



REPORT



Adolescent-Friendly Sexual and Reproductive Health Services in Rwanda: Healthcare Workers' Perspectives

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1. BACKGROUND

Good sexual and reproductive health (SRH) is "a state of complete physical, mental and social well-being in all matters relating to the reproductive system" for both men and women, including adolescents. (UNFPA, 2022) Every individual has the right to make their own choices about their SRH and family planning. (United Nations Human Rights, 2018) Adolescent sexual and reproductive health is a global public health concern: young people face specific barriers to accessing SRH services including stigma, lack of confidentiality, restrictive healthcare worker (HCW) attitudes, and the absence of youth-friendly facilities. (Morris & Rushwan, 2015)

Rwanda experiences challenges with the adequate provision of SRH services and commodities. The maternal mortality rate is estimated at 248 per 100,000 live births. Currently, 58% of married women and 48% of sexually active unmarried women are using a modern contraceptive, yet 37% of sexually active unmarried women have unmet family planning needs, and 39% of births in the past five years were unwanted or mistimed. (NISR, MOH & ICF, 2021) Rwanda has invested in adolescent-friendly health services through its national Adolescent-Friendly Service (AFS) accreditation system, which assesses facilities against standards covering privacy, confidentiality, staff training and service range. The National FP/ASRH Strategic Plan 2018–2024 sets out Rwanda's policy commitments to improving adolescent access to SRH services. (MoH, 2018)

In 2022/23, a baseline HCW survey found that 79% of health facilities in the four study districts were accredited as adolescent-friendly and 80% reported providing SRH services to adolescents. (HAI, 2023) This endline survey revisits these indicators in 2026 to assess change. This report presents findings from 71 health facilities across Gasabo, Gatsibo, Nyagatare and Nyarugenge districts. One healthcare worker per facility was interviewed, and data collectors conducted a structured facility observation. Findings are presented alongside 2022 baseline figures to enable trend assessment.

2. RESEARCH METHODOLOGY

The Healthcare Worker Survey is part of the European Union (EU) funded Solutions for Supporting Healthy Adolescents and Rights Protection (SHARP) Project. It was conducted by teams from Rwanda NGO Forum on HIV/AIDS and Health Promotion (RNGOF) and Health Action International (HAI) using a structured questionnaire adapted from the HAI/World Health Organization (WHO) Methodology.¹ The questionnaire covered: (1) the range and conditions of adolescent-friendly SRH (AFSRH) services offered; (2) availability of policy documents and monitoring processes; (3) training, outreach and community engagement activities; (4) healthcare worker attitudes towards adolescent SRH; and (5) physical facility conditions. One healthcare worker per facility was selected as the primary respondent. The facility observation section was completed by the data collector independently.

The sample comprised 71 health facilities: 51 public, 16 private and four faith-based, across all four study districts. The 2022 baseline covered 97 facilities. The reduction in sample size reflects that, during the data collection period, some facilities were found to be non-operational, either due to voluntary closure or government closure related to compliance issues, particularly among health posts and dispensaries, and in such cases, it was also not possible to identify equivalent facilities to replace them in the sample.

Table 1. HCW survey sample in 2026 by district and sector

	Gasabo	Gatsibo	Nyagatare	Nyarugenge	Total
Public	12	13	16	10	51
Private	3	5	2	6	16
Faith-based	2	0	2	0	4
Total	17	18	20	16	71

Baseline 2022: Gasabo n=24, Gatsibo n=26, Nyagatare n=25, Nyarugenge n=22, Total n=97

¹ Measuring Medicine Prices, Availability, Affordability and Price Components. 2nd edition. WHO, HAI. (2008). Geneva: Switzerland.

