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MOBILITY MATTERS:

THE ROLE OF TRANSPORT SERVICES IN SUPPORTING ACCESS TO SEXUAL REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENT GIRLS AND YOUNG WOMEN

FINDINGS FROM FOUR AFRICAN COUNTRIES

APRIL 2023

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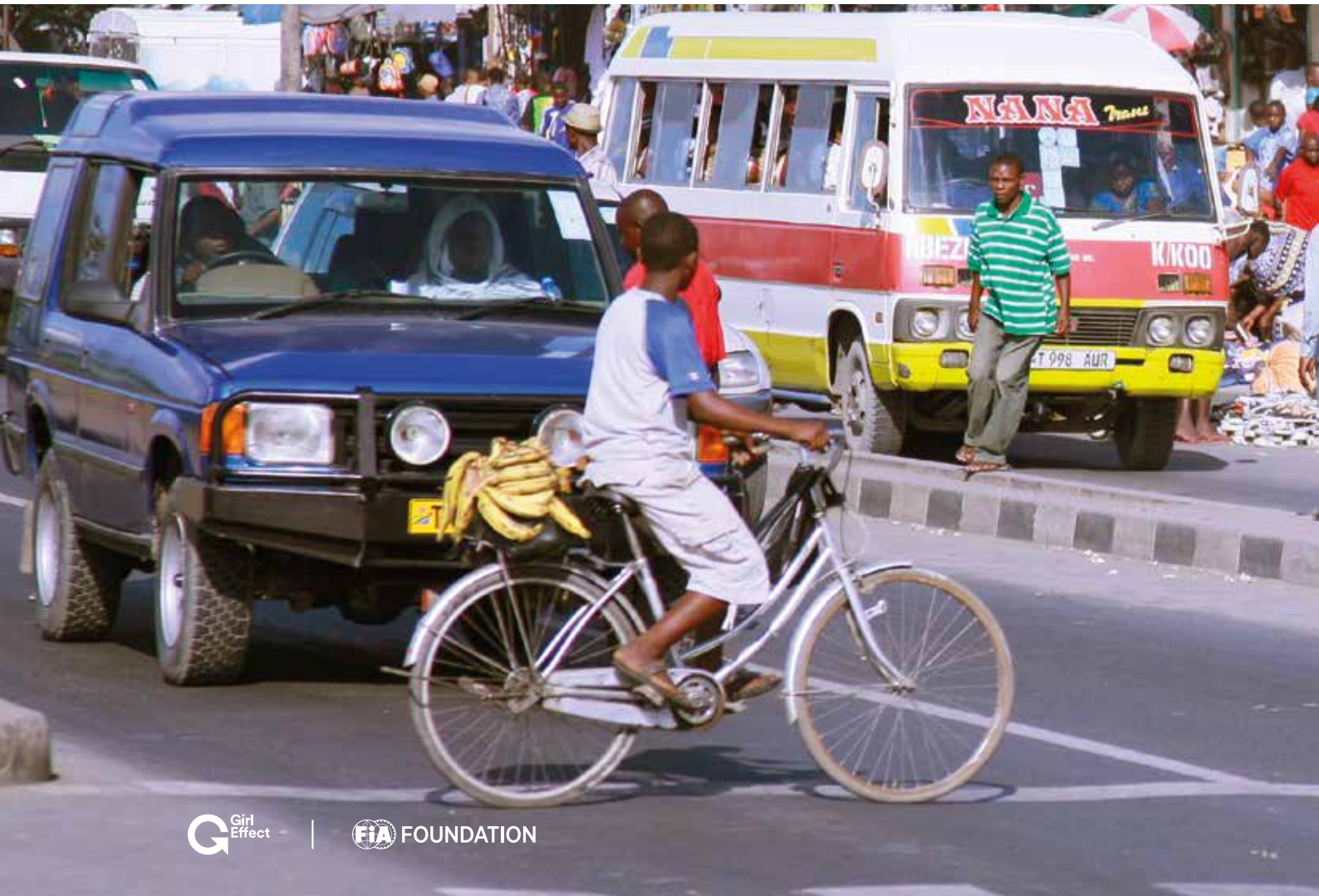

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EXECUTIVE SUMMARY

Plan International recently described the situation facing adolescent girls and young women (AGYW) as a 'shadow pandemic'. Women and girls are experiencing higher rates of sexual violence, child marriage and teenage pregnancy as well as differential access to services and gender-specific restrictions to reproductive rights.[1] As Low and Middle-Income Countries (LMICs) continue to tackle the impact of COVID-19 and adapt to new ways of living, women and girls' ability to access Sexual and Reproductive Health (SRH) services safely is more important than ever.

Whilst the key issue in this regard is the availability of these SRH services, and social acceptance of their use, too little work has been done to understand how physical access affects uptake also. In previous research, geographical distance, high transport costs and poor infrastructure are recognised as critical barriers to SRH service access.[2] Women's physical mobility in LIMCs, relative to men's, is resource-constrained, complex and multi-faceted.[3] Poor transport options, affordability, fear of sexual harassment and geographical distance are all key impediments for AGYW in their daily lives, negatively impacting their ability to access the services they need. [4] A structured examination of the specific enablers and challenges that AGYW face in their journey to access SRH services is long overdue.

This study is intended to take up that challenge, and has focused on what those challenges are. It uses direct evidence, collected by Girl Effect's Technology Enabled Girl Ambassadors (TEGAs), a network of 18-24 years old trained in qualitative research methods, capturing data in audio, survey and video format, to develop a picture of girls' mobility experiences with an explicit focus on the availability, accessibility, safety and reliability of existing mobility modes, in urban, peri-urban, and rural locations across Nigeria, Malawi, Tanzania, and Rwanda.

Overall, 200 household-level individual interviews (IDIs) with female respondents aged 15-19 were conducted, equally split across geographies (160 IDIs with AGYW, 20 IDIs with adolescent girls with disabilities, and 20 interviews with young mothers). In addition, four interviews with experts on SRHR and mobility issues were hosted to discuss policies, insights and themes in the two fields.

This generated a wealth of first hand testimonies of the barriers and enablers to AGYWs' mobility in accessing SRH services; the effects of mobility-related challenges on girls' ability to maintain good SRHR; and a set of recommendations based upon their experiences and desire for change, to improve their access to SRHR.

Key findings with respect to girls' mobility and access to SRH services were as follows:

1. **There is a lack of fixed standardised pricing** for intermediate modes of transport. Respondents noted that operators changed their prices depending on different factors: demand surge, destinations, weather conditions and road conditions. The minimization of passenger loads on transport negatively affected respondents during the COVID pandemic as they faced much higher prices. These increased costs have not subsided with a return to higher passenger load following the lifting of social distancing and movement restrictions.
2. There is a real fear that the modes of transport which they use **expose them to harassment**. Concerns were expressed around name-calling and sexual harassment while using transit especially in remote/desolate areas or in the dark.
3. **The infrastructure around mobility is poor.** Girls expressed concern about reckless driving and high road traffic collisions (RTCs); overcrowding of buses; broken seats; poor-quality roads.

These challenges are even more complex for girls with disabilities (GPWD) and young mothers. For example, GPWD with physical ailments felt discriminated against by vehicle operators. Regular public bus transport is not always physically accessible, buses are not low-floor and drivers do not allow sufficient time for anyone with a disability to board. There is no provision of reserved or priority seating for those with disabilities, or those travelling with children.

Whilst mobility is not the only challenge when accessing SRH services, the evidence of this study shows that it is an important one. It is also an area where the girls questioned in this study have some key recommendations for change, such as:

- Consistent and affordable costing practises across IMT
- Female-operated transport including walking groups for women
- Community led pick-and-drop services for AGYW linked to NGO implemented services
- Discounted/subsidised pricing for young mothers and girls with disabilities
- Greater regulatory systems on traffic including screening of driver licensing and traffic safety education campaigns
- Greater investment in walking and cycling infrastructure

Further details on these recommendations and others can be found in the report.

LIST OF ACRONYMS

LMIC	Lower and Middle-Income Countries
AGYW	Adolescent Girls and Young Women
SRHR	Sexual and Reproductive Health and Rights
SRH	Sexual and Reproductive Health
FGM	Female Genital Mutilation
TEGA	Technology Enabled Girl Ambassadors
GE	Girl Effect
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infections
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immuno-Deficiency Syndrome
FLHE	Family Life and HIV Education
YM	Young Mothers
PWD	Persons with Disabilities
GPWD	Girls (Persons) with Disabilities
DHS	Demographic and Health Survey
HDI	Human Development Index
IMT	Intermediate Mode of Transport
TZ	Tanzania
RW	Rwanda
MW	Malawi
NG	Nigeria

INTRODUCTION AND BACKGROUND

Women's physical mobility in Low and Middle-Income Countries (LIMCs), relative to men's, is resource-constrained, complex and multi-faceted.[5] Poor transport options, affordability, fear of sexual harassment and geographical distance are all key impediments for young women and adolescent girls in their daily lives, negatively impacting their ability to access the services they need[6], including Sexual and Reproductive Health (SRH) services.

The COVID-19 pandemic has exacerbated many gender imbalances and reversed some hard-won progress around access to health, education, employment and more. Plan International has termed this the 'shadow pandemic': Women and girls are experiencing higher rates of sexual violence, child marriage, teenage pregnancy and differential access to services and gender-specific restrictions to reproductive rights.[7] In addition, the pandemic has impacted the supply and provision of wider sexual health services.[8]

The barriers to SRH services have become particularly difficult for many adolescent girls and young women (AGYW). At the beginning of the pandemic, AGYW experienced minimal mobility while isolated at home or unable to go to school or move around communities to access SRH services.[9] As LMICs continue to tackle the impact of COVID-19 and adapt to new ways of living, women and girls' ability to access SRH services safely is more important than ever.

