COMMENTARY

SRHM SEXUAL AND REPRODUCTIVE HEALTH MATTERS
MORE THAN A JOURNAL

The importance of power and agency in a universal health coverage agenda for adolescent girls

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Keywords: adolescent girls, violence, economic justice, access to services, agency, gender norms

Introduction

Achieving the ambitious Universal Health Coverage (UHC) agenda requires challenging and changing entrenched gender and social norms, and structures of power, in order to reach across identities and towards the most vulnerable, marginalised and excluded. Since the September 2019 endorsement by UN member states of the UHC Political Declaration, we have seen calls for increased attention to adolescent health as a core element of UHC, and for a gender lens on UHC targets and goals.[1,2] Adolescent girls exist at a troubled intersection of discriminations based on gender and age, which is exacerbated by other structural inequalities for all too many girls and vulnerable adolescents. Drawing on Plan International's extensive work with adolescent girls, we recommend a feminist reframing of girls' access to sexual and reproductive health and rights (SRHR) which centres their agency and decision-making beyond the point of health services. Looking at the UHC agenda through the lens of adolescent girls' agency and decision-making opens a vital perspective on both its possible short-comings and transformative potential.

In looking at girls' health access through an agency lens, we must first acknowledge both the myriad contexts and identities that shape their decision-making, and the shifting ways in which adolescent girls navigate their relationships to power in order to define and realise their opportunities and aspirations.[3] We will highlight here the need to fully understand and unpack the power structures that regulate girls' mobility, sexuality, and educational and economic opportunities, and in particular the use of violence to maintain systems of gender inequalities, in order to transform health systems to reach them. In order to ensure that UHC does, in fact, reach adolescent girls and other vulnerable and marginalised adolescents, we need to exercise a greater understanding of the influence and impacts of social norms and gender inequality on their agency and health decision-making.

Gender inequalities and girls' access to health

There is a robust and growing body of literature on the impact of gender norms and inequalities in health.[4] Health systems must account for the individual and structural impacts of gender- and age-based inequalities, including:

- lack of access to or prioritisation for household resources, leading to delays in seeking services and increased reliance on informal providers;[5]
- increased burden of caretaking responsibilities, increasing exposure to disease;[5]
- disproportionate risks for violence, in particular sexual violence, with associated reproductive and mental health impacts and increased risk for self-harm;[6] and
- restrictions on girls' mobility and access to information.[7]

The influence of gender inequality on girls' and women's health is pervasive: gender norms dictate not only their access to health information and services, but also what and when girls eat, how they move through their communities, what types of educational and economic opportunities are available to them, and how they spend their

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increasingly limited free time. There is considerable evidence around the restriction of girls' mobility, including expectations of how they should behave in public, and the harmful effects that these restrictions and expectations have on their development and health.[7] As girls age through adolescence, restrictions on their mobility become more severe, while boys experience fewer restrictions on their time and movements: both shifts, which are grounded in gender norms and inequalities, have profound effects on their changing health risks.[1,3] The burden of household care work, which increases as girls age, alienates them from public life, restricting their ability to access health care, enter into the civic space, engage with their peers and friends, and stunts their social development.[8] This withdrawal from public life has dire consequences for girls' and women's self-worth, self-efficacy, and empowerment, contributing to a lack of agency over their bodies and lives. Social and gender norms often restrict girls' exposure to the public realms of society, restricting their access to their peers and potential role models within community spaces and limiting their conceptions of what opportunities are available to them.[3]

Access to health services is also impacted by policies setting differential ages of consent for girls and boys, or for married or unmarried adolescents, which frequently codify and reinforce gender norms.[9] The lack of agency experienced by adolescent girls is exacerbated by the double-bind issue of consent: "While adolescents are in need of protective policies, their ability to consent for their own care cannot be undermined."[1] Health structures and services are shaped by both policy and community norms that reinforce parental or spousal control over girls' access to information, treatment, and care. In their call for greater attention to adolescent health in the UHC agenda, Plan International UK and partners note that "many countries will need to rethink how adolescence is dealt with in current legal frameworks" in order to expand a universal service model to adolescents.[1]

Rethinking poverty and health decision-making

The gendered lack of control over their own or household resources has a disproportionate impact on adolescent girls. For women and girls, access to financial resources is frequently inversely related to their health care need, making public financing of integrated health services vital to make them accessible at the point of delivery. It is entirely feasible to use national and global financing mechanisms to reorient existing, vertical health systems and services to implement comprehensive, integrated, user-centred primary health programmes.[10]

However, we can only improve adolescent health outcomes for girls if we take removing financial barriers to health care as a starting point. We must also begin to look at how poverty interplays with gender, violence, and other forms of marginalisation to impact the agency and health decision-making of adolescent girls. Outside of the health system, poverty impacts girls' lives and choices, driving lack of access to education, increased burdens of household and care work, and pressures placed on girls to marry early to relieve their economic burden on their families.[5] As girls enter adolescence, poverty combines with pre-existing gender inequalities to curtail the opportunities they perceive as available to them and increase the social pressure they experience to perceive their economic value in terms of their sexual and reproductive potential.[11] The need to protect their reputation, and in turn their ability to marry well, is too often seen as their best opportunity to contribute to their families in a setting where educational employment opportunities are largely absent, leading girls to further restrict their own access to health, in particular sexual and reproductive health, services. The internalisation of these norms factors into the decisions they make about what risks they are willing to take in pursuit of education, employment, and health services.[11] Ensuring coverage for girls in UHC financing will require additional investments into financial protection and literacy and a radical revaluing of girls' economic power and potential.[2]