3. RESULTS

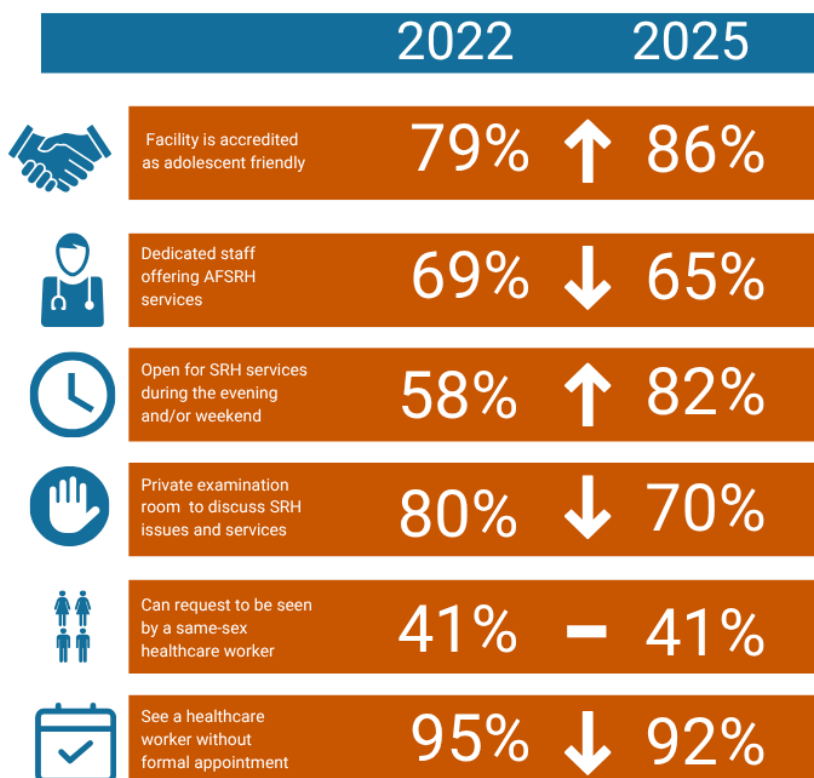
3.1. Adolescent-friendly SRH Services

The proportion of facilities accredited as adolescent-friendly increased from 79% in 2022 to 85.9% in 2026. This improvement was observed across all sectors, with all four faith-based facilities (100%) and 88.2% of public facilities now holding accreditation. The proportion of facilities providing AFSRH services was very high at 94.4% overall, from 80% in 2022.

Walk-in access remained consistently high at 91.5% of facilities, comparable to the 2022 baseline figure of 95%, demonstrating that adolescents can generally access a healthcare worker without needing a formal appointment, an important enabler of service uptake among young people who may be reluctant to seek help through formal channels. However, the proportion of facilities with a dedicated staff member offering adolescent-friendly SRH services declined slightly from 69% in 2022 to 64.8% in 2026. This is a concerning trend, as dedicated staff are critical to the quality and consistency of care provided to adolescents, who benefit from interacting with providers who are specifically trained and assigned to meet their needs rather than serving the general patient population alongside other duties.

Access to a same-sex healthcare worker on request, an important indicator of privacy and acceptability for adolescents seeking sensitive reproductive health services was reported by 40.8% of facilities, a figure that remains essentially unchanged from 2022 (41%). This persistently low proportion across both survey periods suggests a structural gap that has not improved despite broader progress on adolescent-friendly accreditation, and may continue to deter some adolescents, particularly young women, from seeking the services they need.

The availability of private examination rooms declined from 80% in 2022 to 70.4% in 2025. This decline is of particular concern in the private sector, which showed the greatest deficit with only 31.2% of private facilities having a dedicated private examination room. The absence of private consultation space is a significant barrier to confidential and youth-friendly service delivery, as adolescents who cannot be assured of privacy when discussing reproductive health concerns are less likely to disclose their needs fully or return for follow-up care.



A notable positive development was the increase in facilities open during evenings and/or weekends for SRH services, from 58% in 2022 to 81.7% in 2026. This improvement is significant for adolescent access, as after-hours availability reduces the risk of students missing school to attend health facilities. Staff trained in intrauterine device (IUD) insertion declined from 70% to 59.2%, while implant-trained staff increased from 68% to 74.6%.

