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Understanding the Barriers to Girls' School Return: Girls' Voices from the Frontline of the COVID-19 Pandemic in East Africa

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Photo credit - *Girl Up Initiative Uganda (Uganda)*

AMPLIFY's mission is to amplify the voices, work, and collective impact of community-driven organizations focused on the power and potential of adolescent girls. We do this by strengthening organizational efficiencies, creating opportunities for collaborative learning, building evidence and engaging in global policy and practice fora. AMPLIFY is a collective of partner organizations, governed by an East Africa-based Board of Directors elected from amongst the membership.

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EXECUTIVE SUMMARY

In March 2020, with the declaration of the global Coronavirus pandemic, schools closed around the world. In East Africa, the first school re-openings were in Tanzania in June, but schools remained closed in Kenya and Rwanda for seven to ten months and in Uganda for over one year. Research shows that the negative impacts of both the economic devastation of the pandemic and the associated school closures were particularly acute for vulnerable children and most especially for girls. [1] [2]

This study examines the pandemic-related experiences of 382 vulnerable adolescent girls in Kenya, Rwanda, Uganda and Tanzania who were school-enrolled prior to the COVID-19 closures. Participants largely came from rural communities, living in the catchment areas of the AMPLIFY Girls community-driven organizations (CDOs) who collaborated on this study. Focus Group Discussions (FGDs) were conducted with girls who had already or who were planning to return to school, and In-Depth Interviews (IDIs) were conducted with girls who had dropped out during the pandemic. Approximately 56% of the 108 girls who had dropped out of school were currently or recently pregnant, and approximately 30% of girls who said they were planning to return to school also reported being pregnant.

At the highest level, our findings suggest that pregnancy is the primary driver of girls' dropout from school during the pandemic, but that pregnancy is a symptom of underlying, acute, economic vulnerabilities and is augmented by situations of social and physical isolation that are often mutually reinforcing. **The overwhelming majority of FGD participants cited transactional sex for basic goods (such as food, clothing, and menstrual hygiene products) as the primary cause of unintended pregnancies in their communities.** Accordingly, we found that economic precarity leading to transactional sex and unintended pregnancies was the most common pathway leading to girls' dropout.

PRIMARY PATHWAY TO GIRLS' DROPOUT

Economic Hardship → Transactional Sex → Unintended Pregnancy → School dropout
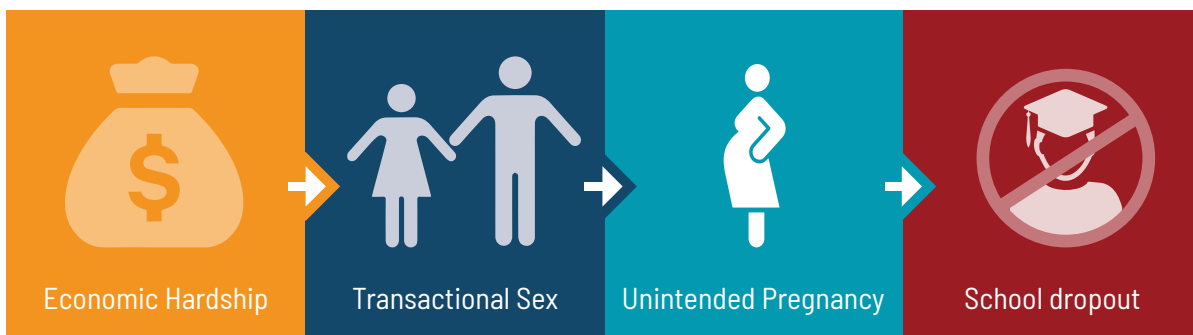
1. Rafaeli, Tal, and Geraldine Hutchinson. (2020) "The Secondary Impacts of COVID-19 on Women and Girls in Sub-Saharan Africa." United Kingdom: K4D: Knowledge, Evidence and Learning for Development.

2. Neetu J., Roy C., Mwangi, M., Raval, N. & McGovern, T. (2021). COVID-19 and gender-based violence (GBV): hard-to-reach women and girls, services, and programmes in Kenya. Gender & Development, 29:1, 55-71.

