpa.org/data/world-population-dashboard
	Contraceptive uptake, teenage pregnancy and access to safe abortion Multiple factors exacerbate adolescents' vulnerability to early and unintended pregnancies, and unintended pregnancies persist in Kenya with less than half of unmarried (45%) and married (62%) women aged 15 - 49 years using modern contraceptives (UNFPA, SWOP Data, 2021). Abortion in Kenya is regulated by Article 26(IV) of the country's Constitution, which states that: "Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law" (Constitution of Kenya (2010), Article 26(4)). While the Kenyan Constitution provides a platform for improving women's access to safe abortion, access to safe abortion options remains problematic for Kenyan AGYW. This is enmeshed with largely negative social attitudes toward women who seek safe abortions. In an effort to avert social stigma, young women opt to delay termination requests or choose unsafe abortion options that lead to detrimental health outcomes (Izugbara, Egesa, & Okelo, 2015; Izugbara et al., 2020; Mutua et al., 2015; Ushie, et al., 2018).
	Gender-based violence, harmful cultural practices and child marriage The scourge of GBV in Kenya remains high, placing girls and young women at a higher risk of HIV infection and poor SRH outcomes. The practice of female genital mutilation (FGM) continues as well, despite programmes that seek to teach about the negative implications of this practice. UNFPA reports that 27% of women and girls in Kenya have undergone FGM (UNFPA, 2017). Recently Kenya's president, Uhuru Kenyatta, committed to end the practice of FGM in his country by 2022 and indicated a legal ban of the practice (Cohen et al., 2020). Challenges in curbing this practice might be due to the fact that '[t]he recognition of customary law and existence of a dual legal system in some of the countries creates an impediment to dealing with harmful cultural practices effectively and leaves young people vulnerable' (UNFPA, 2017, p. 16). Child marriage is a major public health and human rights concern in Africa with a high number occurring in Kenyan rural communities (UNICEF, 2016; UNFPA, 2019; Lowe et al., 2021). Lowe and colleagues (2021) found that there is a preference to delay marriage amongst girls, but that persisting norms encouraging having large families are widely held. This continue to undermine SRHR progress.
	Same-sex relations Same-sex relations continue to be illegal in Kenya (Ndiso, 2019). Before 2018, police officers who suspected a person of same-sex relations, could force anal inspection of the 'suspect'. Today same-sex relations are still outlawed and the guilty can face sentences of up to 14 months imprisonment (Wilner, 2020).

UGANDA	**Adolescent and youth population** Adolescents and young people between the ages of 10 – 24 year make up over a third (34.6%) of the Ugandan population. https://www.unfpa.org/data/world-population-dashboard
	Contraceptive uptake, teenage pregnancy, access to safe abortion and child marriage In Uganda less than half of women aged 15 - 49 years are currently using modern contraceptives. This is true for both unmarried (32%) and married (41%) women (UNFPA, SWOP Data, 2021). Teenage pregnancy remains prevalent, at approximately 25% among women aged 15-19 (BOS & ICF 2018). This has been attributed to limited access to SRHR services, especially among vulnerable and underserved youth. Unintended pregnancies often occur within the context of coerced sex, child marriage or transactional sex (Cover et al., 2017). Approximately 46% of girls are married before the age of 18 years. Areeba, (2021), studying the link between early marriage and contraceptive use found that 66.8% of women who married early were not using contraceptives. In addition, the author found that education, religion and socio-economic status strongly influenced reported contraceptive use. While abortion in Uganda is legal, it is restricted to cases where the pregnancy is dangerous for the mother (Nteziyaremye, 2020). This continues to make adolescent girls vulnerable to unsafe abortion practices when they experience unintended pregnancies (HRAPF, 2017).
	Gender-based violence The Uganda Demographic and Health Survey (UDHS) 2016, reported a prevalence rate of 51% amongst women and 52% amongst men who have ever experienced physical GBV. Women however, are three times more likely to experience sexual violence (22% among women vs. 8% amongst men). The National Policy on Elimination Of Gender Based Violence in Uganda was adopted early in 2016 and revised in 2019. The revision reaffirms government commitments to put strategies in place, i) To reduce the prevalence of gender based violence and foster a zero tolerance environment. ii) To promote comprehensive care and support services to survivors/victims of gender-based violence. iii) To provide a framework for ensuring accountability and elimination of impunity for gender-based violence (p. 21). The progress made to prevent sexual and gender-based violence (SGBV) in Uganda, is noteworthy (Mugabe, 2021). However, FGM continues to be practiced; and while sensitization against the practice is ongoing in conservative communities across Uganda, its impact is limited as this tradition is still valued by both men and women in some Ugandan states (Mugabe, 2021).
	Same-sex relations Same-sex relations are criminalised in Uganda (UNFPA, 2017). The Ugandan context continues to be hostile to gender non-conforming individuals. This is particularly worrying among youth who face multiple and intersecting challenges due to their sexuality (AHA 2014 https://www.hrw.org/news/2014/05/14/uganda-anti-homosexuality-acts-heavy-toll).
SENEGAL	**Adolescent and youth population** Adolescents and young people between the ages of 10 – 24 years make up just under a third (32.3%) of the Senegalese population. https://www.unfpa.org/data/world-population-dashboard