Table 2. Adolescent-friendly SRH service indicators, 2022 and 2026

Adolescent-friendly SRH service indicators, 2022 and 2026	Baseline 2022 (%)	Public (n=51) (%)	Private (n=16) (%)	Faith-based (n=4) (%)	Overall (n=71) (%)
Service availability					
Facility is accredited as adolescent-friendly	79	88.2	75.0	100.0	85.9
Facility provides AFSRH services to adolescents	80	98.0	81.2	100.0	94.4
Facility has dedicated staff for AFSRH	69	72.5	37.5	75.0	64.8
Facility open evenings and/or weekends for SRH	58	84.3	68.8	100.0	81.7
Adolescents can be seen without formal appointment	95	92.2	87.5	100.0	91.5
Physical access					
Adolescents can request same-sex healthcare worker	41	43.1	43.8	0.0	40.8
Facility has private examination room	80	80.4	31.2	100.	70.4
Clinical capacity					
Staff trained in IUD insertion and removal	70	66.7	50.0	0.0	59.2
Staff trained in implant insertion and removal	68	86.	50.0	25.0	74.6

3.2. Policies, Training and Outreach

Policy documents and guidelines form the essential foundation upon which consistent, high-quality and rights-based service delivery is built. When healthcare workers have access to the relevant laws, strategic plans and clinical guidelines, they are better equipped to provide services that are aligned with national standards and that respect the rights of adolescent clients.

In 2025, 78.9% of facilities had the new Law N° 026/2025 on Healthcare Services available on site. This law, enacted in September 2025, replaces the previous Medical Liability Law 42/2012 and introduces updated provisions governing healthcare service delivery in Rwanda. Because it is a new instrument, no direct comparison with 2022 is possible. The District Work Plan was available in 80.3% of facilities, a marginal improvement from 79% in 2022, indicating that local planning documents remain widely accessible across facility types. The proportion of facilities with processes in place to update staff when new healthcare policies are developed stood at 88.7%, suggesting that most facilities have functional mechanisms for communicating policy changes to their workforce, a critical enabler of responsive service delivery.

The proportion of facilities where staff received a refresher training on AFSRH in the previous 24 months remained similar to the 2022 baseline at 45.1%, compared to 46% in 2022. While the overall figure appears stable, it masks large and deeply concerning sector disparities that demand targeted intervention. In the public sector, 58.8% of facilities reported that staff had received recent refresher training, reflecting the benefit of government-coordinated capacity-building programmes. In stark contrast, only 6.2% of private facilities and 25.0% of faith-based facilities reported recent refresher training. The near-total absence of training in the private sector is particularly alarming given that private facilities serve a significant proportion of adolescents, especially in urban areas, and yet the healthcare workers in these facilities are operating with the least current knowledge and skills for adolescent-friendly service provision. Without deliberate mechanisms to extend training to the private and faith-based sectors through professional associations, accreditation requirements or incentive-based programmes, this gap may persist and widen.

Educational materials on SRH targeted at adolescents were available in 57.7% of facilities, a modest improvement from 54% in 2022, demonstrating some progress in equipping facilities with the information resources adolescents need. Educational materials targeting parents and guardians, which play an important role in building family support for adolescent health-seeking behaviour were available in 43.7% of facilities, up from 34% in 2022, a more notable improvement that reflects growing recognition of the importance of engaging the broader social environment around adolescents. Community outreach for SRH was conducted by 50.7% of facilities, and 52.1% organised group discussions or talks for adolescents on SRH topics within or beyond the facility. These activities are valuable not only for spreading health information but also for normalising conversations about sexual and reproductive health in communities where stigma remains a barrier.

Perhaps the most encouraging finding in this section is the substantial increase in the proportion of facilities with a community committee that provides input into health services, which grew from just 9% in 2022 to 22.5% in 2026. Community committees represent a meaningful mechanism for accountability and for ensuring that health services are responsive to the needs of the communities they serve, including adolescents. This more than doubling of community committee coverage in three years reflects an important structural gain that should be sustained and deepened, with deliberate efforts to ensure that adolescents themselves are represented and given a genuine voice within these committees.

