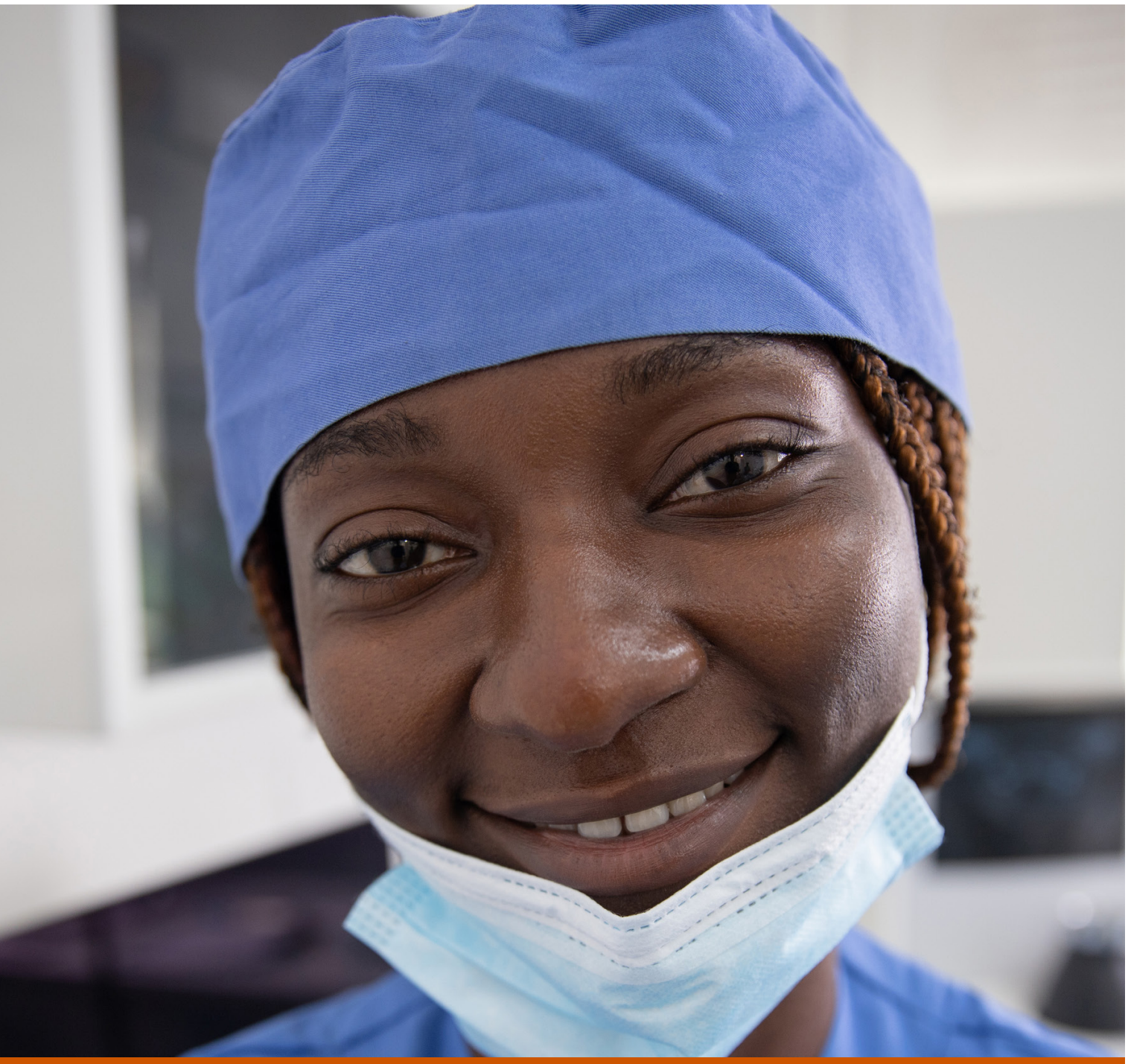

ADOLESCENT-FRIENDLY HEALTH SERVICES IN **RWANDA**

Healthcare Workers' Perspectives on Barriers and Services Offered

sharp
Solutions for Supporting Healthy Adolescents

ADOLESCENT-FRIENDLY HEALTH SERVICES IN **RWANDA**

HEALTHCARE WORKERS' PERSPECTIVES ON BARRIERS AND SERVICES OFFERED

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Acknowledgments
Special thanks to the data collectors for the collection of research data, and the healthcare workers who participated in the research.

JUNE 2023

HEALTH ACTION INTERNATIONAL

Funded by the European Union

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HAIWEB.ORG

This publication has been produced with the financial support of the European Union. Its contents are the sole responsibility of Health Action International and do not necessarily reflect the views of the European Union.