There is a notable data gap in relation to the role that mobility plays in AGYW access of SRH services, in both the available infrastructure and the experiences while using various transport modes. This is particularly true of experiences and perspectives of young mothers (YM) and Girls (Persons) with Disabilities (GPWD). Geographical distance, high transport costs and poor infrastructure have been highlighted as critical barriers to SRH service access in the small body of existing research.[10]

RESEARCH OBJECTIVES

Girl Effect and the FIA Foundation designed a qualitative study to investigate the mobility enablers and challenges that AGYW face in their journey to access services, including perspectives from GPWD and YM. The study specifically focuses on their access to SRH services, the factors that impact their ability to access these services, and asking the girls themselves how their journeys should be improved.

The focus of the study is on the East and West African context, specifically in Tanzania, Malawi, Rwanda, and Nigeria.

Key objectives of the study were to:

- Develop a picture of girls' mobility experiences with an explicit focus on the availability, accessibility, safety and reliability of existing mobility modes.
- Explore the barriers and enablers to AGYWs' mobility in general and inclusive of accessing SRH services.
- Assess the impact of mobility-related challenges on girls' lives with a focus on their ability to maintain positive SRH attitudes and behaviours.
- Develop a set of recommendations relevant to critical stakeholders that can impact or change the mobility of adolescents, especially girls, based upon their experiences and desire for change, for advocacy to improve girls' mobility generally including and concerning accessing SRHR.

METHODOLOGY

Girl Effect implemented the research in all four countries utilising the Technology Enabled Girl Ambassador Network (TEGA). TEGA is a network of qualitative research trained AGYW who employ a customised mobile phone-based data collection application to conduct interviews capturing data in audio, multiple choice survey and video formats. This approach lends itself to more robust insights as peers speaking with peers adds a level of comfort and trust allowing the respondent to feel more free and comfortable in the discussion.

Urban and rural localities were explored in all four countries, and peri-urban locations were additionally explored in Malawi, Rwanda and Nigeria. Full details on specific places in-county can be found in the annexe.

The study employed qualitative methods and consisted of 200 individual interviews of girls and women between the ages of 15 and 19 including girls living with disabilities and young mothers.

Location	TEGA In Depth Interviews (IDI)		
	AGYW	GPWD	YM
Rwanda	40	5	5
Malawi	40	5	5
Tanzania	40	5	5
Nigeria	40	5	5
Total	200		

All data collected in this study was discussed in a validation workshop with local experts, the TEGAs and representatives of the respondents to triangulate findings and make sure that the results emerging are valid.

The research sought to answer the following overarching questions:

- What are girls' mobility options in general, including their access to SRH services in their area?
- What mobility-specific challenges do they face in general and inclusive of accessing SRH services?
- What are the enablers to good mobility experiences in general and inclusive of their access to SRH services?
- How have mobility options been altered by the Covid-19 pandemic, if at all? What impact has this had on girls' mobility?
- What are the specific issues faced by girls with different accessibility needs/disabilities when travelling, including their access to SRH services?
- What are adolescent mothers' specific issues when travelling, including their access to SRH services?
- What impacts do poor/good mobility options impact girls' ability to maintain good SRHR?

The youth-friendly tool for the interviews can be found in the annexe, see research instruments.

A total of five interviews were conducted with key informants. All of whom are experts in their respective fields and represented different organisations with expertise across the transport, climate change sectors exploring intersections with gender and SRHR. The interviews with key informants validated findings from the literature review and supported insights from girls on their mobility experiences accessing SRH services.

The study was designed to give a snapshot of experiences in each of the four countries. While outreach specifically sought to incorporate marginalised voices who experience additional mobility barriers, the report is limited to young mothers and GPWD who were comfortable consenting to the interview. Further, given the breadth of geography included there are not sufficient findings to justify an analysis across rural, urban, peri-urban categorization.

GLOBAL AND COUNTRY CONTEXT

Global Context

Globally, young people remain a notably neglected group, especially in relation to transport infrastructure planning.[11] This is despite the significant, and growing youth population, particularly in Africa where 60% of the population is under 25.[12] Transport networks are vital to access education, health and other services for both their current wellbeing but also for their future livelihood and prospects.

The importance of transport for urban young people is directly recognised in Sustainable Development Goal (SDG) 11.2: provide access to safe, affordable, accessible and sustainable transport systems with special attention to the needs of those in vulnerable situations.[13] Further, equitable transport and access to services is crucial to achieving many SDGs, including SDG3 (Good health and well-being), SDG4 (Quality education), SDG 5 (Gender equality), and SDG 8 (decent work and economic growth). Evidence shows that improvements in mobility accessibility has a multidimensional impact on reducing aggregate poverty and reducing household poverty is unlikely without considering the mobility of young people.[14]

While experiences vary amongst girls in different countries, there is symmetry in factors that impact girls' and young women's mobility. Specific research focused on the mobility needs of young women and girls accessing services is scarce. However, the few studies that have explored this have found girls in rural areas experience a complex interplay of mobility constraints such as negative and pervasive social norms and poor physical access which are linked to low educational achievement.

Safety is frequently cited as a barrier to mobility including road-traffic collisions and gender-based violence while navigating public spaces and using transport modes. Research has found that gaps in transport infrastructure, combined with the threat of sexual harassment on journeys, represent significant barriers to gendered mobility in both in public spaces and on transport modes.[15] These concerns hamper many AGYW's journeys to school, alongside the challenges of affordability and access.

Whilst primary and secondary education completion rates by gender differ across the continent, it has been well documented that girls' participation in formal secondary education, training and in the workforce is substantially lower than that of boys. Social conventions, transport and social issues often form an important component of this trend, through the precise patterning of the transportation and mobility barriers experienced, and the ways in which transport factors interact with other constraints vary from country to country.

Much transport design and policy relies on an assumption of users capable of "high mobility"[16] where individuals are expected to have the necessary physical, cognitive, technical, societal and economic capacities[17] to access and use transport. Transport limitations further contribute to social exclusion by restricting access to activities that enhance people's life chances and wellbeing, especially those with disability.[18] There is a clear disability-inclusion capacity gap in research and in-country policies and systematic reviews of transport policies and guidelines in several African countries found many countries omit, or only superficially include, PWD in their transport policy framework.[19] Where there is research on the intersection of PWDs and gender, highlights heightened risks of sexual abuse for young women and girls.[20] Further, PWDs are frequently excluded from SRH services, often due to lack of adequate training of health staff, lack of sexuality education, and SRH information not tailored to include appropriate content nor presented in an accessible format.[21]

Evidence Gaps

With regard to access to SRH services from a mobility perspective the literature is sparse and varies by country. What is consistent across the board is there is a dearth of literature focused on the experiences of adolescents with disabilities, let alone GPWDs. Knowledge on adolescents with disabilities is seemingly limited to household survey data on their education. Thus, there is a need for more up-to-date data along with research to reveal the extent and the key aspects of the disadvantage and marginalisation each particular group of girls faces.

Conclusions

Research across the four geographies exploring the experiences of adolescent girls is varied. It demonstrates how young people's mobility experiences, needs and risks are embedded in power relations and vary with gender, age and location. It also points to the scale and range of uncertainties that so many young people now face globally as they negotiate daily mobility or immobility. Significant research gaps are identified, including the need for more in-depth action research involving young people's ability to access SRH services.

COUNTRY PROFILES

NIGERIA

Population: 216 million

Youth population: 32% aged 10-24[22]

Economic Status: 31% of the population live on less than $2.15 a day[23]

HIV rates: 1.9 million (all ages) of which 230,000 adolescents aged 10–19 live with HIV[24]. HIV prevalence among adolescents in Nigeria is estimated at 3.5 %, the highest in West and Central Africa

Sexually Active before 18 (AGYW): 57%[25]

Median age for sexual intercourse debut (AGYW) of Sexual Activity debut: 17%[26]

Women who were first married by age 18 (% of women ages 20-24): 43%[27]

Young Mothers (% of those aged 15-19 who have children and/or currently pregnant): 19% between 15-19 are mothers or pregnant[28]

Policy on Comprehensive Sexuality Education: Gender responsive life skills-based HIV and sexuality education is part of the curriculum only in secondary schools[29]

The main form of transport is the Keke Napep[30], a motorised taxi for up to 3 passengers and walking.[31] However, in rural areas access to reliable transport to cross long distances is a challenge. In terms of maternal health outcomes, according to the 2018 NDHS data, motorcycles/scooters are the most prevalent mode of transportation, accounting for 31% of births in a health facility.

There remains pervasive and social stigma around sex and SHR services, which can be a barrier for young women and girls to access SRH services, especially in rural areas.[32] There is, however, explicit state commitment to challenge stigma and improve access to SRH services. Nigeria's Family Planning vision for 2030 is to have a country where everyone - including young people and vulnerable populations - can make informed choices with equitable and affordable access to quality family planning.