Table 3. Policies, training and outreach indicators, 2022 and 2026

Policies, training and outreach indicators, 2022 and 2025	Baseline 2022 (%)	Public (n=51) (%)	Private (n=16) (%)	Faith-based (n=4) (%)	Overall (n=71) (%)
Policy documents available at facility					
Law N° 026/2025 on Healthcare Services (NEW — no 2022 comparison)	—	82.4	62.5	100.0	78.9
District Work Plan	79	82.4	68.8	100.0	80.3
FP/ASRH Strategic Plan 2018-2024	82	76.5	56.2	100.0	73.2
National HIV/care guidelines	83	82.4	62.5	100.0	78.9
Processes in place to update staff on new policies	81	94.1	68.8	100.0	88.7
Training and outreach					
Staff refresher training on AFSRH in past 24 months	46	58.8	6.2	25.0	45.1
Educational materials for adolescents available	54	72.5	6.2	75.0	57.7
Educational materials for parents/guardians available	34	54.9	6.2	50.0	43.7
Facility provides community outreach on SRH	46	64.7	6.2	50.0	50.7
Facility organises group SRH discussions for adolescents	45	64.7	6.2	75.0	52.1
Community engagement					
Facility has a community committee	9	31.4	0.0	0.0	22.5
Adolescents asked for input on SRH service design	19	31.4	0.0	25.0	23.9
Facility works with adolescent peer educators	33	49.0	0.0	50.0	38.0

3.3 Healthcare Worker Attitudes

Healthcare worker attitudes towards adolescent SRH are critical determinants of service quality and accessibility. Attitudes shape not only what services are offered but how they are offered, whether an adolescent feels judged, welcomed, informed or dismissed. Table 4 presents responses to 11 attitude statements from healthcare workers, compared to 2022 baseline figures, and reveals a picture of mixed progress with one deeply alarming regression.

The most striking and concerning finding of this entire survey is the sharp increase in the proportion of healthcare workers who agreed with the statement “I advise adolescents to abstain from sex when they seek contraceptives at the health facility.” This increased from 43% in 2022 to 85.9% in 2026, a rise of 42.9 percentage points in just three years. This finding is deeply alarming from a public health perspective. Adolescents who present at a health facility seeking contraceptives are already making a responsible and health-seeking decision. They are seeking to protect themselves from unintended pregnancy and, in the case of condoms, from sexually transmitted infections including HIV.

This practice directly undermines the core purpose of adolescent-friendly SRH services and is likely to contribute to increased rates of unintended pregnancy, unsafe abortion and disengagement from health services among young people who feel judged rather than helped. The scale of this shift from fewer than half to nearly nine in ten healthcare workers suggests that this is not an individual phenomenon but a systemic one, potentially reflecting the influence of institutional, religious or community-level norms on clinical practice, or inadequate values clarification in recent training programmes. This finding warrants the most urgent attention from programme managers, district health authorities, national policymakers and the SHARP programme team.

Perceptions of barriers to adolescent access also worsened across multiple indicators, suggesting that the experience of adolescents seeking SRH services at health facilities has deteriorated since 2022. The proportion of healthcare workers who agreed that “costs of SRH services are a barrier to adolescents at this facility” increased from 31% in 2022 to 43.7% in 2026, a 12.7 percentage point increase. This growing perception of cost as a barrier is particularly concerning given that most public-sector SRH services are covered under Rwanda’s community-based health insurance scheme, and may reflect either actual increases in costs charged, gaps in insurance coverage among adolescent clients, or a heightened awareness among healthcare workers of the financial constraints their adolescent clients face. The proportion of healthcare workers who agreed that “waiting times are a barrier to adolescents” rose sharply from 13% in 2022 to 32.4% in 2026, indicating that delays in receiving care are increasingly seen as deterring young people from seeking services or returning for follow-up. Long waiting times are a well-documented barrier to adolescent health service uptake globally, particularly among young people who may be attending facilities discreetly and cannot afford to be seen waiting for extended periods. Most strikingly, the proportion of healthcare workers who agreed that “adolescents feel welcome and safe at this facility” fell dramatically from 96% in 2022 to 77.5% in 2026, a decline of 18.5 percentage points. This shift from near-universal agreement to less than four in five is a significant regression and is particularly troubling when read alongside the abstinence-advising finding: it is plausible that adolescents are feeling less welcome precisely because the attitudes of healthcare workers have shifted in ways that are perceptible to young clients. Similarly, the proportion of healthcare workers who agreed that they have “enough time to sufficiently treat and answer” adolescents’ questions declined from 94% in 2022 to 67.6% in 2026, suggesting that staff capacity constraints are increasingly affecting the quality of adolescent-focused consultations.