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1. BACKGROUND

Access to sexual and reproductive health (SRH) services forms a crucial building block of health systems. Poor access to SRH services can result in early and unintended pregnancies, maternal mortality, HIV and sexually transmitted infections (STIs), as well as complications from untreated STIs, such as pelvic inflammation, specific types of cancer, and pregnancy and fertility issues. A health system is well equipped to provide SRH commodities and services when people are enabled to decide on pregnancy, to have a healthy pregnancy and safe childbirth, to protect themselves against STIs and HIV/AIDS, and are properly treated in a timely manner if transmission occurs. For a thriving society, it is also crucial that adolescents, a group often faced with additional challenges in accessing services, can access the SRH services they need to live healthy lives and protect themselves against key health risks.

Unfortunately, Rwanda experiences many challenges with the adequate provision of adolescent-friendly SRH (AFSRH) services. This research was conducted to study the provision of AFSRH services and attitudes of healthcare workers in Gasabo, Gatsibo, Nyagatare and Nyarungenge districts in Rwanda.

2. METHODOLOGY

This study was conducted by Rwanda NGO Forum (RNGOF) and Health Action International (HAI) as part of the Solutions for Supporting Healthy Adolescents and Rights Protection (SHARP) programme, funded by the European Union. The research was approved by the Rwanda National Ethics Committee (ref: 465/RNEC/2022) and was supported by the Rwanda Ministry of Health.

This study used an adjusted version of the HAI/World Health Organization (WHO) Methodology[1] and, through a cross-sectional survey design, to gather insight into the provision of AFSRH services in Rwandan health facilities. Teams of data collectors visited 97 health facilities from the public, private, faith-based and associative sectors to assess:

1. The type of SRH services being offered at the health facility.
2. To whom these services were offered, and whether parent/guardian consent was needed.
3. The measures in place at the health facility to improve access to SRH services for adolescents.
4. The attitudes and perspectives of the healthcare worker on AFSRH services.
5. Indicators on the general state of the health facility.

Health facilities that were included in the research ranged from health posts to teaching hospitals. One healthcare worker in every health facility was requested to provide the above information. In addition, eight questions were answered by the data collector based on their observations at the health facility. Healthcare workers were asked for their consent to participate in the study.

1. Measuring Medicine Prices, Availability, Affordability and Price Components. 2nd edition. World Health Organization, Health Action International. (2008). Geneva: Switzerland.

3. FINDINGS

Table 1 shows the distribution of surveyed healthcare workers across sectors and urban/rural locations. A total of 59 healthcare workers from the public sector, 32 from the private sector, and six from the faith-based sector were surveyed.

The specific findings from this report are presented in six different sections: Section 1 describes the provision of adolescent-friendly services, Section 2 goes into detail on the SRH services being offered as well as their costs, Section 3 highlights some of the processes for policies, management and oversight, Section 4 sets out the findings around training, education and outreach, and Section 5 shows statistics on visible characteristics of the health facility, as filled in by the data collectors. Finally, Section 6 focusses on recommendations from healthcare workers to improve the provision of AFSRH services.

Table 1. Number of surveyed healthcare workers per sector and urban/rural location.

	Public	Private	Faith-based	Total
Urban	19	21	3	**43**
Rural	40	11	3	**54**
Total	**59**	**32**	**6**	**97**

3.1 Provision of Adolescent-friendly Services

Overall, 79% of healthcare workers indicated that their health facility was officially accredited as an adolescent-friendly health facility (see Table 2). Interestingly, these numbers differed considerably between the sectors, with the public (98%) and faith-based (100%) sectors having a lot more officially accredited adolescent-friendly facilities than the private sector (41%). Similar numbers of healthcare workers said that their health facility offered AFSRH services, irrespective of whether they were officially accredited as an adolescent-friendly health facility.