Disability remains a significant barrier to accessing health care and SRH services, for example 71% of people living with disability reported being unable to access disability-specific health services.[33] Other research has shown that educational resources, and services for SRH, are inaccessible to PWDs despite the reportedly high rates of risky sexual behaviour among this group.[34]

MALAWI

Population: 19 million

Youth population: 51% under the age of 18[35]

Economic Status: 62% live in multidimensional poverty[36]

HIV rate of all ages: 990,000[37]

Sexually Active before 18 (AGYW): 64%[(38)]

Median age for sexual intercourse debut (AGYW): 17

Women who were first married by age 18: 47%[39]

Young Mothers (% of those aged 15-19 who have children and/or currently pregnant): 32%[40]

Policy on Comprehensive Sexuality Education: Gender responsive life skills-based HIV and sexuality education is part of the curriculum both in primary and secondary schools [41]

On average, 40% of households in Malawi own a bicycle with a higher incidence in rural areas (42%) compared to urban areas (29%). Car ownership is comparatively lower with 3% of households, on average, owning a car although it is considerably higher in urban areas (13%) compared to rural areas (2%).[42]

It should be noted that Malawi's roadways are heavily used by non-motorized users, particularly pedestrians and cyclists, for whom there is minimal provision.[43] This is of particular concern as research has found that Road traffic collisions (RTCs) involving young people are the main cause of death among young people - many of whom were pedestrians.[44]

The life of the average adolescent girl in Malawi is governed by a complex set of social norms that determines the "place" of girls and women in society, including the appropriate time for sexual activity, marriage, desired family size, and the (non) use of family planning.[45] This is consistent with research with young boys who believe sexual coercion, harassment and assault to be an acceptable strategy for obtaining sex from girls.[46] For most, this environment often results in girls dropping out of school, marrying early, becoming sexually active at a young age, not using prophylaxis which often results in pregnancy or contracting STIs.

Upon signing the SDGs in 2015, Malawi publicly committed to all goals including goal 5, Gender Equality. The 2018 Gender equality index showed Malawi ranking 172 out of 189 countries on measures related to reproductive health rights and political participation.[47] However, the Malawi Government says they are committed to implementing the comprehensive and integrated approaches to SRHR despite the financial and institutional challenges.

RWANDA

Population: 13 million

Youth population: 31% aged 10-24[48]

Economic Status: 52% of the population live on less than $2.15 a day[49]

HIV rate (of all ages): 230,000[50]

Sexual Activity: Median age for sexual intercourse debut (AGYW): 20

Women who were first married by age 18 (% of women ages 20-24): 6%[51]

Young Mothers (% of those aged 15-19 who have children and/or currently pregnant): 5%[52]

Policy on Comprehensive Sexuality EducationSex Education: Gender responsive life skills-based HIV and sexuality education is part of the curriculum both in primary and secondary schools

Transport ownership is comparatively lower in Rwanda compared to the three other geographies. According to the 2019-20 DHS survey, only 14% of households own a bicycle. This proportion is slightly higher in rural areas (15%) compared to urban areas (7%) with car and motorcycle ownership being negligible by comparison: only 2% of households, on average, own a car.[53] Concerning public transport, the motorcycle is the dominant vehicle representing 49% of vehicles on the road although only 17% of these vehicles have registered licences to operate under commercial use, thus many motorcycles may be operating illegally as public transport vehicles.[54]

Persistent discriminatory social norms and expectations against girls prevail. From an early age, girls are socialised to work hard to meet societal expectations and maintain a 'good' reputation, which can result in gender-based violence and early pregnancy in adolescence.[55] Half of adolescent girls (15-19) reported have experienced physical or sexual violence.[56]

Teenage pregnancy rates are rising in Rwanda, despite prolonged and targeted government interventions through increased sex education, teenage mentoring and broadened access to legal abortions. The National Youth Policy, although it touches on adolescents' SRH, does not specify strategic mechanisms for implementing universal and comprehensive SRHR for young people.[57] Also, there is little focus on the particular factors and pathways of change for adolescent girls. Thus there remains significant SRHR coverage gaps, exacerbating the unmet need for SRH services and information.

TANZANIA

Population: 62 million [58]

Youth population: 43% aged 10-24 years[59]

Economic Status: 45% of the population live on less than $2.15 a day [60]

HIV rate (of all ages): 1.7 million [61], 5% of adults

Sexually Active before 18 (AGYW): 60% [62]

Sexual Activity: Median age for sexual intercourse debut (AGYW): 17 [63]

Young Mothers: (% of those aged 15-19 who have children and/or currently pregnant): 26% [64]

Women who were first married by age 18 (% of women ages 20-24): 31% [65]

Policy on Comprehensive Sexuality Education: Gender responsive life skills-based HIV and sexuality education is part of the curriculum both in primary and secondary schools[66]

According to the World Bank (2021), 60% of the population commute by foot, however this is not always by choice. Only a minority of people can afford motorcycles and cars, which together comprise less than 10% of trips. Cycling, as a low-cost, high-efficiency mode of medium-distance transport, has enormous unrealized potential in most cities, but is used for fewer than 10% of trips.[67]

88% of female university students reported sexual harassment on public transport in Tanzania.[68] It has been said that the poor access of women and girls to road transport services has major implications for their wellbeing and future life prospects e.g. education, health and multi-generational poverty.[69]

Although in many communities pre-marital sex is culturally or religiously forbidden, several studies in Tanzania document a high prevalence of premarital sex amongst adolescents.[70] The Tanzanian government has a large body of progressive legislation and policies committed to meeting sexual health needs and providing adolescents with access to free contraceptive services, however the unmet need for modern contraception among young women in Tanzania remains high. Where access to health service providers exists, many are considered unapproachable due concerns around confidentiality, stigma and medical misinformation.[71]


TOYOTA

FINDINGS: ENABLERS AND BARRIERS TO MOBILITY AND ITS IMPACT ON ACCESSING SRH SERVICES

This section outlines the key themes identified from interviews with girls and experts with a focus on the main enablers and barriers to mobility; both generally and with respect to accessing SRH services. The principal barriers to mobility identified through the research are cost and affordability, exposure to harassment and violence, road safety, social barriers, and physical and social barriers related to GPWD.

Cost and Affordability

MALAWI

In Malawi, costs are the biggest barrier to transport use for girls. Many AGYW have little control over their mobility choices as these are tied down to costs/affordability. The issue of cost is particularly acute for young mothers. Young mothers have several travel needs, but their mobility is still an issue due to cost/affordability concerns. For instance, they mention that it costs K800 ($0.80) for a cab and K400 ($0.40) for a motorbike ride. Considering 60% of the population live on less than $2.15 a day, transport is a relatively significant expense for many.

Most AGYW state that while they have limited travel needs, travel options are always available. However, access to these options is a struggle due to the associated cost and the rise in costs of mobility options during the COVID-19 pandemic, which has impacted AGYW's mobility in Malawi profoundly.

> *There are times when fuel is scarce and the operators of the modes of transportation hike the prices. This makes it difficult to access the modes of transportation when one has no money.*
>
> **Young Woman, 18**

> *It has impacted my travelling also. We are unable to visit relatives because of the high transportation costs.*
>
> **Young Woman, 18**

> *Cars had a higher capacity (passenger limit) before COVID-19. Now, the capacity has reduced. This has led to an increase in transport fares. We are ending up paying more.*
>
> **Young Woman, 18**

> *They are not reliable to us because they require money. So, if you do not have money, you fail to travel. Sometimes, my child gets sick. But due to lack of transport, I cannot go to the hospital with him. If it (his condition) worsens then, you are forced to borrow money in order to go to the hospital.*
>
> **Adolescent Girl, 16**

Figure 1: Girls in Malawi on local transport cost and post-COVID price changes.

NIGERIA

In Nigeria, many girls report having their transportation costs covered by family members and relatives, thus acting as an enabler in their mobility. However, respondents do note that costs, even for tricycles (the most reliable means of mobility for many girls due to its relatively cheap cost and availability), are increasing due to rising fuel prices. The issue of affordability is not limited to rising fuel prices. A related issue is the non-standardized costs across mobility types. In most cases, service providers charge passengers how they want, thus inconsistent costing practices make it difficult for girls to plan their journey ahead of time. As a result, girls choose to travel on foot to nearby locations.

> *When my mother and I are going (travelling), my mother pays. It is costly because she pays N500 ($1.09) for me alone and she has to pay N1500 ($3.26) for herself, and if she doesn't pay, then that means I cannot go.*
>
> **Young Woman, 18**

> *The fuel price has increased, they would take you at the price of N80 ($0.17) but now they take you at N150 ($0.33), so you see it has increased. It is challenging because if I do not make money for myself, and ask for money to travel, no one will give this to me, but if I make my own money, I can use it freely.*
>
> **Young Woman, 18**

> *Yes, it has affected their lives because some people don't know the cost of fuel has increased. They would just go to the place they want to go when you reach your destination and give the driver their money, if the man is patient they would just take it but if the person is impatient they tell you to pay more. You see, that has affected the lives of young girls and older women.*
>
> **Adolescent Girl, 16**

Figure 2: Adolescent girls from Nigeria on costs and price rise in transport.

TANZANIA

In Tanzania, AGYW in urban areas tend to move more than those in rural areas, yet both face challenges primarily centred around affordability. While adolescent girls would like to access better and safer modes of transport (such as cars over buses or motorcycles) these are financially out of reach. While the government regulates bus fares, the private sector which operates shared cars is free to set its own prices. This situation works against the economically constrained communities of Tanzania to which most of the respondents belong. As a result – most girls end up walking to most places including to obtain essential services such as to access a hospital, school or a training centre. However, young mothers reported that they are able to rely on family or community members for childcare or financial support for transport costs to health facilities.