More positive findings were observed for attitudes directly related to contraceptive provision, which provide some reassurance that the majority of healthcare workers retain a rights-based orientation towards contraceptive services even as the abstinence-advising finding raises serious concerns about how services are delivered in practice. The proportion of healthcare workers who agreed they were comfortable providing contraceptives to adolescents under 18 years of age was 83.1%, broadly stable compared to 83% in 2022, indicating that the willingness to serve younger adolescents has been maintained. Similarly, 83.1% agreed with providing contraceptives to unmarried women, a consistently high figure that reflects broad acceptance of this dimension of reproductive rights in the Rwandan health system. The proportion of healthcare workers who agreed that “contraceptive use conflicts with my religion and should therefore not be provided to adolescents” declined slightly from 21% in 2022 to 19.7% in 2026, suggesting a modest positive shift in religiously-motivated resistance to contraceptive provision, particularly noteworthy given the high representation of faith-based values in the Rwandan social context.

A note on comparability: the 2022 baseline used a 4-point Likert scale with response options of *Strongly Agree*, *Agree*, *Disagree* and *Strongly Disagree*. The figures presented for 2022 represent the combined proportion of respondents who selected Strongly Agree or Agree. The 2026 endline used a simplified binary Agree/Disagree scale. This change in response format means that direct numerical comparisons between 2022 and 2026 attitude figures should be made with caution, as the binary scale may produce different distributions than a four-point scale. The direction of change observed rather than the precise magnitude should be the primary basis for interpretation.

Table 4. Healthcare worker attitudes regarding adolescent SRH services, 2022 and 2026

Attitude statement (% Agree)	Baseline 2022 (%)	Public (n=51) (%)	Private (n=16) (%)	Faith-based (n=4) (%)	Overall (n=71) (%)
I advise adolescents to abstain from sex when they seek contraceptives	43	90.2	81.2	50.0	85.9
Adolescents should not have sex	44	51.0	25.0	75.0	46.5
I am okay providing contraceptives to unmarried women	88	90.2	81.2	0.0	83.1
I am okay providing contraceptives to adolescents under 18	83	88.2	81.2	25.0	83.1
Contraceptive use conflicts with my religion	21	19.6	6.2	75.0	19.7
I feel comfortable discussing SRH with adolescents	92	84.3	81.2	25.0	80.3
This facility is accessible by foot or public transport	94	58.8	87.5	50.0	64.8
Costs of SRH services are a barrier to adolescents	31	41.2	62.5	0.0	43.7
Waiting times are a barrier to adolescents	13	39.2	18.8	0.0	32.4
Adolescents feel welcome and safe at this facility	96	80.4	81.2	25.0	77.5
I have enough time to treat and answer adolescent questions	94	66.7	75.0	50.0	67.6

Endline 2025 uses binary Agree/Disagree. Baseline 2022 used a 4-point scale; baseline figures = % Agree + Strongly Agree. Red highlight = large change from baseline or concerning finding requiring attention. Yellow = notable decline from baseline.

3.4. Facility Infrastructure and Environment

Data collectors conducted a structured observation of each health facility to assess the physical conditions and visible characteristics relevant to adolescent-friendly service delivery. The findings from these observations are presented in Table 5 and provide an important complement to the self-reported data from healthcare workers, as they reflect what a young person would actually see and experience when entering a facility.

Overall, facilities generally maintained adequate physical infrastructure. Electricity was present in 94.1% of facilities, reflecting Rwanda's significant progress in rural electrification and ensuring that facilities can operate effectively throughout the day and into evening hours. Clean conditions were observed in 91.2% of facilities, and private consultation rooms, essential for confidential discussions about sexual and reproductive health were present in 80.9% of facilities as confirmed by the data collector's observation. These baseline infrastructure indicators suggest that the physical environment in most facilities is conducive to service delivery.

However, the proportion of facilities where SRH materials targeted at adolescents were visibly displayed, such as posters, leaflets, pamphlets or educational videos, was only 42.6%, a notable decline from 57% in 2022. This reduction is concerning because visible SRH information serves two important functions: it raises awareness among adolescents about available services and health topics, and it signals to young people that the facility is a welcoming and safe space where reproductive health is openly discussed without stigma. A facility that displays no SRH materials may inadvertently communicate to an adolescent that such topics are not appropriate to raise, creating an invisible barrier to care-seeking even where services are technically available. Restoring and expanding the availability of adolescent-targeted IEC materials at all facility types should be treated as a priority.