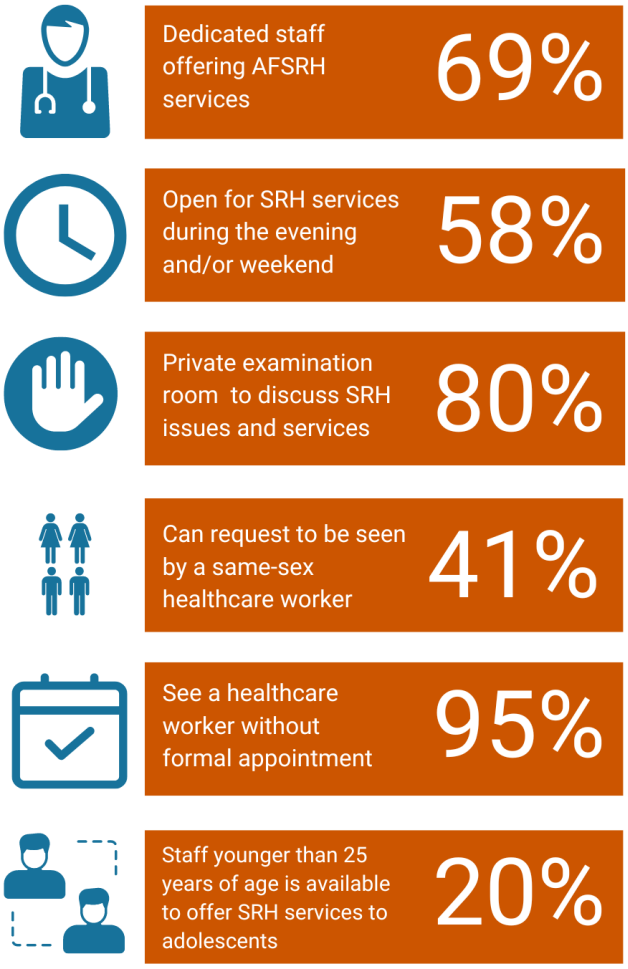
Table 2. Health facilities accredited and offering AFSRH services.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Health facility is an accredited adolescent-friendly health facility	98	41	100	**79**
Health facility provides AFSRH services	97	45	100	**80**

Fifty-two healthcare workers responded to an open question on how services were made adolescent friendly. The most common responses were that adolescents' confidentiality and privacy were respected (32 times). Other common responses were that the health facility had staff trained in AFSRH services (11 times), and that the health facility has a youth-only space/waiting room (nine times). If health facilities did not offer AFSRH services, the healthcare worker was asked for the reason why. In total, 18 healthcare workers answered this question. All of the healthcare workers stated that they do not specialise in AFSRH services, but that they serve all people in general.

Figure 1 lists some common characteristics of adolescent-friendly health services. The study found that, overall, health facilities in Rwanda scored mediocre on these characteristics. For instance, while at 95% of health facilities adolescents could see a healthcare worker without a formal appointment, and 80% had a private examination room, in only 41% of health facilities could they request to be seen by a same-sex healthcare worker. Further, 58% of health facilities were open during the weekend and/or evening, while only 20% of health facilities had staff who are younger than 25 years old and could offer SRH services to adolescents.

Figure 1. Adolescent-friendly organisation of care.



When comparing findings across the sectors, the public sector scored the highest on most indicators, followed by the faith-based sector (see Table 3). For example, 85% and 83% of public and faith-based health facilities, respectively, had dedicated staff offering AFSRH services, compared to 38% in the private sector.

Table 3. Adolescent-friendly organisation of care, per sector.

	Public (%)	Private (%)	Faith-based (%)
Dedicated staff offering AFSRH services	85	38	83
Facility open for SRH services during the evening and/or weekend	63	47	67
Adolescents can see a healthcare worker without formal appointment	95	94	100
Adolescents can request to be seen by a same-sex healthcare worker	49	28	33
Private examination room at the facility where healthcare workers meet with clients to discuss SRH issues and services	92	63	67
Staff working at the health facility who are younger than 25 years and can offer SRH services to adolescents	24	14	17

When zooming in on the ways in which adolescents could make an appointment for SRH services, we found, again, that in almost all health facilities (95%) no appointment was needed (see Figure 2). In the public sector, in 44% of health facilities appointments could be made at the reception, and in 32% of health facilities over the phone (see Annex 1). Other methods for making appointments, such as via text messaging/WhatsApp or online, were generally less commonly used. In the private and faith-based sectors, all options to make appointments were not commonly used.

Figure 2. Ways in which adolescents and youth can make appointments for SRH services.

The survey further asked healthcare workers about their personal opinions on 11 different statements. Their perspectives on these statements can be seen in Table 4. Almost all (96%) healthcare workers indicated that adolescents feel welcome and safe at the health facility, and at ease to access SRH services. Further, 94% of healthcare workers indicated the health facility was easily and safely accessible for adolescents by foot or public transportation, and that they have enough time to sufficiently treat and answer questions of adolescents accessing SRH services. Waiting times at the health facility were seen as a barrier by 13% of surveyed healthcare workers, while cost was mentioned as a barrier to adolescents by 50% and 52% of faith-based and private sector healthcare workers, respectively, and by 19% of those working in the public sector.