> *It is 1000 tshs ($0.43) for a motorcycle from here to school. My parents are not well off like that. I have to walk. Going and coming back. No, I do not feel safe. Because the distance is long. You can walk to school and come back. When you are back, you feel tired and your legs are in pain.*
>
> **Adolescent Girl, 16**

> *(My mother) says the cost of transport has increased a lot which makes it hard to travel. That is why I did not go anywhere this holiday. I am just at home.*
>
> **Adolescent Girl, 15**

> *From my experience, I know about transport for students. Some students buy bicycles and others who cannot afford to buy bicycles, walk. For example, I walk, it is 1km from home to school. The challenge is being late to school (...) The teacher punishes you. You arrive tired. Some people give up on studying because of the distance to school.*
>
> **Adolescent Girl, 16**

Figure 3: Girls from Tanzania on transportation costs and having to "walk" to most places.

RWANDA

In Rwanda, transport costs are less of a barrier, relative to the three other countries, but are still an issue that cuts across all subgroups. Many of those in the sample have close social networks immediately around them, they still live at home and can rely on their families for financial support with transport costs or to provide rides. Therefore many AGYW have a broader range of mobility options, or are better placed to meet unexpected higher fare fees. However, in instances where financial support and/or transport options from families are not available, they too seem to opt for cheaper modes of transportation by choosing to walk or take less physically comfortable rides. The cost issue in Rwanda comes up primarily for young mothers as they have greater mobility needs than their childless counterparts, especially for health services. Sub-town health facilities are easily accessible to young mothers, and community health workers have solid networks and associations with young mothers, but the other target groups remain excluded due to cost reasons.

> *Those options are expensive because before from (location) to (location) it was 700 rwf ($0.65), but now it is 1000 rwf ($0.93) because the price of paraffin has increased.*
>
> **Adolescent Girl, 16**

> *Yes, bicycles are available, for instance when you have to travel from here to (location), you can take a bicycle if you have coins for transport, it is 200 rwf ($0.19) only to reach there, and if you don't have the money you go there on foot. If I had money and were able to afford fare costs. I would take rides and get there fast.*
>
> **Young Woman, 19**

> *I pay a lot of money for a taxi moto, about 1000 rwf ($0.93), a bicycle is 200 rwf ($0.19) to reach (location) and a car of 300 rwf ($0.28), but because of poverty sometimes I walk. I wake up very early and go early so that I reach there on time. It takes me 2 and a half hours, based on how fast I walked. It is in the morning that I use those 2 and a half hours and use the same in the evening. I am tired but because I have no other option I go.*
>
> **Young Woman, 18**

Figure 4: AGYW and young mothers in Rwanda on the rising cost of transport.

Figure 5: Young mothers in Rwanda on the impact of Covid 19 & the inconsistent cost of transport.

> *I always go by a small bus, but because the costs increased most of the time I go on foot.*
>
> **Young Mother, 19**

> *It is expensive in some areas and cheap in others. For instance, when they charge less on a bus it is cheap, sometimes they charge more and it is expensive but you pay anyway because you want to travel.*
>
> **Young Mother, 19**

> *(TEGA) Did the pandemic cause any specific impacts on your mobility or travel options?*
> *(RESP) Yes, because I had to pay twice the price of the ticket I was using before, which consumes a lot of money.*
>
> **Young Mother, 19**

Cost and Affordability: Summary

The issue of cost came out strongly across all subgroups in all four geographies with many describing it as a key impediment to mobility. Considering nearly half, on average, of the populations across the four countries live on less than $2.15 daily, there were some examples from girls in Nigeria and Rwanda that suggest a one-way journey accounts for nearly half of $2.15. As a result, many adolescent girls choose to walk, if the journey is feasible.

The feedback suggests affordability and costs are a major area of concern when it comes to mobility for AGYW in these geographies. The lack of a defined and transparent cost structure for journeys can be unpredictable. Stated fares to passengers are based on arbitrary conditions (e.g. contingent on destination, weather and road conditions), therefore frequently changing. This works to create a double barrier, making it both difficult for individuals to plan their finances and travel to their intended destinations. As with personal safety and road infrastructure, the issue of cost needs urgent regulation that must include informal transport options and not remain limited to only public bus fares. And while walking may overcome barriers to mobility, it does however come with safety considerations: this is explored in the following subsection.

Exposure to harassment & violence

NIGERIA

In Nigeria, the data validation workshops revealed that all sub-groups felt that personal safety was a great challenge that constrained their mobility. Fear of being robbed or physically attacked due to a lack of security personnel on the roads or in public spaces was a particularly strong theme. Nearly all respondents stated there were areas that were communally known as unsafe, and girls are afraid of going to these areas.

The source of this fear is the existence of men who wander about without work or reason and routinely harass women. The harassment is usually a reference to a serious threat of physical violence. Girls also mention the "rude" attitude of tricycle-men. GPWD also reported that there was a fear of being "judged" by the tricycle men because of their disability. Discriminatory practice will be considered in further detail later in the section.

> *You will see girls walking in groups, most of them will walk in groups for security purposes; they will also not, you know, choose to walk very early in the morning when there is no lighting. There will be no women walking on dark streets (...) These inconveniences alone make it so difficult for women in regards to just access services and facilities.*
>
> **Expert Interview**
> UNEP

Figure 6: An excerpt from an interview with an expert on mobility on AGYW's safety concerns when travelling alone.

RWANDA

In Rwanda, safety is a concern for young mothers much more than any other group. When travelling alone, young mothers have access to several modes of transport but prefer to walk or use public transportation due to comfort, safety and cost. Due to these competing considerations, AGYW and young mothers are forced to repeatedly make a personal 'cost-benefit analysis' when they travel and compromise on certain factors due to immediate needs. For example, they might choose to walk due to cost considerations despite safety concerns or choose to take considerably more expensive forms of transport in order to mitigate any safety concerns. Some respondents shared their tactics to feel safer including travelling in groups when possible and keeping contact details of 'known' drivers with whom they have had positive experience. Concerns about driver behaviour were not limited to young mothers, and other girls expressed concerns about 'nefarious' drivers who may take advantage of them physically during journeys.

> *We usually travel as a group of people. There is an exception on a bicycle, I think it is not reliable [safe] because you are just one person, there is no one else you could share a problem with in case it arises.*
>
> **Young Mother, 19**

> *Well it is having a taxi-motorbike driver's number, I call him or a bicycle or a car driver. It is what helps me travel well. When I call them, they come through and it becomes much easier for me, because sometimes you might be in a remote area and call them, they will find you there.*
>
> **Young Mother, 18**

Figure 7: Young Mothers Rwanda on enablers to travelling safely.

TANZANIA

In Tanzania, this study found that while physical safety is a secondary concern to cost, motorcycle taxi use was particularly fraught as many reported that drivers are known to request sexual activity as a form of payment. Girls are harassed on buses both verbally and physically through inappropriate touching. The most commonly experienced type of verbal sexual harassment was name calling which often goes unreported, resulting in perpetrators continually harassing girls and young women.

> *To walk on foot (makes her feel unsafe), because the road that we walk down is surrounded by bushes on each side. (motorcycle riders) have started to intimidate us and people are getting caught randomly, so when you are running late and your buddies have left you for school, you have to go alone and you become worried when you follow them.*
>
> **Adolescent Girl, 16**

> *Like (getting) a bodaboda (motorcycle), during the exam's day. You have prepared enough at home, so you are ready for them, but when you board a motorcycle, a driver starts telling you other things out of the school. As you may know, for us girls, a motorcycle driver starts telling you, 'oh! You know that I love you', and so on. So your ideas and focus change from school (and the exam) to the motorcycle driver's views. I mean, the motorcycle driver confuses you, dah (showing shock).*
>
> **Adolescent Girl, 16**

Figure 8: Girls in Tanzania describe their discomfort with public transport.

MALAWI

In Malawi, the findings suggest that AGYW generally feel unsafe when they are required to walk. For instance, many girls, both married and unmarried, fear a physical assault, sexual harassment and assault including rape.

You can leave this place to go to your village. On the way, you might meet thugs. They can steal money from you. Some may beat you up. Others may just kill you. So, that is what is dangerous.

Adolescent Girl, 17

I do not feel safe when using these modes of mobility. Some may wish to rape me since I am alone.

Adolescent Girl, 15

We are not safe when using these modes of transportation. Most of the modes of transportation are operated by male drivers and conductors who may harass you when you are traveling to rural areas. This can be the case if one is using a minibus as a mode of transportation.

Young Woman, 18

I get afraid when I board a motorcycle. And when it is just two passengers; a man and myself. And when we get to a deserted place. I always think that the man will attack me. I have heard of such issues many times. A person boarded a minibus that did not have passengers. There was just a driver and it was in the evening. When she told the driver about her bus stop, the driver did not stop the vehicle. He did not stop. Then, the driver grabbed her neck. After that, he started touching her. She failed to shout as much as she wanted to do so. After he was done raping her, he left her there. Off he went.

Girl (Person) with Disabilities, 18

Figure 9: Girls in Malawi describe the safety issues they face while trying to commute.

Exposure to harassment: Summary

Though exposure to harassment is secondary to cost, it is still a barrier hindering girls' mobility options. The issue of personal safety is an area of importance for those interviewed and cuts across all subgroups, in all four geographies. Personal safety encompasses sexual harassment, robbery, and threats of sexual and physical violence. The threat of sexual harassment and assault whilst travelling has been well documented and the findings are consistent with existing literature. There are anecdotal mentions of enablers in order to overcome such safety considerations (e.g. travelling as a group; keeping the numbers of known drivers saved). It is still not enough to mitigate the fear of being harassed/ attacked while trying to access services and it can also impact AGYW's ability to travel at will. Interviews with experts corroborate reflections from all subgroups regarding personal safety; both of barriers to mobility (wider in-country safety concerns) and examples of enablers (i.e. girls and women choosing to travel as a group where possible).