	Contraceptive uptake, teenage pregnancy and access to safe abortion According to the United Nations Department of Economic and Social Affairs: Population Division (2017), contraceptive intake in Senegal is estimated at 28%. Senegal is faced with a high rate of teenage pregnancy with 26.4% of girls under age 18 becoming pregnant (World Vision, 2017). According to Cohen et al. (2020, p. 2), 'unintended pregnancy has significant economic and social consequences such as; low levels of education, poor employment opportunities, and inter-generational poverty'. Unintended or unwanted pregnancies happen because of young women's reluctance to use modern contraception. Studies suggest that unmarried young people avoid using contraceptives to hide the fact that they are sexually active. As such, young people found modern contraceptives to be inappropriate for them and ranked traditional ways of preventing pregnancies as more reliable. Health-seeking behaviour of youth is also influenced by health care provider attitudes that reflect stigma and discrimination toward AYP sexual choices (Cohen et al., 2020; Sidze et al., 2014). Termination of pregnancy is criminalised. Although the country's criminal code completely prohibits pregnancy termination, the Code of Medical Ethics allows an abortion if 3 doctors agree that the procedure is necessary to save the pregnant woman's life (Archer, Finden, & Pearson, 2018).
	Gender-based violence, harmful practices and child marriage Despite remarkable progress in policies[2] to keep girls in school and increasing the minimum age for marriage, adolescent girls remain exposed to harmful situations, including being subjected to various types of violence. These include sexual and gender-based violence, including sexual exploitation, harassment and abuse. According to United Nations agencies, nongovernmental organisations and academics, school-related sexual and gender-based violence is a serious problem in the country's education system. Child marriage remains a challenge in Senegal, despite a noticeable decrease in the practice (Save the Children, n.d). A UNICEF (2018) report shows that 1.6 million girls younger than 18 years were married in 2018. A Girls not Brides report indicates that 29% of girls younger than 18 years, and 8% of girls younger than 15 years, marry before the age of 18.
	Same-sex relations Same-sex relations are criminalised[3] in Senegal and gender non-conforming individuals continue to face hostility. This is particularly concerning with respect to youth who face multiple and intersecting challenges due to their sexuality (https://www.africanews.com/2021/05/21/homophobia-the-lifelong-burden-for-homosexuals-in-west-africa// ; Bertolt & Masse, 2019).
ZIMBABWE	**Adolescent and youth population** Adolescents and young people aged of 10 – 24 year make up a significant proportion (33.6%) of the Zimbabwean population. https://www.unfpa.org/data/world-population-dashboard

[2] Selly Ba, *"Violences basées sur le genre au Sénégal : l'arbre qui cache une dangereuse forêt"* (Gender-based violence in Senegal: a dangerous wood that cannot be seen for the trees), 2019, available at: *https://sn.boell.org/fr/vbg-au-senegal-larbre-qui-cache-uneforet-dangereuse*, accessed 02 October 2021.

[3] Penal Code *1965, Article 319 Unnatural Acts*

	Contraceptive uptake, teenage pregnancy and Access to safe abortion Zimbabwe reports high proportions of women aged 15 - 49 years who currently use modern contraceptives. This is true for both unmarried (49%) and married (68%) women (UNFPA, SWOP Data, 2021). However, Zimbabwe still has the highest teenage pregnancy rate in Sub-Saharan Africa, while abortion laws restrict access to women at risk of health complication, incest and rape (Nunu, 2021; RHRN Progress Report, 2019; Zimbabwe's Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Strategy 2017–2021). Nunu (2021), suggests that culture still strongly influence ideas about sex and sexuality within this context. To improve SRH outcomes for AYP, the author proposes an integration of indigenous and modern health systems as an amalgamated approach that could be of great value to the country.
	Gender-based violence, harmful cultural practices and child marriage The UNFPA 2021 dashboard, estimate the intimate partner violence rate at 20%. This high levels of GBV are driven by several factors including patriarchal social norms and gender inequalities. Some of the risk factors associated with IPV were younger age, low economic status, cohabitation and rural residence. In a 2014 survey by Zimbabwe's National Statistics Agency, one in three women ages 20 - 49 reported that they married before age 18 and an estimated 4% married before age 15. Since most child marriages are unregistered customary law unions, the survey is the best indicator of the scale of the problem in Zimbabwe. Child marriage is on a steady decrease, though this phenomenon remains common in mining towns, farming towns and border towns (UNICEF, 2014). In 2015 the Zimbabwean child marriage rate ranged from 10% to 50% in different provinces (Mukamana, Machakanja, & Adjei, 2020; Sithole & Dziva, 2019). In April 2021, Columbus Mavhunga of VOA News, reported that the Zimbabwean government estimated that almost 5000 teenage girls fell pregnant in January and February 2021, while approximately 1800 entered early marriages. Recent literature shows that "…[b]eing out of school has been linked to risky sexual behaviours and unintended pregnancies - both of which are catalysts for early marriage" within the current Zimbabwean context (Bengesai, Amusa, & Makonye, 2021, p. 10).
	Same-sex relations The Zimbabwe Constitution signed into law by former president Robert Mugabe in May 2013, prohibits gay marriage. Article 78(3) states that '[p]ersons of the same sex are prohibited from marrying each other. The law focuses on sexual relationships amongst men only. The general attitude in Zimbabwe towards same sex relations is negative. Many consider homosexuality a foreign import that undermines the country's Christian values (Muparamoto & Moen 2020; Mutanga & Moen, 2020).