Regarding attitudes of healthcare workers, 88% of healthcare workers (92% public, 88% private, 50% faith-based) said they are okay with providing contraceptives to unmarried women. Similar percentages feel comfortable talking about contraceptive and SRH matters with adolescents and providing contraceptives to adolescents. Further, 27% of healthcare workers in the public sector, 61% of healthcare workers in the private sector, and all healthcare workers in the faith-based sector advise adolescents to abstain from sex when they seek contraceptives at the health facility. The percentages of healthcare workers who believe adolescents should not have sex is lower, with 44% of public-, 41% of private-, and 67% of faith-based healthcare workers believing this. About 21% of the surveyed healthcare workers indicated contraceptive use goes against their religion and should therefore not be provided to adolescents, with highest percentage found in the faith-based sector (67%).

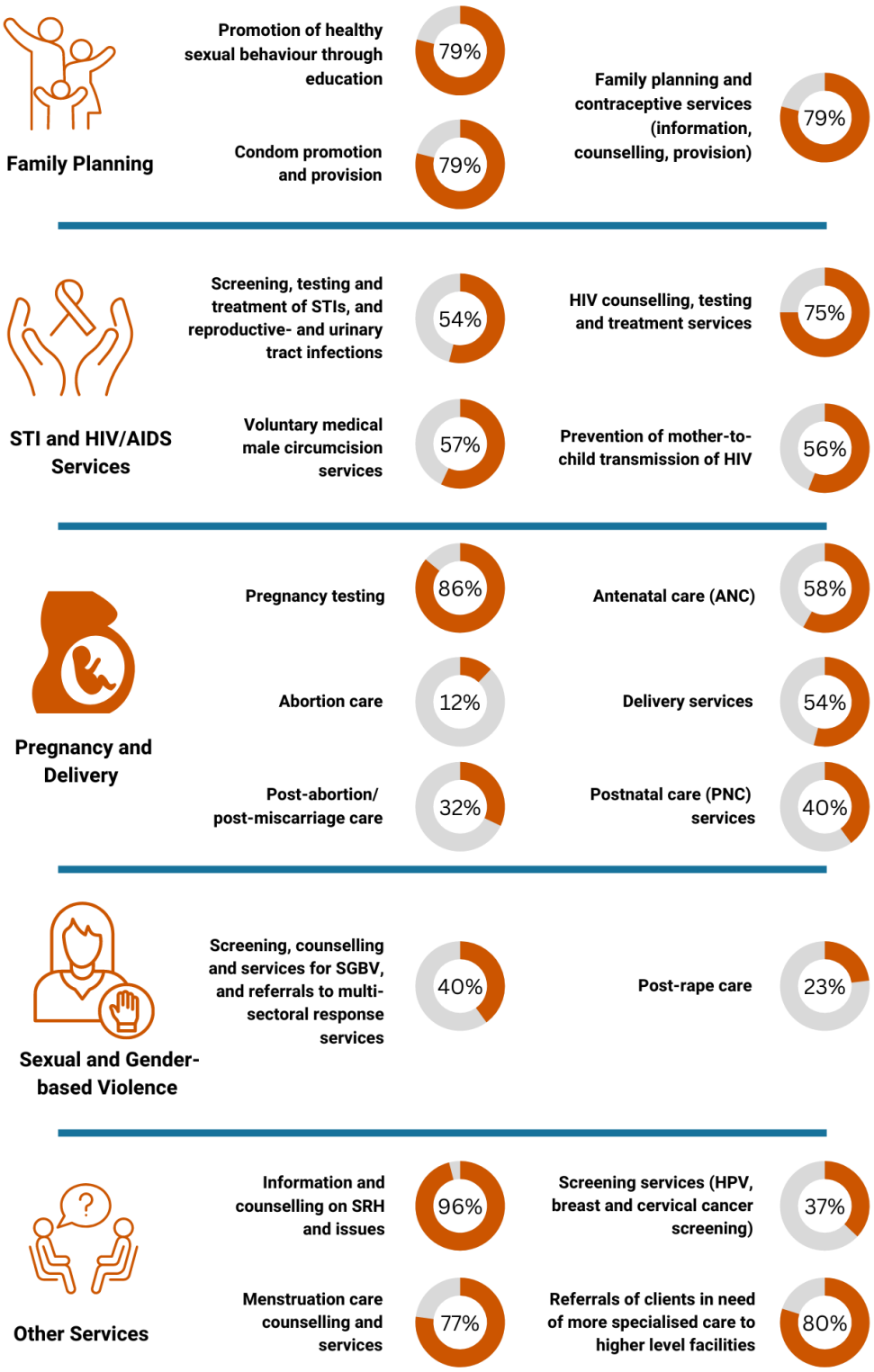
Table 4. Perspectives of healthcare workers on AFSRH services.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
I advise adolescents to abstain from sex when they seek contraceptives at the health facility	27	61	100	**43**
Adolescents should not have sex	44	41	67	**44**
I am okay with providing contraceptives to women who are not married	92	88	50	**88**
I am okay with providing contraceptives to adolescents younger than 18 years	85	87	50	**83**
Contraceptive use goes against my religion and should therefore not be provided to adolescents	19	16	67	**21**
I feel comfortable talking about contraceptives and sexual health matters with adolescents	93	97	50	**92**
This facility is generally easily and safely accessible by foot or public transportation for adolescents	95	94	83	**94**
Costs of SRH services are a barrier to adolescents at this facility	19	52	50	**31**
Waiting times at this facility to receive SRH services are a barrier to adolescents	12	13	17	**13**
Adolescents feel welcome and safe at this facility, and feel at ease to access SRH services	95	97	100	**96**
When offering SRH services to adolescents, I have enough time to sufficiently treat and answer their questions	90	100	100	**94**