Expanding the vulnerability lens: the impact of violence on freedom of choice

The risk, or perceived risk, of violence is a key factor in adolescent girls' decision-making and sense of agency. The threat of gender-based and sexual violence has a constant presence for girls, exacerbated by their age and compounded by other forms of marginalised identity, which significantly impacts their freedom of choice and decision-making. Girls' decisions about who to turn to, when to speak up, how to speak, what questions to ask, where to go, what opportunities are available to

them, and who to associate with are all coloured by the calculations they make about the potential further violence they may experience.[6,11]

A focus on health service responses to violence is vital to the UHC agenda. In addition to the restrictions placed on their mobility as a protective factor, girls face the spectre of sexual, physical, emotional, and economic violence at every turn throughout their lives: whether through sexual exploitation in exchange for school fees or other economic support, physical discipline at home or in schools, street harassment and sexual assault, sexual coercion and intimate partner violence, increased vulnerability to sexual violence as a result of conflict and displacement, or violence in the form of harmful traditional practices.[4,6,11] Displaced adolescents, LGBTQI adolescents, and adolescents living with (dis)ability face up to four times the risk and threat of violence as their peers, and girls who live at the intersections of (dis)ability, displacement, sexuality, and other marginalisation find their risks magnified.[12] Addressing violence cannot be only the responsibility of health systems, and points to the need to ensure that implementation of UHC must engage with ministries and government partners outside of health and finance. In particular, the value of education sector and community partnerships in shifting norms around violence and discrimination, as well as to increase health service provision in places adolescents can safely access, is apparent and under-utilised.[13]

Violence is only one lens through which we recommend refocusing UHC efforts to address vulnerabilities and girls' decision-making ability. We acknowledge and emphasise the need to look beyond poverty and violence to see what prevents adolescents from accessing health services. The UHC agenda has a very strong focus on equity, and implementation will need to take into consideration the many power dynamics within a culture that shape girls' and other marginalised communities' lives. In particular, the ongoing COVID19 crisis lays bare the outsized impacts of complex emergencies on adolescent girls in all their diversity, and the ways in which economic security, education, and access to health services intertwine to shape girls' resilience.

Conclusion: a fully gender-transformative agenda for adolescent girls

When balanced against the UHC focus on structural change to health systems to make them accessible for all, we hope this focus on exploring the factors that influence and shape girls' agency provides a new perspective on key areas for further research and investment. In order to reach the UHC goals, including the all-important goal of "leaving no one behind," health systems will need to reckon with and be prepared to counteract the influence of social and gender inequalities that exist not only within but also beyond their walls.

In the most recent analysis of the *Real Choices, Real Lives* longitudinal cohort study, Plan International researchers have begun to identify "glitches" in the gender socialisation process, or moments in time where girls naturally recognise and challenge gender norms and gender inequality.[3] In particular, girls are sensitive to the different expectations they face in comparison with their male peers when it comes to their responsibility to understand and prevent pregnancy and STI transmission, as well as to safeguard the health of their peers and those around them. These glitches, taken as moments of potential for transformative change, show that gender structures are dynamic and can be shifted towards greater equality, and offer a way forward for investments in adolescent girls' agency and empowerment.

Investing in a comprehensive UHC system which is sensitive and responsive to gender and age will mean acknowledging and addressing these opportunities in order to fully commit to gender-transformative health structures within both health and community settings. Health services for adolescent girls and young women are all-too frequently siloed into sexual and reproductive health care, which is for many adolescent girls their only known access point to health care. SRHR, and particularly adolescent SRHR, is too often labelled "controversial" and vital services are underfunded or left out of a comprehensive care package.[14]

A feminist, agency-centred approach to UHC must go beyond the point of services. In order to ensure that UHC is accessible to adolescents, particularly adolescent girls, in all their diversity, the UHC agenda must:

1. explore discrimination and inequality in access;
2. take an intersectional view of gender alongside other identities and experiences;
3. centre the agency and human rights of all service users; and

4. prioritise meaningful collaboration and participation with girls, women, and marginalised groups through thoughtful and supportive inclusion in all aspects.

Building a universally accessible health system will require going beyond traditional tools for community engagement; we must instead be focused on a radical reimagining of power within both community and health structures. Universal primary health systems must be owned by, supervised by, and accountable to communities, and in particular communities of the most marginalised and vulnerable, if they are to hope to accomplish the global change they seek. For UHC to be truly universal, it must be prepared to bear the responsibility of outreach, of creating space for new voices, and the costs of getting it right, in order to build a health system that is not merely expanded but transformed.

Acknowledgements

The authors would like to gratefully acknowledge Kate Matheson for her support and thought partnership in the development of this analysis.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

Funded by Plan International UK with additional support from the Bill and Melinda Gates Foundation through the Countdown 2030 Europe consortium. All views expressed within are the authors.

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