6.3 *Government's progress on the ESA Commitment: the case of Uganda, Senegal, Kenya and Zimbabwe*

The ESA Commitment is a strategic tool, with measurable and time bound targets, that seeks to accelerate access to quality comprehensive education as well as SRH services for young people in the ESA region. **Uganda** provides CSE in schools, while also making attempts to introduce such education in lower secondary schools (UN, 2015). The country also has CSE policies in place, however, despite policies and programmes, for example, the School Health Policy (SHP) and the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY)[4] programme, both of which support the upscaling of CSE, implementation of CSE in the classroom remains limited (UNESCO, UNFPA & UNAIDS, 2016). Furthermore, the ESA Commitment set the stage for more focused youth-led programmes to be implemented in schools. One such programme was the School-Community Accountability for Girls Education (SAGE) project (DeSoto et al., 2020). Implemented in Ugandan schools during 2016 – 2019, this project aimed to decrease school dropout numbers and other SRH-related adverse effects on girls, by creating a school-home-community partnership to keep adolescent girls safe and with the use of early warning systems provide prompt intervention when girls were at risk. One limitation highlighted by the researchers, however, was its failure to include young boys as a priority group.

Senegal is located in West Africa and has not endorsed the ESA Commitment. The Senegalese government acknowledges the significance of CSE, yet like many low- and middle-income countries, Senegal has struggled to implement and sustain scaled-up national programmes (Adams et al., 2017; Glik, et al., 2016; Chau et al., 2016). Without the standardisation of national or regional CSE targets that aim to hold the government accountable, it is difficult for Senegal to understand and measure their CSE trajectories as a country (Human Rights Watch, 2018). However, despite this, Senegal has done significant work around the provision and implementation of family life education (FLE).

Kenya endorsed the ESA Commitment, which provided time-bound targets to scale up CSE and SRH services for young people (UNFPA, 2017). The country has adopted a multi-sectorial approach to the implementation of CSE, where civil society organisations, the government

[4]https://healtheducationresources.unesco.org/sites/default/files/resources/PIASCY_Helping_pupils_to_stay_safe_290b_EN.pdf

ministries as well as young people work together to improve the state of CSE in the country (Leitch, Mendoza, Waruingi, & Riungu, 2017).

Significant progress regarding the ESA Commitment targets has been observed in **Zimbabwe**. Even prior to becoming a signatory to the ESA Commitment 2013, Zimbabwe had a Life Skills, Sexuality and HIV and AIDS Education Strategic Plan (2012-2015), which catered for children, adolescents and young people from ages 4-18, both in and out of school. Despite concerns resulting from poor collaboration between the education and health ministries, civil society organisations and UN agencies continue to lead country-wide efforts to coordinate programmes directed at realising the ESA commitment (UNESCO, UNFPA & UNAIDS, 2016).

While great strides were made by these countries over the first five years after the inception of the ESA Commitment, the unexpected scourge of the COVID-19 at the end of 2019 dampened the momentum of realising longer term ESA Commitment goals. The protective measures adopted for curbing the spread of COVID-19 inadvertently provided a platform for social, political and religious groups to undermine the human rights of AYP, including LGBTI+ youth.

6.4 Human rights violations against AYP of all SOGI populations during COVID-19

The right to adequate health services is a fundamental human right. Countries have made commitments to protect and uphold this right by signing international conventions and covenants and espoused to develop and implement domestic legislation and policies that uphold such rights. Signatories committed to ensure that their citizens enjoy the highest attainable standard of overall health that is accessible, affordable and non-discriminatory.