3.2 Provision of SRH Services

Figure 3 shows the provision of a broad spectrum of SRH services in all surveyed health facilities. Overall, three of 19 services were offered at 80% or more of health facilities. The most offered SRH services are information and counselling on SRH and issues (96%) and pregnancy testing (86%). The least offered SRH services are abortion care (12% of health facilities) and post-rape care (23%).

Figure 3. Overall percentage of health facilities offering specific SRH Services.



As can be seen in Table 5, when information and counselling on SRH and issues was provided, 97% of facilities also offered it to adolescents under the age of 18. When comparing different sub-groups of adolescents, it was offered without permission from guardians/spouse most frequently to unmarried girls. When promotion of healthy sexual behaviour through education was offered, it was offered to adolescents in 88% of those facilities. The health facilities which offered this service to adolescents were asked whether they provided other means or information to prevent pregnancy besides abstinence. In total, 97% of these health facilities said that they did. When family planning and contraceptive services were offered, 89% of facilities offered this service to adolescents as well. When the health facility offered contraceptives to adolescents, we asked whether adolescents could decide which type of contraceptive they want to use; in 91% of health facilities the adolescent had this choice (public sector 96%, private sector 83%). Condom promotion was offered much less to the younger age groups.

Table 5. Provision of SRH services by health facilities including to specific adolescent groups.

	Information and counselling on SRH and issues	Promotion of healthy sexual behaviour through education	Family planning and contraceptive services	Condom promotion and provision
HFs offering service (%)	96	79	79	79
HFs offering service to adolescents under 18 (%)	97	88	89	97
HFs that offer the service, offer it without permission of guardian/spouse to (%):				
Boys (10-14 years)	85	87	50	83
Boys (15-19 years)	19	16	67	21
Married girls (10-14 years)	93	97	50	92
Married girls (15-19 years)	95	94	83	94
Unmarried girls (10-14 years)	19	52	50	31
Unmarried girls (15-19 years)	12	13	17	13

When comparing the provision of SRH services between sectors, some differences were found. For example, promotion of healthy sexual behaviour through education was offered at 85% of public facilities, 75% of private facilities, and 50% of faith-based facilities (see Table 6). Family planning and contraceptive services, as well as condom promotion, were offered at only 17% of faith-based facilities, and 75% - 88% of public and private facilities. In the private sector, on the other hand, all STI and HIV/AIDS services, pregnancy and delivery services, and sexual- and gender-based violence services were offered at far fewer facilities compared to the public- and faith-based sectors.

Table 6. Percentage of health facilities offering specific SRH services per sector.

	Public (%)	Private (%)	Faith-based (%)
Information and counselling on sexual and reproductive health and issues	95	97	100
Promotion of healthy sexual behaviour through education	85	75	50
Family planning and contraceptive services (information, counselling, provision)	81	88	17
Condom promotion and provision	88	75	17
Menstruation care counselling and services	78	78	67
HIV counselling, testing and treatment services	88	47	100
Prevention of mother-to-child transmission of HIV	71	22	83

	Public (%)	Private (%)	Faith-based (%)
Screening/testing and treatment of STIs, and reproductive- and urinary tract infections	66	25	83
Abortion care	17	6	0
Post-abortion/post-miscarriage care	46	6	33
Pregnancy testing	92	72	100
Antenatal care (ANC)	75	22	83
Delivery services	71	16	83
Postnatal care (PNC) services	53	13	67
Screening services (HPV, breast and cervical cancer screening)	47	16	50
Screening, counselling and services for sexual and gender-based violence, and referrals to multi-sectoral response services	56	9	50
Post rape care	31	6	33
Voluntary medical male circumcision services	71	22	100
Referrals of clients in need of more specialised care to higher level facilities	93	53	100

The survey also asked how many weeks' supply of the birth control pill clients are given per visit; in 45% of health facilities, it was four weeks, with 24% of facilities providing clients with 12 weeks' supply. Fourteen percent of healthcare workers also indicated that the supply depends on the client. Some common long-acting contraceptives are intra-uterine contraceptive devices (IUDs) and implants. They require a trained healthcare worker to insert the product. In the public sector, 78% of the health facilities had a trained healthcare worker who could insert an IUD or a contraceptive implant (see Table 7). In the private sector, 56% of health facilities had a healthcare worker who could insert an IUD and 53% someone who could insert an implant. In the faith-based sector 50%-67% of health facilities had someone who could undertake such a procedure.