> *(Women) would prefer to maybe pay a little bit more and have a safer option. So that might look like a combi taxi that they themselves would actually pay for to go shopping, it's more convenient to them, they feel it's safer, there's a group of them and then and then the money is a little bit more, but the experience is so much better for them.*
>
> **Expert Interview**
> Independent Sustainability Transport Consultant

> *For example, safety and security of women or impact of sexual assault - It's very much on that sort of national and city policy level... you need more police on the street, you need culture, you need culturally, to feel safe in your space.*
>
> **Expert Interview**
> UNEP

Figure 10: Excerpts from interviews with experts on mobility in Africa on women's safety.

Road Safety

MALAWI

In Malawi, all sub-groups mentioned concerns and fear in being involved in RTCs when travelling. This is consistent with previous literature which found RTCs represent the main cause of death among young people in Malawi. However, girls did not prioritise road safety as a key barrier to their mobility, suggesting that perhaps issues of affordability or travel options take precedence over fear of RTCs safety for respondents.

> *There are times when the bicycles are involved in accidents or develop faults. There are some drivers that do not know or follow road rules and regulations. This makes the modes of transportation not safe.*
>
> **Girl (Person) with Disabilities, 18**

> *Some motorcycle operators get drunk whilst on duty. They even forget that they are on the road. And it happens that there could be an oncoming vehicle. In the end, they have a head on collision.*
>
> **Adolescent Girl, 16**

> *Some (taxi drivers) drive cars which are not serviced. Due to this, cars end up in accidents (...) It is very challenging to travel. This is because most drivers from this side of (location) do not have a driver's' license. Sometimes, their cars do not have valid COF and insurance.*
>
> **Adolescent Girl, 15**

Figure 11: Girls in Malawi with concerns on road safety.

NIGERIA

In Nigeria, AGYW reported that aggressive or unpredictable driving can sometimes define whether they feel safe. This is reinforced by interviews with experts who noted that due to a lack of safety regulation in many African countries, it often means that the roads are filled with those who do not have driving licences. Whilst this meets growing mobility demands, it can often lead to untrained drivers on the road who are at an increased likelihood of experiencing RTCs.

Poor quality roads were universally reported as a mobility barrier across all groups, reporting longer and uncomfortable journeys, especially for pregnant women, as drivers try to navigate potholes, flooding, and other road conditions.

> *Sometimes you feel safe and other times you don't. When you look at the driver and notice his [not good] way of operating the [vehicle], you would feel unsafe, but if he looks responsible, you would feel safe.*
>
> **Adolescent Girl, 17**

> *Most (two wheeler and three wheeler drivers) don't have a driving license or insurance (...) On the one hand, they actually provide mobility for people, they do for me, and they are essential, to actually meet the mobilities demand. (...) governments and authorities don't really want to include them (...) as they are accountable for many accidents.*
>
> **Expert Interview**
> Mobility4Africa

Figure 12: Interview excerpts on the lack of safety regulations in Nigeria.

TANZANIA

In Tanzania, AGYW reported concerns about road safety risks, citing poor road conditions, and driving behaviours especially around alcohol and drug use.

RWANDA

Relative to other geographies, there are fewer mentions of RTCs being a barrier to mobility in Rwanda. The few mentioned were stated from the perspective of a pedestrian and a public transport passenger.

> *When the driver is driving at a high speed, it makes you worry about accidents. You get worried if you will arrive safely. Secondly, when the driver is drunk, they can cause an accident. Or when drivers are competing on the roads while knowing they are carrying passengers on the buses, they are playing games on the road, they can cause accidents.*
>
> **Young Woman, 19**

> *We are asking the government to help improve the roads. The roads are not good. When it rains, the roads become very rough. It becomes hard to travel.*
>
> **Adolescent Girl, 16**

> *There are many cars on the tarmac road and a lot of accidents due to the carelessness of the drivers [around] pedestrians.*
>
> **Young Woman, 19**

Figure 13: Girls in Tanzania with concerns on road safety.

> *(Taxi-moto) are not reliable because you can have accidents, in other words it is just putting everything in God's hands (...).*
>
> **Young Mother, 19**

> *Often some drivers of taxi-moto are criminals and sometimes they pass you in unreliable places, you don't want (them) to cross in order to take advantage of you, where they can abuse you, they are not trustworthy.*
>
> **Young Woman, 19**

Figure 14: Girls in Rwanda discussing safety concerns as a pedestrian and as a passenger.

Road safety: summary

Overall, fear and frequency of RTCs, though secondary to cost and personal safety, is a concern for all subgroups in all geographies. All subgroups mentioned concerns around the road, particularly possible RTCs due to precarious driving practices, excessive speeding, lack of safety regulation, bad weather, and poor road conditions. Expert interviews verify the high incidence of RTCs across countries, they also shed light on the fact that while this negatively impacts AGYW and subgroups in accessing services, it is an indication of a wider problem that affects several groups who commute using public transports and/or walk.

Social barriers impacting access to SRH services

MALAWI

In Malawi, all subgroups reported that perceptions of those who use SRH services by members of the community is a barrier to accessing SRH services themselves.

> *(Plan Malawi) talked about pregnancies(in primary school). They said that it is bad to give birth while young. They said that you can be found with cervical cancer. It is also not safe to give birth while young. You can get into big trouble. You can even die. Sometimes you can become anaemic.*
>
> **Young Woman, 18**

> *Some (AGYW) said the methods (e.g. condoms) are bad because they result in some other diseases. Some said that they are too young, do not bring such (contraceptives) at our school.*
>
> **Adolescent Girl, 17**

> *People can speak bad about you. Some also discriminate against you. Some even say 'that person has a child. So, why are you associating with her? What will she say to you?' This is very painful and disappointing. It is as if you planned for all that (the discrimination).*
>
> **Young Mother, 17**

Figure 15: Girls in Malawi on the negative associations of sex and sexual reproduction at a young age.

RWANDA

In Rwanda in addition to mobility constraints, all subgroups mentioned the impact of discriminatory social barriers affecting access to modern contraception, SRH clinics and facilities. The findings imply AGYW may not choose to state where they are going when taking public transport to health care facilities for fear of being judged by drivers and other passengers. Some AGYW mentioned that this does not apply to young mothers for whom access to family planning clinics is acceptable, but for those AGYW who have not given birth, many girls interviewed said they are unable to use such services as they want to avoid discriminatory labelling due to assumed sexual deviance by their social network.

> *There are those who cannot use family planning because they believe that it is a sin, and there are others who use family planning to achieve their desired number of children (...) They perceive (unmarried girls using SRH services) in a wrong way, it is not a good thing...Because she has not yet reached the age of marriage, it is shameful.*
>
> **Young Mother, 19**

> *I can't recommend (SRH services) to teenage girls because I hear people saying that it is very bad and of course it's understandable, it's not good for girls to use them (...) (Girls should only use SRH services) after giving birth, it is when I think (girls) should use them to protect themselves and also for family planning.*
>
> **Adolescent Girl, 16**

> *The reason they (parents) perceive it in a bad way is that they start thinking that their child is getting involved into some really bad habits, sometimes they even have plans of what their child is going to become in the future, it strikes them that you have those kind of bad things (condoms), and they lose trust in you.*
>
> **Girl (Person) with Disabilities, 17**

> *If a girl asked for a condom, they would call her a prostitute.*
>
> **Girl (Person) with Disabilities, 17**

Figure 16: Girls in Rwanda on the negative associations of sex and sexual reproduction at a young age.

NIGERIA

In Nigeria, many AGYW experience mobility challenges when travelling to healthcare facilities, however, the journey is marred by some due to the negative treatment of healthcare providers once they arrive. Some AGYW recount stories from friends and relatives about the negative treatment and attitudes they received from healthcare providers, as a result, it dissuaded AGYW and young mothers due to differential and negative treatment experienced by those in their social network. There were only a few instances where AGYW recounted a specific reason, for instance one girl mentioned that she experienced poor treatment relative to others as she was not 'rich' however, AGYW and young mothers simply mention poor treatment without cause.

> *She said she went to talk to the doctor and she started yelling that she wore a long gown, so now if you are going to give birth you have to dress well before they attend to you. That was why she got angry and left.*
>
> **Adolescent Girl, 17**

> *There is a hospital close to us. I went with a friend of mine to visit someone at the hospital, but the way they treated us was really bad. She went to the hospital because she was not feeling well and she is pregnant. The doctor treated her badly which made me very angry and I want to become a doctor myself. I don't like it when I see people being treated badly.*
>
> **Young Woman, 19**

> *They (friends) tell me they went to the clinic due to period pain, I would tell them I cannot go to the clinic because of period pain, the health workers will treat me badly. I would rather go to the pharmacy and buy pills, and no one has to know (...) When you go (to the clinic) they tell you they don't have (time) or today is not the day for people like you, because sickness like this (period pain) comes to you at once and when you go to the clinic, you don't get what you want, so there is no point going.*
>
> **Young Mother, 19**

> *Honestly, in the clinic, they treat you badly especially if they notice you are not rich.*
>
> **Young Woman, 19**

Figure 17: Girls in Nigeria on the impacts of being treated badly by Health Workers or providers.

TANZANIA

In Tanzania accessibility and negative social perceptions can present as a barrier in accessing SRH services. Similar to Malawi, some AGYW mention that parents and teachers can often employ 'scaremongering' tactics to dissuade girls from acquiring SRH services. And in instances, where girls try to access SRH services, some choose to take the bus but the effects of COVID-19 means there are delays. A secondary barrier to social norms is that the recent pandemic has exacerbated problems with provisions, supply, and providers across the board. It often means girls may have to wait longer for a bus, and once at the SRH facilities, be met with shortages in medications or a lack of health personnel.