Recently, however, the COVID-19 pandemic has strained already limited health systems and disrupted provision of SRHR services and support – making AYP more vulnerable (Teagle & Lynch, 2020). As such, those already vulnerable (i.e., low socio-economic groups, people of colour, and sexual minority groups) are also more likely to experience further vulnerability (Arnove, 2020; Blundell, Dias, Joyce, & Xu, 2020; Chowdhury et al., 2020). It was also established that governments often capitalise on national emergency situations, during which

they are permitted to introduce excessive measures in the name of ensuring citizens' safety (Lührmann, et al., 2020).

The right to health is enshrined in most of our core International human rights conventions, and accountability and monitoring mechanisms have been established to ensure countries uphold these commitments at national, regional and international levels. However, the realisation of these rights in Uganda, Senegal, Kenya and Zimbabwe has been disappointing, especially regarding access to SRHR information, services and support for AYP of all SOGI. Such violations differ within the regions of interest, but continue to limit both the delivery of quality SRH service and the access to these services, making it particularly problematic for the LGBTI+ communities to maintain healthy and safe sexual lives amid COVID-19 (United Nations, 2020).

The COVID-19 pandemic has also impacted the ability of many CSOs to provide SRH services. This can be attributed to the mandatory lockdown conditions that made contact-services barely possible, while drastic reductions in available funding and other resources, impeded programme implementation (@AfricanNGOs & EPIC-Africa, 2020; Teagle & Lynch, 2020). To curb the scale of such gross human rights violations in the ESA region, it has become imperative for national and regional human rights bodies to advocate for justice and hold violators accountable for infringements (https://reliefweb.int/report/world/state-african-regional-human-rights-bodies-and-mechanisms-2019-2020).

Table 2: Overview of Human Rights violations of AYP of all SOGI during the COVID-19 pandemic

COUNTRY	HUMAN RIGHTS VIOLATIONS
UGANDA	The current public health crisis caused by the spread of COVID-19 has already had a profound impact on human rights, health, and wellbeing, globally. In Uganda, it led to restricted access to SRHR information for young people; increased stigma and discrimination towards people living with HIV and decreased access to antiretroviral treatment (ART) and tuberculosis (TB) medication. The pandemic further showed an increase in reports of GBV and mental health issues amongst AYP. Exposure to incest, teenage pregnancy, unsafe abortion, and poor ART adherence also increased (see RHRN, Uganda, Narrative Report– Country Platforms, 2020). LGBTI), and gender non-conforming people, were left particularly vulnerable (RFSL, 2020). It was reported that 20 individuals - 14 men who identify as gay, two who identify as bisexual and four people who identify as transgender were arrested in March 2020 at the Children of the Sun Foundation premises, an LGBTI shelter on the outskirts of Kampala (UNAIDS, 2020). According to a UN (2020) report, rights experts at the UN were shocked to learn that the Ugandan government was using COVID-19 as a smokescreen to target LGBTI persons in the country, subjecting them to police brutality and random arrests. The violation of basic human rights experienced by many Ugandans were linked to their sexual orientation and/or gender identity and expression (see RHRN, Uganda, Narrative Report– Country Platforms, 2020).
SENEGAL	The Senegalese government reportedly imposed a ban on private and public gatherings 10 days prior to proclaiming a state of emergency on 23 March 2020. This ruling was contrary to Article 19 and the International Human Rights law[5] and gave the government the power to govern without parliamentary supervision. During the three month 'lockdown' period (March – June 2020), many violations were reported. These include reports of excessive use of force being used by police and armed groups, and restrictions to the right to health for LGBTI+ people[6]. Senegal was listed as one of the human rights violators, with media restrictions and verbal baiting of journalists being most common (Lührmann et al., 2020).
KENYA	According to SABC News (1 July 2020), the Kenya National Commission on Human Rights reported that 10 people died due to police brutality while COVID-19 measures were being enforced in the country. A further 200 complaints of human right violations were filed against the police. The VOA News (24 September 2020) also reported that Amnesty International Kenya, International Justice Mission Kenya, Haki Africa and the Kituo cha Sheria are suing the Kenyan government of Kenya for human rights violations in the country. The executive director of Kituo cha Sheria Annette Mbogoh, pointed out that during the pandemic, the government's responsibility towards its people was even greater than 'when things are just as normal.' She added that 'during this time' police had a much bigger responsibility to ensure 'that they protect, as opposed to meting [out] violence against the citizenry.' Kenyan media has been silent on the abuse of LGBTI+ people during COVID-19. However, VOA News (24 November 2020) reported that, "when people notice[d] and recognize[d] that in our neighbourhood, we have LGBTQ+ persons, they start to abuse them, they start to victimize them, in a way they feel that they do not want them here". This made access to health services more problematic as LGBTI+ people feared public scrutiny.
ZIMBABWE	The Zimbabwean government was also accused of human rights violations during this period. At the start of the COVID-19 pandemic, the National Association of Social Workers in the country expressed concern regarding reports of corruption by some public officials, and abductions and torture of