Table 7. Capability insertion and removal of intra-uterine contraceptive devices (IUD) and implants.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Someone at the health facility is trained, and can insert and take out an IUD	78	56	67	**70**
Someone at the health facility is trained, and can insert and take out contraceptive implants	78	53	50	**68**

Table 8 displays for which SRH services youth and adolescents must pay. In 60% of public health facilities SRH services are for free. In the private sector, clients did not need to pay for SRH services in 16% health facilities, and in the faith-based sector in 33% of facilities. When looking at the type of products that clients must pay for, they pay for a range of things, including prescription and over-the-counter medications, disposable medical equipment, consultation fees, surgical procedures, lab tests, and day charges for hospitalisation.

Table 8. Costs of services.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
SRH services at the facility which clients need to pay for:				
Family planning	11	74	33	**33**
Maternal health services	39	45	67	**43**
STI treatment services	21	77	33	**40**
HIV/AIDS services	4	23	0	**10**
All of the services are for free	60	16	33	**44**
If any, type of products clients have to pay for:				
Prescription medications	43	40	75	**44**
Over the counter (non-prescription) medications	43	68	25	**54**
Disposable medical equipment (gloves, needles, personal protective equipment)	48	52	25	**48**
Consultation fee	43	60	0	**48**
Day charges for hospitalisation	74	24	50	**48**
Imaging diagnostics	61	16	0	**35**
Surgical procedures	87	28	50	**56**
Lab tests	74	56	50	**63**

3.3 Policies, Management and Oversight

Table 9 provides information on policies and monitoring of the health facility. In the public sector, the most commonly available guideline was the National Guidelines for Comprehensive Care of People Living with HIV in Rwanda (2011) (91%), followed by the National Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan 2018-2024 (90%). In the private sector these were also the most commonly available guidelines, albeit that there they were less available than in the public sector.

The study further found that monitoring of the health facility's SRH services by government officials was done irregularly. In 25% of facilities, government officials visit three or less times during the year. Last, community committees that provide input into the facilities' services and activities, and the involvement of adolescents in the design and implementation of SRH services were very low (9% and 19%, respectively). If adolescents are involved, it is done through group meetings, inclusion in the community committee, through peer educators, or during their visit at the health facility.

Table 9. Policies and monitoring.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
The HF has soft or hard copies of the below guidelines/ policies available for use:				
Medical Liability insurance law no 42/2012 of 22/01/2013 under its article 11: Consent of minors or other incapable persons	68	50	75	**63**
Law No 21/2016 of 20/05/2016 relating to Human Reproductive Health	70	53	75	**65**
District Work Plan	88	61	75	**79**
National Family Planning and Adolescent Sexual and Reproductive Health (FP/ASRH) Strategic Plan 2018-2024	90	67	67	**82**
National guidelines for comprehensive care of people living with HIV in Rwanda (2011)	91	65	80	**83**
Processes are in place at the HF to ensure that staff is updated and informed about changes when a new policy is developed	92	63	83	**81**

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Frequency at which a government official visits to monitor how the health facility is performing with regards to SRH service provision:				
Zero times during the year	2	3	0	**2**
One time during the year	2	25	17	**10**
Two times during the year	12	9	0	**10**
Three times during the year	5	0	0	**3**
Four times during the year (quarterly)	25	0	33	**18**
Five or more times during the year	3	0	0	**2**
At irregular intervals	51	63	50	**55**
Don't know	0	0	0	**0**
The HF has a community committee that provides input into the HF's services and activities	14	0	17	**9**
Adolescents are asked for input into or feedback on the design, planning, implementation and evaluation of SRH services at the HF	25	6	17	**19**

3.4 Training, Education and Outreach

Continuous training of healthcare workers on AFSHR seemed not to occur very regularly: in 61% of the public sector facilities, 40% of the faith-based sector facilities, and 19% of the private sector facilities, healthcare workers had received a refresher training in the last 24 months (see Table 10). Educational SRH materials for adolescents were available at 80% of public health facilities, but only at 33% of faith-based and 9% of private facilities. Education materials for parents/guardians on adolescent SRH services to increase their support were available at fewer public facilities (47%), but the same percentage of faith-based and private facilities. Regarding outreach and education on SRH, 68% of public health facilities provided this for adolescents within the community. This percentage was much lower for private facilities (6%). Similar percentages organised group discussions on SRH. The number of times these group discussions were organised ranged from twice a year to once every week. Peer educators were used by 46% of public health facilities, 33% of faith-based health facilities, and only 9% of private health facilities.