Whilst social barriers to SRH services were mentioned by all subgroups in Tanzania. Young mothers mention instances where social support acts as a key enabler in accessing SRH services compared to adolescent girls with no social support. One Tanzanian young mother shared that her mother advocated accessing SHR services to plan for her second pregnancy, which would allow her greater autonomy over her future.

> *(Taxi-moto) are not reliable because you can have accidents, in other words it is just putting everything in God's hands (...)*
>
> **Young Mother, 19**

> *Often some drivers of taxi-moto are criminals and sometimes they pass you in unreliable places, you don't want (them) to cross in order to take advantage of you, where they can abuse you, they are not trustworthy.*
>
> **Young Woman, 19**

Figure 18: Girls in Tanzania on barriers to accessing SRH services.

Social barriers impacting access to SRH services: Summary

AGYW face many mobility challenges when trying to access SRH services. However AGYW report facing greater challenges once mobility constraints have been overcome. Discriminatory norms about the appropriateness of AGYW accessing SRH services, rude attitude from health personnel and a lack of knowledge about SRH behaviours are all contributing barriers to accessing SRH services. There were a few instances where young mothers mentioned feeling ostracised by their peers in the community as they had a child and thus, many people made assumptions about their character. However, young mothers in the study are less hampered by social norms as it is deemed more acceptable for them to use SRH services, namely family planning clinics, relative to other sub groups.

Physical and social barriers related to GPWD

In this study, GPWD reported facing similar predicaments to those without. Costs and affordability and inaccessible modes of public transport came out as principal barriers. There were slight nuances in experiences such as discriminatory practices, and accessibility adjustments - especially as the impact of COVID-19 prevails. Indeed, in the data validation workshops, GPWD repeatedly stated that one of the reasons they found it tough to use public transport was due to the "rude attitude" of drivers towards them. GPWD in the study stated that the pandemic worsened their predicament; a resonating experience across the world where resource scarcity, school closures and the lack of social interactions impacted peoples lives greatly. But GPWD were challenged further by a lack of means of transportation, which forced them to travel long distances in cases of travel for basic needs fulfilment. Alongside the lockdowns limiting travel, the cost of using services increased, where buses or taxis would charge more for fewer passengers using the services: a principal barrier for those who cannot work due to their disability.

> *The challenge is a ride, during corona drivers went on strike, they didn't take anyone, and there was a challenge with food at home.*
>
> **Girl (Person) with Disabilities, 16**

> *(TEGA) Aah! And what if you want to go to the hospital but there is no public cars or bajaj that you usually use. How will you go to the hospital?*
> *(RESP) At hospital?*
> *(TEGA) Yes!*
> *(RESP) My mother will carry me on her back.*
>
> **Girl (Person) with Disabilities, 18**

Figure 19: GPWD on the impact of limited transport options during Covid-19.

> *I can decide to travel by bicycle, but I need to loan money to ride a bike. They do not accept it. I can also only get a car if I have money. They cannot offer me a free ride simply because I need money. It is not possible. As such, I do not rely on them much.*
>
> **Girl (Person) with Disabilities, 18**

> *I need special arrangements, I can not run after a bus (due to limb disability) when it leaves you behind, you just wait for the next one.*
>
> **Girl (Person) with Disabilities, 17**

> *Yes, there are challenges. For example, finding money for transportation is hard. If the distance is quite long it becomes hard for a person who has no transport money.*
>
> **Girl (Person) with Disabilities, 18**

> *Getting transport fees is the most difficult aspect, the hardest problem is that I am not working for money, there is no one who can call me to plant beans. (Paying for) services for transport, it's a problem. I don't have a walking stick, you see I don't even have a wheelchair to facilitate me.*
>
> **Person with Disabilities & Young Mother, 19**

Figure 20: GPWD experiences across the four countries.

> *We need the government to support us with public transport, our roads and our communities need drainage. The government has to help with public transport because it takes time to get a service.*
>
> **Girl (Person) with Disabilities, 16**

> *The road is not good, we need (the government) to repair the roads because most of the roads are bad.*
>
> **Girl (Person) with Disabilities, 16**

> *There is a challenge, when you take a ride, the road has a lot of potholes, the vehicle will be shaking and you might even hit someone.*
>
> **Girl (Person) with Disabilities, 16**

RECOMMENDATIONS AND CONCLUSIONS

Overall findings

The results in this study illustrate that barriers to mobility are complex and multifaceted for AGYW, young mothers and GPWD aged 15-19. Without a doubt, inconsistent pricing, road conditions, and other safety factors are major constraining factors as far as SRH access is concerned, but so are the prevailing social-norms regarding AGYW in many geographies that discourages and directly restricts free and equitable access to SRH services for youth in these countries.

Five major themes emerged as critical factors impacting youth access to SRHR resources:

1. Cost and affordability
2. Personal safety (e.g. Threat of sexual harassment and violence)
3. Fear and Frequency of RTCs
4. Social barriers impacting access to SRH services
5. Physical and social barriers related to GPWD

Our recommendations are aligned with suggestions made by respondents across all geographies and are presented by theme below.

1. KEY AREA: COST AND AFFORDABILITY

Cost and affordability came out strongly as a principal barrier across all subgroups. The main findings of this study reveal the poor state of motorised transport services and the absence of regulatory practices that make travel safe, affordable and accessible for young people. Respondents ask the government for reform on costs to enable girls to plan their travel and not be presented with differential costing practices.

Young mothers have more travel needs and still face barriers when travelling with children or when pregnant, such as the costs associated with using different modes of transport regularly.

Key recommendation:

- Consistent and affordable costing practises across IMT to ensure girls can plan their journeys, removing arbitrary and inconsistent costing practises.

2. KEY AREA: PERSONAL SAFETY (E.G. EXPOSURE TO HARASSMENT AND VIOLENCE)

In moving around, women and girls, from all four geographies, have to think about how they will protect themselves from sexual harassment and other forms of gender-based violence (GBV). AGYW, young mothers and GPWDs still lack access, especially to comprehensive sexuality education, which may increase their vulnerability to SRHR issues such as risk of HIV and sexual violence. Congestion and overcrowding on buses and other intermediate transportation leaves girls vulnerable to harassment and abuse. Ensuring personal safety across all groups, therefore, remains a priority when thinking about women's mobility.

The threat of violence is not limited to specific modes of transportation as many girls report feeling unsafe walking, as an institutional issue (e.g. due to precarious driving practices by drivers and regulations are not strictly enforced due to resource constraints). Therefore, the likelihood of RTCs makes travelling to health facilities difficult. Additionally, the findings show a disparity in terms of access to SRH services between markedly rural and urban areas wherein the urban areas had relatively more access compared with their rural counterparts. Rural respondents were more likely to be subject to poor road conditions, limited mobility options and SRH and health facilities are considerably further away.

Key recommendations

- Women-led mobility initiatives: Drawing inspiration from other countries e.g. in Uganda, the country's first female on-demand taxi drivers Taxi Divas was launched in October 2020. The drivers are specifically trained in self-protection to address sexual harassment from clients. Other examples include women operated IMT, or; as walking is a popular choice it may be possible to create a community walking bus facilitated by "conductors" who walk alongside a group of girls to make their journey safer.
- Panic alert using digitised tools or SMS services to emit a sound or connect to local authorities that can prevent or aid in a possible attack.
- Increased social norms and behavioural change programming for the male population to decrease acts of sexual harassment and other forms of violence perpetrated against girls and women, in particular while in transit.

3. KEY AREA: ROAD SAFETY

All subgroups mentioned concerns around the road, particularly the high incidence of RTCs due to precarious driving practices and lack of safety regulation. Recommendations to improving safety on the road include addressing poor and, sometimes, unlicensed IMT drivers, as well as addressing the lack of security personnel in known 'unsafe' areas. The findings (from girls and corroborated by expert interviews) suggest that RTCs (or fear of them) are a barrier to mobility and accessing services.

Key recommendations:

- Greater regulatory systems and traffic safety education campaigns: ensure drivers are adhering to the rules of the road safely.
- Greater investment in walking and cycling infrastructure: Often walking and cycling do not receive as much investment compared to vehicular transport infrastructure. The findings suggest many girls choose to walk and personal safety issues related to road conditions can sometimes make their journeys difficult.
- Greater investment in public transport renovations: Local authorities/bodies can emphasise renovating infrastructure and vehicles and regulate the conditions of different mobility types to ensure safety for all travellers.

4. KEY AREA: SOCIAL BARRIERS IMPACTING ACCESS TO SRH SERVICES

When considering the journeys adolescents girls make, the study illustrates not only the difficulties of different transport modalities, but also the stigmatising social-norms experienced by girls when accessing SRH services. Thus, there is a need to work on changing attitudes towards youth access to SRH services, in addition to ensuring these services are physically available to youth and able to meet their needs and wants.

In geographies where community health workers do provide information, most of it is rudimentary and not meant to empower the youth to make informed decisions. It should be noted, however, that some young mothers reported having good relationships with community health workers and some live close to facilities perhaps as social norms are less discriminatory towards mothers accessing SRH and

other health services. Results also show that the youth lack access to youth-friendly reproductive health services due to community stigma towards unmarried girls seeking SRH support.

Key recommendations:

- Confidence building and family negotiation skills for SRHR and service access to help navigate the social-norms landscape barrier for young people.
- Establish strong NGO connections in all areas that can support need-based community transport to and from hospitals/clinics.