[5] https://www.article19.org/resources/senegal-covid-19-response-violates-rights/

[6] https://www.amnesty.org/en/location/africa/west-and-central-africa/senegal/report-senegal/

	Zimbabwean citizens purportedly by state agents. What is concerning is that the government seems to be unfazed by reports of human rights violations in the country (IFSW, 2020). People have been arrested for allegedly participating in protests, and human rights activists expressed their concern that the government might be using the current COVID-19 restrictions to justify the use of force, similar to the previous regime to suppress political criticism (Washington Post, 31 July, 2020). Furthermore, stigma, discrimination and harassment, against LGBTI persons, was exacerbated by COVID-19 lockdown and increased hardships faced by LGBTI persons, when accessing healthcare services (http://newzimbabwe.com/).

7. Proposed advocacy strategies

Table 3: Advocacy priorities

Advocacy Goal: Promote adolescent and youth SRHR through human rights and social justice instruments to address imbalances, inequity and disparities of AYP, of all SOGI.				
Issue	**Approach**	**Target audience**	**Advocacy messages**	**Communication channel**
SRH behavior and practices are embedded within socio-cultural norms and values that perpetuate stigma, discrimination and homophobia.	Championship approach. Traditional and faith leaders as advocacy champions for community engagements with all stakeholders, to build support for the provision of SRHR services and information.	Community stakeholders (Traditional and faith leaders, parents, teachers, AYP of all SOGI).	Access to comprehensive SRHR for AYP of all SOGI is a community priority.	– Community dialogues – Social media platforms
The lack of documenting the impact of social norms on SRHR of all young people, including LGBTI+.	Multisectoral approach to knowledge production. Strengthening partnerships between researchers and civil society organisations (CSOs) to develop, implement and disseminate more robust evidence-based knowledge in relation to the impact of social norms on SRHR among AYP of all SOGI.	CSOs and researchers engaged in SRHR for AYP of all SOGI.	Co-constructing knowledge that aim to improve all lives	– Synthesising data – Evidence dissemination – Multi-media platforms – Academic channels
Inadequately resourced Comprehensive Sexuality Education (CSE) programmes.	Reframing SRHR policies to ensure that CSE programmes benefit from sustainable ringfenced government funding. This will ensure much needed financial support to CSOs. Policy advocacy - CSOs mobilising government to spearhead fundraising.	Policy makers at all levels (continental, regional, national, provincial and district levels).	Inclusive SRHR policy framing is at the core of public + health	– Policy dialogues – Policy briefs – Seminars/webinars

Prioritisation of SRHR for AYP as a development priority.	Championship approach and policy advocacy; Reframing SRHR in a broader development framework that speaks to the AU 2063 agenda and the SDGs, through policy advocacy, making necessary policy changes, removing policies that violates AYPs SRHR and effective policy implementation.	Policy makers and key government departments.	Improved SRH for AYP of all SOGI is a strategic move towards achieving development goals.	– Policy dialogues – Policy briefs – Seminars/webinars
Bridge the gap between policy makers and communities.	Using an inter-group and intergenerational dialogue approach to engage community members to take more active and positive ownership of the overall health on well-being of their young people.	Policy makers Community members Community mobilisers CSOs.	Capacitate communities to advocate for themselves.	– Community dialogues
Poor domestication of regional commitments/policies	Monitoring and Evaluation. AYP and LGBTIQ+ advocacy partners should lobby government for improved data collection and management systems and timeous dissemination of findings, to facilitate accountability. Governments should invest in strengthening the capacity of key players who are tasked with contextualising these policies in order to improve its cultural congruence – making policies more accessible to all.	Governments at all levels (continental, regional, national, provincial and district levels).	Contextualise policies informed 'by us, for us!' Establish monitoring mechanisms.	– Community dialogues, – Forums and digital platforms for knowledge sharing
Accountability for human rights violations	Policy advocacy. Capacity building for monitoring and reporting human rights abuses, etc.	Governments at all levels (continental, regional, national, provincial and district levels), CSOs and researchers, including ethically sound media houses and social platforms.	Human rights-based actions in times of crisis.	– Engaging ethically sound media houses and social platforms distribute correct information timeously, while upholding the human rights of all people.

8. Conclusions

Some of the findings emerging from this review are not new. For example, that cultural norms and values are leveraged against progressive approaches to LGBTI inclusion across the continent, is well-documented. This continues to have a stigmatizing and marginalising effect on LGBTI youth who continue to face significant barriers to education and accessing appropriate, accessible, and friendly SRH support and services. The effects of this ongoing exclusion are apparent in terms of exposure to homophobic and transphobic violence and to continued extremely high levels of HIV among men who have sex with men (MSM) and transgender populations, in particular. This situation is cynically leveraged by politicians who regularly reignite homophobic sentiments during election cycles to foment public opinion and bolster their numbers in the polls, as has been evident in some of the countries included in this study.