Table 10. Training, education and outreach of the health facility.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Staff have received a refresher training on how to provide AFSRH services in the last 24 months	61	19	40	**46**
Educational materials on SRH and healthy sexual behaviour, such as posters, pamphlets, videos or booklets, targeted at adolescents are available at this facility	80	9	33	**54**
Educational materials with key messages on adolescent SRH targeted at parents/guardians to support adolescents to access services, are available at this facility	47	9	33	**34**
The facility provides outreach and/or education on SRH for adolescents within the community	68	6	50	**46**
If yes, frequency per year:				
Two times	9	0	33	**9**

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Three times	10	0	0	**9**
Four times	33	50	0	**32**
Five times	3	0	0	**2**
Six times	8	0	0	**7**
Monthly	26	0	33	**25**
Twice a month	13	50	0	**14**
Every week	0	0	33	**2**
The facility organises group discussions or talks for adolescents on SRH	68	6	33	**45**
If yes, frequency per month:				
Two times	5	0	50	**8**
Three times	8	0	0	**8**
Four times	40	50	50	**45**
Five times	5	0	0	**5**
Six times	0	0	0	**0**
Monthly	23	0	0	**23**
Twice a month	5	0	0	**5**
Every week	13	50	0	**15**
The facility works with adolescent peer educators to provide outreach services to other adolescents	46	9	33	**33**

3.5 The State of the Health Facility

The information in Table 11 was collected based on observations made by the data collectors when they visited the health facilities. It shows that health facilities, overall, were doing well. Areas of improvement include signage with operating hours visible at the health facility (78% public sector, 75% private sector), and materials on SRH targeted at adolescents are visible or provided at the health facility, which was available at 79% of public facilities, 67% of faith-based facilities, and only 16% of private facilities. In the private sector, the presence of private rooms where consults can be held was also low (59%), while clean toilet facilities were also found at only around 50% of private facilities.

Table 11. Information on the state of the health facility based on observations of data collectors.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
Signage with services offered is available and visible at the health facility	88	63	100	**80**
Signage with operating hours is available and visible at the health facility	78	75	100	**78**
Materials targeted at adolescents on SRH are visible or provided at the facility (posters, leaflets, videos, etc.)	79	16	67	**57**
The health facility is clean	97	100	100	**98**
The health facility has private rooms where consults are held	95	59	83	**82**
The health facility has electricity	100	97	100	**99**
The health facility has soap and running water	95	63	100	**84**
The health facility has clean toilet facilities	95	56	83	**81**

3.6 Recommendations by Healthcare Workers

Forty-three healthcare workers gave suggestions on how to improve access to SRH services for adolescents. A WordCloud based on their responses can be found in Figure 4. From this WordCloud it becomes clear that the many healthcare workers talked about the services that are being provided, and a need to increase the types and access to it. Many healthcare workers also mentioned the need for more staff, more staff training, and better availability of SRH commodities at the health facility. Below are some specific quotes from healthcare workers who voiced what could be done.

"Services to be provided 24/7, there should be a room only for adolescent services, training to many other staff, have more than one staff in that service." HCW1

"Increasing community outreach, increase the number of staff in the service, all the services related to adolescents to be free, having young staff in the service, services to be provided not only at the health facility." HCW2

"Establishing the well-known peer education system for adolescents at community level." HCW3

"Increasing the commodities package at health centre level, establishment of adolescent committees at community level, providing ASRH trainings to other staffs, additional staff in the service to be able to work in evenings and weekends." HCW4

"Even if we give contraceptives to adolescents under 18 [...], it is prohibited by the law, the law and policies about ASRH must be changed." HCW5

Figure 4. WordCloud on what could be improved to enable better access to AFSRH services at the health facility.

4. RECOMMENDATIONS

The Convention on the Rights of the Child (1989) (in Article 24) and the African Charter on the Welfare and Rights of the African Child (ACWRAC) (in Article 14) call on governments to 'recognise the right of the child to the enjoyment of the highest attainable standard of health'.[2,3] The ACWRAC (in Article 4) states, 'In all actions concerning the child (person below age 18) undertaken by any person or authority, the best interest of the child shall be the primary consideration.' The government thus has an obligation to consider the evolving capacities of the adolescents, and to provide services and empowerment programmes that ensure their SRH and rights are observed and respected.