5. KEY AREA: PHYSICAL AND SOCIAL BARRIERS RELATED TO GPWD

GPWD have limited travel needs compared to the other groups, however, discriminatory practices and inaccessible modes of transport can present as a barrier to mobility for them.

This study suggests GPWDs could benefit from better regulation in the transport sector, particularly those with physical disabilities.

Key recommendation:

- Mandatory longer waiting times for buses and private transport options, low-floor buses/ fleets, sensitisation of drivers, better sign-posting, and discounted pricing

Conclusions

The findings show that the experiences of all adolescent girls and young women is not monolithic. While much of the barriers are consistent across geographies, there are important differences between and within subgroups. Further participatory research and action is needed to understand further how norms affecting adolescents' SRHR can be changed if physical mobility issues are addressed and encourage youth-inclusive political participation and empowerment in transport planning.

ANNEXES

A. DATA COLLECTION TOOK PLACE IN VARIOUS LOCATIONS WITHIN FOUR COUNTRIES:

- **Malawi:** Lilongwe (Likuni/Chinsapo: urban & Namitete: rural), Mzimba (Mzuzu City: urban & Ekwendeni: peri-urban) and Zomba (Chinamwali: urban & Thondwe: rural).
- **Tanzania:** Temeke region of Dar es Salaam (urban) and Morogoro (rural).
- **Nigeria:** Northern Nigeria: Nassarawa (urban), Ungogo (peri-urban) and Kumbotso (rural).
- **Rwanda:** Nyagatare, Karongi, Rubavu (rural); Gasabo, Nyarugenge, Huye (urban) and Musanze, Ruhango, Bugesera (peri-urban).

B. DATA ANALYSIS - TECHNICAL OVERVIEW

Interviews were analysed using a GE deductive analysis approach and framework. The project delivers the following types of analyses:

1. Qualitative Segment/Code Summaries: Coded quotes that fall into each thematic code.
2. Insight Memos - Summaries of the main takeaways from each sub-group interviewed.
3. Content Analysis Folios- Main takeaways in a root-cause analysis format.
4. Case studies/Case summaries from respondent interviews.
5. Summary Notes and Issue Maps from expert interviews.
6. Narrative Insights Report.
7. A film produced from TEGA Ethnographies.

Qualitative segment code summaries were used to create charts that display relevant quotes from respondents on the main issues that emerged from the data and insight memos were used to arrive upon the main findings of the study on personal safety and affordability of transport for all categories of respondents. Case studies and summaries were used to arrive upon and reinforce the main findings of the study and have been made available in the annexure to use in any media or outputs that may wish to use a storytelling narrative, Summary notes and issue maps from expert interviews helped us contextualise the findings and helped guide the literature review chapter. TEGA experience dossiers were captured as a part of the data validation workshops and helped validate the relevance and truth of record of the findings for the intended target group.

C. RESEARCH INSTRUMENTS

To view 'Research Intruments' douments, please visit: https://docs.google.com/spreadsheets/d/15ZIj6r3N-31h-VAIVG5B_-uJpXRXOoxE/edit?usp=sharing&ouid=117735876416777830196&rtpof=true&sd=true

D. LITERATURE REVIEW

To view 'Literature Review' documents, please visit: https://docs.google.com/document/d/1AonHvwhLrhm0Q8qjWEeInOPjwSKqhefMgR3pFez0v9Y/edit?usp=share_link

E. CASE STUDIES

To view 'Case Studies', please visit: https://drive.google.com/drive/folders/1gVo1D-LGxIv_UBjtEYNsVMY4fJghGvvN?usp=share_link

F. INSIGHT MEMOS

To view 'Insight Memos' documents, please visit: https://drive.google.com/drive/folders/17oxFd1PgdPIJjfROO6PgHcDx054IaAss?usp=share_link

G. TRANSCRIPTS OF EXPERT INTERVIEWS (I, II, III, IV) AND ISSUE MAP

To view Transcripts of Expert Interviews, please visit:

Transcript I:
https://docs.google.com/document/d/1L_mDd48I-NLInekJswMXRtm4P7WGLzKI/edit?usp=share_link&ouid=117735876416777830196&rtpof=true&sd=true

Transcript II:
https://docs.google.com/document/d/1mCip51ufnYlCXXBPMYD0p-aZZ43J13RM/edit?usp=share_link&ouid=117735876416777830196&rtpof=true&sd=true

Transcript III:
https://docs.google.com/document/d/1F77zw92f1sM5LrFMYbrSpCpsBqxYhSAd/edit?usp=share_link&ouid=117735876416777830196&rtpof=true&sd=true

Transcript IV:
https://docs.google.com/document/d/1Pin6Av9BHA2EE9UWhBAKMMKgsKHA2PYZ/edit?usp=share_link&ouid=117735876416777830196&rtpof=true&sd=true

To view the Issue Map, please visit:
https://docs.google.com/presentation/u/0/d/1343PAilk0FlTnpCLeIspD819LZ4-TWiUxbDNbHOuBEI/edit

ENDNOTES

ENDNOTES

1. Ahmed, A., & McGovern, T. (2020). Equity in Health: Sexual and Reproductive Health and Rights.

   Bukuluki, P., Kisaakye, P., Mulekya, F., Mushomi, J., Mayora, C., Palattiyil, G., ... & Nair, H. (2022). Disruption in accessing sexual and reproductive health services among border populations during COVID-19 lockdown in Uganda. Journal of Global Health, 12.
2. Ivanova, O., Rai, M., & Kemigisha, E. (2018). A systematic review of sexual and reproductive health knowledge, experiences and access to services among refugee, migrant and displaced girls and young women in Africa. International Journal of Environmental Research and Public Health, 15(8), 1583.
3. Priya Uteng, T., & Turner, J. (2019). Addressing the linkages between gender and transport in low-and middle-income countries. Sustainability, 11(17), 4555.
4. Kronsell, A., Smidfelt Rosqvist, L., & Winslott Hiselius, L. (2016). Achieving climate objectives in transport policy by including women and challenging gender norms: The Swedish case. International Journal of Sustainable Transportation, 10(8), 703-711.
5. Priya Uteng, T., & Turner, J. (2019). Addressing the linkages between gender and transport in low-and middle-income countries. Sustainability, 11(17), 4555.
6. Kronsell, A., Smidfelt Rosqvist, L., & Winslott Hiselius, L. (2016). Achieving climate objectives in transport policy by including women and challenging gender norms: The Swedish case. International journal of sustainable transportation, 10(8), 703-71.
7. Ahmed, A., & McGovern, T. (2020). Equity in Health: Sexual and Reproductive Health and Rights.

   Bukuluki, P., Kisaakye, P., Mulekya, F., Mushomi, J., Mayora, C., Palattiyil, G., ... & Nair, H. (2022). Disruption in accessing sexual and reproductive health services among border populations during COVID-19 lockdown in Uganda. Journal of Global Health, 12.
8. Church, K., Gassner, J., & Elliott, M. (2020). Reproductive health under COVID-19–challenges of responding in a global crisis. Sexual and reproductive health matters, 28(1), 1773163.
9. UN Women. In Focus: Gender equality matters in COVID-19 response. Retrieved from https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response?gclid=Cj0KCQiA34OBBhCcARIsAG32uvMPydjm-suckD0phUmTonZ_brriF6D1MV0ontVhgwIJiygYsduKJGMaAsuNEALw_wcB .

   Balogun, M., Banke-Thomas, A., Sekoni, A., Boateng, G. O., Yesufu, V., Wright, O., ... & Ogunsola, F. (2021). Challenges in access and satisfaction with reproductive, maternal, newborn and child health services in Nigeria during the COVID-19 pandemic: a cross-sectional survey. PloS one, 16(5), e0251382.
10. Ivanova, O., Rai, M., & Kemigisha, E. (2018). A systematic review of sexual and reproductive health knowledge, experiences and access to services among refugee, migrant and displaced girls and young women in Africa. International Journal of Environmental Research and Public Health, 15(8), 1583.
11. Porter, G., & Turner, J. (2019). Meeting young people's mobility and transport needs: Review and prospect. Sustainability, 11(22), 6193.
12. El Habti, Hicham (2022, September 19). Why Africa's youth hold the key to its development potential. World Economic Forum. Retrieved from https://www.weforum.org/agenda/2022/09/why-africa-youth-key-development-potential/
13. For a list of the sustainable development goals see here: https://sdgs.un.org/goals
14. Porter, G., & Turner, J. (2019). Meeting young people's mobility and transport needs: Review and prospect. Sustainability, 11(22), 6193.
15. Safetipin & FIA Foundation (2020). Expanding Access to opportunities for girls and women: Working towards safe mobility. FIA Foundation Research Series, Paper 12 (2020)

   Allen, H., Vanderschuren, M. & The University of Cape Town, South Africa, (2016). Safe and Sound. FIA Foundation.
16. Kenyon, S., Lyons, G., & Rafferty, J. (2002). Transport and social exclusion: investigating the possibility of promoting inclusion through virtual mobility. Journal of Transport Geography, 10(3), 207-219.
17. Titheridge, H., Mackett, R. L., Christie, N., Oviedo Hernández, D., & Ye, R. (2014). Transport and poverty: a review of the evidence.
18. Currie, G., & Delbosc, A. (2010). Modelling the social and psychological impacts of transport disadvantage. Transportation, 37, 953-966.
19. Vanderschuren, M. J., & Nnene, O. A. (2021). Inclusive planning: African policy inventory and South African mobility case study on the exclusion of persons with disabilities. Health Research Policy and Systems, 19(1), 1-12.)
20. Yousafzai, A. K., Dlamini, P. J., Groce, N., & Wirz, S. (2004). Knowledge, personal risk and experiences of HIV/AIDS among people with disabilities in Swaziland. International journal of rehabilitation research, 27(3), 247-251.)
21. Frohmader, C., & Ortoleva, S. (2014). The sexual and reproductive rights of women and girls with disabilities. In ICPD International Conference on Population and Development Beyond.
22. United Nations (2022). Adolescents and Youth Dashboard - Africa | United Nations Population Fund. Retrieved from https://www.unfpa.org/data/adolescent-youth/.
23. World Bank (2018). Nigeria Data. Retrieved from https://data.worldbank.org/country/nigeria

24. The World Health Organisation (WHO, 2021). Estimated number of people (all ages) living with HIV. Retrieved from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-number-of-people--living-with-hiv Accessed January 31, 2023.