The patriarchal norms pervading African societies and the effects of gender inequality are also not new, but have been exacerbated by the COVID-19 pandemic. This poses genuine concerns for the fight against GBV, FGM, and child marriage as girls, kept out of school and away from SRH information and services, are more likely to bear the unequal burden of the pandemic and negative lifespan consequences.

What is new about this report is that **it contributes to the growing African knowledge base about AYP SRHR, including LGBTI experience, across the continent**. Increasingly, policy makers and decision makers at national and continental levels are demanding data from the continent: in effect *African data for Africa's challenges*. The process of knowledge production and data analysis is increasingly an imperative in support of evidence-based policy making and implementation. However, knowledge is not just necessary for robust policy development and its application, but also is seen by CSOs across the continent as a key pillar of their advocacy efforts in support of youth SRHR, particularly for the most marginalised and vulnerable youth groups. A recent example of this is the UNFPA's launch of guidelines for out-of-school CSE[7] in the region, which has been welcomed by civil society. Increasingly CSOs are

[7] International Technical and Programmatic Guidance on Out-Of-School Comprehensive Sexuality Education: An Evidence-Informed Approach for Non-Formal, Out-Of-School Programmes

entering the knowledge production space, posing and answering burning questions in relation to AYP SRHR, and the findings then form an integral component of their advocacy efforts.

What emerged from the analysis in this report was also **a reflection on the importance of how best to frame the work on youth SRH**. The rights-based approach (youth rights, gender equality, and LGBTI rights) is a predominant global framing which has led to significant advances in the post-World War II context. However, in the local contexts analysed in this report, and in the panAfrican context more broadly, a rights-based framing also has to contend with pervasive norms and cultural values which lead to significant tensions when discussing the rights, particularly of LGBTI people, young people and in relation to gender and sexuality more broadly. Another dominant framing concerns education, access to education, education for all, CSE and inclusive processes of teaching and learning. In the generally conservative education sector, a focus on the importance of access to and completion of education for all young people is one that resonates broadly across the African continent. However, much work has yet to be done in terms of synergising efforts in education and health so as to ensure more robust linkages between young people, including in-school youth, to the SRH support and services that they need.

The public health framing has undoubtedly led to significant progress around HIV, access to testing, treatment and care in the context of the broader development agenda. **The public health framing has been successfully utilised in the pan-African context to include previously severely marginalised groups, such as MSM and trans women**, in the broad key populations rubric. However, public health has also been critiqued in terms of its biomedical approach that arguably leaves broader issues of stigma unchanged.

In short, this report and the analysis contained within it has foregrounded the need for further reflection and engagement, particularly among civil society, of how optimally and most strategically to frame advocacy efforts, just three of which possible framings are mentioned here.

Finally, any analysis of policy and programming in the pan-African space must be cognisant of the funding landscape. What this report and others highlight are the concerns around the **lack of domestic funding support for the implementation of SRHR youth frameworks**. While

global funders continue to substantially support the domestication of SRHR agreements, the COVID-19 pandemic has highlighted the ways in which gains made around youth SRHR can quickly stall or be reversed when already limited funding streams are directed to other issues. It is therefore imperative that civil society, particularly youth-led civil society, amplifies its voice and advocacy efforts in ensuring that all young people have access to the SRHR support and services that they need to participate fully in society and contribute to the broader development agenda of the continent.

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10. Annex 1: Contextualising the Right Here, Right Now programme

A key aspect of ensuring young people's SRHR is the importance of holding governments accountable for the implementation of good quality, sustainable, youth-friendly and accessible SRH services and programming for AYP, of all LGBTI+. The Right Here, Right Now (RHRN) programme (2016-2020) was a strategic partnership between Rutgers (consortium lead), the Asian-Pacific Resource and Research Centre for Women (ARROW), CHOICE for Youth and Sexuality (CHOICE), Dance4life, HIVOS, the International Planned Parenthood Federation Africa Region (IPPFAR), the Latin American and Caribbean Women's Health Network (LACWHN), and the Netherlands Ministry of Foreign Affairs. This report primarily focuses on evaluating the progress, achievements and shortfalls of the African implementation countries (Kenya, Uganda, Zimbabwe and Senegal).

The consortium recognised the range of economic, socio-cultural and political challenges women, girls and adolescents of different sexual orientations and gender identities face when accessing SRHR information, services and support. With the aim to ensure SRHR for AYP across Africa, the RHRN programme was committed to employing apt, rights-based approaches to promote dignity and the elimination stigma, discrimination, limited SRH services, and lack of SRHR information for young people and marginalised groups in the implementation countries.

Summarising the RHRN programme objectives

RHRN recognised the difficulties AYP of all LGBTI+ experience when accessing SRH services. During the 4.5 years of RHRN implementation, the programme made a concerted effort to create a world where everyone can access quality, youth-friendly SRH health services that include accurate SRHR information, contraceptives, and safe abortion. Furthermore, the programme endeavoured to create a platform where young people could use their agency and autonomy to voice and advocate for their own sexual health and well-being.