Signage regarding the services offered at the facility was present in 70.6% of facilities, and signage showing operating hours was similarly present in 70.6%. While these figures represent a decline from 80% and 78% respectively in 2022, they nonetheless indicate that the majority of facilities do provide basic orientation information for visitors. Clear and visible signage is particularly important for first-time visitors and for adolescents who may be attending a facility without an accompanying adult, as it helps them navigate the facility and identify the services relevant to their needs independently and with confidence.

Table 5. Facility infrastructure observation, 2022 and 2026

Facility infrastructure observation, 2022 and 2025	Baseline 2022 (%)	Public (n=51) (%)	Private (n=16) (%)	Faith-based (n=4) (%)	Overall (n=71) (%)
Signage with services offered is visible	80	75.5	50.0	100.0	70.6
Signage with operating hours is visible	78	75.5	56.2	66.7	70.6
Facility is accessible by foot or public transport	94	71.4	87.5	33.3	73.5
SRH materials targeted at adolescents are visible	57	57.1	6.2	0.0	42.6
Health facility is clean	98	95.9	75.0	100.0	91.2
Health facility has private consultation rooms	82	81.6	75.0	100.0	80.9
Health facility has electricity	99	95.9	87.5	100.0	94.1
Health facility has running water	84	53.1	68.8	66.7	57.4
Health facility has soap for handwashing	—	73.5	68.8	100.0	73.5
Health facility has clean toilet facilities	81	91.8	81.2	100.0	89.7

4. CONCLUSIONS

The 2025 endline Healthcare Worker Survey reveals a mixed picture of progress and setbacks in adolescent-friendly SRH services in Rwanda's four study districts, showing both notable gains and worrying reversals. On the positive side, several important structural enhancements have been achieved. A greater number of health facilities have attained accreditation as adolescent-friendly, signaling broader compliance with formal standards designed to make services more appropriate for young people. More facilities are also offering services during evenings and on weekends, which reduces scheduling barriers for adolescents who may be in school or working during regular hours. In addition, community engagement mechanisms around adolescent SRH have become stronger, reflecting improved outreach, coordination, and local support that can help link young people to services. Together, these structural improvements represent meaningful progress in creating the enabling environment adolescents need to access care.

At the same time, the survey uncovers serious and urgent concerns that warrant immediate programmatic attention. The most striking and troubling finding is the sharp increase in the proportion of healthcare workers who advise abstinence rather than providing or recommending contraception to adolescents seeking reproductive health services: this proportion rose from 43% in 2022 to 86% in 2026. This dramatic shift in provider advice is particularly alarming because it directly influences the options presented to adolescents and can limit their ability to protect their sexual and reproductive health. Alongside this change, the survey reports declining scores on measures of whether adolescents feel welcome at facilities and whether staff have adequate time to serve them. Those negative attitudinal and interpersonal trends less welcoming environments and perceived time pressures among staff suggest a deterioration in the quality of adolescent-centred care, even as formal accreditation and access hours improve. In other words, structural gains appear to be outpacing, or in some cases masking, backsliding in the attitudes and behaviours of providers that determine the day-to-day experience and quality of care for adolescents.

5. RECOMMENDATIONS

Based on the full survey findings, several priority actions are recommended to strengthen adolescent-friendly sexual and reproductive health services across the four study districts in Rwanda.