    Badru, T., Mwaisaka, J., Khamofu, H., Agbakwuru, C., Adedokun, O., Pandey, S. R., ... & Torpey, K. (2020). HIV comprehensive knowledge and prevalence among young adolescents in Nigeria: evidence from Akwa Ibom AIDS indicator survey, 2017. BMC Public Health, 20, 1-10.0

25. The Federal Republic of Nigeria. National Population Commission (NPC) [Nigeria] and ICF. (2019). Nigeria Demographic and Health Survey 2018.
26. The Federal Republic of Nigeria. National Population Commission (NPC) [Nigeria] and ICF. (2019). Nigeria Demographic and Health Survey 2018.
27. World Bank (2018). Nigeria Data. Retrieved from https://data.worldbank.org/country/nigeria
28. The Federal Republic of Nigeria. National Population Commission (NPC) [Nigeria] and ICF. (2019). Nigeria Demographic and Health Survey 2018.
29. UNESCO (2021). The journey towards comprehensive sexuality education: global status report. Paris: UNESCO
30. Referred to as "Keke Napep" full-size adult tricycle prices range from ₦180,000 to ₦450,000 depending on the brand and usage to operate. These have replaced the original motorbike ride options, Okada, as regulations banned those. There are also fully open and modified tricycles available, but much less safe to ride in. Rides on a tricycle cost upwards of ₦10 per drop. Studies show that Nigeria's male youth are increasingly opting to invest in and own/operate by renting these tricycles in lieu of full-time work elsewhere.
31. Bishop, T., Barber, C., Charman, S., & Porter, G. (2018). Enhancing understanding on safe motorcycle and three-wheeler use for rural transport. Inception Report, Amend and Transaid. ReCAP project RAF2114A. Retrieved from www. research4cap.org.
32. Igbokwe, U. L., Ogbonna, C. S., Ezegbe, B. N., Nnadi, E. M., & Eseadi, C. (2020). Viewpoint on family life and HIV education curriculum in Nigerian secondary schools. Journal of International Medical Research, 48(1), 0300060519844663.

    Agbemenu, K., Hannan, M., Kitutu, J., Terry, M. A., & Doswell, W. (2018). "Sex will make your fingers grow thin and then you die": The interplay of culture, myths, and taboos on African immigrant mothers' perceptions of reproductive health education with their daughters aged 10–14 years. Journal of Immigrant and Minority Health, 20, 697-704.

33. Smith, N. (2011). The face of disability in Nigeria: a disability survey in Kogi and Niger States. Disability, CBR & Inclusive Development, 22(1), 35-47.
34. Aderemi, Pillay, & Esterhuizen 2013; Groce, Yousafzai, & van der Maas 2007; Olaleye et al. 2007)
35. Republic of Malawi: National Statistical Office (2018). 2018 Malawi population and housing census report. National Statistical Office, Malawi.
36. Republic of Malawi: National Statistical Office (2021). Malawi Multidimensional Poverty Index Report. National Statistical Office, Malawi.
37. The World Health Organisation (WHO, 2021). Estimated number of people (all ages) living with HIV. Retrieved from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-number-of-people--living-with-hiv Accessed January 31, 2023.
38. Republic of Malawi: National Statistical Office and ICF. (2017). Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.
39. Republic of Malawi: National Statistical Office and ICF. (2017). Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.
40. World Bank (2017) . Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant. World Bank. Retrieved https://data.worldbank.org/indicator/SP.MTR.1519.ZS
41. UNESCO (2021). The journey towards comprehensive sexuality education: global status report. Paris: UNESCO
42. Republic of Malawi: National Statistical Office and ICF. (2017). Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.
43. Sundet, M., Mulima, G., Kajombo, C., Gjerde, H., Christophersen, A. S., & Young, S. (2020). Adult pedestrian and cyclist injuries in Lilongwe, Malawi: a cross-sectional study. Malawi Medical Journal, 32(4), 197-204.
44. Schlottmann, F., Tyson, A. F., Cairns, B. A., Varela, C., & Charles, A. G. (2017). Road traffic collisions in Malawi: Trends and patterns of mortality on scene. Malawi Medical Journal, 29(4), 301-305.
45. Chikapa, T. M. (2021). Gender culture and Malawian women's reconciliation of work and family responsibilities. Gender in Management: An International Journal.
46. Izugbara, C. O., & Undie, C. C. (2008). Masculinity scripts and the sexual vulnerability of male youth in Malawi. International Journal of Sexual Health, 20(4), 281-294.
47. Wigle, J. M., Paul, S., Birn, A. E., Gladstone, B., Kalolo, M., Banda, L., & Braitstein, P. (2022). Participation of young women in sexual and reproductive health decision-making in Malawi: Local realities versus global rhetoric. PLOS Global Public Health, 2(11),

48. World Bank (2021). Tanzania Data. Retrieved from https://data.worldbank.org/country/tanzania
49. United Nations (2022). Adolescents and Youth Dashboard - Africa | United Nations Population Fund. Retrieved from https://www.unfpa.org/data/adolescent-youth/.
50. World Bank (2018). Tanzania Data. Retrieved from https://data.worldbank.org/country/tanzania
51. The World Health Organisation (WHO, 2021). Estimated number of people (all ages) living with HIV. Retrieved from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-number-of-people--living-with-hiv Accessed January 31, 2023.
52. Republic of Tanzania: Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF. (2016). Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16.
53. Republic of Tanzania: Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF. (2016). Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16.
54. World Bank (2017) . Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant. World Bank. Retrieved https://data.worldbank.org/indicator/SP.MTR.1519.ZS
55. World Bank (2016). Women who were first married by age 18 (% of women ages 20-24). Retrieved from https://data.worldbank.org/indicator/SP.M18.2024.FE.ZS
56. UNESCO (2021). The journey towards comprehensive sexuality education: global status report. Paris: UNESCO
57. World Bank (2021). Shifting the Mobility Paradigm of Intermediate Cities in Tanzania: Urban Transport for People.
58. Mosha, I., Mapunda, G., Mbotwa, C., & Nyamhanga, T. (2022). Sexual harassment in public transport among female university students in Dar es Salaam, Tanzania. Tanzania Journal of Health Research, 23(4), 1-11.
59. Porter, G., Hampshire, K., Abane, A., Munthali, A., Robson, E., Mashiri, M., ... & Mashiri, M. (2017). Conclusion: Reflecting on Theory and Method, Practice and Policy. Young People's Daily Mobilities in Sub-Saharan Africa: Moving Young Lives, 227-244.
60. Nkata, H., Teixeira, R., & Barros, H. (2019). A scoping review on sexual and reproductive health behaviors among Tanzanian adolescents. Public health reviews, 40(1), 1-15.
61. Pilgrim, N., Jani, N., Mathur, S., Kahabuka, C., Saria, V., Makyao, N., ... & Pulerwitz, J. (2018). Provider perspectives on PrEP for adolescent girls and young women in Tanzania: The role of provider biases and quality of care. PloS one, 13(4).
62. United Nations (2022). Adolescents and Youth Dashboard - Africa | United Nations Population Fund. Retrieved from https://www.unfpa.org/data/adolescent-youth/.
63. World Bank (2016). Rwanda Data. Retrieved from https://data.worldbank.org/country/rwanda
64. The World Health Organisation (WHO, 2021). Estimated number of people (all ages) living with HIV. Retrieved from https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-number-of-people--living-with-hiv Accessed January 31, 2023.
65. (World Bank, 2020). Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant. World Bank. Retrieved https://data.worldbank.org/indicator/SP.MTR.1519.ZS
66. (World Bank, 2020). Women who were first married by age 18 (% of women ages 20-24). Retrieved from https://data.worldbank.org/indicator/SP.M18.2024.FE.ZS
67. Republic of Rwanda. National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF. (2021). Rwanda Demographic and Health Survey 2019-20. Final Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
68. Republic of Rwanda (2012). Public Transport Policy and Strategy for Rwanda.
69. Stavropoulou, M., & Gupta-Archer, N. (2017). Adolescent girls' capabilities in Ethiopia: The state of the evidence. London: GAGE/Overseas Development Institute.
70. Republic of Rwanda. National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF. (2021). Rwanda Demographic and Health Survey 2019-20. Final Report. Kigali, Rwanda, and Rockville, Maryland, USA: NISR and ICF.
71. (DFID, n.d.). Regional Analysis of Youth Demographics: Rwanda." Briefing paper. DFID. Retrieved from https://assets.publishing.service.gov.uk/media/5af954b2e5274a25dbface35/Rwanda_briefing_note__Regional_Analysis_of_Youth_Demographics_.pdf Accessed January 05, 2023

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