To achieve this, RHRN and its partners aimed to use the five-year partnership to:

1. strengthen cooperation within and across national, regional and international levels to undertake concerted advocacy for a progressive and inclusive Sexual and Reproductive Health and Rights (SRHR) agenda; and
2. advocate and hold governments accountable for their adoption of progressive and inclusive policies (and budgets thereof) for the implementation of comprehensive sexuality education and youth-friendly SRH services, including safe abortion.

The project focused on strengthening meaningful and inclusive youth participation by placing young people at the forefront, as champions in advocating for adolescents and young peoples' SRHR. During project implementation, RHRN developed and implemented a safety protocol for frontline defenders, a framework for counselling and offering psychosocial support, as well as evaluation and safe housing initiatives. Additionally, RHRN created a platform or forum through which they capacitated and actively engaged partners in the

development of advocacy strategies that were context specific and grounded in ratified progressive and inclusive SRHR legislations and policies. RHRN also advocated for regional and local governments' accountability for domesticating and allocating sufficient budgets for the implementation of progressive and inclusive policies that offer AYP of all LGBTI+ comprehensive sexual education (CSE) and youth friendly SRH services.

RHRN key programmatic achievements and shortfalls

Despite the challenging circumstances, exacerbated by COVID-19 restrictions, RHRN was able to contribute significantly to the agenda for SRHR advocacy and policy implementation. RHRN contributed to maintaining and strengthening SRHR norm setting in several important Human Rights Council Resolutions towards eradicating harmful cultural practices. The initiative also influenced council members' voting on the renewal of the mandate of the Independent Expert on Sexual Orientation and Gender Identity (SOGI). Furthermore, the Naivasha global meetings in Kenya (26-29 October 2020) created an important platform to reflect on capacity strengthening and building sustainable strategies to achieve social and political change for the SRHR of young people. RHRN moreover facilitated platforms where both AYP advocates and member associations were upskilled to improved their capacity to implement effective strategies for mentoring their programmes effectiveness. These achievements promoted linkages between and outcomes of advocacy at both national, and regional levels (Right Here, Right Now Strategic Partnership Progress Report, 2019: https://aidstream.org/files/documents/Progress-Report-2019-RHRN-FINAL-20200717100739.pdf).

National contributions include:

- *Kenya:* The launch of the Reviewed School Health Policy and the restoration of the Standards & Guidelines for Reducing Morbidity and Mortality from unsafe abortion. On 4 June, 2019,[8] President Uhuru Kenyatta, committed to end the practice of female genital mutilation (FGM[9]) by 2022 and placed a legal ban on the practice. In addition, Kenyan media houses committed to change their reporting on LGBTIQ+ issues to a more positive rhetoric and refrain from the use of discriminatory language (RHRN Progress Report, 2019).
- *Senegal*: The adoption of a law criminalising rape in Senegal in January 2020, known as Act No. 2020-05. This came after constant active campaigns by CSOs advocating for women's rights.
- *Uganda:* There has been commitment from the Ugandan government, in 2019, that the Anti-Homosexuality Act (2014) will not be reintroduced. In addition, the President, who had actively opposed CSE, is now committed to operationalise the National Sexuality Education framework (Republic of Uganda 2018; RHRN Progress Report, 2019).

[8] https://kenya.unfpa.org/en/news/presidential-commitment-end-female-genital-mutilation-2022

[9] **The Prohibition of Female Genital Mutilation Act, 2011**

- *Zimbabwe:* In 2019, the Ministry of Education adopted monitoring tools and SRH-specific indicators into its monitoring and evaluation framework to track the implementation of the School Health Policy.

National shortfalls include:

- *Kenya:* The Kenyan platform experienced pushback from some community factions that opposed 'non-normative' sexuality. Well-funded SRHR group used the 2019 ICPD Nairobi Summit to '*name and shame*' organisations advocating for SRHR for AYP of all LGBTI+. RHRN and other CSOs came under fire, while some platform members reported receiving treats that compromised their safety and make it difficult for them to provide service to these marginalised populations.
- *Senegal*: The objective to create and increase safe spaces where meaningful youth participation could flourish was hampered by violent attacks against LGBTI organisations from mid-2019. In addition, Senegalese platforms members experienced extreme social stigma and scrutiny that labelled them 'a platform that promotes homosexuals' (see Progress Report 2019). In response to this, all LGBTI-related activities were suspended.
- *Uganda:* The initial hesitance to endorse the national guidelines and standards for SRH services by the Health Ministry in September 2017, hampered the roll-out of SRH services and support for AYP. Religious bodies also opposed the roll-out, due to concerns that the SRHR guidelines would compromise the morality of communities. This increased the vulnerability and health risks of AYP during the onset of COVID-19, as AYP had no policy framework to enforce their health needs, while social distancing regulations worsened the situation.
- *Zimbabwe:* Zimbabwe made great strides around advocacy for women's SRHR, though COVID-19 hampered their ability to implement intended activities that included public gatherings; accessing SRHR beneficiaries, and restricted internet connection for virtual activities.