This study has shown that, in general, Rwanda is making strides in offering adolescent-friendly SRH services. In the public sector, 98% of health facilities were accredited as adolescent-friendly, and 85% had dedicated staff offering AFSRH services. In the private sector, these numbers were generally lower. However, there are also still areas where AFSRH services in Rwanda can be improved. Below, some of these areas are highlighted, and recommendations on how to improve services are provided. One general recommendation is that partnerships between the government and the private sector should be increased and strengthened so SRH services in the private sector are also up to par. Further, the government should increase the regular monitoring of SRH services offered at health facilities, across all three sectors, since more than half of health facilities are monitored irregularly, and 20% of health facilities are monitored at least quarterly.

Opening Hours

The issue of opening hours largely affects provision of ASFRH services. This study found that 58% of surveyed facilities are not open during the evening or the weekend. Hence, provision of services is limited, especially for adolescents who go to school during the day. To improve access to AFSRH services, the government should improve efficiency and effectiveness at the health facilities, youth-friendly corners and youth-friendly centres:

- Increasing the opening hours in the evening, and opening the health facilities, youth-friendly corners and youth-friendly centers for specified hours during the weekend.

Healthcare Workers and Adolescent Involvement

This study has shown that only 20% of health facilities had staff of 25 years of age or younger available to offer AFSRH services. There is thus a lack of age-appropriate healthcare workers able to facilitate the needs of adolescents seeking these services. Adolescents often face issues with opening up about their need for services:

- Talking to healthcare workers that are close in age who can help guide them on provision of SRH services without discrimination or humiliation, can help remove this barrier.
- There is a need for meaningful involvement of adolescents in the design and implementation of SRH programmes within health facilities, and youth-friendly centres and corners.
- There is also a need to strengthen the peer education system for adolescents, whereby Adolescent Peer Educators can be fully empowered and are able to provide high quality and adolescent-friendly SRH services and commodities to their fellow peers, without stigma and discrimination.

2. UN General Assembly, Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3.

3. Organization of African Unity (OAU), African Charter on the Rights and Welfare of the Child, 11 July 1990, CAB/LEG/24.9/49 (1990).

Costs of Care

In this study, it was shown that healthcare providers saw affordability of SRH services as a problem for adolescents. This was especially the case in the private and faith-based sectors:

- The government and development partners should improve the supply chain of commodities, including for contraceptives at the health centre level.
- Special focus should be put on the youth-friendly corners and centres to ensure costs for adolescents are not the reason why they are not accessing services.

Dedicated Staff

While 85% of public sector health facilities and 83% of faith-based health facilities had dedicated staff offering AFSRH services, in the private sector this was only the case in 38% of health facilities:

- This poses a huge threat to the provision of AFSRH services because there is a need for staff who are dedicated to assist adolescents and who are assigned specifically to aid in the SRH service provision to adolescents to ensure the best possible care.
- As previously mentioned, there is a need to strengthen the peer education system for adolescents.

Adolescent-friendly Spaces and Materials

This study showed that there is a poor utilisation or lack of AFSRH spaces and materials, specifically in private facilities. A private examination was for example present in 63% of private health facilities, and education materials targeted at adolescents were available at only 9%. To tackle this, the government, in collaboration with the private sector, should:

- Strengthen the capacity of healthcare workers through training and mentorship on adolescent-friendly, gender- and disability-inclusive SRH service provision.
- Conduct mass media interventions for awareness creation and demand generation for SRH services and contraceptives among adolescents.
- Equip health facilities, and youth-friendly corners and centres with up-to-date IEC materials on SRH.

Post-rape and Abortion Care

In Rwanda, post-rape care (offered by 23% of facilities), abortion care (offered by 12% of facilities) and post-abortion care (offered by 32% of facilities) are services that are lagging behind. For instance, there is a lack psychosocial support and counselling, post-rape kits are not provided, and there is a lack of knowledge and guidance on legal procedures to follow. The following steps should be taken to improve these services:

- Conduct awareness-raising campaigns among adolescents, the community and healthcare workers regarding the existing laws or policies that stipulate the provision of post-rape and safe abortion services.
- Advocate for the development and dissemination of guidelines for the counselling of victims of rape and violence to all health facilities, and youth-friendly corners and centres.

ANNEX 1

Table 1. Ways in which adolescents and youth can make appointments for SRH services*.

	Public (%)	Private (%)	Faith-based (%)	Overall (%)
At the reception	44	28	17	**37**
Over the phone	32	28	17	**30**
Via text messaging/WhatsApp	22	19	17	**21**
Online	19	9	17	**15**
No appointment needed/walk in	95	94	100	**95**

*Multiple answers were possible.

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