Resulting from pandemic-related pregnancies, we found that the primary barriers to girls' school return are toxic home, school and community environments that view pregnancy from a moral lens. Whereas respondents very rarely reported that their families were unsupportive of girls' education, girls frequently noted that their communities were discouraging towards *pregnant* girls' education. **Our research suggests that the social stigma surrounding teen pregnancy and motherhood is the single biggest factor keeping girls from returning to school post-pandemic.**

Although pregnancy and stigmatization of pregnancy were the most frequently cited reasons for girls' drop out or failure to return to school, these barriers exist within a tapestry of vulnerabilities, and complex challenges facing girls during the pandemic. To make sense of the universe of the barriers to girls' school return, we group the phenomena emerging from this study into the following five categories:
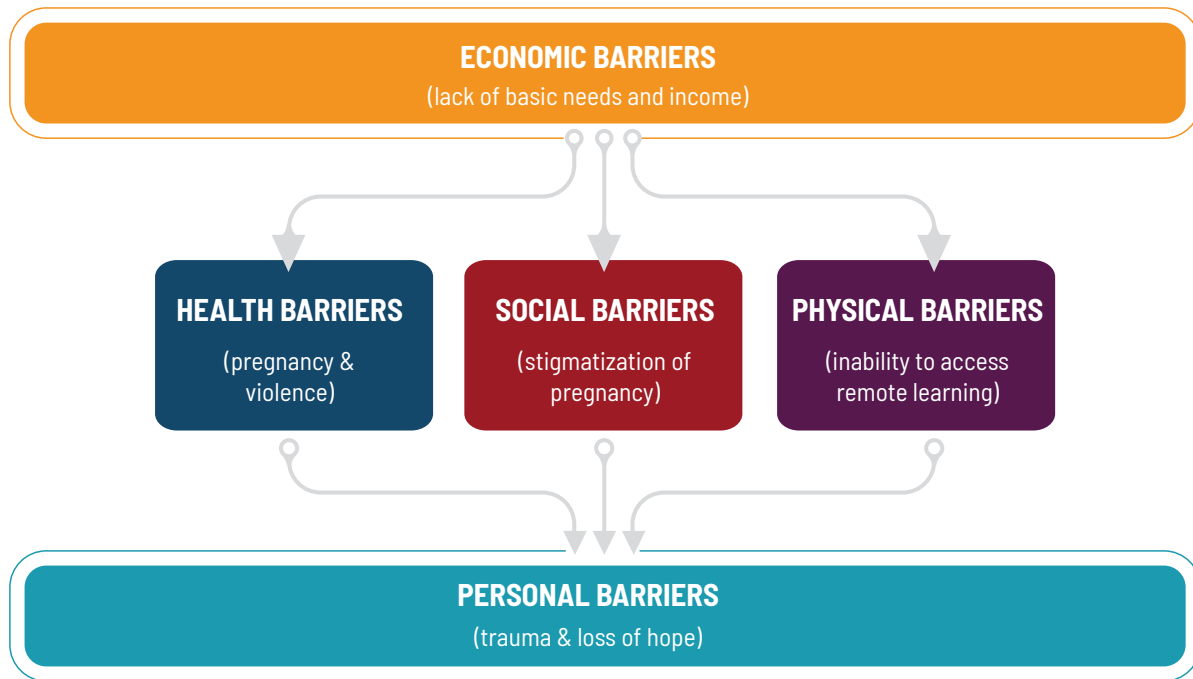
Physical Barriers that kept girls from engaging in remote learning and physically kept them from accessing school. These included unequal access to remote learning technologies, unsupportive learning environments, and relocation and/or displacement.

Economic Barriers such as loss of guardian or guardian income, leading to a lack of basic needs, increasing pressure to earn income, food insecurity, and almost uniformly, a lack of financial resources for school materials and fees.

Health Barriers primarily unintended pregnancies, and health outcomes associated with girls' experiences of both sexual and physical violence, violence against pregnant girls, reduced access to sexual and reproductive health information and services and girls' inability to access sufficient nutrition while pregnant.

Social Barriers centering around the stigmatization and isolation of pregnant girls both at home and at school. These barriers included hostile home environments and toxic school and peer culture, as well as early and forced marriage.

Personal Barriers characterized especially by an acute loss of hope for the future, increasing social, economic and academic anxieties that stem from their wider experience of the other barriers cited in this study.

FIGURE 1 ILLUSTRATES PROPORTIONATELY ALL THE BARRIERS MENTIONED BY GIRLS, ACCORDING TO THE FREQUENCY OF MENTION.

Notably, these barriers were related to each other in very specific ways. The economic vulnerabilities cited by girls served to drive the health and social barriers to school return (most of which centered around the condition of early and unintended pregnancies). The cascading impact of economic hardship leading to other types of vulnerabilities in the form of violence, food insecurity, and social stigma served to compound girls' anxieties about school, their futures, and academic performance and created a sense of hopelessness that was pervasive throughout the study population. This hopelessness was augmented by physical barriers: specifically, girls' struggle to access remote and digital learning which heightened their fears of falling behind, being socially isolated, and being 'too old' to return." These relationships are depicted in Figure 2.