RHRN African regional forum virtual meeting data (26–29 October 2020)

At the end of the project, in October 2020, a RHRN forum meeting was hosted. With its theme '**Keeping the momentum for SRHR of young for people in Africa'**, members from four countries in Africa joined by strategic partners reflected on the achievements, challenges and suggested implications for regional SRH future programming (see Table 4).

Table 4: Summary of conclusions, challenges and suggested Implications for SRH programming

CONCLUSIONS /CHALLENGES	IMPLICATIONS FOR SRH PROGRAMMING
1. The level of education of parents as primary educators of adolescent girls and young women (AGYW) was a primary challenge. It was highlighted that culture and low levels of education restrict parents' ability to talk to AGYW and foster a supportive environment.	– Youth need to have access to accurate SRHR information. – Platform members should hosting multi-generational interventions with an aim to teach young girls and their parents more about their bodies, how they work and what risks they might face. – Implementers should stay mindful of local cultural norms and standard and use language that is 'non-offensive' when providing services. With this said, it was highlighted that the delivery of and access to comprehensive SRH services should remain paramount.
2. The adoption of strategic policies in Africa, does not always ensure its successful implementation. The forum highlighted that implementers should put the same level of effort into programme implementation as they put into advocacy activities. This will ensure that policies are implemented at a ground level and governments are held responsible for its success, monitoring and evaluation.	– It is important that developing countries are provided with funding and skills (by local governments and the international development community) to ensure that countries have appropriate resources for the implementation of policies. – Adequate funding will enable civil society and government organisations in their effort to focus on implementing SRH programmes, while advocacy activities continue as a parallel focus. – Strengthening coalition between RHRN, SRHR programmatic partners and local judiciaries may be advantageous to ensure policy frameworks are implemented. With the backing of judiciaries, RHRN can spearhead the development of effective accountability strategies, forcing governments to promote SRHR.
3. The effects of global/national disasters should be factored in when developing future programmes. The lessons learned during the COVID-19 period should inform SRHR programming moving forward.	– In an effort to decrease programme vulnerabilities, SRH implementation activities should make provision for crisis periods. These might include disease outbreaks, but should also take into account the local political climate as well as possible backlash that may prohibit implementation and service delivery. This is especially imperative for countries experiencing hostilities around sensitive issues including SRHR for AYP of all LGBTI+1. – This is/should be the responsibility of both the health ministries and civil society.
4. There is still a 'mismatch' between SRHR policies and laws in ESA countries. Contradicting laws negatively affect SRH service delivery to AYP of all LGBTI+ and impact advocacy activities.	– Sex and sexuality continue to induce human rights violations in Africa. With so many robust legal frameworks in place, it is important that the next RHRN programme advocate for the review and amendment of such frameworks in order to oppose restrictive policies. – Advocacy strategies similar to those used to promote the review of the Termination of Pregnancy (ToP) Act in Zimbabwe and opposing the Anti-gay bill in Uganda, should continue to be a pivotal mandate of RHRN and its partners.

5. Human rights violations by government go unnoticed as government justify their actions using contradicting laws. It is important to emphasize that criminalising sex and sexuality is a human rights violation.	– Although the COVID-19 pandemic exacerbated human rights violations, Africa has been grappling with such contraventions for decades. – Greater involvement of AYP of all LGBTI+ in developing, implementing and advocating for democratic, human rights focused policies should be a key focus for future programming.
6. The scarcity of SRH financing in the ESA region has made service provision and programming limited.	– Since 2020, global focus turned to curbing the spread of the corona virus. COVID-19 became the financial priority as all public health resources was commandeered toward managing the scourge. – SRH funding has been the stepsister to HIV and TB for many years or has been conflated within the scope of HIV. – Sexual and Reproductive health and its accompanying rights is the overarching public health sphere under which HIV, STIs and other related infection/deceases should be considered. Going forward, this should be highlighted and funding strategies should reflect this.
7. Ensuring the safety & security of Advocates, especially during the COVID-19 period, was challenging.	– With lockdown restrictions at varying levels across these countries, the implementation of programmes and the delivery of comprehensive SRHR services was hindered. – A possible solution that RHRN can spearhead is that of securing ringfenced funding to develop regional frameworks that facilitate the progress and continuation of programming during tumultuous times (whether induced by political or pandemic climates). – A key focus here should be the safety of the Advocates and programme implementors, while continuing visibility and ensuring access to comprehensive SRH services and support.