1. Address the abstinence-only advising pattern urgently	The most urgent priority is to address the sharp increase in the proportion of healthcare workers who advise adolescents to abstain from sex when they seek contraceptives, which rose from 43% in 2022 to 86% in 2026. This trend requires immediate action through targeted refresher training delivered in collaboration with district health authorities, with a strong emphasis on rights-based, non-judgmental provision of contraceptives to all clients, including adolescents. Such training should reinforce the principle that adolescents who seek contraceptive services are making a responsible health-seeking decision and should be supported with accurate information and respectful counselling rather than being discouraged from accessing care. In addition, attitudinal assessment should be integrated into AFS accreditation reviews so that facility performance is measured not only by structural readiness but also by the values and behaviours of healthcare workers who interact with adolescents.
2. Improve refresher training access in the private sector	A second important priority is to improve access to refresher training in private health facilities. Although the overall proportion of facilities where staff received AFSRH refresher training in the previous 24 months remained at 45.1%, the sector differences are very large, with 58.8% of public facilities reporting recent training compared with only 6.2% of private facilities and 25.0% of faith-based facilities. This imbalance is particularly concerning because adolescents also rely on private and faith-based services, yet providers in those settings appear to have far less access to current adolescent-friendly SRH training. To reduce this gap, programme managers should explore practical mechanisms for bringing private and faith-based providers into national training efforts, including partnerships with professional associations, inclusion within accreditation-related requirements, and incentive-based models that encourage participation. Expanding training more equitably across sectors would help ensure that adolescents receive consistent, high-quality services wherever they seek care.
3. Address the decline in private examination room availability	The decline in private examination room availability also requires attention. The proportion of facilities with private consultation space fell from 80% in 2022 to 70.4% in 2026, and the private sector showed the largest shortfall, with only 31.2% of private facilities having a dedicated private examination room. This finding is especially worrying because confidentiality is central to adolescent-friendly care, particularly when young clients are discussing sensitive reproductive health issues. Adolescents are less likely to disclose their needs fully, or to return for follow-up care, if they cannot be assured of privacy during consultations. For this reason, investment in facility infrastructure should prioritise the protection and expansion of private consultation spaces, including in private facilities where the gap is greatest. Where full structural upgrades are not immediately possible, lower-cost adaptations should be considered to improve privacy and confidentiality for adolescent clients.

4. Reinstate SRH information materials for adolescents	Another key recommendation is to reinstate SRH information materials targeted at adolescents. The proportion of facilities displaying such materials fell from 57% to 42.6%, reducing both access to information and the visible presence of adolescent-friendly messaging in facilities. These materials are important because they help normalise discussions of sexual and reproductive health, increase awareness of available services, and signal to young people that the facility is a safe and welcoming place to seek care. Facilities should therefore be supported to restore posters, leaflets, pamphlets, and other educational resources in visible locations and ensure that the content remains relevant and appropriate for adolescent audiences. Maintaining these materials consistently across facility types would strengthen both service awareness and the broader adolescent-friendly environment.
5. Investigate cost and waiting time barriers	The survey findings also suggest that cost and waiting time barriers should be investigated further. The proportion of healthcare workers who agreed that costs of SRH services are a barrier to adolescents increased from 31% in 2022 to 43.7% in 2026, while the proportion who agreed that waiting times are a barrier rose from 13% to 32.4%. These increases indicate that adolescents may be facing growing financial and time-related obstacles when seeking care, or that healthcare workers are increasingly aware of such challenges. Programme teams should work with facility managers to identify the root causes, including staffing constraints, patient flow, commodity availability, and any insurance-related access issues that may affect adolescents. Once these causes are better understood, facilities can introduce practical measures to reduce delays and ensure that cost does not discourage young people from accessing needed services.
6. Sustain and expand community engagement gains	Community engagement gains should also be sustained and expanded. The proportion of facilities with a community committee increased from 9% in 2022 to 22.5% in 2026, representing an important achievement that should be protected and built upon. Community committees can support accountability, local dialogue, and better responsiveness to the needs of the population, including adolescents. These gains should be deepened by ensuring that adolescents themselves are represented in these structures and given a meaningful voice in discussions and decisions about SRH service delivery. Facilities should also continue working with adolescent peer educators and other community-based actors to strengthen outreach, reduce stigma, and support stronger links between young people and health services.

Finally, broader efforts should be made to strengthen the overall quality of adolescent-centred care. The decline in the proportion of healthcare workers who agreed that adolescents feel welcome and safe at the facility, from 96% in 2022 to 77.5% in 2026, together with the drop in the proportion who agreed they have enough time to treat and answer adolescent questions, from 94% to 67.6%, points to a need for renewed attention to the client experience. Adolescents are more likely to seek care again when they are treated respectfully, listened to carefully, and given adequate time to ask questions and receive clear explanations. Supervisors and programme implementers should therefore reinforce respectful communication, supportive supervision, and workload management so that adolescent consultations are not rushed or judgmental. This will help ensure that the positive structural changes seen in accreditation and service availability are matched by real improvements in the everyday experience of adolescent clients.

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