FIGURE 2 RELATIONSHIPS BETWEEN BARRIERS TO GIRLS' SCHOOL RETURN

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ECONOMIC BARRIERS
(lack of basic needs and income)

HEALTH BARRIERS        SOCIAL BARRIERS        PHYSICAL BARRIERS
(pregnancy &           (stigmatization of     (inability to access
violence)              pregnancy)             remote learning)

PERSONAL BARRIERS
(trauma & loss of hope)
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Our analysis makes clear that girls are experiencing protracted trauma during COVID-19—trauma that is much larger and long-lasting than the period of school closures. The daily experience of violence, acute poverty, stress, anxiety, stigmatization and insecurity have all served to deteriorate girls' psychological and emotional health, making school return unlikely without sustained and holistic care for multiple facets of their wellbeing.

Girls offered many important solutions and policies that they felt could support their continued learning. Recognizing the complex nature of their own needs, common features of these recommendations were their holistic nature and their deep care for the social and emotional aspects of girls' wellbeing, particularly pregnant girls. The vast majority of girls felt that psychosocial support, combined with community norm shift and sensitization around *pregnant* girls' value, their needs, rights and opportunities would be profoundly impactful. Girls had many suggestions for government including: strengthening reintegration policies, making schools more supportive of pregnant girls' and young mothers' needs, in addition to community-based strategies for preventing early and unwanted pregnancies. Girls also wanted better access to the necessary tools for participating in remote learning and more structured support and encouragement for engaging in home-learning.

Our synthesis of these findings and girls' recommendations leads us to the following calls to action to support girls' school return. We divide these into actions that should be taken immediately to halt attrition in the short term, and actions that should be taken in the medium and long term to prevent future dropout.

SHORT-TERM ACTIONS:

- **Provision of immediate economic relief—specifically menstrual health supplies, food and school fees** for both pregnant and non-pregnant girls. Removing the immediate economic pressures associated with risky behaviors and dropout is a necessary and basic prerequisite for returning girls to school.

- **Trauma counseling and mentorship. The vast majority of girls are experiencing both acute and protracted trauma.** Psychosocial support and counseling are necessary to encourage girls (both pregnant and not pregnant) that it is possible to return to school. Mentorship by either peers or adult women can provide girls with a sense of connection, belonging, and hope.

- **Pathways for pregnant girls to continue learning.** As work is undertaken in the long term to make schools more girl-friendly and less toxic to pregnant girls, pregnant young women require opportunities for learning outside the formal system. This might include private tutoring, private schooling, vocational training or other creative solutions.

- **Investment in physical and social infrastructure for digital learning.** The pandemic is long from over in East Africa, and school closures are likely to continue. Vulnerable girls require immediate access to remote learning resources such as data, devices or hardcopy materials, combined with communities of support such as study circles and teacher guidance to help them remain engaged and motivated.

LONG-TERM ACTIONS:

- **Make schools girl-friendly and supportive of pregnancy and young-motherhood through policy and enforcement.** Explicit policy action is needed to support pregnant girls and young mothers' right to complete their education. This must be combined with protracted engagement with schools to shift social stigmas and school-based policies around how pregnant girls are treated and what resources are made available to them to support their physical and emotional health and well-being.

- **Combat social stigma around pregnancy, and raise awareness about girls' rights and needs in the community.** This work is best done through community sensitization efforts and facilitated dialogue with girls, families, community leaders, men and boys.

- **Establish psychosocial support networks** for girls and their families to navigate the social, emotional and health consequences related to unintended pregnancies, violence, and economic hardship. These might take a variety of forms including mental health services, peer-to-peer counseling, and/or adult mentorship.

- **Establish multiple access points for SRH information and services.** The COVID-19 pandemic has laid bare the ways in which girls rely almost entirely on schools for sexual and reproductive health information and access to menstrual health hygiene products. Finding ways to embed these resources creatively within communities will improve resilience and prevent health vulnerabilities in the future.

We further recommend one over-arching call to action in both the short-term and long-term:

Invest in community driven organizations to do this work. Schools, governments and multi-national NGOs are not well-suited to meet the variety, complexity and long-term trajectory of what girls require. Supporting girls' mental health, effecting community norm change, creating and maintaining community-based sources of support in the short and long term can only be done by organizations that have established community relationships and trust, flexible and creative approaches, access to the most vulnerable girls, and the ability to adapt to rapidly to changing local and global crises.

These actions are not an either/or recommendation: stemming pandemic losses in girls' education will require that we pursue all of these strategies simultaneously. Just as our findings suggest that girls' needs are layered and complex, the supports they require are holistic, deep and best delivered by organizations already embedded within communities. Rather than bypass CDOs in non-crisis times, donors and governments should proactively invest in CDOs as part of a long-term commitment to community and global resilience.

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